Feasibility of Collaborative Assessment and Management of Suicidality–Brief Intervention in an Emergency Department With Youth Who Are Suicidal

Morganne Reid, PhD, Francesca Fernandez, MA,† Jessica Gerner, MA,†*
Raymond Tucker, PhD,‡ Claudia R. Morris, MD,,§*
John Constantino, MD,,§ and David A. Jobes, PhD†*

Background: Emergency departments (EDs) are key entry points for many youth experiencing suicidal thoughts and behaviors into mental health care. ED clinicians play a critical role in crisis intervention, prevention, and linking patients to ongoing care, yet many report uncertainty when assessing for and managing suicidal risk. The Collaborative Assessment and Management of suicidal thoughts and behaviors [Collaborative Assessment and Management of Suicidality (CAMS)] is an evidence-based, suicide-focused intervention that has been adapted into a single session [CAMS–Brief Intervention (CAMS-BI)].

Objective: This study tested the use of CAMS-BI with youth who are suicidal and presenting to a pediatric ED.

Methods: Participants (aged 12 to 21 y; n = 20) were approached in the ED and completed distress measures before and after CAMS-BI. Following standard discharge timelines was prioritized.

Results: Analyses supported CAMS-BI's feasibility for ED youth populations, given the observed low rate of intervention refusal (8.7%) and high completion rate (87%). Participation in the study did not delay ED discharge times. Youth receiving CAMS-BI reported significantly lower distress postintervention, $d = 0.45$. Three-month follow-up indicated reductions in ED-return rates (0%) compared with youth who did not receive the intervention (15%), and strong patient engagement with outpatient treatment following CAMS-BI was notable (88% attended follow-up appointment).

Conclusions: This pilot study provides evidence for CAMS-BI's feasibility for youth in fast-paced ED settings and its clinical value to quickly decrease distress. Future directions include larger, more rigorous replications to fine-tune CAMS-BI implementation into ED workflows.

Key Words: suicide prevention, behavioral health

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The number of youth dying by suicide each year is increasing, and rates of suicidal thoughts and behaviors (STB) among adolescents are on the rise.[1,2] Correspondingly, emergency department (ED) utilization for youth with suicide-related crises is also increasing.[3] Despite the surge, ED clinicians frequently report challenges related to assessment, disposition decisions, and access to timely follow-up care, underscoring the need for brief, evidence-based interventions that can be delivered within the ED.[4,5]

Inpatient care is a common next step for youth presenting to the ED with STB.[6,7] However, research highlights the "revolving door" phenomenon, indicating that many youth are readmitted within 3 months postdischarge from inpatient care and there can be increased risk postdischarge.[8,9] There are challenges to engaging in outpatient care postdischarge, particularly for youth insured with Medicaid or for those who have never received outpatient care before visiting the ED.[10,11] Specifically, only ~50% of Medicaid-insured youth receive any outpatient follow-up within 30 days postdischarge from the ED for a mental health concern.[12] This difficulty is compounded by the limited availability of outpatient therapy providers and intensive programs (eg, Partial Hospitalization Programs and Intensive Outpatient Programs).[13] Moreover, many youth who experience STB report fluctuations over hours and from day-to-day, highlighting the ED as a critical point for early and timely intervention.[9,14] However, not all EDs are well equipped to manage youth who are suicidal.

Single-session interventions have been proposed as a scalable approach for acute care settings like EDs; however, many existing youth-focused single-session interventions (eg, motivational interviewing, therapeutic assessments, safety planning interventions) have primarily improved treatment utilization rather than clinical outcomes such as distress or STB.[12–17] The Collaborative Assessment and

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From the *Department of Pediatrics, Emory University School of Medicine, Atlanta, GA; †Department of Psychology, The Catholic University of America; ‡Department of Psychology, Louisiana State University; and §Children's Healthcare of Atlanta, Atlanta, GA.
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Reprints: Morganne Reid, PhD, 1920 Briarcliff Road NE, Atlanta, GA 30320 (e-mail: morganne.reid@choa.org).

