The Collaborative Assessment and Management of Suicidality (CAMS) Framework:

Grounding in Philosophy and Reaching Towards Future Developments

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CAMS-care, LLC
Today the field of suicidology is exploding…

- Suicide research is increasing exponentially
- VA and DOD are spending multi-millions on suicide prevention
- State legislation *requiring* suicide-specific training for mental health professionals continuing education (e.g., Washington)
- The potential impact of the lived-experience and attempt survivor movement
- An increasing emphasis on evidence-based treatments
- **National Action Alliance (Clinical Care Task Force → “Zero Suicide” movement to raise the standard of clinical care) at a systems level.**
But there is still a professional crisis...

Clinical Work with Suicidal Patients: Ethical Issues and Professional Challenges (PPRP: Jobes, Rudd, Overholser, & Joiner, 2008)

1. Issues of sufficient informed consent about suicide risk.

2. Issues of competent and thorough assessment of suicide risk.

3. Little use of evidence-based clinical interventions and treatments for suicide risk.

4. Issues with risk management and paralyzing concerns about malpractice liability.
A Significant Policy Development

Sentinel Event Alert

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Detecting and treating suicide ideation in all settings

The rate of suicide is increasing in America.¹ Now the 10th leading cause of
death,² suicide claims more lives than traffic accidents³ and more than twice
as many as homicides.⁴ At the point of care, providers often do not detect
the suicidal thoughts (also known as suicide ideation) of individuals (including
children and adolescents) who eventually die by suicide, even though most of
them receive health care services in the year prior to death. Usually for
reasons unrelated to suicide or mental health.⁵,⁶ Timely, supportive continuity
of care for those identified as at risk for suicide is crucial, as well.⁷

Through this alert, The Joint Commission aims to assist all health care
organizations providing both inpatient and outpatient care to better identify and
treat individuals with suicide ideation. Clinicians in emergency, primary and
behavioral health care settings particularly have a crucial role in detecting
suicide ideation and assuring appropriate evaluation. Behavioral health
professionals play an additional important role in providing evidence-based
treatment and follow-up care. For all clinicians working with patients with
suicide ideation, care transitions are very important. Many patients at risk for
suicide do not receive outpatient behavioral treatment in a timely fashion
following discharge from emergency departments and inpatient psychiatric
settings.⁸ The risk of suicide is three times as likely (200 percent higher) the
first week after discharge from a psychiatric facility⁹ and continues to be high
especially within the first year¹⁰ and through the first four years¹¹ after
discharge.

This alert replaces two previous alerts on suicide (issues 46 and 7). The
suggested actions in this alert cover suicide ideation detection, as well as the
screening, risk assessment, safety, treatment, discharge, and follow-up care
of at-risk individuals. Also included are suggested actions for educating all
staff about suicide risk, keeping health care environments safe for individuals
at risk for suicide, and documenting their care.

Some organizations are making significant progress in suicide prevention.¹²
The “Perfect Depression Care Initiative” of the Behavioral Health Services
Division of the Henry Ford Health System achieved 10 consecutive calendar
quarters without an instance of suicide among patients participating in the
program. The U.S. Air Force’s suicide prevention initiative reduced suicides by
one-third over a six-year period. Over a period of 12 years, Askern and Barxum
Hospital near Oslo, Norway implemented continuity-of-care strategies and
achieved a 54 percent decline in suicide attempts in a high-risk population with
a history of poor compliance with follow-up. Additionally, the hospital’s
multidisciplinary suicide prevention team accomplished an 88 percent success
rate for getting patients to the aftercare program to which they were referred.¹³
Dallas’ Parkland Memorial Hospital became the first U.S. hospital to
implement universal screenings to assess whether patients are at risk for
suicide. Through preliminary screenings of 100,000 patients from its hospital
and emergency department, and of more than 50,000 outpatient clinic
patients, the hospital has found 1.5 percent of patients there to be at high
suicide risk and up to 4.5 percent to be at moderate risk.¹⁴
A Stepped Care Model for Suicide Care

Safety Planning
CRP + RFL
Means Restriction can be used throughout

Suicide-specific Care at Each Step
From Least to Most Restrictive Intervention

- Crisis Center Hotline Support + Follow-up
- Brief Intervention + Follow-up
- Outpatient Care
- Emergency Respite Care
- Partial Hospitalization
- Inpatient Psychiatric Hospitalization

- CAMS
- DBT, CT-SP
- MI
- PACT
- TMBI

Adapted from Jobes, D. (2014)
The Collaborative Assessment and Management of Suicidality (CAMS)
THE CATHOLIC UNIVERSITY OF AMERICA
COUNSELING CENTER

SUICIDAL STATUS FORM

NAME: ___________________________ CLIENT I.D.#: ___________________________

ADDRESS: ________________________ TELEPHONE #: ________________________

PARENTS’ NAME, ADDRESS AND TELEPHONE (if known): ________________________

________________________________________

DID THE INDIVIDUAL:

Commit suicide
Make a serious attempt
Make a gesture

Talk about suicide
Other (please specify) ________________________

IS THE INDIVIDUAL A CURRENT CENTER CLIENT?

