Ministry of
Children and Family
Development

Working with Specific Groups of Children and Youth at Risk for Suicide

A supplemental guide for mental health practitioners focused on Indigenous and LGBTQ2S+ youth, self-harming practices, and the role of social media in recognizing and responding to suicidal behaviours

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Background

Recently published provincial reports confirm that suicide and suicidal behaviours among youth in British Columbia remain serious concerns. Suicide is the leading cause of injury-related death among children and youth in BC, surpassing deaths due to motor vehicle accidents or overdoses (BC Coroners Service, 2019).

The most recent **Adolescent Health Survey** from the McCreary Centre Society (Smith, et al. 2019) documents that 17% of students in BC, grades 7-12, seriously considered killing themselves in the last year. Five per cent of the youth surveyed reported that they had made a suicide attempt in the last year. More females attempted suicide in the previous year (7%) compared with males (3%). A total of 17% of students had cut or injured themselves on purpose without trying to kill themselves in the past year, which was an increase from 15% in 2013. Meanwhile, 17% of youth reported engaging in non-suicidal self-harming behaviours. Forty-seven per cent of non-binary youth self-harmed in the past year.

The **BC Coroners Service** conducted a review of the circumstances of all youth (age 10-18) suicides in the province over the five-year period of 2013-2018. There were 111 suicides among youth during this time. The frequency of suicides among this age group has remained relatively stable over the past 20 years, with an average of 19 deaths per year, representing a rate of 5.7 per 100,000 (BC Coroners Service, 2019). Older youth (15-18) were more likely to die by suicide than those who were under 15. The most common method for suicide was hanging, followed by firearms, and jumping from a height. Three times as many males died by suicide than females. Indigenous youth were disproportionately represented, with 23% of all youth suicides identified as Indigenous.

In 2014, the Child and Youth Mental Health Policy Team published, ***Practice Guidelines for Working With Children and Youth At-Risk for Suicide in Community Mental Health Settings.*** The purpose was to provide Child and Youth Mental Health (CYMH) practitioners with up-to-date guidelines that could support their therapeutic work with children and youth at risk for suicide and suicidal behaviours. The guidelines described recommended approaches for assessing and responding to suicidal behaviours among children and youth aged 19 and under, with a specific focus on community-based treatment contexts. Emphasis was given to research-informed, strengths-based, culturally responsive, socially just approaches, which situate suicidal distress within specific contexts and recognize young people and their families as knowledgeable and capable collaborators.

The following **values and principles** guided the compilation of the practice guidelines:

- Youth and parent engagement
- Culturally responsive
- Family-centred care
- Communities as healing contexts
- Inter-professional collaboration
- Transdisciplinary

- Critical health literacy
- Flexible
- Context sensitive
- Aspirational
- Research informed
- Social justice oriented
- Practical & realistic
- Trauma-informed care

Impetus for the Supplement

Six years after the publication of the *Practice Guidelines for Working with Children and Youth At-Risk for Suicide in Community Mental Health Settings*, rates of suicide and suicidal behavior in British Columbia have remained steady. Based on a consultation process with selected CYMH practitioners in 2019, it became apparent that the *Practice Guidelines* were generally perceived to be useful, but that they could be enhanced even further through the addition of specific content. As a way to reflect the complexity and severity of distress that many young people who attend CYMH exhibit, and to support practitioners in their roles, CYMH practitioners recommended that new content be added.

In this 2020 supplement, particular attention is given to addressing the needs, concerns, and contexts of **Indigenous youth[1]; LGBTQ2S+ youth**[2]; as well as **youth who engage in self-harming practices[3]**. Content that addresses the **digital lives of young people** and the role of social media in recognizing and responding to suicidal behaviours has also been included as well.

While the original practice guidelines, and this supplement, are aimed at CYMH practitioners, it is important to clarify that youth suicide is complex and its prevention will require multiple, multi-sector strategies that go beyond the provision of formal health/mental health services to **engage with the social determinants of mental health** (World Health Organization, 2014). This includes taking specific actions to eradicate childhood trauma and abuse, family violence, poverty, racism, economic inequality, discrimination against sexual and gender minorities, bullying, and other forms of adversity – all of which have been linked to increased risks for mental health problems and suicide (Cha, et al. 2018; Rose, 2019; WHO, 2014; Wikinson & Pickett, 2018). **Policies, community education, and institutional practices** need to be mobilized alongside **individual mental health services** as part of any comprehensive youth suicide prevention strategy.

[1] For the purposes here "Indigenous" is an inclusive category that includes First Nations, Inuit and Métis children and youth, regardless of where they live.

[2] LGBTQ2S+ is an inclusive category that includes lesbian, gay, bisexual, transgender, two-spirit, questioning, non-binary, gender non-conforming, intersex, asexual and queer youth. Throughout this document, other umbrella terms such as "queer" or "sexual and gender minority youth (SGMY)" will be used inter-changeably with LGBTQ2S+

[3] Self-harm refers to non-suicidal self-injuries which typically take place in the absence of an intention to die.

Approach & Organization

Informed by the guiding values of the original document, this supplement considers context-sensitive, research-informed, culturally responsive, trauma-informed, youth and family-centred care to be central pillars of the therapeutic relationship when working with youth at risk for suicide and self-harm. Cultivating a relationship based on **mutual respect, recognition, cultural humility**, and also being able to **witness another's experience** of distress through **empathy, care** and **understanding** is key (Lachal, et al. 2015).

The material summarized here is meant to amplify and contextualize (not replace) the content included in the original *Practice Guidelines*. For example, several promising treatments exist which specifically target depression and suicidal behaviours among youth (e.g., CBT; DBT) (McCauley, et al. 2018; Oud, et al. 2019) and these were summarized in the original *Practice Guidelines*. For this supplement, attention is focused on **youth who are marginalized** (e.g., LGBTQTS+ or Indigenous youth), who often face **unique stressors** related to racism, colonialism, heteronormativity, and bi/trans/homophobia. Reflecting the commitment to **critical health literacy,** which was a guiding principle in the original *Practice Guidelines*, this supplement continues to place value on critical approaches that challenge dominant assumptions, recognize the role of power relations in experiences of mental health, and mobilize social and political actions to address inequities and injustice.

Many well-established mental health interventions have been designed and tested with Euro-western populations; however many questions remain about their effectiveness and appropriateness for young people, ethno-racial groups, and other cultural minorities (Blackdeer & Wolf, 2020; Gone, 2015: Ralph & Ryan, 2017). As a result, we need to be prepared to **culturally tailor approaches** and consider a **diversity of practices** that can respond to the unique histories, contexts, and challenges faced by minoritized youth. For example, youth who are non-white, queer, or transgender face unique stressors as a result of living in a world that stigmatizes, marginalizes, and/or mis-recognizes them, which can leave some of these youth more vulnerable to mental health problems, including depression, substance misuse, self-harm, and suicidality (Bochicchio, et al., 2020).

