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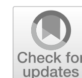

The Hope Institute Approach to Suicidal Risk

Derek Lee[1] · David Jobes[2]

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Abstract

Over 16 million Americans struggle with serious thoughts of suicide; deaths by suicide have increased significantly over the past 30 years and represent a major public health concern in the United States and around the world. In the U.S. almost 50,000 people die by suicide making it the 11th leading cause of death impacting millions across the country. Historically, clinical work related to suicide has relied on the assessment of risk factors for suicide and an over-reliance on increasingly brief inpatient psychiatric admissions and a medication-only treatment approach, both of which have either little, mixed, or no support for effectively reducing suicidal risk. Moreover, these interventions can be expensive and may even *increase* the risk of suicide. At the national level there is an increasing awareness of the need for new community-based approaches to suicidal risk that rely on proven, suicide-specific treatments. To this end, The Hope Institute (THI) model relies on evidence-based treatments within a community care setting focusing on stabilization thereby averting emergency department or inpatient admissions. This article seeks to provide an overview of The Hope Institute approach as a compelling alternative outpatient approach with promising effectiveness that warrants further research.

Keywords Suicide · Psychotherapy · Effectiveness · CAMS · DBT

In 2023 16,600,000 American adults and adolescents reported having *serious thoughts of suicide* (SAMHSA, 2024) and 2,356,000 Americans attempted suicide. A total of 49,476 died by suicide in 2022 making it the 11th leading cause of death in the U.S. (CDC, 2024). The emotional costs of suicide are enormous as upwards of 30 loved ones are meaningfully impacted by each suicide as "loss survivors" (Cerel et al., 2018). The economic costs of suicide in the U.S are staggering—suicide and self-harm cost over $500 billion in medical costs, work loss costs, value of statistical life, and quality of life costs in 2020 (CDC, 2024). Bottom line, suicidal suffering and behaviors represent a major mental and public health challenge in the U.S. and around the world. Serious suicidal thoughts and rising rates of suicidal behaviors underscore the utter inadequacy of our suicide prevention approaches overall, and further highlight our inadequate standard clinical care response for patients who are suicidal.

As Jobes (2017) has noted the modal contemporary clinical response to suicidal risk centers on a "medical model" approach relying on expensive emergency department (ED) visits, brief inpatient admissions, and a medication-only approach for mental disorders. However, these common approaches do not reliably reduce suicidal risk and can actually *increase* risk (Jobes & Barnett, 2024). It is well documented that risk of suicide significantly *increases* in the weeks, months, and even *years* following discharge inpatient psychiatric admission (Mortier et al., 2024). Randomized controlled trial (RCT) in clinical suicidology overwhelmingly shows that suicide-focused psychological treatments are by far the most effective clinical approaches for suicidality (Jobes et al., 2015). Replicated RCTs—with independent validation—show that psychological treatments targeting suicidal ideation and behaviors reliably reduces suicidal thoughts and behaviors, independent of diagnosis. The treatments that rise to the highest level of experimental rigor, investigating the *causal* impact of the interventions through RCTs are: Dialectical Behavior Therapy (DBT), Cognitive Therapy for Suicide Prevention (CT-SP), Brief Cognitive Behavioral Therapy (BCBT), and the Collaborative

✉ Derek Lee
derek.lee@ttuhsc.edu

David Jobes
jobes@cua.edu

[1] Texas Tech University Health Sciences Center, Lubbock, USA

[2] Catholic University of America, Washington, DC, USA

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Assessment and Management of Suicidality (CAMS) (Jobes & Barnett, 2024). With 30+ years of accumulated RCT evidence for proven clinical approaches, Goldstein Grumet and Jobes (2024) have pointedly asked: *why are these treatments not more widely used within routine clinical practice?*

Suicide-Focused Care Policy Developments

Abysmal epidemiological data, abject suffering of millions, and slow uptake of proven clinical care, have collectively prompted major policy initiatives to fundamentally change suicide-focused clinical care. Such policies shift focus away from medical model care (i.e., treating mental disorders) to a systems-level approach using evidence-based suicide-focused clinical care. The two most notable policy initiatives are "Zero Suicide" and the newly launched "National Strategy for Suicide Prevention."

Zero Suicide

Zero Suicide is a "process-improvement" policy designed to transform system-wide suicide-focused care (National Action Alliance for Suicide Prevention, 2012; 2024). Zero Suicide has seven core elements: "Lead," "Train," and "Improve" (structural components for systems-level change). Clinical components of Zero Suicide emphasize fidelity and quality improvement and use a "clinical care pathway" emphasizing: "Identify," "Engage," "Treat," and "Transition." Together these elements raise the standard of suicide-care within a "just culture."

