



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

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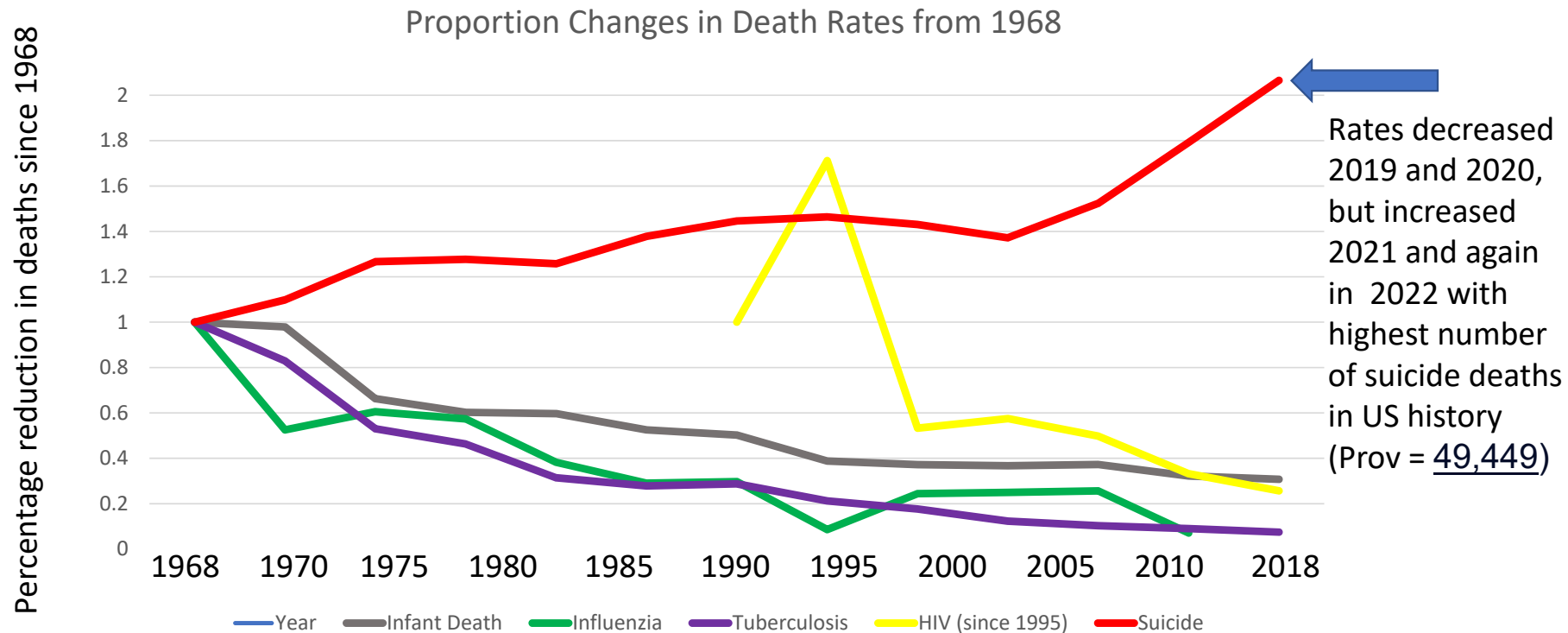
CAMS-care Webinar
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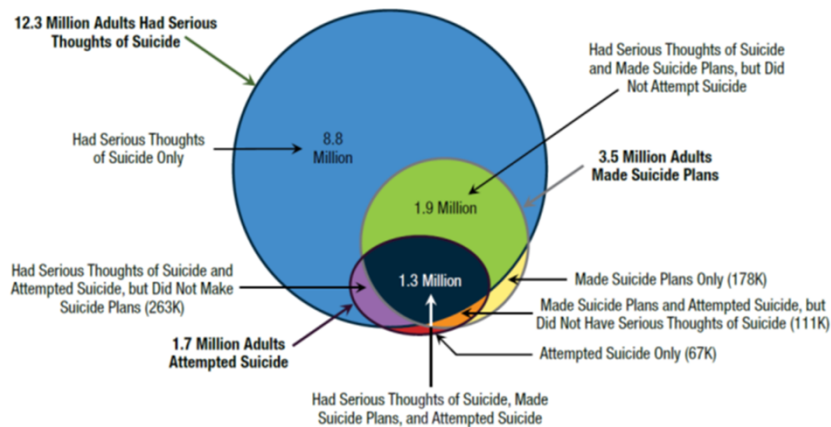
50+ Years Addressing Leading Causes of Death in the United States of America



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/cmfi-icd10.html> on Nov 10, 2019 7:07:31 PM

The Importance of Suicidal Ideation

Figure 47. Adults Aged 18 or Older with Serious Thoughts of Suicide, Suicide Plans, or Suicide Attempts in the Past Year; 2021



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.

Editorial Reflections on Suicidal Ideation

David A. Jobes¹ and Thomas E. Joiner²

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According to the Substance Abuse and Mental Health Services Administration (SAMHSA) in the United States, 10.4 million American adults have serious thoughts of ending their lives by suicide each year (SAMHSA, 2016). In that same year, we further know that 1.4 million American adults attempted suicide while approximately 47,000 across all ages died by suicide (Drapeau & Michon, 2016). While suicidologists and public health officials are understandably preoccupied with suicides and suicide attempts, we have recently begun to reflect on those with suicidal ideation who too often escape the focused attention of our suicide prevention research, clinical treatments, and even national health-care policies. Upon reflection, the prevalence of suicidal ideation in the United States is truly staggering: 10,400,000 people experiencing thoughts of ending their lives is more than the population of the US state of Georgia. From an international perspective, this figure is roughly the size of the population of the Czech Republic.

As suicide prevention researchers, we understand the appeal of observable suicidal behaviors with implications for morbidity and mortality. However, the morbidity of suicidal ideation should not be underestimated. As a focus of research, suicidal ideation tends to be a more elusive, ephemeral, and often fluid construct. But the proportion of people who experience serious suicidal thoughts represents the larger mass of the suicide iceberg below the surface of the water. Suicide deaths and attempts represent the tip of this iceberg, which is dwarfed by the much larger problem, at least with regard to numbers, of all the people beneath the surface who are experiencing suicidal misers, often in silence.

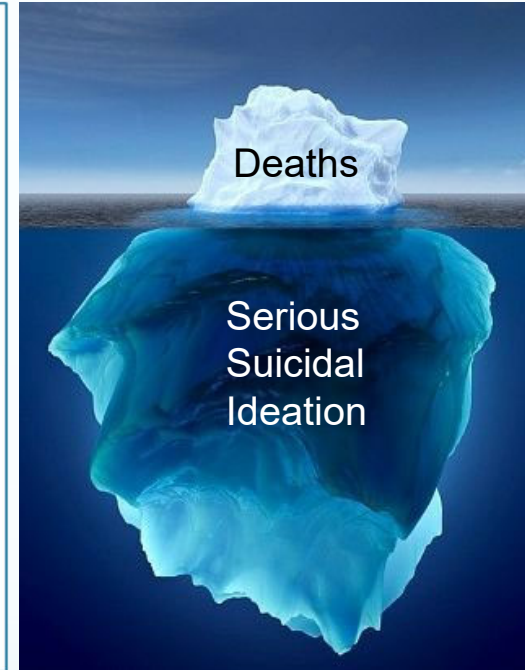
The definition of suicidal ideation offered by the Centers for Disease Control and Prevention in the United States (Crowe, Orvaschel, & Madsen, 2011), echoing the US National Strategy for Suicide Prevention, is: "...Thoughts of engaging in suicide-related behavior." This is an apparently broad definition for a phenomenon that includes, but is not limited to, specific plans to die and explicit intent

to die imminently. As we argue here, all aspects of suicidal ideation deserve attention; these two specific instances certainly do, since they signal imminent danger for self-inflicted death.

In a meta-analysis conducted by Franklin and colleagues (2017), the number-one risk factor for future episodes of suicidal ideation was prior suicidal ideation. While this finding is unsurprising, it highlights the recurrent and chronic nature of suicidal ideation, and underscores key aspects of its morbidity. In terms of predicting death by suicide, the same meta-analysis found that suicidal ideation was the third most potent predictor of future death by suicide, behind only prior psychiatric hospitalizations and prior suicide attempts. It should be added that in the Franklin et al. meta-analysis, all predictors were relatively weak (e.g., odds ratios between approximately 2 and 4, even for those in the top third). It is important to note that prior psychiatric hospitalizations were the leading predictor of later suicide deaths; notably, suicide ideation is one of the most common reasons for hospitalizations (e.g., Lewin, 2008). The same logic can be applied to risk for suicide attempt in the Franklin et al. meta-analysis: suicidal ideation was not among the top five predictors of future attempt, but psychiatric hospitalizations were. Again, hospitalizations are often precipitated by suicidal ideation.