Yes____ Name of Counselor ________________________
No____ Unknown

IS THE INDIVIDUAL A PREVIOUS CLIENT OF THIS CENTER?

Yes____ Client I.D.# (if known) ________________________ Counselor ________________________
No____ Unknown

HAS THE INDIVIDUAL BEEN SEEN BY THE HEALTH CENTER FOR THIS OR A RELATED OCCURANCE?

Yes____ No____

Unknown

If yes, outline below what you know of the contact:

________________________________________

PERSON supplying the INFORMATION to the COUNSELING CENTER:

Name __________________________ Telephone #: __________________________

Address __________________________

Position/Relationship to the individual: __________________________

BRIEF SUMMARY OF INFORMATION (continue on back if necessary):

________________________________________

DISPOSITION - Please state the evidence that persuades you that there is not a clear and imminent danger for this client (continue on back):

________________________________________

your name __________________________ date __________________________
First session of CAMS—SSF Assessment, Stabilization Planning, Driver-Specific Treatment Planning, and HIPAA Documentation
At Its Core, What is CAMS?

CAMS is a therapeutic framework for applying the SSF.

It’s 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
- Flexible and “Nondenominational”—across theories and techniques
The CAMS Philosophy: Approaching Suicide
Critique of Current Approach to Suicide Risk: THE REDUCTIONISTIC MODEL (Suicide = Symptom of Psychopathology)

Traditional treatment = inpatient hospitalization, treating the psychiatric disorder, and using no suicide contracts…
The Collaborative Assessment and Management of Suicidality (CAMS) identifies and targets **suicide** as the primary focus of assessment and intervention…
The CAMS approach:
Building a strong alliance and increasing patient motivation
What is **DRIVING this person’s** suicide risk?

(Jobes et al., 2011; Tucker et al., 2015)

- **Indirect Drivers**: Factors that make **this person** feel like s/he is in a state of “dis-ease” or “dis-order”
  - Examples include: negative life events, psychosocial stressors, psychiatric illnesses
  - These may be profoundly painful, but they **do not necessarily trigger acute crises**.

- **Direct Drivers**: The way **this person** thinks/feels about indirect drivers that sets suicide up as an option.
  - Suicidal ideation and behaviors are **functional**. They are possible solutions for pain.
  - By definition, direct drivers must be idiosyncratic.
Indirect Driver(s)*

*Some examples of indirect drivers that included above include:
- Depression
- PTSD Symptoms
- Relationship Problems
- Marital Conflict
- Substance Abuse
- Bad Grades
- Homelessness
- Financial Difficulties
- Pending Deployment
- Unemployment
- Chronic Medical Issues
- Incarceration

Suicide as an Option
Direct drivers bridge the gap. They explain how this person gets from indirect drivers to considering/choosing suicide as an option.

“A lot of people struggle with X, but not everyone who does wants to kill themselves. How are you seeing X that makes you feel like suicide is an option or the only option for dealing with it?”
CAMS THERAPEUTIC WORKSHEET: UNDERSTANDING YOUR SUICIDALITY

Date of Session: __________________________ Session #: __________________________

I. PERSONAL STORY OF SUICIDALITY

Why are you suicidal? How do you understand your suicidality? How do you understand your relationship to suicide? What is your personal story?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

II. DRIVERS OF SUICIDALITY

Problem #2:

Problem #3:

Now let us examine the factors underlying your suicidality, or what we refer to as “drivers.” Please only complete those sections that have relevance toward your own experience of suicidality. Your answers may overlap with the information you provided on the Suicide Status Form in the first therapy session. However, new information may also be added over the course of treatment in order to most accurately reflect your personal experience of suicidality.

What are the “direct drivers” that lead me to feeling suicidal?

Specific thoughts (e.g., “It would be easier on everyone if I were dead.”)

________________________________________________________________________

Specific feelings (e.g., “I just feel so much shame.”)

________________________________________________________________________

Specific behaviors (e.g., “When I waste time all day long.”)

________________________________________________________________________

Specific themes (e.g., patterns in relationships or self-concept)

________________________________________________________________________

From Managing Suicidal Risk: A Collaborative Approach, Second Edition, by David A. Jobes. Copyright © 2016 The Guilford Press. Permission to photocopy this material is granted to purchasers of this book for personal use or use with individual clients (see copyright page for details). Purchasers can download additional copies of this material (see the box at the end of the table of contents).
What are the “indirect drivers” that lead me to feel suicidal?