While some have taken issue with the name (Zero Suicide), as a policy it is perhaps the single most successful initiative of its kind to date. Some contend that Zero Suicide creates unrealistic expectations, neglects the complexity of the issue, implies that suicide deaths are the fault of providers or care systems. There is however impressive correlational research that Zero Suicide reduces suicidal suffering and behaviors. In a large health care system in Australia use of Zero Suicide was associated with significantly lower risk of repeated suicide attempts with an approximate 23.3% reduction of suicides (Turner et al., 2021). Similarly, Laymen et al. (2021) note a statistically significant association between Zero Suicide and reduced suicidal behaviors.

Despite these data, Goldstein Grumet and Jobes (2024) argue that within use of Zero Suicide there is an under-emphasis of the "treat" element. While using the C-SSRS assessment (Posner et al., 2011) and the Stanley-Brown Safety Plan Intervention (Stanley & Brown, 2012) reflect the Zero Suicide elements of *identify* and *engage,* neither *treats the causes* of suicidality (i.e., *Treat suicidal thoughts and behaviors using evidence-based treatments*). But clinicians do not commonly use evidence-based treatments for suicidal risk and 70% of people who die by suicide are not engaged in mental health (Jobes & Chalker, 2019). Suicide risk thus creates an unfortunate mutual avoidance dynamic between clinicians and patients. Providers are wary of patients who are suicidal; patients are wary of providers. Survey research shows providers favoring hospitalization for suicidal risk (Rozek et al., 2023) while other research shows that patients who are suicidal may not share this information because they do not want to be hospitalized (Blanchard & Farber, 2020). This standoff is a losing formula for decreasing suffering and saving lives. Instead of alienating patients, readily available, effective, and desirable suicide-focused care to decrease suffering and help save more lives is imperative.

National Strategy for Suicide Prevention

In April of 2024, the U.S. Surgeon General introduced the National Strategy for Suicide Prevention (NSSP), a non-partisan blueprint for the federal government to guide the next decade of our suicide prevention efforts. The national strategy emphasizes four strategic directions: (1) Community-Based Suicide Prevention, (2) Treatment and Crisis Services, (3) Surveillance, Quality Improvement, and Research, and (4) Health Equity in Suicide Prevention. Directions 1 and 2 are most relevant to our present discussion. The first strategic direction again emphasizes systems-level considerations (like Zero Suicide). Goal 8 within the second strategic direction emphasizes integrating effective suicide-focused care as a core component of care delivery. Evidence-based suicide-focused care is thus central to the NSSP.

The Importance of the 988 Lifeline and Use of Telehealth

Beyond suicide-focused policy developments, there are two additional developments to consider. First, the creation of the "988 Suicide & Crisis Lifeline" as an alternative to calling 911 for a mental health crisis is a watershed development—988 is now transforming crises care in the U.S. However, the roll out of 988 has made clear that we do not have a community "safety net" for those in acute suicidal crises. Within the media and larger public there is an emerging awareness that emergency department "care" and psychiatric admissions for suicidal risk are often inadequate. These expensive medical interventions often do not work and can actually *increase* suicide risk post-discharge (Jobes & Barnett, 2024)! Within NSSP, 988 is a major focus and there is a markedly increased focus on crises services for suicidal risk as well.

Birth of the Hope Institute

The Hope Institute was born of practical necessity. In the fall of 2020, mental health issues and resources were in a state of crisis (Runkle et al., 2021). As available mental health care became increasingly limited, there was an urgent need for a readily available clinical resource to handle mental health crises, particularly related to suicidal ideation. Perrysburg Counseling Services, in Ohio, had a history of working with patients who had suicidal thoughts using a rapid intake and treatment protocol. Given wait list challenges at the time, there was an increased need to *stabilize* people in suicidal crises so they could safely wait for outpatient care. Moreover, providers in this setting embraced an evidence-based suicide-focused acute care model that primarily used Collaborative Assessment and Management of Suicidality (CAMS—Jobes, 2023) along with key elements of Dialectical Behavior Therapy (DBT—Linehan, 1993).

