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Implementation of the Collaborative Assessment and Management of Suicidality in a UK National Health Service adult mental health service: A case series

--Manuscript Draft--

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Abstract:	Background: The Collaborative Assessment and Management of Suicidality (CAMS) is an evidence-based approach to reducing suicidal ideation. To date, there is limited evidence of the feasibility of implementing CAMS within the UK's National Health Service (NHS). Aims: The paper aims to describe the implementation of CAMS in an NHS adult mental health service and to report data on engagement and change in self-rated suicidal ideation. Method: Data on engagement, suicidal ideation, and care pathways were gathered for 88 people who started CAMS. Results: 75% of participants completed CAMS. Attendance rates were good. Self-rated suicidal ideation decreased significantly, with 68% of completers reporting a decrease. Participants with Emotionally Unstable Personality Disorder (EUPD) showed higher initial ratings of suicidal ideation but similar improvements. Just over half the participants were referred for psychological therapy after CAMS. Limitations: As an uncontrolled case series, the study could not conclude that changes in suicidal ideation were due to CAMS. It was not possible to report on changes in suicidal behavior. Key demographic data were missing. Conclusion: Implementation of CAMS in an NHS setting appears feasible and merits further study.
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The authors

Article type: Research Trends

Main Title: Implementation of the Collaborative Assessment and Management of Suicidality in a UK National Health Service adult mental health service: A case series

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Conflict of Interest

Eoin Galavan is a CAMS-care consultant and trainer.

David Jobes is co-owner of CAMS-care LLC and has received research funding from the National Institute of Mental Health and book royalties from Guilford Press.

All other authors declare no competing interests.

Authorship

Paul Bayliss, conceptualization, writing – original draft, writing – review & editing; Thomas Richardson, conceptualization, data curation, formal analysis; Lorraine Bell, conceptualization; Eoin Galavan, conceptualization; Jamie Rutland-Lawes, investigation; Chloe Nowell, investigation; Melanie Osafo, investigation; David Jobes, conceptualization, writing – review & editing.

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Paul Bayliss and Thomas Richardson share first authorship.

Implementation of the Collaborative Assessment and Management of Suicidality in a UK National Health Service adult mental health service: A case series

Abstract

Background: The Collaborative Assessment and Management of Suicidality (CAMS) is an evidence-based approach to reducing suicidal ideation. To date, there is limited evidence of the feasibility of implementing CAMS within the UK's National Health Service (NHS).

Aims: The paper aims to describe the implementation of CAMS in an NHS adult mental health service and to report data on engagement and change in self-rated suicidal ideation.

Method: Data on engagement, suicidal ideation, and care pathways were gathered for 88 people who started CAMS. Results: 75% of participants completed CAMS. Attendance rates were good. Self-rated suicidal ideation decreased significantly, with 68% of completers reporting a decrease. Participants with Emotionally Unstable Personality Disorder (EUPD) showed higher initial ratings of suicidal ideation but similar improvements. Just over half the participants were referred for psychological therapy after CAMS. Limitations: As an uncontrolled case series, the study could not conclude that changes in suicidal ideation were due to CAMS. It was not possible to report on changes in suicidal behavior. Key demographic data were missing. Conclusion: Implementation of CAMS in an NHS setting appears feasible and merits further study.

Keywords: suicide risk, suicide prevention, mental health services

Introduction

Suicide is a behavior not a mental illness, and suicide risk is linked to social factors including poverty, homelessness, and unemployment (Knipe et al., 2022). However, diagnosable mental disorders confer at least an eight-fold increase in suicide risk (Too et al., 2019). The National Confidential Inquiry into Suicide and Safety in Mental Health (2023) found that 27% of people who ended their lives had contact with mental health services in the preceding year.