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Management of Suicidality (CAMS) is a suicide-specific intervention, which can include caregivers as well, with evidence supporting reductions in suicidal ideation, distress, and hopelessness across brief treatment courses.[18,19] Recently, a condensed single one-hour session adaptation —"CAMS–Brief Intervention" (CAMS-BI)—was developed for hospital settings and demonstrated promising reductions in distress among suicidal thoughts.[20,21] Despite its flexibility and foundations in evidence-based approaches such as therapeutic assessment, collaborative stabilization planning, and lethal means safety, it has yet to be evaluated with youth.[22,23]

The primary objective for this study was to assess the feasibility of CAMS-BI in a pediatric ED by evaluating the participants' rate of refusal and engagement. Specifically, feasibility was defined as $<25\%$ CAMS-BI refusal of approached patients and $\geq 50\%$ of consented participants completing the entire protocol. The secondary objective was to assess preliminary outcomes of the intervention through short-term measures.

METHODS

All procedures and measures were approved by the hospital Institutional Review Board. To establish feasibility, participants' rates of refusal and engagement were assessed. After caregiver consent and youth assent, the latter being particularly important for intervention buy-in and engagement, participants and their caregivers (if available in-person) completed the CAMS-BI protocol with a study staff member (a licensed psychologist or a doctoral student clinician). The Suicide Status Form (SSF-5) was completed with only the patient and clinician present, and caregivers subsequently joined to complete the "Stabilization Support Plan."[18] The intervention protocol was adapted from a pilot study conducted with adult inpatients.[20] The study's short-term outcomes, subjective units of distress (SUDS) and caregiver confidence ratings, were collected preintervention and immediately postintervention. We assessed 2 facets of caregiver confidence: their perceived ability to support their child in a suicidal crisis once they arrive home and perceived capacity to create a stable environment. The protocol was designed to be a brief $\leq$2-hour suicide-specific intervention with research measures included, administered during participants' time in the ED, and optimally cause no delay in typical clinical flow or discharge routines. Given this study assessed feasibility and acceptability, participation in CAMS-BI did not influence disposition decisions.

To examine longer-term outcomes, we examined the rate of outpatient treatment engagement postdischarge from the ED and ED return rates for STB. A propensity-scored matched sample of youth who did not receive CAMS-BI was used to cross-sectionally compare ED return rates. As part of the hospital's mental health care crisis, some patients are offered outpatient treatment with a psychiatrist and/or CAMS therapy in an outpatient setting. These appointments are typically made in the ED (unless the patient is psychiatrically hospitalized at an external hospital) and scheduled within several days following discharge. To examine postdischarge outcomes, medical charts were reviewed at 3 months following participation in CAMS-BI. Specifically, we examined attendance of follow-up outpatient sessions and returns to the ED for STB in those who completed CAMS-BI. Attendance of outpatient appointments in the CAMS-BI sample was compared with rates of session attendance for patients who were in the ED but did not receive CAMS-BI (ie, baseline no-show rate for outpatient CAMS services).

Measures

Ask Suicide-Screening Questions

The Ask Suicide-Screening Questions (ASQ) is a 5-item (scored from 0 to 5) nonproprietary suicide risk screening tool designed for use in ED departments for youth populations and exhibits high sensitivity and validity.[24]

Subjective Units of Distress

SUDS is a self-report measure to capture one's distress and can be presented on a visual scale such as a "thermometer."[25] While there are a variety of visual SUDS scales available for use, this study's chosen SUDS "thermometer" scale was sourced from Oakey-Frost et al.[20] Participants were instructed to select one number on a thermometer labeled from zero ("no distress") to 100 ("the worst distress ever experienced").

Caregiver Survey

A 2-item questionnaire was developed to briefly assess caregivers' confidence levels preintervention and postintervention. If present, caregivers were asked how confident they felt in their ability to support their child during a suicidal crisis (described as "ie, knowing what to do and not to do"), as well as how confident they felt in their ability to create a stable home environment to help reduce their child's suicide risk. Caregivers were instructed to rate both items on a 5-point Likert scale from 1 ("not at all") to 5 ("very").

Interventions

Collaborative Assessment and Management of Suicidality–Brief Intervention

CAMS-BI followed a similar protocol to that of Oakey-Frost and colleagues, with participants and clinicians completing the SSF-5, which has been used and normed with adolescent samples.[20,26,27] To increase participants' comfort and openness (as many participants endorsed significant family conflict), the SSF was typically completed without their caregiver present. If available, the caregiver joined the session only to complete the Stabilization Support Plan, which is a plan the caregiver, clinician, and participant develop together for how the caregiver can support their child in the future if STB reoccur. There are various sources that describe "CAMS-4Teens" and related research to date in more detail.[18,27–29] CAMS-BI is very similar to the first session of "CAMS-4Teens" with some modifications for engaging the patient and family, and treatment planning.