The supplement is organized into four main sections:

1. Given the disproportionately high rates of suicide and suicidal behaviours observed among Indigenous youth in BC, the first section summarizes promising approaches for working with Indigenous youth in culturally safe and meaningful ways.
2. The second section addresses the unique needs of sexual and gender minority youth (SGMY) youth who also experience elevated rates of suicide and self-harm, relative to their heterosexual and cis-gendered counterparts.
3. The third section summarizes strategies for working in a compassionate and useful way with youth who engage in self-harming practices.

4. The fourth and final section is devoted to addressing social media and youth suicide prevention.

Throughout this supplement, there is explicit consideration given to **conceptualizations of suicidal despair**, which do not necessarily take depression - or other mental health disorders- as the natural, or only, starting place. In many cases, suicidality and self-harming behaviours among these populations can be helpfully understood as *responses* to particular histories and contexts of injustice and hate (Richardson, 2016; Reynolds, 2016).

When it comes to thinking about **youth identity**, there is a strong emphasis placed on **intersectionality**. An **intersectional framework** (Havinsky, 2014) conceptualizes identity as multiple and fluid. Race, ethnicity, sexual orientation, gender identity, ability and class all intersect with one another along multiple axes of oppression and privilege. An intersectional mindset can be a helpful framework for mental health practitioners to adopt. Specifically, it can illuminate that some youth (e.g., racialized trans youth or two-spirit Indigenous youth), face multiple forms of oppression and stigma as a consequence of living in a world that continues to see straight, white, cis-gendered, and able-bodied youth as the normative centre (Erney & Weber, 2018).

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Indigenous Youth

The resilience and strength of Indigenous children, youth, families and communities is undeniable and is all the more remarkable when considered in the context of colonial violence, land theft, genocide, forced separation of children from their families, multi-generational losses, historical trauma, and the legacy of residential schools. At the same time, colonization has had a pervasive, collective and corrosive impact on Indigenous peoples' health and well-being (Gone et al., 2019). For several decades now, disproportionately high rates of suicide (as well as other negative health outcomes such as substance misuse, self-harm, and trauma-related conditions) have been observed among Indigenous peoples, relative to the general population (Cha et al., 2018; Gone et al., 2019). In addition to contributing to elevated suicide rates, **institutional racism and colonial violence** have also led to social and economic disadvantage (e.g., entrenched poverty, unstable or overcrowded housing, high levels of unemployment); inequitable funding, over-representation of Indigenous children in the child welfare system, distrust of service providers and lack of access to basic services among many Indigenous peoples (Goodkind et al., 2011; Gone, 2013).

In order to provide **meaningful, contextualized and culturally safe mental health care** to Indigenous youth, practitioners need to understand the role of historical trauma and ongoing colonial violence in the lives of Indigenous children, youth, families and communities (Blackdeer & Silver Wolf, 2020; Goodkind, et al. 2011).

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Indigenous Healing Frameworks

When Indigenous youth have a strong **connection to their culture, teachings, and spiritual practices**, they are less likely to experience poor mental health, including depression and suicide (Goodkind, et al. 2011). The **First Nations Mental Wellness Continuum Framework** (Health Canada, 2015) articulates a comprehensive way of thinking about mental wellness that is grounded in Indigenous culture and values and draws on a holistic notion of personhood. More specifically:

> Mental wellness is supported by culture, language, Elders, families, and creation, and is necessary for healthy individual, community and family life. First Nations embrace the achievement of whole health—physical, mental, emotional, spiritual, social, and economic wellbeing— through a coordinated, comprehensive approach that respects, values, and utilizes First Nations cultural knowledge, approaches, languages, and ways of knowing (p. 1).

At the centre of the Mental Wellness Continuum (Health Canada, 2015) are hope, meaning, purpose, and belonging. These are the cultural foundations for living well:

> **Hope** refers to imagining a positive future for oneself and one's family that is grounded in a strong sense of identity, Indigenous values, and a belief in spirit.
>
> **Meaning** encompasses the past, present and future and comes through a recognition of the interconnectedness of life, where individuals, families and communities are all part of creation.
>
> **Purpose** comes through activities of daily living that make a meaningful contribution, including caring for oneself and others, pursuing meaningful work or education, or reconnecting with culture.

Belonging arises from the knowledge and experience of being deeply intertwined with the living world, including families, communities, culture, and the environment.

A **holistic understanding of health and wellness** does not separate mental health from physical, emotional, or spiritual health. It means seeing persons as **relational beings** who are in active relationships with families, ancestors, future generations, plants, animals and the natural living world. Healing efforts that **build on existing cultural strengths, support connections to family and culture**, and centre Indigenous ceremonies, stories, and worldviews are important pathways to healing for many Indigenous youth.

Historical Trauma and Culture as Healing

Indigenous historical trauma is distinct from other forms of psychological trauma because it is *colonial* in origin, *collective* in impact, *cumulative* across adverse events and *cross-generational* in the transmission of risks and vulnerability (Gone, et al. 2019, p.21, emphasis in original). When indicators of depression and suicide among Indigenous youth are understood through the lens of historical trauma, the treatment can shift towards enabling increased **participation in traditional cultural practices** that involve Elders and healers, and incorporate local healing traditions (e.g., sweat lodges, smudging ceremonies, talking circles) (Gone, 2013). This shift in the areas of spiritual transformation, collective identity, purpose and meaning-making create powerful possibilities for cultural reclamation. They also stand as important **counter-colonial interventions**. In this way, **'culture as treatment'** is simultaneously spiritual, political and pragmatic (Gone, 2013).

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Culturally Safe and Accountable Care

Given the rich diversity across First Nations, Métis and Inuit communities, it is essential that practitioners take the time to get to know the particular circumstances, cultural traditions and histories of the youth they are working with as a way to **avoid simplistic explanations** or stereotypical understandings. Many Indigenous youth are no longer living in their home communities, and as a result of **colonization**, many have fractured relationships with their own cultural contexts, communities and traditions. In BC, the vast majority of Indigenous peoples are living "off-reserve" in urban contexts. Mental health practitioners should make every effort to **understand the unique family histories and cultural pathways** shaping the lives of the particular Indigenous youth and families they are working with. As part of

culturally safe care, practitioners should also **recognize themselves as culture-bearers,** who bring their own cultural knowledge, assumptions and worldviews to the therapeutic relationship.

Beyond providing '**culturally safe'** care, which typically means providing care based on respectful engagement in an **environment free of racism and discrimination**, where power imbalances are addressed to achieve the outcome of **safety for all clients** (BC First Nations Health Authority), practitioners are also encouraged to cultivate a stance of cultural humility (Goodkind, et al, 2011). **Cultural humility** typically involves engaging in processes of **ongoing self-reflection and critique**, undertaking efforts to reduce imbalances in power, and developing genuine partnerships. According to Tait, Mussell and Henry (2019):

> Cultural humility places the onus on the service provider to approach interactions with Indigenous clients in a humble and open manner, recognizing a bicultural exchange where both parties bring unique perspectives, understandings, and cultural experiences (p. 24).

