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Barriers and Facilitators to Implementing the Collaborative Assessment and Management of Suicidality (CAMS)

Ehizele K Iyayi
Catholic University of America
Jessica L Gerner
Catholic University of America
Kevin Crowley
CAMS CARE
Jennifer A Crumlish
Catholic University of America
David A Jobes
jobes@cua.edu

Catholic University of America

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Abstract

Objective

Suicide is a major public health problem, with suicidal ideation experienced by about 16.5 million Americans. The Collaborative Assessment and Management of Suicidality (CAMS) has been empirically proven to reduce suicidal ideation across various randomized controlled trials in outpatient and inpatient settings. Implementing CAMS likely requires specific adaptations to address setting-specific barriers and promote facilitators. A recent paper exists identifying barriers and facilitators for suicide prevention interventions in general but no published paper to date has done this for CAMS specifically.

Methods

This scoping review of PsycINFO, EBSCOhost, and PubMed examined CAMS papers describing barriers, facilitators, and adaptations in various settings. Data was mapped onto Consolidated Framework for Implementation Research (CFIR) domains using a data table.

Results

The 23 included CAMS implementation papers spanned various populations, e.g. teens, and settings, from short-term crisis to inpatient, in the United States, Europe, and Australia. Common barriers were in the inner setting (available resources and leadership engagement) and outer setting (patient needs/resources). Common facilitators were in the intervention characteristics (adaptability and relative advantage).

Conclusion

CAMS was perceived to be uniquely adaptable to various settings and populations. Teams with more leadership support and time had an easier time implementing CAMS. Compared to other treatments for suicidal ideation, brief cognitive behavioral therapy and dialectical behavioral therapy, the flexibility of CAMS was perceived to be an advantage. Future research should examine the usability and effectiveness of CAMS in inpatient settings and with patients with borderline personality disorder.

Highlights

- CAMS treats suicidal ideation but no paper has reviewed barriers and facilitators
- This scoping review found that the adaptability of CAMS was its major facilitator
- Future research should test CAMS in inpatient settings and with personality disorders

Introduction

In 2025, an estimated 16.5 million adults and teenagers in the United States experienced suicidal ideation (SAMHSA, 2026). The Collaborative Assessment and Management of Suicidality (CAMS) is a therapeutic framework for individuals with suicidal ideation and behaviors (Jobes, 2023). CAMS is characterized by its direct focus on suicide as the primary presenting problem; its reliance on direct, nonjudgmental communication with the suicidal patient; and its emphasis on therapist-patient collaboration in assessment and treatment planning. In contrast to other interventions, it is theory-agnostic and designed to be flexibly implementable with any treatment philosophy across settings.

CAMS is organized around the Suicide Status Form (SSF), on which patients rate various affective states associated with suicide (psychological pain, stress, agitation, hopelessness, and self-hate) as well as their overall risk of suicide. The patient and therapist collaboratively identify the primary motivations for the patient's suicidality, referred to as "drivers," as well as develop a treatment plan and timeline to address each specific driver. At each session, the therapist and patient also collaboratively create or update the CAMS Stabilization Plan, which includes lethal means restriction, coping skills, the contact information of personal and professional supports, and identifies and addresses barriers to treatment. CAMS SSF use continues until 3 consecutive sessions of patient-reported management of suicidal thoughts and behaviors and self-rated overall risk of suicide of 1 or 2 out of 5.

Since its inception, CAMS has been tested in various observational studies, demonstrating reductions in the 5 SSF affective states and in suicidal ideation across settings around the world (e.g., Adrian et al., 2022; Arkov et al., 2008). CAMS has demonstrated greater or faster reductions in suicidal ideation compared to alternative treatments in randomized (e.g., Jobes et al., 2017) and non-randomized controlled trials (e.g., Ellis et al., 2017). Other randomized controlled trials (RCTs) have found decreases in suicidal ideation following CAMS but no evidence of superiority to dialectical behavioral therapy (DBT; Andreasson et al., 2016) or treatment as usual (Comtois et al., 2023; Johnson et al., 2019). In one RCT of suicidal inpatients, those treated with CAMS had reduced suicide attempts compared to treatment as usual (Santel et al., 2023). CAMS has been tested across the care continuum and in diverse populations, including college students, military members, and adolescents (see Table 1).