Overview to the Hope Institute

Within the Hope Institute model, suicidal risk for all patients is initially identified using the ASQ (Horowitz et al., 2012) or the C-SSRS (Posner et al., 2011) as both are well constructed, non-proprietary, and available online. With suicidal ideation identified, The Hope Institute endeavors to quickly engage all patients in CAMS-guided care within days of contact.

The Hope Institute use of CAMS

The Hope Institute uses CAMS with potentially more frequent sessions per week than might be typical. Central to CAMS is a multi-purpose assessment, treatment planning, tracking, and clinical outcome tool called the "Suicide Status Form" (SSF). There are three phases of CAMS that use three versions of the Suicide Status Form: (1) the first session, (2) all interim care, and (3) the final outcome disposition session.

CAMS First Session

CAMS immediately starts clinical care focusing on suicidal risk in the first session. Clinicians ask permission to take a seat next to the patient to respond to quantitative and qualitative assessment variables (written in the patient's hand). Patients rate five-point rating scales (the "Suicide Status Form Core Assessment") of psychological pain, stress, agitation, hopelessness, self-hate, and overall behavioral risk of suicide. Additional qualitative variables focus on written descriptions of these variables along with reasons for living and reasons for dying (among other variables). Clinicians then take over assessing risk and warning variables (side-by-side), collaboratively completing the first session assessment phase of CAMS. It is noteworthy that the first session assessment of CAMS functions as a *therapeutic assessment* as per two studies (Oakey-Frost et al., 2024; Poston & Hanson, 2010). After assessment, the dyad shifts to CAMS treatment planning that is focused on stabilizing patients thereby averting emergency department or inpatient admissions. The CAMS Treatment Plan relies on the initial completion of the CAMS Stabilization Plan (Tyndal et al., 2022) and identification of patient-articulated "drivers"—problems that cause the patient's suicidality (Lynch, 2022).

Interim Care

All subsequent CAMS sessions use the interim SSF forms that begin with SSF Core Assessment ratings and end with a CAMS Treatment Plan update. Within all interim sessions the CAMS Stabilization Plan is further crafted and various interventions are used to address and treat the patient's suicidal drivers.

Final Outcome-Disposition Session

When the dyad realizes three successive consecutive sessions where overall behavioral risk is reduced and effective management of suicidal thoughts feelings, and behaviors has been established, CAMS can be concluded using the final outcome-disposition version of the SSF. Suicidal ideation may still linger at the end of CAMS, but the patient has nevertheless established a reliable ability to manage such thoughts and feelings along with behavioral stability.

Other Considerations

CAMS sessions are conducted during a patient's initial contact (next day appointments, or NDA's) and there is the potential use of multiple sessions per week to ensure a patient's relative stability within outpatient care. Consequently, the clinical dyad may meet up to four sessions/week to help ensure behavioral stability. Flexibility is a signature feature of The Hope Institute; other interventions, including engaging family or social supports, can be done to address a patient's drivers. "CAMS-4Teens" is used with adolescents and relies heavily on the support of parents using the CAMS Stabilization Support Plan (Jobes, 2023). Additional significant others—spouses or friends—can also be engaged using the Stabilization Support Plan. Patients with drivers focused on parents or siblings might lead to family therapy.

Beyond relying primarily on CAMS, Hooe Institute care also routinely integrates elements of Dialectic Behavior

Therapy (DBT). The combined use of CAMS and DBT—and their complementary nature—has increasingly become a focus in clinical trial research and practice (Jobes & Rizvi, 2024; Pistorello et al., 2021). Use of CAMS and DBT, ensures full spectrum treatment of suicidal risk, from acute to chronic states, to reduce suicidal ideation and behaviors respectively (Jobes & Rizvi, 2024; Lee, 2024).

The Hope Institute Use of DBT

The Hope Institute thus routinely uses DBT skills to augment CAMS because of data supporting DBT Skills as a standalone intervention. The Hope Institute facility had a history of successfully running DBT skills sessions which reduced the need for new training and expedited implementation.

DBT skills-focused sessions were originally developed to be used in weekly group modules on a 48-week (12 month) treatment cycle (Linehan, 2014). As a short-term approach, The Hope Institute does not provide a 12-month course of care as DBT skills training is modified for short term use similar to modifications using the DBT skills for adolescents (Rathus & Miller, 2014). A group modality is used for standard DBT skills sessions, following a schedule of modules focused on distress tolerance, emotional regulation, interpersonal effectiveness, and dialectics. New patients typically start during the orientation week of one of the modules and attend weekly until they have completed all modules, often completing the cycle twice. All sessions and modules build toward the composite acquisition of DBT skills, and the fact that individuals can enter into the process at different points demonstrates the modular nature of the program. There is no inherent starting module in the standard use of DBT.