Other aspects that contribute to **culturally safe and accountable care** include (Goodkind et al, 2011; Gone, 2004; Ralph & Ryan, 2017; Richardson & Reynolds, 2014):

- Recognize that counselling and therapy are never neutral and many mainstream evidence-based mental health practices are based on the experiences of western, white, European populations
- Intentionally create a space of trust, safety, and respect
- Be aware of one's own cultural assumptions, biases and values and how this affects practice
- Be knowledgeable about clients' cultural contexts, histories and worldviews
- Understand the harm caused by structural racism, discrimination and harmful stereotyping
- Ensure all assessment and treatment practices are culturally appropriate and build on individual and cultural strengths
- Work collaboratively with Elders, traditional healers, and other community members in response to youth needs and preferences
- Create opportunities for the active involvement of youth in determining culturally safe care
- Include family member perspectives in treatment planning

Culturally safe, appropriate and accountable care for Indigenous youth is not something that can be standardized or pre-packaged in advance. It requires an understanding of the **cultural diversity among and within Indigenous groups**; a recognition of the high levels of mobility, intersectionality, and increasing urbanization within this population, and an appreciation for the complexity of living in this globalized, highly networked, digital age. Themes of **fluidity, dexterity, and hybridity** are helpful to think about when working with First Nations, Métis or Inuit youth and their families across these multiple sites of cultural differences and fluid identities (Gone, 2015).

Promising Approaches

Our Life Program

As part of a broader suite of interventions aimed at supporting the mental health of Native American youth, the *Our Life* program is a six-month intervention that draws on **cultural teachings and traditional ceremonies** as a way to facilitate Indigenous youth well-being (Goodkind et al., 2012). Initial results from a preliminary evaluation indicated that this was a promising program that led to favourable results (Blackdeer & Silver Wolf, 2020). The program is offered through a **psychoeducational group** structure. Key features of the program include:

- Recognizing and healing historical trauma
- Reconnecting to traditional culture
- Social skill building
- Strengthening family relationships

Response-Based Practices and Structuring Safety

Response-based practice, which is explicitly grounded in a **commitment to social justice**, is one possible framework to consider. Rather than conceptualize Indigenous youth who engage in suicidal behaviours as mentally ill or passive victims, it can be helpful to recognize their suicidal actions as **active forms of resistance** to violence, injustice and mistreatment (Richardson, 2016). Such a "**response-based**" approach recognizes that even in the most adverse and dire of circumstances, individuals respond in ways that reveal their capacities for resistance against injustice. Practitioners can actively work against reproducing colonial violence by exploring *how* young Indigenous people have responded to, and resisted, historical trauma and practices of cultural genocide, which in some cases may include silence, withdrawal, self-harm, substance use, and suicide. Assisting young people to see suicidal behaviours as '**understandable forms of protest'** or '**spirited refusals** to be dominated' can open up new possibilities for living that centre dignity, justice, and human agency (Richardson, 2016).

Through **helpful curiosity**, asking questions that **centre the person's dignity** and wisdom, **anticipating potential risks**, and **negotiating consent** as an ongoing process, practitioners can begin the process of structuring safety. **Structuring safety** is particularly important when working with survivors of historical trauma and their families. It involves taking careful and deliberate steps to allow for predictability, consistency, and **'safe-enough' conversations** to take place (Richardson & Reynolds, 2014). Example questions that practitioners might ask themselves as they begin the process of structuring safety include (Richardson & Reynolds, 2014):

- How does this space (room, agency, office) foster safety?
- How does my performance of myself (tone, posture, clothing, attitude) foster safety?

- How do I locate my privilege and acknowledge my cultural location in an attempt to foster safety? (p.152)

Micro-Reconciliation

In addition to supporting Indigenous youth through the provision of culturally safe and accountable mental health interventions, there is also a need to engage in **system-level and structural reforms**. This includes addressing the social determinants of Indigenous health to redress well-documented inequities in education, income, access to services, employment, safe housing, food security and funding for child and family services. It also means following through on the Calls to Action made by the **Truth and Reconciliation Commission of Canada**, which includes settling Indigenous land claims, implementation of Indigenous rights and First Nations' Treaty Rights, and reforming the health and human service sector (Tait, Mussell & Henry, 2019).

In addition to these vitally important structural changes at the macro-level, there is also another level where **transformative work** can and must occur and that is in the **everyday interactions** between First Nations, Inuit and Métis peoples and Canada's settler population. This **inter-subjective and ethical space** can be thought of as a site for '**micro-reconciliation**" (Tait, Musell & Henry, 2019). Micro-reconciliation efforts are optimally suited to take place in everyday work environments where there is an individual and collective investment in reconciliation. Micro-reconciliation is collective work that needs to be done together with Indigenous peoples taking the lead and driving the change.

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It is through three overlapping practices where actions towards micro-reconciliation may be realized: acknowledgement, witnessing, and moral courage. These are elaborated below (Tait, Mussell & Henry, 2019):

> **Acknowledgement** - genuine inter-subjective acknowledgement in local settings of the degree and impact of trauma and injustices experienced by Indigenous peoples (p. 28)
>
> **Witnessing-** ability of the collective workforce to critically assess taken-for-granted assumptions held about Indigenous peoples that are built into institutional structures and daily practices across the human service sector (p. 30)
>
> **Moral Courage**- In a reconciliation climate that supports a safe environment for individuals to speak up (providers and recipients), leaders, administrators, and mentors within the system must be empowered to constructively redirect abuse, prejudice, and discrimination towards

transformative dialogue, solutions, structural change, and forms of restitution. Indigenous knowledge keepers are key facilitators in this process (p. 32)

System-Level Transformations

Recent efforts have been undertaken by First Nations communities to transform their mental health services in ways that are directly responsive to the needs of Indigenous, youth, families and communities. For example, the Eskasoni First Nation of Eastern Cape Breton Island recently re-configured their whole mental health service delivery system to be **community-led and owned**. Priorities included: early identification; rapid access (i.e., user friendly and barrier-free); appropriate care; continuity of care; meaningful youth and family engagement; and research and evaluation (Hutt-McLeod, et al. 2019). The concept of '**two-eyed seeing'** informs their approach to service delivery. Two-eyed seeing is based on the idea that both Western and Indigenous ways of knowing/practicing have unique and valuable contributions to make in supporting youth well-being. A team approach means youth have access to a range of supports, cultural activities, laddered care, and multiple providers including lay persons, peers as well as specialized mental health practitioners. The guiding philosophy is to meet youth where they are at, engage them in what interests them, and also teach and learn about wellness from a holistic and culturally informed perspective.