**Indirect drivers**: Underlying factors that contribute, but do not necessarily lead to, acute suicidal ideation, feelings, and behaviors (e.g., homelessness, depression, substance abuse, PTSD, isolation).

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**III. SUICIDAL CONCEPTUALIZATION**

![Diagram of suicidal conceptualization]

1. **Suicide as an Option**

2. **Describe bridges and barriers to going to the next level**

3. **Direct Drivers (transpose information here)**

4. **Describe bridges and barriers to going to the next level**

5. **Indirect Drivers (transpose information here)**
CAMS: “Driver”-Oriented Treatment

- The patient’s **self-defined** problems are the basis for a “driver”-oriented treatment plan

- Over the course of CAMS we try to “sharpen” the drivers and get more “direct.”

- Targeting and treating suicidal drivers can help make suicidal coping obsolete
The Suicide Status Form (SSF): Putting Philosophy into Practice
First session of CAMS—SSF Assessment, Stabilization Planning, Driver-Specific Treatment Planning, and HIPAA Documentation

CAMS Interim Tracking Sessions

CAMS Outcome/Disposition Session
**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).

<table>
<thead>
<tr>
<th>Rank</th>
<th>Item</th>
<th>Low Pain</th>
<th>High Pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1) RATE PSYCHOLOGICAL PAIN (hurt, anguish, or misery in your mind; not stress, not physical pain):</td>
<td>1 2 3 4 5</td>
<td>High pain</td>
</tr>
<tr>
<td></td>
<td>What I find most painful is:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>2) RATE STRESS (your general feeling of being pressured or overwhelmed):</td>
<td>1 2 3 4 5</td>
<td>High stress</td>
</tr>
<tr>
<td></td>
<td>What I find most stressful is:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>3) RATE AGITATION (emotional urgency; feeling that you need to take action; not irritation; not annoyance):</td>
<td>1 2 3 4 5</td>
<td>High agitation</td>
</tr>
<tr>
<td></td>
<td>I most need to take action when:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>4) RATE HOPELESSNESS (your expectation that things will not get better no matter what you do):</td>
<td>1 2 3 4 5</td>
<td>High hopelessness</td>
</tr>
<tr>
<td></td>
<td>I am most hopeless about:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>5) RATE SELF-HATE (your general feeling of disliking yourself; having no self-esteem; having no self-respect):</td>
<td>1 2 3 4 5</td>
<td>High self-hate</td>
</tr>
<tr>
<td></td>
<td>What I hate most about myself is:</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

N/A 6) RATE OVERALL RISK OF SUICIDE: | Extremely low risk: | Extremely high risk (will not 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.

<table>
<thead>
<tr>
<th>Rank</th>
<th>REASONS FOR LIVING</th>
<th>Rank</th>
<th>REASONS FOR DYING</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

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

### Section B (Clinician):

<table>
<thead>
<tr>
<th>Y/N</th>
<th>Suicide ideation</th>
<th>Describe:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Frequency</td>
<td>per day</td>
</tr>
<tr>
<td></td>
<td>Duration</td>
<td>seconds</td>
</tr>
<tr>
<td>Y/N</td>
<td>Suicide plan</td>
<td>When:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Where:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>How: Access to means Y/N</td>
</tr>
<tr>
<td>Y/N</td>
<td>Suicide preparation</td>
<td>Describe:</td>
</tr>
<tr>
<td>Y/N</td>
<td>Suicide rehearsal</td>
<td>Describe:</td>
</tr>
<tr>
<td>Y/N</td>
<td>History of suicidal behaviors</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Single attempt</td>
<td>Describe:</td>
</tr>
<tr>
<td></td>
<td>Multiple attempts</td>
<td>Describe:</td>
</tr>
<tr>
<td>Y/N</td>
<td>Impulsivity</td>
<td>Describe:</td>
</tr>
<tr>
<td>Y/N</td>
<td>Substance abuse</td>
<td>Describe:</td>
</tr>
<tr>
<td>Y/N</td>
<td>Significant loss</td>
<td>Describe:</td>
</tr>
<tr>
<td>Y/N</td>
<td>Relationship problems</td>
<td>Describe:</td>
</tr>
<tr>
<td>Y/N</td>
<td>Burden to others</td>
<td>Describe:</td>
</tr>
<tr>
<td>Y/N</td>
<td>Health/pain problems</td>
<td>Describe:</td>
</tr>
<tr>
<td>Y/N</td>
<td>Sleep problems</td>
<td>Describe:</td>
</tr>
<tr>
<td>Y/N</td>
<td>Legal/financial issues</td>
<td>Describe:</td>
</tr>
<tr>
<td>Y/N</td>
<td>Shame</td>
<td>Describe:</td>
</tr>
</tbody>
</table>

### Section C (Clinician):

**TREATMENT PLAN** (Refer to Sections A & B)

<table>
<thead>
<tr>
<th>Problem #</th>
<th>Problem Description</th>
<th>Goals and Objectives</th>
<th>Interventions</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Self-Harm Potential</td>
<td>Safety and Stability</td>
<td>Stabilization</td>
<td>Plan Completed</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

YES ____ NO ____ Patient understands and concurs with treatment plan?

