The Collaborative Assessment and Management of Suicidality (CAMS)

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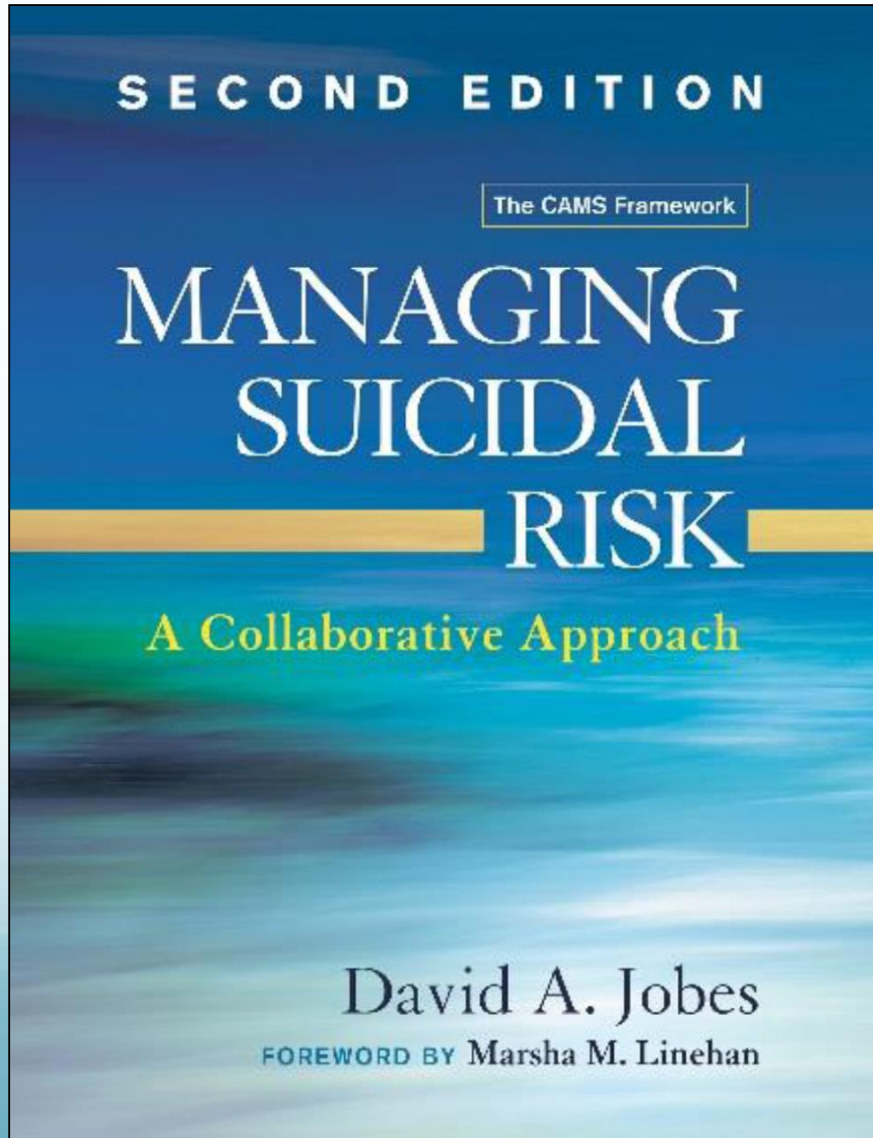
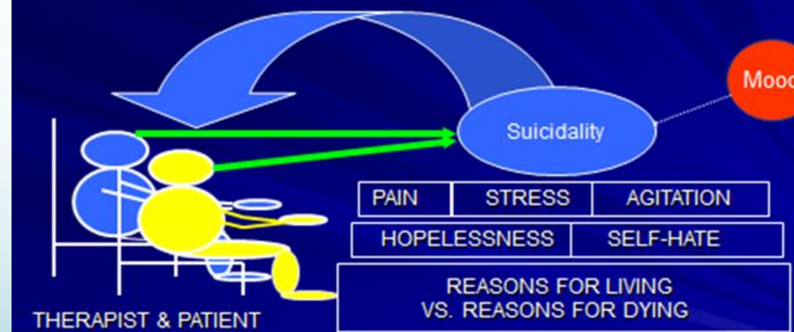




The four pillars of the CAMS framework:

1) Empathy
2) Collaboration
3) Honesty
4) Suicide-focused

Goal: Build a strong therapeutic alliance that increases patient-motivation; CAMS targets and treats *patient-defined* suicidal "drivers"

First session of CAMS—SSF Assessment, Stabilization Planning, Driver-Specific Treatment Planning, and HIPAA Documentation

CAMS Interim Tracking Sessions

CAMS Outcome/Disposition Session

Adherence to the CAMS Approach

CAMS is a therapeutic framework, used until suicidal risk resolves. Adherence requires thorough suicide assessment and problem-focused interventions that target and treat patient-defined suicidal "drivers."

CAMS Philosophy

- Empathy for suicidal states—no shame, no blame
- Collaboration with suicidal patient in all aspects of the intervention
- Honesty and transparency throughout clinical care

CAMS as Therapeutic Framework

- Focus on Suicide—from beginning to middle to end
- Outpatient Oriented—goal is to keep a suicidal patient in outpatient care (if possible)
- Flexible and "Nondenominational"—used across theories and uses range of techniques

Overview to CAMS Assessment and Care

CAMS is a suicide-specific therapeutic framework, emphasizing five core components of collaborative clinical care (over 10-12 sessions/3 months).

Component I. Collaborative Assessment of Suicidal Risk

Component II. Collaborative Treatment Planning

- → Attend treatment reliably as scheduled over the next three months
- → Reduce access to lethal means
- → Develop a self-oriented coping strategy on CAMS Stabilization Plan
- → Create interpersonal supports and connectedness

Component III. Collaborative Understanding of the Patient's Suicidal Drivers →
Relationship issues (especially family)

- → Vocational issues (what do they do?)
- → Self-related issues (self-worth/self-esteem)
- → Pain and suffering—general and specific

Component IV. Collaborative Problem-Focused Interventions that target and treat patient-defined drivers

Component V. Collaborative Development of Reasons for Living

- → Develop plans, goals, and hope for the future
- → Develop guiding beliefs—a post-suicidal life (e.g., lessons in living)

CAMS—First Session

CAMS Suicide Status Form Initial Session

Patient: Kevin Clinician: David Jobes Date: 6/23 Time: noon

Section A (*Patient*):

Rate and fill out each item according to how you feel right now.
Then rank in order of importance 1 to 5 (1=most important to 5=least important).