Within a short-term approach, The Hope Institute uses specific modules from the areas of mindfulness, dialectics, distress tolerance, emotional regulation, and interpersonal effectiveness that can be taught independently or arranged into a group sequence which enables a patient to immediately use skills if they are struggling. This modular approach also allows patients to attend groups one to three times/week; Varied modules of applicable skills, can function independently of each other reducing knowledge gaps that might interfere with effective use. DBT skills groups are conducted with fidelity, however the full DBT intensive model is not used as care is focused, brief, and stabilization-oriented.

The Hope Institute Policies and Procedures

At a policy level The Hope Institute only sees people who are acutely suicidal and in need of behavioral stabilization, offering short-term, suicide-focused, outpatient care using intensive doses of evidence-based care and endeavoring to avert emergency departments and inpatient admissions. The goal is to stabilize patients and optimally refer them on to appropriate longer-term care. The Hope Institute clinical procedures and practices follow the tenants of CAMS and DBT which shape and define all care (Jobes & Rizvi, 2024; Lee, 2024). Research now shows that telehealth can be as effective as face-to-face care (Fernandez et al., 2021; Lee et al., 2023). Moreover, clinical trial research has established that both CAMS and DBT training and care can be effectively provided via telehealth (Kassing et al., 2024). Hope Institute providers thus embrace telehealth to better reach more patients and increase accessibility.

Staffing and Training

Staffing is a major priority for The Hope Institute. The facilities rely on mental health professionals with master's degrees or higher who are appropriately licensed. All clinicians are trained in The Hope Institute model, including the use of CAMS and DBT Group Skills. Even when someone has previous applicable training, that provider will be retrained through The Hope Institute to assure congruency and understanding of the model. Training is provided by the same clinicians that provide ongoing supervision and consultation, which provides additional congruency. All clinicians receive ongoing weekly clinical supervision to ensure the fidelity to the model in accordance with the DBT consultation team approach.

Populations Served

The Hope Institute has served children as young as 5 through adults in their 70's. Publications in development will demonstrate the effectiveness of The Hope Institute for different demographic, cultural, ethnic, and underserved populations. To date, there have been no statistically significant differences in outcomes based on age, race, culture, sex, or gender identity (Lee, 2024). Data is being collected in facilities in Ohio, Arizona, Colorado, and Georgia, where diverse and underserved patient populations (e.g., African American, Indigenous Americans, and Hispanic) have been seen with considerable clinical success.

Criteria for Discharge

The Hope Institute relies primarily on the criteria for discharge set forth by the CAMS framework. This includes three consecutive sessions with reductions in a patient's overall risk SSF rating for suicide, no suicidal behavior, and effectively managing suicidal thoughts and feelings. Although the discharge criteria should primarily focus on evidence, the clinician's judgement—and patient's perspective—should also factor into discharge decision-making.

Ethical and Liability Considerations

The Hope Institute presents an outpatient model th`at respects and aligns with the ethical and legal requirements to provide the least restrictive care possible (Jobes & Barnett, 2024). By emphasizing least restrictive outpatient care, The Hope Institute enables patients to continue to work or go to school, reducing major disruption to their routines and lives. Using CAMS and DBT also helps overtly foster enhanced support of others while patients use new coping skills within the natural home setting and work environments.

Fear of malpractice liability is a common concern that often prompts restrictive care. However, as argued by Jobes and Barnett (2024), the single best possible risk management strategy for suicidality is to adherently provide evidence-based clinical care. The Hope Institute model embraces evidence-based, suicide-focused, care that is extremely well-documented. The criteria for treatment and discharge are forthright, measurable, and quantifiable with a clear goal of achieving stability. In the event of a suicidal death, the pursuit of wrongful death tort litigation by surviving loved ones is significantly reduced within the model because both CAMS and DBT routinely engage family and friends in support of clinical care which is evidence-based and well-documented thereby markedly reducing liability (Jobes, 2023; Jobes & Barnett, 2024).

