# CAMS-care Framework: Malpractice and Ethical Issues with Suicidal Patients Supplemental Handout

## Assessing/Determining Risk

**Question:** We know and always hear that healthcare providers have a duty to hospitalize when a client/patient is in imminent danger. **What exactly is "imminent danger" and how do I know when I need to hospitalize someone?**

**Response**: This is a difficult question to answer, in part because there are over *60* different definitions of "imminent danger" in the legal and psychological literature! A common approach is that if you believe there is a possibility of a self-harm act within the next **24 hours**, hospitalization may be necessary.

It's critical to first consider whether hospitalization will be in the suicidal client/patient's best interest. Most contemporary hospital stays are very brief and emphasize psychiatric stabilization over evidence-based suicide specific treatment. Because of this, it's unfortunately the case that such hospitalizations can actually have a negative effect and even *increase* the individual's suicide risk post discharge.

In the CAMS Framework it is our goal to keep the suicidal client/patient out of the hospital, if possible. This requires a very thoughtful assessment of risk, a productive discussion about their access to lethal means, and a strong clinical sense based on the risk assessment, the stabilization plan and the treatment plan that the client/patient has the tools, resources, and the will to be stable until the next appointment.

**Question:** Are there suicide risk factors or warning signs that will help me predict whether my client/patient is likely to take his or his own life in the next 24 hours?

**Response:** Many suicide risk factors have been proposed that indicate someone *may* be at a higher risk for suicidal behaviors at some point in their life. So have suicide-specific warning signs that emphasize recent changes in things like emotion dysregulation, agitation, suicidal ideation, and isolation. But, while it is incredibly important to take these variables into account, neither grouping will tell you whether **this client** can leave your office on their own.

The Suicide Status Form (SSF) gauges risk factors and warning signs in service of a broader, person-specific drivers-focused conceptualization. Within the CAMS framework, "drivers" are unique to each individual; they are problems in a person's life that put someone in a state of "dis-ease" or "dis-order". They are the problems suicide is intended to solve.

At the end of each interim CAMS session, the clinician has the opportunity to revisit the client/patient's treatment plan. This is when you will determine whether the drivers you've identified are still the same or whether you can "sharpen" them further.

**Question:** Since there are so many suicide risk factors to consider, are there certain ones with which the clinicians should be most concerned?

**Response:** While all the risk factors listed on the SSF are important to consider, several research studies have indicated that *hopelessness* and *self-hate* may be particularly strong indicators of suicide risk. Similarly, clients/patients who describe a very high wish to die and a very low wish to live may also be particularly concerning.

In Section B of the SSF, we recommend that you also pay close attention to the client/patient's suicide attempt history. Two or more bona fide lethal attempts (meaning the person acted with the intent to die) is always a red flag. Additionally, the more attempts, the more concern. Access to lethal means increases an individual's suicide risk, as well. And then there are a few other variables, such as insomnia, coupled with substance abuse and dysregulation – this is someone with whom you should be very concerned.

**Question:** If a client/patient marks all "5s" on the SSF core assessment (section A), does this indicate that he or she should be hospitalized?

**Response:** The ratings that a patient gives at the beginning of the assessment are not necessarily going to drive the treatment disposition. Clinicians should take the time to complete the SSF in collaboration with the client/patient. Completing the SSF can be eye-opening for the clinician and therapeutic for the client/patient. You could find that they have a very profound reason for living – and that one crucial reason for living could take suicide off the table. Or you may learn that they do not have a suicide plan, have no idea what lethal means they would use and have never made a previous attempt. If the clinician turns to hospitalization in the first 10 minutes of the session, all the additional information that would follow by filling out the CAMS SSF would be unknown.

The clinician should continue to work collaboratively with the client/patient on a treatment plan with the goal of keeping him or her out of the hospital, if possible. This can allow the client/patient to "unpack" what they are going through and keep the clinician from making premature assumptions.

The disposition should be based on the treatment plan and especially the CAMS Stabilization Plan. If you can negotiate a robust stabilization plan, if the client/patient is willing to surrender all lethal means, if you develop some problem-solving strategies, all this should give the clinician confidence that their client/patient is willing to find other ways to cope, rather than taking his or her life.

## Consultation and Documentation

**Question:** If I am struggling with determining whether a client/patient should be hospitalized, should I seek consultation from a supervisor or another trusted clinician?

**Response:** It is always good practice to consult with other clinicians about your cases, whether it is around assessing suicide risk or other challenges. Not only should you consult with others, but you should always

document such consultations in your case note section of the SSF or somewhere else in your medical record notes. These are very protective practices, particularly with suicidal clients/patients.