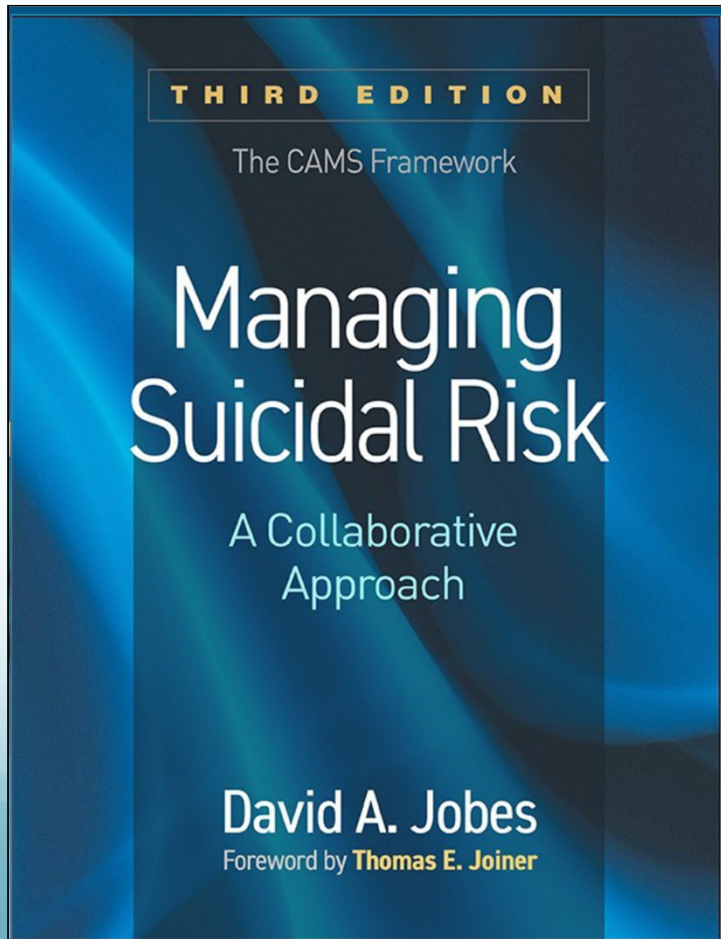
It is possible, upon reflection, to in any way diminish an ideational morbidity. Behavioral morbidity deserves its due. But ideational morbidity is a regular emphasis in mental health, regarding, for example, worry in generalized anxiety disorder, obsessions in obsessive-compulsive disorder, grandiosity in the manic phase of bipolar conditions, and delusions in psychotic disorders. One may counter that these ideational factors have behavioral consequences, to which we reply that so do suicidal ideational factors.

Some believe that suicidal behavior can occur in the absence of prior ideation. We see skepticism, for at least two reasons. First, it is not at all clear that those who attempt suicide, survive, and are then queried about their prior

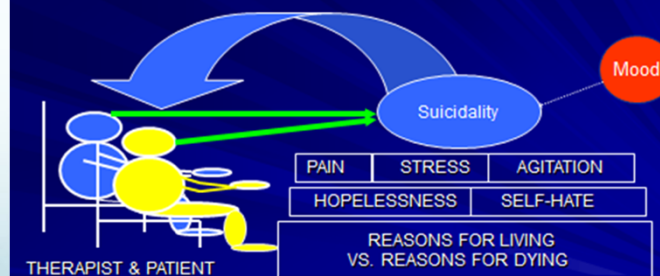


2021 SAMHSA data adds 3,300,000 teens who also have serious thoughts of suicide

The Collaborative Assessment and Management of Suicidality (CAMS)



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



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

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 Weber Date: 6/3/23 Time: 1:00pm

Section A (Patients)
 Rate and fill out each item according to how you feel (add lines). There is a scale of importance 1 to 5 (1 is most important to 5 is least important).

1) RATE PSYCHOLOGICAL PAIN (hurt, anguish, or misery in your mind, past stress, past physical pain)
 Low pain: 1 2 3 4 5 High pain: 5
 What I find most painful is: *being rejected by my own friends*

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

3) RATE AGITATION (emotional urgency, feeling that you need to take action, past irritations, past annoyance)
 Low agitation: 1 2 3 4 5 High agitation: 5
 I most need to take action when: *someone does something unforgivably*

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
 I am most hopeless about: *everything*

5) RATE SELF-HATE (your general feeling of disliking yourself, hating no self-interest, hating no self-report)
 Low self-hate: 1 2 3 4 5 High self-hate: 5
 What I hate most about myself is: *everything*

6) RATE OVERALL RISK OF SUICIDE: Extremely low risk (will kill self) 1 2 3 4 5 Extremely high risk (will kill self)

7) How much is being suicidal related to thoughts and feelings about yourself? Not at all: 1 2 3 4 5 Completely
 To how much is being suicidal related to thoughts and feelings 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. There is a scale of importance 1 to 5.

Reasons for Living	Rank	Reasons for Dying	Rank
my mom	1	people don't get it if they do	1
maybe something will change	2	nothing will change	2
get better	3	if I don't succeed I'll succeed	3
I see how Breaking Bad is	4	people would be better off if I was dead	4

I wish to live in the following extent: Not at all: 0 1 2 3 4 5 6 7 8 9 Very much
 I wish to die in the following extent: Not at all: 0 1 2 3 4 5 6 7 8 9 Very much
 The one thing that would make me no longer suicidal is: *being able to clearly hang on everyone and then myself*

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

Section B (Clinician)
 Describe: I think about it a lot since 7
 1) Suicide ideation: frequency *per day* or week *per week* or month *all the time*
 2) Suicide plan: When *at home before GF comes home*
 Where *at home* Access to means *N/A*
 How *bullet* Access to means *N/A*

3) Suicide rehearsal: Describe: *Put belt around neck*
 4) History of suicidal behaviors: Describe: *Jump attempt*
 Frequency *Multiple attempts*
 Describe: *GF says yes*

5) Impulsivity: Describe: *GF says yes*
 6) Substance abuse: Describe:
 7) Significant loss: Describe:
 8) Relationship problems: Describe: *GF left me/mother*
 9) Burden to others: Describe:
 10) Health/physical problems: Describe: *only sleeps 3-4 hours a night*
 11) Sleep problems: Describe: *only sleeps 3-4 hours a night*
 12) Legal/financial issues: Describe:
 13) Name: Describe: *Kevin*

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 Complete GF	3 wks
2	Self-hate	↓ Self-hate	Psychotherapy: CBT BA VtE counseling	3 mths
3	People don't get it / betrayal	Find ways to help others get it	Psychotherapy: CBT BA CT?	3 mths

YES NO Patient understands and concurs with treatment plan?
 YES NO Patient at treatment danger of suicide (hospitalization indicated)?
 Clinician Signature: *David Weber* Date: 6/3/23

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

Section C (Stabilization)
 What to reflect on to help me:
 1. Conversation with girlfriend about life
 2. Remove the belt
 3.

Things I can do to cope differently when I am in a suicidal state:
 1. Exercise
 2. Watching "Breaking Bad"
 3. Write in journal
 4. Read "Changing to Live"
 5. Walk to local Best Buy
 6. Call or text emergency contact number: *Lifeline 988, Crisis Text Line, 602 HOME to 747474*

People I can call for help or to decrease my isolation:
 1. Mom
 2.

Attending treatment as scheduled:
 Mental health: *N/A* Services I will try:
 1.
 2.

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

Section D (Clinician Assessment/Evaluation)
 MEDICAL STATUS/EXAM (check appropriate items)
 ANEMIA: DEMENTIA: LETHARGIC: STUPIDITY:
 OTHER:

ORIENTED TO: PERSON: PLACE: TIME:
 MOOD: EUPHIMIC: FLAT: ANGRY:
 AFFECT: APPROPRIATE: APPROPRIATE: APPROPRIATE: APPROPRIATE:
 THOUGHT CONTENT: DELUSIONS: DELUSIONS: DELUSIONS: DELUSIONS:
 OTHER:

PERCEPTION: DISTORTED: DISTORTED:
 OTHER:

PHYSICAL: RAPID: SLOW: SLURRED: IMPROVED: IMPROVED:
 OTHER:

MENTAL STATUS/EXAM (check appropriate items)
 THOUGHT CONTENT: DELUSIONS: DELUSIONS: DELUSIONS: DELUSIONS:
 OTHER:

PERCEPTION: DISTORTED: DISTORTED:
 OTHER:

