**CAMS Rating Scale (CRS)**

Clinician: ___________  Patient Initials: ___________  Date of Session: ___________

ID#: ___________  Rater: ___________  Date of Rating: ___________

Session #: ___________  ( ) Videotape  ( ) Audiotape  ( ) Live observation

( ) Adherence  ( ) Spot-check

Directions: The CAMS framework entails several key components, which are reflected in the organized subsections of the CRS. For each session, assess the clinician on a scale from 0 to 6 and record the rating on the line next to each item number. At the end of each subsection, provide written feedback justifying the scores given, regardless of how well adherence was met.

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**Part I – Therapeutic Philosophy**

1) ____ The clinician expressed empathy with the patient’s suicidal wish.

   0 = The clinician had a judgmental, controlling attitude towards the suicidal patient.

   2 = The clinician acknowledged the suicidal wish in a neutral fashion.

   4 = The clinician acknowledged a non-judgmental understanding of the suicidal patient.

   6 = The clinician communicated a deep appreciation for why and how the patient is suicidal.

2. ____ All assessments were conducted interactively with substantial input from both clinician and patient.

   0 = The clinician dominated the assessment, talked over/interrupted the patient.

   2 = The clinician somewhat engaged the patient in the assessment process.

   4 = The clinician effectively engaged the patient in an interactive assessment.

   6 = The clinician and patient engaged in a highly interactive assessment with substantial shared input.
3. _____ The treatment plan was designed and modified interactively with substantial input from both clinician and patient.

   0 = The clinician did not engage the patient in interactive treatment planning (e.g., did not use side-by-side seating; told the patient what treatment would entail in a directive manner).

   2 = The clinician somewhat engaged in interactive treatment planning but mostly ignored patient’s input.

   4 = The clinician consistently sought patient’s input to design/modify the treatment plan.

   6 = The clinician substantially engaged patient in highly interactive treatment planning.

4. _____ All interventions (in-session) were selected and modified interactively with substantial input and participation from both clinician and patient.

   0 = The clinician did not seek or ignored patient’s input on treatment interventions.

   2 = The clinician somewhat sought input from patient on treatment interventions.

   4 = The clinician consistently sought and used patient input to interactively select and modify interventions.

   6 = The clinician sought substantial input from the patient to interactively select and modify interventions.

Any additional comments, suggestions, and feedback for clinician’s improvement with regard to collaboration:

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________________________________________________________________________________________

Suicide Focus

5. _____ The clinician clarified the CAMS agenda to focus on factors related to the suicidal wish any time it appeared needed; when factors arise that are not directly or indirectly leading to suicidality for this patient, they are acknowledged as important, but not the focus of the current work.
0 = The clinician completely ignores CAMS agenda and the session focuses on factors that are not related to suicidality.

2 = The clinician somewhat acknowledges the CAMS agenda but does not consistently redirect discussion back to suicide drivers.

4 = The clinician does clarify the CAMS agenda and constructively re-directs the patient back to suicidal drivers.

6 = The clinician reliably clarifies the CAMS agenda and skillfully re-directs focus back to suicidal drivers.

Any additional comments, suggestions, and feedback for clinician’s improvement with regard to suicide focus:

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Part II – Clinical/Session Framework

Assess for Risk

6. ____ The dyad followed the framework for initiating and completing the SSF assessment at the beginning of the session.

*Initial session: The dyad completed sections A and B of the SSF
**Subsequent sessions: The dyad completed section A of the SSF

0 = The dyad did not completed the SSF assessment at any point during the session.

2 = The dyad completed the SSF assessment, though it was not initiated and completed at the beginning of the session.

4 = The SSF was initiated at the beginning of the session, though it may not have been completed in a timely fashion.

6 = The SSF assessment was initiated and completed at the beginning of the session. For the initial session, the SSF was initiated within five minutes; the SSF was initiated at the very beginning of subsequent sessions.
Any additional comments, suggestions, and feedback for clinician’s improvement with regard to risk assessment:

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Treatment Planning

7. ___ The dyad developed and discussed/updated the use of a Crisis Response Plan (CRP), Safety Plan (SP), or CAMS Stabilization Plan (CSP), which includes regularly attending therapy sessions, addressing barriers to care, means restriction, decreasing isolation, and use of a coping card.

0 = The CRP/SP/CSP was neither completed nor discussed/updated during the session.

2 = The CRP/SP/CSP was developed, but contains options that are not likely to be feasible/effective for the patient when experiencing a suicidal crisis.

4 = The CRP/SP/CSP reflects the options that are likely to work, though the discussion regarding the CRP/SP/CSP could be fleshed out with greater detail to increase the likelihood of being effective.

6 = The CRP/SP/CSP contains useful, patient-specific coping options, which are discussed in detail and revisited/amended as needed in follow-up sessions.

8. ___ The treatment plan identifies and targets the most relevant direct and/ or indirect drivers of suicidality as determined by the dyad.
   *Direct Drivers: Specific thoughts (e.g., “It would be easier on everyone if I were dead), feelings (e.g., “I just feel so much shame), and behaviors (e.g., interpersonal conflict with partner).
   *Indirect Drivers: Underlying factors that contribute, but do not necessarily lead to acute suicidal ideation (e.g., homelessness, depression, substance abuse, PTSD, isolation).

0 = The treatment plan does not target the most relevant drivers of suicidality.

