

# A Developmentally Informed Approach to the Collaborative Assessment and Management of Suicide (CAMS) for Adolescents (CAMS-4Teens) and Engaging Parents in Treatment

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Suicide is the second leading cause of death for adolescents in the United States, and rates have continued to rise in the past decade. Flexible and brief suicide-specific interventions are needed to address this public health crisis. Review of the existing evidence base for adolescent suicide-specific care identifies parental involvement as a key component of intervention, particularly in acute care settings; however, when and how to integrate parents into treatment remains less clear. In attempts to address this issue, a developmental adaptation of the Collaborative Assessment and Management of Suicide for Adolescents (CAMS-4Teens) is reviewed, and the CAMS Parent Report Form (CAMS PRF) is introduced as a key strategy to integrate parents effectively and efficiently into treatment. The development of the CAMS PRF and approaches to implement the tool in clinical practice are described.

### **Clinical Impact Statement**

Clinicians should empathically assess parent characteristics to make both patient-centered and family-centered decisions. Nonjudgmental and empathic parent assessment can help to engage parents and ensure that treatment plans and disposition/discharge plans reflect the parents' strengths and needs as well as the patients' priorities and preferences.

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As the second leading cause of death for individuals 10 to 24 years old, adolescent suicidality,

defined here to include suicidal thoughts and behaviors, including nonsuicidal self-injury and suicide attempts, represents a global public health crisis (Glenn et al., 2020; the first leading cause of death for this age range is motor vehicle accidents; Centers for Disease Control and Prevention, 2021). Despite coordinated efforts to support intervention and prevention for this population, rates of adolescent suicidality have demonstrated marked increases in the past decade—increasing as much as 56% from 2007 to 2017 (Curtin & Heron, 2019; Plemmons et al., 2018), and observed increases as high as 50% in possible suicide attempts since the start of the COVID-19 pandemic (Yard et al., 2021). More granular analyses indicate significant risk may be

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most pronounced for historically marginalized populations, including Black, Indigenous, and Latinx youth, who may face significant barriers to accessing care (Bridge et al., 2018; Kann et al., 2018; Lee & Wong, 2020; Lindsey et al., 2019; Nestor et al., 2016).

Currently, there are only a few evidence-based suicide prevention programs (EBSPs) that have demonstrated efficacy with adolescents (Ougrin et al., 2015; Robinson et al., 2018). Central themes of these suicide-specific interventions include the integration of continuous risk assessment and monitoring, active crisis prevention and safety planning, and a suicide-specific focus that differentiates them from traditional diagnostic-driven interventions (Asarnow & Mehlum, 2019). Common among the existing EBSPs is the inclusion of parents in risk management and treatment, albeit via different approaches; what has yet to be clearly articulated is how clinicians can effectively assess and incorporate parent perspectives into adolescent EBSPs.

In the current article, we describe one approach to guide parental participation in EBSPs utilizing the Collaborative Assessment and Management of Suicide (CAMS) framework adapted for use with adolescents (CAMS-4Teens). To that end, we introduce the CAMS Parent Report Form (PRF) and discuss its potential utility as a tool to support the effective integration of caregivers into adolescent suicide-specific care. Finally, we discuss future directions in the development and evaluation of CAMS-4Teens.

### **Developmental and Family Factors Associated With Adolescent Suicidality**

Adolescence represents a unique developmental risk period for suicidality as adolescents navigate increasingly complex social, academic, and personal demands, while concurrently experiencing uneven neurodevelopmental maturation that enhances emotional reactivity and influences social decision making. A majority of adolescents traverse these developmental transitions without incident; however, an increasing number of youth experience suicidal crises during this period that necessitate intervention.