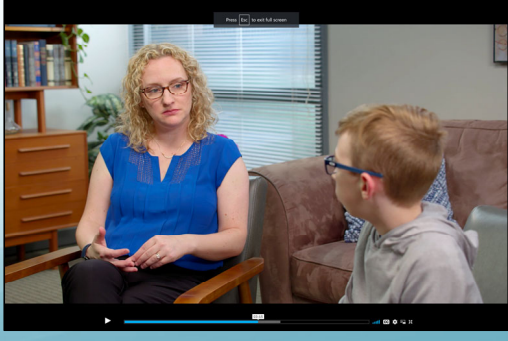
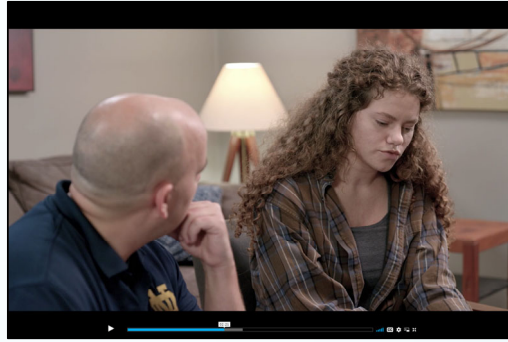
PHYSICAL: RAPID: SLOW: SLURRED: IMPROVED: IMPROVED:
 OTHER:

NON-VERBAL BEHAVIOR OBSERVATION:
 DIAGNOSTIC IMPRESSIONS/COMORBID DIAGNOSES:
Depressed - Major Depression

CLINICAL JUDGMENT: CONCERN ABOUT PATIENT'S RELATIVE STABILITY (check one and explain):
 None: Explaination: *Multiple suicidal thoughts, high SSF score*
 Mild: Explaination: *Suicidal thoughts, less history of suicidal ideation, but willing to try CAMS for 3 months*
 Moderate
 Severe
 Extreme

CLINICAL JUDGMENT: CONCERN ABOUT PATIENT'S RELATIVE STABILITY (check one and explain):
 None: Explaination: *Multiple suicidal thoughts, high SSF score*
 Mild: Explaination: *Suicidal thoughts, less history of suicidal ideation, but willing to try CAMS for 3 months*
 Moderate
 Severe
 Extreme

CASE NOTES:
 Kevin is a 32 year old white male who is unemployed and living with his girlfriend who has recent divorce. He is suicidal ideation and has thoughts of suicide. He has low income and limited coping skills. But he is verbal and somewhat engaged by the treatment being offered. He reports high risk but needs to complete work CAMS stabilization plan, etc. He is in an old patient's car.
 Next Appointment Scheduled: *Thurs* Treatment Modality: *Individual CBT*
 Clinician Signature: *David Weber* Date: 6/3/23



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 Weber Date: 7/1/23 Time: 1:00pm

Section A (Patients)
 Rate and fill out each item according to how you feel (add lines).

1) RATE PSYCHOLOGICAL PAIN (hurt, anguish, or misery in your mind, past stress, past physical pain)
 Low pain: 1 2 3 4 5 High pain: 5

2) RATE STRESS (your general feeling of being pressured or overwhelmed)
 Low stress: 1 2 3 4 5 High stress: 5

3) RATE AGITATION (emotional urgency, feeling that you need to take action, past irritations, past annoyance)
 Low agitation: 1 2 3 4 5 High agitation: 5

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

5) RATE SELF-HATE (your general feeling of disliking yourself, hating no self-interest, hating no self-report)
 Low self-hate: 1 2 3 4 5 High self-hate: 5

6) RATE OVERALL RISK OF SUICIDE: Extremely low risk (will kill self) 1 2 3 4 5 Extremely high risk (will kill self)

In the past week:
 Suicide Thoughts/Feelings: Managed Thoughts/Feelings: Suicidal Behavior: *N*

Section B (Clinician)
 Evolution of suicidality: If current overall risk of suicide < 3, in past week, no suicidal behavior and effectively managed suicidal thoughts/feelings: If 3 or higher: 2nd session
 Complete SSF Outcome/Disposition Form at 3rd consecutive session.

CAMS TREATMENT PLAN UPDATE

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	Self-harm Potential	Safety and Stability	CAMS Stabilization Plan Complete GF	11 wks
2	Self-hate	↓ self hatred ↑ compassion	Courtesy to Live Chapter 1 Psychotherapy & CBT	11 wks
3	People don't get it	↑ trust ↑ support	4th Psychotherapy Behavioral Activation	11 wks

Next Appointment Scheduled: *Thurs* Date: *7/1/23*
 Clinician Signature: *David Weber* Date: 7/1/23

CAMS SUICIDE STATUS FORM (SSF-5) INTERIM SESSIONS page 2 of 4

Section B (Clinician)
 Describe: *Kevin is a 32 year old white male unemployed living with his GF who has recent divorce. He is suicidal ideation and has thoughts of suicide. He has low income and limited coping skills. But he is verbal and somewhat engaged by the treatment being offered. He reports high risk but needs to complete work CAMS stabilization plan, etc. He is in an old patient's car.*

CAMS OUTCOME/DISPOSITION (Check all that apply):
 Continuing outpatient psychotherapy
 Hospitalization
 Inpatient hospitalization
 Referral to
 Other: *ongoing w/ GF*
 Next Appointment Scheduled (if applicable): *Thurs*
 Clinician Signature: *David Weber* Date: 7/1/23

CAMS SUICIDE STATUS FORM (SSF-5) OUTCOME/DISPOSITION FINAL SESSION
 Patient: Kevin Clinician: David Weber Date: 7/1/23 Time: 1:00pm

Section A (Patients)
 Rate and fill out each item according to how you feel (add lines).

1) RATE PSYCHOLOGICAL PAIN (hurt, anguish, or misery in your mind, past stress, past physical pain)
 Low pain: 1 2 3 4 5 High pain: 5

2) RATE STRESS (your general feeling of being pressured or overwhelmed)
 Low stress: 1 2 3 4 5 High stress: 5

3) RATE AGITATION (emotional urgency, feeling that you need to take action, past irritations, past annoyance)
 Low agitation: 1 2 3 4 5 High agitation: 5

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

5) RATE SELF-HATE (your general feeling of disliking yourself, hating no self-interest, hating no self-report)
 Low self-hate: 1 2 3 4 5 High self-hate: 5

6) RATE OVERALL RISK OF SUICIDE: Extremely low risk (will kill self) 1 2 3 4 5 Extremely high risk (will kill self)

In the past week:
 Suicide Thoughts/Feelings: Managed Thoughts/Feelings: Suicidal Behavior: *N*

Where were any aspects of your treatment that were particularly helpful to you? If so, please describe these. Be as specific as possible.
*Session 9 - awareness of self
 Kevin, myself, searching the web.
 Call in a crisis, I got the pizza*

What have you learned from your clinical care that could help you if you become suicidal in the future?
Call in a crisis, I got the pizza

Next Appointment Scheduled (if applicable): *Thurs*
 Clinician Signature: *David Weber* Date: 7/1/23

CAMS SUICIDE STATUS FORM (SSF-5) OUTCOME/DISPOSITION FINAL SESSION page 2 of 4

Section D (Clinician Assessment/Evaluation)
 MEDICAL STATUS/EXAM (check appropriate items)
 ANEMIA: DEMENTIA: LETHARGIC: STUPIDITY:
 OTHER:

ORIENTED TO: PERSON: PLACE: TIME:
 MOOD: EUPHIMIC: FLAT: ANGRY:
 AFFECT: APPROPRIATE: APPROPRIATE: APPROPRIATE: APPROPRIATE:
 THOUGHT CONTENT: DELUSIONS: DELUSIONS: DELUSIONS: DELUSIONS:
 OTHER:

PERCEPTION: DISTORTED: DISTORTED:
 OTHER:

PHYSICAL: RAPID: SLOW: SLURRED: IMPROVED: IMPROVED:
 OTHER:

MENTAL STATUS/EXAM (check appropriate items)
 THOUGHT CONTENT: DELUSIONS: DELUSIONS: DELUSIONS: DELUSIONS:
 OTHER:

PERCEPTION: DISTORTED: DISTORTED:
 OTHER:

PHYSICAL: RAPID: SLOW: SLURRED: IMPROVED: IMPROVED:
 OTHER:

NON-VERBAL BEHAVIOR OBSERVATION:
 DIAGNOSTIC IMPRESSIONS/COMORBID DIAGNOSES:
Major Depression

CLINICAL JUDGMENT: CONCERN ABOUT PATIENT'S RELATIVE STABILITY (check one and explain):
 None: Explaination: *Kevin SSF scores lower, managed suicidal thoughts and feelings, less suicidal ideation, but still needs to try CAMS for 3 to 6 months in a current*
 Mild: Explaination: *Kevin SSF scores lower, managed suicidal thoughts and feelings, less suicidal ideation, but still needs to try CAMS for 3 to 6 months in a current*
 Moderate
 Severe
 Extreme

CASE NOTES:
 Kevin is a 32 year old white male. Final CAMS session but will continue in individual therapy high risk but less history of suicidal ideation. He is verbal and somewhat engaged by the treatment being offered. He reports high risk but needs to complete work CAMS stabilization plan, etc. He is in an old patient's car.
 Next Appointment Scheduled: *Thurs* Date: *7/1/23*
 Clinician Signature: *David Weber* Date: 7/1/23

CAMS Interim Sessions

CAMS Outcome/Disposition Final Session

Form-fillable PDF of the SSF for telehealth CAMS sessions

Home Tools test-result.pdf Danny Johnson SS... x Using a Tablet-Base... NIH_NOA_1R44AA... retreat.pdf