Statistical Analyses

Demographic data were gathered through medical chart review. Descriptive statistics for demographic and primary outcome variables (ie, SUDS and individual caregiver confidence items) were calculated. Participants' rates of refusal and completion were tallied to understand the feasibility of CAMS-BI with ED-presenting youth. As it was critical that the study did not interrupt routine clinical flow, the number of CAMS-BI sessions interrupted by

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other medical staff is also described to further depict acceptability of CAMS-BI in a real-world ED setting. To test if there were any changes in SUDS or caregiver confidence ratings preintervention to postintervention, paired-samples *t* tests were calculated. Based on effect sizes from previous research, the current analyses are moderately powered to detect preintervention-to-postintervention effects.[20] Effect sizes were estimated using Cohen *d*. Approximately half of youth participants' (n = 9) caregivers were unavailable during the intervention. Therefore, descriptives were calculated to observe if postintervention distress scores differed between groups (caregivers present vs. absent).

Comparison of 3-month ED return rates between those who did and did not receive CAMS-BI was conducted using propensity score matching to improve comparability between groups. A 1:1 match was performed based on age, sex, initial ASQ level, and disposition status, given that disposition outcomes differ by patient risk level. It should be noted that disposition decisions were typically made before the participant received CAMS-BI. Propensity scores were estimated using logistic regression, and cases were matched to controls using nearest-neighbor matching.

Our goal in using propensity score matching was to reduce confounding and provide a more balanced, descriptive comparison of ED return rates rather than to support definitive inferential conclusions. Although a comparison of ED readmission could have been conducted using Fisher exact test, a total sample of N = 88 would be required to detect a medium effect with 80% power, and N = 785 would be required to detect a small effect. Because our available sample was substantially smaller than these thresholds, we did not conduct formal significance testing of ED return rates and instead present the matched-group results descriptively.

RESULTS

Patient Population

For this feasibility trial, 23 youth ages 12- to 21-years old presenting to a large southeastern children's hospital ED for STB and self-reported high to imminent risk on the ASQ (ASQ score of ≥1 or "yes" to questions 1 to 5) and their caregivers were eligible to receive CAMS-BI.[24] Exclusion criteria included any youth who were nonspeaking, experiencing active psychosis, currently in foster care, and those with limited English proficiency. Referrals came from Behavioral and Mental Health Specialists (ie, licensed professional counselors, social workers), the psychiatry consult team, attending psychiatrists, or hospital research coordinators routinely conducting chart and ED board reviews. Our sample of youth participants were predominantly non-Hispanic Black females with a mean age of 14.6 years (SD = 1.64) who presented to the ED for suicidal ideation, which was listed as the chief complaint by the ED attending physician (Table 1).

Acceptability of Collaborative Assessment and Management of Suicidality–Brief Intervention

Twenty-three participants were identified for potential participation by ED staff, after which research staff reached out by phone to participants' families to confirm eligibility. Of the 23 who met eligibility criteria, 20 were included in our final sample to achieve a goal sample of 20 participants who completed the intervention (Fig. 1). Two participants declined the intervention when approached, and 1 participant withdrew midway following a negative interaction with hospital staff external to the study. The majority of youth participants approached to engage with the study participated. Specifically, 8.7% (2/23) of youth participants refused the study, while 87% of participants (20/23) completed the full intervention. The study's incompletion rate was 4.3% (1/23). Of the 20 participants who completed the intervention, half (n = 10) experienced session interruptions, which included medical staff activities, such as collecting vital signs and medication administration. The intervention was provided within the patient's standard length of stay (eg, while waiting for clinical care, assessment, discharge, or transfer) and did not delay discharge time.

Immediate Efficacy of Collaborative Assessment and Management of Suicidality–Brief Intervention

CAMS-BI led to a significant reduction in distress from preintervention (M = 39.55, SD = 24.72) to postintervention (M = 28.50, SD = 24.55), $t(19) = 2.57$, $P = 0.02$, $d = 0.45$ [95% CI (0.08, 0.82)]. There was a statistically significant change observed in caregiver confidence levels in their ability to support their children during a suicidal crisis from preintervention to postintervention, $t(10) = -2.39$, $P = 0.04$, $d = 0.47$ [95% CI (0.04, 0.94), Table 2]. However, there were no significant changes pre/post CAMS-BI in terms of caregivers' reported confidence in their ability to create a stable environment, $t(10) = -1.00$, $P = 0.34$, $d = -0.24$ [95% CI (−0.76, 0.27)].

