Collaborative Assessment and Management of Suicidality (CAMS)[1]

Knowledge of basic principles and rationale for CAMS

An ability to draw on knowledge that the CAMS framework is a structured but flexible clinical support tool intended for workers from a variety of professional backgrounds and levels of skill intended to be used to both assess and manage suicidal risk
An ability to draw on knowledge that CAMS sessions are guided by a structured 'suicide status form'
An ability to draw on knowledge that each session should include both assessment and intervention along with a treatment plan update
An ability to draw on knowledge that CAMS is based upon a core philosophy of care including:
explicitly demonstrating empathy for the high level of distress experienced by people who are suicidal
a highly interactive style of collaboration in the assessment and treatment process
honesty and transparency in all aspects of communication
An ability to draw on knowledge that the primary focus of CAMS is on the prevention of suicidal behaviour (rather than addressing suicidality as a symptom of another mental health problem and so making the latter the primary focus)
An ability to draw on knowledge that a person in a CAMS framework is engaged as a key partner in therapy by focusing on the person-defined problems ('suicidal drivers') that lead to suicidal thoughts, feelings, and behaviours
An ability to draw on knowledge that CAMS is oriented towards keeping a person who is suicidal out of an inpatient setting (wherever this is possible and appropriate)

Ability to maintain a collaborative focus

An ability to maintain a highly collaborative focus throughout the treatment by:
setting out the practitioner's role as a coach, guide or collaborator in the process
building up a shared understanding of the suicide risk as defined by both parties
prioritising discussion of the person's point of view (in terms of key drivers of the suicidal state)
co-constructing plans that address risk with, rather than for, the person
adopting a seating position in the room, which physically enables the person and therapist to work together when co-constructing written summaries during assessment and treatment planning

[1] Source: Jobes DA. Managing Suicidal Risk: A Collaborative Approach. Second Edition. New York: Guilford Press; 2016.

Ability to conduct a risk assessment using CAMS

An ability to pace and structure an assessment appropriately (e.g. introducing the topic of suicidal risk early in the session while engaging a person sensitively)
An ability to help a person identify, discuss and rate core risk and warning factors that may relate to their suicidality, such as:
acute states such as hurt, anguish or misery
feelings of being pressurised or overwhelmed
agitation (a sense of emotional urgency or need to take action)
thoughts such as hopelessness or self-hatred
guilt or shame
An ability to help a person rate the degree to which being suicidal relates to thoughts and feelings about themselves or other people
An ability to help a person rate their overall likelihood of acting upon suicidal thoughts
An ability to help a person identify ‘reasons for living’ and ‘reasons for dying’
An ability to help a person identify the relative relationship between their wish to live and their wish to die
An ability to help a person to begin prioritising the key issues that are contributing to their suicidal behaviour
An ability to assess empirically-based risk factors and warning signs in collaboration with the person in a non-judgemental matter including:
suicidal ideation (its frequency and duration)
suicide planning, preparation and rehearsal
history of suicidal behaviours (single or multiple attempts)
a history of impulsivity (as indicated by the person’s perceptions of their own behaviour)
substance use
significant losses that may be acting as precipitants (either single or cumulative)
relationship problems
a strong sense of being a burden to others
significant and/or enduring health problems
sleep problems
major legal/financial issues
shame

Ability to co-construct a treatment plan

Orientation

An ability to foster collaboration and individual choice through discussion of a person’s options, including the choice to end their life, while maintaining an orientation towards helping them commit to treatment
An ability to create a 'stabilisation plan’ that helps a person to identify actions they can take (such as reducing access to lethal means, alternative coping behaviours and sources of social support they can call upon) when they are feeling suicidal
An ability to use motivational techniques to capitalise on people’s ambivalence about suicide and create an intention to choose to live, at least for a finite time period
An ability to strike a balance between communicating empathy for a person’s suicidal wish and helping them consider other, more effective, ways to have their needs met
An ability to negotiate a mutually agreed period of time during which a person agrees to put the choice to end their life to one side and follow their suicide-specific treatment plan

	ensuring that this is an adequate period of time for the intervention to be effective (typically about 3 months/6 to 8 sessions)
	making it clear that this is a critical condition to embarking on treatment
An ability to convey in an honest and straightforward manner the clinician's duty and responsibility to act on clinical judgement if the person is in clear and imminent danger, and to arrange hospitalisation or intensive home treatment if necessary	

Intervention

An ability to draw on knowledge that a CAMS treatment plan should contain no more than three problems (one of which should focus on a person's potential for self-harm), and also include the goals of any intervention and the methods that will be used,	
An ability to ensure that the first step in stabilisation planning is an empathic discussion that focuses on removing a person's access to lethal means of harming themselves	
An ability to construct a 'coping hierarchy' with the person that consists of a number of steps that they can use to manage suicidal thoughts and feelings, redirecting behaviour and moving attention away from a narrowing focus on suicide, including:	
	restriction of access to means
	self-soothing activities
	distracting activities
	pleasurable or absorbing activities
	using their social network effectively
An ability to help the person overcome obstacles in constructing the hierarchy, such as lack of ideas and/or hopelessness	
An ability to help the person identify people they can contact in an emergency, including family, carers and friends, professionals and crisis lines, if coping strategies fail to work	
An ability to help the person begin prioritising the key problems that are driving suicidality by identifying two focal problems for the remaining part of the intervention	
An ability to target and treat the problems driving suicidality, which may be:	
	direct (those problems that cause a person to want to end their life in an urgent and pressing way)
	indirect (those issues, problems or concerns that make a person vulnerable to suicidal states but do not directly cause them to become acutely suicidal, for example homelessness, isolation, insomnia, trauma history)
An ability to make use of appropriate treatment strategies or onward referrals to assist a person in tackling their suicidal drivers, aiming to get to the root of why these issues compel them to consider suicide	
An ability to make use of the CAMS approach in a flexible way in subsequent sessions, moving from a focus on assessment to an emphasis on increasing a person's coping skills and targeting the focal problems identified by the assessment	

Ending therapy

An ability to identify when it is safe and appropriate to end the CAMS intervention, usually on the basis of consistent feedback from the person (over a period such as 3 to 4 weeks) that indicates that they are at very low overall risk of ending their life, for example:	
	they have been able to manage their thoughts and feelings
	they have not engaged in any self-harm, or made any behavioural preparations for suicide
	they have increased their knowledge and use of a range of coping strategies
Towards the end of successful CAMS-guided care, an ability to focus on reasons for living and a life worth living with purpose and meaning	
An ability to judge whether continuation of therapy is appropriate and to discuss the options open to the person, for example:	
	if therapy will continue with the same therapist, negotiating a new treatment contract so that the work can shift towards addressing the ongoing direct and indirect drivers identified in the initial assessment
	if therapy will continue with a new agency or therapist, supporting this transition by identifying how and when this will be done
Where end of treatment has been mutually agreed as the most appropriate course of action, an ability to support the person by offering occasional ‘booster’ sessions	