YES ____ NO ____ Patient at imminent danger of suicide (hospitalization indicated)?

---

Patient Signature: ___________________ Date: ____________  Clinician Signature: ___________________ Date: ____________

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CAMS Suicide Status Form (SSF-IV-R) STABILIZATION PLAN

Ways to reduce access to lethal means:

1. 

2. 

3. 

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

1. 

2. 

3. 

4. 

5. 

6. Life or death emergency contact number: 

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

1. 

2. 

3. 

Attending treatment as scheduled:

Potential Barrier: Solutions I will try:

1. 

2. 

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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

THOUGHT CONTENT: WNL OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY

ABSTRACTION: WNL NOTABLY CONCRETE OTHER:

SPEECH: WNL RAPID SLOW SLURRED IMPOVERISHED INCOHERENT

MEMORY: GROSSLY INTACT

REALITY TESTING: WNL

NOTABLE BEHAVIORAL OBSERVATIONS:

________________________________________________________

DIAGNOSTIC IMPRESSIONS/DIAGNOSIS (DSM/ICD DIAGNOSES):

________________________________________________________

________________________________________________________

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

☐ LOW (WTL/RFL) Explanation:

☐ MODERATE (AMB)

☐ HIGH (WTD/RFD)

CASE NOTES:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Next Appointment Scheduled: ___________________ Treatment Modality:

________________________________________________________________________

Clinician Signature ___________________ Date ___________________
## 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**

## 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: __________________________

<table>
<thead>
<tr>
<th>Problem #</th>
<th>Problem Description</th>
<th>Goals and Objectives</th>
<th>Interventions</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Self-Harm Potential</td>
<td>Safety and Stability</td>
<td>Stabilization</td>
<td>Plan Updated</td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>3</td>
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</tbody>
</table>

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

**MENTAL STATUS EXAM (circle appropriate items):**

<table>
<thead>
<tr>
<th>Alertness:</th>
<th>Alert</th>
<th>Drowsy</th>
<th>Lethargic</th>
<th>Stuporous</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oriented To:</td>
<td>Person</td>
<td>Place</td>
<td>Time</td>
<td>Reason for Evaluation</td>
<td>Other:</td>
</tr>
<tr>
<td>Mood:</td>
<td>Euthymic</td>
<td>Elevated</td>
<td>Dysphoric</td>
<td>Agitated</td>
<td>Angry</td>
</tr>
<tr>
<td>Affect:</td>
<td>Clear &amp; Coherent</td>
<td>Goal-Directed</td>
<td>Tangential</td>
<td>Circumstantial</td>
<td>Other:</td>
</tr>
<tr>
<td>Thought Continuity:</td>
<td>WNL</td>
<td>Obsessions</td>
<td>Delusions</td>
<td>Ideas of Reference</td>
<td>Bizarreness</td>
</tr>
<tr>
<td>Thought Content:</td>
<td>WNL</td>
<td>Notably Concrete</td>
<td>Other:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Abstraction:</td>
<td>WNL</td>
<td>Rapid</td>
<td>Slow</td>
<td>Slurred</td>
<td>Impoverished</td>
</tr>
<tr>
<td>Speech:</td>
<td>Grossly Intact</td>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Memory:</td>
<td>WNL</td>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reality Testing:</td>
<td>WNL</td>
<td>Other:</td>
<td></td>
<td></td>
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<tr>
<td>Notable Behavioral Observations:</td>
<td></td>
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**DIAGNOSTIC IMPRESSIONS/DIAGNOSIS (DSM/ICD DIAGNOSES):**

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

- **MILD (WTI/RFL)**
  - Explanation:

- **MODERATE (AMB)**
  - Explanation:

- **HIGH (WTD/RFD)**
  - Explanation:

**CASE NOTES:**

<p>| | | |</p>
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Next Appointment Scheduled: ________  Treatment Modality: ________

Clinician Signature: ________  Date: ________

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### CAMS Suicide Status Form (SSF-IV-R) Outcome/Disposition Final Session

**Patient:** __________________________  **Clinician:** __________________________  **Date:** __________  **Time:** __________

---

### 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.

What have you learned from your clinical care that could help you if you became suicidal in the future?

