Innovations in Clinical Suicide Prevention: CAMS Update and *Managing Suicidal Risk: A Collaborative Approach (3rd edition)*

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THE CATHOLIC UNIVERSITY of AMERICA

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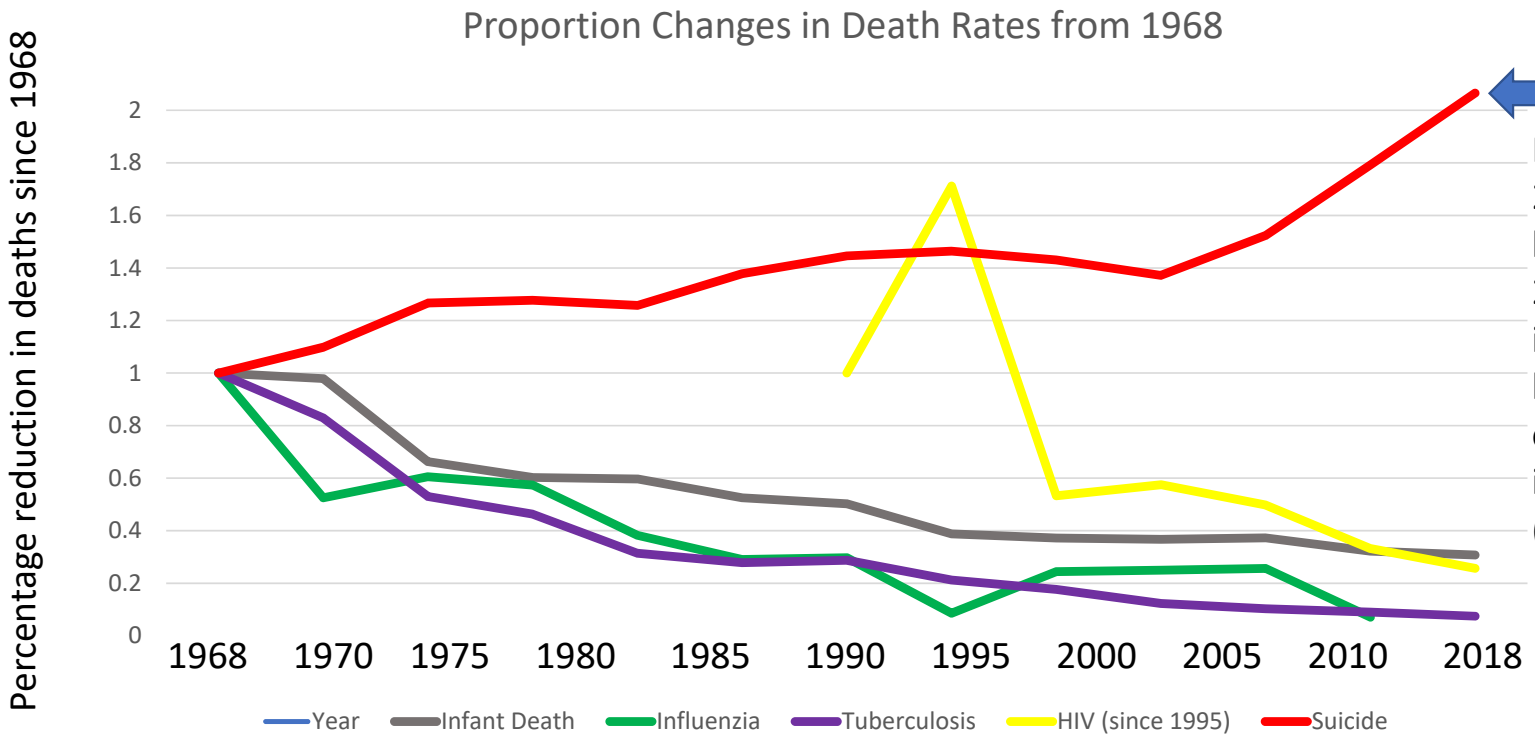
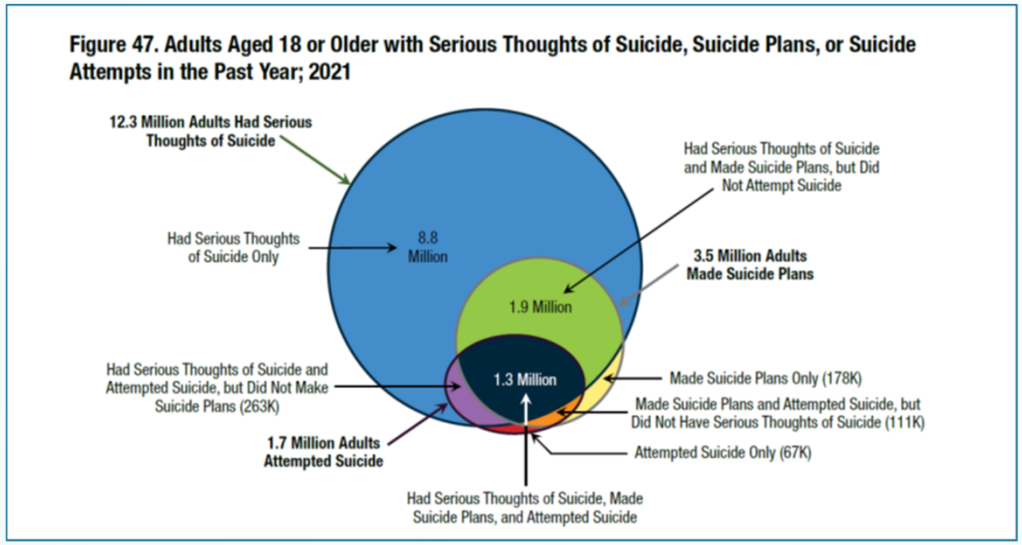
50+ Years Addressing Leading Causes of Death in the United States of America



Rates decreased 2019 and 2020, but increased 2021 and again in 2022 with highest number of suicide deaths in US history (Prov = 49,449)

Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1968-2016 on CDC WONDER Online Database, released June 2017. Data are from the Compressed Mortality File 1999-2016 Series 20 No. 2U, 2016, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/cmf-icd10.html on Nov 10, 2019 7:07:31 PM

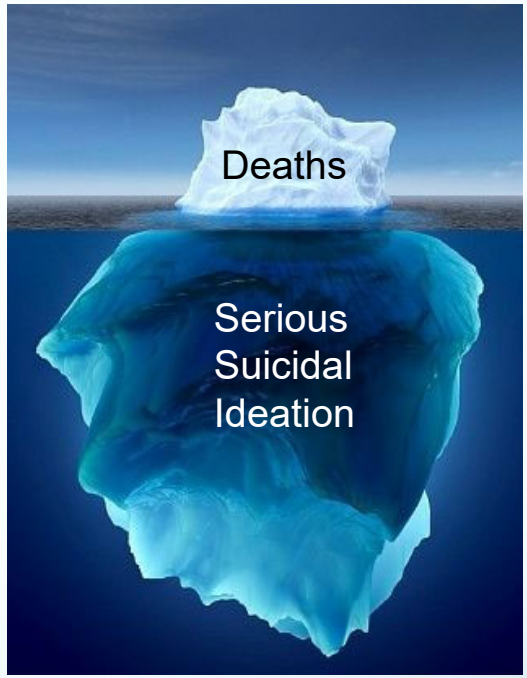
The Importance of Suicidal Ideation



Editorial

Reflections on Suicidal Ideation

David A. Jobes[1] and Thomas E. Joiner[2]

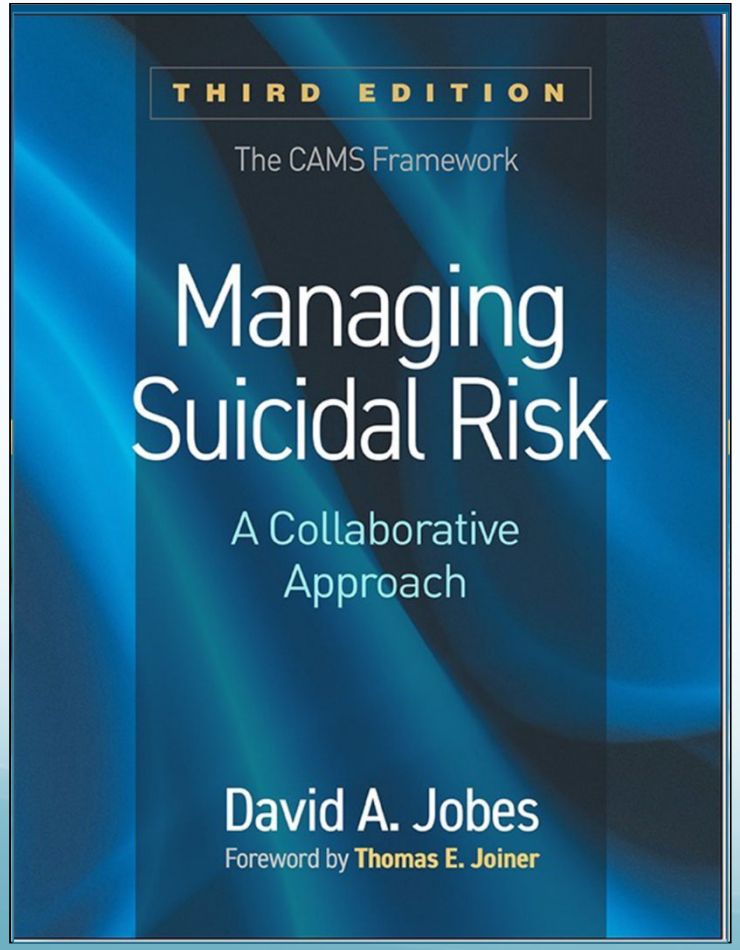


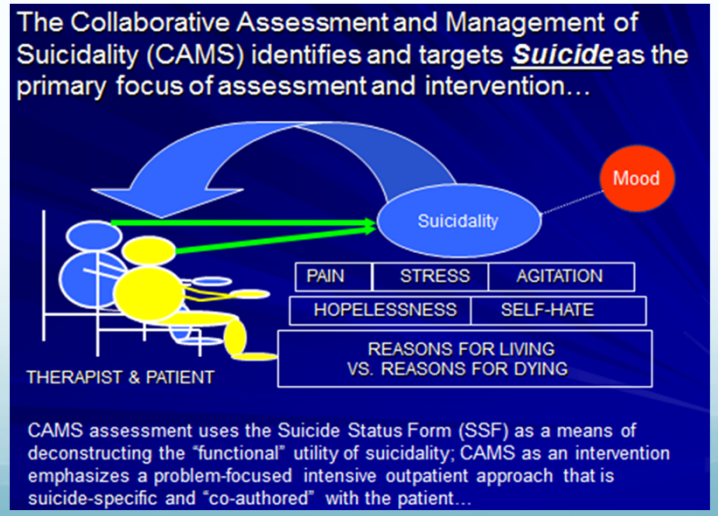
In 2021, there were **15,600,000** total Americans with serious suicidal thoughts!

We are understandably preoccupied with attempts and deaths. But why do we not appreciate the largest population challenge of all? Our biggest challenge are those American adults and teens with *serious thoughts of suicide* in the past 30 days.

2021 SAMHSA data adds 3,300,000 teens who also have serious thoughts of suicide

The Collaborative Assessment and Management of Suicidality (CAMS)





The four pillars of the CAMS framework:

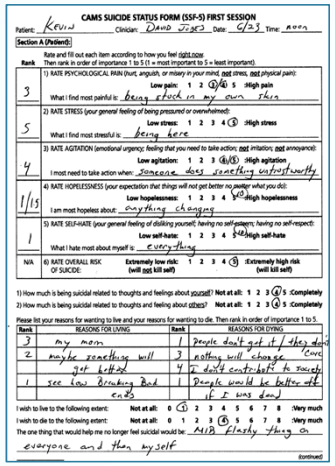
1) Empathy

2) Collaboration

3) Honesty

4) Suicide-focused

Goal: Build a strong therapeutic alliance that increases patient-motivation; CAMS targets and treats *patient-defined* suicidal "drivers"


CAMS SUICIDE STATUS FORM (SSF-5) FIRST SESSION

Patient: Kevin Clinician: David Jobes Date: 6/23 Time: noon

Section A (Patient):

Rate and fill out each item according to how you feel right now.

1) RATE PSYCHOLOGICAL PAIN (hurt, anguish, or misery in your mind, not stress, not physical pain): Low pain: 1 2 ③ 4 5 :High pain
What I find most painful is: being stuck in my own skin

2) RATE STRESS (your general feeling of being pressured or overwhelmed): Low stress: 1 2 3 4 ⑤ :High stress
What I find most stressful is: being here

3) RATE AGITATION (emotional urgency; feeling that you need to take action; not irritation; not annoyance): Low agitation: 1 2 3 ④ 5 :High agitation
I most need to take action when: someone does something untrustworthy

4) RATE HOPELESSNESS (your expectation that things will not get better no matter what you do): Low hopelessness: 1 2 3 4 ⑤ :High hopelessness
I am most hopeless about: anything changing

5) RATE SELF-HATE (your general feeling of disliking yourself; having no self-esteem; having no self-respect): Low self-hate: 1 2 3 4 ⑤ :High self-hate
What I hate most about myself is: everything

6) RATE OVERALL RISK OF SUICIDE: Extremely low risk: (will not kill self) 1 2 3 4 ⑤ :Extremely high risk (will kill self)

1) How much is being suicidal related to thoughts and feelings about yourself? Not at all: 1 2 3 ④ 5 :Completely
2) How much is being suicidal related to thoughts and feeling about others? Not at all: 1 2 3 ④ 5 :Completely

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING
3	my mom	1	People don't get it / they don't care
2	maybe something will change	3	nothing will change
	get better	4	I don't want/don't to society
1	see how breaking Bad ends	1	People would be better off if I was dead

I wish to live to the following extent: Not at all: 0 ① 2 3 4 5 6 7 8 :Very much
I wish to die to the following extent: Not at all: 0 1 2 3 ④ 5 6 7 8 :Very much
The one thing that would help me no longer feel suicidal would be: ANA finally talking to everyone and then myself

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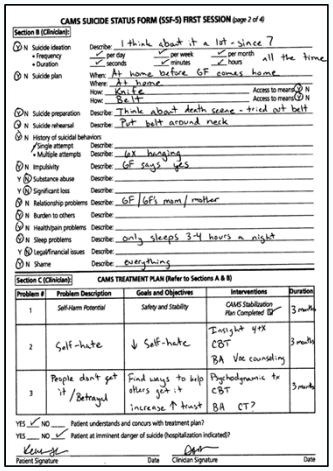

CAMS SUICIDE STATUS FORM (SSF-5) FIRST SESSION (page 2 of 4)

Section B (Clinician):

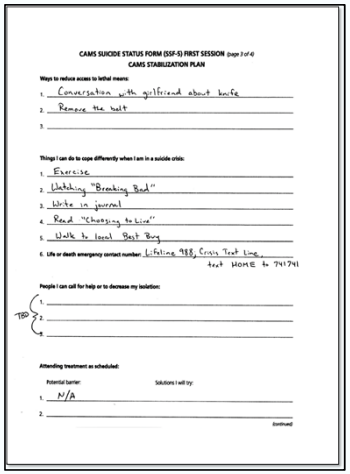
N Suicide ideation • Frequency • Duration — Describe: I think about it a lot - since 7 — per day ✓ per week ✓ per month — seconds minutes hours all the time
N Suicide plan — When: At home before GF comes home — Where: At home — How: Knife / Belt — Access to means? Y N
N Suicide preparation — Describe: Think about death scenes - tried on belt
N Suicide rehearsal — Describe: Put belt around neck
N History of suicidal behaviors — Single attempt / • Multiple attempts — Describe: ER hanging
N Impulsivity — Describe: GF says yes
Y N Substance abuse — Describe:
Y N Significant loss — Describe: GF / GFs mom / mother
N Relationship problems
N Burden to others
N Health/pain problems
N Sleep problems — Describe: only sleeps 3-4 hours a night
Y N Legal/financial issues
N Shame — Describe: everything

Section C (Clinician): CAMS TREATMENT PLAN (Refer to Sections A & B)

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	Self-Harm Potential	Safety and Stability	CAMS Stabilization Plan Completed ☑	3 months
2	Self-hate	↓ Self-hate	Insight ↑ tx CBT BA Voc counseling	3 months
3	People don't get it / Betrayal	Find ways to help others get it ↑ trust	Psychodynamic tx CBT BA CT?	3 months

YES ✓ NO ___ Patient understands and concurs with treatment plan?
YES ___ NO ✓ Patient at imminent danger of suicide (hospitalization indicated)?