Rank	
3	1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*): **Low pain:** 1 2 3 (4) 5 **:High pain** What I find most painful is: being stuck in my own skin
5	2) RATE STRESS (*your general feeling of being pressured or overwhelmed*): **Low stress:** 1 2 3 4 (5) **:High stress** What I find most stressful is: being here
4	3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*): **Low agitation:** 1 2 3 (4)/(5) **:High agitation** I most need to take action when: Someone does something untrustworthy
1/1.5	4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*): **Low hopelessness:** 1 2 3 4 5 (10) **:High hopelessness** I am most hopeless about: anything changing
1	5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*): **Low self-hate:** 1 2 3 4 5 (10) **:High self-hate** What I hate most about myself is: everything
N/A	6) RATE OVERALL RISK OF SUICIDE: **Extremely low risk:** (will **not** kill self) 1 2 3 4 (5) **:Extremely high risk** (will kill self)

1) How much is being suicidal related to thoughts and feelings about yourself? **Not at all:** 1 2 3 (4) 5 **: completely**
2) How much is being suicidal related to thoughts and feelings about others? **Not at all:** 1 2 3 (4) 5 **: completely**

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING
3	my mom	1	people don't get it / they don't care
2	maybe something will get better	3	nothing is going to change
		4	I don't contribute to society
1	See how Breaking Bad ends	1	people would be better off if I was dead

I wish to live to the following extent: Not at all: 0 (1) 2 3 4 5 6 7 8 : Very much
I wish to die to the following extent: Not at all: 0 1 2 3 (4) 5 6 7 8 : Very much

The one thing that would help me no longer feel suicidal would be: MIB flash thing on everyone and then myself

CAMS Session #1 (Cont.)

CAMS Suicide Status Form Initial Session

Section B (*Clinician*):

(Y) N	Suicide ideation	Describe: I think about it a lot - since 7
	○ Frequency ○ Duration	✓ per day ✓ per week ✓ per month / ✓ seconds ✓ minutes ✓ hours — all the time
(Y) N	Suicide plan	When: At home before GF comes home Where: At home How: Knife — Access to means (Y) N How: Belt — Access to means (Y) N
(Y) N	Suicide preparation	Describe: Think about death scene · tried out belt
(Y) N	Suicide rehearsal	Describe: Put belt around neck
(Y) N	History of suicidal behaviors	
	• Single attempt	Describe:
	• Multiple attempts	Describe: 6x hanging
(Y) N	Impulsivity	Describe: GF says yes
Y (N)	Substance abuse	Describe:
Y (N)	Significant loss	Describe:
(Y) N	Relationship problems	Describe: GF / GF's mom / mother
(Y) N	Burden to others	Describe:
(Y) N	Health/pain problems	Describe:
(Y) N	Sleep problems	Describe: Only sleeps 3-4 hours a night
Y (N)	Legal/financial issues	Describe:
(Y) N	Shame	Describe: everything

Section C (*Clinician*): **TREATMENT PLAN** (Refer to Sections A & B)

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	*Self-Harm Potential*	*Safety and Stability*	*Stabilization Plan Completed* ☑	3 months
2	Self-hate	↓ Self-hate	Insight 4 tx CBT BA Voc counseling	3 months
3	People don't get it / Betrayal	Find ways to help others get it increase ↑ trust	Psychodynamic tx CBT BA CT?	3 months

YES ✓ NO ___ Patient understands and concurs with treatment plan?
YES ___ NO ✓ Patient at imminent danger of suicide (hospitalization indicated)?

Patient Signature — Clinician Signature

Drivers

Stabilize

CAMS Suicide Status Form STABILIZATION PLAN

Ways to reduce access to lethal means:

1. Conversation with girlfriend about knife
2. Remove the belt
3.

Things I can do to cope differently when I am in a suicide crisis (consider crisis card):

1. Exercise
2. Watch "Breaking Bad"
3. Write in journal
4. Read "Choosing to Live"
5. Walk to local Best Buy
6. Life or death emergency contact number: 555-750-1093
   1-800-273-TALK

People I can call for help or to decrease my isolation:

TBD
1.
2.
3.

Attending treatment as scheduled:

Potential Barrier: — Solutions I will try:

1. N/A
2.

The importance of restricting access to lethal means

Section D (*Clinician Post-Session Evaluation*):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS: (ALERT) DROWSY LETHARGIC STUPOROUS
OTHER: ______

ORIENTED TO: (PERSON) (PLACE) (TIME) (REASON FOR EVALUATION)

MOOD: EUTHYMIC ELEVATED (DYSPHORIC) AGITATED ANGRY

AFFECT: FLAT BLUNTED CONSTRICTED (APPROPRIATE) LABILE

THOUGHT CONTINUITY: (CLEAR & COHERENT) GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL
OTHER: ______

THOUGHT CONTENT: (WNL) OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY
OTHER: ______

ABSTRACTION: (WNL) NOTABLY CONCRETE
OTHER: ______

SPEECH: (WNL) RAPID SLOW SLURRED IMPOVERISHED INCOHERENT
OTHER: ______

MEMORY: (GROSSLY INTACT)
OTHER: ______

REALITY TESTING: (WNL)
OTHER: ______

NOTABLE BEHAVIORAL OBSERVATIONS: ______

DIAGNOSTIC IMPRESSSIONS/DIAGNOSIS (DSM/ICD DIAGNOSES):

Deferred - R/o Major Depression

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

- ☐ **LOW (WTL/RFL)**
- ☑ **MODERATE (AMB)**
- ☐ **HIGH (WTD/RFD)**

Explanation: Multiple attempt history; high SSF core assessment ratings; long history of suicidal ideation - but willing to try CAMS for 3 months

CASE NOTES:
Kevin is a 32 year old white male who is unemployed and living with his girlfriend at her mom's house. He is isolated, hopeless and hates himself. He has few resources and limited coping skills. But he is verbal and somewhat intrigued by the treatment being offered. He reports high risk, but based on compliance and CAMS stabilization plan, can be managed on an outpatient basis.

Next Appointment Scheduled: Thurs Treatment Modality: Individual: insight + CBT

[signature] 6/23

Clinician Signature Date

CAMS Interim Tracking/Update Session

CAMS Suicide Status Form Tracking/Update Interim Session

Patient: Kevin Clinician: David Jobes Date: 7/1 Time: 1 pm

Section A (*Patient*):

Rate each item according to how you feel right now.

