The CAMS Approach to Managing Suicide Risk

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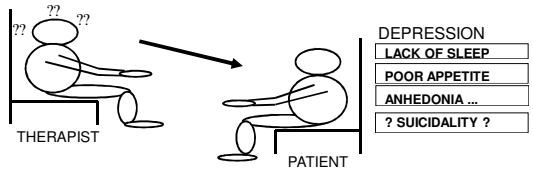
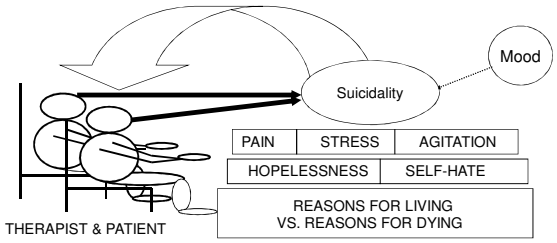
Critique of Current Approach to Suicide Risk: THE REDUCTIONISTIC MODEL (Suicide = Symptom of Psychopathology)



Traditional treatment = inpatient hospitalization, treating the psychiatric disorder, and using no suicide contracts…

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

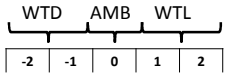


CAMS assessment uses the Suicide Status Form (SSF) as a means of deconstructing the "functional" utility of suicidality; CAMS as an intervention emphasizes a problem-focused intensive outpatient approach that is suicide-specific and "co-authored" with the patient…

Calculation of the Suicide Index Score From the SSI to Create Typologies

- SIS = WTL score – WTD score
  - SIS range is -2 to 2
  - Higher scores = greater WTL

- Trichotomize into 3 typologies
  - Wish to Live = Positive #s
  - Ambivalent = Zero
  - Wish to Die = Negative #s



Trying to predict reductions in suicidal ideation using first session SSF ratings

- BHM is administered prior to every session
- BHM item #10 (thoughts of ending life) was used as a proxy measure of on-going suicidal ideation

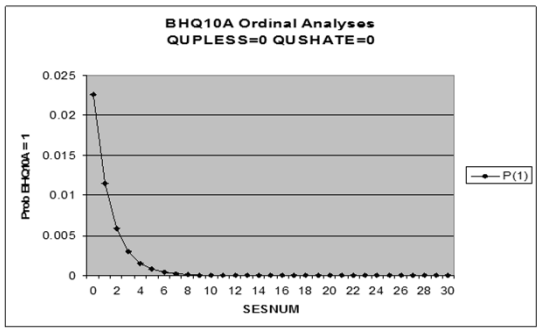
Sessions 1 2 3 4 5 6 7 8 9 10.....

Initial SSF Ratings:

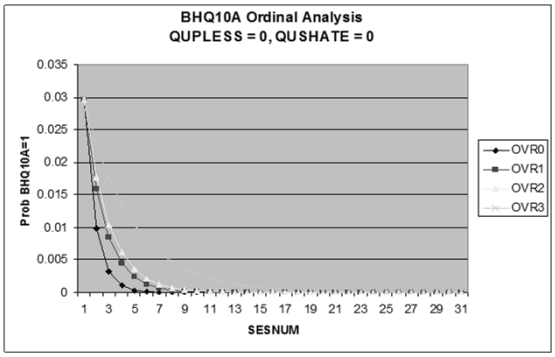
- Pain
- Stress
- Agitation
- Hopelessness
- Self Hate
- Overall Risk

BHM: "Thoughts of ending your life"

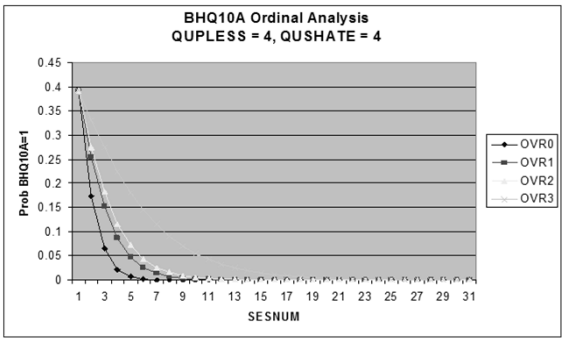
Suicidal Outpatient sample from the Johns Hopkins University Counseling Center (n=60)