100% You are screen sharing Stop Share

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

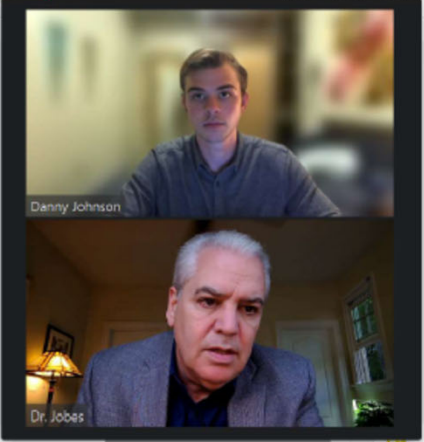
1) How much is being suicidal related to thoughts and feelings about yourself? Not at all: (1) (2) (3) (4) (5) : completely

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
<u>4</u>	<u>something good might happen</u>	<u>1</u>	<u>I hate this limbo</u>
<u>2</u>	<u>my dog</u>	<u>3</u>	<u>the earth is dying</u>
<u>3</u>	<u>rock climbing</u>	<u>4</u>	<u>racial and political injustice</u>
<u>1</u>	<u>my family</u>	<u>5</u>	<u>politics</u>
		<u>2</u>	<u>escape</u>

I wish to live to the following extent: Not at all: (0) (1) (2) (3) (4) (5) (6) (7) (8) : Very much



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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

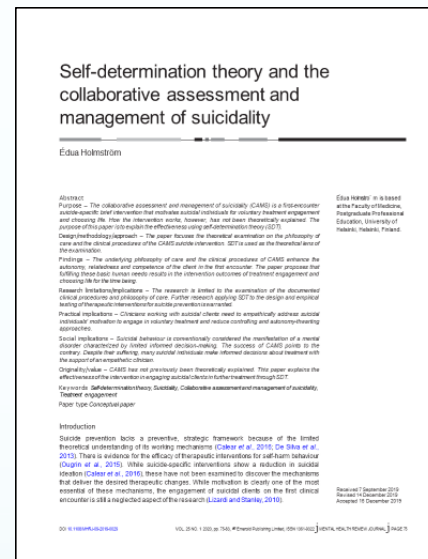
CAMS is a therapeutic framework, that is used to manage suicidal thoughts and feelings and establish behavioral stability. Adherence requires thorough suicide-focused assessment and treatment of patient-identified suicidal “drivers.”

CAMS Philosophy

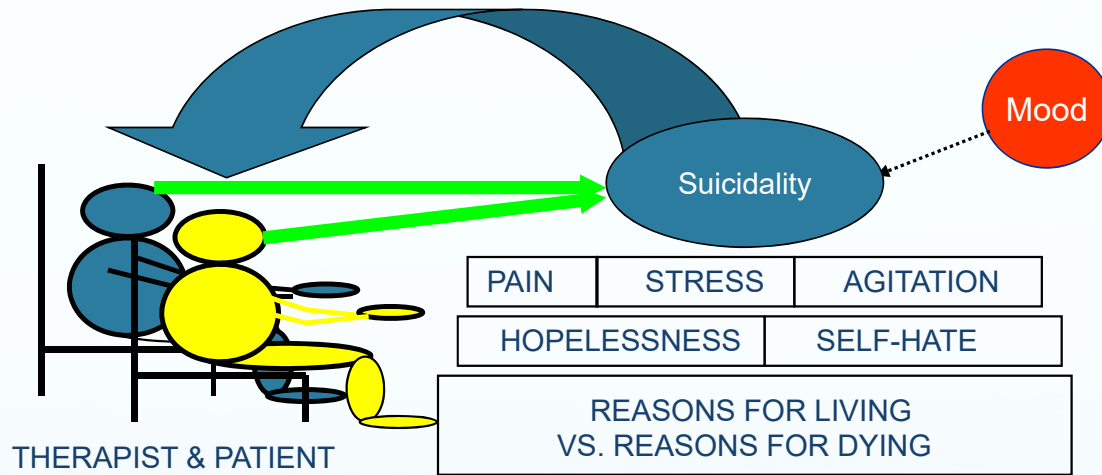
- Empathy for suicidal states—no shame, no blame
- Collaboration with the patient in all aspects of care
- Honesty and transparency throughout clinical care

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






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



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.

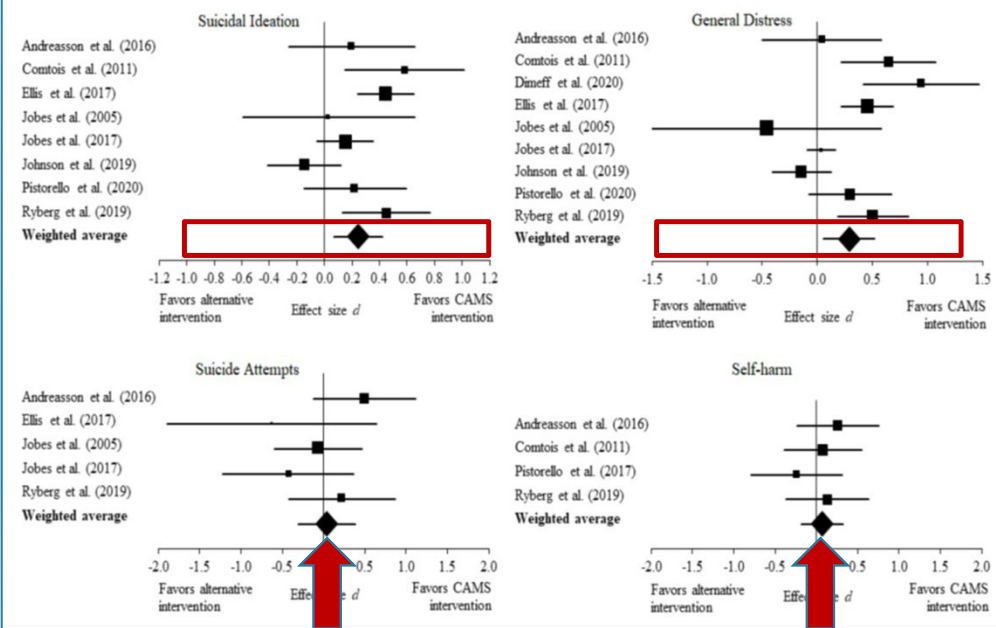
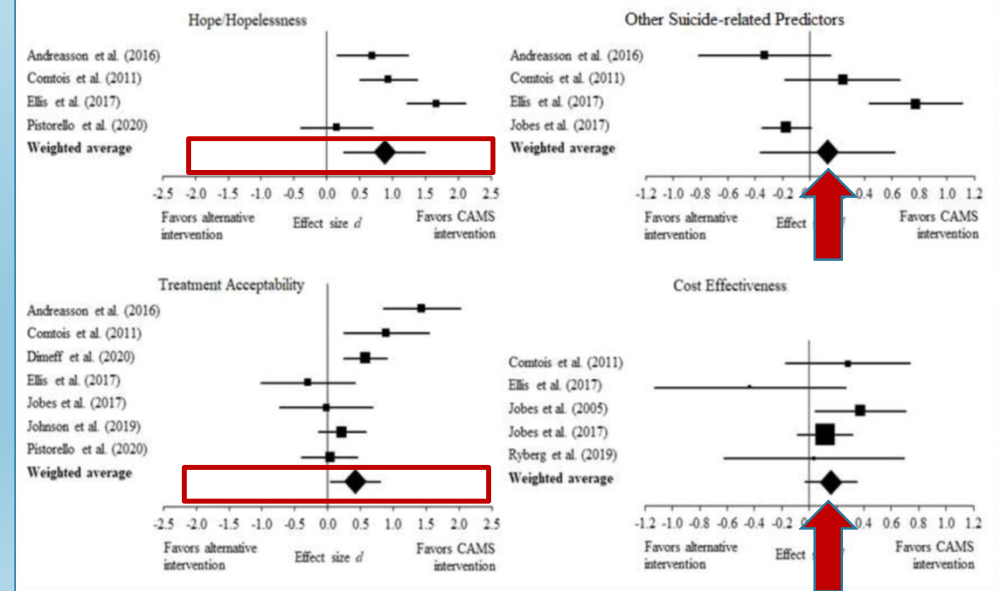


Figure 3. Forest plot of effect sizes for hope/hopelessness, other suicide-related predictors, treatment acceptability, and cost effectiveness.



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

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

Santel et al. BMC Psychiatry (2022) 22:100000
<https://doi.org/10.1186/s12888-022-03594-4>

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

Miriam Santel^{1*}, Thomas Biebl¹, Frank Neuner², Michaela Berg³, Kristina Hennig-Fest⁴, David A. Jobes⁵ and Martin Driessen^{1*}

Abstract

Background: The Collaborative Assessment and Management of Suicidality (CAMS) is a therapeutic framework that has been shown to reduce suicidal ideation and overall symptom distress. CAMS has not been previously evaluated in a standard acute inpatient mental health care setting with only short treatment times for suicidal patients. In this randomized controlled trial (RCT) we are investigating whether CAMS is more effective than Enhanced Treatment as Usual (E-TAU) in reducing suicidal thoughts as primary outcome variable. We are also investigating depressive symptoms, general symptom relief, and the quality of the therapeutic alliance as secondary outcomes.