General Outcomes of the Hope Institute Approach

Given the success and replication of several clinics across the nation, we would like to describe some general outcomes thus far to provide a better conceptual understanding of The Hope Institute. For example, the initial findings from The Hope Institute in Perrysburg showed that 98% of clients ($n=58$) were successfully discharged. In the following 90 days, 93% reported no ongoing issues, resulting in 5% recidivism (Lee, 2024). The 2% not successfully discharged were referred to a higher level of care (i.e., inpatient hospitalization). The length of care ranged from 1 to 16 weeks, with an average of 5.6 weeks; the number of weekly sessions ranged from 1 to 4, with an average of 1.3. Of the 98% successfully discharged from The Hope Institute, 79% were referred to ongoing services.

Stabilization Related to Suicidal Risk

The Hope Institute has now rendered care to over 1,000 patients across three main clinics. Approximately 15% of individuals treated did not have an underlying mental health condition and did not require further care while the other 85% were able to receive standard outpatient treatment from existing providers or were seen at clinics in their community. Within the Perrysburg sample, statistically significant pre-post reductions in suffering and suicidal ideation as measured by the CAMS SSF Core Assessment was observed (Lee, 2024).

Recidivism

The Perrysburg recidivism rate has generally not exceeded 5% within 90 days of discharge and this has been consistent with the offices in other states. This finding across clinics is noteworthy because recidivism is expensive and deeply discouraging to patients, families, and providers. Common references by mental health providers of "frequent flyers" reveals a pejorative and unfortunate attitude the arises from "revolving door" patients who repeatedly return with suicidal risk and instability clearly showing the ineffectiveness of previous care.

Cost-Effectiveness

The Hope Institute treatment costs are markedly cheaper than emergency department or inpatient care (that is too often ineffective). Moreover, the use of CAMS and DBT emphasizes the importance of least restrictive outpatient care which ensures that many patients do not have to miss work and family members can support their loved ones outside of work hours. The Hope Institute care can help ensure that patients and their families limit expensive medical care. A typical visit to the emergency department for a mental health crisis cost $5000–$6000 (Taber et al., 2015) while an inpatient stay may cost $10–20,000. In contrast, the average course of Hope Institute care for six weeks is approximately half the cost of a single ED visit (Lee, 2024).

Discussion

We have endeavored to address a major public and mental health concern for millions of Americans who struggle each year with serious thoughts of suicide. The medical model approach that is routinely used relies on restrictive, expensive, ineffective, non-evidence-based, care that inherently discourages patients, families, and providers. Given the failures of existing approaches, innovative suicide-focused policy initiatives have proliferated in recent years emphasizing evidence-based, suicide-focused clinical care, that is optimally provided within the community (Goldstein Grumet & Jobes, 2024). The Hope Institute approach offers a possible remedy for dealing with many contemporary challenges related to suicidal risk. The Hope Institute relies on CAMS and DBT using an intensive patient-centered outpatient approach that is evidence-based, least-restrictive, and

cost-effective, and complies with many elements of new suicide-focused policies. The model has been successfully replicated across three locations with encouraging clinical and cost-effectiveness. But beyond this conceptual overview, it is important to mention something about the countless insights, impressions, and anecdotes that may speak to the "secret sauce" of The Hope Institute approach to contemporary challenges of suicidal risk.

The Hope Institute Environment and Staff Morale

One might think that with a singular focus on suicide, clinics would have a dark and heavy atmosphere, but this is not the case. Hope Institute environments are calm, upbeat, bright, and quite positive. Patients quickly realize that these are clinics where suicidal suffering is directly and meaningfully addressed with proven treatments that reduce suicidal suffering and behaviors (Jobes & Rizvi, 2024). An essential element of The Hope Institute atmosphere is created by carefully hiring skilled clinicians who deeply care. Importantly, staff have *chosen* to do challenging suicide-focused work; staff take pride in their work, and it shows.

Hope Institute staff are not burned-out, angry, or just going through the motions; clinics maintain remarkably low rates of turnover and staff morale is excellent. Providers are excited about the life saving work that they do. Staff tend to bond and become valued colleagues and close friends. A family-like atmosphere with strong professional relationships. A unique trust among staff is forged within the cauldron of providing life-saving care. Staff feel supported, appreciated, and routinely report that they "have each other's back." Weekly consultation team fashioned after the model used in DBT also reduces burnout and improves staff morale. Active consultation between staff members helps create needed support and validation and contributes to an upbeat and healing atmosphere. Staff are well compensated and receive excellent benefits. Generous vacation leave is given and time off is encouraged—even required sometimes—self-care, personal recovery, and getting re-energized are all priorities within the culture.