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Other organizational and **system-level** considerations include (Goodkind et al, 2011; Gone, 2004):

- Develop organizational cultural competence (e.g., leadership commitments to anti-racism and decolonizing practices through education, policies, supervision)
- Aim for accessible, barrier-free, youth friendly, culturally appropriate services that meet young people where they are
- Provide ongoing decolonizing and anti-racism training for white and racialized settler practitioners aimed at dismantling anti-Indigenous racism and harmful stereotyping
- Remunerate Indigenous healers, knowledge keepers and Elders for their service and expertise
- Evaluate clinical processes and outcomes for their positive and (potential) negative impacts
- Engage in deliberate hiring practices to ensure diversity of clinical and administrative staff
- Support, mentor and hire Indigenous practitioners, managers, and health care leaders

LGBTQ2S+ Youth

A robust body of research confirms that sexual and gender minority youth (i.e., lesbian, gay, bisexual, transgender, questioning, two-spirit, genderqueer) are at elevated risk for mental health problems such as depression, suicidality, substance misuse, and self-harm when compared with their straight, cis-gendered peers (Bochicchio, et al., 2020; Cha, et al., 2018; Mc Dermott. & Roen, 2016). These **mental health inequities** have largely been explained in terms of 'minority stress' which recognizes that the difficulties experienced by many LGBTQ2S+ youth is a **consequence of living in a heteronormative, cisgender dominant society** (Bidell & Stepleman, 2017). Queer youth are more likely to experience family rejection, peer victimization and harassment, social exclusion, and discrimination, which in turn, potentially heightens their vulnerability to depression, suicide and self-harm. In other words, there is nothing that makes LGBTQ2S+ youth inherently unstable or suicidal. It is the cumulative effects of negative, invalidating and hostile responses from their families, peers, and other key socializing contexts that contribute to poor mental health outcomes among this group (Bidell & Stepleman,2017; Levy, Russon & Diamond, 2016).

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For some of these youth, suicidal behavior and self-harming practices come to 'make sense' as a response to, or escape from, discrimination, mis-recognition, and marginalization. When LGBTQ2S+ youth also live in contexts of material deprivation and/or experience other forms of violence and oppression (i.e., anti-Black racism or colonial violence), the risks for self-harm and suicide are often intensified (McDermott & Roen, 2016). More specifically, Indigenous and racialized youth who identify as LGBTQ2S+ are more likely to experience family rejection, be placed in multiple out-of-home care settings, face insecure housing and/or homelessness, experience poorer education outcomes and come to the attention of the justice system more often than their straight, white, cis gendered peers (Erney & Weber, 2018). Thus, competent and affirming mental health care for LGBTQ2S+ youth starts with having a deep understanding of the **unique and complex stressors** faced by queer youth and a recognition of their intersectional identities.

Therapeutic Alliance

Many LGBTQ2S+ youth do not access mental health services, and when they do seek help, they often terminate treatment early. This is made all the more likely if their encounters with

the mental health system are not perceived to be safe (i.e., **physically, culturally and emotionally safe)** or affirming.

The **intake interview** is usually the first point of contact and represents a key opportunity for CYMH practitioners to develop a strong therapeutic alliance with LGBTQ2S+ youth (Solomon, Heck, Reed & Smith, 2017). Key therapeutic tasks at this stage include: establishing trust, collecting information in a sensitive manner, developing a working alliance, and cultivating an ethical space for working together in a respectful and affirming way. A comprehensive assessment with LGBTQ2S+ youth requires gathering specific information, while at the same time taking the time to build a relationship based on **care, collaboration, respect and empathy** (Iacono, 2019; Solomon, Heck, Reed & Smith, 2017). Key considerations include:

- Conduct a thorough biopsychosocial and sociopolitical assessment that includes a consideration of risks, stressors, strengths, goals and resources across multiple contexts
- Consider the impact of LGBTQ2S+ minority stress (i.e., prejudice, discrimination, internalized oppression)
- Learn about coming out/disclosure processes
- Attend to multiple intersectional identities and other potential forms of stigma (i.e., ethnicity, class, ability, etc.)
- Assess current family dynamics and availability of social support
- Maintain an LGBTQ2S+ affirmative stance that recognizes multiple and fluid gender and sexual identities
- Use language that is inclusive and resists binary thinking and categories
- Address youth by their preferred pronouns and chosen name
- Assess for suicide and self-harm

Practitioners often unwittingly **reproduce dominant heteronormative assumptions and cisgender perspectives** by assuming heterosexual status. Taking active steps to become aware of one's own assumptions, values and biases is an important clinical competency when working with LGBTQTS+ youth (Solomon, Heck, Reed & Smith, 2017). Practitioners are strongly encouraged to conceptualize **gender and sexual identity as part of a fluid and dynamic continuum** rather than thinking in terms of two opposite sexes (males/females) or two mutually exclusive sexual orientations (gay/straight). Simply asking youth how they identify may not capture their full experience. This can only be understood through a series of **sensitively-worded, open-ended questions** about their behaviours, attractions, identity labels and the **meanings** these have for them (Solomon, Heck, Reed & Smith, 2017).

Practitioners should also make every effort to **use language that matches their clients'** language, regarding their **sexual and gender identities**. This means using the client's **preferred pronouns** and chosen name. For trans youth, **chosen name use** is part of the social transition process to align one's gender expression with one's gender identity and it is part of gender affirming care. A recent study found that transgender youth who were able to use their chosen name in multiple contexts exhibited fewer depressive symptoms and lower rates of suicide ideation and behavior (Russell Pollitt, Li, & Grossman, 2018).

Lastly, while some LGBTQ2S+ youth experience distress as a result of their sexual or gender minority status, this is not always the source of their despair and this should not be assumed. In other words, practitioners are **cautioned against overinterpreting the role of LGBTQ2S+ identity in a young person's experience of distress** (Solomon, Heck, Reed & Smith, 2017). As part of building a strong therapeutic alliance, practitioners should take the time to understand the particular experience of the young person, which means attending to their unique context, history, and social relations.

Gender Affirming Care

When working with **transgender and gender non-conforming children or youth**, practitioners need to treat each child or youth as unique. **Affirmative care** starts with recognizing and accepting that the gender identity and associated behaviours expressed by a child or youth are true. The clinician's role is to empathically support the child/youth in a way that recognizes and supports their identities and expressions (Edwards-Leeper, Leibowitz, & Sangganjanavanich, 2016). **Gender variations are not disorders** and it is important for practitioners to understand transgender identities as normal variants of human gender identity (Solomon, Heck, Reed, & Smith, 2017). From an affirmative care perspective, practitioners can help parents and caregivers to understand that only an individual child/youth can determine their gender identity. When working with transgender and gender non-conforming children and youth, there is a **strong need for flexibility**. **Individually tailored approaches** that include advocacy, education, individual and family counselling, parent consultation and coaching are all important elements (Edwards-Leeper, Leibowitz, & Sangganjanavanich, 2016).

Key considerations when **working with gender non-conforming children** in an affirming way include (Edwards-Leeper, Leibowitz, & Sangganjanavanich, 2016):

- Take the child's lead
- Be prepared for a change in identity later on
- Help the child to navigate expectations
- Do not assume a single or stable trajectory
- Prioritize child's well being
- Thoroughly consider all risks and benefits
- Understand the influential role of parents/caregivers and involve them as much as possible
- Recognize that a social transition can occur gradually or partially
- Use language that allows for future gender exploration while minimizing shame (i.e., don't presume a child's future identity)

For older transgender and gender non-conforming youth, additional considerations come to the fore (Edwards-Leeper, Leibowitz, & Sangganjanavanich, 2016). For example, these youth may also present with other complexities (autism spectrum, eating disorders, self-harm, trauma) which will require careful consideration. For older youth who may be considering surgery, ensuring they have access to high-quality information regarding their options (e.g., Trans Care BC) is important. **Parents will need additional support**, which may include addressing their experiences of grief and loss. **Cultural and religious factors** that constrain

possibilities for living for gender non-conforming youth will need to be addressed. Religious and/or sociopolitical conservatism on the part of parents (or practitioners) can sometimes lead to strong negative emotional responses and can contribute to **internalized homo/transphobia** among transgender and gender non-conforming youth (Rivers, et al. 2018). Supporting these youth to navigate societal expectations and pressures, and helping them to **resist being positioned as abnormal, failed or shamed,** is a vitally important part of the work (McDermott & Roen, 2016).