Methods/Design: This RCT is designed as a single-center, two-armed, parallel group observer-blinded clinical effectiveness investigation. We are recruiting and randomizing 88 participants with different diagnoses, who are admitted as inpatients because of acute suicidal thoughts or behaviors into the Clinic for Psychiatry and Psychotherapy, Ev. Hospital Bethel in Bielefeld, Germany. The duration of treatment will vary depending on patients' needs and clinical assessments ranging between 10 and 40 days. Patients are assessed four times, at admission, discharge, 1 month, and 5 months post-discharge. The primary outcome measure is the Beck Scale for Suicide Ideation. Other outcome measures are administered as assessment timepoints including severity of psychiatric symptoms, depression, reasons for living, and therapeutic relationship.

Discussion: This effectiveness study is being conducted on an acute ward in a psychiatric clinic where patients have multiple problems and diagnoses. Treatment is somewhat limited, and therapists have a large caseload. The results of this study can thus be generalizable to a typical inpatient psychiatric hospital setting.

(Continued on next page)

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BMC



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frontiersin.org

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 Neuner², Michaela Berg³, Carolin Steuwe⁴, David A. Jobes⁵, Martin Driessen^{1*} and Thomas Biebl^{1†}

¹Clinic of Psychiatry and Psychotherapy, University Hospital OVG, of Datteln University, Datteln, Germany; ²Department of Clinical Psychology and Psychotherapy, Datteln University, Datteln, Germany; ³Department of Psychology, The Catholic University of America, Washington, DC, United States

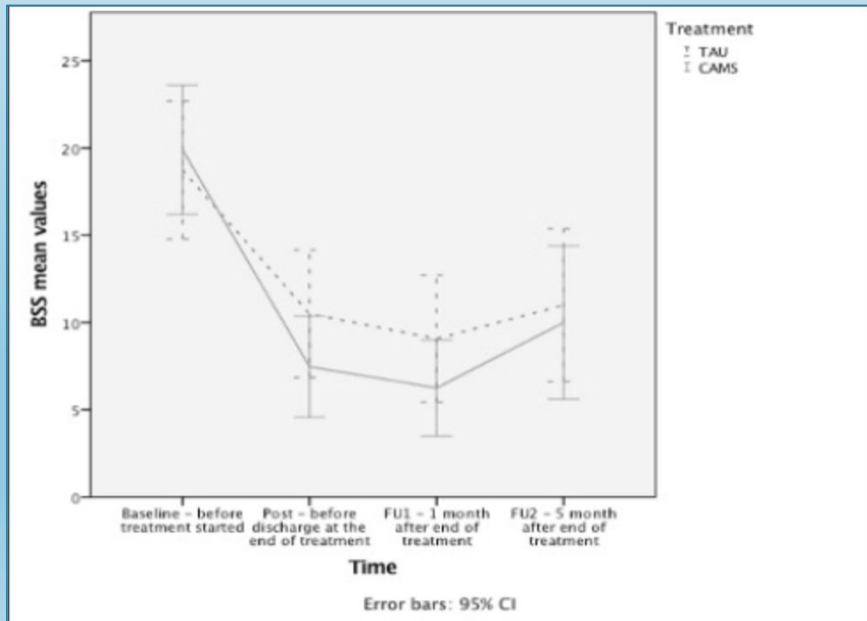
Background: Although use of inpatient close hospital intervention for suicide risk is common, the evidence for inpatient treatments that reduce suicidal thoughts and behaviors is remarkably limited. To address this need, this novel feasibility pilot randomized controlled trial compared the use of the Collaborative Assessment and Management of Suicidality (CAMS) to enhanced treatment as usual (E-TAU) within a standard acute inpatient mental health care setting.

Objective: We hypothesized that CAMS would be more effective than E-TAU in reducing suicidal thoughts and behaviors. As secondary outcomes we also investigated depressive symptoms, general symptom burden, reasons for living, and quality of the therapeutic relationship.

Methods: All patients were admitted due to acute suicidal thoughts or behaviors. They were randomly assigned to CAMS (n = 43) or E-TAU (n = 45) and assessed at four time points (admission, discharge, 1 month and 5 months after discharge). We used mixed-effects models, effect sizes, and relative change analyses to compare improvements across and between treatment groups over time.

Results: Inter-treat analyses of 88 participants (mean age 32.1, SD = 13.5, n = 47 (53% females) showed that both groups improved over time across all outcome measures with no significant between-group differences in terms of change in suicidal ideation, depression, reasons for living, and distress. However, CAMS showed larger effect sizes across all measures, for treatment completers CAMS patients showed significant improvement in suicidal ideation (p = 0.01) in comparison to control patients. CAMS patients rated the therapeutic relationship significantly better (p = 0.02) than E-TAU patients and were less likely to attempt suicide within 4 weeks after discharge (p = 0.05).

Conclusion: CAMS and E-TAU were both effective in reducing suicidal thoughts and symptom distress. Within this feasibility RCT the pattern of results was generally supportive of CAMS suggesting that inpatient use of CAMS is both feasible and promising. However, our preliminary results need further replication within well-powered multi-site randomized controlled trials.



Bielefeld Germany

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



Health Services Research & Development

IIR 17-065 – HSR&D Study

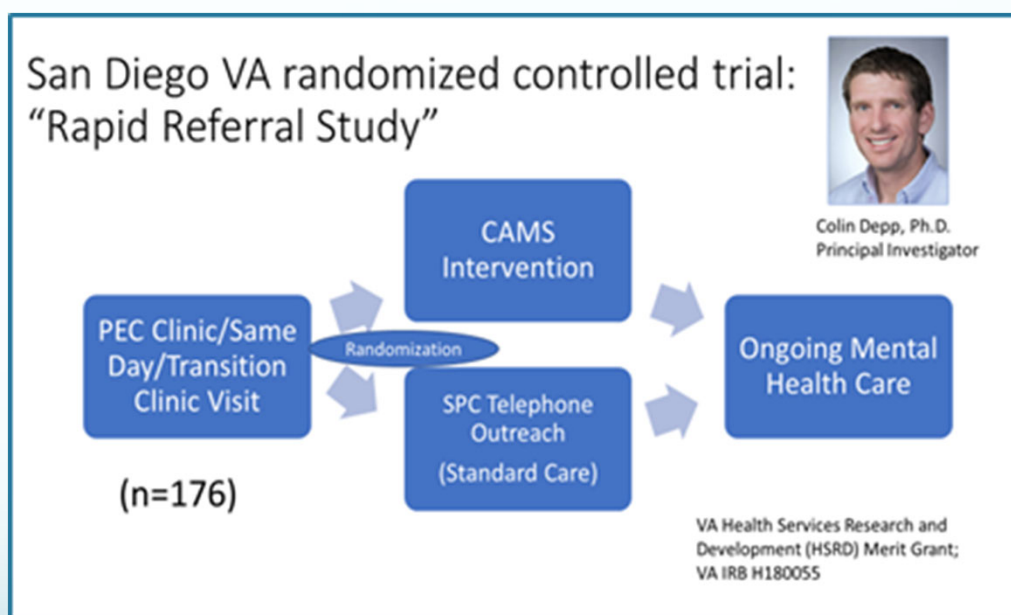
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IIR 17-065 **Rapid Referral to Suicide Specific Intervention in Psychiatric Emergency Care**
Collin Andrew Depp PhD
San Diego, CA
Funding Period: October 2018 - March 2023

Abstract

This revised proposal responds to HSR&D's Targeted Solicitation for Health Services Research on Suicide Prevention. Same-day psychiatric emergency clinics are increasingly implemented and are a best practice in increasing access to mental health care and in suicide prevention. Our preliminary data indicate a high frequency of suicidal ideation and recent suicidal behavior among Veterans accessing same-day mental health evaluation, and yet fewer than half of Veterans with these risk factors engage in outpatient mental health appointments that are set following their initial acute evaluation. To reduce risk of suicide during the transition from acute to outpatient care, it is unclear if models that "bridge" the transition should emphasize telephone outreach, as delivered by Suicide Prevention Coordination teams, or suicide-specific psychotherapy, such as Collaborative Assessment and Management of Suicidality (CAMS). CAMS is a brief transdiagnostic evidence-based psychotherapy that is recognized