Proven Models of Care

Both patients and staff benefitted from using evidence-based clinical treatments—CAMS and DBT—that are validating, patient-centered, collaborative, and singularly focused on decreasing suffering and the pursuit of lives worth living. Using these interventions helps increase clinical confidence, which instills faith in providers to work effectively with challenging patients. Patients in turn benefit from working with clinicians who are confident; placebo effects help change brain chemistry and invariably instill a sense of hope (Jobes, 2023).

The Hope Institute staff also see their patients from assessment, through treatment, to outcome disposition and discharge within an intensive short-term approach to care. In other settings, different providers provide different components of care. For example, within inpatient care a nurse may do an admission intake, an attending psychiatrist may prescribe medications, and a social worker may then help discharge the patient after a brief stay. Too often, the inpatient experience can feel disjointed and even uncaring. In contrast, Hope Institute patients and clinicians routinely share and celebrate a sense of achievement over a course of care that is singularly aimed at decreasing suffering and increasing behavioral stability.

The Hope Institute culture also normalizes open and respectful discussions of suicidal thoughts and feelings which can help decrease stigmatization. Patients directly benefit from talking openly and honestly about their thoughts and feelings related to suicide without fear of police being called or being hospitalized unnecessarily. Such feelings about suicide are recognized and validated—blame and shame are never a part of the patient's experience. The spirit of normalization and de-stigmatization is central to the culture and all communications. The steady validation and acceptance by staff helps patients' feel relief, appreciated, and normal, enabling a patient to feel human and not like an outlier on the fringes of society.

The infectious spirit of validation in these clinics also extends to family members and loved ones of patients as well, helping to normalize their experience thereby reducing their guilt, frustration, and despair. Indeed, loved ones of patients marvel about actually being listened to by providers and then supported. Loved ones also appreciate that there is no agenda to "get rid of" their loved one to an ED or inpatient unit. Because CAMS and DBT are used, family members and loved ones are routinely engaged as part treatment and are routinely involved in discharge planning at the end of care. That *suicide risk is treatable* by using proven clinical care is perhaps the most important emphasis for patients, loved ones, and staff alike. For many, The Hope Institute mission can be a shock for patients and loved ones. However, after negative experiences within conventional care, The Hope Institute approach is quickly embraced and often seen as a corrective clinical experience and a welcomed answer to silent prayers. To this end, we would note that within a meta-analysis of nine CAMS clinical trials, the single biggest effect for CAMS overall was increasing hope and decreasing hopelessness (Swift et al., 2021). There is a reason that "Hope" is the name of these suicide-focused clinics.

Patient Satisfaction

While we have not directly collected data, we can anecdotally report countless examples of patient satisfaction with The Hope Institute clinical experience. This may be particularly true for patients who have previously experienced traditional medical model crisis care. Among various considerations, patients and families appreciate lower costs, better and quicker access to care, and minimally invasive programming (allowing patients to continue with school/work/life in general). The Hope Institute is singularly devoted to decreasing human suffering and saving lives which has a collective impact on clinic culture and everyone involved—staff, patients, and loved ones. Satisfaction with care is celebrated every day by active and former patients, ranging from comments of gratitude in sessions, grateful calls from family members, and individuals who speak out at community events, crediting The Hope Institute for saving their life.

Conclusion

This article provides a conceptual overview of a new model of short-term suicide-focused care. The challenges of suicidal risk are formidable and existing "medical model" approaches are inadequate and may even *increase* suicide risk. The Hope Institute offers a distinctly different approach to care, a much needed and potential remedy for the 16 M Americans who wrestle with serious thoughts of suicide. The approach is consistent with emerging policies that argue for community based, suicide-focused, clinical care that uses evidence-based approaches. Preliminary use of The Hope Institute across three clinics is promising—the model is both feasible and has been replicated in different locations. Relying on CAMS and DBT, The Hope Institute offers genuine promise for an alternative approach to suicide-care by reducing suffering, increasing stability, and opening the door to the possibility of a life worth living.

Author Contributions DL and DJ cowrote the main manuscript text. DL provided led with narrative and THI outline. DJ provided substantial history, current state of affairs, and CAMS information. All authors reviewed and approved the manuscript.

Data Availability No datasets were generated or analysed during the current study.

Declarations

Competing Interests Financial interests: The authors declare they have no financial interests. Non-financial interests: Both authors are on the board of directors of The Hope Institute of America and receive no compensation as members of the board of directors. Additionally, author DJ currently serves as CEO, focused on integrity of the model and receives no compensation.

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