Promising Treatment Approaches

A **combination of individual and family therapy/parent training** shows the most promise in the treatment of suicidal youth (Busby, et al. 2020; Cha, et al. 2018).There is not much research examining the effectiveness of mental health treatments that specifically target suicidal LGBTQ2S+ youth. A small number of Cognitive Behavior Therapy (CBT) and non-CBT interventions have been adapted for use with LGTBTQTS+ youth who experience a wide range of mental health challenges, with promising results (Bocchicio, et al. 2020). **Recommended adaptations** for this population include (Bocchichio, et al. 2020; Craig, Austin & Alessi, 2013; Rivers, et al. 2018):

- affirm LGBTQ2S+ identities
- acknowledge the unique role of minority stress
- make distinctions between environmental/social factors over which youth have no control (e.g., homo/bi/transphobia) and problematic behaviours, thoughts or feelings that they can modify (e.g., internalized oppression, self-harm, negative self-evaluation)
- validate young peoples' self-reported experiences of discrimination
- consider how grief and potential loss of relationships may be contributing to distress
- take account of the shifting context within which youth are attempting to access support
- support youth to cope with negative responses to disclosure of sexual orientation or gender identity as risks for suicide and self-harm are often elevated following disclosure

Minority Stress Framework

According to minority stress theory, LGBTQ2S+ youth face unique stressors as a result of their marginalized social positioning. This includes structural discrimination, homophobic violence, and historical trauma. By adopting a **minority stress framework**, practitioners are better able to understand the youth's experiences of distress, which in turn reduces the likelihood that they will blame themselves for their problems (Bocchicio, et al. 2020). The minority stress model places a strong emphasis on teaching LGBTQ2S+ youth specific coping skills, problem-solving, and self-regulating skills for dealing with **stigmatized identities**, which may include replacing self-harming behaviours with more adaptive coping strategies (Iacono, 2019). The minority stress framework helpfully directs attention **towards structural forms of discrimination, homophobia, and transmisogyny** as a way of understanding and contextualizing LGBTQ2S+ youth experiences of distress. At the same time, it is important to

avoid over-simplifying the relationship between social causes and individual distress or allow the social causes to fade from view. As McDermott and Roen (2016) argue, we need to move beyond a narrow focus on homophobic bullying or victimization when trying to understand queer youth distress and **consider the wider problem of heteronormativity** and the ways it has to be negotiated by queer youth. For example, LGBTQ2S+ youth are often burdened with having to navigate silence and secrecy, surveillance, and misrecognition, all of which take an enormous emotional toll. We must also be very cautious about relying on treatment approaches that focus exclusively on individual behavior change - placing the onus on LGBTQ2S+ youth to cope better, become more resilient, or learn how to wait it out - leaving the wider systems of injustice and violence against LGBTQ2S+ youth untouched.

Attachment-Based Family Therapy

While many LGBTQ2S+ youth are living healthy and fulfilling lives, and experience caring and supportive family relationships, a significant number of queer youth experience rejection from parents and family which places them at higher risk for mental health problems, including suicide and self-harm (Bocchcio, et al. 2020). Several studies have confirmed that parental rejection, criticism, and invalidation have profoundly negative effects on sexual minority youth.

"We must also be very cautious about relying on treatment approaches that focus exclusively on individual behavior change - placing the onus on LGBTQ2S+ youth to cope better, become more resilient, or learn how to wait it out - leaving the wider systems of injustice and violence against LGBTQ2S+ youth untouched."

Parental rejection not only leaves the child or adolescent feeling shame about themselves, it also isolates them from a potential source of support when faced with discrimination in other contexts. **Parental support and connectedness** have been shown to minimize the harmful effects of homophobic harassment and bullying. Sexual minority youth who report that they have supportive and accepting families are less likely to attempt suicide and more likely to have better health, social support, and higher esteem (Levy, Russon & Diamond, 2016).

Attachment-based family therapy targets parent-child and family relationships and holds significant promise for reducing risks for suicide and suicidal behavior among LGBTQ2S+ youth, as it increases parents' capacity to be supportive, accepting and nurturing of their child's sexual orientation and gender identity (Diamond, et al., 2012; Levy, Russon & Diamond, 2016). A significant part of the therapeutic work with families is dedicated to exploring the **meaning and process of 'acceptance'.** For example, re-framing acceptance as an *ongoing process* can help to reduce frustration and improve the quality of relationships

between parents and youth. Practitioners can validate young peoples' desires for parental acceptance, while at the same time helping them to understand that it may take some time (Levy, Russon & Diamond, 2016).

> *"Sexual minority youth who report that they have supportive and accepting families are less likely to attempt suicide and more likely to have better health, social support, and higher esteem."*

There are five overlapping **phases of attachment-based family therapy**, each with their own distinct therapeutic tasks (Levy, Russon & Diamond, 2016):

Task 1. Relational Reframe. The primary task is to assist the child and parent to better understand their processes of relating. The focus is on relational repair.

Task 2. Adolescent Alliance Building. The focus here is on getting to know the youth better, understanding the experience of depression or suicidality, learning more about their sexual identity and coming out process, and figuring out what gets in the way of talking to parents. It also involves preparing the adolescent to talk with their parents in an upcoming session.

Task 3. Parent Alliance Building. During this phase of treatment, the focus in on helping parents to better understand their own stressors and attachment/trauma history and how this affects their parenting. The primary aim is to increase parental motivation to learn new attachment promoting parenting skills. Part of the work may involve supporting parents to work through feelings of shame, loss, guilt in relation to being parents of an LGB adolescent.

Task 4. Repairing Attachment. The main task here is to assist the family to have a corrective attachment experience: the child can bring up difficult emotions and the parents can offer comfort, protection and care. The clinician helps the parents to fully listen to the child's account before offering their response.

Task 5. Promoting Autonomy. In this final phase of treatment, there is a shift away from an explicit focus on ruptures in the parent-child relationship towards a focus on anticipating challenges in the adolescent's life with the parent providing a secure base of support. The focus is on using their new skills in a mutually satisfying and validating manner.