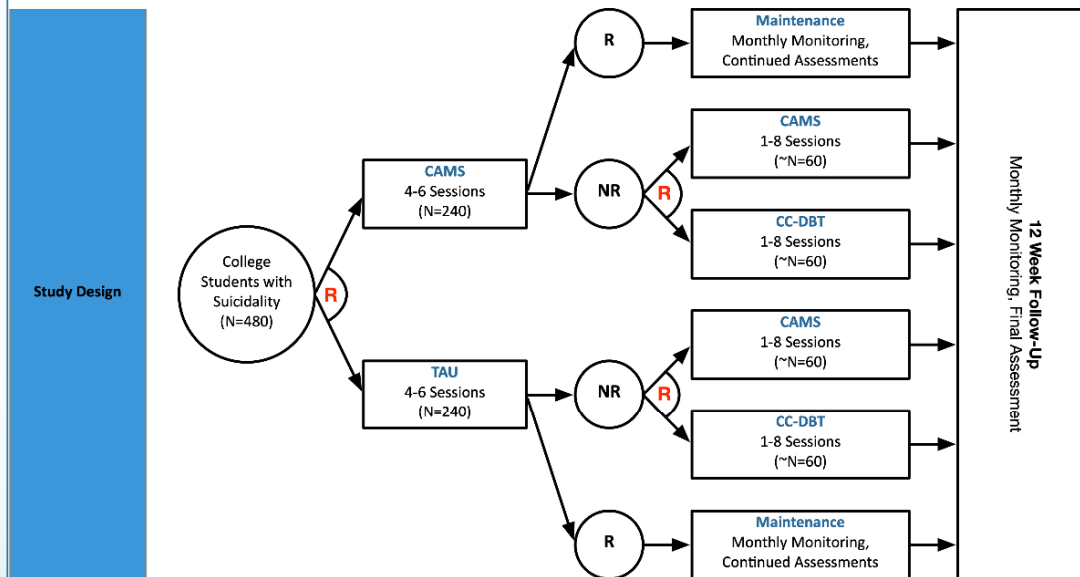
Now standing up a “Suicide Stabilization Clinic” at SD VAMC focused on suicide-specific care, training young clinical providers, and cost-effectiveness!



Comprehensive Adaptive Multisite Prevention of University student Suicide



Figure 1. CAMPUS Trial Study Design
(Comprehensive Adaptive Multisite Prevention of University student Suicide)



Stages and Duration	Baseline Pre-screening, Consent, Baseline Assessment	Stage 1 Treatments 4-6 Weeks				Tailoring Variable	Stage 2 Treatments 1-8 Weeks		Follow-Up Assessment 12 Weeks Post-Treatment
Study Week	-1	0	3	6	7	10	14	26	
Assessments	↑		↑	↑		↑	↑	↑	

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)

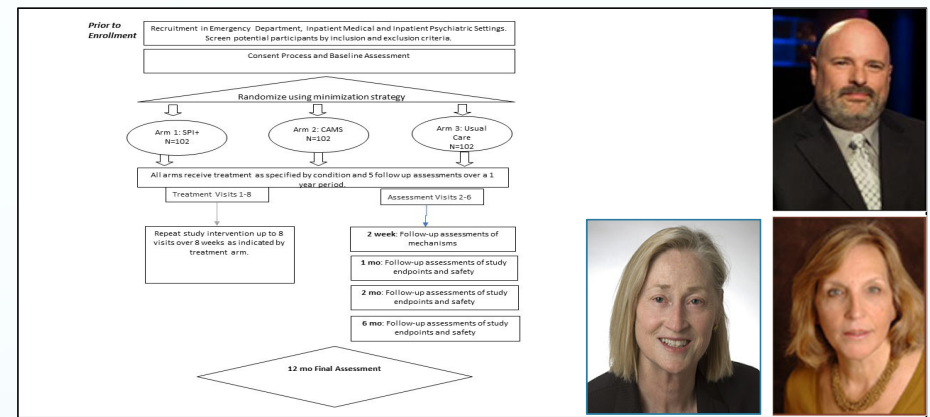
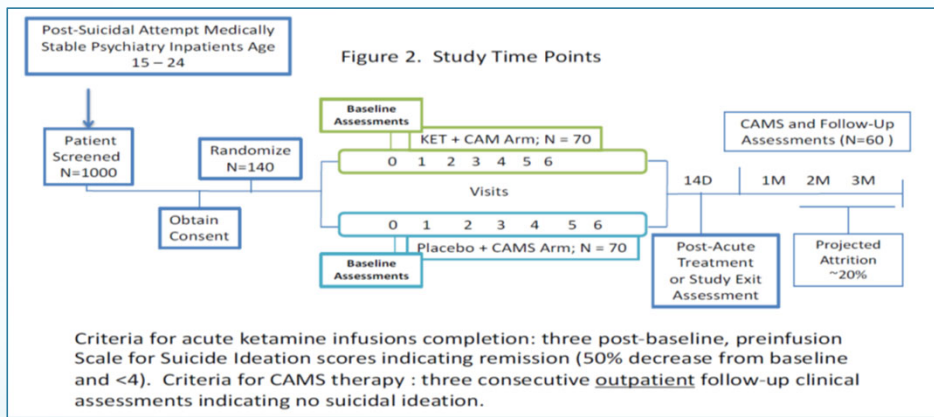


NIMH R01 Funded “CAMS-4Teens” RCT’s

CAMS & Ketamine RCT

Cleveland Clinic & Mass General Hospital
(PI’s: Anand & Falcone)

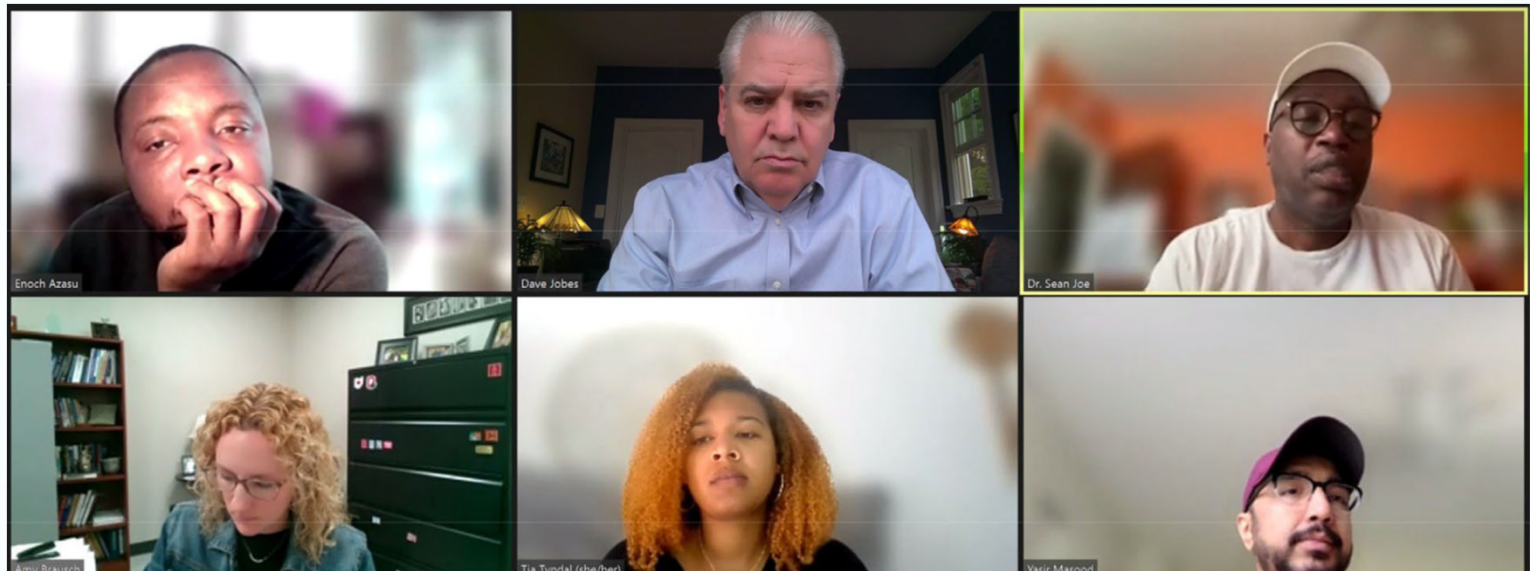
CAMS-4Teens vs. SPI+ vs. TAU
Seattle Children's & Nationwide
(PI’s: Adrian & Bridge)



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).