Kevin Patient Signature Date — Clinician Signature Date


CAMS SUICIDE STATUS FORM (SSF-5) FIRST SESSION (page 3 of 4)
CAMS STABILIZATION PLAN

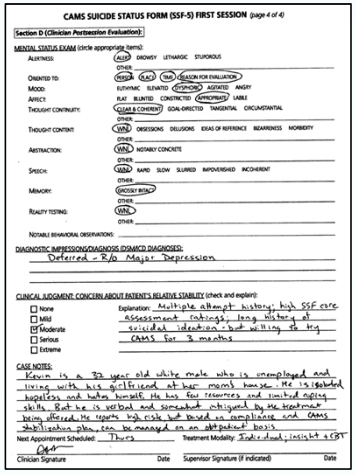
Ways to reduce access to lethal means:
1. Conversation with girlfriend about knife
2. Remove the belt
3.

Things I can do to cope differently when I am in a suicide crisis:
1. Exercise
2. Watching "Breaking Bad"
3. Write in journal
4. Read "Choosing to Live"
5. Walk to local Best Buy
6. Life or death emergency contact number: Lifeline 988, Crisis Text Line, text HOME to 741741

People I can call for help or to decrease my isolation:
TBD 1. 2. 3. 4.

Attending treatment as scheduled:
Potential barrier: Solutions I will try:
1. N/A
2.

(continued)


CAMS SUICIDE STATUS FORM (SSF-5) FIRST SESSION (page 4 of 4)

Section D (Clinician Portsession Evaluation):

MENTAL STATUS EXAM (circle appropriate items):
ALERTNESS: (ALERT) DROWSY LETHARGIC STUPOROUS
ORIENTED TO: (PERSON) PLACE TIME REASON FOR EVALUATION
MOOD: EUTHYMIC ELEVATED (DYSPHORIC) AGITATED ANGRY
AFFECT: FLAT BLUNTED CONSTRICTED (APPROPRIATE) LABILE
THOUGHT CONTINUITY: (CLEAR & COHERENT) GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL
THOUGHT CONTENT: (WNL) OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY
ABSTRACTION: (WNL) NOTABLY CONCRETE
SPEECH: (WNL) RAPID SLOW SLURRED IMPOVERISHED INCOHERENT
MEMORY: (GROSSLY INTACT)
REALITY TESTING: (WNL)
NOTABLE BEHAVIORAL OBSERVATIONS:

DIAGNOSTIC IMPRESSIONS/DIAGNOSIS (DSM/ICD DIAGNOSES):
Deferred - R/O Major Depression

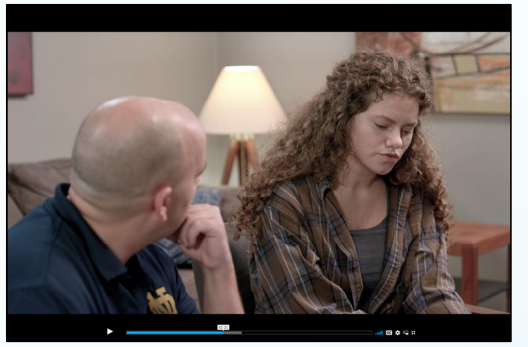
CLINICAL JUDGMENT CONCERN ABOUT PATIENT'S RELATIVE STABILITY (check and explain):
☐ None ☐ Mild ☑ Moderate ☐ Serious ☐ Extreme
Explanation: Multiple attempt history; high SSF score; assessment taking; long history of suicidal ideation - not willing to try CAMS for 3 months

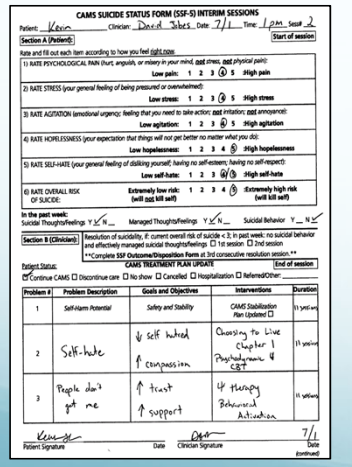
CASE NOTES:
Kevin is a 32 year old white male who is unemployed and living with his girlfriend at her mom's house. He is isolated, hopeless and hates himself. He has few resources and limited coping skills. But he is verbal and somewhat intrigued by the treatment being offered. He reports high risk, but based on compliance and CAMS stabilization plan, can be managed on an outpatient basis.

Next Appointment Scheduled: Thurs Treatment Modality: Individual; Insight + CBT

Clinician Signature Date — Supervisor Signature (if indicated) Date

First session of CAMS—SSF-5 Assessment, Stabilization Planning, Driver-Focused Treatment Planning, and HIPAA Documentation




CAMS SUICIDE STATUS FORM (SSF-5) INTERIM SESSIONS

Patient: Kevin Clinician: David Jobes Date: 7/1 Time: 1pm Sess# 2 Start of session

Section A (Patient):

Rate and fill out each item according to how you feel right now.

1) RATE PSYCHOLOGICAL PAIN (hurt, anguish, or misery in your mind, not stress, not physical pain): Low pain: 1 2 3 ④ 5 :High pain
2) RATE STRESS (your general feeling of being pressured or overwhelmed): Low stress: 1 2 3 ④ 5 :High stress
3) RATE AGITATION (emotional urgency; feeling that you need to take action; not irritation; not annoyance): Low agitation: 1 2 3 ④ 5 :High agitation
4) RATE HOPELESSNESS (your expectation that things will not get better no matter what you do): Low hopelessness: 1 2 3 4 ⑤ :High hopelessness
5) RATE SELF-HATE (your general feeling of disliking yourself; having no self-esteem; having no self-respect): Low self-hate: 1 2 3 ④ 5 :High self-hate
6) RATE OVERALL RISK OF SUICIDE: Extremely low risk: (will not kill self) 1 2 3 4 ⑤ :Extremely high risk (will kill self)

In the past week: Suicidal Thoughts/Feelings Y ✓ N ___ Managed Thoughts/Feelings Y ✓ N ___ Suicidal Behavior Y ___ N ✓

Section B (Clinician): Resolution of suicidality, if current overall risk of suicide < 3: in past week: no suicidal behavior and effectively managed suicidal thoughts/feelings ☐ 1st session ☐ 2nd session
Complete SSF Outcome/Disposition Form at 3rd consecutive resolution session.

CAMS TREATMENT PLAN UPDATE — End of session

Patient Status: ☑ Continue CAMS ☐ Discontinue care ☐ No show ☐ Cancelled ☐ Hospitalization ☐ Referred/Other:

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	Self-Harm Potential	Safety and Stability	CAMS Stabilization Plan Updated ☐	11 yes/no
2	Self-hate	↓ self hatred ↑ compassion	Choosing to Live Chapter 1 Psychodynamic & CBT	11 yes/no
3	People don't get me	↑ trust ↑ support	& therapy Behavioral Activation	11 yes/no

Kevin Patient Signature Date — Clinician Signature 7/1 Date

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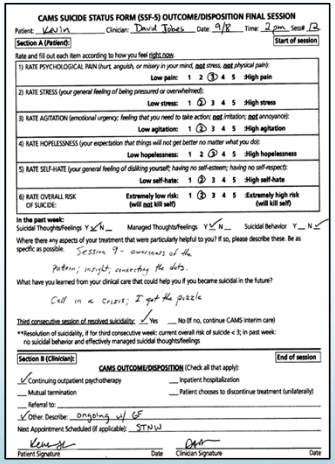
CAMS SUICIDE STATUS FORM (SSF-5) INTERIM SESSIONS (page 2 of 2)


CAMS SUICIDE STATUS FORM (SSF-5) OUTCOME/DISPOSITION FINAL SESSION

Patient: Kevin Clinician: David Jobes Date: 9/8 Time: 2pm Sess# 12 Start of session

Section A (Patient):

Rate and fill out each item according to how you feel right now.

1) RATE PSYCHOLOGICAL PAIN (hurt, anguish, or misery in your mind, not stress, not physical pain): Low pain: 1 2 ③ 4 5 :High pain
2) RATE STRESS (your general feeling of being pressured or overwhelmed): Low stress: 1 ② 3 4 5 :High stress
3) RATE AGITATION (emotional urgency; feeling that you need to take action; not irritation; not annoyance): Low agitation: 1 ② 3 4 5 :High agitation
4) RATE HOPELESSNESS (your expectation that things will not get better no matter what you do): Low hopelessness: 1 2 ③ 4 5 :High hopelessness
5) RATE SELF-HATE (your general feeling of disliking yourself; having no self-esteem; having no self-respect): Low self-hate: 1 ② 3 4 5 :High self-hate
6) RATE OVERALL RISK OF SUICIDE: Extremely low risk: (will not kill self) 1 ② 3 4 5 :Extremely high risk (will kill self)

In the past week: Suicidal Thoughts/Feelings Y ✓ N ___ Managed Thoughts/Feelings Y ✓ N ___ Suicidal Behavior Y ___ N ✓

Where there any aspects of your treatment that were particularly helpful to you? If so, please describe these. Be as specific as possible. Session 7 - overcame the pattern; insight; connecting the dots.

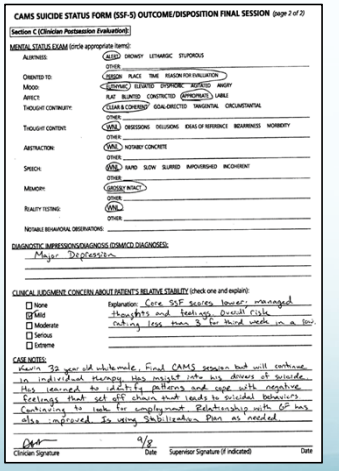
What have you learned from your clinical care that could help you if you became suicidal in the future? Call in a crisis; I got the puzzle

Third consecutive session of resolved suicidality: ✓ Yes ___ No (If no, continue CAMS interim care)
**Resolution of suicidality, if for third consecutive week: current overall risk of suicide < 3; in past week: no suicidal behavior and effectively managed suicidal thoughts/feelings

Section B (Clinician): End of session

CAMS OUTCOME/DISPOSITION (Check all that apply):
✓ Continuing outpatient psychotherapy ___ Inpatient hospitalization
___ Mutual termination ___ Patient chooses to discontinue treatment (unilaterally)
___ Referral to:
✓ Other Describe: ongoing w/ GF
Next Appointment Scheduled (if applicable): STNW

Kevin Patient Signature Date — Clinician Signature Date


CAMS SUICIDE STATUS FORM (SSF-5) OUTCOME/DISPOSITION FINAL SESSION (page 2 of 2)

Section C (Clinician Portsession Evaluation):

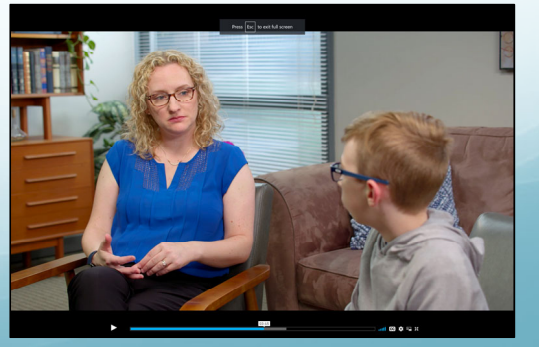
MENTAL STATUS EXAM (circle appropriate items):
ALERTNESS: (ALERT) DROWSY LETHARGIC STUPOROUS
ORIENTED TO: (PERSON) PLACE TIME REASON FOR EVALUATION
MOOD: (EUTHYMIC) ELEVATED DYSPHORIC AGITATED ANGRY
AFFECT: FLAT BLUNTED CONSTRICTED (APPROPRIATE) LABILE
THOUGHT CONTINUITY: (CLEAR & COHERENT) GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL
THOUGHT CONTENT: (WNL) OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY
ABSTRACTION: (WNL) NOTABLY CONCRETE
SPEECH: (WNL) RAPID SLOW SLURRED IMPOVERISHED INCOHERENT
MEMORY: (GROSSLY INTACT)
REALITY TESTING: (WNL)
NOTABLE BEHAVIORAL OBSERVATIONS:

DIAGNOSTIC IMPRESSIONS/DIAGNOSIS (DSM/ICD DIAGNOSES):
Major Depression

CLINICAL JUDGMENT CONCERN ABOUT PATIENT'S RELATIVE STABILITY (check one and explain):
☐ None ☑ Mild ☐ Moderate ☐ Serious ☐ Extreme
Explanation: Core SSF scores lower; managed thoughts and feelings. Overall risk rating less than 3 for third week in a row.

CASE NOTES:
Kevin 32 year old white male. Final CAMS session but will continue in individual therapy. Has insight into his drivers of suicide. Has learned to identify patterns and cope with negative feelings that set off chain that leads to suicidal behaviors. Continuing to look for employment. Relationship with GF has improved. To use Stabilization Plan as needed.