The family environment, including the parent–adolescent relationship, significantly impacts adolescent well-being and mental health (Adrian et al., 2018; Ati et al., 2021; Dardas et al., 2018; Ougrin et al., 2015; Wagner et al., 2003), and these factors

play a central role in both adolescent suicide risk and intervention. Although the parent–child relationship is often a source of distress among adolescents who are suicidal, parents also play a key role in protecting against potential suicide risk. Specific parent factors, including parental warmth, monitoring, and use of consistent discipline, buffers suicide risk even within the context of other high-risk factors. Parents' use of effective strategies, such as problem solving, reduces suicide risk even in the presence of less effective interpersonal interactions (e.g., invalidation; Aiken et al., 2019). Promoting parents' adaptive support of their adolescent during a suicidal crisis is a necessary ingredient in effective adolescent EBSPs, and, as briefly reviewed above, the complexities of the adolescent–parent relationship often obfuscate the best approach to integrating parents into treatment.

### **Parental Participation in Evidence-Based Suicide Prevention (EBSP) Programs for Adolescents**

The last decade has seen tremendous growth in the empirical evaluation of EBSPs for youth (Kothgassner et al., 2020; Mann et al., 2021). The growing evidence base for adolescent suicide prevention is promising, and, at the same time highlights important opportunities for improving strategies to engage and treat youth who are at risk for suicide. Overall, caregiver participation appears key, both conceptually (for safety planning and means restriction) and empirically (Kothgassner et al., 2020; Ougrin et al., 2015; Robinson et al., 2018). Indeed, meta-analytic findings of adolescent suicide-specific care revealed two central characteristics of effective interventions (i.e., reduced self-harm and suicidal ideation): (a) a clear family component and (b) multiple sessions (Kothgassner et al., 2020; Ougrin et al., 2015; Robinson et al., 2018). Promoting caregiver involvement and support is critical for culturally responsive adolescent suicide specific care. Family support, caregiver engagement, and improving connectedness have been central components of culturally adapted suicide prevention initiatives for Black, Indigenous and Latinx youth (Doria et al., 2021; Molock et al., 2008; Silva & Van Orden, 2018). However, clinicians must proceed carefully when integrating caregivers into treatment, as pre-existing disruptions in the caregiver-adolescent relationship may negatively impact key aspects of

effective suicide-specific care, namely therapeutic alliance (Ibrahim et al., 2018).

A parent's cultural background can influence their beliefs about suicide, mental health treatment, and whether and how to seek help (Goldston et al., 2008). Due to historic and current patterns of racial and ethnic minoritized individuals' mistreatment by health care systems, many racial and ethnic minoritized parents may be distrustful of medical and mental health providers and may prefer to receive support from alternative sources (e.g., churches, community members, or traditional healers; Goldston et al., 2008). Socioeconomic status (SES) also plays a role in parents' beliefs about treatment, with lower SES being associated with less positive expectations for treatment efficacy (Nock & Kazdin, 2002). Parental stress also negatively impacts parent expectations for treatment (Nock & Kazdin, 2002). Since economic hardship can increase parental stress, as well as creating additional barriers to engagement (e.g., scheduling and transportation limitations), and ethnic minoritized parents may also experience higher levels of stress due to acculturation conflicts and discrimination (Goldston et al., 2008), clinicians need to be aware of and assess parenting stress as well as their treatment beliefs and preferences. Taken together, there is a compelling need to thoughtfully incorporate caregivers into adolescent suicide-specific care without disrupting other necessary aspects of effective care, including engagement and alliance with the adolescent patient.

Recent critical reviews have highlighted moderating factors that appear to influence the relative impact of including parents in treatment, including the need to balance parent-adolescent integration within sessions (i.e., to support coordinated skill practice; Dardas et al., 2018; Lewinsohn et al., 1990) with developmental needs of adolescents (e.g., individual sessions; Brent et al., 1997). Existing EBSPs for adolescents incorporate parents in some way, utilizing a range of approaches such as brief check-ins with parents, individual parent-only sessions, or joint parent-adolescent sessions (Cottell et al., 2018; Kothgassner et al., 2020; Miller et al., 2006). Indeed, interventions that include joint parent-adolescent sessions demonstrate relative advantage over adolescent-only interventions (Asarnow et al., 2002; Diamond et al., 2010; Spirito et al., 2015).