				
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

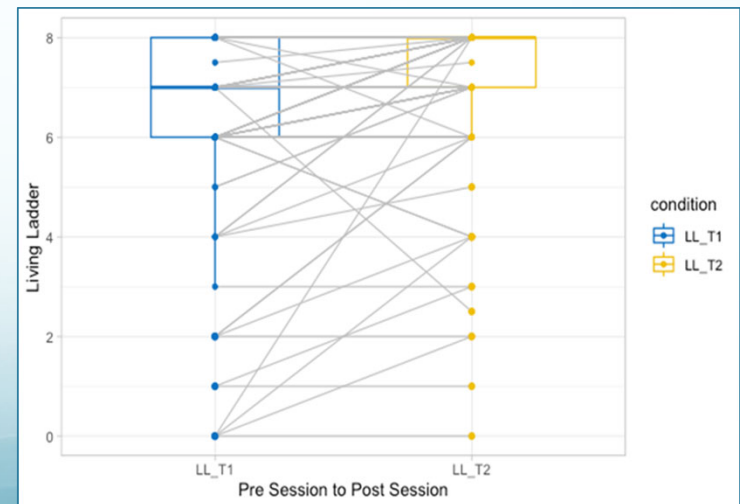
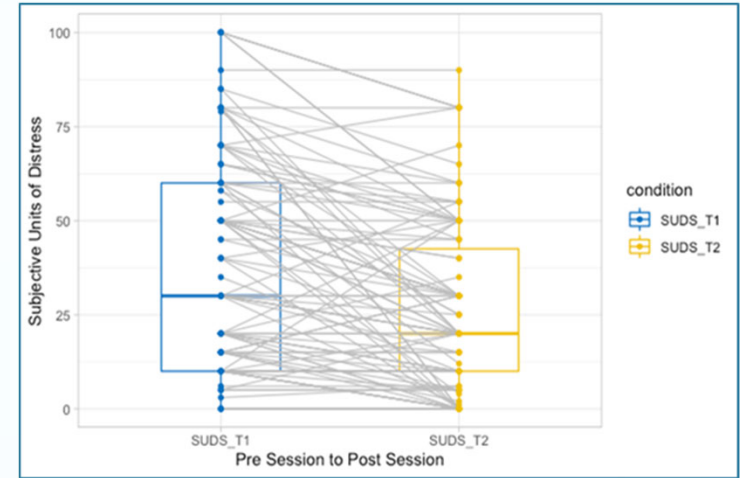
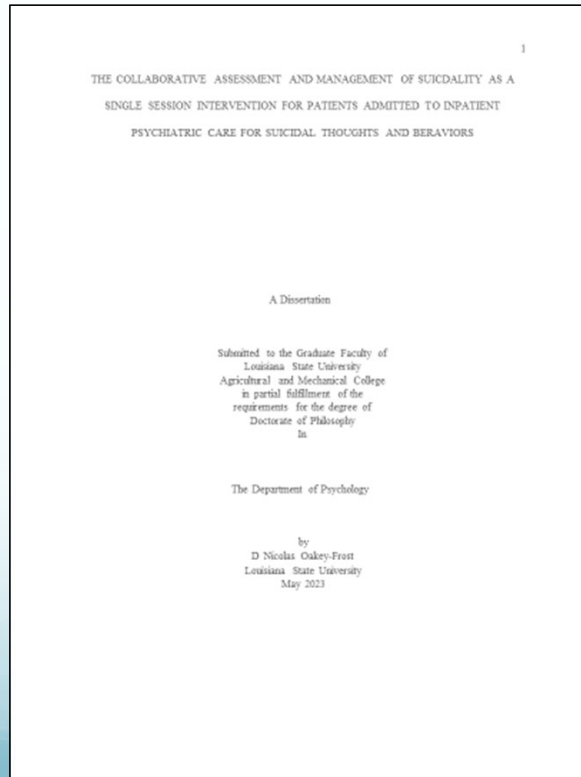
CAMS-Brief Intervention (CAMS-BI)



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



D Nicolas Oakey-Frost



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. Yates¹, David A. Jobes², Amanda H. Kerbrat¹, Katherine Anne Coriois³

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

* p.mccutchan@americanu.edu



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, Coriois KA (2022) Costs, benefits, and cost-benefit of Collaborative Assessment and Management of Suicidality versus enhanced treatment as usual. *PLoS ONE* 17(2): e0262292. <https://doi.org/10.1371/journal.pone.0262292>

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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.

PLOS ONE | <https://doi.org/10.1371/journal.pone.0262292> February 3, 2022

1/17

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 Gunthart, Ph.D.

David A. Jobes, Ph.D., ABPP

Dean of the College of Arts and Sciences

Date

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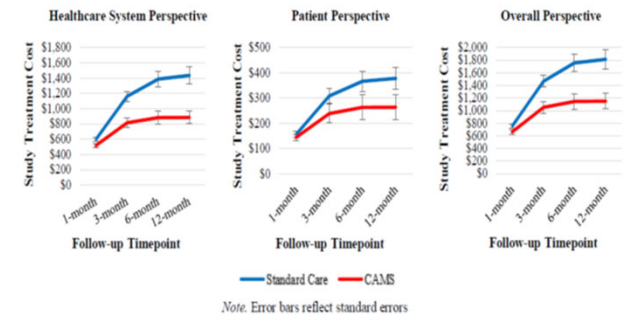


Two studies of CAMS cost-effectiveness compared to control care... (OWL & AFS)

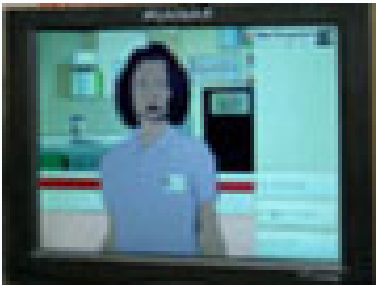
Dr. Phoebe McCutchan

Figure 1

Mean Cumulative Study Treatment Costs Across Time



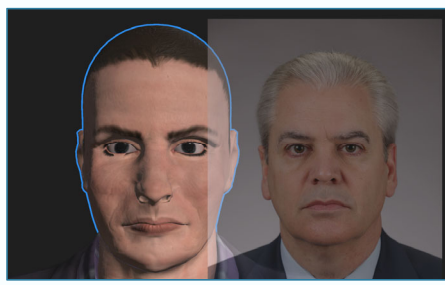
NIMH-funded SBIR projects and NIAAA-funded study: CAMS-RAS → “JASPR Health” for suicidal risk in EDs and primary care (Linda Dimeff, Kelly Koerner, & David Jobes)



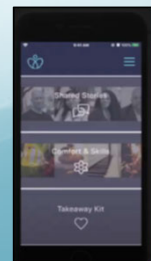
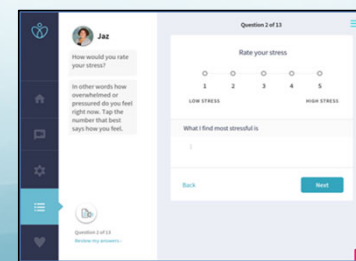
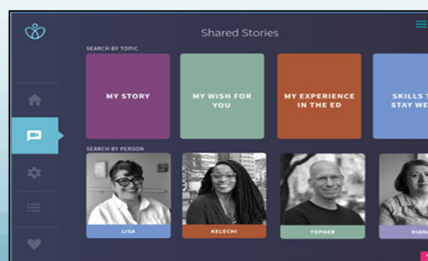
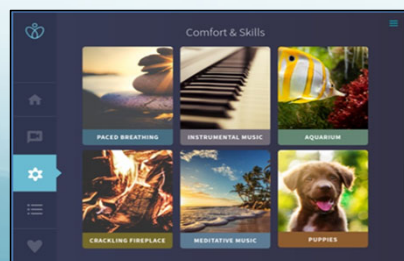
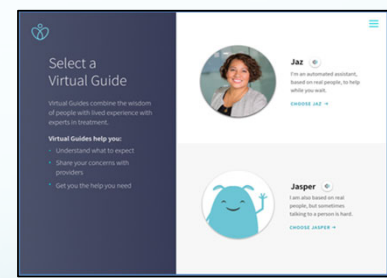
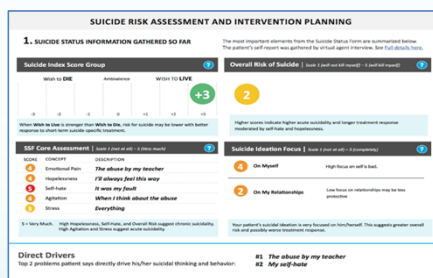
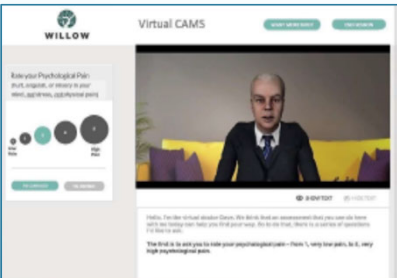
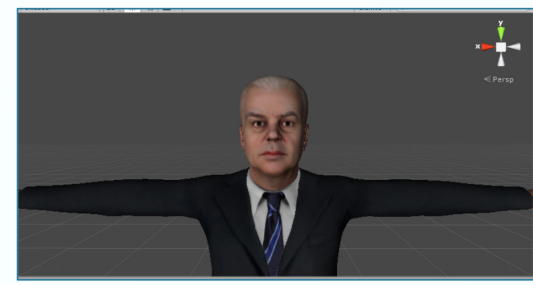
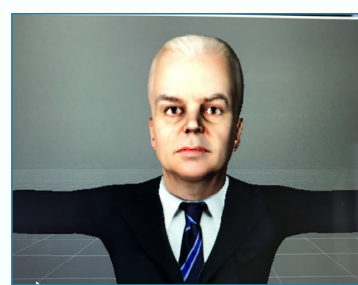
“Nurse Louise”



“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: _____ 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).

