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The Collaborative Assessment and Management of Suicidality (CAMS) Stabilization Plan for Working With Patients With Suicide Risk

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The Collaborative Assessment and Management of Suicidality (CAMS) provides clinicians with an evidence-based suicide-focused therapeutic framework to help patients understand and manage suicidal thoughts and behaviors. A key component in CAMS suicide-focused treatment planning is the development and use of the CAMS Stabilization Plan (CSP). The CSP is used to ensure between-session safety and stability by helping patients learn to cope differently, enabling clinicians to care for suicidal patients on an outpatient basis, and thereby rendering suicidal-oriented coping obsolete. While implementing and maintaining the CSP, clinicians work to identify, target, and treat patient-identified suicidal drivers aimed at lowering the patient's suicide risk. The CSP employs a collaborative, flexible, and problem-focused approach creating a unique dynamic between clinician and patient as they work together to address the patient's suicidal struggle. CAMS allows clinicians to be flexible in their approach to treating suicidal behavior, utilizing techniques and tools they know, while providing them with a unique framework to engage their suicidal patients. Additionally, there is an overt and ongoing emphasis on encouraging patients to cultivate purpose and meaning in their lives with plans, goals, and hope for the future—ultimately leading patients to discover a life worth living, which is the final focus in CAMS-guided care.

Clinical Impact Statement
Question: How can clinicians engage suicidal patients in utilizing an ongoing stabilization plan? ***Findings:*** Through the Collaborative Assessment and Management of Suicidality Stabilization Plan (CSP) clinicians can engage patients in a collaborative, flexible, and problem-focused approach to reduce a patient's suicide risk. ***Meaning:*** CAMS guided treatment planning works to develop and modify a patient's stabilization plan, as well as identify patient-articulated suicidal drivers which are targeted and treated across the course of CAMS. ***Next Steps:*** By increasing clinician use of suicide-focused crisis management planning there is real promise for decreasing suicidal suffering and saving more lives.

Keywords: collaborative assessment and management of suicidality, stabilization plan, suicide, suicidal-drivers, safety planning

The Collaborative Assessment and Management of Suicidality (CAMS) is an evidence-based, suicide specific therapeutic framework developed by David A. Jobes (Jobes, 2016). Within this framework, clinicians are encouraged to use evidence-based approaches, techniques, and strategies in which they have expertise to tailor their treatment approach to each patient. The flexibility found in CAMS allows clinicians to work within their theoretical approach while providing comprehensive care to suicidal patients.

At the center of the CAMS approach is the emphasis on collaboration and building a strong therapeutic alliance; the clinician and the patient work closely together to develop a shared understanding of the problems, issues, or concerns that most compel the patient to take their life (Jobes, 2016). The collaborative nature of CAMS is literal and symbolic. The side-by-side seating arrangement used in CAMS helps to emphasize the importance of a clinical partnership between the dyad. Furthermore, through the interactive and collaborative assessment and deconstruction of the patient's suicidality using the Suicide Status Form, the patient is invited to actively inform and contribute to their own suicide-specific treatment plan, functioning as a "coauthor" of their own treatment.

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Another key component of the CAMS philosophy is empathy with the patient's suicidal suffering. Within CAMS, there is no room for blaming or shaming of suicidal patients. Rather, the clinician endeavors to understand the patient's suicidal wish from an empathetic and nonjudgmental perspective. However, it is important to note that empathy of suicidal states does not equal endorsement of suicidal behavior. Rather, it allows the patient to open up so that the dyad can discuss and explore alternative and adaptive ways of coping and getting needs met.

Finally, honesty and transparency are essential in CAMS-guided care. CAMS clinicians communicate to their patients that they understand that suicide is an option, and that ultimately, they have limited control in their patients' actions. However, the patients are also informed about the clinicians' legal obligations of initiating inpatient hospitalization when encountering a patient at imminent risk of suicide. Nevertheless, CAMS clinicians clearly indicate their desire to collaboratively establish an *outpatient* treatment plan.