1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*):	**Low pain: 1 2 3 (4) 5 :High pain**
2) RATE STRESS (*your general feeling of being pressured or overwhelmed*):	**Low stress: 1 2 3 (4) 5 :High stress**
3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*):	**Low agitation: 1 2 3 (4) 5 :High agitation**
4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*):	**Low hopelessness: 1 2 3 4 (5) :High hopelessness**
5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*):	**Low self-hate: 1 2 3 (4)/(5) :High self-hate**
6) RATE OVERALL RISK OF SUICIDE:	**Extremely low risk: (will not kill self) 1 2 3 4 (5) :Extremely high risk (will kill self)**

In the past week: Suicidal Thoughts/Feelings Y✓ N__ Managed Thoughts/Feelings Y✓ N__ Suicidal Behavior Y__ N✓

Section B (*Clinician*):

Resolution of suicidality, if: current overall risk of suicide <3; in past week: no suicidal behavior and effectively managed suicidal thoughts/feelings ☐ 1st session ☐ 2nd session

Complete **SSF Outcome Form at 3rd consecutive resolution session**

TREATMENT PLAN UPDATE

Patient Status:

☐ Discontinued treatment ☐ No show ☐ Cancelled ☐ Hospitalization ☐ Referred/Other: ____________

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	*Self-Harm Potential*	*Safety and Stability*	*Stabilization* *Plan Updated* ☑	11 sessions
2	Self-hate	↓ self hatred ↑ compassion	Choosing to Live Chapter 1 Psychodynamic ψ CBT	11 sessions
3	People don't get me	↑ trust ↑ support	ψ therapy Behavioral Activation	11 sessions

Patient Signature Clinician Signature

Section C (*Clinician Post-Session Evaluation*):

MENTAL STATUS EXAM (circle appropriate items):

- ALERTNESS: (ALERT) DROWSY LETHARGIC STUPOROUS OTHER: ____
- ORIENTED TO: (PERSON PLACE TIME REASON FOR EVALUATION)
- MOOD: EUTHYMIC ELEVATED (DYSPHORIC) AGITATED ANGRY
- AFFECT: FLAT BLUNTED CONSTRICTED (APPROPRIATE) LABILE
- THOUGHT CONTINUITY: (CLEAR & COHERENT) GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL OTHER: ____
- THOUGHT CONTENT: (WNL) OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY OTHER: ____
- ABSTRACTION: (WNL) NOTABLY CONCRETE OTHER: ____
- SPEECH: (WNL) RAPID SLOW SLURRED IMPOVERISHED INCOHERENT OTHER: ____
- MEMORY: (GROSSLY INTACT) OTHER: ____
- REALITY TESTING: (WNL) OTHER: ____

NOTABLE BEHAVIORAL OBSERVATIONS: ____

DIAGNOSTIC IMPRESSSIONS/DIAGNOSIS (DSM/ICD DIAGNOSES):

Major Depression

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

- ☐ **MILD (WTL/RFL)**
- ☑ **MODERATE (AMB)**
- ☐ **HIGH (WTD/RFD)**

Explanation: Continues to have high SSF core assessment ratings; is managing suicidal thoughts and feelings

CASE NOTES:

Kevin 32 year old white male, unemployed, lives with GF at her mother's house. Completed CAMS Therapeutic Worksheet today and discussed history of abuse that contributes to self-hate. Self-hate is a primary driver of suicide for him. Updated his treatment plan to note self-hate related to trauma history. Discussed Behavioral Activation for goal-setting

Next Appointment Scheduled: Thurs Treatment Modality: Individual; CBT + insight

Clinician Signature Date 7/1

Beyond Stability: Treating the Drivers

- DBT chain analysis to identify triggers and points of intervention
- Teach 4-step problem solving
- Teach mindfulness and mentalization
- Various covert sensitization techniques
- Assertiveness training/role plays
- Najavits (2002) “Seeking Safety Treatment”
  - Safe coping skills (Part I)
  - Safe coping skills (Part 2)
  - Detaching from emotional pain (grounding)
    - Mental grounding
    - Physical grounding
  - Taking Good Care of Yourself

CAMS-Guided Care and a Life Worth Living

- There should be an overt emphasis on developing and consolidating coping and problem-solving skills and techniques.
- There should be an overt emphasis on actively developing Reasons for Living and systematically eliminating existing Reasons for Dying.
- There should be an emphasis on future thinking/planning (protective factors) including:
  - The development of short- and long-term plans and goals.
  - The development of hope for the future.
  - The development or further consolidation of guiding beliefs.
  - Developing a life worth living.

Resolution and Clinical Outcomes

Over three month of CAMS-guided care, we are seeking:

Completion of Sections A-B of the SSF Outcome/Disposition

- Resolution of suicidality if:
- 1) current overall risk of suicide <3;
- 2) in past week, no suicidal behavior and
- 3) effectively managed suicidal thoughts/feelings

- ❑ Patient’s CAMS-guided care comes to an end; the patient is appropriately debriefed and referred to further care if indicated.
- ❑ SSF Outcome Form HIPAA page is completed after final CAMS session (Section C).

CAMS Outcome/Disposition Final Session

(12)

CAMS Suicide Status Form Outcome/Disposition Final Session

Patient: Kevin Clinician: David Jobes Date: 9/8 Time: 2 pm

Section A (*Patient*):

Rate each item according to how you feel right now.

1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*):
Low pain: 1 2 (3) 4 5 **:High pain**

2) RATE STRESS (*your general feeling of being pressured or overwhelmed*):
Low stress: 1 (2) 3 4 5 **:High stress**

3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*):
Low agitation: 1 (2) 3 4 5 **:High agitation**

4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*):
Low hopelessness: 1 2 (3) 4 5 **:High hopelessness**

5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*):
Low self-hate: 1 (2) 3 4 5 **:High self-hate**

6) RATE OVERALL RISK OF SUICIDE:
Extremely low risk: 1 (2) 3 4 5 **:Extremely high risk**
(will not kill self) **(will kill self)**

In the past week: Suicidal Thoughts/Feelings Y✓ N__ Managed Thoughts/Feelings Y✓ N__ Suicidal Behavior Y__ N✓

Were there any aspects of your treatment that were particularly helpful to you? If so, please describe these. Be as specific as possible. Session 9 - awareness of the pattern; insight; connecting the dots

What have you learned from your clinical care that could help you if you became suicidal in the future? Call in a crisis; I get the puzzle

Section B (*Clinician*):

Third consecutive session of resolved suicidality: ✓ Yes __ No (if no, continue CAMS tracking)

**Resolution of suicidality, if for third consecutive week: current overall risk of suicide <3; in past week: no suicidal behavior and effectively managed suicidal thoughts/feelings

OUTCOME/DISPOSITION (Check all that apply):

✓ Continuing outpatient psychotherapy __ Inpatient hospitalization

__ Mutual termination __ Patient chooses to discontinued treatment (unilaterally)

__ Referral to: ______

✓ Other. Describe: ongoing w/ GF

Next Appointment Scheduled (if applicable): STNW

Patient Signature [signed] Clinician Signature [signed]

Section C (*Clinician Post-Session Evaluation*):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS:	(ALERT) DROWSY LETHARGIC STUPOROUS OTHER:
ORIENTED TO:	(PERSON PLACE TIME REASON FOR EVALUATION)
MOOD:	(EUTHYMIC) ELEVATED DYSPHORIC AGITATED ANGRY
AFFECT:	FLAT BLUNTED CONSTRICTED (APPROPRIATE) LABILE
THOUGHT CONTINUITY:	(CLEAR & COHERENT) GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL OTHER:
THOUGHT CONTENT:	(WNL) OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY OTHER:
ABSTRACTION:	(WNL) NOTABLY CONCRETE OTHER:
SPEECH:	(WNL) RAPID SLOW SLURRED IMPOVERISHED INCOHERENT OTHER:
MEMORY:	(GROSSLY INTACT) OTHER:
REALITY TESTING:	(WNL) OTHER:

NOTABLE BEHAVIORAL OBSERVATIONS:

DIAGNOSTIC IMPRESSSIONS/DIAGNOSIS (DSM/ICD DIAGNOSES): Major Depression

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

- ☒ **MILD (WTL/RFL)**
- ☐ **MODERATE (AMB)**
- ☐ **HIGH (WTD/RFD)**

Explanation: Core SSF scores lower, managed thoughts and feelings, overall risk rating less than 3 for third week in a row

CASE NOTES: Kevin 32 year old white male. Final CAMS session but will continue in individual therapy. Has insight into his drivers of suicide. Has learned to identify patterns and cope with negative feelings that set off chain that leads to suicidal behaviors. Continuing to look for employment. Relationship with GF has also improved. Is using Stabilization Plan as needed.