As part of our secondary analysis, caregiver presence's effect on postintervention distress levels was evaluated, specifically while controlling for baseline distress. While the overall model was significant, $F(2, 17) = 7.92$, $P = 0.004$, $R^2 = 0.42$, a closer evaluation revealed that baseline distress levels significantly predicted postintervention distress ratings, $B = 0.69$, $SE = 0.18$, $t(17) = 3.72$, $P = 0.002$. When comparing caregiver present (n = 11) versus absent (n = 9) subgroups, descriptives suggest that both groups had similar decreases in SUDS ratings from preintervention to postintervention (Table 3).

TABLE 1. Sociodemographic and Clinical Characteristics of Youth Participants (n = 20)

Sample Characteristics	n (%)	M	SD
Sex			
Male	5 (25)		
Female	14 (70)		
Nonbinary	1 (5)		
Age		14.6	1.64
12-13	6 (30)		
14-15	5 (25)		
16-17	9 (45)		
Race			
Black or African American	13 (65)		
White	6 (30)		
Native Hawaiian or other Pacific Islander	1 (5)		
Ethnicity			
Hispanic	2 (10)		
Non-Hispanic	18 (90)		
Referral reason			
Suicidal ideation	13 (65)		
Suicide attempt	7 (35)		

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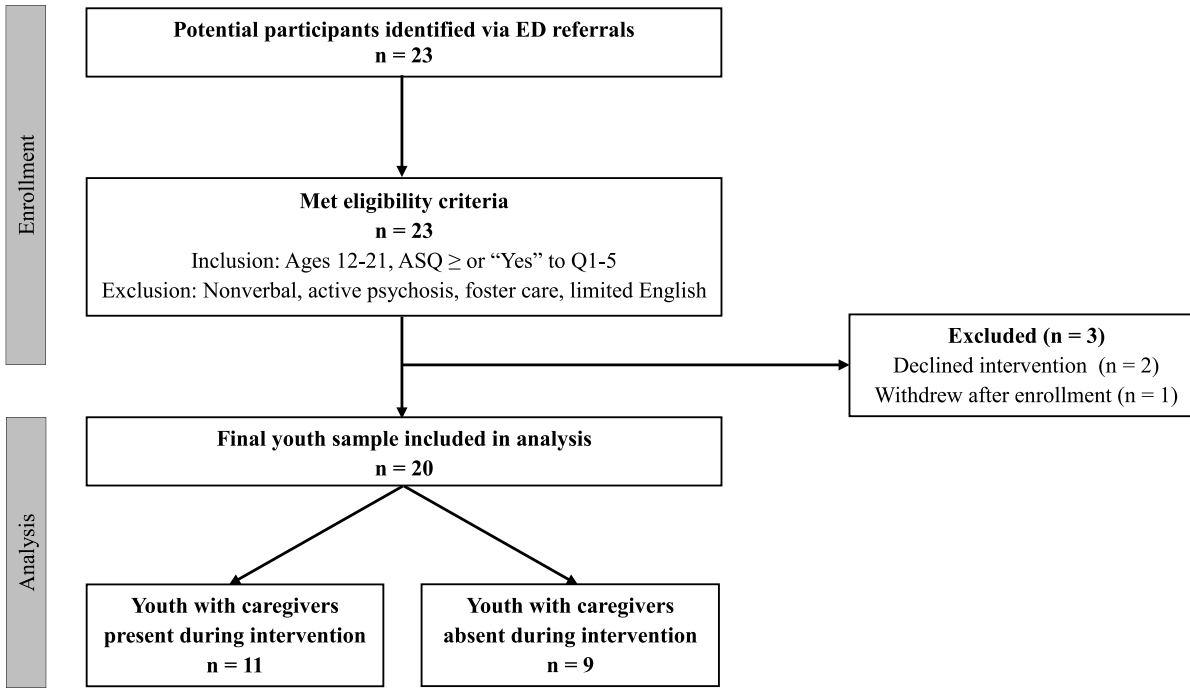

FIGURE 1. Flow of youth participants and caregivers through the CAMS-BI feasibility trial. ASQ indicates Ask Suicide-Screening Questions; CAMS-BI, Collaborative Assessment and Management of Suicidality–Brief Intervention; ED, emergency department.