Suicide prevention should therefore be a priority in publicly-funded mental health services such as the UK's National Health Service (NHS). However, previous literature suggests that standard tools for assessing suicide risk are of limited clinical utility (Hawton et al., 2022). Further, there is limited and mixed evidence that treating mental illness reduces suicidality. Even first-line treatments such as antidepressants have an equivocal evidence base (e.g. Lagerburg et al., 2023). Amongst psychological therapies, only those which directly address suicide risk such as Cognitive Therapy for Suicide Prevention and Dialectical Behaviour Therapy (DBT) have demonstrated effectiveness (Mann et al., 2021). These therapies are resource-intensive, requiring lengthy training, limiting their availability, and prompting calls for a "stepped care" approach to suicide risk (Jobes, 2023).

The Collaborative Assessment and Management of Suicidality (CAMS) approach incorporates several key principles of other evidence-based interventions. CAMS includes a structured assessment exploring an individual's "drivers" of suicide risk, a collaborative safety plan, and a "therapeutic framework" to address the identified drivers. Within this framework, practitioners may use various interventions, spanning psychotherapy, skills training, problem-solving, and social approaches. Although the length of CAMS is guided by change in self-rated risk scores, typical duration is six to eight sessions (Jobes, 2023).

1 A meta-analysis identified nine controlled trials comparing CAMS to other treatments
2 (mostly “treatment as usual”): CAMS was more effective at reducing suicidal ideation,
3 distress, and hopelessness, but was no more effective at reducing suicide attempts or self-
4 harm (Swift et al., 2021). Treatment acceptability, in terms of dropouts and satisfaction, was
5 good. Later research suggests that CAMS may reduce suicidal behavior amongst people
6 recently discharged from inpatient psychiatric care (Santel et al., 2023).
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8 Emotionally Unstable Personality Disorder (EUPD; also known as borderline
9 personality disorder), is linked to an elevated risk of suicide attempts (Grilo & Udo, 2021).
10 EUPD is common in a range of mental health settings and has been found to be present in
11 11% of community mental health team caseloads (Keown et al., 2002). As previously
12 discussed, there have been calls for a “stepped care” approach to suicide prevention, and
13 interventions such as DBT for EUPD are evidence-based but can be time and resource
14 intensive (Gunderson, 2015). There has been limited research on the effectiveness of CAMS
15 as a briefer and potentially more accessible intervention when used with people with a
16 diagnosis of EUPD: A 2022 systematic review on crisis-based interventions for suicidality in
17 EUPD found only four trials, none of which used CAMS (Wood & Newlove, 2022). One trial
18 however found similar effectiveness for CAMS when compared with DBT (Andreasson et
19 al., 2016).
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21 CAMS has been evaluated in various settings, including student counselling centres,
22 crisis services, outpatient and inpatient mental health services, military health services, and
23 veterans’ services (Swift et al., 2021). However, most trials have been conducted in the USA.
24 Given differences in suicide rates between the UK and USA (Pritchard et al., 2021), as well
25 as different mental health service provisions, it is unclear the extent to which these findings
26 apply in UK NHS settings. CAMS has been implemented in several NHS mental health
27 settings (Iqbal, 2023). However, to date only one preliminary evaluation has been published
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(Brown et al., 2020). Thus, we aimed to build on these preliminary findings by describing the implementation and outcomes of CAMS in our service. We also intended to analyse the impact of an EUPD diagnosis on outcomes.

Method

Design and Service

An open case series design was used. This study was an evaluation of routine clinical practice: CAMS was implemented across an acute psychiatric ward, crisis resolution home treatment team (CRHT), and three community mental health teams (a short-term assessment team and two longer-term recovery teams) in a city in southern England. We trained 60 staff (nurses, occupational therapists, social workers, psychologists, and psychological therapists) in two one-day training sessions. Although all 60 staff were trained, they did not necessarily all have a case which was completed and provided data for the current analysis. After the training, bi-monthly supervision was offered, led by the trainer or by a psychologist or psychological therapist with training and experience in CAMS.

To evaluate the intervention thus implemented, we collected routine data on engagement, suicidal ideation, and care pathways, for people receiving CAMS. All participants had consented for their routinely collected data and medical records to be used for anonymous audit and service evaluation purposes. This was approved as a service evaluation project by the hosting NHS Trust, meaning that formal NHS Ethics approval was not needed.

