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Collaborative Assessment and Management of Suicidality (CAMS)

Program Snapshot

Evidence Ratings*

Promising	Suicidal Thoughts and Behaviors
Promising	Self-Concept
Promising	Depression and Depressive Symptoms
Ineffective	Receipt of Mental Health and/or Substance Use Treatment
Ineffective	Receipt of Health Care
Ineffective	General Functioning and Well-Being

*Ratings definitions can be found in the appendix.

Program Contact

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Dissemination/Implementation Contact

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Program Type

Mental health treatment

Gender

Male
Female
Transgender

Age

18-25 (Young adult)
26-55 (Adult)
55+ (Older adult)

Geographic Locations

Urban
Suburban

Settings

Outpatient Facility
Mental Health Treatment Center

Race/Ethnicity

Asian or Pacific Islander
Black or African American
Hispanic or Latino
White
Other

Implementation/Dissemination

Implementation materials available
Dissemination materials available

Program Description

The Collaborative Assessment and Management of Suicidality (CAMS), was first developed in 1998, as a therapeutic framework that is designed to assess a patient’s suicidal risk, and plan and manage suicide-specific “driver-oriented” treatment. The clinical intervention can be used for a wide range of suicidal patients across outpatient and inpatient treatment settings and different treatment modalities. The framework fundamentally involves a participant’s engagement and cooperation in assessing and managing suicidal thoughts and behaviors, and the therapist’s understanding of the patient’s suicidal thoughts, feelings, and behaviors. The duration of the CAMS treatment varies, depending on the patient’s condition.

A multi-purpose clinical tool, called the Suicide Status Form (SSF), guides the patient’s assessment and treatment and is developed collaboratively between the patient and the practitioner throughout the course of therapy. Specifically, the SSF contains rating-scales and open-ended questions concerning six suicide-related markers including: psychological pain, stress, agitation, hopelessness, self-hate, and overall risk of suicide. The SSF is used for 1) suicide-specific assessment, 2) suicide-specific treatment planning of patient-defined suicidal drivers, 3) tracking of ongoing risk, and 4) clinical outcomes and dispositions.

In 2014, CAMS-care, LLC was formed to promote an integrated model of professional training and dissemination of the intervention making CAMS training broadly accessible to providers around the world, and promoting clinical adherence to the CAMS framework.

Evaluation Findings by Outcome

OUTCOME: SUICIDAL THOUGHTS AND BEHAVIORS

PROGRAM EFFECTS ACROSS ALL STUDIES	<p>This program is promising for reducing suicidal thoughts and behaviors. The review of the program yielded sufficient evidence of a favorable effect. Based on two studies and four measures, the average effect size for suicidal thoughts and behaviors is .40 (95% CI: .07, .57).</p> <p>Click here to find out what other programs have found about the average effect sizes for this outcome.</p>
KEY STUDY FINDINGS	<p>In one study, participants in the intervention condition engaged in slightly fewer suicide attempts and non-suicidal self-injuries at all assessment points, including at baseline, compared with participants in the control condition. However, given the low base rate of these behaviors, no statistical analyses were performed. In the same study, there were no statistically significant between-group differences in beliefs buffering against suicidal behavior (Comtois et al., 2011). In another study, participants in the intervention group reported statistically significant reductions in suicidal ideation and in cognitions that increase risk of suicide, compared with participants in the comparison group (Ellis et al., 2015).</p>
MEASURES	<p>Comtois et al. (2011): Suicide Attempt and Self-Injury Count (SASI-C); Reasons for Living Scale (RFL) Ellis et al. (2015): Beck Scale for Suicide Ideation (BSS); Suicide Cognitions Scale (SCS)</p>
ADDITIONAL DETAILS	<p>This outcome was also assessed at a 12-month follow-up period (Comtois et al., 2011). Follow-up findings are not rated and therefore do not contribute to the final outcome rating.</p>

OUTCOME: SELF-CONCEPT

PROGRAM EFFECTS ACROSS ALL STUDIES	<p>This program is promising for improving self-concept. The review of the program yielded sufficient evidence of a favorable effect. Based on two studies and two measures, the average effect size for self-concept is .58 (95% CI: .12, .82).</p> <p>Click here to find out what other programs have found about the average effect sizes for this outcome.</p>
KEY STUDY FINDINGS	<p>In one study, Comtois et al. (2011) found that participants in the intervention group reported greater optimism and hope from baseline to the 6-month assessment, compared with participants in the control condition. In another study, Ellis et al. (2015) found that both intervention and comparison groups</p>

	showed statistically significant improvement in their reported hopelessness from pretest to posttest, but the intervention group did not improve to a significant degree beyond the comparison group.
MEASURES	Comtois et al. (2011): Optimism and Hope Scale (OHS) Ellis et al. (2015): Beck Hopelessness Scale (BHS)
ADDITIONAL DETAILS	This outcome was also assessed at a 12-month follow-up period (Comtois et al., 2011). Follow-up findings are not rated and therefore do not contribute to the final outcome rating.