2 = The treatment plan targets several drivers of suicidality, but does not place heavy emphasis on the most relevant drivers for the patient.

4 = The treatment plan reflects several of the most relevant drivers for the patient.

6 = The treatment plan targets the most relevant drivers that specifically contribute to the patient’s suicidality.
9. ___ The treatment plan establishes the use of suicide-specific, problem-focused interventions to target and treat the drivers of suicidality.
   
   * Suicide specific interventions: Removing access to means, addressing suicide-promoting beliefs, and increasing interpersonal connectedness that directly address the thoughts, feelings, and behaviors which are linked to suicidality for this patient while making connections between direct and indirect drivers.

   0 = The treatment plan does not reflect the use of suicide-specific interventions to address the drivers.

   2 = The treatment plan reflects the use of some suicide-specific strategies related to common drivers, though they do not map directly onto the patient’s specific drivers.

   4 = The treatment plan reflects the use of suicide specific interventions, though with more effort they could be fine tuned to more adequately address the intricate details of the patient’s drivers (e.g., citing behavioral activation as a strategy for interpersonal thwartedness, when a more specific strategy related to attending activities or spending time with family and friends would be more helpful).

   6 = The treatment plan reflects the use of suicide specific interventions that are directly linked to patient-specific themes and cues of suicidality that have been established as drivers.

Any additional comments, suggestions, and feedback for clinician’s improvement with regard to treatment planning:

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Intervention

10. ___ Every session should include the use of suicide-specific, problem-focused interventions to target and treat the drivers of suicidality.

   *Suicide specific interventions: Removing access to means, addressing suicide-promoting beliefs, and increasing interpersonal connectedness that directly address the thoughts, feelings, and behaviors which are linked to suicidality for this patient while making connections between direct and indirect drivers.

   **If incorporating the CAMS Therapeutic Worksheet (CTW), it should be used in session 2 and referenced in sessions thereafter as necessary.
0 = The in-session therapeutic approaches do not reflect the use of suicide-specific interventions to address the drivers.

2 = The in-session therapeutic approaches are related to the drivers, though they are not explicitly linked to the manner in which the driver is leading the patient to consider suicide as an option for solving problems (e.g., focusing on distorted cognitions, but not relating this approach back to perceived burdensomeness as a direct driver of suicidality).

4 = The in-session therapeutic approaches reflect the use of suicide-specific interventions, though with more effort they could be fine tuned to more adequately address the intricate details of the patient’s drivers (e.g., using emotion regulation strategies to target drivers of suicidality without discussing ways to implement specific to patient’s environmental and internal cues).

6 = The in-session therapeutic approaches reflect the use of suicide-specific interventions that are directly linked to patient-specific themes and cues of suicidality that have been established as drivers.

11. ___ Every session should include a discussion about hope, reasons for living, and future plans and goals.

0 = The in-session therapeutic approaches do not address hope, reasons for living, and/or future plans and goals.

2 = The in-session therapeutic approaches include briefly discussing the topic of hope, reasons for living, and/or future plans and goals in a way that does not encourage the client’s participation.

4 = The in-session therapeutic approaches include a didactic discussion of hope, reasons for living, and/or future plans and goals, but the clinician does not incorporate this discussion into establishing treatment goals.

6 = The in-session therapeutic approaches include a didactic discussion about hope, reasons for living, and/or future plans and goals that is woven into establishing concrete treatment goals.

Any additional comments, suggestions, and feedback for clinician’s improvement with regard to intervention:

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________________________________________________________________________
Part III – Overall Rating

12. ___ How would you rate the clinician’s overall adherence to the CAMS framework?

   0 = The session did not include collaboration or focus on drivers of suicidality, and the assessment/treatment protocol was not followed.

   2 = The clinician managed the session adequately, but the content of the session only rarely reflected the essential elements of CAMS.

   4 = The clinician focused on suicide drivers and completed the assessment/treatment approaches, though the session was unfocused or non-collaborative for short periods of time.

   6 = The clinician attended to all aspects of CAMS, with consistent collaboration and focus on drivers throughout the session, as well as meaningful use and completion of the assessment/treatment protocol.

13. ___ How receptive was the patient to this model of treatment?

   0 = The patient was completely unwilling to engage in the CAMS session that focused on suicide drivers.

   2 = The patient was somewhat receptive to CAMS, but displayed frequent attempts to sway the conversation towards another subject and/or was hesitant to collaborate with the clinician regarding assessment and treatment of suicide drivers.

   4 = The patient was willing to engage in the CAMS model, but required several prompts to stay on task

   6 = The patient was completely engaged throughout the session, with a desire to discuss and address their own suicidality through the CAMS model.

14. ___ How comfortable did the clinician seem?

   0 = The clinician was not comfortable discussing the patient’s suicidality using the CAMS model.

   2 = The clinician completed most necessary components of the assessment/treatment protocol, but displayed no spontaneity in the session, as marked by a lack of follow-up questions and discussions regarding information provided by the patient.
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4 = The clinician displayed comfort implementing the CAMS model throughout the session, showing only a few instances where he/she was unsure how to engage the patient further or stumbled a bit when completing aspects of the assessment/treatment protocol.

6 = The clinician displayed complete comfort throughout the session, showing a mastery of the CAMS philosophy, insight into the required assessment/treatment protocol, and a willingness to take calculated risks and engage fully with the patient regarding their suicidality.

Any additional comments, suggestions, and feedback for clinician’s improvement:

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