The CAMS approach (and its use of a multipurpose clinical tool called the "Suicide Status Form"—SSF) is supported by extensive clinical research through numerous correlational/open trials, quasi-experimental studies, and five randomized controlled trials (RCTs; e.g., Ellis et al., 2015, 2017). The findings from the RCTs comparing CAMS with "enhanced care as usual" (E-CAU) or treatment as usual (TAU) in outpatient and inpatient settings with college students, U.S. Army soldiers, and community mental health patients reveal that CAMS guided care is superior in reducing suicidal ideation, overall symptom distress, depression, and hopelessness compared to E-CAU and TAU (Comtois et al., 2011; Jobes et al., 2017; Pistorello et al., 2020; Ryberg et al., 2019).

CAMS Treatment Overview

Within the CAMS theoretic framework, suicidal thoughts and behaviors are seen as coping mechanisms or as ways to problem-solve and meet a patient's need (Jobes & Drozd, 2004). Suicidal thoughts/behaviors thus have a "functional" role as patient's endeavor to problem-solve and get their needs met via suicide. Such needs range from a desire to control others or means to end suffering. A CAMS clinician endeavors to understand their patient's unique idiosyncratic reasons for considering suicide. This is an intentional move away from the traditional approach of suicide treatments, which often focuses on diagnosing and treating psychiatric illness as a means of reducing the symptoms of suicidal thoughts and behaviors. CAMS instead focuses on suicide as the target problem, emphasizing an assessment and deconstruction of the patient's suicidality. This is accomplished through identifying patient-defined "suicidal drivers" which are problems and issues that compel the patient to consider suicide (Jobes et al., 2016). By identifying the patient's suicidal drivers (e.g., a romantic breakup, imminent financial crisis, or intense suicidal self-hatred), the clinician can gain a greater level of empathy and depth of understanding for a patient's attraction to suicide.

CAMS First Session Engagement and the Use of the SSF

The CAMS Stabilization Plan (CSP) is embedded in the assessment and treatment planning process of every CAMS-guided session. Starting in session 1, the CSP is a critical element within each stage of care. Once a patient reports current suicidal ideation through a screening assessment or by verbal query, the process of using CAMS may begin.

First Session SSF Section A-Core Assessment

The first session of CAMS employs the initial use of the Suicide Status Form (SSF) to conduct a collaborative in-depth assessment of the patient's suicidal struggle (Jobes, 2016). Sitting side-by-side (with the patient's permission), the dyad completes the SSF together. The form consists of several Likert scales, qualitative assessments, and rankings from the patient's perspective. The SSF "Core Assessment" consists of six constructs: psychological pain, stress, agitation, hopelessness, and self-hate as well as overall (behavioral) risk of suicide. Patients are asked to rate each of the constructs on a one to five scale (i.e., low pain to high pain) as well as provide written responses to prompts (e.g., "What I find most painful is: _____"). Next, there is an assessment of how much a patient's suicidal thoughts and feelings relate to themselves versus others from 'not at all' to 'completely' on a five-point scale. The form continues with a section for patients to list both their reasons for living and reasons for dying and rank them based on importance. The patient is then asked to rate their wish to live and their wish to die using a nine-point scale from "not at all" to "very much." Lastly, the patient is asked to note "one thing that would help them to no longer feel suicidal" in an open-response format.

First Session SSF Section B-Risk Assessment

Section B of the SSF is completed by the clinician in the side-by-side arrangement and consists of an evaluation of fifteen objective suicide risk and warning variables (e.g., suicide ideation frequency, suicide plans, history of suicidal behavior, etc.). Each part of SSF Section B is worked on with the patient in order to uncover the unique nature of the patient's suicidal suffering. SSF Sections A and B can be used to uncover or identify the "suicidal drivers" that compel the patient to consider suicide. It can also be used to identify a patient's suicide plan and access to lethal means, which helps to establish the building blocks for the CSP. This assessment enables the dyad to deconstruct the patient's suicidality which will help inform a comprehensive suicide-focused treatment plan.