---

### 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 discontinue treatment (unilaterally)
- Referral to: __________________________  
- Other. Describe: __________________________

Next Appointment Scheduled (if applicable): __________________________

Patient Signature __________________________  Date __________  Clinician Signature __________________________  Date __________

---

CAMS Suicide Status Form (SSF-IV-R) Copyright David A. Jobes, Ph.D., All Rights Reserved
### Section C (Clinician Outcome Evaluation):

#### MENTAL STATUS EXAM (circle appropriate items):

- **Alertness:** Alert, Drowsy, Lethargic, Stuporous, Other: ____________________
- **Oriented to:** Person, Place, Time, Reason for Evaluation, Other: ____________________
- **Mood:** euthymic, Elevated, Dysphoric, Agitated, Angry, Other: ____________________
- **Affect:** Flat, Blunted, Constricted, Appropriate, Labile, Other: ____________________
- **Thought Continuity:** Clear & Coherent, Goal-Directed, Tangential, Circumstantial, Other: ____________________
- **Thought Content:** WNL, Obsessions, Delusions, Ideas of Reference, Bizarre, Morbid, 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 IMRESSIONS/DIAGNOSIS (DSM/ICD DIAGNOSES):  
__________________________
__________________________
__________________________

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

- **Low (WTL/RFL)**  
  Explanation: ____________________

- **Moderate (AMB)**  
  ____________________

- **High (WTD/RFD)**  
  ____________________

#### CASE NOTES:  
__________________________
__________________________
__________________________
__________________________
__________________________

Clinician Signature: ____________________  Date: ____________________

---

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

(in progress!!!)
What does the evidence say?
**Psychometrics of the Core SSF**  
(Jobes et al., 1997; Conrad et al., 2009)

**TABLE 3**  
Convergent Validity: Correlations Between SSF-II Items and Established Measures of Similar Constructs

<table>
<thead>
<tr>
<th>SSF-II Item</th>
<th>Measure</th>
<th>n</th>
<th>Spearman rho</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>BHQ-20</td>
<td>113</td>
<td>-0.35*</td>
</tr>
<tr>
<td></td>
<td>OQ-45.2</td>
<td>127</td>
<td>0.45*</td>
</tr>
<tr>
<td></td>
<td>OMMP</td>
<td>110</td>
<td>0.43*</td>
</tr>
<tr>
<td>Stress</td>
<td>PI-III</td>
<td>129</td>
<td>0.12</td>
</tr>
<tr>
<td></td>
<td>STICSA-S</td>
<td>130</td>
<td>0.36*</td>
</tr>
<tr>
<td></td>
<td>STICSA-T</td>
<td>136</td>
<td>0.27*</td>
</tr>
<tr>
<td></td>
<td>STICSA-Total</td>
<td>121</td>
<td>0.31*</td>
</tr>
<tr>
<td>Agitation</td>
<td>STICSA-S</td>
<td>128</td>
<td>0.42*</td>
</tr>
<tr>
<td></td>
<td>STICSA-T</td>
<td>134</td>
<td>0.28*</td>
</tr>
<tr>
<td></td>
<td>STICSA-Total</td>
<td>119</td>
<td>0.36*</td>
</tr>
<tr>
<td></td>
<td>BIS</td>
<td>133</td>
<td>0.36*</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>BHS</td>
<td>140</td>
<td>0.52*</td>
</tr>
<tr>
<td>Self-hate</td>
<td>BST</td>
<td>141</td>
<td>-0.37*</td>
</tr>
<tr>
<td>Overall Risk</td>
<td>L-RFL</td>
<td>137</td>
<td>-0.51*</td>
</tr>
</tbody>
</table>

*Correlation is significant at p < .01 (one-tailed).

**TABLE 2**  
Factor Analysis Results: Spearman Promax Rotated Factor Pattern

<table>
<thead>
<tr>
<th>SSF-II Item</th>
<th>Factor 1</th>
<th>Factor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-hate</td>
<td>.88***</td>
<td>-0.09</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>.85***</td>
<td>.05</td>
</tr>
<tr>
<td>Pain</td>
<td>.74***</td>
<td>.10</td>
</tr>
<tr>
<td>Agitation</td>
<td>-0.07</td>
<td>.92***</td>
</tr>
<tr>
<td>Stress</td>
<td>.12</td>
<td>.78***</td>
</tr>
</tbody>
</table>