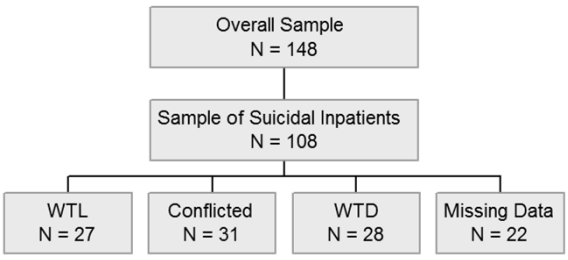
The SSF Overall Risk of Suicide rating differentially predicts reductions in suicidal thoughts



The effect is moderated by SSF ratings of Hopelessness and Self-Hate



Study 4: Mayo Clinic Inpatients (n=108) RFL/RFD Cross Sectional Results (*Jobes, Stone, & Wagner, 2010*)



Mayo Clinic RFL/RFD Cross Sectional Data (n=108) (Jobes, Stone, Wagner, & Lineberry, 2010)

Measures	RFL	AMB	RFD	Test
Beck Hopelessness Scale	10.17	12.62	15.01	$F = 5.23^{**}$
Reasons for Living Inventory	179.00	141.88	148.53	$F = 5.14^{**}$
WTL/WTD Suicide Index Score	3.49	1.83	-2.03	$F = 18.24^{***}$
Suicide Attempts	**RFL**	**AMB**	**RFD**	**Test**
0-1 Attempts	15	10	6	
2 or more Attempts	5	11	15	Chi-Sq = 7.83*

* p < .05, ** p < .01, *** p < .001

Adherence to CAMS: PI Collaboration (from Denver/Seattle CAMS trials)

CAMS is a therapeutic framework, used until suicidal risk resolves. Adherence to CAMS requires thorough suicide assessment and problem-focused interventions that target and treat suicidal "drivers" (i.e., patient-defined problems that put their life at risk).

Therapeutic Philosophy

1. Collaboration
   - Empathy with the suicidal wish
   - Clarify the CAMS agenda
   - All assessments/interventions are interactive
2. Suicide-focus ultimately guides all therapeutic activity

Clinical Framework

1. Assess index and on-going suicide risk using the SSF
2. All SSF-guided interventions are meant to eliminate suicidal drivers
   - A suicide-specific treatment plan with Crisis Response/Safety Plan/Stabilization Plan
   - Reduce access to lethal means
   - Insure treatment attendance
   - Problem-focused interventions are used to target and treat key suicidal drivers
   - Beyond coping, CAMS care should foster a life worth living

Overview to CAMS Assessment and Care

CAMS is a suicide-specific therapeutic framework, emphasizing five core components of collaborative clinical care (over 10-12 sessions/3 months).

- Component I. Collaborative Assessment of Suicidal Risk
- Component II. Collaborative Treatment Planning
  - → Attend treatment reliably as scheduled over the next three months
  - → Reduce access to lethal means
  - → Develop and use a Coping Card as part of Crisis Response Plan
  - → Create interpersonal supports
- Component III. Collaborative Understanding of the Patient's Suicidal Drivers
  - → Relationship issues (especially family)
  - → Vocational issues (what do they do?)
  - → Self-related issues (self-worth/self-esteem)
  - → Pain and suffering—general and specific
- Component IV. Collaborative Problem-Focused Interventions
- Component V. Collaborative Development of Reasons for Living
  - → Develop plans, goals, and hope for the future
  - → Develop guiding beliefs—a post-suicidal life (e.g., lessons in living)

CAMS SSF Stabilization Planning: An Orientation and Philosophy of Care

- The central treatment goal within CAMS is to establish a viable outpatient treatment plan that can keep the patient *out* of the hospital.
- This goal is largely achieved by the careful development of the SSF Stabilization Plan (also referred to as a Crisis Response Plan or Safety Plan).
  - Be clear about the legal statutes pertaining to imminent danger to self; overtly discuss goal of developing a viable outpatient treatment plan
  - Provide direction and guidance about the goal of establishing stability and outpatient safety
  - Emphasize mutual give and take
  - Be transparent, let the patient know your thinking and your agenda
  - Empathically appreciate suicidality as a means of dealing with seemingly unbearable pain
  - However, always raise the question: Is suicide in fact the *best* way to cope?

