Kevin Crowley's
CAMS Clinical Corner

Hi everyone! I hope you're all doing well.

It's wonderful to connect with you again. This quarter, I wanted to consider a topic I'm often asked in initial systemic conversations: who on a multidisciplinary team is best placed to use CAMS?

I'd like to offer my thoughts and team-focused suggestions in the **Clinical Musings** section. Then, please note a new, free video on this topic and CAMS for acute care settings in the **Conclusion/New Resource** section.

Clinical Musings:
How Do Multidisciplinary Teams Use and Support CAMS?

I am very fortunate that I can connect with clinicians across a variety of geographical areas (nationally and internationally), settings, and contexts. It's very gratifying to be able to discuss CAMS and see whether the SSF as a standalone tool or CAMS as a broader treatment framework can be helpful for organizations' suicide care pathways. And regardless of context, there tends to be one question I get more frequently than others:

Who is the right fit for CAMS?

On the surface, this question seems to refer to patients/clients/consumers and knowing who benefits most an evidence-based protocol.

But that's not always what people are asking.

Just as commonly, people wonder about this from a broader systemic and implementation level: *Who on our multidisciplinary team is best placed to deliver CAMS, and how can others support it?*

Had you asked me that question 15 years ago, my answer would have been more straightforward and categorical. I would have told you that CAMS typically fell in the domain of mental and behavioral health providers (i.e., psychologists, counselors, social workers, and trainees under supervision) who were actively looking to provide psychotherapy to patients who are currently suicidal.

But healthcare has changed.

Post-pandemic demands, workforce shortages/turnover, and practical realities of high-acuity care/under-resourced settings have necessitated expanding that answer. In limiting CAMS to a specific discipline, we do many providers, settings, and ultimately patients a disservice.

I think better clarifiers include:

Who's playing what role on your team, in terms of evidence-based, suicide-focused care?

Who on your team would be tasked with:

- Delivering “deep dive” risk assessment beyond screening?
- Collaboratively developing safety planning type interventions?
- Involved in treatment planning or coordinating care discussions?

And who on the team would be suggesting or “selling” this process, or supporting it when implemented?

Not everyone tasked with risk assessment/determination, safety planning, and treatment planning is a mental health or behavioral health specialist. I’ve worked with several teams where these responsibilities have needed to be taken on by case managers, psychometrists, psych techs, or medical professionals (e.g., psychiatrists/residents, nurses) just to name a few. And we continue to be excited with the data gathered around feasibility and effectiveness of CAMS intervention in these cases!

But this reality necessitates focusing on team role versus terminal degree. And there are implications for each essential role in CAMS administration, spanning those who **suggest**/“**sell”** CAMS initially, **sign** forms with patients/clients, and **support** the framework once initiated.

Suggesting/“Selling” CAMS

CAMS can be a hard thing to promote, simply by virtue of its being a suicide-focused assessment and treatment framework. There are a lot of myths and hesitations that patients voice around both, often rooted in negative experiences they’ve had before! And to complicate matters further, I know that I’m not always the first person trying to suggest CAMS with a patient/client as a mental/behavioral health provider. Most patients first disclose suicidal thoughts and risk to someone like a peer support

specialist, case manager, or medical provider like a primary care physician or nurse practitioner.

This is not a bad thing! Someone getting to a place where they can be this vulnerable with their medical provider or peer speaks volumes about comfort fostered. And in many cases, these providers are uniquely positioned to invite that comfort and provide validation. Peer support specialists, for example, often offer a level of credibility and relatability that goes beyond anything I can as a “Doc.”

But for someone in this initial “gatekeeper” role, responding to client vulnerability can feel very difficult. It sometimes requires stepping outside of one’s own comfort zone into someone else’s perspective. That’s why there’s such benefit in remembering/using **general guidelines** like:

- There’s ***nothing*** wrong with genuinely inquiring about suicide and trying to understand someone’s experience.
- We will ***not*** put ideas in people’s heads, or “make things worse” if we’re approaching suicide a transparent, non-shaming way.
- Responding to someone’s vulnerability with care and attention shows that they were right to “gamble” on us.
- Understanding risk factors and warning signs, particularly ones relevant for your particular setting and patient population, can help make sure questions are appropriately being asked even when a person doesn’t acknowledge thoughts or risk on a screener.