Postdischarge Emergency Department Return Rates and Treatment Engagement

For those who received CAMS-BI, no patients returned to the ED for STB within 3 months postdischarge from the ED, but one patient returned to the ED for nonsuicidal self-injury. Three youth in the propensity score-matched sample returned to the ED for STB within 3 months of discharge (15%). Of those who had an outpatient CAMS appointment scheduled (n = 8), 6 attended their first session, 1 rescheduled and subsequently attended, and 1 did not attend their first appointment. Of note, some patients who participated were placed on a psychiatric hold (n = 8), which required that they be transferred to an external inpatient psychiatric facility and therefore did not receive a referral to the outpatient CAMS clinic (Table 4).

DISCUSSION

This feasibility study provides preliminary outcomes of CAMS-BI for youth presenting with STB in a pediatric ED. As such, completion, engagement, and retention rates are reported, which are common considerations for evaluating an intervention's clinical feasibility.[30] CAMS-BI proved remarkably feasible for youth presenting to fast-paced ED settings. Indeed, the observed refusal rate was low (8.7%); completion rate for the intervention was high (87%), even though half of sessions were interrupted by routine ED care. Importantly, CAMS-BI was completed within existing ED workflows and did not extend length of stay, supporting its scalability as a BI in ED settings. Notably, Black adolescent females have experienced the highest increase in STB within the last decade.[31] The majority of our sample were Black females, highlighting that CAMS-BI can be an effective intervention for this historically psychiatrically underserved group, a result that corresponds with past research demonstrating similar psychometric SSF performance in Black versus White adults receiving CAMS-BI.[32]

Consistent with prior adult research, youth who received CAMS-BI showed immediate reductions in subjective distress postintervention.[20] Decreasing acute distress is an important clinical outcome for STB crisis intervention, such as that provided in pediatric ED settings.[33] Our results support the feasibility of delivering a collaborative, suicide-focused intervention that includes a therapeutic assessment and a stabilization plan resulting in short-term emotional relief within a single encounter. While our study relied on a doctoral-level graduate student and psychologist supervisor, other para-professional trainees and telehealth platforms can also provide this intervention.[34] The option of administering CAMS-BI with supervised mental health professionals in training is a valuable means for increasing the ED mental health workforce. Although preliminary, these results reinforce the importance of integrating therapeutic elements into acute suicide risk assessment and

TABLE 2. Preintervention to Postintervention Changes in Caregiver Confidence

	Pre		Post			
Outcome Variable	**M**	**SD**	**M**	**SD**	***d***	**95% CI**
Confidence supporting child during suicidal crisis	4.17	0.83	4.67	0.65	0.47	0.04, 0.94
Confidence in creating stable environment	4.75	0.45	4.92	0.29	-0.24	-0.76, 0.27

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TABLE 3. Participants' SUDS by Caregiver Presence Subgroup

		SUDS Preintervention		SUDS Postintervention	
Participant subgroup	**n**	**M**	**SD**	**M**	**SD**
Caregiver present	11	44.18	24.69	33.89	24.97
Caregiver absent	9	34.55	28.76	21.11	16.91

SUDS indicates subjective units of distress.

suicide-specific management.[22] This study lends support to CAMS-BI helping to ensure that suicide-focused care is evidence-based, least restrictive, and cost-effective.

Caregiver confidence findings were mixed, with improved confidence in supporting their children during a suicidal crisis, but no apparent increase in caregivers' perceived ability to create a stable environment. This discrepancy may reflect limitations with the brief 2-item measure. While the items were developed by the research team to be face-valid, they were not taken from previously established self-report measures.[35] As such, it is possible that the item examining the ability to create a safe environment could be interpreted as meaning a psychologically safe, socially safe, and/or means-safe environment. Similarly, guardians may feel confident in ensuring stability at home but not at school, and thus the item assessing may not be ideal for assessing what is and is not in a guardian's control. Although assessment of these multifaceted constructs was reduced to 2 items to support research feasibility in the ED, our findings are still important. Across qualitative and quantitative studies, caregivers of adolescents who experience STB convey a need for psychoeducational resources related to safety planning, preventative activities, and practical and educational tools to aid their empowerment during youth crises.[36] Such tools influence caregiver confidence levels and engagement and compliance with postdischarge referrals and treatment plans for youth.[37,38] Future studies should incorporate validated caregiver-focused measures to understand how brief suicide interventions influence these family factors.