Next Appointment Scheduled: Thurs Treatment Modality: CBT, insight

[signed] 9/8

Clinician Signature Date

CAMS Suicide Status Form (SSF-IV-R) (Initial Session)

Patient: Kevin Thomas Clinician: Sophia Owen Date: 8/26/2018 Time: 10am

Section A (*Patient*):

Rank — Rate and fill out each item according to how you feel right now.
Then rank in order of importance 1 to 5 (1=most important to 5=least important).

Rank	Item
3	1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind not stress, not psysical pain*): Low pain : ☐1 ☐2 ☐3 ☑4 ☐5 : High pain What I find most painful is: being stuck in my own skin
5	2) RATE STRESS (*your general feeling of being pressured or overwhelmed*): Low stress : ☐1 ☐2 ☐3 ☑4 ☑5 : High stress What I find most stressful is: being here
4	3) RATE AGITATION (*emotional urgency: feeling that you need to take action, not irritation; not annoyance*): Low agitation: ☐1 ☐2 ☐3 ☐4 ☑5 : High agitation I most need to take action when: Someone does Something untrustworthy
1/1.5	4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*): Low hopelessness: ☐1 ☐2 ☐3 ☐4 ☑5 :High hopelessness I am most hopeless about: anything Changing
1	5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*): Low self-hate: ☐1 ☐2 ☐3 ☐4 ☑5 :High self-hate What I hate most about myself is: everything
N/A	6) RATE OVERALL RISK OF SUICIDE: Extremely low risk: (will not kill self) ☐1 ☐2 ☐3 ☐4 ☑5 :Extremely high risk (will kill self)

1) How much is being suicidal related to thoughts and feelings about yourself? Not at all: ☐1 ☐2 ☐3 ☐4 ☑5 :completely

2) How much is being suicidal related to thoughts and feelings about others? Not at all: ☐1 ☐2 ☐3 ☑4 ☐5 :completely

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

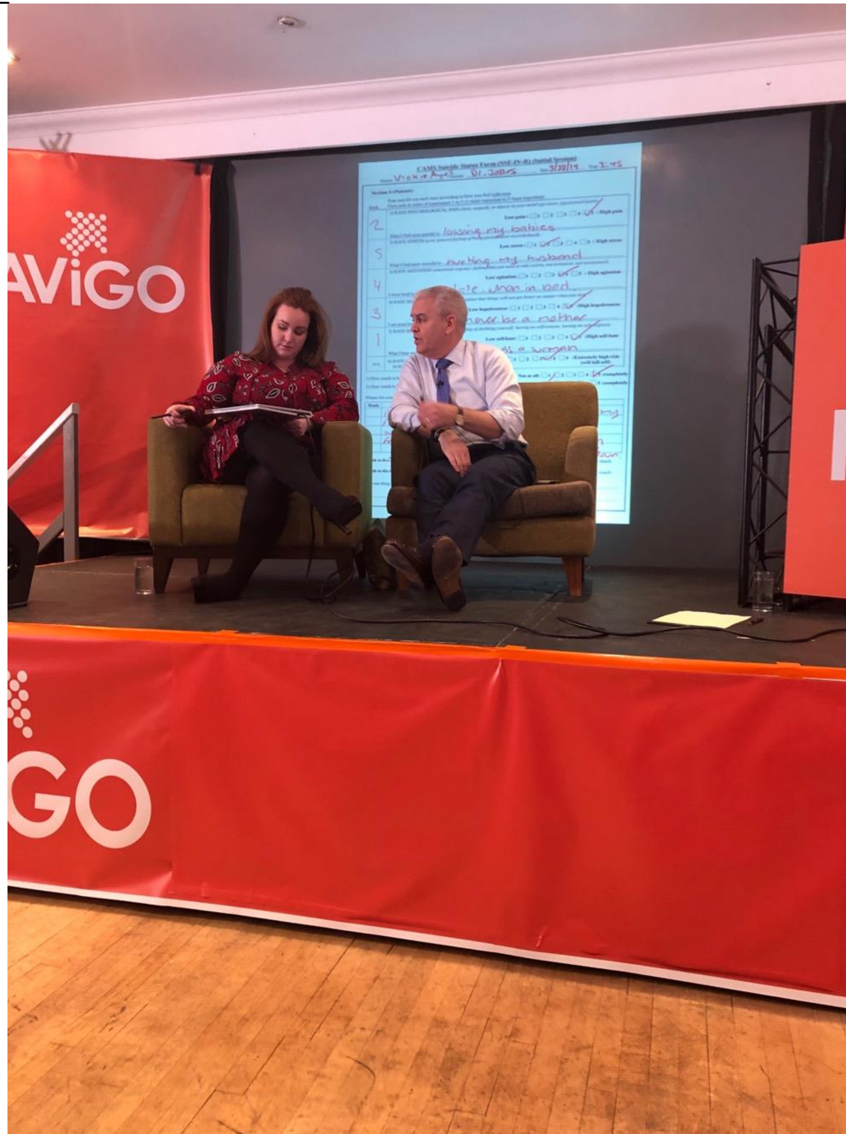
Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING
3	my mom	1	people don't get it / they don't care
2	maybe something will get better	3	nothing is going to chang[e]
1	See how Breaking Bad ends	4	I don't contribute to [socie]ty
		1	people would be [better] off if I was dead