*Value is greater than 0.4

**TABLE 5**  
Comparison of Suicidal Patients to Nonsuicidal Patients on SSF-II Items

<table>
<thead>
<tr>
<th>SSF item</th>
<th>Suicidal patients</th>
<th>Nonsuicidal patients</th>
<th>Univariate F</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Pain</td>
<td>3.62</td>
<td>1.24</td>
<td>3.44</td>
</tr>
<tr>
<td>Stress</td>
<td>3.87</td>
<td>1.25</td>
<td>3.78</td>
</tr>
<tr>
<td>Agitation</td>
<td>2.90</td>
<td>1.24</td>
<td>2.93</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>3.81</td>
<td>1.29</td>
<td>2.83</td>
</tr>
<tr>
<td>Self-hate</td>
<td>3.74</td>
<td>1.31</td>
<td>2.88</td>
</tr>
<tr>
<td>Overall risk</td>
<td>2.68</td>
<td>1.27</td>
<td>1.55</td>
</tr>
<tr>
<td>OQ-45 total</td>
<td>125.22</td>
<td>23.13</td>
<td>130.47</td>
</tr>
</tbody>
</table>

*F statistic is significant at p < .001.

**Reliability**

The first three test-retest t-test analyses yielded correlations that were statistically significant (Pain = .33, Stress = .23, Agitation = .35); however, the findings were more robust for the latter three variables (Hopelessness = .46; Self-Hate = .57, Overall Risk = .51). All correlations were significant at the p < .001 level, except the SSF stress correlation, which was significant at p < .05.
<table>
<thead>
<tr>
<th>Authors</th>
<th>Sample/Setting</th>
<th>n</th>
<th>Significant Results</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jobes et al., 1997</td>
<td>College Students</td>
<td>106</td>
<td>Pre/Post Distress, Pre/Post Core SSF</td>
</tr>
<tr>
<td></td>
<td>Univ. Counseling Ctr.</td>
<td></td>
<td></td>
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<tr>
<td>Jobes et al., 2005</td>
<td>Air Force Personnel</td>
<td>56</td>
<td>Between Group Suicide Ideation, ED/PC Appts.</td>
</tr>
<tr>
<td></td>
<td>Outpatient Clinic</td>
<td></td>
<td></td>
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<tr>
<td>Arkov et al., 2008</td>
<td>Danish Outpatients</td>
<td>27</td>
<td>Pre/Post Core SSF, Qualitative findings</td>
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<tr>
<td></td>
<td>CMH Clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jobes et al., 2009</td>
<td>College Students</td>
<td>55</td>
<td>Linear reductions, Distress/Ideation</td>
</tr>
<tr>
<td></td>
<td>Univ. Counseling Ctr.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nielsen et al., 2011</td>
<td>Danish Outpatients</td>
<td>42</td>
<td>Pre/Post Core SSF</td>
</tr>
<tr>
<td></td>
<td>CMH Clinic</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Ellis et al., 2012</td>
<td>Psychiatric Inpatients</td>
<td>20</td>
<td>Pre/Post Core SSF, Suicidal Ideation, depression, hopelessness</td>
</tr>
<tr>
<td>Ellis et al., 2015</td>
<td>Psychiatric Inpatients</td>
<td>52</td>
<td>Suicide ideation and cognitions</td>
</tr>
<tr>
<td>Ellis et al., 2017</td>
<td>Inpatients (&amp; post-discharge)</td>
<td>104</td>
<td>SI, cognitions, depression, hopelessness, funct. impare, well-being, psych flexibility</td>
</tr>
</tbody>
</table>
# Randomized Controlled Trials of CAMS

<table>
<thead>
<tr>
<th>Principal Setting &amp; Population</th>
<th>Design &amp; Method</th>
<th>Sample Size</th>
<th>Status Update</th>
<th>Investigator</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comtois Harborview/Seattle</td>
<td>CAMS vs. TAU</td>
<td>32</td>
<td>2011 published (Jobes)</td>
<td>article</td>
<td>article</td>
</tr>
<tr>
<td>CMH patients</td>
<td>Next-day appts.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Andreasson Danish Centers</td>
<td>DBT vs. CAMS</td>
<td>108</td>
<td>2016 published (Nordentoft)</td>
<td>article</td>
<td>article</td>
</tr>
<tr>
<td>CMH patients</td>
<td>superiority trial</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Jobes Ft. Stewart, GA</td>
<td>CAMS vs. E-CAU</td>
<td>148</td>
<td>2017 published article</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pistorello Univ. Nevada (Reno)</td>
<td>SMART Design</td>
<td>62</td>
<td>Manuscript (Jobes) in preparation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>College Students</td>
<td>TAU/CAMS/DBT</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Ryberg (Fosse) Norwegian</td>
<td>CAMS vs. TAU</td>
<td>100</td>
<td>Manuscript in preparation</td>
<td></td>
<td></td>
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<tr>
<td>Centers</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Comtois Harborview/Seattle</td>
<td>CAMS vs. TAU</td>
<td>200</td>
<td>Intent to treat (Jobes) underway</td>
<td></td>
<td></td>
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<tr>
<td>Suicide attempters</td>
<td>Post-Hosp. D/C</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Depp et al San Diego VAMC</td>
<td>CAMS vs. Outreach</td>
<td>176</td>
<td>Grant awarded</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Walk in Veterans</td>
<td>Same Day Services</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Research Article: CAMS Feasibility Trial for NDA Services

