CAMS-care UK
Treat Suicide Risk

Strengthening Response Across Services

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CAMS:
Collaborative Assessment and Management of Suicidality

The critical gap: suicide prevention in NHS services

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Treat Suicide Risk

A persistent public health crisis

Approximately 7,000 deaths by suicide per year in England and Wales, with the national rate remaining essentially unchanged since 2008 despite successive government strategies.

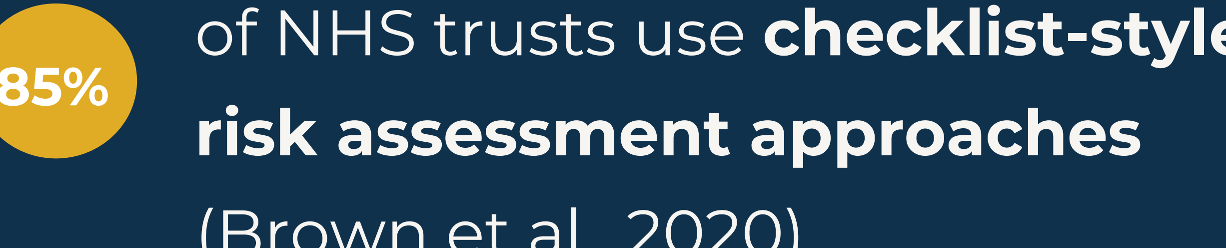
The guidance vacuum

There is currently **no NICE-approved, suicide-specific intervention pathway** for NHS mental health services.

Existing NICE guidance addresses self-harm (NG225) and depression (NG222) but does not specify an evidence-based treatment framework targeting suicidality directly as a primary clinical outcome.

"Recent systematic evidence confirms the limited clinical utility of risk tools for predicting suicide, which is 'unacceptable' as their **use can result in unnecessarily restrictive treatment options**."
— Chan et al., 2016; Quinlivan et al., 2017

Current practice



85% of NHS trusts use **checklist-style risk assessment approaches** (Brown et al., 2020)

2/3 rely on **locally devised adaptations** lacking formal psychometric validation

"**Risk stratification tools don't work**... they create a tick-box culture" — NHS England, 2025

The policy-practice mismatch

NHS England's April 2025 guidance mandates eliminating risk stratification tools and adopting relational, therapeutic approaches.

The scale of need: avoidable premature mortality

Epidemiological data

~10 **per 100,000**
UK suicide rate, unchanged for over a decade

100+ **people affected**
by every single death

Lifetime prevalence

1 in 5 adults in England report experiencing suicidal thoughts at some point in their lifetime, yet the vast majority never access treatment.

Service contact paradox

Only **26–27%** of individuals who die by suicide were in contact with NHS specialist mental health services in the 12 months prior to death.

Reinterpreting the '25% service contact' statistic

Absence of NHS mental health service contact does not equate to an absence of help-seeking.

Many individuals consult primary care clinicians, access voluntary sector organisations, engage private therapists, or seek assistance through community, faith, or peer networks.

Current surveillance systems do not routinely capture these contacts, limiting understanding of where support is accessed and where prevention opportunities are missed.

A more integrated, whole-system perspective is needed.

The structural prevention gap: late presentation

Stigma as primary barrier

Stigma is the primary upstream barrier preventing people from seeking help early. Internalised stigma negatively predicts willingness to seek help across all targets.

- Help-seeking delay for self-harm thoughts: **1–2 years** (Beckmann et al., 2021)
- Severity of psychopathology **positively correlated with delay** — most unwell wait longest
- Even after a suicide attempt, **fewer than 35%** had prior help-seeking behaviour

The crisis intervention challenge

By the time a suicidal patient reaches NHS crisis services, **psychological constriction, hopelessness, and entrapment are often already entrenched** .

This aligns with Joiner's Interpersonal Theory of Suicide:

Suicidal desire develops through thwarted belongingness and perceived burdensomeness , progressing to acquired capability.

The oncological analogy

Intervening at this late stage leaves **limited therapeutic time to reverse suicidal drivers** , meaning treatment effectiveness may be constrained by timing rather than clinical skill or intent.

> "The absence of any validated early-identification pathway means the NHS is predominantly treating **stage 4 presentations** , then measuring whether the treatment reduces cancer mortality and finding, unsurprisingly, that the results are modest."

Recovery narratives from individuals who have experienced and survived suicidality may reduce stigma, increase willingness to seek help, and foster hope—factors closely associated with earlier engagement.

Evidence base: suicide-specific interventions

A class of evidence-based, suicide-specific interventions has emerged internationally, distinct from treatments for depression or self-harm recurrence. These interventions share common characteristics that make them suitable for acute and crisis settings.

Direct targeting

Target **suicidality directly** regardless of psychiatric diagnosis, rather than treating underlying disorders.

Brief, structured formats

Brief, structured formats suitable for acute and crisis settings, typically 10-12 sessions.

Cognitive-behavioural approaches

Use **cognitive-behavioural approaches** targeting issues that make a person suicidal: hopelessness, perceived burdensomeness, emotion dysregulation.