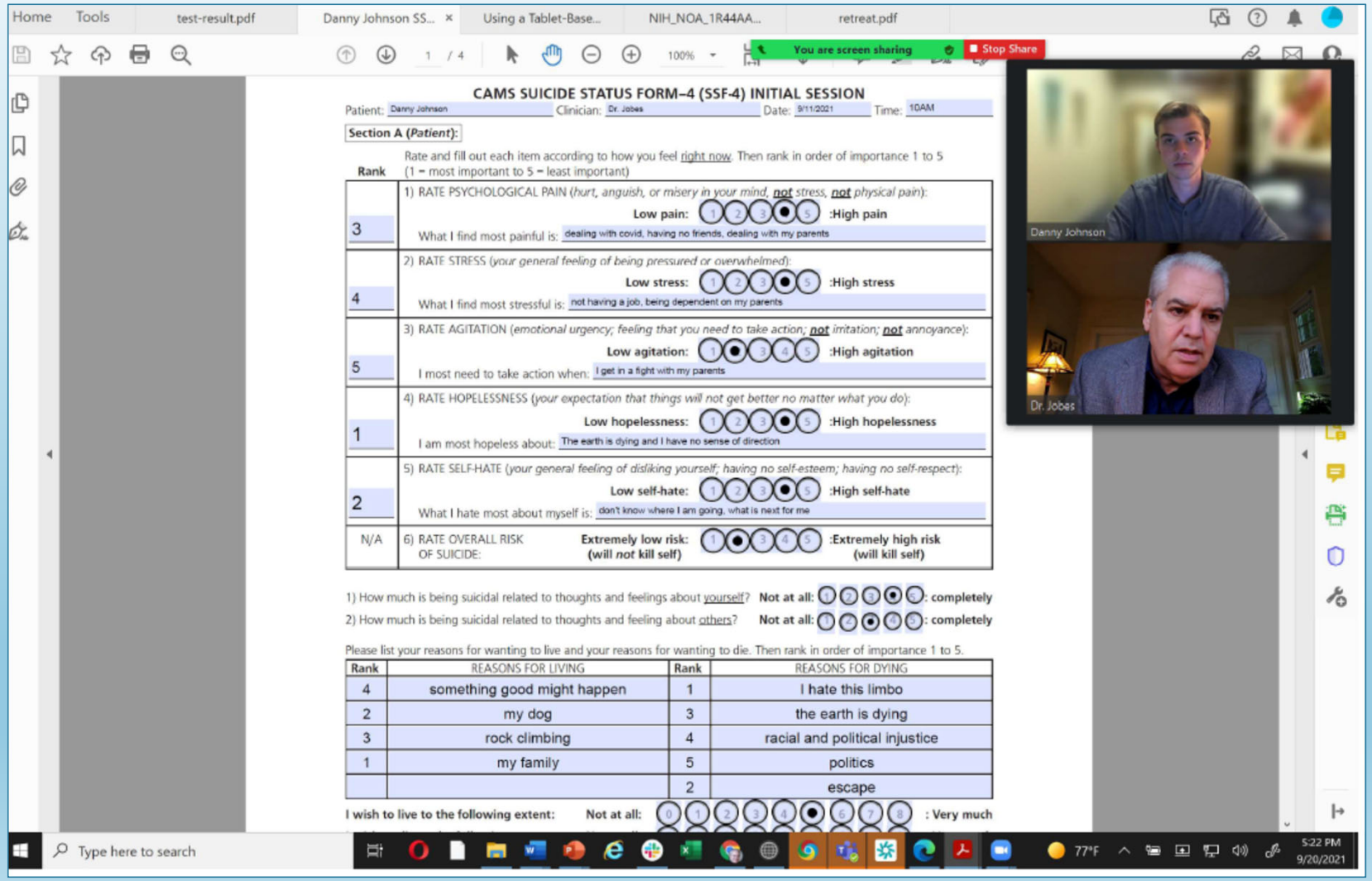
9/8 Clinician Signature Date — Supervisor Signature (if indicated) Date



CAMS Interim Sessions

CAMS Outcome/Disposition Final Session

Form-fillable PDF of the SSF for telehealth CAMS sessions



CAMS SUICIDE STATUS FORM–4 (SSF-4) INITIAL SESSION

Patient: Danny Johnson Clinician: Dr. Jobes Date: 9/11/2021 Time: 10AM

Section A (*Patient*):

Rate and fill out each item according to how you feel right now. Then rank in order of importance 1 to 5 (1 = most important to 5 = least important)

Rank	
3	1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*): Low pain: 1 2 3 ● 5 :High pain What I find most painful is: dealing with covid, having no friends, dealing with my parents
4	2) RATE STRESS (*your general feeling of being pressured or overwhelmed*): Low stress: 1 2 3 ● 5 :High stress What I find most stressful is: not having a job, being dependent on my parents
5	3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*): Low agitation: 1 ● 3 4 5 :High agitation I most need to take action when: I get in a fight with my parents
1	4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*): Low hopelessness: 1 2 3 ● 5 :High hopelessness I am most hopeless about: The earth is dying and I have no sense of direction
2	5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*): Low self-hate: 1 2 3 ● 5 :High self-hate What I hate most about myself is: don't know where I am going, what is next for me
N/A	6) RATE OVERALL RISK OF SUICIDE: Extremely low risk: (will *not* kill self) 1 ● 3 4 5 :Extremely high risk (will kill self)

1) How much is being suicidal related to thoughts and feelings about yourself? Not at all: 1 2 3 ● 5 : completely

2) How much is being suicidal related to thoughts and feeling about others? Not at all: 1 2 ● 4 5 : completely

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

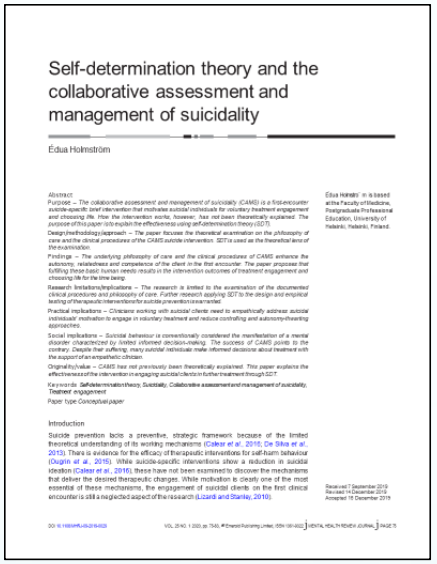
Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING
4	something good might happen	1	I hate this limbo
2	my dog	3	the earth is dying
3	rock climbing	4	racial and political injustice
1	my family	5	politics
		2	escape

I wish to live to the following extent: Not at all: 0 1 2 3 4 ● 6 7 8 : Very much

Guilford Press has authorized CAMS-care LLC to negotiate licenses with major electronic medical record companies to install the SSF on their default EMR platforms

Adherence to the CAMS Approach

CAMS is a therapeutic framework, that is used to manage suicidal thoughts and feelings and establish behavioral stability. Adherence requires thorough suicide-focused assessment and treatment of patient-identified suicidal “drivers.”


Self-determination theory and the collaborative assessment and management of suicidality

Édua Holmström


Personal View

Assessment of suicide risk in mental health practice: shifting from prediction to therapeutic assessment, formulation, and risk management

CAMS Philosophy

- Empathy for suicidal states—no shame, no blame
- Collaboration with the patient in all aspects of care
- Honesty and transparency throughout clinical care

CAMS as Therapeutic Framework

- Focus on Suicide—from the beginning, to the middle, and to the end
- Outpatient Oriented—goal of stability and using outpatient care
- Flexible and “Nondenominational”—across theories and techniques

The Collaborative Assessment and Management of Suicidality (CAMS) identifies and targets *Suicide Drivers* as the primary focus of assessment and intervention

ARCHIVES OF SUICIDE RESEARCH
https://doi.org/10.1080/13811118.2022.2151958

Routledge
Taylor & Francis Group

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The Content of Patient-Identified Suicidal Drivers within CAMS Treatment Planning

Thomas Lynch, Victoria Colborn Bathe, and David A. Jobes

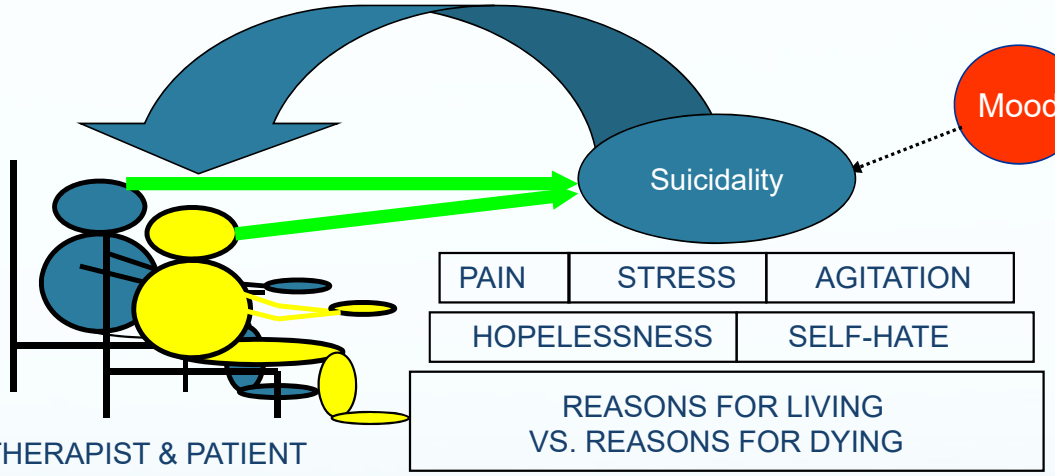
ABSTRACT

The Collaborative Assessment and Management of Suicidality (CAMS) is an evidence-based, suicide-focused, clinical framework that effectively treats people who are suicidal across clinical settings. A central tool within CAMS is the Suicide Status Form (SSF) which is a multi-purpose assessment, treatment planning, tracking, to clinical outcome tool that guides suicide-focused care from the start of CAMS treatment to completion. Previous SSF assessment research investigated the content of patient-written qualitative responses to SSF assessment prompts which were reliably coded into twelve content categories. Four coding categories captured 70% of written responses revealing the content of patients' suicidal ideation which centered on: relationships, vocation, the self, and unpleasant internal states. While qualitative SSF assessment research has thus revealed key information about suicidal ideation content, patient-identified "drivers" of suicide within CAMS treatment planning have not yet been examined qualitatively. "Drivers" of suicide are the issues that compel one to consider suicide, and ultimately become the focus of CAMS treatment; thus, it is important to examine their qualitative content. The present exploratory study investigated suicide driver content collected in the context of two randomized controlled trials of CAMS. Reliably coded qualitative content of patient-articulated drivers were comparable to previously noted SSF content assessment results, emphasizing the following driver issues: (1) Relationships, (2) Unpleasant Internal States (e.g., suffering and anxiety), (3) Role Responsibility (vocational concerns), and (4) the Self (e.g., self-hatred or esteem issues). These four coding themes captured 70% of 332 total treatment planning drivers obtained from 166 patients who were suicidal and seeking treatment. Implications of these findings are discussed.

KEYWORDS

CAMS; drivers; suicidal ideation; treatment planning

Central to effective assessment and treatment of suicide risk is the need to understand the suicidal mind. Jobes and Joiner (2019) have argued that despite an understandable preoccupation with suicide behaviors, we should consider the importance of suicidal ideation, in and of itself. Research has shown us that suicidal ideation is much more complex when we seek to understand the words of those who have suicidal thoughts. Jobes et al. (2004) studied the written responses of 119 college students and 33 U.S. Air Force Airmen who were suicidal analyzing patient-written responses to open-ended prompts on the Suicide Status Form (SSF) in a first session of the Collaborative Assessment and Management of Suicidality (CAMS—Jobes, 2016). CAMS is a suicide-focused clinical intervention with



Approximately 72% of n=166 from two CAMS RCTs (with inter-rater Kappa's = .78+) content of treatment planning drivers were reliably captured by four domains:

1. Relational concerns (25%)
2. Misery and distress (22%)
3. Vocational issues (12%)
4. Self-related issues (12%)

(Lynch et al., 2022)

CAMS assessment uses the Suicide Status Form (SSF) to deconstruct the "functional" utility of suicidality; CAMS as an intervention emphasizes a driver-focused intensive outpatient approach that is suicide-specific and "co-authored" with the patient…

Correlational and Open Clinical Trial Support for SSF/CAMS

Authors	Sample/Setting	n =	Significant Results
Jobes et al., 1997	College Students	106	Pre/Post SSF Core Assessment and symptom distress
Jobes et al., 2005	USAF Outpatients	56	Between-group suicidal ideation; ED/PC appts reductions
Arkov et al., 2008	Danish CMC Outpatients	27	Pre/Post SSF Core Assessment and qualitative findings
Jobes et al., 2009	College Students	55	Linear reductions in suicidal ideation and distress
Nielsen et al., 2011	Danish CMH Outpatients	42	Pre/Post SSF Core Assessment reductions
Ellis et al., 2012	Psychiatric Inpatients	20	Pre/Post SSF Core Assessment; reduced suicidal ideation, depression, hopelessness
Ellis et al., 2015	Psychiatric Inpatients	52	Reduced suicide ideation; changes in SI cognitions
Ellis et al., 2017	Inpatients (& post-discharge)	104	Impacts suicidal ideation, depression, hopelessness, functional impairment, well-being, psychological flexibility
Graure et al., 2021	Outpatients—CMH/SME	61	Pre/post SSF Core Assessment reductions
Adrian et al., 2021	Teenage outpatients	22	Pre/post suicidal ideation reductions; benchmark results

Randomized Controlled Trials Supporting CAMS

Authors	Sample/Setting	n =	Significant Experimental Results
Comtois et al., 2011	CMH Outpatients Harborview—Seattle, WA	32	Reduced Suicide Ideation and Symptom Distress, Increased Hope, Patients Preferred CAMS
Andreasson et al., 2016	CMH Outpatients Copenhagen Denmark	108	Mixed findings: CAMS was as effective as DBT for Self Harm and Suicide Attempts
Jobes et al., 2017	Soldier Outpatients Ft. Stewart, GA	148	Reduced Suicide Ideation in 6-8 sessions; Moderator findings: Resiliency, Symptom Distress, Decreased ED visits; Cost-Effective
Ryberg et al., 2019	Inpatients/Outpatients Oslo Norway	78	Reduced Suicide Ideation and Symptom Distress Moderator finding: CAMS improves poor working alliance
Pistorello et al., 2020	College Student Outpatients University of Nevada, Reno	62	Reductions in Suicide Ideation and Depression Moderator finding: Reductions in Hopelessness
Comtois et al., 2022	CMH Outpatients (SME)	150	Mixed findings: TAU worked better early, CAMS worked better later in terms of Suicidal Ideation and Symptom Distress; Clinicians were more satisfied with CAMS
Santel et al (2023)	Psychiatric Inpatients Bielefeld Germany	88	Decreased Suicide Ideation, Symptom Distress, and Suicide Attempts Post-D/C; Stronger Alliance

The effectiveness of the Collaborative Assessment and Management of Suicidality (CAMS) compared to alternative treatment conditions: A meta-analysis

Swift et al's (2021) meta-analysis of nine CAMS clinical trials: CAMS is a "well supported" intervention for suicidal ideation as per CDC criteria

Figure 2. Forest plot of effect sizes for suicidal ideation, general distress, suicide attempts, and self-harm.