First Session SSF Section C—The CAMS Treatment Plan

Still sitting side-by-side, a suicide-specific treatment plan is developed under Section C of the first session SSF. The #1 problem of the CAMS Treatment Plan to be addressed is the patient's self-harm potential, followed by problems #2 and #3 which are specific to each patient. Self-harm potential is the primary concern because it is a central consideration in the intentional pursuit of *outpatient care*. While an inpatient stay is sometimes necessary to save a life, there is correlational evidence that such stays are associated with *increased* risk of suicide postdischarge (Goldacre et al., 1993; Wolfersdorf, 2000). Therefore, the decision to hospitalize or not rests on developing a thoughtful and satisfactory plan should the patient face an acute between-sessions suicidal crisis. To this end, the CSP is discussed, developed, and negotiated as

the key intervention that can fundamentally support the viability of pursuing outpatient care.

Successful completion of the CSP helps ensure between-session safety and stability. The CSP is intended to increase a patient's ability to cope with a suicidal "dark moment" effectively averting suicidal behaviors. Importantly, the CSP is not the same as a "no-suicide" contract, which is essentially just a short-term promise initiated by the clinician to get a patient to not engage in suicidal behaviors (Rudd et al., 2006), and in recent years no-suicide contracts have been proven to be ineffective when compared to Crisis Response Plans (Bryan et al., 2017) and Safety Planning (Stanley et al., 2018). In other words, stabilization planning emphasizes what a patient *will* do versus promising what they *will not do* as we see with traditional no-harm/no-suicide contracts. Therefore, the two main goals of CAMS-guided treatment planning are: (a) the development and modification of the patient's CSP and (b) the identification of patient-identified suicidal drivers, which are targeted and treated across the course of CAMS (e.g., using CBT techniques, behavioral activation, medication, insight-oriented psychotherapy, pain management, etc.).

Completion of the CAMS Stabilization Plan

The CSP has four main components that include: (a) reducing access to lethal means, (b) developing a list of coping and problem-solving strategies and emergency numbers to call, (c) a focus on decreasing isolation and increasing relational support, and (d) identifying and addressing any potential barriers to attending therapy.

The CSP engagement begins with a very frank discussion of reducing access to lethal means (which is one of the most important considerations to averting an inpatient admission). Reducing access to lethal means has been shown in several studies to be an effective method for decreasing suicide risk (Daigle, 2005; Mann et al., 2005). As noted in the CAMS philosophy, clinicians should endeavor to be empathetic, honest, and transparent with their patient, engaging in a forthright discussion of both the legal obligation of protection from harm as well as the goal of helping the patient obtain a new way to cope that gives them the chance at a meaningful life. Although a client may struggle to give up lethal means, CAMS clinicians can highlight that suicide does not have to be the patient's way of navigating the world and a bridge can be built to introduce ways of coping differently. Examples of lethal means restriction include removing medications, knives, ropes, and firearms from a patient's home. For means where access cannot be completely removed, reducing access is the goal (e.g., access to tall buildings, railroad tracks, bridges, etc.). With patient permission and an appropriate release of information, means may be secured by a trusted individual in the patient's life and verified with the clinician.

Developing good coping skills with a suicidal patient is a bit of an art. Suicidal patients are not suicidal 24 hr a day/7 day a week. Instead, there are moments when patients are triggered by their suicidal drivers, potentially placing them at risk for suicidal behaviors. In such moments, the goal is for the patient to use their CSP to learn new ways to cope and weather the storm on their own. The list of 5 coping strategies is meant to redirect, delay, distract, and/or help self-soothe if the patient finds themselves in the midst of an acute suicidal crisis (e.g., going for a walk, reading a book, watching a movie, or calling a friend). The whole idea with this portion of the CSP is that the patient will work their way through coping items 1–5 and if they are still in an acute crisis, then they will know that it is an emergency and that they need to reach out for help (e.g., the National Suicide Prevention Lifeline, 1–800-273-TALK or the National Textline, 741741). At the end of the first session, the patient should always receive a copy of their CSP or take a picture of it on their phone so that they may access it in moments of need.