Two systematic reviews of controlled trials of CAMS have been conducted. In the first, Hanratty et al. (2019) concluded that given that there were few, significantly heterogenous trials, there was not enough evidence suggesting CAMS was efficacious for suicidal ideation, attempts, and deliberate self-harm. Second, Swift et al. (2021) found meta-analytic evidence suggesting that CAMS was more effective in reducing suicidal ideation than treatment as usual. Both reviews focused on efficacy and did not report on implementation outcomes. With increasing evidence that CAMS is efficacious, a review of how CAMS is implemented in clinical settings is necessary to guide clinical implementation and future research. In addition, since CAMS has been implemented in various settings and populations, reporting on CAMS adaptations would provide suggestions for researchers and clinicians facing barriers in implementing CAMS.

The Consolidated Framework for Implementation Research (CFIR) organizes barriers and facilitators to implementation into five key domains—intervention characteristics, individual characteristics, implementation process, inner setting, and outer setting (Damschroder et al., 2009)—compiled from constructs shared across implementation theories. It has been used in various settings (Kirk et al., 2016) including mental health settings (Galvin et al., 2022; Mutschler et al., 2022). Kasal et al. (2023) used the framework to summarize barriers and facilitators to suicide prevention interventions broadly, finding that these concentrated in the outer setting domain and intervention characteristics.

CFIR is a particularly natural fit for characterizing CAMS. Because CAMS is theory-agnostic, brief, and compatible with a range of treatments, its adoption may rely less on its content than on how adaptable, complex, and its perceived relative advantage over alternative suicide-focused interventions, aligning with CFIR's intervention characteristics domain. At the same time, CAMS use depends on clinicians receiving CAMS training and having institutional support so they have the time and opportunity to utilize CAMS effectively. Since CAMS has been utilized with clinical populations ranging from adolescents, adults, and military personnel, to patients diagnosed with depression, psychosis and borderline personality disorder, CFIR's outer setting captures how well the intervention fits different patients' needs. Given this fit, this paper analyzes the extent to which Kasal et al.'s findings apply to CAMS, using CFIR to conduct a scoping review of CAMS implementation across settings and to summarize barriers, facilitators, and adaptations.

Methods

This scoping review follows the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) (Tricco et al., 2018). A protocol was not published in advance.

The search was conducted up to March 2026 in three databases: PsycINFO, EBSCOhost, and PubMed. The keywords were developed based on a combination of keywords used in a systematic review of CAMS interventions (Hanratty et al., 2019) and a scoping review of implementation of suicide prevention (Kasal et al., 2023) (Figure 1). Studies were included if they were published in English in a peer-reviewed journal and reported adaptations, barriers, or facilitators of CAMS. Literature reviews were excluded.

Data was extracted from the included studies using the CFIR domains and subdomains (Damschroder et al., 2009). The intervention characteristics domain captures how complex, adaptable, trialable, costly, and effective the intervention is, and whether it is perceived as evidence-based and advantageous. The outer setting characteristics domain captures patient needs and resources, networking, and internal and external pressure to implement the intervention. The inner setting characteristics domain captures the internal structure, culture, networks, incentives, receptivity, and resources. The individual characteristics domain captures implementers' knowledge, self-efficacy, stage of change, and organizational identification. The process domain captures how much implementation is planned, how engaged leaders are, how well the plan is executed, and how much feedback is reviewed and debriefed. A table was

created with one row per included study and one column per CFIR subdomain, and each facilitator and barrier was entered under its corresponding subdomain.

Results

48 unique records were found and 23 articles were included. Table 1 presents a categorization of the included studies, as well as the most common barriers, facilitators, and adaptations across settings and populations. 6/23 (26%) of the included studies were conducted outside the United States. The rest were conducted in the United States. Most of the international studies were conducted in Europe (n=5; 22%) and 1 was conducted in Australia.