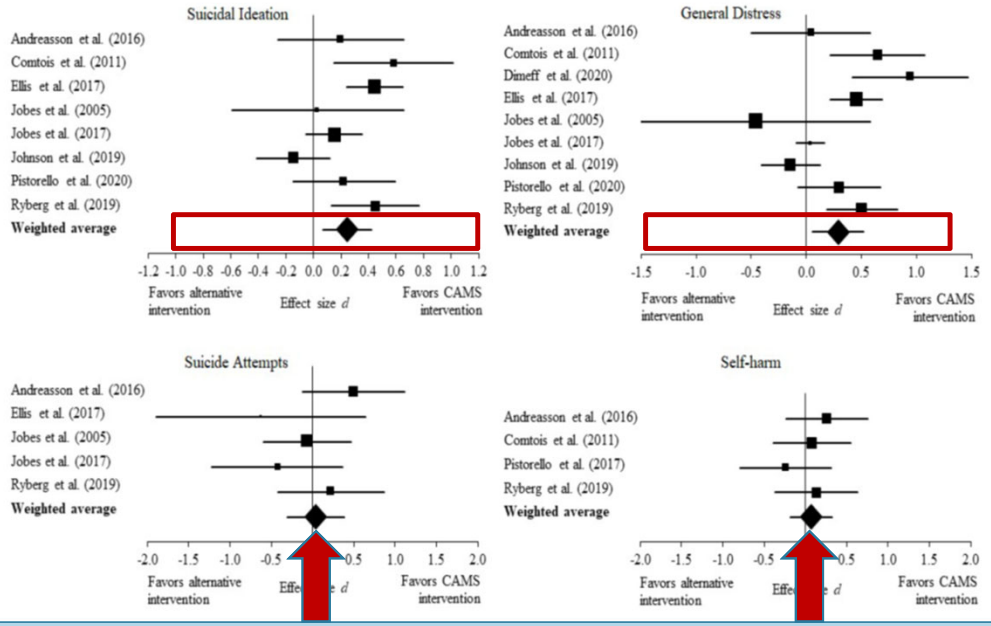
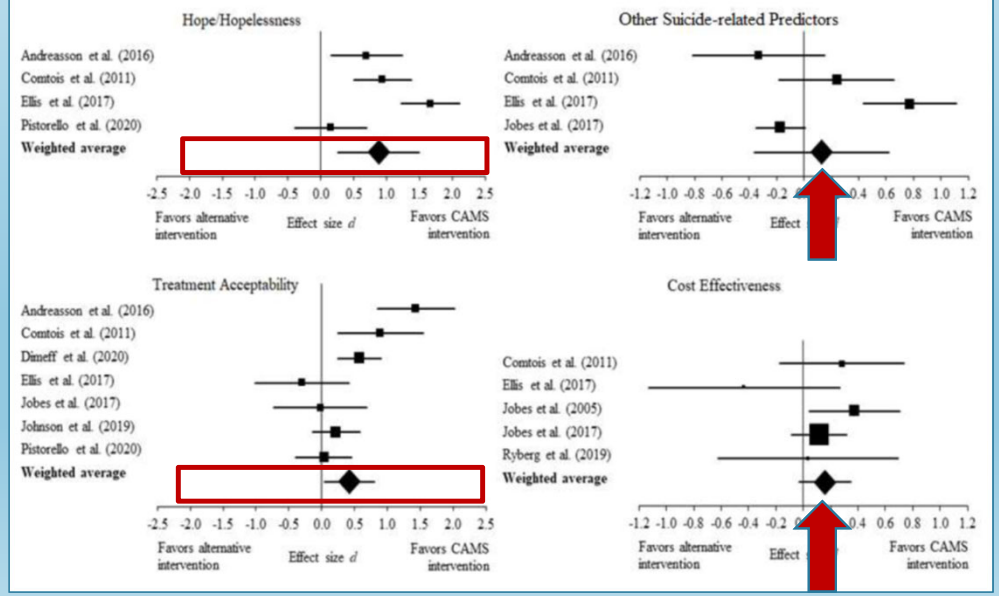


Figure 3. Forest plot of effect sizes for hope/hopelessness, other suicide-related predictors, treatment acceptability, and cost effectiveness.



Miriam Santel's inpatient CAMS RCT (n=88)

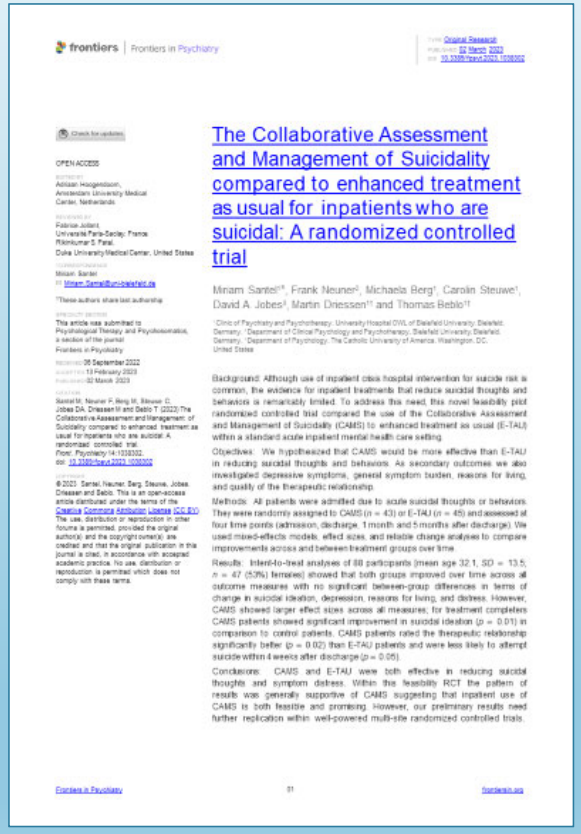
BMC Psychiatry

STUDY PROTOCOL Open Access

Collaborative Assessment and Management of Suicidality (CAMS) compared to enhanced treatment as usual (E-TAU) for suicidal patients in an inpatient setting: study protocol for a randomized controlled trial

Abstract

BMC



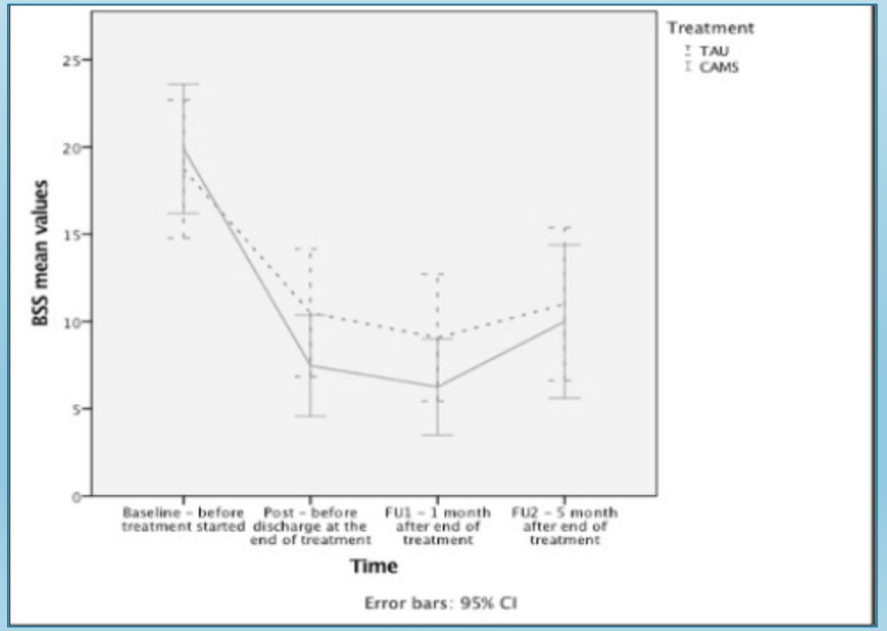
frontiers | Frontiers in Psychiatry

The Collaborative Assessment and Management of Suicidality compared to enhanced treatment as usual for inpatients who are suicidal: A randomized controlled trial

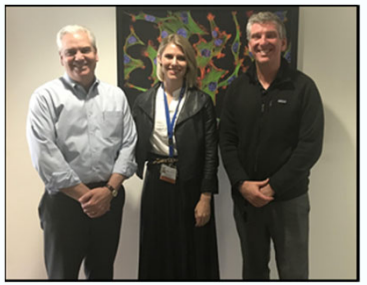
Miriam Santel[1]*, Frank Neuner[2], Michaela Berg[1], Carolin Steuwe[1], David A. Jobes[3], Martin Driessen[1†] and Thomas Beblo[1†]

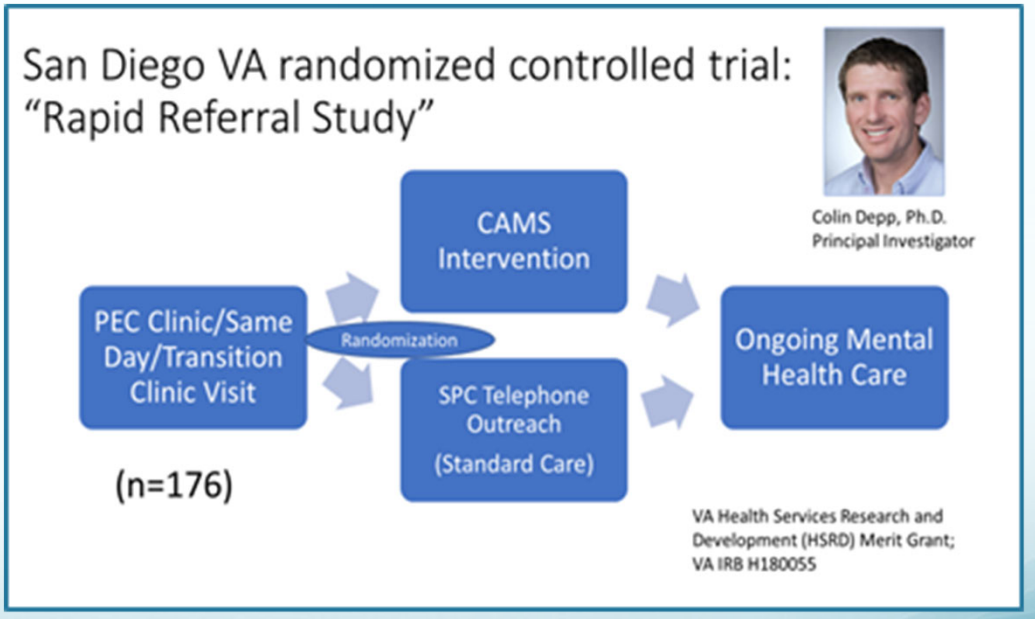
Bielefeld Germany

Significant CAMS results for suicidal ideation, better alliance, and decreased suicide attempts post-discharge (high risk period)



San Diego VAMC CAMS RCT—Depp et al (data collection ends in Spring 2024)

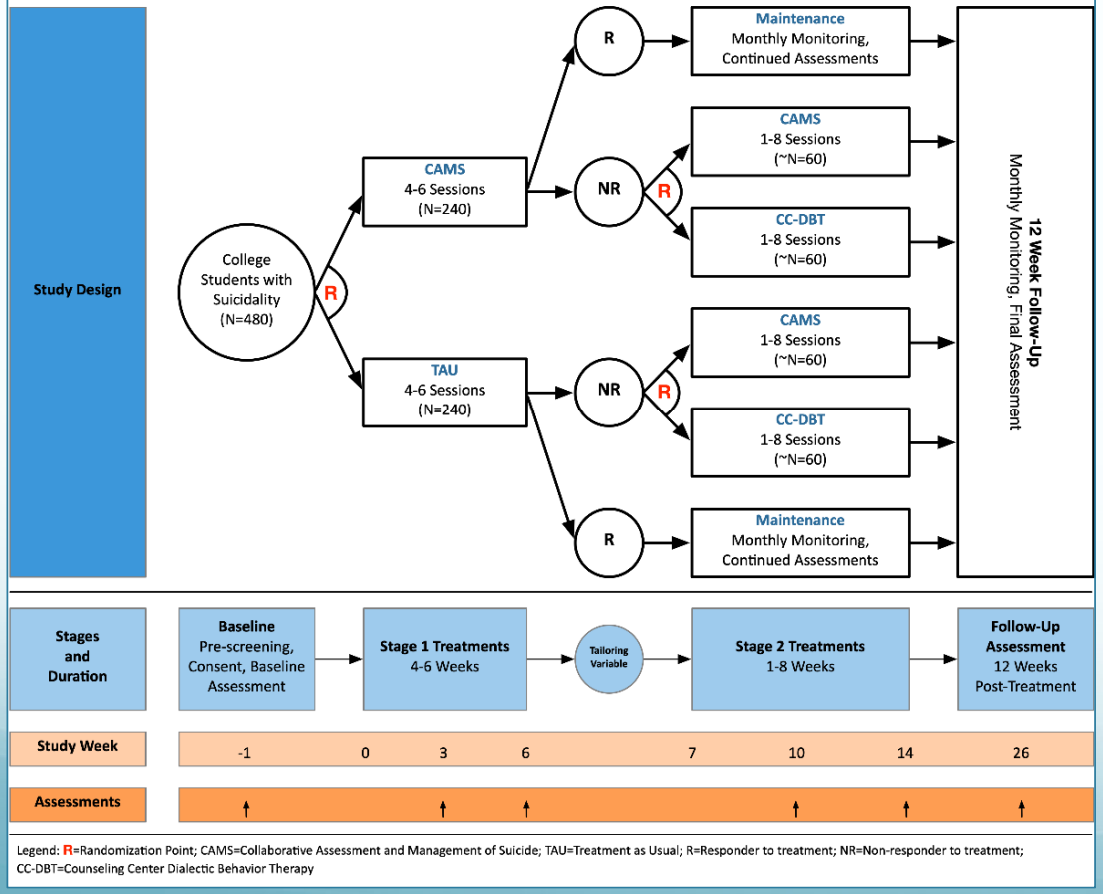




Now standing up a "Suicide Stabilization Clinic" at SD VAMC focused on suicide-specific care, training young clinical providers, and cost-effectiveness!

Comprehensive Adaptive Multisite Prevention of University student Suicide

Figure 1. CAMPUS Trial Study Design
(**C**omprehensive **A**daptive **M**ultisite **P**revention of **U**niversity student **S**uicide)



Legend: R=Randomization Point; CAMS=Collaborative Assessment and Management of Suicide; TAU=Treatment as Usual; R=Responder to treatment; NR=Non-responder to treatment; CC-DBT=Counseling Center Dialectic Behavior Therapy

The CAMPUS Study

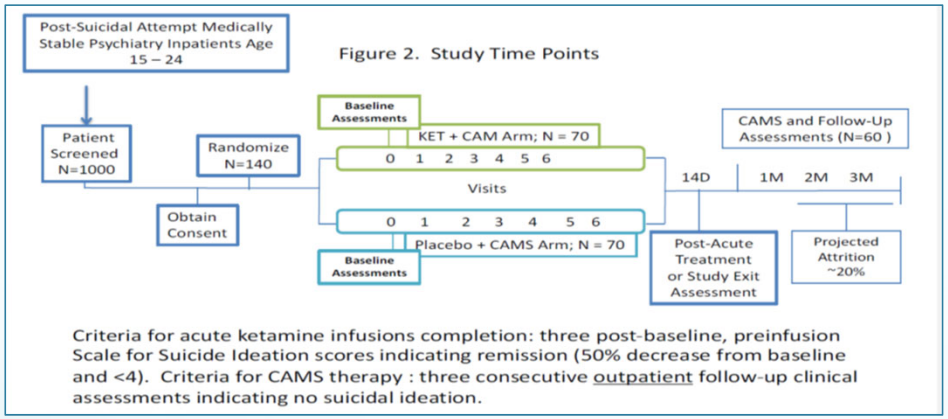
NIMH-funded ($11M) multisite SMART of n=480 college students who are suicidal at four university counseling centers (University of Oregon, University of Nevada-Reno, Duke University, and Rutgers University).

Authorized to do a feasibility trial for academic years 2020-2022 to study online training and online treatment.