Collaborative alliance

Emphasise **collaborative therapeutic alliance** and skill-building for crisis management.

The four major interventions

BCBT
Brief Cognitive-Behavioural Therapy

CT-SP
Cognitive Therapy for Suicidal Patients

ASSIP
Attempted Suicide Short Intervention Program

CAMS
Collaborative Assessment and Management of Suicidality

Introducing CAMS (Collaborative Assessment and Management of Suicidality)

A structured, collaborative, suicide-specific clinical framework

A rigorously tested, suicide-specific framework

CAMS provides a structured framework for understanding what is driving a person's suicidal distress, not just the surrounding mental health presentation.

A shift from prediction toward collaboration

Instead of categorising people into risk levels, CAMS supports **side-by-side clinical work** that focuses on the person's lived experience, their drivers of distress, and what will help them stay safe.

The role of the Suicide Status Form (SSF)

The SSF guides a shared exploration of key domains such as psychological pain, hopelessness, agitation and self-hate, and leads to a co-produced stabilisation plan that is meaningful and actionable.

In 6-8 sessions CAMS is **shown to increase hope, reduce distress/ hopelessness and change beliefs about suicide** across 9 trials to date.

Delivering on NHS England's Staying Safe from Suicide guidance through CAMS

NHS England priority	What this means in practice	How CAMS framework delivers this
Move away from risk stratification	End checklist prediction; use relational approaches	Suicide Status Form (SSF) enables collaborative, suicide-specific assessment
Person-centred, therapeutic relationship-based care	Involve people as partners; trauma-informed practice	Co-produced assessment and plans; stronger alliance
Meaningful safety planning	Personalised, dynamic plans	Individualised stabilisation plans updated each session
Consistency and governance	Reduce variation; clear documentation	Standardised framework and structured SSF record
Workforce capability	Equip staff with evidence-based tools	Accredited training, ongoing supervision, implementation support
Outcome-focused, least-restrictive care	Reduce unnecessary hospitalisation	Safe community-based management; improved outcomes
Whole-system integration	Consistent approaches across settings	Scalable across NHS, universities, and third sector

CAMS: the strongest evidence base

14	7	2
Open Clinical Trials	**Published RCTs**	**Meta-Analyses**
Published	Randomised Controlled Trials	Supportive

Swift et al. (2021) Meta-Analysis

Analysis of **9 RCTs (n=749)** comparing CAMS to active alternatives:

Suicidal Ideation	**d=0.25*** **
General Distress	**d=0.29** **
Hope/Hopelessness	**d=0.88*** **
Treatment Acceptability	**d=0.42***

*p<0.05, **p<0.01, ***p<0.001

CDC Classification

CDC classifies CAMS as **"Well Supported"** —the **highest tier** of their Continuum of Evidence.

"Replicated CAMS results show significant reductions in suicidal ideation, overall symptom distress, depression, and hopelessness."

Santel et al. (2023) RCT

German RCT (n=88) in acute inpatient settings: **0 vs 3 suicide attempts** in 4 weeks post-discharge (p=0.05).

37% vs 7% reliable improvement in suicidal ideation (p=0.01)

No intervention to date has more RCTs for reducing serious suicidal ideation and overall symptom distress than CAMS.

Comparison: why CAMS over alternatives?

Brief CBT

Rudd et al., 2015

- **60% reduction** in suicide attempts vs TAU
- Developed for **US military populations**
- **No UK implementation** data

Cognitive Therapy

Brown et al., 2005

- **~50% reduction** in re-attempts vs usual care
- Manualised but **lacks UK implementation**
- No scalability evidence

ASSIP

ASSIP

Gysin-Maillart et al., 2016

- **Failed replication** in independent studies
- 2025 RCT: **higher re-attempt rates** (IRR=3.19, p=.02)
- Inconsistent evidence base

CAMS

Jobes, 2000-present

- **Robust RCT evidence** with 7 published trials
- **Proven NHS scalability** (Navigo, Hampshire)
- **CDC "Well Supported"** classification
- **Significant attempt reduction** (Santel et al., 2023)

CAMS is the only suicide-specific intervention with both robust RCT evidence and proven NHS scalability