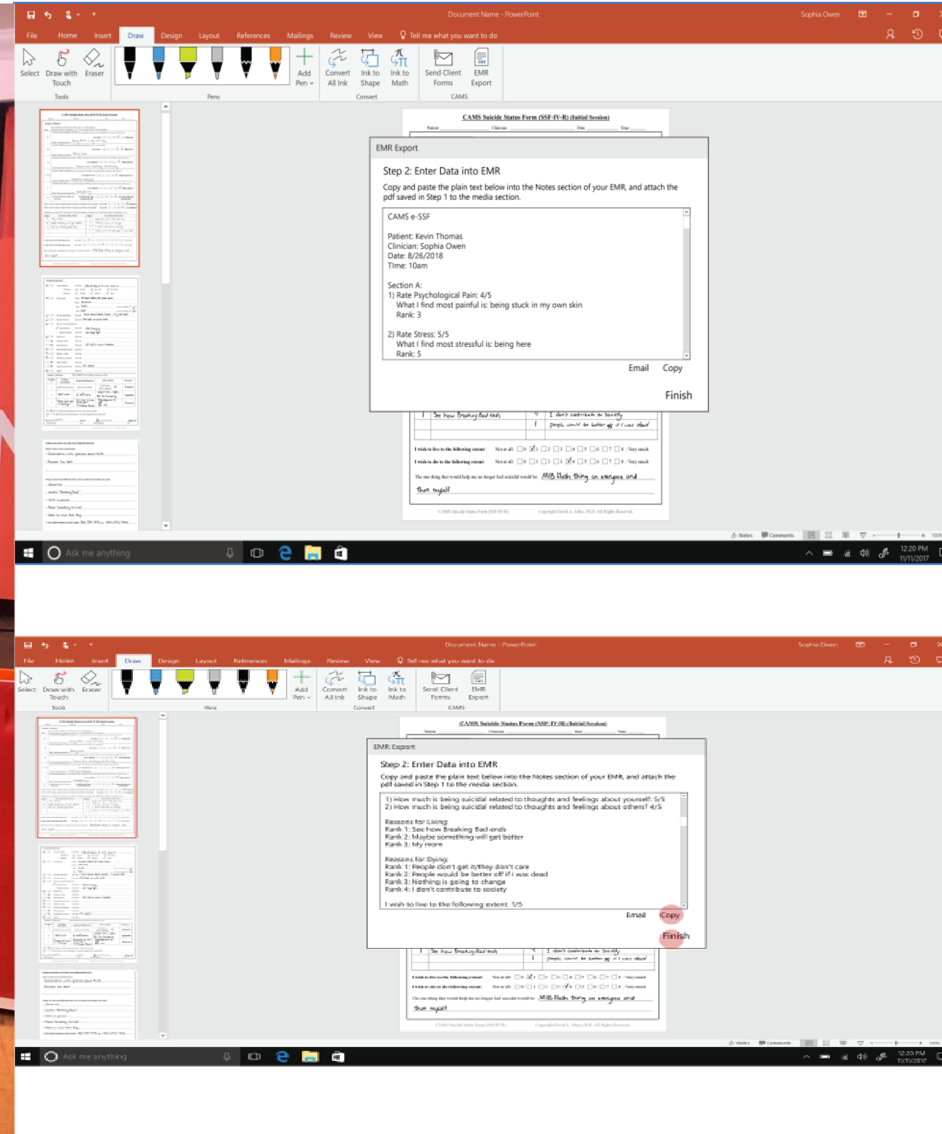
I wish to live to the following extent: Not at all: ☐0 ☑1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 : Very much

I wish to die to the following extent: Not at all: ☐0 ☐1 ☐2 ☐3 ☑4 ☐5 ☐6 ☐7 ☐8 : Very much

The one thing that would help me no longer feel suicidal would b[e]:
MIB flash thing on everyone and then myself

CAMS Suicide Status Form (SSF-IV-R) Copyright David A. Jobes, Ph.D. All Rights Reserved.





Correlational and Open Clinical Trial Support for SSF/CAMS

Authors	Sample/Setting	n =	Significant Results
Jobes et al., 1997	College Students Univ. Counseling Ctr.	106	Pre/Post Distress Pre/Post Core SSF
Jobes et al., 2005	Air Force Personnel Outpatient Clinic	56	Between Group Suicide Ideation, ED/PC Appts.
Arkov et al., 2008	Danish Outpatients CMH Clinic	27	Pre/Post Core SSF Qualitative findings
Jobes et al., 2009	College Students Univ. Counseling Ctr.	55	Linear reductions Distress/Ideation
Nielsen et al., 2011	Danish Outpatients CMH Clinic	42	Pre/Post Core SSF
Ellis et al., 2012	Psychiatric Inpatients	20	Pre/Post Core SSF Suicidal Ideation, depression, hopelessness
Ellis et al., 2015	Psychiatric Inpatients	52	Suicide ideation and cognitions
Ellis et al., 2017	Inpatients (& post-discharge)	104	SI, cognitions, depression, hopelessness, funct. impare, well-being, psych flexibility

Randomized Controlled Trials of CAMS

Principal Investigator	Setting & Population	Design & Method	Sample Size	Status Update
Comtois (Jobes)	Harborview/Seattle CMH patients	CAMS vs. TAU Next-day appts.	32	★ 2011 published article
Andreasson (Nordentoft)	Danish Centers CMH patients	DBT vs. CAMS superiority trial	108	★ 2016 published article
Jobes (Comtois et al)	Ft. Stewart, GA US Army Soldiers	CAMS vs. E-CAU	148	★ 2017 published article
Ryberg (Fosse)	Norwegian Centers Outpatient/inpatient	CAMS vs. TAU	78	★ 2019 published article
Pistorello (Jobes)	Univ. Nevada (Reno) College Students	SMART Design CAMS/TAU/DBT	62	Manuscript in preparation
Comtois (Jobes)	Harborview/Seattle Suicide attempters	CAMS vs. TAU Post-Hosp. D/C	150	ITT complete; on-going assess
Santel et al	German Crisis Unit Inpatients	CAMS vs. TAU	110	ITT complete; on-going assess
Depp et al	San Diego VAMC Walk-in Veterans	CAMS vs. Outreach Same day services	176	RCT preparation on-going

AFSP-Funded CAMS vs.TAU RCT (Comtois & Jobes et al., 2011)

SSI

CAMS | TAU

Mean with 80% CI: 0, 5, 10, 15, 20, 25

Time (in months): 0, 2, 4, 6, 12

Reasons for Living

CAMS | TAU

Mean with 80% CI: 160, 180, 200

Time (in months): 0, 2, 4, 6, 12

OQ-45

CAMS | TAU

Mean with 80% CI: 50, 60, 70, 80, 90, 100

Time (in months): 0, 2, 4, 6, 12

Hope Scale

CAMS | TAU

Mean with 80% CI: 30, 35, 40

Time (in months): 0, 2, 4, 6, 12

Significantly higher patient satisfaction ratings and better clinical retention...