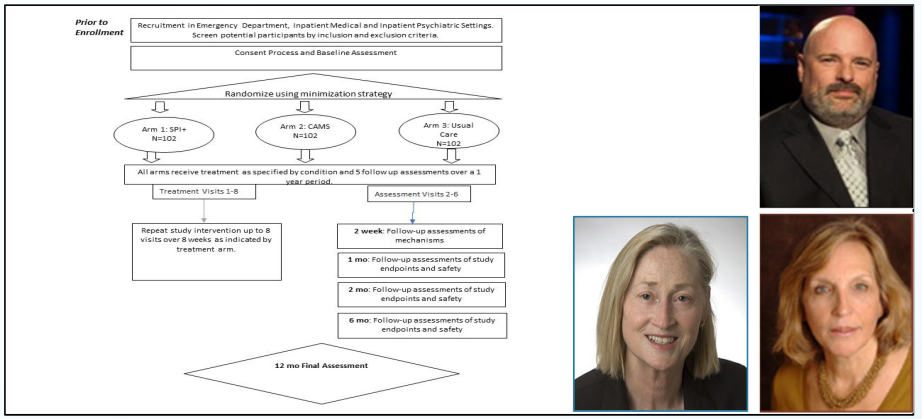
The actual trial (finally) began Fall 2022; one more year of data collection (2023-2024)

NIMH R01 Funded "CAMS-4Teens" RCT's

CAMS & Ketamine RCT
Cleveland Clinic & Mass General Hospital
(PI's: Anand & Falcone)

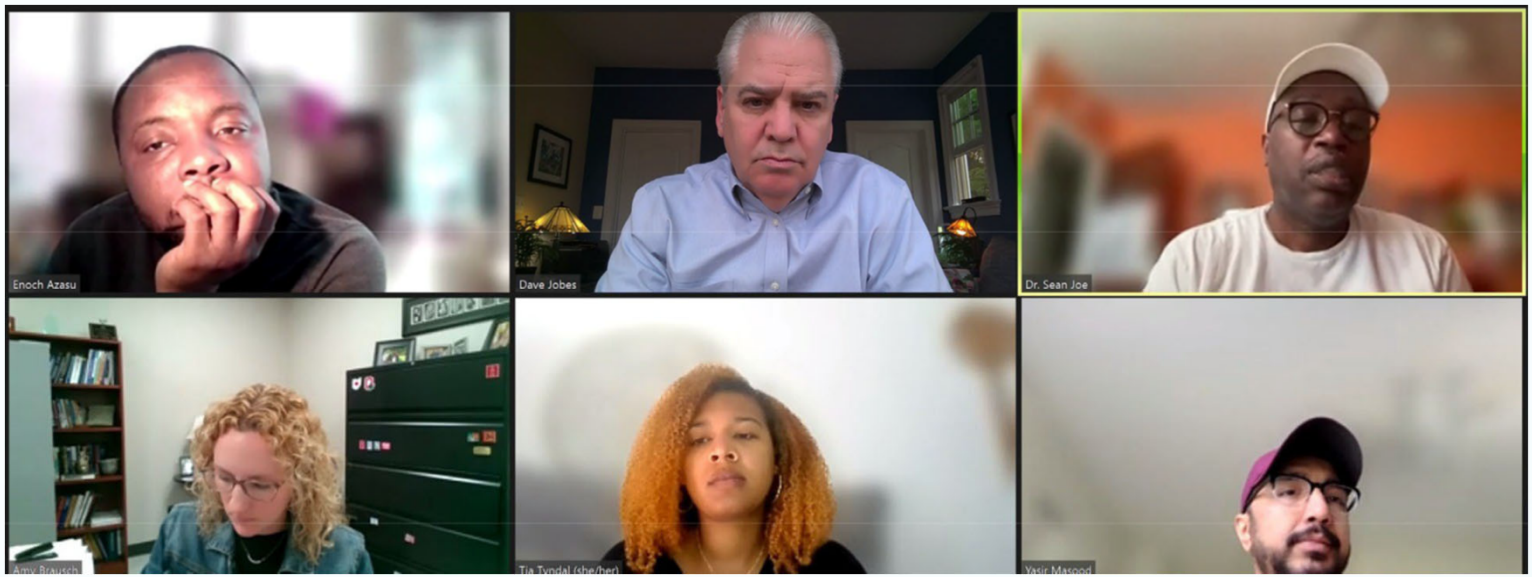


CAMS-4Teens vs. SPI+ vs. TAU
Seattle Children's & Nationwide
(PI's: Adrian & Bridge)



A new PCORI grant has been funded: ECT vs IV Ketamine plus CAMS post D/C

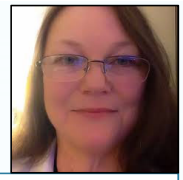
CAMS Feasibility Study of Teens who are Black/LBGTQ+



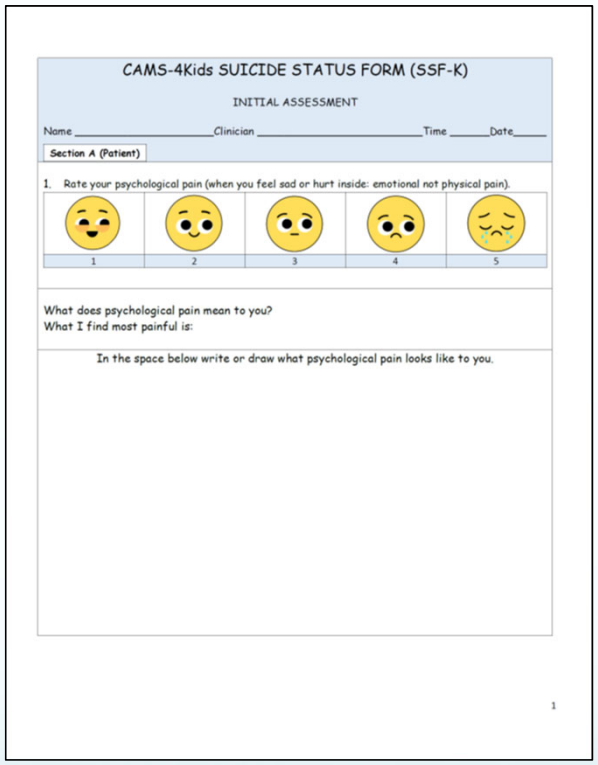
Tia Tyndal's doctoral dissertation with Dr. Sean Joe at the University of Washington in St Louis

Dr. Amy Brausch and new psychometric study of the SSF with teens who are black and suicidal…

Feasibility trial of “CAMS-4Kids” (n=10)



- We have been authorized to conduct a small feasibility trial with n=10 children ages 4-11 who are suicidal
- Major considerations about working optimally with parents
- Family-focus vs. child-focus when creating this new intervention



CAMS-4Kids SUICIDE STATUS FORM (SSF-K)

INITIAL ASSESSMENT

Name _____ Clinician _____ Time _____ Date_____

Section A (Patient)

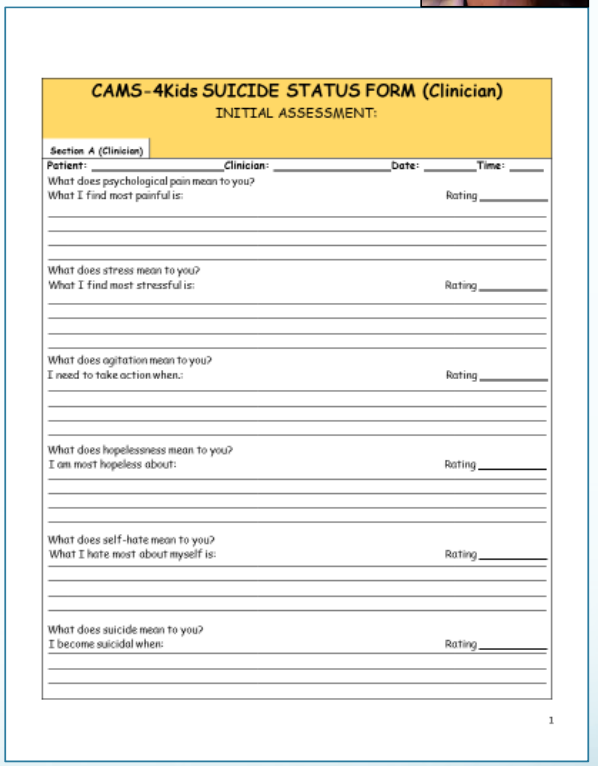
1. Rate your psychological pain (when you feel sad or hurt inside: emotional not physical pain).

1 2 3 4 5

What does psychological pain mean to you?
What I find most painful is:

In the space below write or draw what psychological pain looks like to you.

1



CAMS-4Kids SUICIDE STATUS FORM (Clinician)

INITIAL ASSESSMENT:

Section A (Clinician)

Patient: _____ Clinician: _____ Date: _____ Time: _____

What does psychological pain mean to you?
What I find most painful is: Rating _____

What does stress mean to you?
What I find most stressful is: Rating _____

What does agitation mean to you?
I need to take action when.: Rating _____

What does hopelessness mean to you?
I am most hopeless about: Rating _____

What does self-hate mean to you?
What I hate most about myself is: Rating _____

What does suicide mean to you?
I become suicidal when: Rating _____

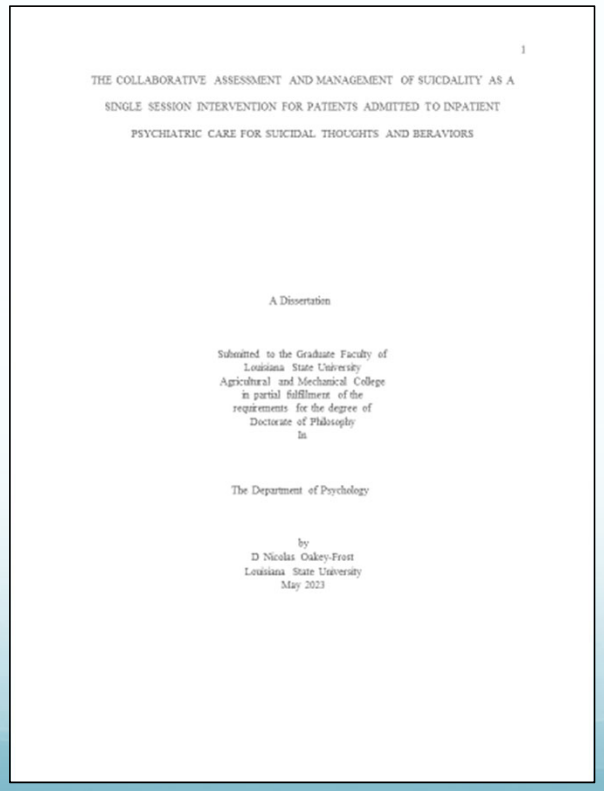
1

- Plan is to use highly adapted parallel version of the SSF
- Emphasis on initial informed consent with parents
- Provide a menu of dispositions for families to consider
- Pilot data will enable us to seek funding for larger RCT’s

CAMS-Brief Intervention (CAMS-BI)

D Nicolas Oakey-Frost

LSU Psychology Department Mitigation of Suicide Behavior Lab led by Dr. Ray Tucker has been using CAMS-BI with inpatients.



1

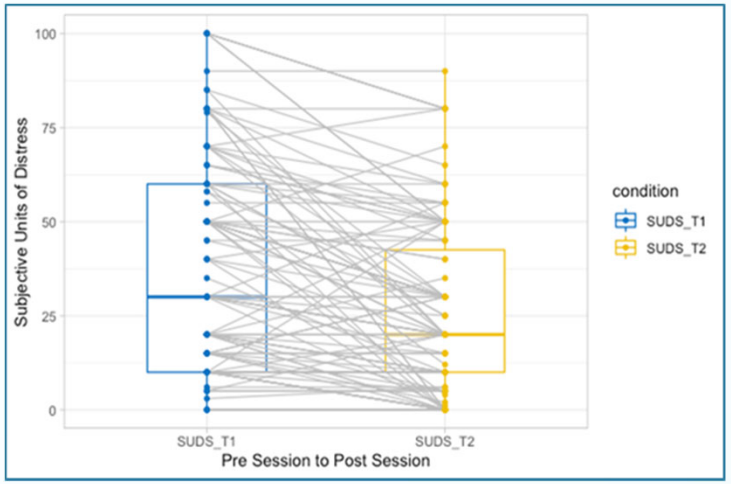
THE COLLABORATIVE ASSESSMENT AND MANAGEMENT OF SUICDALITY AS A SINGLE SESSION INTERVENTION FOR PATIENTS ADMITTED TO INPATIENT PSYCHIATRIC CARE FOR SUICIDAL THOUGHTS AND BERAVIORS

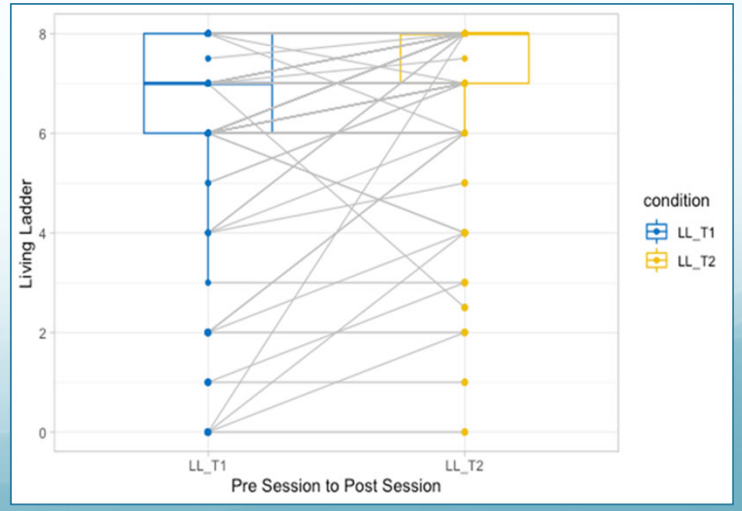
A Dissertation

Submitted to the Graduate Faculty of
Louisiana State University
Agricultural and Mechanical College
in partial fulfillment of the
requirements for the degree of
Doctorate of Philosophy
In

The Department of Psychology

by
D Nicolas Oakey-Frost
Louisiana State University
May 2023





The Cost-Effectiveness of CAMS

PLOS ONE

RESEARCH ARTICLE

Costs, benefits, and cost-benefit of Collaborative Assessment and Management of Suicidality versus enhanced treatment as usual

Phoebe K. McCutchan[1*], **Brian T. Yates**[1], **David A. Jobes**[2], **Amanda H. Kerbrat**[3], **Katherine Anne Comtois**[3]

1 Department of Psychology, American University, Washington, DC, United States of America, 2 Department of Psychology, The Catholic University of America, Washington, DC, United States of America, 3 Center for Suicide Prevention and Recovery, Department of Psychiatry and Behavioral Sciences, University of Washington, Seattle, WA, United States of America

* phoebe.mccutchan@gmail.com

Abstract

Suicide rates have been steadily increasing in both the U.S. general population and military, with significant psychological and economic consequences. The purpose of the current study was to examine the economic costs and cost-benefit of the suicide-focused Collaborative Assessment and Management of Suicidality (CAMS) intervention versus enhanced treatment as usual (ETAU) in an active duty military sample using data from a recent randomized controlled trial of CAMS versus ETAU. The full intent-to-treat sample included 148 participants (mean age 26.8 years ± 5.9 SD years, 80% male, 53% White). Using a micro-costing approach, the cost of each condition was calculated at the individual level from a healthcare system perspective. Benefits were estimated at the individual level as cost savings in past-year healthcare expenditures based on direct care reimbursement rates. Cost-benefit was examined in the form of cost-benefit ratios and net benefit. Total costs, benefits, cost-benefit ratios, and net benefit were calculated and analyzed using general linear mixed modeling on multiply imputed datasets. Results indicated that treatment costs did not differ significantly between conditions; however, CAMS was found to produce significantly greater benefit in the form of decreased healthcare expenditures at 6-month follow-up. CAMS also demonstrated significantly greater cost-benefit ratios (i.e., benefit per dollar spent on treatment) and net-benefit (i.e., total benefit less the cost of treatment) at 12-month follow-up. The current study suggests that beyond its clinical effectiveness, CAMS may also convey potential economic advantages over usual care for the treatment of suicidal active duty service members. Our findings demonstrate cost savings in the form of reduced healthcare expenditures, which theoretically represent resources that can be reallocated toward other healthcare system needs, and thus lend support toward the overall value of CAMS.