Our descriptive analyses suggest that caregiver presence was not required for youth to experience reductions in distress. While family involvement is often recommended in interventions for adolescents with STB, requiring caregiver participation may limit feasibility in real-world contexts where logistical barriers, family conflict, and availability of caregivers vary widely, particularly for adolescents experiencing STB.[39–41] Compared with other ED-based approaches that require full caregiver participation in the intervention (eg, Family-Based Crisis Intervention, the SAFETY program), CAMS-BI may offer a more flexible model that remains accessible to a broader range of youth while still incorporating caregiver support when possible.[42,43] Importantly, these interventions share the common goal of averting inpatient hospitalizations and the potential iatrogenic effects this care can have.[33,43] We hope to examine in larger studies whether the CAMS-BI intervention is as effective with or without caregivers present, as youth who are suicidal without a caregiver present may be as in need of or more in need of suicide-specific support from a caring adult.

TABLE 4. Disposition Decisions by ED Staff

Disposition	**n (%)**
Not hospitalized and referred to outpatient CAMS	6 (30)
Hospitalized and referred to outpatient CAMS	5 (25)
Hospitalized and not referred to outpatient CAMS	8 (40)
Out of state	1 (5)

CAMS indicates Collaborative Assessment and Management of Suicidality; CRC, crisis recovery clinic; ED, emergency department.

Finally, exploratory postdischarge outcomes were encouraging but should be interpreted cautiously. None of the youth who received CAMS-BI, regardless of guardian involvement, returned to the ED for STB within the 3 months following care, whereas 3 youth in the matched sample readmitted. This comparison should not be interpreted as a clear statistical demonstration of the intervention's effectiveness compared with ED treatment as usual, but as preliminary data demonstrating need for continued research. Similarly, most youth referred for outpatient CAMS services attended at least one follow-up session. Given the high priority for increasing ED services that reliably help transition patients to utilizing outpatient care, initial data supporting linkage of care are promising.[44]

Limitations

Several limitations warrant consideration. The small sample size, particularly the number of caregivers available to participate, limits generalizability and confidence in observed effects. The absence of a randomized comparison group prevents conclusions about efficacy relative to standard ED care or another ED-based intervention. This did not allow for a direct comparison of whether CAMS-BI specifically reduces distress, or simply time passing in the ED. In addition, sessions often occurred alongside routine clinical interruptions (ie, meeting with attending physician, vitals check, and meals) or pending hospitalization decisions, reflecting real-world conditions but introducing potential confounds when interpreting intervention-specific effects. Caregiver participation occurred in just over half of sessions, highlighting a potential implementation challenge and the clear need for flexible approaches in future work (eg, telehealth, in-home care). We are encouraged by statistically significant results showing decreases in suicidal suffering, suggesting better dispositions to optimize clinical outcomes for patients and caregivers. While we are optimistic about these feasibility results, further replication within larger well-powered clinical trials is needed to potentially enhance our ability to clinically help save young lives from suicide. Future research should also examine implementation strategies that optimize caregiver involvement while maintaining feasibility in acute care settings.

CONCLUSIONS

This feasibility pilot study provides preliminary evidence that CAMS-BI is an acceptable and potentially

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effective BI for youth who are suicidal in pediatric EDs. The intervention demonstrated strong engagement, immediate reductions in distress, and increased guardian confidence in supporting their youth while reducing near-term ED readmission. Future research is needed to determine whether CAMS-BI can enhance suicide prevention efforts within EDs, which act as a vital service delivery system for youth with STB, and act as a tool for providers, who report the need for tools in managing youth with STB.[3–5] With a sample made up of 70% underrepresented youth, we have shown the potential merit of a brief suicide-focused intervention for significantly decreasing suicide-related suffering with the very real prospect of making suicide-related ED visits a more therapeutic and helpful experience for both children and their caregivers.