OUTCOME: DEPRESSION AND DEPRESSIVE SYMPTOMS

PROGRAM EFFECTS ACROSS ALL STUDIES	This program is promising for reducing depression and depressive symptoms. The review of the program yielded sufficient evidence of a favorable effect. Based on one study and one measure, the effect size for depression and depressive symptoms is .44 (95% CI: -.11, .98). Click here to find out what other programs have found about the average effect sizes for this outcome.
KEY STUDY FINDINGS	There were no statistically significant between-group differences in the reduction of depressive symptoms from pretest to posttest (Ellis et al., 2015).
MEASURES	Ellis et al. (2015): Patient Health Questionnaire (PHQ-9)
ADDITIONAL DETAILS	None provided.

OUTCOME: RECEIPT OF MENTAL HEALTH AND/OR SUBSTANCE USE TREATMENT

PROGRAM EFFECTS ACROSS ALL STUDIES	This program is ineffective for reducing receipt of health care. The review of the program yielded sufficient evidence of a negligible effect. Based on one study and one measure, the effect size for receipt of health care is -.51 (95% CI: -1.38, .35). Click here to find out what other programs have found about the average effect sizes for this outcome.
KEY STUDY FINDINGS	Participants in the intervention condition had slightly fewer emergency department admissions overall, compared with participants in the control condition. However, given the low base rate of health services, no statistical analyses were performed (Comtois et al., 2011).
MEASURES	Comtois et al. (2011): Treatment History Interview – Short Form (THI)
ADDITIONAL DETAILS	This outcome was also assessed at a 12-month follow-up period (Comtois et al., 2011). Follow-up findings are not rated and therefore do not contribute to the final outcome rating.

OUTCOME: RECEIPT OF HEALTH CARE

PROGRAM EFFECTS ACROSS ALL STUDIES	This program is ineffective for reducing receipt of mental health and/or substance use treatment. The review of the program yielded sufficient evidence of a negligible effect. Based on one
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	<p>study and two measures, the average effect size for receipt of mental health and/or substance use treatment is $-.17$ (95% CI: $-.78, .14$).</p> <p>Click here to find out what other programs have found about the average effect sizes for this outcome.</p>
KEY STUDY FINDINGS	<p>Participants in the intervention condition had slightly fewer emergency department admissions for behavioral health reasons, compared with participants in the control condition. However, given the low base rate of health services, no statistical analyses were performed. There were also no clear findings with regard to the number of days spent in inpatient psychiatric services (Comtois et al., 2011).</p>
MEASURES	<p>Comtois et al. (2011): Treatment History Interview – Short Form (THI)</p>
ADDITIONAL DETAILS	<p>This outcome was also assessed at a 12-month follow-up period (Comtois et al., 2011). Follow-up findings are not rated and therefore do not contribute to the final outcome rating.</p>

OUTCOME: GENERAL FUNCTIONING AND WELL-BEING

PROGRAM EFFECTS ACROSS ALL STUDIES	<p>This program is ineffective for reducing general functioning and well-being. The review of the program yielded sufficient evidence of a negligible effect. Based on one study and one measure, the effect size for general functioning and well-being is $.59$ (95% CI: $-.28, 1.46$).</p> <p>Click here to find out what other programs have found about the average effect sizes for this outcome.</p>
KEY STUDY FINDINGS	<p>Participants in the intervention group reported a statistically significant reduction in psychological distress from baseline to 6-month posttest, compared with participants in the control condition (Comtois et al., 2011).</p>
MEASURES	<p>Comtois et al. (2011): The Outcome Questionnaire-45 (OQ-45)</p>
ADDITIONAL DETAILS	<p>This outcome was also assessed at a 12-month follow-up period (Comtois et al., 2011). Follow-up findings are not rated and therefore do not contribute to the final outcome rating.</p>

Study Evaluation Methodology

COMTOIS ET AL. (2011)

STUDY DESIGN NARRATIVE	<p>Participants were adults with a recent suicide attempt or at imminent risk, recruited from the psychiatric emergency and consultation liaison psychiatry services and inpatient psychiatry services of a county-owned hospital. Random assignment to study condition was conducted via a minimization algorithm matching for gender, history of suicide attempt, pre-existing use of psychotropic medications, and history of substance abuse. Participants randomized to the control condition received standard care, which included an intake with the psychiatrist or psychiatric nurse practitioner followed by 1–11 visits with a case manager, and as-needed medication management. Usual care in this study was enhanced to ensure that the time spent with a clinician was equivalent in both study conditions, with a minimum of four sessions scheduled.</p>
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SAMPLE DESCRIPTION

The sample comprised 29 patients (14 in the intervention group, 15 in the enhanced care-as-usual group), with a mean age of 37 years. The majority of the sample was female (62%) and white (66%), with 14% black, 3% Asian, 3% Latino, and 13% other. The average annual income of the sample was \$30,000 or less for the majority of participants (around 84%) and almost half (45%) had not received any postsecondary education or training. There were no statistically significant differences between the groups on background characteristics.