OPEN ACCESS

Citation: McCutchan PK, Yates BT, Jobes DA, Kerbrat AH, Comtois KA (2022) Costs, benefits, and cost-benefit of Collaborative Assessment and Management of Suicidality versus enhanced treatment as usual. PLoS ONE 17(2): e0262592. https://doi.org/10.1371/journal.pone.0262592

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Data Availability Statement: Public sharing of data used in this study is prohibited under the protocol approved by the U.S. Army Medical Research and Development Command Office of Research

COLLABORATIVE ASSESSMENT AND MANAGEMENT OF SUICIDALITY IN THE AFTERCARE FOCUS STUDY: COSTS, COST-EFFECTIVENESS, BENEFITS, AND COST-BENEFIT

By

Phoebe K. McCutchan

Submitted to the

Faculty of the College of Arts and Sciences

Of American University

In Partial Fulfillment of

The Requirements for the Degree of

Doctor of Philosophy

In

Clinical Psychology

Chair: _____
Brian T. Yates, Ph.D.

_____
Kathleen Gunthert, Ph.D.

_____
David A. Jobes, Ph.D., ABPP

_____
Dean of the College of Arts and Sciences

_____
Date

2023

American University

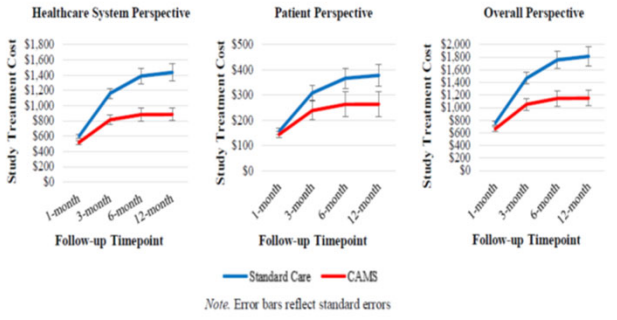
Washington, D.C. 20016

Two studies of CAMS cost-effectiveness compared to control care… (OWL & AFS)

Dr. Phoebe McCutchan

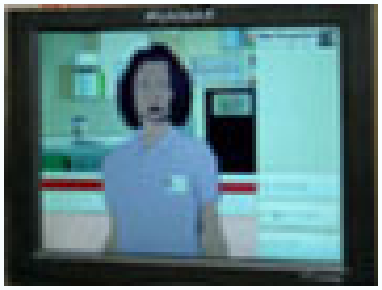
Figure 1

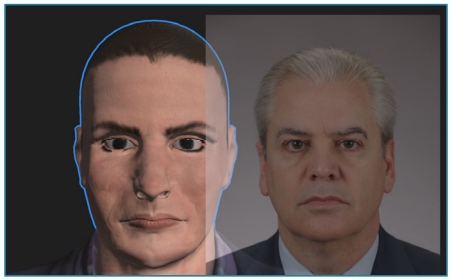
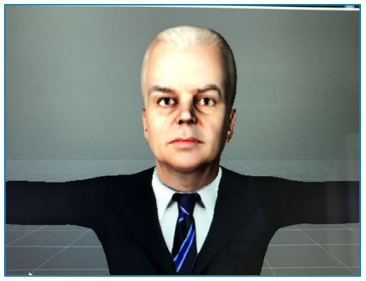
Mean Cumulative Study Treatment Costs Across Time



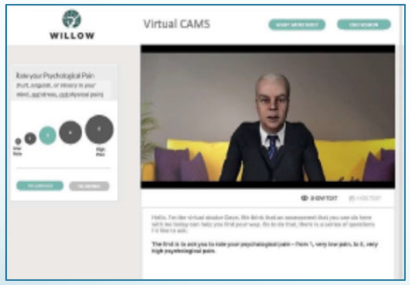
Note. Error bars reflect standard errors

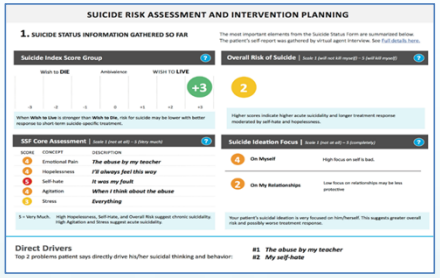

NIMH-funded SBIR projects and NIAAA-funded study: CAMS-RAS → "JASPR Health" for suicidal risk in EDs and primary care (Linda Dimeff, Kelly Koerner, & David Jobes)

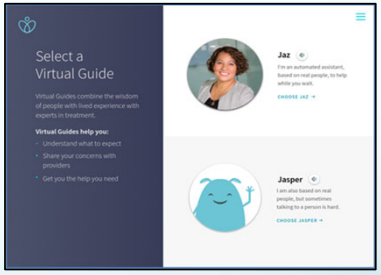


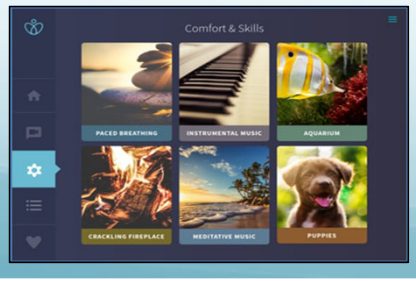



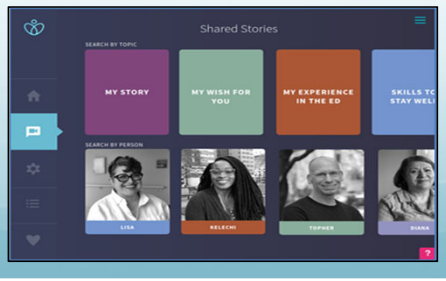

"Nurse Louise" "Dr. Dave?" (The initial relational agent prototypes were a bit scary!)

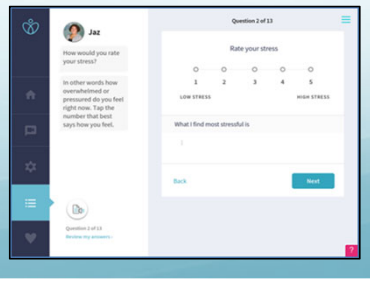








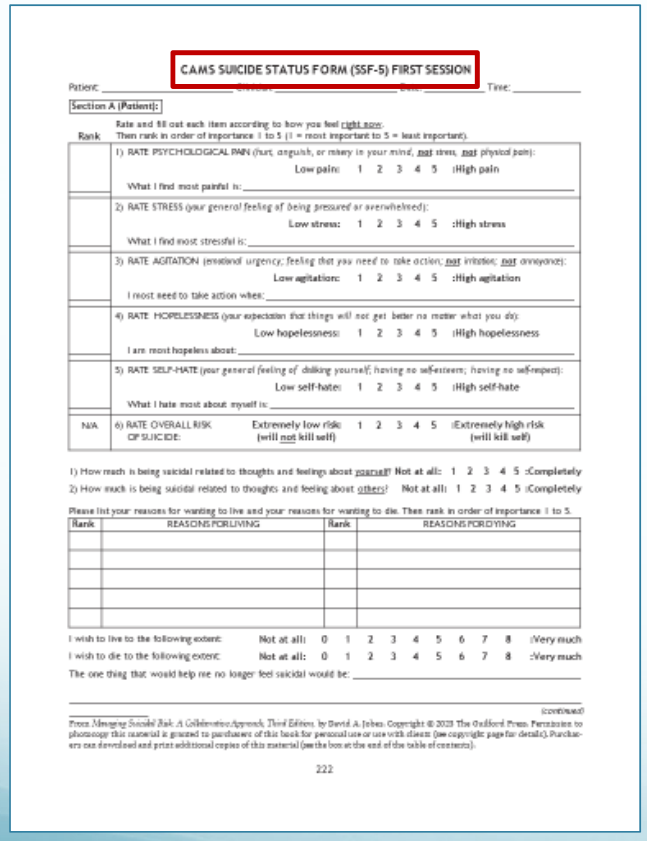




Managing Suicidal Risk: A Collaborative Approach (3rd edition)

- New case study of "Carmen"—an adolescent who attempted suicide in CAMS over 12 sessions of care
- Increased focus on youth and diversity, equity, and inclusion—adapting CAMS across cultures
- 65% new material in comparison to the 2nd edition
- Suicide Status Form-5 (SSF-5) and obtaining fillable PDF copies of all CAMS clinical documents
- Revision of the optional CAMS Therapeutic Worksheet (CTW)
- Stabilization Support Plan (featuring lethal means restriction—the CALM approach)
- Appendix of contemporary mental health care developments related to suicide prevention
- Appendix featuring CAMS-related empirical research—10 open trials, 7 RCTs, 2 meta-analyses
- Optional Living Status Form (LSF)
- CAMS Quick Check Preparation Guide (QCPG)
- CAMS Rating Scale (CRS) for coding adherence for clinical trials and supervision feedback
- New frequently asked questions (FAQs)

Suicide Status Form-5 (SSF-5)



CAMS SUICIDE STATUS FORM (SSF-5) FIRST SESSION

Patient: _____ Clinician: _____ Date: _____ Time: _____

Section A (Patient):

Rate and fill out each item according to how you feel right now.
Then rank in order of importance 1 to 5 (1 = most important to 5 = least important).

Rank	
	1) RATE PSYCHOLOGICAL PAIN (hurt, anguish, or misery in your mind; not stress, not physical pain): Low pain: 1 2 3 4 5 :High pain. What I find most painful is: _____
	2) RATE STRESS (your general feeling of being pressured or overwhelmed): Low stress: 1 2 3 4 5 :High stress. What I find most stressful is: _____
	3) RATE AGITATION (emotional urgency; feeling that you need to take action; not irritation; not annoyance): Low agitation: 1 2 3 4 5 :High agitation. I most need to take action when: _____
	4) RATE HOPELESSNESS (your expectation that things will not get better no matter what you do): Low hopelessness: 1 2 3 4 5 :High hopelessness. I am most hopeless about: _____
	5) RATE SELF-HATE (your general feeling of disliking yourself; having no self-esteem; having no self-respect): Low self-hate: 1 2 3 4 5 :High self-hate. What I hate most about myself is: _____
N/A	6) RATE OVERALL RISK OF SUICIDE: Extremely low risk (will not kill self) 1 2 3 4 5 :Extremely high risk (will kill self)

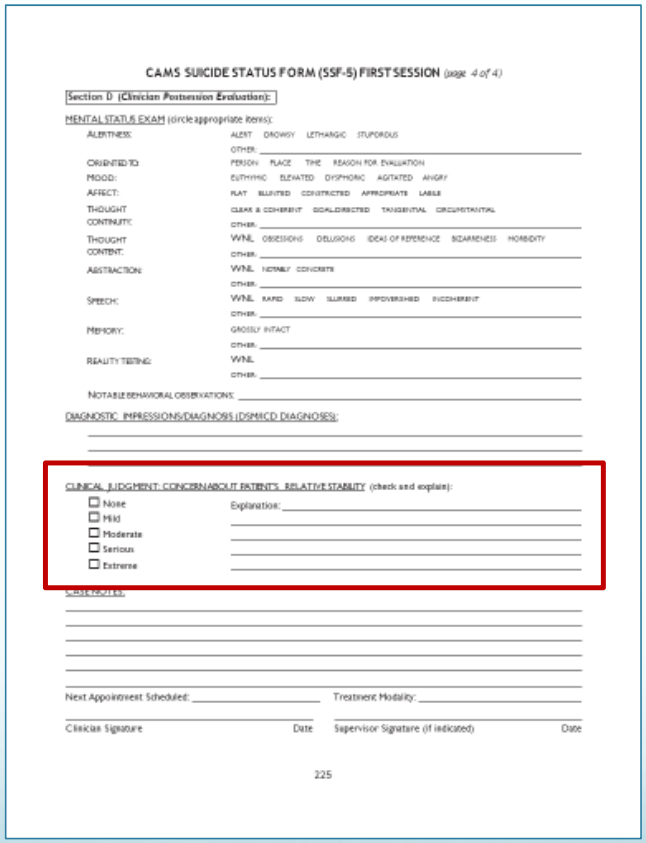
1) How much is being suicidal related to thoughts and feelings about yourself? Not at all: 1 2 3 4 5 :Completely
2) How much is being suicidal related to thoughts and feeling about others? Not at all: 1 2 3 4 5 :Completely

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING

I wish to live to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 :Very much
I wish to die to the following extent: Not at all: 0 1 2 3 4 5 6 7 8 :Very much
The one thing that would help me no longer feel suicidal would be: _____

(continued)



CAMS SUICIDE STATUS FORM (SSF-5) FIRST SESSION (page 4 of 4)

Section D (Clinician Postsession Evaluation):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS: ALERT DROWSY LETHARGIC STUPOROUS
OTHER: _____
ORIENTED TO: PERSON PLACE TIME REASON FOR EVALUATION
MOOD: EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY
AFFECT: FLAT BLUNTED CONSTRICTED APPROPRIATE LABILE
THOUGHT CONTINUITY: CLEAR & COHERENT GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL
OTHER: _____
THOUGHT CONTENT: WNL OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY
OTHER: _____
ABSTRACTION: WNL CONCRETE
OTHER: _____
SPEECH: WNL RAPID SLOW SLURRED IMPOVERISHED INCOHERENT
OTHER: _____
MEMORY: GROSSLY INTACT
OTHER: _____
REALITY TESTING: WNL
OTHER: _____

NOTABLE BEHAVIORAL OBSERVATIONS: _____

DIAGNOSTIC IMPRESSIONS/DIAGNOSIS (DSM/ICD DIAGNOSES):

_____
_____

CLINICAL JUDGMENT: CONCERN ABOUT PATIENT'S RELATIVE STABILITY (check and explain):

☐ None
☐ Mild
☐ Moderate
☐ Serious
☐ Extreme

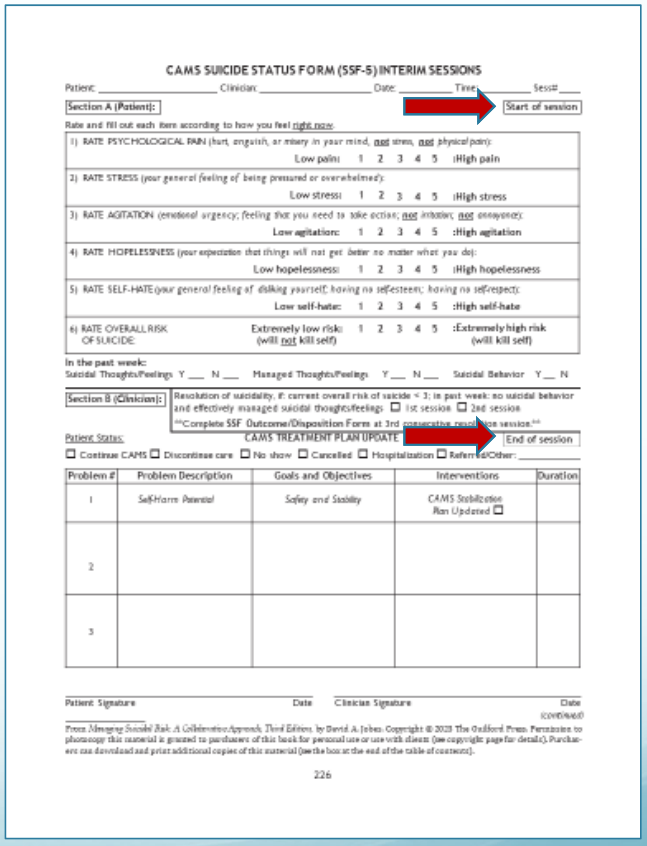
Explanation: _____

CASE NOTES:

_____
_____
_____
_____
_____
_____

Next Appointment Scheduled: _____ Treatment Modality: _____

Clinician Signature Date Supervisor Signature (if indicated) Date



CAMS SUICIDE STATUS FORM (SSF-5) INTERIM SESSIONS

Patient: _____ Clinician: _____ Date: _____ Time: _____ Sess# ___

Section A (Patient): Start of session

Rate and fill out each item according to how you feel right now.

