Collaborative Assessment and Management of Suicidality

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Q. What is Collaborative Assessment and Management of Suicidality?

A. Collaborative Assessment and Management of Suicidality (CAMS) is a therapeutic framework for the assessment and treatment of suicidality that can be applied across different theoretical models and treatment approaches (Jobes, Gregorian, & Colburn, 2018). CAMS is not in itself a treatment; therapists use their clinical experience and interventions of choice, but follow the key requirements of the framework, which include focusing on addressing patient-defined factors that contribute to suicidality and conducting all work in a collaborative manner (Jobes, 2006). CAMS includes suicide risk assessment, treatment planning, and management of suicide risk. The Suicide Status Form is used throughout CAMS as a multipurpose tool for assessment, documentation, and tracking.

Q. What is the theoretical model underlying CAMS for suicidality?

A. In CAMS, suicide is conceptualized as a complex and multifactorial event. CAMS is considered a "philosophy of care" that does not prescribe particular treatments or theoretical approaches (Jobes et al., 2018). A goal of CAMS is to assist the patient in learning alternative coping strategies. The clinician works collaboratively with the patient to identify suicidal "drivers" and to understand how suicidal thoughts and behaviors function as coping strategies (Jobes, 2009). A central component of CAMS is a collaborative assessment and treatment planning process in which the patient is actively involved in the treatment plan. He or she identifies how suicide can be understood as a means of coping, and contributes insights into alternative strategies to cope with patient-defined problems (Jobes, 2016; Jobes, 2018). This approach is designed to encourage the development of a strong therapeutic alliance that incorporates the patient's insight to heighten motivation (Jobes, 2018).

Q. Is CAMS recommended as a treatment framework for suicidality in the Military Health System (MHS)?

A. No. The *2019 VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide* does not include CAMS.

The MHS relies on the Department of Veterans Affairs (VA)/Department of Defense (DoD) clinical practice guidelines (CPGs) to inform best clinical practices. The CPGs are developed under the purview of clinical experts and are derived through a transparent and systematic approach that includes, but is not limited to, systematic reviews of the literature on a given topic and development of recommendations using a graded system that takes into account the overall quality of the evidence and the magnitude of the net benefit of the recommendation. A further description of this process and CPGs on specific topics can be found on the VA clinical practice guidelines website.

Q. Do other authoritative reviews recommend CAMS as a treatment framework for suicidality?

A. No. Other authoritative reviews have not substantiated the use of CAMS for suicidality.

Several other recognized organizations conduct systematic reviews and evidence syntheses on psychological health topics using similar grading systems as the VA/DoD CPGs. These include the Agency for Healthcare Research and Quality (AHRQ) and Cochrane.

- AHRQ: No reports on the treatment of suicidality were identified.
- Cochrane: A 2016 systematic review of psychosocial interventions for self-harm in adults did not include any CAMS studies (Hawton et al., 2016).

Q. Is there any recent research on CAMS as a treatment for suicidality?

A. An August 2019 literature search identified four randomized controlled trials (RCTs) of CAMS. A recently published RCT of 78 participants with suicidal ideation comparing CAMS to treatment as

usual (TAU) found that suicidal ideation was significantly reduced in the CAMS group compared to TAU at six months, but not at 12-months (Ryberg, Zahl, Diep, Landro, & Fosse, 2019). No differences were found in suicide attempts or self-harm between groups. A second RCT compared CAMS to enhanced care as usual in 148 soldiers with significant suicidal ideation (Jobes et al., 2017). Both study groups improved over time across all outcome measures. CAMS patients were significantly less likely to report suicidal ideation compared to control at 3-month follow-up, but not at 1-, 6-, or 12-month follow-up, and no other differences were found between groups. A third RCT compared CAMS to dialectical behavior therapy (DBT) in 108 adults with borderline personality traits or disorder and a recently attempted suicide, and found no significant differences between DBT and CAMS for reduction in self-harm or suicide attempts (Andreasson et al., 2016). A fourth trial was a feasibility study comparing CAMS to enhanced care as usual in 32 suicidal patients (Comtois et al., 2011). CAMS patients showed significant reductions in suicidal ideation compared to enhanced care as usual.

Q. What conclusions can be drawn about the use of CAMS in the MHS?

A. CAMS tools, such as the Suicide Status Form, may be useful to clinicians for the assessment and management of suicidal patients. However, the evidence base for CAMS would benefit from additional RCTs. Although the CAMS framework has been investigated in a number of research studies (Jobes et al., 2018), only four of these studies are RCTs. Of these RCTs, one was a feasibility trial with a small sample (Comtois et al., 2011), one was a non-inferiority trial comparing CAMS with a specific intervention for a specific population (Andreasson et al., 2016), and one had a modest sample size (Ryberg et al., 2019). The fourth, the largest RCT to date, found that both CAMS and the enhanced care as usual group improved, and CAMS was only found superior in respect to suicidal ideation at the 3-month follow-up (Jobes et al., 2017).

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