To further support the patient, the CSP seeks to underscore and strengthen a patient's relational support. Through identifying people in the patient's life who could help them such as close family members, friends, mentors, clergy, and so forth, the patient can learn to draw on more support to help deal with an acute suicidal crisis. Moreover, this aspect of the CSP also emphasizes the importance of decreasing social isolation, which has been shown to be helpful for addressing suicidal thoughts and behaviors (Berardelli et al., 2018). The supportive individuals on the CSP may sometimes be invited by the clinician to attend a CAMS therapy session with the patient. In some cases, the use of a "Crisis Support Plan" can be established with a spouse or supportive friend to have guidance as to how to best support the patient (Bryan et al., 2017).

Finally, the last step to completing the CSP is to identify any potential therapy-interrupting behaviors and plan out potential remedies. These are what may often be referred to as barriers to treatment. Identifying barriers early in the treatment planning allows the clinician and patient time to find ways to adequately address them. Examples of some common barriers to treatment may be transportation to sessions, childcare during sessions, financial resources to continue treatment, or medical issues that may interrupt treatment. Efforts should therefore be made in the development of the CSP to decrease or eliminate these barriers, such as connecting clients with local agencies that provide childcare, bus passes, or free transportation; working with clients on a sliding scale basis; or connecting with a patient's other care providers.

Completion of Problems #2 and #3

After completing the CSP, there is a box to check under the CAMS Treatment Plan to that effect; a duration for using the intervention is also noted. The first session CAMS Treatment Plan is finally completed by identifying Problems #2 and # 3, which are otherwise referred to as "direct drivers" in CAMS parlance. These drivers are specific to each individual and represent the problems or issues that most compel them to consider suicide. The goal is to establish the top two drivers of a patient's suicidal ideation which will then become key foci of treatment going forward. For each problem, the clinician assists in identifying therapeutic goals/objectives and will propose various interventions for each problem. Although as a framework CAMS is not a psychotherapy, it creates a vehicle for treating these problems/suicidal drivers. Once the CAMS Treatment Plan is complete, the patient is asked if they understand and concur with the plan. At this time, it is also decided through clinical judgment if the patient is at imminent danger and therefore in need of inpatient care. Both parties sign the first session SSF and copies are given to the patient.

First Session SSF Section D-Record Keeping

After successful completion of the first session of CAMS, Section D of the SSF is completed by the clinician. This additional

documentation addresses valuable "medical record" information and provides thorough "progress note" documentation. Elements of Section D include: a mental status exam, a provisional *DSM* or ICD diagnosis, a judgment about overall risk, and ample space is provided for a narrative case note of the session.

CAMS Tracking/Update Interim Sessions

Within CAMS-guided care, all sessions following the first and prior to the final session are referred to as "tracking/update interim" and a briefer version of the SSF is used for these sessions (the interim SSF is 2 pages vs. the 4 pages of the first session SSF) (Jobes, 2016).

Interim Sessions SSF Section A

The Tracking/Interim SSF Section A of the "SSF Core Assessment" is done at the start of every interim session. It is important to note there should always be a check-in about any use of the CSP and a review of what has worked and what has not, so that the CSP can be modified or updated based on its use (or lack thereof). It is sometimes difficult to get patients to use their CSP, so the clinician needs to gently persist: "where is it, what gets in the way of using it?"

Interim Sessions SSF Section B

Every interim CAMS session ends with revisiting and updating the CAMS Treatment Plan and double checking about Problems #2 and #3 to ensure that the problem/driver is still relevant and needs to remain a focus of treatment within CAMS guided care. The suicide-focused treatment plan within CAMS is thus dynamic and flexible as the dyad update, modify, and revise their treatment focus on problems/drivers based on what happens in their life and within their sessions. Relatedly, the goals/objectives and potential interventions listed to address each problem/driver can also be amended as indicated over the course of CAMS-guided care.