1) RATE PSYCHOLOGICAL PAIN (hurt, anguish, or misery in your mind, not stress, not physical pain):	Low pain: 1 2 3 4 5 :High pain
2) RATE STRESS (your general feeling of being pressured or overwhelmed):	Low stress: 1 2 3 4 5 :High stress
3) RATE AGITATION (emotional urgency; feeling that you need to take action; not irritation; not annoyance):	Low agitation: 1 2 3 4 5 :High agitation
4) RATE HOPELESSNESS (your expectation that things will not get better no matter what you do):	Low hopelessness: 1 2 3 4 5 :High hopelessness
5) RATE SELF-HATE (your general feeling of disliking yourself; having no self-esteem; having no self-respect):	Low self-hate: 1 2 3 4 5 :High self-hate
6) RATE OVERALL RISK OF SUICIDE:	Extremely low risk (will not kill self) 1 2 3 4 5 :Extremely high risk (will kill self)

In the past week:
Suicidal Thoughts/Feelings Y ___ N ___ Managed Thoughts/Feelings Y ___ N ___ Suicidal Behavior Y ___ N

Section B (Clinician): Resolution of suicidality, if current overall risk of suicide < 3; in past week: no suicidal behavior and effectively managed suicidal thoughts/feelings ☐ 1st session ☐ 2nd session
Complete SSF Outcome/Disposition Form at 3rd consecutive session.

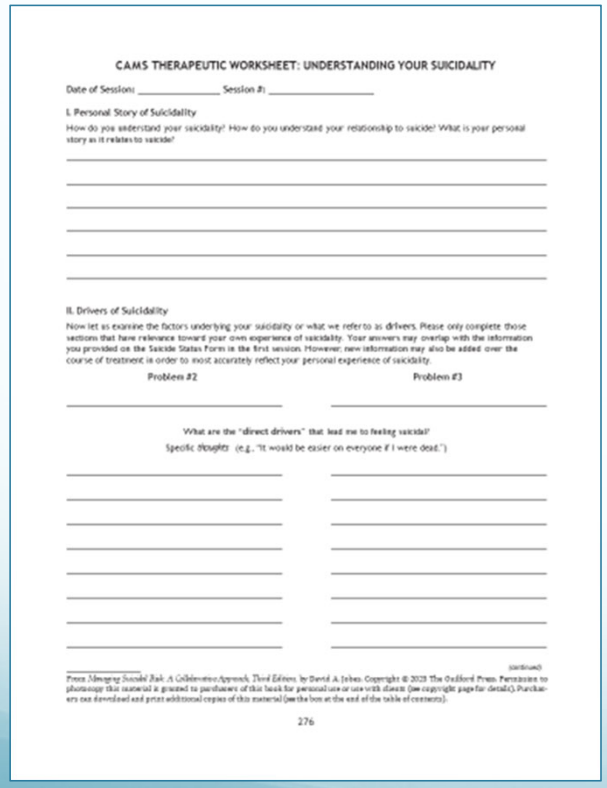
Patient Status: CAMS TREATMENT PLAN UPDATE: End of session
☐ Continue CAMS ☐ Discontinue care ☐ No show ☐ Cancelled ☐ Hospitalization ☐ Referred/Other: _____

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	Self-Harm Potential	Safety and Stability	CAMS Stabilization Plan Updated ☐	
2				
3				

Patient Signature Date Clinician Signature Date

(CONTINUED)

CAMS Therapeutic Worksheet (CTW)



CAMS THERAPEUTIC WORKSHEET: UNDERSTANDING YOUR SUICIDALITY

Date of Session: _____ Session #: _____

I. Personal Story of Suicidality

How do you understand your suicidality? How do you understand your relationship to suicide? What is your personal story as it relates to suicide?

II. Drivers of Suicidality

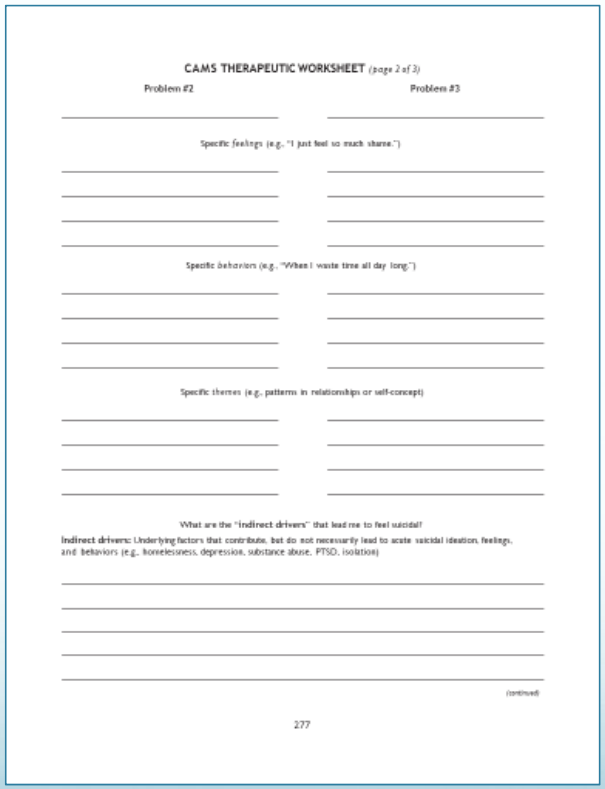
Now let us examine the factors underlying your suicidality or what we refer to as drivers. Please only complete those sections that have relevance toward your own experience of suicidality. Your answers may overlap with the information you provided on the Suicide Status Form in the first session. However, new information may also be added over the course of treatment in order to most accurately reflect your personal experience of suicidality.

Problem #2 Problem #3

What are the "direct drivers" that lead me to feeling suicidal?

Specific thoughts (e.g., "It would be easier on everyone if I were dead.")

(continued)



Problem #2 Problem #3

Specific feelings (e.g., "I just feel so much shame.")

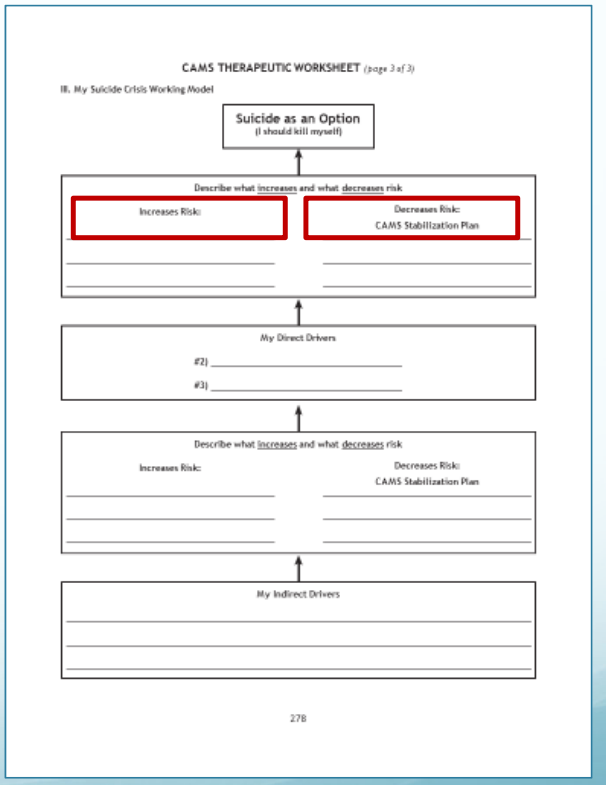
Specific behaviors (e.g., "When I waste time all day long.")

Specific themes (e.g., patterns in relationships or self-concept)

What are the "indirect drivers" that lead me to feel suicidal?

Indirect drivers: Underlying factors that contribute, but do not necessarily lead to acute suicidal ideation, feelings, and behaviors (e.g., homelessness, depression, substance abuse, PTSD, isolation)

(continued)



III. My Suicide Crisis Working Model

Suicide as an Option
(I should kill myself)

Describe what increases and what decreases risk

Increases Risk: Decreases Risk: CAMS Stabilization Plan

My Direct Drivers

#2) _____

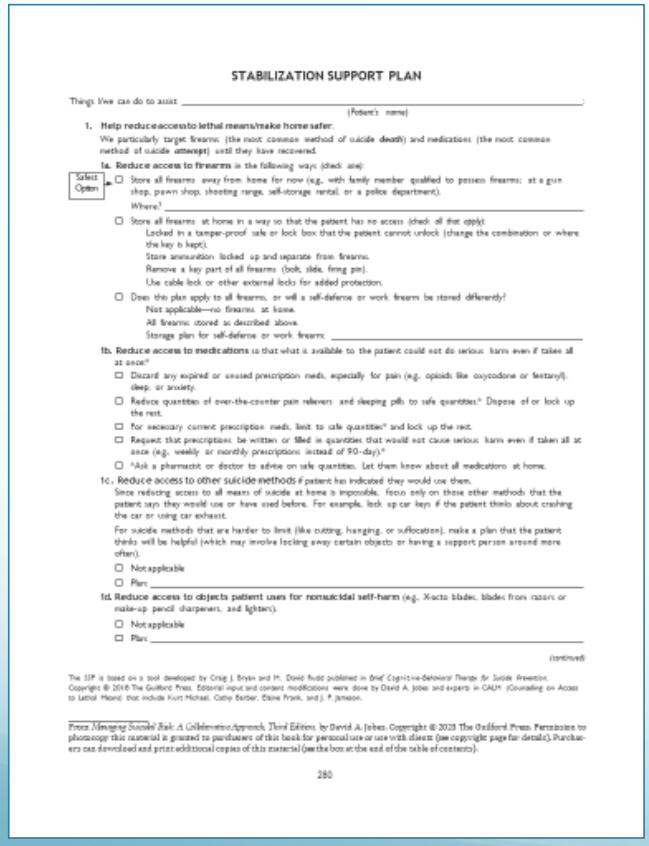
#3) _____

Describe what increases and what decreases risk

Increases Risk: Decreases Risk: CAMS Stabilization Plan

My Indirect Drivers

Stabilization Support Plan (SSP)
CAMS Living Status Form (CLSF)



STABILIZATION SUPPORT PLAN

Things I/we can do to assist _____:
(Patient's name)

1. **Help reduce access to lethal means/make home safer:**
We particularly target firearms (the most common method of suicide **death**) and medications (the most common method of suicide **attempt**) until they have recovered.

1a. Reduce access to firearms in the following ways (check one):

Select Option ▸
- ☐ Store all firearms away from home for now (e.g., with family member qualified to possess firearms; at a gun shop, pawn shop, shooting range, self-storage rental, or a police department).
  Where? _____
- ☐ Store all firearms at home in a way so that the patient has no access (check all that apply):
  Locked in a tamper-proof safe or lock box that the patient cannot unlock (change the combination or where the key is kept).
  Store ammunition locked up and separate from firearms.
  Remove a key part of all firearms (bolt, slide, firing pin).
  Use cable lock or other external locks for added protection.
- ☐ Does this plan apply to all firearms, or will a self-defense or work firearm be stored differently?
  Not applicable—no firearms at home.
  All firearms stored as described above.
  Storage plan for self-defense or work firearms: _____

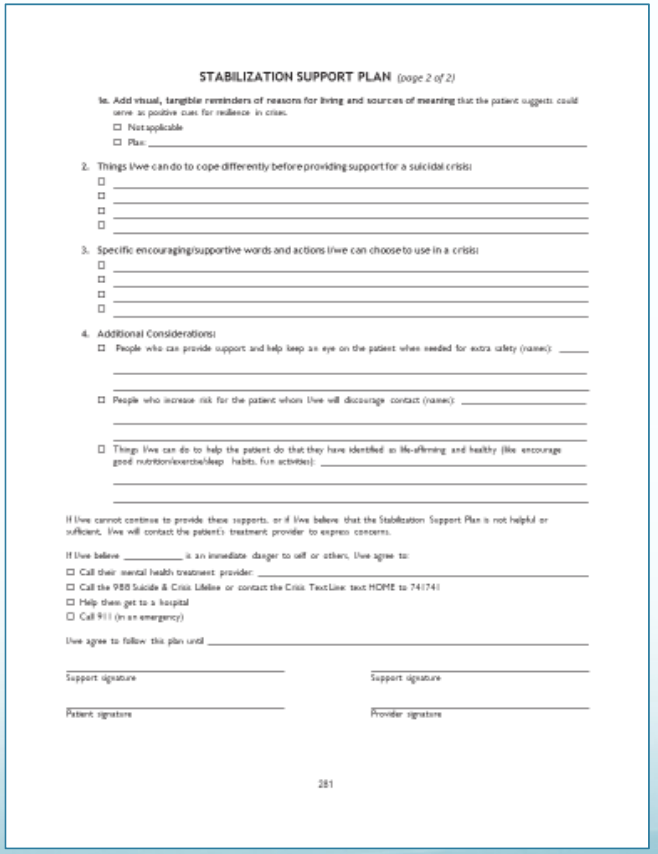
1b. Reduce access to medications so that what is available to the patient could not do serious harm even if taken all at once:*
- ☐ Discard any expired or unused prescription meds, especially for pain (e.g., opioids like oxycodone or fentanyl), sleep, or anxiety.
- ☐ Reduce quantities of over-the-counter pain relievers and sleeping pills to safe quantities.* Dispose of or lock up the rest.
- ☐ For necessary current prescription meds, limit to safe quantities* and lock up the rest.
- ☐ Request that prescriptions be written or filled in quantities that would not cause serious harm even if taken all at once (e.g., weekly or monthly prescriptions instead of 90-day).*
- ☐ *Ask a pharmacist or doctor to advise on safe quantities. Let them know about all medications at home.

1c. Reduce access to other suicide methods if patient has indicated they would use them.
Since reducing access to all means of suicide at home is impossible, focus only on those other methods that the patient says they would use or have used before. For example, lock up car keys if the patient thinks about crashing the car or using car exhaust.
For suicide methods that are harder to limit (like cutting, hanging, or suffocation), make a plan that the patient thinks will be helpful (which may involve locking away certain objects or having a support person around more often).
- ☐ Not applicable
- ☐ Plan: _____

1d. Reduce access to objects patient uses for nonsuicidal self-harm (e.g., X-acto blades, blades from razors or make-up pencil sharpeners, and lighters).
- ☐ Not applicable
- ☐ Plan: _____

(continued)

The SSP is based on a tool developed by Craig J. Bryan and M. David Rudd published in *Brief Cognitive-Behavioral Therapy for Suicide Prevention*. Copyright © 2018 The Guilford Press. Editorial input and content modifications were done by David A. Jobes and experts in CAMS (Counseling on Access to Lethal Means) that include Kurt Michael, Cathy Barber, Elaine Frank, and J. F. Jameson.