- Approached by Clinician (N=49)
  - Assessor Screen (N=49)
    - Accepted into Study (N=41)
      - Randomization Sample (N=32)
        - Started CAMS (N=16)
          - Withdrawn from study Required intensive services (N=2)
            - Completed Study Assessments (N=11)
        - Started ECAU (N=16)
          - Dropped treatment (N=5)
            - Completed Study Assessments (N=9)
          - Dropout (N=11)
            - Completed treatment (N=10)
          - Withdrawn from study Court-ordered to treatment (N=1)

- Rejected at Screening (N=8)
  - Leaving the country = 1
  - Currently had provider = 3
  - Denied SI = 3
  - Wanted different treatment = 1

- Did not attend first session (N=9)

Figure 1. Consort diagram.
CAMS RCT (Comtois et al., 2011)

**Research Article**

**Collaborative Assessment and Management of Suicidality (CAMS): Feasibility Trial for Next-Day Appointment Services**

Katherine Anne Comtois, Ph.D., MPH,1,2 David A. Joiner, Ph.D.,2 Stephen S. O'Connor, M.B., B.S.,2 David A. Eiden, Ph.D.,2 Karin James, M.D., A.B.,2,3 Gilbo E. Elmore, B.A.,2,3 Anne J. Lamberg, Ph.D.,2,3 Anna Hobbs, M.D.,2 and Christine Turkington-Farrell, M.D.,2

**Background**

Despite the ubiquity of suicidality in behavioral health settings, empirical support for effective treatment is sparse and disappointing. The importance of treating suicidality and associated mood and affective problems is well documented. However, evidence for the efficacy of available treatments is limited. The Collaborative Assessment and Management of Suicidality (CAMS) trial was a feasibility study of a next-day appointment (NDA) collaborative treatment strategy. This study included a larger feasibility study, a 12-week intervention, and a randomized control trial (RCT) with a 12-month follow-up. The CAMS RCT was conducted at 4 sites across the United States.

**Methods**

The Collaborative Assessment and Management of Suicidality (CAMS) trial was a randomized, controlled trial that compared the CAMS RCT (collaborative treatment strategy) with a treatment-as-usual (TAU) condition. The primary outcome was the percentage of patients who met criteria for treatment success (defined as no suicidal ideation, no suicide attempts, and no severe suicidal behavior).

**Results**

Patients in the CAMS RCT condition were more likely to meet criteria for treatment success than those in the TAU condition. The CAMS RCT also resulted in significantly higher patient satisfaction ratings and better clinical retention.

**Key words**

suicide attempt, suicide prevention, risk assessment, crisis intervention, follow-up, clinical trial.

**Introduction**

More than 33,000 suicides occurred in the United States in 2019, with nearly 1.5 million attempted suicides. Suicide is a significant public health problem, with millions of Americans having experienced any thoughts or plans of suicide or recent suicide attempts in the past year. The suicide rate is approximately 10 times higher in persons with a history of suicide attempts compared to the general population. The purpose of this study was to evaluate the feasibility and acceptability of the CAMS RCT compared to TAU.
Operation Worth Living (OWL)

Consenting Suicidal Soldiers (n=148)

- **Experimental Group**
  - CAMS
  - 3 months of outpatient care (n=73)

- **Control Group**
  - E-CAU
  - 3 months of outpatient care (n=75)

**Dependent Variables:**
- Suicidal Ideation/Attempts
- Symptom Distress
- Resiliency
- Primary Care visits
- Emergency Department Visits
- Hospitalizations