Youth Who Engage in Self-Harm

Self-harming practices are typically understood as deliberate actions to inflict harm on one's body (e.g., cutting, burning, hitting, picking skin) in the absence of an intention to die, and for

purposes not socially sanctioned (Muehlenkamp,et al. 2012). Elevated rates of self-harm have been observed among young females, Indigenous youth and LGBTQ2S+ youth (Robinson, 2017). These behaviours typically begin in adolescence and **repeated self-harm** is very common (Curtis, et al. 2019)

Many challenges exist trying to measure and account for self-injurious behaviours. This is because slightly different terms are used in different jurisdictions and there is no standardized definition. For example, "**deliberate self-harm**" and "**self-injury**" and "**non-suicidal self-injury**" are all used, sometimes interchangeably and sometimes with different nuances (i.e., with or without intention to die). There is a lot of **overlap** across these categories and self-harm is often a risk factor for subsequent suicide (Iyengar, et al., 2018; Muehlenkamp et al 2012). The vast majority of young people who engage in self-harming behaviours do not come to the attention of formal service providers, and there is often a great deal of **secrecy and shame** surrounding the behaviors (Curtis, et al. 2019).

From a research perspective, trying to get a clear sense of who engages in self-harm, the contexts within which it occurs, and with what frequency, largely depends on how self-injury is conceptualized and defined. Dominant medical and psychological ways of knowing strongly influence how self-harming practices are understood, enacted, and experienced (Chandler, 2016; Chandler et al. 2020). To date, self-harming behaviors have largely been associated with being **young, female, and White**, and expressed primarily through **self-cutting** (Chandler, 2015). Self-harm has also been linked to specific mental disorders such as **depression, anxiety, substance use and borderline personality disorder**. Children and youth with autism and other developmental disorders often have elevated risks for self-harm and suicide, and we are only now starting to advance our understanding in this area (Cassidy, et al. 2020). One potential consequence of understanding self-harm through too narrow a frame is that certain types of people (i.e., males, racialized and other cultural minority groups) come to be excluded from research about self-injury (Chandler, 2016).

Self-harm is commonly conceptualized as an attempt to cope with and/or regulate intense emotions and distress (Curtis, et al. 2019). At the same time, the specific meaning of self-harming practices can never be known in advance and will be unique to each young person. Many **contradictions and complexities** exist in how self-harm is understood and managed. For example, self-harm is simultaneously understood as hidden/secretive *and* "attention-seeking", without appreciating that it could be both/and, or something else altogether depending on the context. It is judged to be irrational/impulsive *and* also an attempt at rational coping. Young people who self-harm are routinely encouraged to engage in "help-seeking" and yet they often encounter strong negative moral judgements when they do seek help and make their self-inflicted wounds visible. Quite often, the **embodied, relational and emotional qualities** of self-harm are minimized in favour of individual psychological accounts and explanations (Chandler, 2016). Clinical guidelines for treating self-harm, based on narrow understandings, should always be critically considered for their appropriateness and relevance when working with diverse groups of youth.

"Young people who self-harm are routinely encouraged to engage in "help-seeking" and yet they often encounter strong negative moral judgements when they do seek help and make their self-inflicted wounds visible."

Therapeutic Alliance and Psychosocial Assessment

Understanding the entangled mesh of biomedical, psychological, social, cultural and political factors in the emergence of self-harm - without necessarily needing to pinpoint the origin of distress - is an important first step (Chandler et al. 2020). Developing a strong **therapeutic relationship** based on **respect, trust, compassion, and empathy** is foundational to all therapeutic relationships. Many young people with self-inflicted wounds report experiencing harsh and brutalizing treatment from healthcare providers (Chandler, 2016), which severely compromises their ability to receive necessary care and nurturing support.

When young people who self-harm do report a **positive care experience**, these are some of the qualities they mention (Chandler, 2016; Curtis, et al. 2019):

- being supported to talk and narrate one's own experience
- having one's wounds and body treated gently
- receiving care that is nurturing
- not being morally judged as "crazy" or undeserving of help
- having a trustworthy person to talk to
- having an explicit conversation about confidentiality (and its limits)

Creating opportunities for **collaboration** and consistently demonstrating empathy and respect to young people who self-harm are important guiding principles. When building relationships with youth who engage in self-harm, a comprehensive **psychosocial assessment** should ideally include a thorough investigation of each of the following domains (NICE, 2011):

- skills, strengths and assets
- coping strategies
- mental health problems or disorders
- physical health problems or disorders
- social circumstances and problems
- psychosocial and occupational functioning, and vulnerabilities
- recent and current life difficulties, including personal and financial problems
- the need for psychological intervention, social care and support, occupational rehabilitation, and also drug treatment for any associated conditions

When **assessing risks for repetitive self-harm**, the following factors should be assessed and documented (NICE, 2011):

- methods and frequency of current and past self-harm
- current and past suicidal intent
- depressive symptoms and their relationship to self-harm
- any psychiatric illness and its relationship to self-harm
- the personal and social context and any other specific factors preceding self-harm, such as specific unpleasant affective states or emotions and changes in relationships
- specific risk factors and protective factors (social, psychological, pharmacological and motivational) that may increase or decrease the risks associated with self-harm
- coping strategies that the person has used to either successfully limit or avert self-harm or to contain the impact of personal, social or other factors preceding episodes of self-harm
- significant relationships that may either be supportive or represent a threat (such as abuse or neglect) and may lead to changes in the level of risk
- immediate and longer-term risks.

Promising Treatment Approaches

Treatment decisions should be undertaken following a **thorough and personalized** clinical assessment that considers the perspectives of young people, their caregivers and/or parents, as appropriate (Carter, et al. 2016). While evidence is limited (Robinson, 2017), **dialectical behavior therapy** for adolescents (DBT-A), **cognitive behaviour therapy** (CBT) and **mentalization based treatment** for adolescents (MBT-A) have all been shown to hold the most promise in the treatment of self-harm (Iyengar, et al. 2018).

Problem-solving treatment approaches such as CBT and DBT-A that directly target individual thoughts, behaviours, and regulatory processes have shown evidence of effectiveness in reducing self-harming behaviours (Iyengar, et al. 2018). These approaches teach **problem-solving, emotion regulation and communication skills** and typically include a **strong family systems component** (e.g., family therapy, parent training, parent support). The National Institute for Health and Care Excellence (NICE) (2011) also recommends tailored treatments that include elements of cognitive behavioral, psychodynamic and problem-solving therapies when working with youth who self-harm.

DBT-A is noteworthy for its targeted therapeutic focus on reducing self-harm and it has been shown to be effective at reducing the frequency of self-harm over the long-term, with very few relapses, especially when augmented with follow-up treatment (Mehlum, et al. 2019). Specific components of DBT-A directly **address hopelessness** and these may be of particular significance in reducing self-harm among adolescents (Mehlum et al. 2019):

- psychoeducational strategies that help young people to make links between self-harming behaviours and their goals
- commitment strategies that help young people to consider risks and benefits of the choices they make

- teaching dialectical thinking that works to challenge polarizing or 'black-and-white' thinking
- cultivating reasons for living and helping young people to build a worthwhile life

MBT-A is a manualized psychodynamic therapeutic intervention, rooted in attachment theory. It focuses on impulsivity and affect regulation and supports youth to learn how to represent their feelings in emotionally challenging situations. It is typically a one-year intervention that includes weekly individual and family-based therapy and has shown promise in the treatment of self-harm (Iyengar, et al. 2018).