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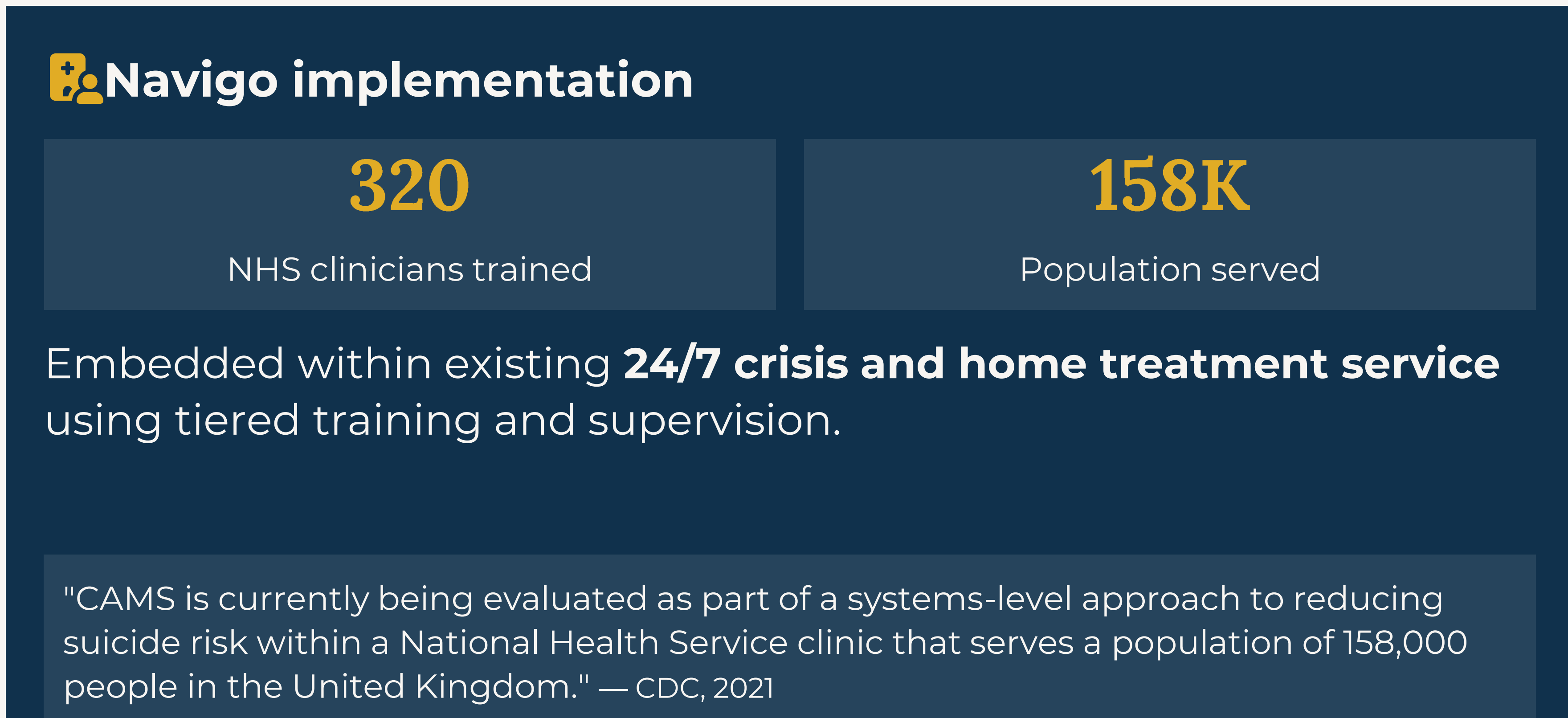
Implementation feasibility: proven in NHS



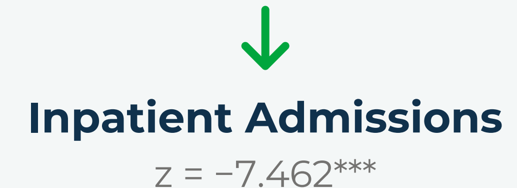
Training requirements

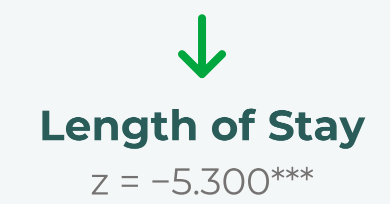
- ✓ **One-day workshop** + 3-hour online
- ✓ Observed practice & supervision
- ✓ **Less intensive** than DBT training
- ✓ Average **12-session episode**

Infrastructure

Minimal new infrastructure required —only reorientation of existing crisis and community pathways.

Population-Level Outcomes (Brown et al., 2020)





***$p<0.001$ | Sustained reduction in local suicide rates following implementation

£ **CAMS is not merely cost-neutral; it carries strong potential for systemic cost savings**

Strengthening our response to suicidality

Traditional risk prediction approaches fall short

Evidence is clear that these approaches do not support safe or confident clinical practice and can result in restrictive treatment options.

CAMS is a validated, structured framework for suicide-specific clinical practice

A transdiagnostic, suicide-specific framework that helps clinicians understand the drivers of distress and move away from checklist-style risk assessment

The SSF supports meaningful, co-produced care

A shared structure for exploring drivers of suicidality and developing personalised, practical stabilisation plans.

CAMS is supported by the strongest evidence base

Among suicide-specific interventions, CAMS has the most extensive RCT evidence for reducing serious suicidal ideation and symptom distress.

CAMS integrates within existing systems of care

CAMS enhances, rather than replaces, existing systems of care. It embeds within current pathways to strengthen clinical consistency, support governance expectations, and improve the quality of suicide-specific practice.

Continuing the conversation

If this session has prompted reflections on how CAMS could strengthen practice in your service, we'd like to talk further.

We can offer an informal discussion to explore:

- how suicide-specific care aligns with national expectations
- where CAMS may complement your existing pathways
- what clinical implementation looks like in real-world settings

These conversations are context-led and shaped around your service's priorities.

Go to our website or email us to start the conversation

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