But beyond those general guidelines, front line providers on multidisciplinary teams using CAMS also find value in having “conversational overviews” of the what’s going to happen should someone move forward. I’ve found it helpful to offer teams CAMS-specific talking points like the following:

- “CAMS is a suicide-focused assessment and treatment that has a **lot** of evidence and has helped a lot of people.”
- “Suicide-focused care should not just mean another checklist and safety plan.”
- “CAMS is an approach that wants to help you feel **stable** before/during crises. But it also is equally invested in **treating the pain** that makes you want to die.”
    - “CAMS wants to treat the pain **driving** suicide to the top of your option list.”
- “The person you’re meeting with is ***not*** going to just try and send you to the hospital. They will work really hard to see if there’s any way to do suicide-focused care **outside** of the hospital.”

Providing this information up front, transparently and directly, is often *the* step that convinces someone to actually give CAMS a shot.

This process **cannot happen** without patient buy in.

Any provider on the team who can help facilitate buy in is directly involved in both saving this person’s life and making their life feel more worth living.

“Signing” CAMS

This is the short hand I’ve used for providers who deliver the CAMS intervention. It refers to the fact that providers in this role are “signing” the treatment plan once finished along with clients, and it allows me to keep my “3 S” alliteration!

“Supporting” CAMS

Once this process has been initiated, a CAMS clinician can regularly provide updates for the team on this client's engagement,

successes/challenges with safety/stability, and understanding of drivers. With a sharper understanding of drivers comes clearer focus on goals and relevant interventions for changing this person's relationship with suicide. And when this understanding, language, and conceptualization are shared by an entire team, many things become possible.

One potential option simply comes from leveraging services team members would already be directly providing! It's not uncommon, for example, for CAMS providers to recommend medication consultation, occupational therapy, family therapy/support groups, assistance from chaplains, or logistical resources like financial/housing assistance. So, it's very frequently the case that "supporting CAMS" is as easy as providing standard services as normal, but doing so while also understanding and speaking to how these services can make life more worth living.
Even if not providing requested drivers-specific interventions, team members could support CAMS implementation directly in several ways, including:

- Using shared language (like "**drivers**" or "**the pain suicide is trying to solve**") to maintain continuity and reinforce concepts across contacts.
- Asking patients about their drivers and how their understanding of drivers changes over time
    - *Conversations along these lines with peer support specialists often feel very therapeutic.*
- Transparently discussing whether recommendations offered will target drivers, stability concerns, symptom remission, or something else.

    - *Medication providers, for example, might note that specific prescriptions might not affect drivers, but might reduce symptoms enough for other work to be more fruitful.*
- Inviting dynamic, collaborative feedback about service goals directly from the patient. As someone's understanding of drivers evolves, they may have evolving ideas about how specific services may (or may not) make life feel more living.
    - *Case managers, for example, can regularly check in to see whether consumers feel the package of treatment services received is adequately addressing their drivers.*
- Consistently and genuinely praising this person's willingness to engage suicide-focused care and fight for a life they feel is worth living.

Conclusion/New Resource

Effective CAMS implementation **cannot** happen if administration and discussions are pre-emptively limited to specific providers with specific expertise. It necessitates aligning the model with the roles people play on their team, whether "suggesting"/"selling," "signing," or "supporting" the framework. Whatever role, the goal is the same: to create a consistent, collaborative approach to understanding and **treating** *this person's* suicidal risk.

Even without full CAMS "fluency," team members who become "conversational" in core concepts, like "drivers" or distinguishing between prevention and treatment, can have a meaningful impact. The more people work to convince patients they are "worth being uncomfortable for," the more likely these patients are to *actually* believe it.

Additional information about these topics and acute medical/acute CAMS adaptations can be found in this brand new, free video we made in the last few months. Please feel free to access as helpful, and share with anyone who might be interested!

Looking forward to speaking with you again soon! Please don't hesitate to reach out if I can be helpful for you or your team in the meantime.

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