Depression and Anxiety 28:963–972 (2011)

Research Article

COLLABORATIVE ASSESSMENT AND MANAGEMENT OF SUICIDALITY (CAMS): FEASIBILITY TRIAL FOR NEXT-DAY APPOINTMENT SERVICES

Katherine Anne Comtois, Ph.D. M.P.H.,[1*] David A. Jobes, Ph.D.,[2] Stephen S. O'Connor, Ph.D.,[1] David C. Atkins, Ph.D.,[1] Karin Janis, B.A.,[1] Chloe E. Chessen, B.A.,[1] Sara J. Landes, Ph.D.,[1,3] Anna Holen, M.D.,[1] and Christine Yuodelis-Flores, M.D.[1]

Background: Despite the ubiquity of suicidality in behavioral health settings, empirically supported interventions for suicidality are surprisingly rare. Given the importance of resolving suicidality and therapists' anxieties about treating suicidal patients, there is a clear need for innovative services and clinical approaches. The purpose of the current study was an attempt to address some of these needs by examining the feasibility and use of a new intervention called the "Collaborative Assessment and Management of Suicidality" (CAMS) within a "Next-Day Appointment" (NDA) outpatient treatment setting. Methods: As part of a larger feasibility study, n = 32 suicidal patients were randomly assigned to CAMS care versus Enhanced Care as Usual (E-CAU) in an outpatient crisis intervention setting attached to a safety net hospital. Intent to treat suicidal patients were seen and assessed before, during, and after treatment (with follow-up assessments conducted at 2, 4, 6, and 12 months). Results: The feasibility of using CAMS in the NDA setting was clear; both groups appeared to initially benefit from their respective treatments in terms of decreased suicidal ideation and overall symptom distress. Although patients rated both treatments favorably, the CAMS group had significantly higher satisfaction and better treatment retention than E-CAU. At 12 months post-treatment, CAMS patients showed significantly better and sustained reductions in suicidal ideation, overall symptom distress, and increased hope in comparison to E-CAU patients. Conclusions: CAMS was both feasible in this NDA setting and effective in treating suicidal ideation, distress, and hopelessness (particularly at 12 months followup). Depression and Anxiety 28:963–972, 2011. © 2011 Wiley Periodicals, Inc.

Key words: suicide; attempted suicide; psychotherapy; risk assessment; crisis intervention; feasibility studies; clinical trial

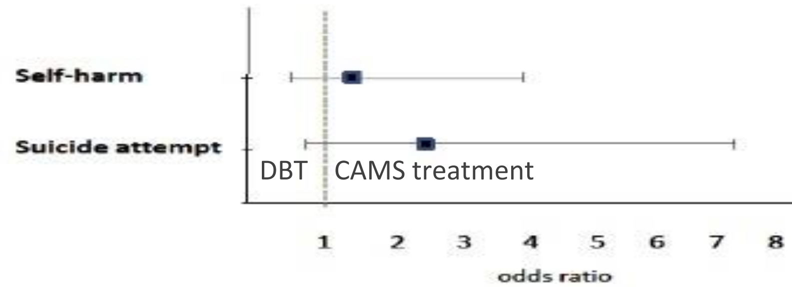
INTRODUCTION

REGION H

Mental Health Services

Andreasson et al., 2016
DBT vs. CAMS Superiority RCT

Figure 1. Odds ratio with 95% confidence intervals of non-suicidal self-injury and suicide attempts, favoring CAMS treatment.



Depression and Anxiety 00:1–11 (2016)

Research Article

EFFECTIVENESS OF DIALECTICAL BEHAVIOR THERAPY VERSUS COLLABORATIVE ASSESSMENT AND MANAGEMENT OF SUICIDALITY TREATMENT FOR REDUCTION OF SELF-HARM IN ADULTS WITH BORDERLINE PERSONALITY TRAITS AND DISORDER—A RANDOMIZED OBSERVER-BLINDED CLINICAL TRIAL

Kate Andreasson, M.D., Ph.D.,[1,2*] Jesper Krogh, M.D., D.M.Sc.,[1] Christina Wenneberg, M.D.,[1] Helle K. L. Jessen, M.D.,[1] Kristine Krakauer, M.D.,[1] Christian Gluud, M.D., D.M.Sc.,[3] Rasmus R. Thomsen, Cand. Psych.,[4] Lasse Randers, Cand. Psych.,[1] and Merete Nordentoft, M.D., D.M.Sc.,[1]

Background: Many psychological treatments have shown effect on reducing self-harm in adults with borderline personality disorder. There is a need of brief psychotherapeutical treatment alternative for suicide prevention in specialized outpatient clinics. Methods/Design: The DiaS trial was designed as a pragmatic single-center, two-armed, parallel-group observer-blinded, randomized clinical superiority trial. The participants had at least two criteria from the borderline personality disorder diagnosis and a recent suicide attempt (within a month). The participants were offered 16 weeks of dialectical behavior therapy (DBT) versus up to 16 weeks of collaborative assessment and management of suicidality (CAMS) treatment. The primary composite outcome was the number of participants with a new self-harm (nonsuicidal self-injury [NSSI] or suicide attempt) at week 28 from baseline. Other exploratory outcomes were: severity of borderline symptoms, depressive symptoms, hopelessness, suicide ideation, and self-esteem. Results: At 28 weeks, the number of participants with new self-harm in the DBT group was 21 of 57 (36.8%) versus 12 of 51 (23.5%) in the CAMS treatment (OR: 1.90; 95% CI: 0.80–4.40; P = .14). When assessing the effect of DBT versus CAMS treatment on the individual components of the primary outcome, we observed no significant differences in the number of NSSI (OR: 1.60; 95% CI: 0.70–3.90; P = .31) or number of attempted suicides (OR: 2.24; 95% CI: 0.80–7.50; P = .12). Conclusion: In adults with borderline

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Clinical Trial Registration: Clin.trials.gov; Clinical Trial Number: NCT01512602.

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Table 3. Distribution of BPD criteria in the trial population

BPD-criteria[1]	2	3	4	5	6	7	8	9
Participants (n)	14	13	22	15	11	17	13	3
%	13.0	12.0	20.4	13.9	10.2	15.7	12.0	2.8