Across EBSPs, parents partake in suicide crisis prevention planning, as they play a key role in prevention strategies that reduce access to means,

including environmental interventions and enhanced parental monitoring and supervision. However, despite recognition that parents must be involved in crisis prevention planning, predictors of parental engagement in safety planning and stabilization are not well understood. In one study by Foster et al. (2021), of multiple conceptual factors examined, only parental self-efficacy positively predicted parents' adherence to safety planning. These findings highlight the importance of identifying idiographic factors that may impact parents' involvement in suicide-specific care, a necessary component within EBSPs.

Many EBSPs, such as DBT-A, SAFETY, RAP, family-focused CBT, and Attachment-based Family Therapy (ABFT) include coordinated, or parallel, adolescent-parent sessions (Asarnow et al., 2015, 2017; Esposito-Smythers et al., 2019; Pineda & Dadds, 2013). These interventions point toward the importance of active parental involvement not only in treatment, but in individual sessions; however, specific strategies (i.e., the "how") clinicians may use that systematically incorporate parents' assessment and prioritized needs, while maintaining collaboration and engagement with the adolescent patient are needed.

Interventions need to be tailored to fit each individual family's needs and priorities; (Asarnow et al., 2022) currently approaches tend to take an a priori stance on the amount and manner of parent involvement that will be needed. Existing adolescent EBSPs prioritize the parent-child relationship as a central treatment target that may occur at the expense of other factors that the adolescent may perceive to be more substantial. Subsequently, adolescents may not feel "heard" regarding their preferences for care or their priorities, and ultimately this may contribute to poor treatment engagement, a notable obstacle in adolescent suicide prevention (Burns et al., 2008; Trautman et al., 1993). To that end, following a review of the CAMS framework we will introduce a specific tool designed to support clinicians in balancing adolescent priorities and parental perspectives in treatment.

### **Collaborative Assessment and Management of Suicidality (CAMS)**

CAMS is a flexible suicide-specific intervention with replicated efficacy in resolving suicidality within adults (Comtois et al., 2011; Jobes, 2016;

Swift et al., 2021). As indicated in the name, the CAMS intervention promotes collaboration between the provider and the patient to ensure that the patient is engaged with an empathetic, collaborative, and patient-centered care. CAMS takes a somewhat atheoretical approach to suicidality. Rather than positing a reason or set of reasons (e.g., clinical depression) that explain suicide risk, and then prescribing a treatment approach to address those reasons, CAMS uses a distinctly idiographic framework—recognizing that while there are many commonalities in terms of risk factors and the processes by which suicidality develops, each person who is suicidal has their own idiosyncratic drivers (i.e., their unique reasons why suicide is an option for them). CAMS clinicians thus treat these patient-defined drivers versus treating theoretically derived concerns (Jobes, 2016). Viewed through this lens, CAMS fosters clinicians' nonjudgmental and empathic curiosity to understand the patient's perspective and identify alternative methods of problem-solving (Jobes, 2016). An integral part of CAMS is to closely monitor ongoing risk for suicide in each session and to keep the focus of treatment on suicidal risk. Assessment of suicide-specific risk factors, treatment engagement, and treatment progress occurs each session through collaborative completion of the Suicide Status Form (SSF) which is a multipurpose assessment, treatment planning, tracking, to clinical outcome tool. Given the high number of adolescents who report suicidal ideation and their poor compliance with treatment, this approach offers the opportunity to collaboratively identify and begin to address the factors driving suicide ideation at the onset of treatment and across the course of CAMS-guided care.