Ongoing assessment of the effectiveness of the CSP is key to its effectiveness. Clinicians may find that different strategies may be needed to fully address a patient's problem-drivers. We also encourage CAMS clinicians to always foster a sense of hope over the course of CAMS-guided care. This is accomplished through encouraging patients to develop meaningful plans and attainable goals. Fostering a patient's hope for the future can often strengthen their commitment to treatment and help to diminish their previous reliance on suicidal coping (Jobes et al., 2016).

Interim Sessions SSF Section C

After every interim session of CAMS, the clinician completes Section C of the interim version of the SSF, again providing additional medical record documentation such as judgment about overall suicide risk and narrative case notes which can function as the medical record. This is an important step for all clinicians to consistently engage in as it helps to protect them from future malpractice liability.

CAMS Outcome/Disposition Session

In order for clinical resolution to be met, a patient must have three consecutive sessions where their overall suicide risk rating is meaningfully reduced (i.e., 2 or below on the 5-point rating form of the SSF Core Assessment) as well as effective management of suicidal thoughts and feeling with no evidence of any suicidal behaviors (Jobes, 2016). Several studies have shown that resolution often takes place in 6–8 sessions of CAMS and the vast majority of patients will resolve in 12 sessions (Jobes et al., 2008; Pistorello et al., 2020). Once a patient achieves criteria for clinical resolution over three successive sessions, their CAMS case is considered resolved and the patient and clinician complete the Outcome/Disposition version of the SSF to bring CAMS-guided care to a close. The Outcome SSF is similar to the interim version of the SSF and consists of a final SSF Core Assessment; a section for dispositional next steps (e.g., mutual termination, continued care beyond CAMS, referral to group, drop-out, etc.) to ensure there is a complete medical record of the case; and clinician documentation of the patient's mental status exam, diagnosis, overall risk for suicide, observations, and a final narrative case note.

Case Example

Eve[1] is a 20-year-old college student with a family history of physical and emotional abuse particularly at the hands of her mother. As a gifted student, Eve was able to "escape" her "toxic" family by obtaining a scholarship to an excellent university, where she majored in French. Eve had a history of self-harm and two overdose suicide attempts in high school, the latter led to a week-long psychiatric hospitalization. While she otherwise had an upbeat disposition and was very high functioning, Eve could slip into serious states of suicidal despair. Since her hospitalization, there had been delusional episodes in which she heard voices beseeching her to take her life. While hospitalized she received psychological testing, which diagnosed her with major depression-recurrent (with psychotic features) and borderline personality disorder.

Eve began seeing a private practitioner paid for by her wealthy but distant father. Eve completed an intake form prior to her first appointment and acknowledged frequent thoughts of suicide. Eve's clinician "Jean" was well-trained in CAMS and prepared to engage in the CAMS framework as of their initial session. Eve was very receptive to CAMS, she felt validated and relieved that her clinician seemed to understand her ongoing suicidal struggles. They worked through Section A of the first session SSF and completed the Section B assessment as well. When Jean announced to Eve that the goal of this approach was to keep her out of inpatient care, she felt immediately relieved. But Jean noted to achieve that goal a solid Stabilization Plan would have to be crafted.

As they started to work on the plan, Eve was struck that Jean was very insistent about the "stash" of medications she had for overdosing. After some discussion she agreed to turn over her stash to her roommate (who was well aware of Eve's issues) for safe keeping. Having agreed to this, they then moved to identify 5 coping strategies that included: journaling, talking to her roommate, taking a hot shower, playing a video game, and reading parts

[1] In compliance with the APA ethics code, all names have been disguised in this case example.

of a new book called Choosing to Live (Ellis & Newman, 1996). Jean also provided various hotline and support lines and even noted her personal cell number. Together, they also identified people who could help decrease Eve's isolation. See Appendix for Eve's completed CSP. Finally, they negotiated a meeting time that accommodated her busy work and academic schedule. With the CSP complete, Jean asked Eve to identify the two problems that made her suicidal. Without hesitation Eve said: my horrible mother and never having a boyfriend.