Participants

Participants were all 88 people under the care of our teams who started CAMS and who had consented to their data being used for research. The sample was 53.4% ($n=47$) female and 46.6% ($n=41$) male. In terms of settings, 43.2% ($n=38$) were under the care of the

assessment team, 36.4% ($n=32$) under the CRHT, 17% ($n=15$) under the recovery teams, and 3.4% ($n=3$) on the ward. In terms of practitioner, 61.4% ($n=54$) were seen by a psychological therapist or psychologist and 38.6% ($n=34$) were seen by other professionals including nurses, social workers, and occupational therapists. Participants had a wide range of diagnoses, although 48.9% ($n=42$) were identified as having a diagnosis of Emotionally Unstable Personality Disorder (EUPD) or EUPD traits, potentially alongside other diagnoses.

Outcome measures

We collected data on attendance, completion, and clinical pathways after CAMS from clinical records. We also collected data on self-reported “Overall Risk of Suicide”, a measure of suicidal ideation which is rated on a 1-5 scale during each CAMS session. This scale forms part of the Suicide Status Form used during CAMS. This “Overall Risk of Suicide” scale has evidence of criterion-prediction validity (distinguishing suicidal from non-suicidal people) and convergent validity (significant correlations with measures of reasons for living) in both clinical and non-clinical samples (Conrad et al, 2009; Jobes et al., 1997). Brausch et al. (2019) found significant correlations between this scale and implicit and self-reported measures of suicide risk, further supporting its validity.

Data analysis

We used paired-sample t-tests to compare scores between the first and last CAMS sessions. We used a mixed factorial ANOVA to compare outcomes for those with and without a diagnosis of EUPD.

Results

Attendance and completion rates

A total of 75% of participants ($n=66$) completed CAMS and 25% ($n=22$) disengaged. The number of sessions attended ranged from 1 to 14 with a mean of 5.5 ($SD=2.6$). The number

of sessions unattended ranged from 0 to 6 with a mean of 0.9 ($SD=1.5$). This represents a non-attendance rate of 14.1%.

Change in suicidal ideation

Of those who completed CAMS, 68.2% ($n=45$) reported a decrease in suicidal ideation, 28.8% ($n=19$) reported no change, and 3% ($n=2$) reported an increase. A paired sample t-test for completers ($n=66$) found that suicidal ideation decreased significantly from first session; $M=3.4$, $SD=1.1$, to final session; $M=2.4$, $SD=1.3$, $t=8.6$ ($df=65$), $p<.001$, one-tailed.

Clinical pathways

After CAMS, 38.7% of participants ($n=34$) were referred for psychological therapy within the mental health service in addition to their usual support. Just over half of these referrals were for DBT or a DBT-based skills group. A further 19.3% ($n=17$) remained with their usual mental health team for ongoing support, while 1.1% ($n=1$) was referred to an intermediate “Step 3.5” team between primary and secondary care. A further 15.9% ($n=14$) were signposted to NHS Talking Therapies services in primary care, while 23.9% ($n=21$) were discharged to primary care without further input. Data were unavailable for 1.1% ($n=1$).