From the outset, CAMS was developed with the goal of providing a brief, trainable, and flexible intervention to decrease suicide risk (Jobes, 2016). Consistent with this goal, the average length of successful treatment ranges from six to eight sessions (Comtois et al., 2011; Jobes et al., 2017), and in a superiority clinical trial CAMS exhibited comparable behavioral outcomes to more resource-intensive DBT (Andreasson et al., 2016). For adults, CAMS is considered a well-established suicide-specific intervention and results have been replicated across multiple clinical trials conducted by several investigative teams (Jobes, 2012; Swift et al., 2021). In addition to reducing suicidal ideation and behavior, CAMS has consistently reduced distress, depressive symptoms, and hopelessness (Comtois et al.,

2011; Jobes, 2012; Pistorello et al., 2020). A recent meta-analysis of CAMS in adult samples found in comparison to control treatments, CAMS reduces suicidal ideation, distress, and hopelessness while increasing treatment acceptability and hope (Swift et al., 2021). Evidencing its flexibility, CAMS has been effectively implemented in multiple, outpatient health care settings (Comtois et al., 2011; Ellis et al., 2012a, 2012b; Jobes et al., 2005), thereby promising to reduce strain on psychiatric emergency care settings attempting to support patients with suicidality. CAMS has been implemented with a wide range of patient populations (e.g., college students, veterans, and inpatient populations) and has resulted in sustainable improvement, with some patients maintaining treatment gains up to 1 year later (Comtois et al., 2011). Taken together, CAMS is an effective and flexible intervention that may be integrated into a scalable suicide-specific care for broader public health impact (Jobes et al., 2018).

### CAMS-4Teens and the PRF

Given the promising outcomes for adults, some clinicians working with youth at risk for suicide have used CAMS to address a clinical need. Emerging evidence suggests that CAMS is well-suited for adolescent populations (Jobes, 2012; Jobes et al., 2019b). Work in this area includes initial evidence of feasibility (Jobes, 2012; O'Conner et al., 2014; Ridge-Anderson et al., 2017), and favorable psychometric evaluation of the CAMS Suicide Status Form in an adolescent inpatient sample (Brausch et al., 2020). Initial psychometric evaluation of the SSF found evidence of validity, reliability, and the ability to discriminate between patients who resolved suicidality and those who did not in an adolescent sample (Brausch et al., 2020). A recent open trial of CAMS-4Teens has been completed and adolescents participating in CAMS-4Teens reported significant decreases in psychological pain, agitation, hopelessness, and self-hate (Adrian et al., 2021). Furthermore, benchmarking analyses found clinical outcomes, including decreases in suicide risk during treatment, were consistent with other, more intensive adolescent EBSPs and adult CAMS trials (Adrian et al., 2021). Overall, there is preliminary support for the use of CAMS with adolescents at risk for suicide in acute care settings; however, guidance is needed on how to incorporate caregivers into this collaborative framework.

## Conceptual Overview and Clinical Purpose of the CAMS4-Teens PRF

For some clinicians, there is often an inherent tension when it comes to working with parents of their adolescent patients. Clinicians work to align with their patients, and CAMS clinicians, in particular, are committed to seeing things through the lens of their patient, in the case of CAMS-4Teens clinicians, this means taking their adolescent patient's perspective. Due to both developmental norms and the parent-child relationship difficulties often associated with adolescent suicidality, there is a strong possibility that the adolescent holds some negative views toward their parents. Concurrently, parents' responses to their adolescent's suicidality are shaped by their own history and experiences, all of which may have an impact on treatment. As such, there may be considerable barriers to approaching work with parents from a place of nonjudgmental empathy. Developmental adaptations of CAMS for youth must avoid prescribing specific interventions or strategies a-priori. On the other hand, as clearly demonstrated in the preceding review of the literature, it is indisputable that a developmental adaptation for adolescents must include a process and framework for involving parents in treatment.