The most common barriers were in the inner setting domain, under the subdomains of available resources and leadership engagement. Across studies, clinicians reported that the extra time to complete training in CAMS and to use the SSF with their patients made implementation difficult. It was all the more challenging without institutional support (e.g., Norrod et al., 2025). The second most common barrier was in the outer setting domain, in the patient needs and resources subdomain. Across settings, there was a perception that CAMS was not appropriate for all patients. A commonly cited condition perceived as necessitating an alternative intervention strategy was borderline personality disorder (BPD) (e.g., Phillips et al., 2025; Zbukvic et al., 2022). However, a subgroup analysis of patients treated in the United Kingdom's National Health Service showed that patients with borderline personality disorder diagnosis or traits started and ended with higher suicidal ideation than those without it but had a similar rate of change over time (Bayliss et al., 2025).

The most common facilitators across settings were intervention characteristics, specifically the subdomains of adaptability and relative advantage. Since CAMS does not require that clinicians use a specific theoretical orientation and has a short average session duration (6-8 sessions; Jobes et al., 2023), CAMS was perceived to be more flexible and easier to learn than alternative interventions, most commonly DBT (Blalock et al., 2025; Blossom et al., 2022; Dimeff et al., 2020).

Discussion

Across CAMS studies, the most common barriers were available resources and leadership engagement (inner setting) and patient needs and resources (outer setting). The most common facilitators were found in intervention characteristics, particularly adaptability and relative advantage. The fact that CAMS was implemented across healthcare settings and perceived as suitable in all suggests that CAMS is a good model for stepped care, i.e., suicide prevention at all levels of mental healthcare from outpatient to inpatient contexts (Jobes et al., 2018). Further supporting this is evidence from other studies, that compared to alternative treatments, CAMS most significantly changed providers use of best practices to address suicide (LoParo et al., 2019) and was more cost-effective (McCutchan et al., 2022). Notably, in the current study, leadership support was cited as both a barrier and facilitator, depending on whether it was present: this suggests effective CAMS implementation necessitates administrative support,

whether through leaders addressing concerns and encouraging therapists (O'Neill et al., 2023; Ryberg et al., 2016) or through dedicated training time (Marshall et al., 2014), which also helps offset the resource barrier above.

CAMS shares barriers with other treatments for suicidality. A review of DBT implementation similarly found that lack of leadership support and time were common barriers, and that support eased implementation when leaders reduced providers' non-DBT responsibilities (Toms et al., 2019). Unlike CAMS, however, DBT's suitability was a commonly cited barrier—many included studies suggested that full fidelity to DBT was not feasible.

Less has been published on implementation of brief cognitive behavioral therapy (BCBT) for suicide prevention, but the available literature points to a similar need for administrative support, given the prior CBT experience and specialized training BCBT requires (Diefenbach et al., 2024). Both papers reporting on facilitators, an RCT (Diefenbach et al., 2024) and an implementation study (McLaughlin et al., 2025), found that having administrative support made implementation possible, and that supportive leadership helped providers find time to learn and implement BCBT (McLaughlin et al., 2025). Time remained the second most common barrier, and process changes targeting time were rated most helpful by BCBT providers, who also expressed a desire to shorten BCBT from its validated 10-12 session recommendation. In contrast, CAMS can be implemented in as little as one session and averages 6-8 sessions, which providers felt made it well-adapted to short-term care settings (Adrian et al., 2024; Comtois et al., 2011; Oakey-Frost et al., 2024). The biggest barrier to BCBT reported in the implementation study was difficulty finding eligible outpatients (McLaughlin et al., 2025); because CAMS can be flexibly applied across levels of care, some organizational leaders implementing CAMS avoided this barrier by implementing it across the full continuum (e.g., Ryberg et al., 2016).