**Question:** What kind of documentation should a clinician create when working with a suicidal client/patient to limit their malpractice liability?

**Response:** Documentation is crucial when it comes to issues of malpractice liability. As most plaintiff attorneys will tell you, "if it was not written down, it did not happen." It has been argued that 80-90% of what determines, in the mind of the attorney, whether a malpractice case should be pursued depends principally on the quality and completeness of the written medical record (Simpson & Stacy, 2004; Wise et al., 2005).

When you are using the CAMS SSF, the documentation is being done as you go. The SSF can be part of the medical record. It meets the criteria for a "Progress Note" under the Health Insurance Portability Accountability Act (HIPAA). Additionally, the final page in every session of CAMS specifically maps out your judgement of overall suicide risk and the case note section provides additional protection.

## Treatment Duration

**Question:** How do I know how long to treat a client/patient with the CAMS Framework?

**Response:** The spirit of the CAMS framework is that you are not asking your client to sign on for "endless treatment." We typically recommend 8-12 sessions because our clinical research has shown most people respond to CAMS within that time frame. That is an ample window for us to determine whether someone is responding and to assess other options if she/he is not.

In addition, setting a finite amount of sessions is important to many suicidal clients/patients who may be reluctant to try a new approach. Understanding that they are agreeing to a limited number of sessions has proven to be an effective way to increase initial "buy in" and motivation.

## Managing "Suicide-Specific" Care

**Question:** The CAMS treatment plan seems to focus solely on the client/patient's suicide risk. Shouldn't I also (or primarily) be treating other identified diagnosis, such as depression or anxiety?

**Response:** We understand that adopting a "suicide-focused perspective" could be a shift in mindset for many clinicians who were trained in the medical model (DSM). And it makes sense to think of suicide as a "symptom" of a broader disorder in this context; it's criterion 9 for a major depressive episode and number 5 for borderline personality disorder, for example. But medical and psychosocial research **consistently** suggests that addressing depression or other disorders as primary targets **does not necessarily impact** suicidal ideation or behaviors. Suicide is not unique to these disorders; clinicians in our trainings *regularly* note both that they have worked with people who meet criteria for these diagnoses who are not suicidal and that they have worked with suicidal patients whose distress was better captured by something completely different.

In CAMS, we focus on the client/patient's suicide risk **as the problem to be treated** because the research overwhelmingly tells us that this is the best way to reduce suicide ideation, self-harm and attempt behavior.

**Question:** What if the "driver" indicated on the client/patient's SSF requires expertise beyond the clinician's training? Say, for example, the client identifies trauma as a direct or indirect driver. When should the clinician refer the client/patient to another, "more appropriate" provider? Should we address things like trauma/substance abuse before addressing suicide?

**Response:** It is important to stabilize the client/patient around their suicide risk before referring them on to a more specific treatment (like something trauma focused). Research indicates that effective, suicide-focused care can be done in the context of comorbid substance use/trauma symptoms, etc. In fact, in our clinical research trials, we have had some of our best outcomes with that sequence of care.

## Brief Intervention

**Question:** I work in a crisis support clinic, where I only see the client/patient for one session. Is it worthwhile to stir up all these things, identify suicide risk drivers and then refer them to another clinician who may not be CAMS trained?

**Response:** Many clinicians use CAMS effectively in a one-touch or maybe two-touch respite setting. We refer to it as the CAMS Brief Intervention or CAMS BI. And, when we know a clinician only has one session with a client, we don't recommend any changes from the SSF Initial Session guidelines.

The SSF initial session forms guide patients through gathering data for risk determination, constructing a collaborative safety/stabilization plan, addressing lethal means, and providing recommendations for ongoing care that reflect **this person's** individual drivers. These four outcomes are considered best practice for a contact with a suicidal patient, and if they are conducted in a way that directly facilitates a collaborative therapeutic relationship, is there any more that could have been done in a single session?

## Lethal Means Restriction

**Question:** It sounds like removing the lethal means is a critical element of the stabilization plan. If the client/patient will not completely remove the weapon or pills from their home, should this person be hospitalized?

**Response:** Fully removing access to lethal mean(s) is often ideal when drafting a safety/stabilization plan. However, there can be very legitimate reasons why a client/patient cannot or will not do that. For example, someone with bipolar disorder who thinks of overdosing may need his medication to maintain psychiatric stabilization. The gun that a rape victim fantasizes about using could allow her to feel safe alone in her home. Or the city bus someone thinks about stepping in front of could be the only way he is able to get to work.