These respective paradoxes—the idiographic nature of CAMS versus the imperative of parental involvement in treatment and the need to align with one's adolescent clients versus the imperative of engaging parents in treatment—directly led to the development of the PRF. Developed at the Suicide Prevention Laboratory at Catholic University by the second author to mirror the process of completing the CAMS SS (i.e., collaborative-framework, engaging the parent through written responses), the PRF (see [online supplemental materials](#)) assesses various domains that are likely to influence parental behavior related to their adolescent's experience of suicidality (Jobs et al., 2019a).

The PRF mirrors Section A of the SSF in form, process, and purpose. It includes a series of questions about a parent's emotional responses to their child's suicidality, their sense of self-efficacy and awareness about their child's suicidality, and their willingness to participate in treatment. Each question includes a 5-point Likert scale (1 = low, 5 = high) and an open-ended sentence completion prompt (e.g., "What I feel most guilty about is . . ."). As on

the SSF, the PRF also includes two bidimensional pairs of scales designed to assess the parent's attitudes toward parenting roles and toward suicide more generally. Finally, the PRF concludes with another open-ended sentence-completion prompt that highlights the parent's most pressing treatment priority, similar to the "one thing" response on the SSF.

To assess their emotional response to their child's suicidality, caregivers rate the extent to which they are experiencing a number of discrete emotions, including sadness, fear/worry, guilt/regret, anger/frustration; these particular emotions are the most commonly reported by parents of adolescents who are suicidal (Greene-Palmer et al., 2015; Wagner et al., 2000). Caregivers also rate their perceived awareness of their adolescent's suicidal drivers, their perceived confidence in responding to their child's suicidality, and their willingness to participate in treatment—potentially uncovering clear targets of intervention with caregivers (Czyz et al., 2019). To assess attitudes toward parenting and suicide, caregivers respond to four items that assess perceived responsibility for their child's emotional well-being (i.e., caregiver-responsibility, child-responsibility) and their degree of suicide stigma. They are then prompted to share what they think would contribute to resolution of their adolescents' suicidality. By gathering both nomothetic (rating scales) and idiographic (sentence-completion prompts) information about the parent's current experience across several domains, the PRF is designed to offer clinicians a route to seeing things through the lens of the parent, which opens the door to holding a genuinely empathic and nonjudgmental stance when working with the parent.

Ideally, the process of completing the PRF would replicate the process of completing the SSF: In a parent-only meeting held within the first or second session of CAMS-4Teens the clinician would, with the parent's permission, take a seat next to the parent to guide them as they complete the PRF, providing clarification as needed and offering brief reflections and validation to convey empathy and to normalize the parent's experience. Within the context of a crisis care clinic, this has been accomplished by involving two clinicians, an adolescent clinician, and a parent clinician, into acute treatment services. However, in the context of traditional outpatient therapy, given the likely acuity of the adolescent patient's distress, it may not be advisable to replace an individual session with a

parent-only session at the very early stages of treatment. Additionally, there are often time and financial constraints that preclude the scheduling of two therapy sessions per week. In these cases, it may be more pragmatic/feasible to have the parent complete the PRF as a self-report questionnaire initially; this would provide the clinician valuable information about the parent's current capacity and needs in terms of their participation in treatment, and the clinician could schedule a session to go through the PRF in more depth with the parent later.

In settings offering a higher level of care, these particular barriers to the PRF process may not apply. Although time is always a limited resource, it may be appropriate and feasible for the clinician to meet individually with the parent to complete the PRF, either as part of the discharge process (in the case of short-term hospitalizations) or intake process (e.g., for intensive outpatient or residential programs). In both cases, taking the time to develop an understanding of how the parent is experiencing their child's suicidality, and doing so in a nonjudgmental way, has the potential to normalize the parent's experience and substantially increase the likelihood that the parent will remain engaged and feel connected to the treatment process as it progresses. As importantly, the PRF uncovers potential needs and values that the parent has, offering some direction for the clinician regarding the types of support the parent would benefit from. In some families, the parent may have some attachment difficulties or emotion regulation deficits of their own; other parents may lack parenting skills and knowledge; and in every family, the parent's cultural values and attitudes toward treatment needs to be considered when it comes to treatment planning. Each parent and family have different needs and priorities, and each requires a different approach (Leffler et al., 2020). Some parents may benefit from psychoeducation and/or a coping skills group; others may warrant a referral for therapy of their own; some parents should be encouraged to access and bolster their existing community supports and resources; and of course, family therapy sessions may be the most helpful course of action, depending on the adolescent patient's preferences, which are held in the highest priority. The PRF allows the clinician to make decisions about parent involvement in treatment that are as family-centered as CAMS treatment planning is patient-centered.