The CAMS-guided care with Jean evolved—their interim work centered on in-sight oriented psychotherapy about her abusive mother and efforts to better engage her father who seemed interested in being more supportive. They also did some CBT work and explored the prospect of online dating, which was both scary and exciting. A referral was made to a consulting psychiatrist who prescribed a SSRI for depression and low dose neuroleptic for her transient delusional thinking. Steady headway was made for a handful of sessions and the medication seemed to have an impact on the voices and delusional thinking. She was very tentatively emailing a young man she met online, and they were working toward actually meeting. Eve had used her CSP a handful of times and mindfulness had been added for coping which proved helpful.

As they were moving toward resolution, unbeknownst to Jean, after tremendous pressure from her mom Eve had agreed to visit her one weekend. Her mom said she wanted to make amends and even booked a train ticket for her to visit. The visit was an absolute disaster, and Eve fought with her mother the entire time. Eve left early and by the time she attended her Monday AM session with Jean she was actively psychotic. She reported that when she woke up, she was certain that a surgeon had broken into her apartment and surgically removed her hands transplanting someone else's hands. The voices urged her to go into the kitchen and burn off the foreign hands on the gas stove! But even in the midst of psychosis, Eve somehow recalled her CSP and struggled to do each coping step until she left for her appointment with Jean (accompanied by her roommate).

Jean called the consulting psychiatrist from their session and he offered to immediately see Eve who went straight to his office with her roommate. He doubled her antipsychotic medication and Eve quickly recovered and felt better in a matter of days. When she next met with Jean, they agreed that her mother must be cut out of her life. Over the next three sessions Eve did much better and seemed relieved to have closed the door on her mother. She also had a successful lunch date with "Paul", who was very nice and agreed to take things slowly. Eve and Jean mutually celebrated their resolution from CAMS after 11 eventful sessions.

Eve went on to date Paul and after a year they moved in together. She graduated from college magna cum laude and landed a job teaching French at a local private school. Cutting her mother out of her life was transformative; her father in turn stepped up and became an increasingly positive and supportive dad. She and Jean terminated their work together after 15 months. In their final session, Eve tearfully thanked Jean and earnestly told her that she had saved her life. Jean gently corrected her departing patient saying ". . . no Eve, actually we saved your life!"

Conclusion

Conceptually, the CSP may be considered a "cousin" of the Stanley and Brown Safety Plan and the Rudd and Bryan Crisis Response Plan as these approaches share similar elements (Bryan et al., 2017; Stanley et al., 2018). But while the CSP shares key elements and techniques used in other safety planning methods (e.g., lethal means counseling, coping skills, and relational supports), what sets CAMS apart is that the CSP exists within an evidence-based *treatment* of suicidal risk that is supported by extensive clinical trial research. Across several trials, we have seen the clear therapeutic value of identifying, targeting, and treating patient-identified suicidal drivers. But critically, this is accomplished because of the successful development and use of the CSP, which helps the patient to learn to cope differently, thereby rendering suicidal-oriented coping obsolete. This added aspect for directly treating suicidal risk is what makes CSP more than just an acute crisis management tool. In conclusion, we have seen the field of clinical suicidology transformed by the use of suicide-focused crisis management planning, which can play a key role managing suicidal suffering and ultimately saving more lives.

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(*Appendix follows*)

Appendix

Eve's Completed CAMS Stabilization Plan

CAMS STABILIZATION PLAN

Ways to reduce access to lethal means:

1. Turn over medication to roommate (leave voicemail verification)
2. _____
3. _____

Things I can do to cope differently when I am in a suicide crisis (consider crisis card):

1. Journaling
2. Talking to roommate (Beth)
3. Take hot shower
4. Play video games
5. Read from Choosing to Live
6. **Life or death emergency contact number:** 1-800-273 TALK, Textline 741741, Jan's # 333-555-1234

People I can call for help or to decrease my isolation:

1. Beth (roommate)
2. Bill
3. Penny

Attending treatment as scheduled:

Potential barrier:	Solutions I will try:
1. ~~Home~~ Classes?	Meet in A.M. instead of afternoon
2.	

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