REFERENCES

1. Curtin S, Garnett M. *Suicide and homicide death rates among youth and young adults aged 10-24 years: United States, 2001-2021*, NCHS Data Brief. National Center for Health Statistics. 2023. doi:10.15620/cdc:128423
2. Ivey-Stephenson AZ, Demissie Z, Crosby AE, et al. Suicidal ideation and behaviors among high school students—Youth Risk Behavior Survey, United States, 2019. *MMWR Suppl*. 2020;69:47–55.
3. Bommersbach TJ, Olfson M, Rhee TG. National trends in emergency department visits for suicide attempts and intentional self-harm. *Am J Psychiatry*. 2024;181:741–752.
4. Bowden CF, Worsley D, Esposito JM, et al. Pediatric emergency departments' readiness for change toward improving suicide prevention: a mixed-methods study with US leaders. *J Am Coll Emerg Physicians Open*. 2022;3:e12839.
5. Rheinberger D, Wang J, McGillivray L, et al. Understanding emergency department healthcare professionals' perspectives of caring for individuals in suicidal crisis: a qualitative study. *Front Psychiatry*. 2022;13:918135.
6. Kim Y, Krause TM, Lane SD. Trends and seasonality of emergency department visits and hospitalizations for suicidality among children and adolescents in the US from 2016 to 2021. *JAMA Netw Open*. 2023;6:e2324183.
7. Sheridan DC, Lin A. Emergency department adolescent suicidality: a pilot study to determine how common actual attempts are. *Pediatr Emerg Care*. 2022;38:e458–e461.
8. Blader JC. Symptom, family, and service predictors of children's psychiatric rehospitalization within one year of discharge. *J Am Acad Child Adolesc Psychiatry*. 2004;43:440–451.
9. Czyz EK, Horwitz AG, Arango A, et al. Short-term change and prediction of suicidal ideation among adolescents: a daily diary study following psychiatric hospitalization. *J Child Psychol Psychiatry*. 2019;60:732–741.
10. Doupnik SK, Passarella M, Terwiesch C, et al. Mental health service use before and after a suicidal crisis among children and adolescents in a United States national Medicaid sample. *Acad Pediatr*. 2021;21:1171–1178.
11. Karaca Z, Moore BJ. Costs of emergency department visits for mental and substance use disorders in the United States, 2017. *Healthcare Cost and Utilization Project (HCUP) Statistical Briefs #257*, Medical Benefits. Agency for Healthcare Research and Quality (US). 2022;37:6–8. https://login.proxy.library.emory.edu/login?url=https://www.proquest.com/trade-journals/costs-emergency-department-visits-mental/docview/2526913843/se-2
12. Hoffmann JA, Krass P, Rodean J, et al. Follow-up after pediatric mental health emergency visits. *Pediatrics*. 2023;151:e2022057383.
13. Ghose SS, Beehler S, Pinals DA, et al. Youth inpatient and residential treatment psychiatric beds: national trends and potential causal factors, 2010-2022. *Psychiatr Serv*. 2025;76:343–349.
14. Kivelä L, van der Does WAJ, Riese H, et al. Don't miss the moment: a systematic review of ecological momentary assessment in suicide research. *Front Digit Health*. 2022;4:876595.
15. Asarnow JR, Baraff LJ, Berk M, et al. An emergency department intervention for linking pediatric suicidal patients to follow-up mental health treatment. *Psychiatr Serv*. 2011;62:1303–1309.
16. Grupp-Phelan J, Stevens J, Boyd S, et al. Effect of a motivational interviewing-based intervention on initiation of mental health treatment and mental health after an emergency department visit among suicidal adolescents: a randomized clinical trial. *JAMA Netw Open*. 2019;2:e1917941.
17. Ougrin D, Boege I, Stahl D, et al. Randomised controlled trial of therapeutic assessment versus usual assessment in adolescents with self-harm: 2-year follow-up. *Arch Dis Child*. 2013;98:772–776.
18. Jobes DA. *Managing Suicidal Risk: A Collaborative Approach*, 3rd edn. Guilford Press; 2023.
19. Swift JK, Trusty WT, Penix EA. The effectiveness of the collaborative assessment and management of suicidality (CAMS) compared to alternative treatment conditions: a meta-analysis. *Suicide Life Threat Behav*. 2021;51:882–896.
20. Oakey-Frost N, Crapanzano KA, Gerner J, et al. An observational pilot of the collaborative assessment and management of STB brief intervention (CAMS-BI) for adult inpatients. *Gen Hosp Psychiatry*. 2023;S0163-8343:00154–00158.
21. Oakey-Frost N, Moscardini EH, Cowan T, et al. The Suicide Status Form-4 (SSF-IV) as a potentially therapeutic suicide risk assessment tool. *Suicide Life Threat Behav*. 2025;55:e13128.
22. Hawton K, Lascelles K, Pitman A, et al. Assessment of suicide risk in mental health practice: shifting from prediction to therapeutic assessment, formulation, and risk management. *Lancet Psychiatry*. 2022;9:922–928.
23. Ketabchi B, Chaudhary S, Cieslak K, et al. Youth suicide prevention in the emergency department: lethal means counseling 101. *Ann Emerg Med*. 2025;86:415–426.
24. Horowitz LM, Bridge JA, Teach SJ, et al. Ask Suicide-Screening Questions (ASQ): a brief instrument for the pediatric emergency department. *Arch Pediatr Adolesc Med*. 2012;166:1170.
25. Wolpe J. *The Practice of Behavior Therapy*, 4th Edition. Pergamon Press; 1990
26. Adrian M, McCauley E, Gallop R, et al. Advancing Suicide Intervention Strategies for Teens (ASSIST): study protocol for a multisite randomised controlled trial. *BMJ Open*. 2023;13:e074116.
27. Brausch AM, O'Connor SS, Powers JT, et al. Validating the Suicide Status Form for the Collaborative Assessment and Management of STB in a psychiatric adolescent sample. *Suicide Life Threat Behav*. 2020;50:263–276.
28. Adrian M, Blossom JB, Chu PV, et al. Collaborative assessment and management of STB for teens: a promising frontline intervention for addressing adolescent STB. *Pract Innov*. 2022;7:154–167.
29. Vergara GA, Mandel AA, Adrian MC, et al. CAMS-4Teens, suicide index score typologies, and family factors. *J Affect Disord*. 2026;394:120540.
30. Teresi JA, Yu X, Stewart AL, et al. Guidelines for designing and evaluating feasibility pilot studies. *Med Care*. 2022;60:95–103.
31. Cooper AM, Visoki E, Tran KT, et al. Prevalence of suicidal ideation and suicide attempts by race and gender in three large U.S. adolescent cohorts. *Am J Psychiatry*. 2025;182:945–949.
32. Oakey-Frost N, Divers R, Moscardini EH, et al. Factor structure and measurement invariance of the suicide status form-IV. *Assessment*. 2024;31:574–587.
33. Ward-Ciesielski EF, Rizvi SL. The potential iatrogenic effects of psychiatric hospitalization for suicidal behavior: a critical review and recommendations for research. *Clin Psychol Sci Pract*. 2021;28:60–71.