Recommendations

Two priority areas for future research emerged from this review. First, one study found CAMS equally effective at reducing suicidal ideation for patients with BPD diagnosis or traits (Bayliss et al., 2025), contrasting with other studies suggesting that BPD was a barrier to the use and effectiveness of CAMS (Phillips et al., 2025; Zbukvic et al., 2022). Future research should measure suicidal ideation outcomes stratified by BPD diagnosis to confirm whether Bayliss et al.'s findings generalize. Second, evidence on CAMS implementation in inpatient settings was sparse in this review and warrants further study.

Limitations:

Many included studies did not report on every CFIR subdomain—for example, few studies reported providers' pre-implementation attitudes, organizational policy incentives, program champions, or the amount of leadership engagement and resources available. As a result, the information reported here reflects only what was published, not necessarily what occurred. This review is further limited in that not

all CAMS treatment studies reported on barriers and facilitators. Five relevant studies were excluded because they did not describe implementation process or outcomes.

Conclusion

Because of its flexibility, CAMS can be successfully implemented and adapted across various settings and clinical populations. As a theory-agnostic treatment model with shorter training and shorter sessions than DBT and BCBT, CAMS may be easier to disseminate widely for suicide prevention at all levels of care—provided implementers have sufficient time and leadership support. Future research should test whether CAMS works as well in inpatient settings and with patients with BPD.

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Declarations

Competing Interests

Dr. David A. Jobes has received royalties from Guilford Press and is the co-owner of CAMS-care, a training and consultation company.

Author Contribution

EKI and JLG conceived of the project. EKI wrote the main manuscript text, prepared the tables, and figures. All authors reviewed the manuscript.

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Table

Table 1 *Adaptations, barriers, and facilitators across settings*

	Included studies	Adaptations	Barriers	Facilitators
Teens	(Adrian et al., 2022, 2024; Blossom et al., 2022)	Parents also report on their experience of their child's suicidality	Not enough added time to have parent complete form with clinician in session	CAMS adaptable – add interventions & trialable – higher level of care when needed
Telehealth	(Dimeff et al., 2020; Kassing et al., 2025; Moore et al., 2024; O'Neill et al., 2023; O'Toole et al., 2019)	CAMS forms in medical record Telehealth risk/emergency assessment plan	Technology issues Issues assessing body language	Convenience – in client reach, access to forms and resources
University Counseling Center	(Blalock et al., 2025; Kassing et al., 2025; Phillips et al., 2025; Pistorello et al., 2017)	Using CAMS either at all levels of care, reference or framework depending on service needs	Harder to train non-psychologists	Admin support
Brief/Crisis Interventions	(Adrian et al., 2024; Comtois et al., 2011; Oakey-Frost et al., 2024; O'Neill et al., 2023)	Added case management	High long-term case management needs	CAMS well-adapted for short-term care
ED	(Dimeff et al., 2020)	Virtual therapist, peer videos, post-discharge messages and clinical decision making tool	Too complex to extend into more contexts	Easy to use, helpful, distract
Inpatient	(Ellis, Daza, et al., 2012; Ellis et al., 2009; Ellis, Green, et al., 2012)	SSF once a week Assessed current and worst point drivers	Abrupt discharges	Frequent team meetings
Hospital systems	(Adrian et al., 2022; Bayliss et al., 2025; Marshall et al., 2014; Monahan et al., 2020; Norrod et al., 2025; Ryberg et al., 2016; Walukevich-Dienst et al., 2021; Zbukvic et al., 2022)	Various staff trained– nurses, nurse practitioners, occupational therapists, social workers, counselors, psychologists, psychiatrists	Time consuming Lots of paperwork Not appropriate for all patients Low uptake from non-psychologists	Admin support Frequent check-ins and team meetings

Figures

Search string: (implement* OR dissemin* OR diffus* OR "scal* up" OR applicat* OR adapt OR title("feasibility" OR "pilot")) AND ("Collaborative Assessment and Management of Suicidality" OR (suicid* AND CAMS))

