Implementation Recommendations for Utilizing
The Collaborative Assessment and Management of Suicidality ("CAMS") in K-12 Schools
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The implementation recommendations described below are intended to be general guidelines for administrators and educators to consider when attempting to scale up the use of CAMS in K-12 schools.

Promoting a Continuum of Care in Schools across Multiple Systems of Care

CAMS is most effective in schools when it is but one part of a comprehensive suicide prevention infrastructure that includes many related, but distinct elements. The elements include but are not limited to:

1. existing policies and procedures designed to help assess, manage, monitor, and follow-up with students who exhibit risk of self-harm (e.g., documentation, notification of parents/guardians, safety planning);
2. a pre-existing, community-based 24/7 mobile crisis service, good working inter-agency relationships with child protective services, law enforcement (e.g., school resource officers); and
3. an active referral list of licensed, community practitioners who are competent in the area of child and adolescent mental health (or standing agreements with the same).

As described above, CAMS can be a complementary service element that can be feasibly integrated into existing systems of assessment and intervention. For example, if schools have historically used the Columbia Suicide Severity Rating Scale, the instrument can be used as justification to refer a student for a CAMS assessment. The CAMS assessment process or supporting documentation should not be modified in any way, but collecting collateral information (e.g. Columbia) can be helpful if there is a mechanism to share and integrate related data to promote student safety.

In addition to the aforementioned elements being present prior to CAMS implementation, it is helpful to have broad educative and intervention components across the 3 tiers of support, especially in schools that subscribe to the Multi-Tiered Systems of Support (MTSS) Model. For example, Tier 1 might include suicide prevention education models or exposure to Social-Emotional Learning (SEL) curricula, whereas Tier 2 supports might include substance abuse prevention programming or small topic-focused groups facilitated by counselors and social workers who work for the schools. CAMS should be considered a Tier 3 intervention.

Memoranda of Agreement (MoA)

Ideally, schools should have articulated, signed agreements with community partners and licensed practitioners in advance of attempting to utilize CAMS in schools. Those same providers should be trained in the CAMS model. Trying to respond in an ad hoc manner to students at risk for suicide is not recommended. The policies, procedures, and designated roles should be clear and repeatable. Before implementation, all agreements and procedures should be reviewed carefully and vetted by the District Office of General Counsel.

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Similar to developing MoAs, schools who elect to implement CAMS as part of a comprehensive suicide prevention strategy should develop the necessary consent documents to enable qualified CAMS practitioners to complete, at a minimum, the Initial CAMS Suicide Status Form ("SSF"). Though school personnel trained and vetted as CAMS practitioners are great candidates to complete the Initial SSF during an acute crisis event, it might not be feasible for those same practitioners to provide on-going CAMS-Care for students with Initial SSF findings that indicate a need for follow-up care. Thus, it is essential for schools to develop Release of Information (RoI) documents to expedite appropriate referrals and to prevent lapses in the continuum of care. Community practitioners who are qualified to provide on-going CAMS treatment should be represented on the list of active referral sources.

Scope of Practice and Competency Expectations

Given that the implementation of a CAMS-care model in schools involves a diverse array of constituents with varying levels of expertise and roles in mental health, education, and school administration, all school staff would benefit from being exposed to the concepts, philosophies, and methods of CAMS. However, schools should be particularly selective about who is charged with the responsibility of overseeing and using CAMS in practice. For example, credentialed counselors, school social workers, or school psychologists who are trained and personally invested in the CAMS model are ideal candidates to complete the Initial SSF. However, completing the CAMS Initial SSF during an acute crisis should be a voluntary role that includes appropriate supervision and guidance in real time. Supervisors can either be school personnel (e.g., a Director of Student Services or Special Education with a mental health license) or licensed community providers. Under these circumstances, the CAMS practitioner should complete the SSF as instructed and not depart in any way from the standardized procedures established by CAMS as the Suicide Status Form version 4 is a core element of what makes CAMS an evidence-based assessment and treatment plan.

As a general rule, staying within the bounds of a professional scope of practice means that the practitioner is trained, experienced, licensed, and otherwise competent to perform the functions expected of the role (suicide risk assessment) with the population being served (e.g., children and adolescents). Scope of practice and competency guidelines are especially relevant when completing the Initial SSF. Regardless of the age of the student, the SSF should be completed as designed, with the only caveat being that the student should be able to read and understand the document, especially Section A. Administration of the Initial SSF does not vary based on age or grade; consequently, the use of CAMS with various age groups will depend on the competencies to do so, as described above. Minimally, those who are charged with completing the Initial SSF should be: a) appropriately trained (including CAMS), b) possess an appropriate human service graduate degree, c) supervised, credentialed or licensed, and d) experienced in conducting suicide risk assessments with populations of interest (i.e., children and adolescents).

Training

CAMS-care provides a variety of training options for school systems, educators, social workers, counselors, school psychologists, and clinicians. Relevant trainings include:

An **Educational Day** that outlines the suicide problem, the field of suicidology, evidenced based treatments and an overview of CAMS and using CAMS to assess and treat suicidal patients. This course is suitable for a wide audience, typically up to 200 people, including teachers, social workers, counselors, school psychologists, administrators, and emergency responders.

CAMS Adherence Training for clinicians who would like to use the Collaborative Assessment and Management of Suicidality ("CAMS") in their practice or day to day work. CAMS Adherence can be achieved by reading Dr. Jobes's book, Managing Suicidal Risk, Second Edition: A Collaborative Approach, watching the CAMS Foundational video, attending a one day Role Play Training workshop and participating in consultation calls following the Role Play Training to work through cases and best practices for using the Suicide Status Form.

More information about these trainings is available at CAMS-care.com or by contacting Dr. Kevin Crowley at camscare.crowley@gmail.com.