ELLIS ET AL. (2015)

STUDY DESIGN NARRATIVE

Intervention group participants with recent suicidal ideation or attempts were recruited from three adult treatment programs in a private, not-for-profit, psychiatric hospital. Participant selection was closed after a reasonable number of CAMS cases had been completed, after which a treatment-as-usual sample was selected through propensity score matching on age, gender, hospital treatment program, suicide severity, and prior suicide attempts. All participants received intensive inpatient treatment. The only difference between the intervention and comparison conditions was that patients in the intervention condition received individual therapy from a CAMS-trained therapist, whereas patients in the treatment-as-usual condition received individual therapy from a therapist who had not been trained in CAMS.

SAMPLE DESCRIPTION

This study included 52 participants (26 in the intervention group, 26 in the treatment-as-usual group), with a mean age of 33 years. The majority of the participants were female (69%) and white (92.3%). There were no statistically significant differences between the groups on background characteristics.

References

STUDIES REVIEWED

Comtois, K. A., Jobes, D. A., O'Connor, S. S., Atkins, D. C., Janis, K., Chessen, C. E., ... Yuodelis-Flores, C. (2011). Collaborative Assessment and Management of Suicidality (CAMS): Feasibility trial for next-day appointment services. *Depression and Anxiety, 28*(11), 963–972.

Ellis, T. E., Rufino, K. A., Allen, J. G., Fowler, J. C., & Jobes, D. A. (2015). Impact of a suicide-specific intervention within inpatient psychiatric care: The Collaborative Assessment and Management of Suicidality. *Suicide and Life-Threatening Behavior, 45*(5), 556–566.

SUPPLEMENTAL AND CITED DOCUMENTS

None provided.

OTHER STUDIES

Andreasson, K., Krogh, J., Wenneberg, C., Jessen, H. K., Krakauer, K., Gluud, C., ... Nordentoft, M. (2016). 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. *Depression and Anxiety, 33*(6), 520–530.

Resources for Dissemination and Implementation *

** Dissemination and implementation information was provided by the program developer or program contact at the time of review. Profile information may not reflect the current costs or availability of materials (including*

newly developed or discontinued items). The dissemination/implementation contact for this program can provide current information on the availability of additional, updated, or new materials.

Implementation/Training and Technical Assistance Information

The first step in the recommended approach to CAMS training is to engage book-based, live, or web/online content training in the CAMS model. Following content training, interested learners are encouraged to further engage in a 1-1.5 days of live role-play training, and participate in clinical consultation calls to support their use of the intervention (coaching calls can be done for clinicians who have not done role-play training).

Although licensed professionals usually implement the program, case managers and paraprofessionals may be trained as well, either as individuals or in groups to engage in hybrid versions of the intervention.

CAMS-care provides the only authorized training in CAMS content, live role-play training, and follow-up “coaching” calls for clinicians using CAMS with suicidal patients. A major supplement to CAMS training is *Managing Suicidal Risk: A Collaborative Approach*, which was published in 2006; the 2nd edition of this book is scheduled for release on August 19, 2016 (in both hard copy and e-book formats).

According to the program developer, CAMS has been implemented in many clinical settings, including the Oklahoma Department of Mental Health and Substance Abuse; The Warrior Resiliency Program at Ft. Sam Houston, Texas; New York Mental Health Association in New York State; and St. Joseph Healthcare, Ontario, Canada, Walter Reed National Military Medical Center, Bethesda MD), and numerous university counseling centers across the country.

Dissemination Information

Dissemination occurs through the developer’s website: www.coms-care.com. The website includes program information, training options, research information, and background resources.

Specific audiences for training and dissemination resources include licensed professional clinicians, case managers, paraprofessionals, and administrators. Descriptive resources about the program are free; costs for training and implementation materials are listed in the Summary Table of RFDI Materials.

Training and implementation materials include online guidance, textbooks, live role-play sessions, and phone consultations.

Summary Table of RFDI Materials

Description of item	Required or optional	Cost	Where obtained
Implementation Information			
Textbook, <i>Managing Suicidal Risk: A Collaborative Approach 2nd Edition</i> (available August 19, 2016) For clinicians	Optional	\$40	
CAMS-care live and web/on-line content training	Optional	Varies	www.cams-care.com
CAMS-care live role-play training with CAMS-care consultants For clinicians 6–9 hours	Optional	Varies	www.cams-care.com

Consultation phone calls with CAMS-care consultants For clinicians One to eight, 1-hour phone sessions	Optional	\$190 per hour	www.cams-care.com
Dissemination Information			
CAMS-care website For providers and administrators	Optional	Free	www.cams-care.com

Appendix

Evidence Rating Definitions

Effective

The evaluation evidence has strong methodological rigor, and the short-term effect on this outcome is favorable. More specifically, the short-term effect favors the intervention group and the size of the effect is substantial.

Promising

The evaluation evidence has strong methodological rigor, and the short-term effect on this outcome is favorable. More specifically, the short-term effect favors the intervention group and the size of the effect is substantial.

Ineffective

The evaluation evidence has sufficient methodological rigor, but there is little to no short-term effect. More specifically, the short-term effect does not favor the intervention group and the size of the effect is negligible. Occasionally, the evidence indicates that there is a negative short-term effect. In these cases, the short-term effect harms the intervention group and the size of the effect is substantial.