STABILIZATION SUPPORT PLAN *(page 2 of 2)*

1e. Add visual, tangible reminders of reasons for living and sources of meaning that the patient suggests could serve as positive cues for resilience in crisis.
- ☐ Not applicable
- ☐ Plan: _____

2. Things I/we can do to cope differently before providing support for a suicidal crisis:
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

3. Specific encouraging/supportive words and actions I/we can choose to use in a crisis:
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____
- ☐ _____

4. Additional Considerations:
- ☐ People who can provide support and help keep an eye on the patient when needed for extra safety (names): _____
- ☐ People who increase risk for the patient whom I/we will discourage contact (names): _____
- ☐ Things I/we can do to help the patient do that they have identified as life-affirming and healthy (like encourage good nutrition/exercise/sleep habits, fun activities): _____

If I/we cannot continue to provide these supports, or if I/we believe that the Stabilization Support Plan is not helpful or sufficient, I/we will contact the patient's treatment provider to express concerns.

If I/we believe _____ is an immediate danger to self or others, I/we agree to:
- ☐ Call their mental health treatment provider: _____
- ☐ Call the 988 Suicide & Crisis Lifeline or contact the Crisis Text Line: text HOME to 741741
- ☐ Help them get to a hospital
- ☐ Call 911 (in an emergency)

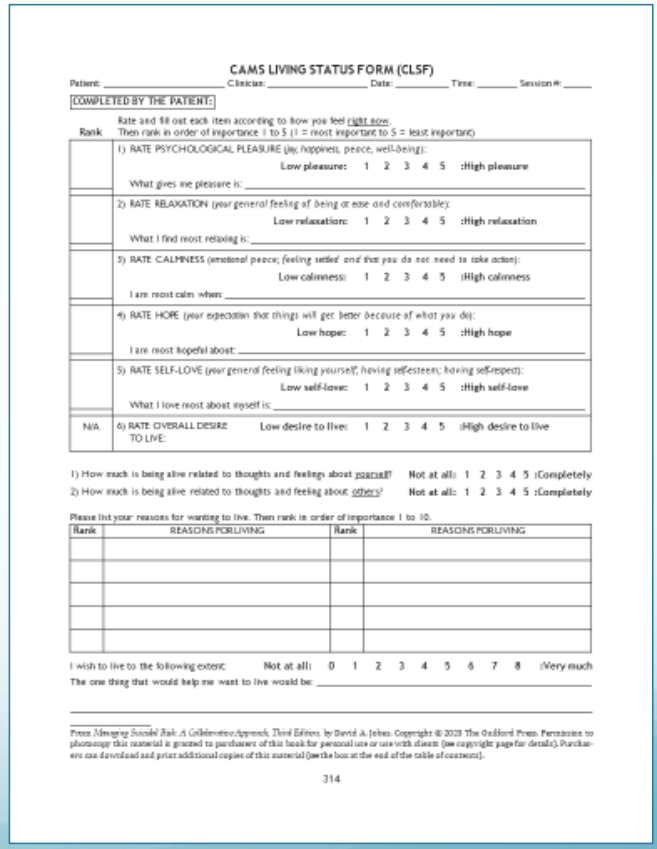
I/we agree to follow this plan until _____

_____ Support signature

_____ Support signature

_____ Patient signature

_____ Provider signature



CAMS LIVING STATUS FORM (CLSF)

Patient: _____ Clinician: _____ Date: _____ Time: _____ Session #: _____

COMPLETED BY THE PATIENT:

Rank — Rate and fill out each item according to how you feel *right now*.
Then rank in order of importance 1 to 5 (1 = most important to 5 = least important)

Rank	
	1) RATE PSYCHOLOGICAL PLEASURE (*joy, happiness, peace, well-being*): **Low pleasure:** 1 2 3 4 5 :**High pleasure** What gives me pleasure is: _____
	2) RATE RELAXATION (*your general feeling of being at ease and comfortable*): **Low relaxation:** 1 2 3 4 5 :**High relaxation** What I find most relaxing is: _____
	3) RATE CALMNESS (*emotional peace; feeling settled and that you do not need to take action*): **Low calmness:** 1 2 3 4 5 :**High calmness** I am most calm when: _____
	4) RATE HOPE (*your expectation that things will get better because of what you do*): **Low hope:** 1 2 3 4 5 :**High hope** I am most hopeful about: _____
	5) RATE SELF-LOVE (*your general feeling liking yourself; having self-esteem; having self-respect*): **Low self-love:** 1 2 3 4 5 :**High self-love** What I love most about myself is: _____
N/A	6) RATE OVERALL DESIRE TO LIVE: **Low desire to live:** 1 2 3 4 5 :**High desire to live**

1) How much is being alive related to thoughts and feelings about *yourself*? **Not at all:** 1 2 3 4 5 :**Completely**
2) How much is being alive related to thoughts and feeling about *others*? **Not at all:** 1 2 3 4 5 :**Completely**

Please list your reasons for wanting to live. Then rank in order of importance 1 to 10.

Rank	REASONS FOR LIVING	Rank	REASONS FOR LIVING

I wish to live to the following extent: **Not at all:** 0 1 2 3 4 5 6 7 8 :**Very much**
The one thing that would help me want to live would be: _____

_____

CAMS Quick Check Preparation Guide

CAMS SUICIDE STATUS FORM (SSF-5) FIRST SESSION

ASSESSMENT (APPROXIMATELY 30 MINUTES)

- ☐ Broach topic of suicide early in the session (within first 5 minutes).
- ☐ Introduce the "CAMS Suicide Status Form (SSF-5) First Session" document, and request permission to sit next to patient.
- ☐ With permission granted, take a seat next to the patient and have them complete Section A with your help (20 minutes).
- ☐ Take SSF back and complete Section B, which is done by the clinician with the patient's help, and do not get bogged down (10 minutes).

TREATMENT PLANNING (APPROXIMATELY 20 MINUTES)

- ☐ Introduce treatment planning and complete SSF-5 Section C, which is done by the clinician with the patient's help.
- ☐ Address Problem #1 by developing the CAMS Stabilization Plan with the patient—this is a top priority to complete prior to ending the session.
- ☐ Then identify the patient's two suicide-causing problems as Problem #2 and #3 (i.e., their direct drivers) respectively and write in goals/objectives, interventions, and anticipated duration (most respond in 6–8 weekly sessions; 12 sessions would be a fuller dose of CAMS-guided care).
- ☐ When discussing Problems #2 and #3, be sure to introduce the notion of suicidal "drivers."
- ☐ Patient and clinician both sign form; make copies of SSF pages 1–3 (Sections A–C; including the CAMS Stabilization Plan) and give these documents to the patient before they leave (alternatively the patient may take pictures of these documents on their smartphone before departing).

FURTHER DOCUMENTATION (APPROXIMATELY 5 MINUTES)

- ☐ Clinician then completes SSF Section D after session; the entire SSF Initial Session (including the SSF Stabilization Plan if used) is then scanned electronic medical records (Sections A–D).

CAMS SUICIDE STATUS FORM (SSF-5) INTERIM SESSIONS

ASSESSMENT (APPROXIMATELY 1-5 MINUTES)

- ☐ At the start of each interim session, have the patient complete "Section A" (the SSF Core Assessment) on the SSF-5 interim sessions tool.
- ☐ Review the Section A assessment ratings and get a sense of how the patient has been doing since the last meeting.
- ☐ Ask specifically about any suicide-related thoughts/feelings/behaviors in the past week and note responses on the form.

WITHIN-SESSION FOCUS (APPROXIMATELY 35-40 MINUTES)

- ☐ Check in about the CAMS Stabilization Plan—where is it, and are they using it? Did it work? Does it need to be modified? If needed be sure to modify as indicated.
- ☐ Focus on CAMS Treatment Plan Problems #2 and #3; be sure to work on the notion of suicidal "drivers."

Indirect Drivers → Direct Drivers → Suicidal Behaviors

- ☐ Consider optional use of "CAMS Therapeutic Worksheet" as of Session 2 to help clarify direct and indirect drivers of suicide (tool can be used later or revisited if desired).
- ☐ Otherwise, always focus CAMS interim sessions on treating and modifying the patient's direct drivers (focusing primarily on direct drivers but attending to indirect drivers, too).

TREATMENT PLANNING (AT LEAST 10 MINUTES)

- ☐ End all interim session by collaboratively completing Section B of the Interim Sessions form.
- ☐ Completely revisit the patient's problem/drivers and modify goals and objectives, interventions, or duration as indicated with patient's input.
- ☐ Patient and clinician sign form; make a copy for the patient (or have them take a picture).

FURTHER DOCUMENTATION (APPROXIMATELY 5 MINUTES)

- ☐ Clinician completes Section C of the Interim Session SSF after the session and the entire SSF document is scanned into electronic record (Sections A–C) following each interim session of CAMS.

CAMS SUICIDE STATUS FORM (SSF-5) OUTCOME/DISPOSITION FINAL SESSION

ASSESSMENT (APPROXIMATELY 10 MINUTES)

- ☐ If patient meets criteria for "resolution" (defined as three consecutive sessions where current overall risk of suicide < 3, the patient reports no suicidal behavior, and the patient has been effectively managed suicidal thoughts/feelings), the patient completes "Outcome/Disposition Final Session" form Section A.
- ☐ At the bottom of Section A, the clinician confirms resolution criteria have indeed been met. *If criteria are not met, conduct session as a CAMS interim session (and monitor for resolution criteria to be reached at some future point).*

WITHIN-SESSION FOCUS (APPROXIMATELY 30 MINUTES)

- ☐ Review what has been helpful.
- ☐ Review what the patient will do should they become suicidal in the future.
- ☐ Endeavor to discuss what will make their life worth living; explore their plans, goals, and hope for the future.
- ☐ Consider optional use of the Living Status Form (for particularly enthusiastic responders to CAMS-guided care).

CAMS OUTCOME/DISPOSITION (APPROXIMATELY 10 MINUTES)

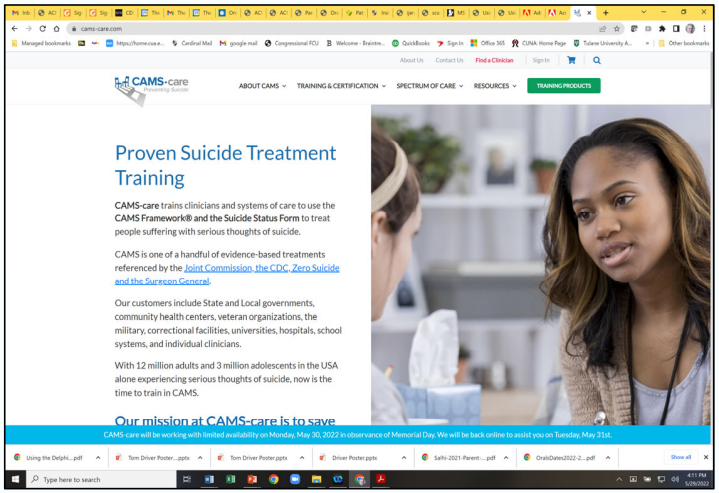
- ☐ End session by collaboratively completing Section B of the CAMS Outcome/Disposition Final Session form.
- ☐ Discuss outcome and disposition, and any further follow-up care.
- ☐ Patient/clinician sign form; make a copy for the patient (or have patient make a picture copy).

FURTHER DOCUMENTATION (APPROXIMATELY 5 MINUTES)

- ☐ Clinician completes Outcome/Disposition Final Session form, Section C, after the session; then scan entire document into electronic records (Sections A–C).

How do we get clinicians to use a proven treatment?

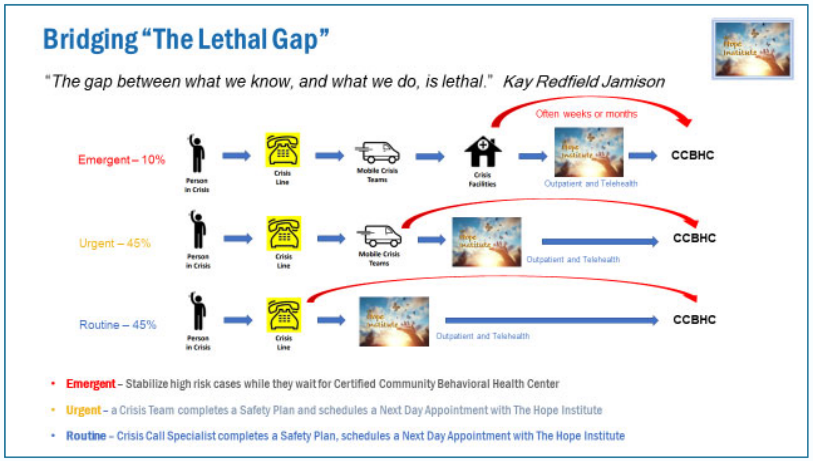
Dissemination and implementation research shows that integrated training is best for changing clinician behaviors to use a new treatment with adherence




THE CATHOLIC UNIVERSITY OF AMERICA
Collaborative Assessment and Management of Suicidality – Integrated Training Model Impact on Clinician Competency
A DISSERTATION
Submitted to the Faculty of the
Department of Psychology
School of Arts and Sciences
Of The Catholic University of America
In Partial Fulfillment of the Requirements
For the Degree
Doctor of Philosophy
By
Maureen E. Bowers
Washington, DC
2021
1

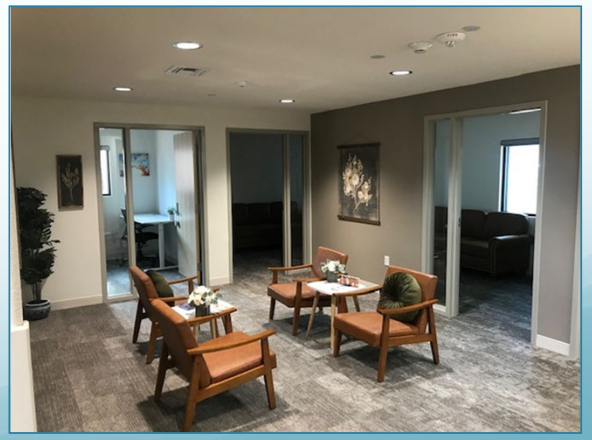
From the unpublished Bowers' dissertation, each component of the CAMS "Integrated Training Model" (ITM) is value-added and effective for significant improvements in attitude, knowledge, and skill by the end of ITM training.

The Hope Institute(Derek Lee)



Using CAMS and DBT, The Hope Institute is stabilizing patients who are suicidal with outpatient suicide-focused care in Perrysburg OH in 5-6 weeks!

New Hope Institute in Chandler School District in Arizona with more to come!



Post 988, we need to rethink crisis stabilization

As Chair of the AFSP Public Policy Council, I help lead our efforts to inform, shape, and craft mental health and suicide-related policy and legislation at the federal, state, and local levels.

Can we create a new legislative act that supports funding for new initiatives in the suicide crisis stabilization? Such initiatives would be:

- Suicide-focused
- Evidence-based
- Least restrictive
- Self-sustaining
- Use quality assurance research to ensure effectiveness

Thank You CatholicU SPL and CAMS-care!