DiaS trial

At 28 weeks: DBT Self Harm = 21; CAMS = 12
DBT Attempts = 12; CAMS = 5

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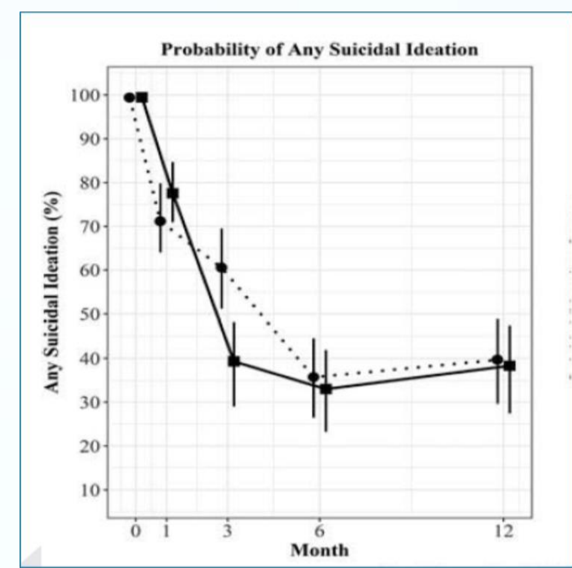
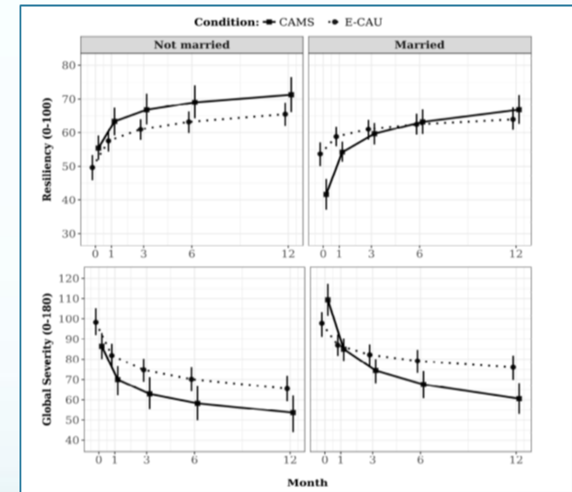
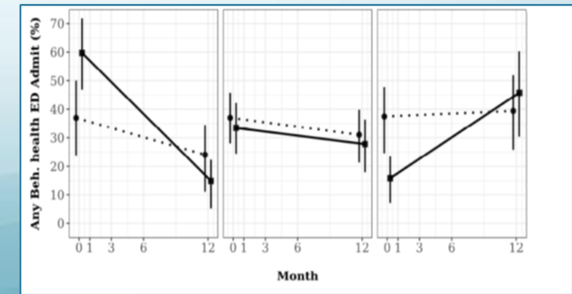
DoD-Funded Operation Worth Living (OWL) Project: CAMS vs. E-CAU RCT at Ft. Stewart, GA



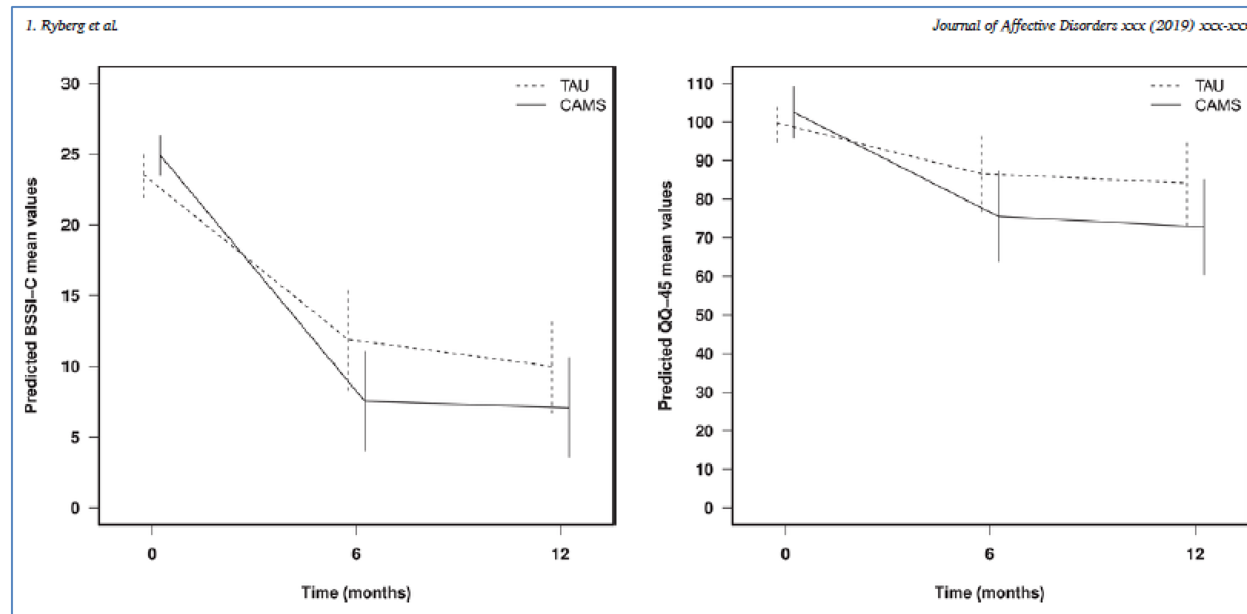




VESTRE VIKEN

CAMS significantly reduced suicidal ideation and overall symptom distress among inpatients and outpatients (n=78)

Oslo Norway



Journal of Affective Disorders

Research paper

Managing suicidality within specialized care: A randomized controlled trial

Wenche Ryberg, Per-Henrik Zahl, Lien My Diep, Nils Inge Landrø, Roar Fosse

Wenche Ryberg, PhD Candidate and specialist in clinical psychology
Vestre Viken Hospital Trust, Mental Health and Addiction
Department of Research and Development

NIMH-Funded R-34; PI: Jacque Pistorello, Ph.D.; Co-I: David Jobes, Ph.D. (n=62)

NEWS FLASH: NIMH R01 has been funded!!!

Figure 1. College Student Client Flow through the SMART

Stage 1

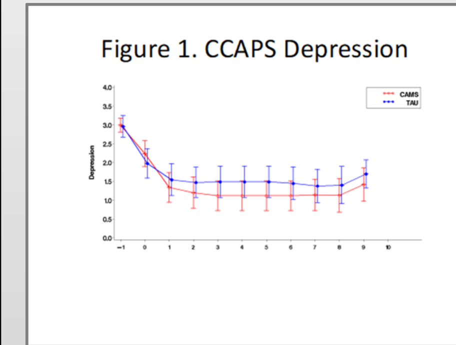
Random Assignment → CAMS (8 Weeks) → Assessment: Adequate Response?
- YES → Monitoring, Post and Follow-Up
- NO → Random Assignment → CAMS (16 Weeks) / DBT (16 Weeks)

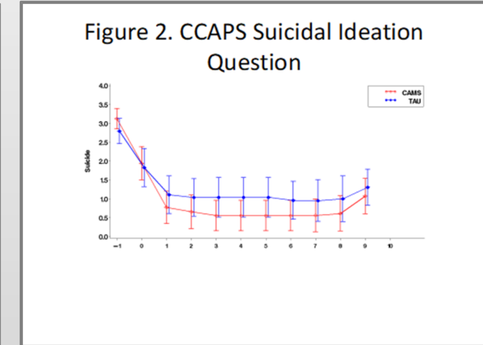
Random Assignment → TAU (8 Weeks) → Assessment: Adequate Response?
- YES → Monitoring, Post and Follow-Up
- NO → Random Assignment → CAMS (16 Weeks) / DBT (16 Weeks)