Parent Support and Education

Ensuring that parents have their own network of **social support**, **access to education** and resources, and opportunities to learn **parenting strategies to reduce conflict, improve communication, and manage strong emotional responses**, are important aspects of the overall care plan. Parents report that these specific strategies and approaches help them to manage their own distress, enabling them to be more **responsive to their child's needs** (Curtis, et al. 2019):

- Receiving prompt and adequate care and guidance from mental health providers
- Receiving information and access to resources on mental health, self-harm, and what to expect (from services providers or online)
- Being invited to be active contributors to the overall care plan
- Feeling heard and understand; having their feelings normalized
- Receiving tailored interventions that meet the specific needs of this particular youth/family
- Learning practical strategies for coping and responding in a constructive way (e.g., listening skills; self-regulation skills; communication skills; conflict resolution skills, etc.)

"Ensuring that parents have their own network of social support, access to education and resources, and opportunities to learn parenting strategies to reduce conflict, improve communication, and manage strong emotional responses, are important aspects of the overall care plan."

Parents of youth who engage in self-harm typically report feeling fear, uncertainty, shame, and guilt - all of which interfere in parents' ability to provide **constructive care and support** (Curtis, et al. 2019). Quite understandably, parents are often very upset when they first learn that their child is engaged in self-harming behaviours. For parents of youth who repeatedly self-harm, the **strain of caring** for them can take an enormous toll on parental well-being. Negative responses from parents in response to the self-harm (e.g., harsh judgement, anger,

withdrawal, increased attempts to control) can intensify distress in the young person, potentially making the re-occurrence of self-harm all the more likely.

Supporting parents to **strengthen their relationships** with their child in a way that communicates **care, respect, love, and empathy** are vitally important. In practical terms, this means helping parents to learn how to engage in the following behaviours (Curtis, et al. 2019):

- talking and listening in a non-judgemental way
- remaining calm
- demonstrating care and affection
- acknowledging intensity of child's distress
- asking for feedback about how they can be helpful
- making themselves available
- facilitating referrals to professional services as necessary
- respect privacy as much as possible

Digital Lives of Youth

Regardless of where they live, the vast majority of young people spend considerable time online (Bailey, et al. 2018). Ninety two per cent of adolescents report going online daily, with a quarter of these youth acknowledging that they are 'almost constantly connected' (Perry, et al. 2016, p. 74). Young people use a wide variety of devices, including smartphones, computers, tablets, laptops and gaming consoles (Nesi, 2020) to access digital content such as music, videos, news, maps, educational opportunities, self-help, and games. They engage in online socializing, shopping, learning, and activism, and are regular users of social networking sites such as Facebook, Instagram, Twitter, Snapchat and TikTok. Young people are able to both consume and create digital content, with YouTube being one of the most popular sites (Nesi, 2020). Research confirms that when young people are struggling with mental health concerns, including thoughts of suicide and self-harm, they often use social media to communicate their distress (Bailey, et al. 2018; Gibson & Trnka, 2020). This has led to growing interest among researchers and mental health practitioners to better understand how to safely and effectively harness existing web-based technologies and social media to promote youth mental health and well-being and reduce risks for suicide.

"Research confirms that when young people are struggling with mental health concerns, including thoughts of suicide and self-harm, they often use social media to communicate their distress."

Digital technologies, including websites and mobile applications, can offer a number of specific **benefits** in relation to suicide prevention and the reduction of self-harm. These include (Bailey et al. 2018; Gibson & Trnka, 2020; Nesi, 2020; Toombs et al. 2020):

- easily accessible for all, including those who live in rural and remote areas
- enables potential intervention following disclosure of suicide risk
- offers opportunities for entertainment and creative expression
- provides a platform for accessing non-judgmental support and shared experiences
- reduces isolation and provides social connection
- offers the chance for young people to offer support to others
- creates multiple access points for youth to receive help 24-7
- offers a low-cost/free alternative for those who cannot access local services
- serves as a supplemental form of support to traditional face-to-face mental health services
- connects with youth where they are already at
- has the potential to offer access to culturally based resources for Indigenous youth
- aligns well with young peoples' desires for independence and privacy

At the same time, a number of **concerns** have also been identified regarding the role of the internet, digital technologies, and social media, in relation to youth suicide and self-harm. These include (Bailey, et al. 2018; Marchant et al. 2017; Nesi, 2020):

- potential normalizing of suicide and self-harm
- cyber-bullying, trolling, and other forms of online harassment
- personal information is often displayed publicly
- negative social comparison and competition through the form of 'likes' and 'views'
- contagion concerns arising through the sharing of graphic imagery, including explicit suicide methods which may be 'triggering' to vulnerable youth
- creation of user-generated content increases potential for poor quality or inaccurate information to be spread
- excessive screen time displacing healthy behaviours, including good sleep hygiene

"The main challenge is to create pathways for young people to navigate their way to tools and online spaces that are safe, trustworthy and helpful, offering users the opportunity for meaningful and constructive online engagement, while minimizing the potential for harm."

Promising Approaches

Suicidal and self-harming youth are typically reluctant to seek help from formal mental health services. Very often they express their distress to peers via social networking sites and in online forums. Given that young people are '**almost constantly connected,**' learning how to use the potential of digital tools for youth suicide prevention is important (Perry, et al. 2016).

Websites, mobile apps, and social media networking sites all have the potential to offer positive benefits to young people, especially those who are suicidal. The potential benefits of these web-based and mobile applications sit alongside potential risks and concerns (Perry, et al. 2016). The main challenge is to create pathways for young people to navigate their way to tools and online spaces that **are safe, trustworthy and helpful,** offering users the opportunity for meaningful and constructive online engagement, while minimizing the potential for harm (Marchant, et al.2017).

Web-based tools and mobile applications aimed at improving child and youth mental health and reducing risks for suicide and self-harm have increased in recent years. While evidence is limited regarding the effectiveness of digital interventions for preventing youth suicide and self-harm (Franco-Martin, et al. 2018; Perry, et al. 2016; Toombs, et al. 2020), some guiding principles can be understood from the published literature. Two main strategies are particularly useful for child and youth mental health practitioners: **e-mental health strategies** (e.g., screening, assessment, treatment) and **digital opportunities for prevention and mental health promotion**, which includes supporting young people to navigate to safe, **'life promoting' online spaces**.

E-Mental Health Strategies

E-mental health strategies refers to the delivery of child and youth mental health services through the internet (web-based) or other digital technologies such as mobile phones. In the broader health sector, these strategies are typically referred to as "eHealth" which includes the use of any technology to deliver health services or "mHealth" which refers to the specific use of mobile devices (Ondersma & Waters, 2020). Distance-based approaches to the delivery of mental health services were originally designed to increase access for greater numbers of youth and families; however in the context of the current Covid-19 pandemic, the need for high quality interventions that can be delivered remotely has become even more pressing.