**Measures:**
- SSI, OQ-45, SASI-Count, CDRISC, PCL-M, SF-36, NSI, THI... (at 1, 3, 6, 12 months)
<table>
<thead>
<tr>
<th>Outcome</th>
<th>CAMS</th>
<th>E-CAU</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any suicidal ideation (SSI)</td>
<td>6.63</td>
<td>5.38</td>
</tr>
<tr>
<td>Any suicide-related episode</td>
<td>1.47</td>
<td>1.30</td>
</tr>
<tr>
<td>Any behavioral health-related episode</td>
<td>1.15</td>
<td>1.27</td>
</tr>
<tr>
<td>Any suicide-related wellness check/escort</td>
<td>1.29</td>
<td>1.23</td>
</tr>
<tr>
<td>Any behavioral health-related wellness check/escort</td>
<td>1.05</td>
<td>1.11</td>
</tr>
<tr>
<td>Any suicide-related ER visit</td>
<td>2.03</td>
<td>1.39</td>
</tr>
<tr>
<td>Any behavioral health-related ER visit</td>
<td>1.62</td>
<td>1.15</td>
</tr>
<tr>
<td>Any suicide-related IPU admission</td>
<td>1.90</td>
<td>1.02</td>
</tr>
<tr>
<td>Any behavioral health-related IPU admission</td>
<td>1.59</td>
<td>1.08</td>
</tr>
<tr>
<td>Any suicide attempt/hospitalization</td>
<td>2.07</td>
<td>1.56</td>
</tr>
<tr>
<td>Symptom distress (OQ-45)</td>
<td>5.58</td>
<td>4.96</td>
</tr>
<tr>
<td>PTSD symptoms (PCL-M)</td>
<td>3.48</td>
<td>3.07</td>
</tr>
</tbody>
</table>

**Pre-Post Effect Sizes**

- **small effect** = 0.2
- **medium effect** = 0.5
- **large effect** = 0.8

CAMS had large effects

But so did E-CAU...

**Note.** “Post-intervention” assessed at 3 months.
Significant 3 month finding for CAMS eliminating suicidal ideation

No significant between-group differences on suicide attempts (only 9 in the study)
How is CAMS being applied across the systemic levels discussed?
A Stepped Care Model for Suicide Care

Suicide-specific Care at Each Step
From Least to Most Restrictive Intervention

CAMS

Adapted from Jobes, D. (2014)
New Developments on the Horizon
Figure 1. College Student Client Flow through the SMART
CAMS-Relational Agent System

"Dr. Dave"

NIMH-funded SBIR Phase I: Linda Dimeff, David Jobes, & Kelly Koerner
**CAMS-RAS Report**

**SUICIDE RISK ASSESSMENT AND INTERVENTION PLANNING**

**1. SUICIDE STATUS INFORMATION GATHERED SO FAR**

<table>
<thead>
<tr>
<th>Suicide Index Score Group</th>
<th>Wish to DIE</th>
<th>Ambivalence</th>
<th>WISH TO LIVE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>-3</td>
<td>-2</td>
<td>-1</td>
</tr>
</tbody>
</table>

When *Wish to Live* is stronger than *Wish to Die*, risk for suicide may be lower with better response to short-term suicide-specific treatment.

**Overall Risk of Suicide** | *Scale 1 (will not kill myself) – 5 (will kill myself)*

Higher scores indicate higher acute suicidality and longer treatment response moderated by self-hate and hopelessness.

**SSF Core Assessment** | *Scale 1 (not at all) – 5 (very much)*

<table>
<thead>
<tr>
<th>SCORE</th>
<th>CONCEPT</th>
<th>DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Emotional Pain</td>
<td><em>The abuse by my teacher</em></td>
</tr>
<tr>
<td>4</td>
<td>Hopelessness</td>
<td><em>I’ll always feel this way</em></td>
</tr>
<tr>
<td>5</td>
<td>Self-hate</td>
<td><em>It was my fault</em></td>
</tr>
<tr>
<td>4</td>
<td>Agitation</td>
<td><em>When I think about the abuse</em></td>
</tr>
<tr>
<td>2</td>
<td>Stress</td>
<td><em>Everything</em></td>
</tr>
</tbody>
</table>

5 = Very Much. High Hopelessness, Self-Hate, and Overall Risk suggest chronic suicidality. High Agitation and Stress suggest acute suicidality.

**Suicide Ideation Focus** | *Scale 1 (not at all) – 5 (completely)*

- **On Myself**
  - High focus on self is more concerning

- **On My Relationships**
  - Low focus on relationships may be less protective

Your patient’s suicidal ideation is very focused on him/herself. This suggests greater overall risk and possibly worse treatment response.

**Direct Drivers**

Top 2 problems patient says directly drive his/her suicidal thinking and behavior:

- **#1** The abuse by my teacher
- **#2** My self-hate
CAMS for Kids

CAMS-K: Core Constructs

1. Psychological Pain:

<table>
<thead>
<tr>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1.______________________________________________________________________
2.______________________________________________________________________
3.______________________________________________________________________
4.______________________________________________________________________
5.______________________________________________________________________

CAMS-K: Core Concepts

1. Psychological Pain: _Pain in heart_

1. I'm happy. Play with sister.
2. Sad, no one wants to play with me.
3. Mad face, angry.
4. Smile, cry, stay in room.
5. Angry, sad, I can feel the pain in my heart.
The evolution of CAMS

Assessment

Treatment

Outcomes

3rd Edition