The clinician then uses this information to inform the conceptualization of the caregiver-adolescent relationship, and a discussion of the

drivers of suicide for the adolescent. Indeed, use of the CAMS PRF may help uncover discrepancies between adolescent and caregiver. Increasingly there is evidence that reporter discrepancies point toward important clinical targets of intervention during adolescent mental health treatment (Bonadio et al., 2022; De Los Reyes et al., 2013, 2019). In the case of CAMS-4Teens, issues identified during completion of the SSF and PRF may point toward a need for individual skill building (e.g., parental validation). Then, clinicians may use information gathered from the PRF, and identified discrepancies noted between the adolescent and the parent, to help facilitate a conversation with the adolescent and caregiver about new ways of responding to emotional misery and extending treatment to include commonly needed caregiver components (i.e., parent management training, communication skills, increasing caregiver distress tolerance skills, and psychoeducation). Importantly, the PRF is not used to supplant the adolescent's perspective or collaboration in the treatment planning, but rather used as an adjunctive source of information about potential contributors to insufficient treatment response to consider with the adolescent. The goal of the PRF is to assist clinicians in efficiently and effectively making family-centered decisions regarding caregiver involvement in treatment and determining what caregivers need most (i.e., their "drivers") to support their adolescent's treatment success. Similar to the original CAMS SSF, the PRF lends itself well to integration into suicide-specific care in acute care settings as it helps clarify and refine treatment focus within the context of acute care while simultaneously identifying longer-term treatment targets. In this regard, the PRF effectively clarifies treatment goals that can be addressed in acute care settings while also facilitating transition to longer term care (i.e., helping identify treatment goals for ongoing outpatient therapy), addressing a key challenge of suicide-specific intervention in acute care settings.

### Summary and Future Research

The goal of this clinical perspective was to synthesize key elements of caregiver involvement in existing adolescent suicide risk intervention programs and consider how caregivers can be supported to facilitate their youth's reduction in suicidality. As outlined in the preceding literature

review, parental involvement is a requisite component of adolescent EBSPs. Concurrently, treatment engagement remains a primary concern in suicide prevention and clinicians must balance the need for parental involvement while prioritizing the therapeutic relationship with the adolescent patient. To that end, we introduced CAMS PRF as a strategy deployed in CAMS-4Teens and reviewed how this form can be used to effectively integrate caregivers into adolescent suicide-specific care. Initially, clinicians may use the PRF to identify parental strengths and challenges to help with individual skill-building. Clinicians may also find discrepancies between the PRF and SSF clinically useful in helping to understand adolescent–parent interaction patterns and clinicians may use this information to help guide a conversation between the adolescent patient and parents.

Several steps are needed to evaluate the impact of caregiver inclusion in suicide intervention programs, and to further refine the use of the PRF. It is important to evaluate the feasibility of administering the PRF, in terms of both clinician and parent time availability. Our research team is working toward a psychometric evaluation of the PRF to demonstrate its reliability and validity with diverse samples. We are soliciting feedback about the wording of various items in terms of relevance, specificity, and clarity. We would also like to evaluate patterns of response on the PRF that may predict trajectories of suicidality and be linked to specific parent focused intervention modules. Finally, we are evaluating our crisis clinic program which utilized CAMS-4Teen and the PRF as the guiding framework in this brief intervention.

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