Stabilization Planning Continued

- Negotiate around time considerations and explore possibilities for delaying suicidal behavior in lieu of trying new and better ways of coping (self-soothing).
- The value of ***delay, distract, and redirect…***
- Continuously seek a good faith, time-specific, willingness to give treatment a chance.
- CAMS care should focus on:
  - (a) increasing pain tolerance
  - (b) creating alternative and better ways of coping
  - (c) ultimately making a life worth living

Stabilization Planning Conintued

- **Use the full range of treatment modalities and interventions**
- **Carefully consider the "dose" of care**
- **Actively enlist the help of family and friends (with the patient's consent) as possible component of treatment**
- **Think ahead and actively develop comprehensive crisis contingency plans**

Safety Planning: 6 Steps (Stanley & Brown, 2010)

1. Recognizing warning signs
2. Employing internal coping strategies without needing to contact another person
3. Socializing with others who may offer support as well as distraction from the crisis
4. Contacting family members or friends who may help to resolve a crisis
5. Contacting mental health professionals or agencies
6. Reducing the potential for use of lethal means

Center for the Treatment and Prevention of Suicide (2008) GK Brown (2005)

Beyond Stability: Treating the Drivers

- DBT chain analysis to identify triggers and points of intervention
- Teach 4-step problem solving
- Teach mindfulness and mentalization
- Various covert sensitization techniques
- Assertiveness training/role plays
- Najavits (2002) "Seeking Safety Treatment"
  - Safe coping skills (Part I)
  - Safe coping skills (Part 2)
  - Detaching from emotional pain (grounding)
    - Mental grounding
    - Physical grounding
  - Taking Good Care of Yourself

CAMS Care Continued

- There should be an overt emphasis on developing and consolidating coping and problem-solving skills and techniques.
- There should be an overt emphasis on actively developing Reasons for Living and systematically eliminating existing Reasons for Dying.
- There should be an emphasis on future thinking/planning (protective factors) including:
  - The development of short and long term plans and goals.
  - The development of hope for the future.
  - The development or further consolidation of guiding beliefs.

CAMS Care and a Life Worth Living

- There should be an overt emphasis on developing and consolidating coping and problem-solving skills and techniques.
- There should be an overt emphasis on actively developing Reasons for Living and systematically eliminating existing Reasons for Dying.
- There should be an emphasis on future thinking/planning (protective factors) including:
  - The development of short and long term plans and goals.
  - The development of hope for the future.
  - The development or further consolidation of guiding beliefs.
  - Developing a life worth living.

Resolution and Clinical Outcomes

Over three month CAMS-PFT treatment period, we are seeking:

Completion of Sections A-B

- Resolution of suicidality if:
  - 1) current overall risk of suicide <3;
  - 2) in past week, no suicidal behavior and
  - 3) effectively managed suicidal thoughts/feelings

- ❑ SSF Outcome Form HIPAA page is completed after final CAMS session (Section C).
- ❑ Patient's CAMS care comes to an end; patient is appropriately debriefed and referred to further care if indicated.

Lessons in Living: A Post-Suicidal Life

- Trans-theoretical guiding notions about developing a meaningful life worth living
- It must be more than just "relapse prevention"
- Disposition out of CAMS may include:
  - Congruence or self-discrepancy theory
  - Zimbardo's time perspective—Past/Present/Future
  - Agency vs. Communion theory
  - Perhaps a "Living Status Form" (LSF)

Reality of CAMS

- What are the virtues of CAMS?
  - Replicated evidence-base for changing ideation, hope, and symptom distress
  - Flexible/non-denominational—can be used in a range of settings and modalities
  - Designed to create a strong alliance and increase patient motivation
  - Is designed to keep the patient out of the hospital
  - Is fairly easy to train in a less labor intensive manner
  - Adherence is relatively easy to achieve; mastery comes quickly
  - Is correlated with reductions in non-mental health care utilization (less costs)
  - Should significantly help reduce malpractice liability
- What are the problems with CAMS?
  - No published data on impacting suicide attempt behaviors (yet)
  - Electronic version of the SSF is still under development
  - Some uncertainty about certain constructs (e.g., suicidal "drivers")
  - For beginners, first session may take more than 50 minutes
  - Full course of treatment may run 12 sessions (5% may exceed 20 sessions)
  - The different SSF documents can be confusing for beginners

Malpractice Liability, Competent Practice, and Cases of Suicide (Jobes & Berman, 1993)

- **Know the three "pillars" for reducing malpractice liability (i.e., malpractice wrongful death torts):**

  (a) Forseeability,

  (b) Treatment planning

  (c) Follow-up/follow-through