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34. O'Neill JC, O'Callaghan ET, Sullivan S, et al. Novel telehealth adaptations for evidence-based outpatient suicide treatment: feasibility and effectiveness of the crisis care program. *Healthcare (Basel)*. 2023;11:3158.
35. Czyz EK, Horwitz AG, Yeguez CE, et al. Parental self-efficacy to support teens during a suicidal crisis and future adolescent emergency department visits and suicide attempts. *J Clin Child Adolesc Psychol*. 2018;47(suppl 1):S384–S396.
36. Branjerdporn G, Erlich F, Ponraj K, et al. What is helpful and what is challenging for the caregivers of young people receiving interventions to prevent suicide? caregivers' perspectives—a rapid scoping review. *Children (Basel)*. 2023;10:1801.
37. Ewell Foster C, Magness C, Czyz E, et al. Predictors of parent behavioral engagement in youth suicide discharge recommendations: implications for family-centered crisis interventions. *Child Psychiatry Hum Dev*. 2022;53:1240–1251.
38. King CA, Hovey JD, Brand E, et al. Suicidal adolescents after hospitalization: parent and family impacts on treatment follow-through. *J Am Acad Child Adolesc Psychiatry*. 1997; 36:85–93.
39. Wharff EA, Ginnis KM, Ross AM. Family-based crisis intervention with suicidal adolescents in the emergency room: a pilot study. *Soc Work*. 2012;57:133–143.
40. Alvarez-Subiela X, Castellano-Tejedor C, Villar-Cabeza F, et al. Family factors related to suicidal behavior in adolescents. *Int J Environ Res Public Health*. 2022;19:9892.
41. Mathew A, Saradamma R, Krishnapillai V, et al. Exploring the family factors associated with suicide attempts among adolescents and young adults: a qualitative study. *Indian J Psychol Med*. 2021;43:113–118.
42. Ginnis KB, White EM, Ross AM, et al. Family-based crisis intervention in the emergency department: a new model of care. *J Child Fam Stud*. 2015;24:172–179.
43. Asarnow JR, Berk M, Hughes JL, et al. The SAFETY Program: a treatment-development trial of a cognitive-behavioral family treatment for adolescent suicide attempters. *J Clin Child Adolesc Psychol*. 2015;44:194–203.
44. Brodsky BS, Spruch-Feiner A, Stanley B. The zero suicide model: applying evidence-based suicide prevention practices to clinical care. *Front Psychiatry*. 2018;9:33.

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