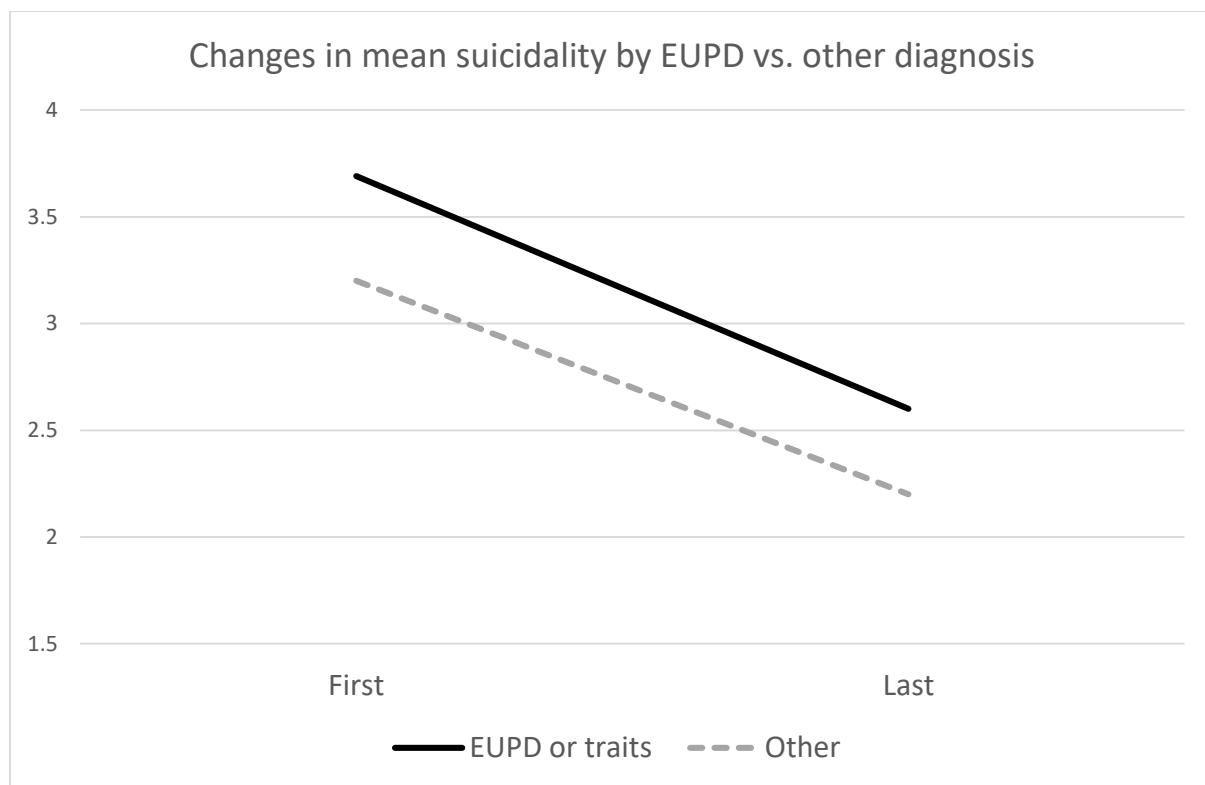
Sadly, one participant (1.1%) died by suicide shortly after completing CAMS, despite reporting no suicidality in their final session.

Impact of EUPD

When comparing treatment completion and outcomes between those with a diagnosis of EUPD or EUPD traits ($n=42$) and those without ($n=46$), there was no significant difference in disengagement rates between the EUPD group (32.6%, $n=14$), and the non-EUPD group (17.8%, $n=8$): $\chi^2=2.56$, $p>.05$. An independent samples t-test found that initial ratings of suicidal ideation were higher for the EUPD group ($M=3.7$, $SD=1.1$) compared to the non-EUPD group ($M=3.2$, $SD=1.1$): $t(86)=2.35$, $p<.05$, two-tailed. A mixed factorial ANOVA

1 compared changes in suicidal ideation for completers over time as a within subjects' factor,
2 and EUPD diagnosis as a between subjects factor. This found a main effect of a significant
3 reduction in suicidal ideation over time: $F=72.5, p<.01, \text{partial eta squared}=.53$. There was
4 no interaction between EUPD diagnosis and changes in suicidality over time: $F=0.1, p>.05,$
5 $\text{partial eta squared}=.00$. Figure 1 displays the change over time for EUPD and non-EUPD
6 groups. Finally independent samples t-tests showed that those with EUPD cancelled or did
7 not attend more sessions ($M=1.3, SD=1.9$) than those without EUPD ($M=0.6, SD=1.0$):
8 $t(85)=2.08, p<.05$, two-tailed. Those with EUPD also had a larger total number of sessions
9 ($M=6.2, SD=3.0$) compared to those without EUPD ($M=4.9, SD=1.9$): $t(86)=2.5, p<.05$, two-
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46 Figure 1: Changes in suicidality over time by EUPD diagnosis
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Discussion

Summary of results

Attendance and completion rates were favourable, suggesting CAMS is acceptable and feasible. We found significant reductions in self-reported suicidality. This accords with previous trials (Swift et al. 2021) and adds to the limited literature about the acceptability and potential effectiveness of CAMS in NHS services (Brown et al., 2020). Psychological therapy was recommended for just over half the participants after CAMS, suggesting CAMS can help identify longer-term psychological needs and act as a bridge to therapy.