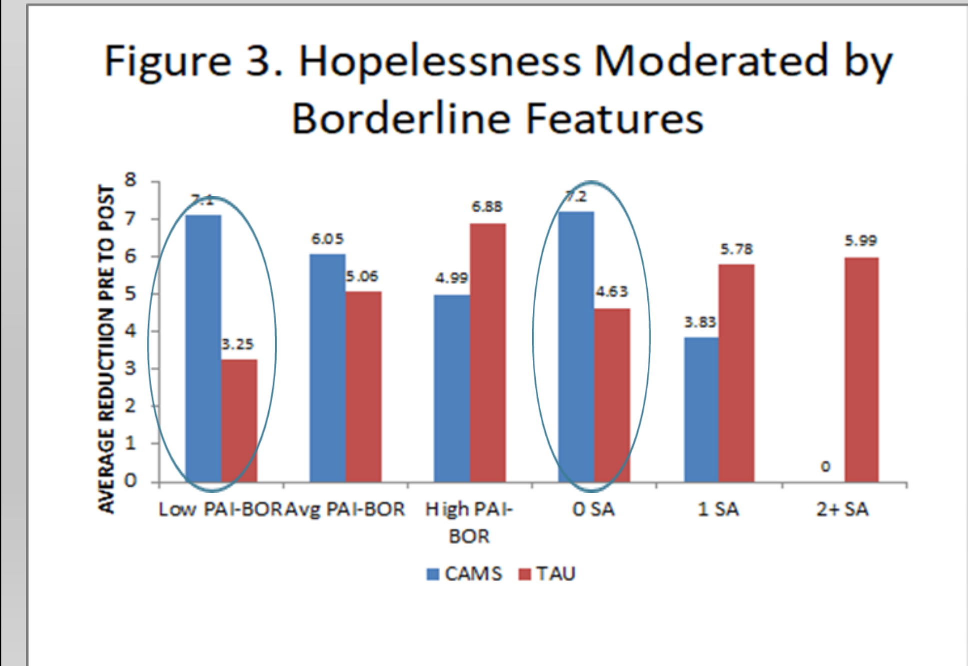
Stage 2

Significant Stage 1 findings for CAMS on **depression and suicidal ideation…**

CAMS = Collaborative Assessment and Management of Suicidality
DBT = Comprehensive Dialectical Behavior Therapy
TAU = Treatment as Usual





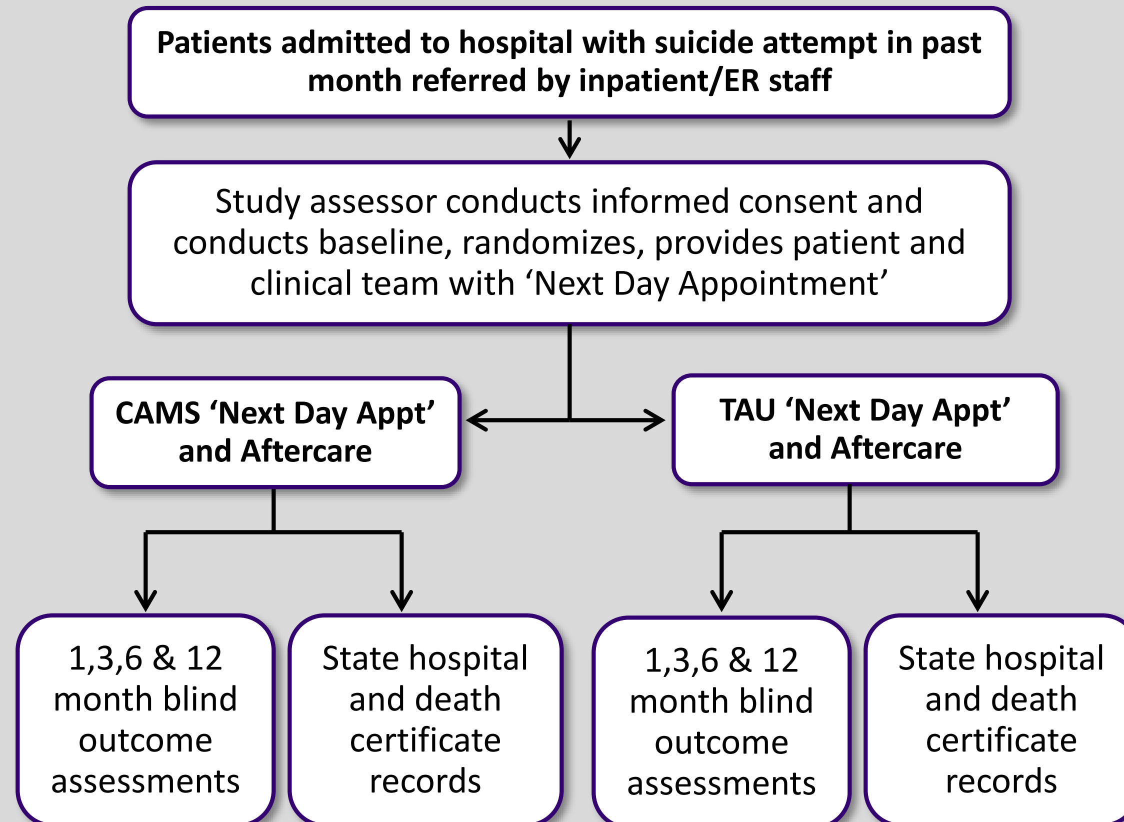


Summary of CAMS Research Findings to Date

- **Across 8 published non-randomized clinical trials of CAMS, 1 meta-analysis, and 4 published randomized controlled clinical trials, and 1 unpublished RCT (a total of 70+ publications):**
  - CAMS quickly reduces suicidal ideation in 6-8 sessions
  - CAMS reduces overall symptom distress, depression, hopelessness, and changes suicidal cognitions
  - CAMS increases hope and improves clinical retention to care
  - Patients like CAMS and the process of doing CAMS
  - CAMS works better with less severe patients at baseline presentation (impact with borderline patients is mixed)
  - CAMS decreases ED visits among certain subgroups
  - CAMS appears to have a promising impact on self-harm behavior and suicide attempts (but replication is needed)
  - CAMS is relatively easy to learn (adherence is typically attained with first patient)

Aftercare Focus Study (AFS)

PI: Kate Comtois
Co-PIs: David Atkins, Heidi Combs, Shaune Demers, Ryan Kimmell, Jagoda Pasic, David Jobes
Research Coordinator: Karin Hendricks



Funded by AFSP from 2015-2019
Target sample size = 150

Primary Aims:

1. Evaluate whether CAMS for suicidal NDA patients results in a significant reduction in suicidal behavior compared to TAU.
2. Evaluate whether CAMS for suicidal NDA patients results in significant reductions in suicidal ideation *and intent* as well as related improvements in other mental health markers compared to TAU.
3. Evaluate whether CAMS for suicidal NDA patients is more satisfactory to patients than TAU.

For more information, contact **mhsrtlab@uw.edu**

Rapid Referral Study: Randomized Controlled Trial

Colin Depp, Ph.D.
Principal INvestigator

PEC Clinic/Same Day/Transition Clinic Visit

Randomization

CAMS Intervention

SPC Telephone Outreach

(Standard Care)

Ongoing Mental Health Care

VA Health Services Research and Development (HSRD) Merit Grant;
VA IRB H180055

NIMH-Funded R43 and R44 V-CAMS SBIR ED Projects

Thank You!