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 irritability; 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: _____

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 feelings 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. This 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: _____

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Press, Managing Suicide Risk: A Collaborative Approach, Third Edition, by David A. Jobes. Copyright © 2023 The Oxford Press. Permission to photocopy this material is granted to purchasers of this book for personal use or use with clients (see copyright page for details). Purchasers are encouraged and print additional copies of this material (see the box at the end of the table of contents).

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

Section D (Clinician Postsession Evaluation):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS: ALENT DROWSY LETHARGIC STUPOROUS
OTHER: _____

ORIENTED TO: PERSON PLACE TIME REASON FOR EVALUATION

MOOD: EUPHYMIC ELEVATED DYSPHORIC AGITATED ANGRY

AFFECT: FLAT BLANKETTED CONRICTED APPROPRIATE LABEL

THOUGHT CONTENT: CLEAR & COHERENT DISORGANIZED TANGENTIAL ORGANIZATIONAL
OTHER: _____

THOUGHT CONTENT: WNL OBSCURE DELUSION IDEAS OF REFERENCE SCANDALOUS HOBBY
OTHER: _____

ABSTRACTION: WNL FORMALLY CONCRETE
OTHER: _____

SPEECH: WNL RAPID SLOW SLURRED IMPROVERISHED EUCHEMATIC
OTHER: _____

MEMORY: GROSSLY IMPACT
OTHER: _____

REALITY TESTING: WNL
OTHER: _____

NOTABLE BEHAVIORAL OBSERVATIONS: _____

DIAGNOSTIC IMPRESSIONS/DIAGNOSES (DSM-5/CD DIAGNOSES): _____

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

None Explanation: _____

Mild _____

Moderate _____

Serious _____

Extreme _____

Next Appointment Scheduled: _____ Treatment Modality: _____

Clinician Signature _____ Date _____ Supervisor Signature (if indicated) _____ Date _____

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CAMS SUICIDE STATUS FORM (SSF-5) INTERIM SESSIONS

Patient: _____ Clinician: _____ Date: _____ Time: _____ 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 irritability; 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 3rd session 4th session 5th session 6th session 7th session 8th session 9th session 10th session 11th session 12th session 13th session 14th session 15th session 16th session 17th session 18th session 19th session 20th session 21st session 22nd session 23rd session 24th session 25th session 26th session 27th session 28th session 29th session 30th session 31st session 32nd session 33rd session 34th session 35th session 36th session 37th session 38th session 39th session 40th session 41st session 42nd session 43rd session 44th session 45th session 46th session 47th session 48th session 49th session 50th session 51st session 52nd session 53rd session 54th session 55th session 56th session 57th session 58th session 59th session 60th session 61st session 62nd session 63rd session 64th session 65th session 66th session 67th session 68th session 69th session 70th session 71st session 72nd session 73rd session 74th session 75th session 76th session 77th session 78th session 79th session 80th session 81st session 82nd session 83rd session 84th session 85th session 86th session 87th session 88th session 89th session 90th session 91st session 92nd session 93rd session 94th session 95th session 96th session 97th session 98th session 99th session 100th session

Section C (Clinician): CAMS TREATMENT PLAN UPDATE

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	Self-Harm Potential	Safety and Stability	CAMS Stabilization Plan Updated <input checked="" type="checkbox"/>	
2				
3				

Patient Signature _____ Date _____ Clinician Signature _____ Date _____

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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.

<p>Problem #2</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Problem #3</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
---	---

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)

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CAMS THERAPEUTIC WORKSHEET (page 2 of 3)

<p>Problem #2</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>	<p>Problem #3</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
---	---

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., pattern 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., loneliness, depression, substance abuse, PTSD, isolation)

(continued)

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CAMS THERAPEUTIC WORKSHEET (page 3 of 3)

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

(continued)

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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. (Patient's name)

We particularly target firearms (the most common method of suicide death) and medications (the most common method of suicide attempt) until they have received.

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

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).
 Stove immediately 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 firearm: _____

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 non-suicidal self-harm (e.g., Xacto blades, blades from razors or nail-up pencil sharpeners, and lighters).

Not applicable
 Plan: _____

(continued)

The SSP is based on a tool developed by Craig J. Bryan and H. David Rudd published in *Brief Cognitive-Behavioral Therapy for Suicide Prevention*. Copyright © 2016 The Oxford Press. Editorial input and content modifications were done by David A. Jobes and experts in CAMS. Counseling on Access to Lethal Means may include Kurt Hickman, Colin Barber, Elaine Frank, and J. P. Jansson.

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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 (name): _____

People who increase risk for the patient whom I/we will discourage contact (name): _____

Things I/we can do to help the patient do that they have identified as life-affirming and healthy (I/we 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 TextLine 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 _____

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CAMS LIVING STATUS FORM (CLSF)

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

[COMPLETED BY THE 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 PLEASURE (e.g., 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 feelings 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: _____

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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 Problems #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 forms; 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 into electronic medical records (Sections A–D).

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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 problems/drivers and modify goals and objectives, interventions, or duration as indicated with patient's input.
- Patient and clinician sign forms; 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.

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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 forms; make a copy for the patient (or have patient make a picture copy).

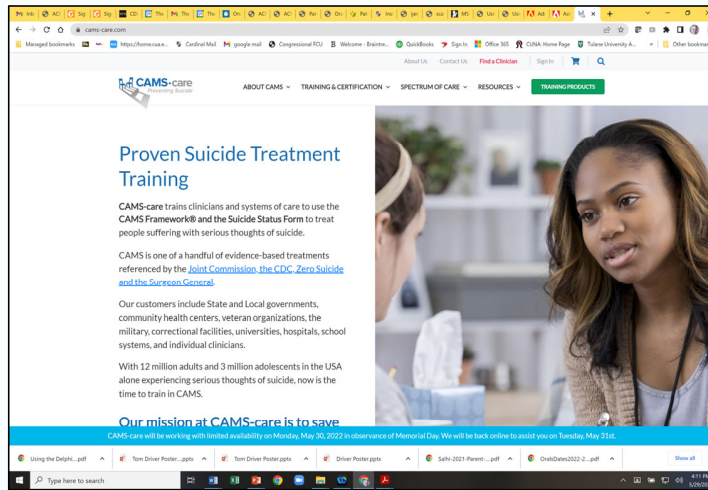
FURTHER DOCUMENTATION (APPROXIMATELY 5 MINUTES)

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

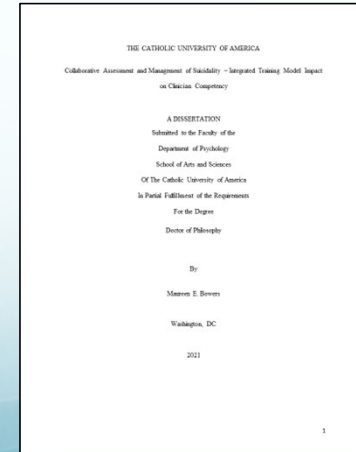
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How do we get clinicians to use a proven treatment?

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



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.

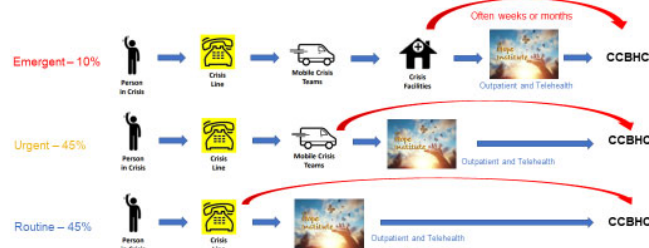


The Hope Institute (Derek Lee)



Bridging "The Lethal Gap"

"The gap between what we know, and what we do, is lethal." Kay Redfield Jamison



- **Emergent** – Stabilize high risk cases while they wait for Certified Community Behavioral Health Center
- **Urgent** – a Crisis Team completes a Safety Plan and schedules a Next Day Appointment with The Hope Institute
- **Routine** – Crisis Call Specialist completes a Safety Plan, schedules a Next Day Appointment with The Hope Institute



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!

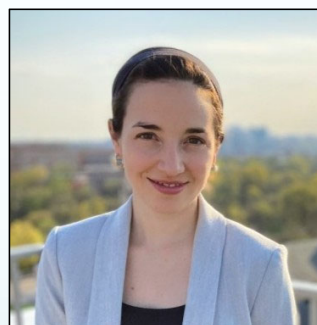
New Hope Institute in Chandler School District in Arizona with more to come!



Post 988, we need to rethink crisis stabilization

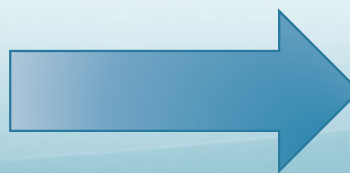


As Chair of the AFSP Public Policy Council, I help lead our efforts to inform, shape, and craft mental health and suicide-related policy and legislation at the federal, state, and local levels.



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!