In terms of the acceptability of the intervention, a 25% disengagement rate is comparable to the 18% disengagement rate in inpatient military veterans receiving CAMS (Johnson et al., 2019) and 27% seen in college students (Pistorello et al., 2021). Previous service evaluations within the same service have shown dropout rates ranging from a low of

13% for a Bipolar Psychoeducation Group (Richardson & White, 2019), through 21% for one-to-one Acceptance and Commitment Therapy (Richardson et al., 2018), 43% for one-to-one Cognitive Behavioural Therapy (CBT) for psychosis (Richardson et al., 2019), 55% for trauma-focused CBT and 63% for Eye-Movement Desensitization and Reprocessing (Hayward et al., 2023) to a high of 76% for an emotional coping skills group (Raman & Richardson, 2019). This suggests that the current intervention had high acceptability compared to many other psychological therapies delivered by the same service within a complex secondary care population. However, there was not any detailed information about reasons for dropout which would have been helpful.

In terms of the impact of EUPD, the results show that those with a diagnosis of EUPD started with more severe suicidal ideation, but suicidal ideation reduced in a similar way to those without EUPD. This provides further tentative support, along with other limited evidence (Andreasson et al., 2016), that CAMS can be delivered effectively with this population. It is important to note that although dropout rates did not differ significantly, there was a trend towards more dropouts in the EUPD group. Also, those with EUPD missed or cancelled more sessions and had a higher total number of sessions. This may reflect the emotional and behavioural instability and relational difficulties associated with this diagnosis. This suggests that a flexible approach to appointment times and number of sessions may be useful when delivering CAMS in this high-risk population.

The fact that one participant ended their life by suicide after CAMS merits further discussion. Although their death cannot be attributed to CAMS, it is of note that they reported no suicidal ideation during their final CAMS session. There is a considerable literature around non-reporting of suicidal ideation. In summary, Obegi (2021, p.92) notes that “denial of suicidal ideation among ideators, attempters, and suicide decedents is an alarmingly

common occurrence,” with around half of decedents denying suicidal ideation in the week before their death. Berman (2022) estimates that the proportion denying suicidal ideation is even higher, at around 70%. Various reasons for non-reporting have been posited, including rapid changes in suicidal ideation, determination to die, the belief that disclosure of suicidal thoughts is pointless, stigma, shame, and fears of overreaction and hospitalization. In the case of our participant, there was evidence that they had planned their suicide even before their last CAMS session, suggesting that a strong determination to die might have been amongst the reasons for their denial. Despite this outcome, a collaborative approach founded on warmth and trust seems to remain our best hope of assessing suicidal ideation (Obegi, 2021, p.94), alongside an acknowledgement that suicidal ideation alone is an imperfect predictor of suicidal behaviour.

Challenges to implementation

Challenges to implementation included the sheer number of people presenting with suicidal ideation. Stepped-care models (e.g. Jobes, 2023) suggest that CAMS should be offered to all those with suicidal ideation, but in reality, capacity was limited. Unfortunately, our data could not shed light on those most likely to benefit from CAMS compared to standard care or other interventions. This is a limitation and an indication that further research is needed.