Figure 1

Search strategy

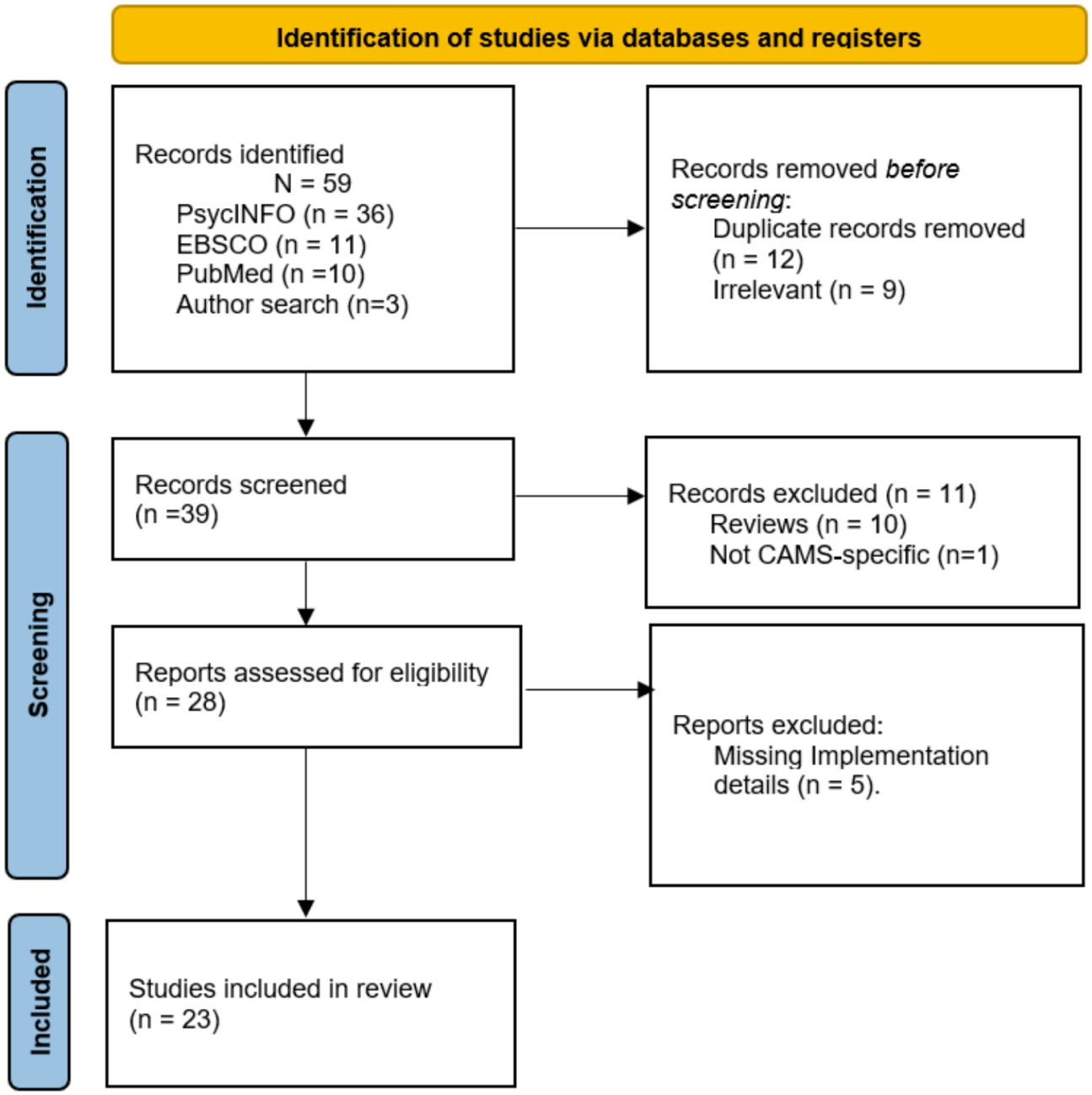


Figure 2

Extraction flowchart & Exclusion Reasons