Technologies can be used to provide short-term crisis management, longer term therapy, or psychosocial skill-building sessions. They can be highly interactive or passive (i.e., information transmission). They can be provided over the **phone** or through **videoconferencing** platforms (e.g., Zoom). **Mobile apps**, **text messaging** services, and other **web-based psychosocial interventions** such as mindfulness exercises, problem-solving skill-building

tools, and meditation programs can all be utilized as part of a comprehensive approach to mental health care.

There are **potential barriers** when using eHealth technologies that mental health practitioners should be aware of, particularly when working with **Indigenous youth**, where cultural content and appropriateness are of the utmost importance (Toombs et al. 2020):

- technological difficulties
- integration challenges
- rapport building challenges
- language, communication and confidentiality

A number of specific recommendations have been identified for enhancing the quality of **ehealth interventions for Indigenous youth,** which address both **content and process** (Toombs et al. 2020):

- Community consultation and incorporation of community knowledge – consulting community members to include cultural teachings allows for appropriate cultural modifications
- Clear communication of content- youth prefer to access the content in multiple ways (e.g., music, videos, animation, plain language text, etc.)
- Tailor content to meet youth needs and community context- youth prefer personalized information that is tailored to their specific needs vs. standardized and generic content
- Use of congruent in-person and ehealth strategies- integrate distance-based technologies with in-person services as appropriate
- Use of transdiagnostic treatment approaches- use strategies that target symptoms across diagnoses to address common factors underlying the most frequent diagnoses among Indigenous youth (e.g., cognitive reappraisal skills)

Mental Health Apps

Many young people report using their mobile devices to access health information. There are hundreds of free **mobile apps** addressing suicide or self-harm that are available for downloading to a smart phone. The quality is highly variable and some of the apps are explicitly harmful (i.e., encouraging people to engage in self-harm; facilitating access to lethal methods). A recent review analyzed interactive mobile applications addressing suicide prevention according to how well they adhered to current evidence-based guidelines for suicide prevention (Larsen, Nicholas & Christensen, 2016). **Screening, accessing support (peer networks, crisis support), safety planning, delivery of therapeutic content (i.e., CBT), and follow-up after an attempt** (outreach and appointment reminders) were some of the specific features included in these apps.

Though somewhat dated now, two specific apps were identified in the review by Larsen and colleagues (2016) as the most comprehensive and evidence-informed: "Safety Net" and "Mood Tools-Depression Aid" (see Appendix). There is a useful review and rating system of some of the most commonly used mental health applications at One Mind Cyber Guide. The American

Psychiatric Association has also created an App Evaluation Model to aid practitioners in determining which app may be most **safe, useful, evidence-informed and the least harmful**, recognizing the unique needs of each client (Ondersma & Walters, 2020).

Digital Opportunities for Prevention and Mental Health Promotion

Giving and receiving support is an important aspect of feeling purposeful and part of a community. When thinking about harnessing the potential of digital technologies to prevent risks for self-harm and suicide, it is worth considering all of the ways that young people contribute to, and benefit from, online communities based on **respect and reciprocity.** In other words, **informal peer support networks** are extraordinarily significant in supporting youth well-being since we know that most youth prefer to confide in friends (over adults and professionals) when experiencing distress (Gibson & Trnka, 2020).

Social networking sites offer key opportunities for young people to access peer support and experience a sense of **community and belonging**. For young people who have grown up with technology, and have a sophisticated understanding and deep comfort with the use of textual and image-based communication, discussing sensitive issues online, and offering online support to others is both common and natural (Gibson & Trnka, 2020). For many youths, the chance to **develop friendships and communities**, without adult surveillance can be experienced as freeing.

A recent qualitative study (Gibson &Trnka, 2020) asked young people directly about their experiences of giving and receiving support through social media. A number of priorities for **supporting others and being supported online** were identified. These illuminate some of nuanced ways that youth engage with each other through these sites:

- Establishing safety – young people actively seek out trustworthy networks to seek and offer support and they recognize the presence or absence of emotional safety online
- Picking up cues for distress- young people are very skilled at recognizing overt and indirect expressions of distress
- Showing care- young people understand 'care' to mean that people are recognized and seen, especially when they are in distress; care also involves expressing empathic concern for another
- Expressing emotions – young people value being able to honestly express themselves, including giving expression to strong emotions, which may mean being able to vent to another person online
- Exercising tact- young people recognize the need to be sensitive, balanced and tactful and they try to tailor their responses to what the other person might need
- Developing relationships – by giving and receiving support online, the seeds are planted for developing a new relationship or deepening an existing friendship

This study found that young people were extraordinarily skilled at communicating about sensitive topics, were particularly adept at picking up subtle expressions of distress, had well-

developed skills in **online emotional literacy**, and were "thoughtful, careful, and sensitive" (Gibson & Trnka, 2020, p. 245). in the way they engaged in giving and receiving online support.

> *"…young people were extraordinarily skilled at communicating about sensitive topics, were particularly adept at picking up subtle expressions of distress, had well-developed skills in online emotional literacy, and were thoughtful, careful, and sensitive in the way they engaged in giving and receiving online support."*

Finally, most social networking sites (including Twitter, Facebook, Instagram) have clear **safety protocols and policies** to respond to user posts about self-harm or suicide. Specifically, users who express self-harm will often be re-directed to counselling or suicide prevention sources. Certain graphic content showing self-harming practices may be banned and/or unavailable for searching (Marchant, et al. 2017). Some sites include protocols that activate wellness checks and active rescue interventions when suicide risk appears imminent. Balancing safety with privacy concerns are ongoing ethical tensions.

Appendix – Useful Websites & Resources

Indigenous Youth

Eskasoni Mental Health http://www.eskasoni.ca/Departments/25/

Gathering Our Medicine https://gatheringourmedicine.ca/about/

We Matter https://wemattercampaign.org/

Wise Practices https://wisepractices.ca/

LGBTQ2S+Youth

BC Children's Hospital Gender Resources http://www.bcchildrens.ca/health-info/coping-support/gender-resources

PFLAG Canada

www.pflagcanada.ca

Prideline BC

1-800-566-1170 toll-free in BC or 604-684-6869 in the Lower Mainland

Trevor Project https://www.thetrevorproject.org/survey-2020/

Trans Care BC

http://www.phsa.ca/transcarebc/health-professionals/education/trans-intro

Qmmunity: BC's Queer, Trans, and Two-Spirit Resource Centre

www.qmunity.ca

Self-Harming Practices

Calm Harm https://calmharm.co.uk/

NICE Guidelines https://www.nice.org.uk/guidance/cg133

Non-Suicidal Self Injury (NSSI) in Youth http://insync-group.ca/for-professionals/#MentalHealthClinicans

Digital Support

Mindshift CBT/Anxiety Canada https://www.anxietycanada.com/resources/mindshift-cbt/

BreathrApp/Kelty Mental Health https://keltymentalhealth.ca/breathr

Virtual Mental Health Supports for Youth in BC https://www2.gov.bc.ca/gov/content/health/managing-your-health/mental-health-substance-use/virtual-supports-covid-19#youth

Safety Net Mental Health Resource on Facebook https://www.facebook.com/safetynetsuicideprevention/

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