Encouraging staff to use CAMS was challenging. After one year, only 50% of trained staff had taken at least one CAMS case. On the acute ward, only psychological therapists used CAMS, with zero uptake from other professionals. Previous literature suggests that reluctance to engage with suicidal patients may be linked to mistrust, hopelessness, fears of blame, and feelings of responsibility (Fogarty et al, 2023). Anecdotally, all these factors were probably at play. Additionally, staff without a therapeutic training seemed to feel daunted when faced by apparently deep-seated psychological issues such as self-hatred and

1 hopelessness. Supervision helped some staff members to overcome this, particularly where it
2 was available quickly from therapists within their team. For other staff, these fears and
3 obstacles may have been insurmountable and led to avoidance. Thus, the availability of
4 responsive, intensive supervision would seem key to improving uptake.
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9 Implementing CAMS in our CRHT was complicated by the team's shared-caseload
10 model. This was addressed by working closely with the team manager to plan a rota for
11 allocation of CAMS cases, and to plan rosters so that staff could see their allocated CAMS
12 clients regularly. In some cases, support workers and other staff members who saw a client
13 between CAMS appointments could support them to implement strategies identified in their
14 safety plan.
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24 Integrating CAMS documentation into our electronic records system was another
25 challenge. In summary, we began by uploading paper forms only, then progressed to
26 uploading an electronically fillable form. Eventually, we added a CAMS score form into the
27 electronic record and developed a policy around how this related to other risk assessment
28 documents.
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37 **Limitations**

38 The design of our study (an uncontrolled case series) meant that we could not
39 conclude that reductions in suicidality were due to CAMS. Other interventions, spontaneous
40 recovery, or unrelated factors may have contributed to improvements. The study was also
41 limited to demonstrating change in suicidal ideation rather than behavior. This is significant
42 considering the limited evidence that CAMS is effective in reducing suicide attempts (Swift
43 et al., 2021). Conversely, it has been argued that reducing suicidal ideation is an inherently
44 valuable outcome (e.g. Jobes & Joiner, 2019). It is not known in the current data how many
45 cases were seen by each practitioner, and whether this may have impacted outcomes. Those
46 who disengaged may have had an increased in suicidality, so a full randomised controlled
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trial with intent-to-treat analysis is warranted for an accurate estimate of changes in suicidality when CAMS is used in an NHS setting.

An additional limitation was that suicidal ideation was only rated immediately after CAMS, so the longer-term outcomes are unknown. If suicidal ideation were reduced by the supportive therapeutic relationship, it might have rebounded after the end of CAMS. Conversely, if safety planning and other aspects of CAMS helped to embed cognitive and behavioural change, gains might have been maintained. The current study cannot shed light on this question. In future, it would be optimal to collect follow-up data, to investigate the course of suicidal ideation after CAMS has ended.

A further limitation is that we lacked some demographic data, including age and ethnicity. This might have highlighted access issues or differences in response. In future, routinely collecting a range of demographic and clinical data would help to identify trends in engagement and response to CAMS.

The reasons why those with a diagnosis of EUPD needed more sessions are unclear. Further research on the mechanisms of improvement in suicidal ideation through CAMS in this population is needed.

Finally, it is important to acknowledge that we had no data on outcomes from psychological therapy referrals post-CAMS. An analysis of whether CAMS improves engagement or outcomes from follow-on psychological therapies would be useful.

Conclusions

The study suggests that CAMS is acceptable, feasible, and potentially effective in an NHS mental health setting. In future, it will be important to tackle the barriers to implementation encountered here, perhaps most significantly the poor uptake of CAMS by trained practitioners. In inpatient settings, the single-session CAMS Brief Intervention model might be feasible and has emerging evidence of effectiveness (Oakey-Frost et al., 2023).

1 Future research might usefully explore barriers and facilitators to using CAMS and
2 taking up supervision in the NHS. Research might also focus on identifying people most likely
3 to benefit from CAMS, to help target this approach in busy clinical settings. Qualitative or
4 multi-method research exploring people's experiences of CAMS would also be beneficial.
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6 A randomized controlled trial of CAMS in NHS mental health services could provide valuable
7 evidence of effectiveness compared to treatment as usual in such settings. Such a trial should
8 include suicidal behavior as an outcome and should follow up participants after the end of
9 CAMS.
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Biographies

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