Successful lethal means restriction does not always mean complete removal; working with your client to "make the environment safe" by delaying access or cueing positive associations can be lifesaving. For example, will the client/patient lock up the medications or weapon in a box that is covered with pictures or notes that reminds him or her of their reasons for living? Or will they let a trusted third party hold the lethal items for safe keeping? Will the client/patient agree to take another mode of transportation for the next 12 weeks, or stand at least 10 feet back from the curb?

Collaboration around safety planning can, in and of itself, be a positive protective factor. But, despite CAMS' explicit focus on trying to keep patients out of the hospital, they do need to "meet us halfway." If you cannot collaboratively come up with a reasonable solution that convinces you that he or she will be safe, your duty may be to seek hospitalization.

## Coordinating with Other Health Care Professionals

**Question:** In terms of minimizing my malpractice exposure, should I be interacting with my client/patient's other health care providers, for example their psychiatrist?

**Response:** From an ethical standpoint, collaboration and coordination of care is an expectation. Consultations with your client/patient's other health care providers is critical to successful care and must be carefully documented in your records. Don't presume that you can talk with the other health care providers; you may need to get a release from the client/patient.

Having said that, it is also important to note that there needs to be one clear primary provider. If you are the primary care provider you need to be clear that you are embracing that role and that you are responsible for the case, as you carry the most liability and responsibility for the client/patient. This should also be conveyed to the patient; it should be explicitly clear to her/him who they can call in a crisis and how to access that professional resource.

## When a Client /Patient Fails to Return for Treatment

**Question:** What do I do if I start using CAMS with a client/patient and then he or she stops coming to sessions? What are my responsibilities to the client/patient?

**Response:** Every clinical practice should have written policies and procedures in place that address this issue and are thoroughly explained to each client/patient during their first session. Ideally, such policies are available in hard copy (brochure) for each client/patient to take home.

Customary practice would be for the clinician to try and reach the client/patient by phone and/or e-mail, depending on your client/patient's preference. It will be helpful if a third-party contact is included in the client/patient's stabilization plan. And it is important to make a persistent effort and clearly document every attempt you make to contact your client/patient.

You may consider, after several unsuccessful attempts, to send a certified letter stating the missed appointments, the efforts made to contact the client/patient, and your conclusion that the client/patient wants to end the clinical relationship. Provide a date upon which the client/patient must contact you if they wish to keep their case open, and put a copy of the letter along with the certified letter receipt in the case notes. This should be enough documentation to demonstrate that you did everything you could to contact the client/patient.

Should you wish to go "above and beyond," you may want to also consider sending a non-demand follow up note ("caring contact") some time after closing the record in which you ensure the patient that she/he would be welcome to resume services if necessary.

## How to Responsibly Take Time Off from Suicidal Clients/Patients

**Question:** Oftentimes when I have a caseload with many suicidal patients, it can feel like a 24/7 job. How can I responsibly take time away? Go on vacation?

**Response:** It is important that clinicians can, and do, take time away from a heavy caseload. It is not only important for the clinician's well-being, but also for the quality of care a rested clinician will provide to their client/patients.

Your client/patient's stabilization plan should include people they can call for support in a crisis. The stabilization plan should also include the National Suicide Lifeline (1-800-273-TALK) or National Crisis Text Line (741741). Ideally, you will have other clinicians that can cover for you when you are away – and in turn, you can cover for them. Having a professional network of clinicians, you can count on will go a long way to easing your anxiety when you must be away from suicidal clients/patients. And this is not a "bad thing" for patients either! Especially in cases where another clinician who can cover for you is versed in "CAMS," patients can see that there may be multiple options for connecting with effective providers treatment besides you exclusively. (This, of course, doesn't minimize your skill or your relationship; it hopefully helps you feel less pressure!)

**Question:** What if I can no longer work with a suicidal client/patient because I am moving away, or I am taking leave for a medical condition? How can I end the clinical relationship without it being considered abandonment?

**Response:** It is possible to end a clinical relationship without violating your ethics code or leaving your client/patient feeling like you have clinically abandoned them. But it isn't something you can generally accomplish overnight. You need to be thoughtful, seek consultation, create referrals and resources, and do it in a timely manner, so that your client/patient is not taken by surprise. Additionally, all of this process should be thoroughly documented.

Again, this is something you should prepare for by establishing policies and procedures that you can share with clients/patients during their first session, along with your "no-show" policy and any other practice related policies and procedures. There is nothing wrong with including policies and procedures for the "unlikely event" or "unforeseen events." The more you can prepare your client/patients and their families in advance, the better off everyone will be if/when unforeseen events occur. This is good practice; and good clinical practice that is well-documented is invariably highly protective.

*For more information about the CAMS framework or additional training opportunities in it, please contact Kevin Crowley at camscare.crowley@gmail.com.*

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