The Collaborative Assessment and Management of Suicidality (CAMS)

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The Collaborative Assessment and Management of Suicidality (CAMS)

The four pillars of the CAMS framework:

1) Empathy
2) Collaboration
3) Honesty
4) Suicide-focused

Goal: Build a strong therapeutic alliance that increases patient-motivation; CAMS targets and treats patient-defined suicidal “drivers”
First session of CAMS—SSF Assessment, Stabilization Planning, Driver-Specific Treatment Planning, and HIPAA Documentation
Adherence to the CAMS Approach

CAMS is a therapeutic framework, used until suicidal risk resolves. Adherence requires thorough suicide assessment and problem-focused interventions that target and treat patient-defined suicidal “drivers.”

CAMS Philosophy

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

CAMS as Therapeutic Framework

- Focus on Suicide—from beginning to middle to end
- Outpatient Oriented—goal is to keep a suicidal patient in outpatient care (if possible)
- Flexible and “Nondenominational”—used across theories and uses range of techniques
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 a self-oriented coping strategy on CAMS Stabilization Plan
   → Create interpersonal supports and connectedness

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 that target and treat patient-defined drivers

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—First Session

CAMS Suicide Status Form Initial Session

Pat: Kevin  Clin: David Jones  Date: 6/23  Time: noon

Section A (Patient)

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

2. RATE PSYCHOLOGICAL PAIN (that, anguish, or misery in your mind; not stress or physical pain):

- Low pain: 1 2 3 4 5 High pain

3. What I find most painful is: being stuck in my own skin

4. 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

6. RATE AGITATION (increased anxiety, feeling that you need to take action; not irritation or annoyance):

- Low agitation: 1 2 3 4 5 High agitation

7. I most need to take action so: someone does something untrustworthy

8. RATE HOPELESSNESS (your expectation that things will not get better no matter what you do):

- Low hopelessness: 1 2 3 4 5 High hopelessness

9. I am most hopeless about: anything changing

10. 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

11. What I hate most about myself is: everything

12. RATE OVERALL RISK OF SUICIDE:

- Extremely low risk: 1 2 3 4 5 (will not kill self)
- 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. Then rank in order of importance 1 to 5.

<table>
<thead>
<tr>
<th>Rank</th>
<th>REASONS FOR LIVING</th>
<th>Rank</th>
<th>REASONS FOR DYING</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>my mom</td>
<td>6</td>
<td>people would be better off if I was dead</td>
</tr>
<tr>
<td>2</td>
<td>maybe something will get better</td>
<td>3</td>
<td>people don't get it, they don't care</td>
</tr>
<tr>
<td>3</td>
<td>I don't contribute to society</td>
<td>4</td>
<td>nothing is going to change</td>
</tr>
<tr>
<td>4</td>
<td>See how Breaking Bad ends</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

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: miss flash thing on everyone and then myself
CAMS Session #1 (Cont.)

Stabilize Drivers

CAMS Suicide Status Form

STABILIZATION PLAN

1. Conversation with girlfriend about knife
2. Remove the belt

Things I can do to cope differently when I am in a suicide crisis (consider crisis card):
1. Exercise
2. Watch "Breaking Bad"
3. Write in journal
4. Read "Choosing to Live"
5. Walk to local "Best Buy"

Life or death emergency contact number: 555-350-1093
1-800-273-TALK

TBD

Attending treatment as scheduled:

Potential Barrier: Solutions I will try:

1. N/A
2. 

Patient Signature

Clinician Signature
The importance of restricting access to lethal means
Section D (Clinician Post-Session Evaluation):

MENTAL STATUS EXAM (circle appropriate items):
- Alert, oriented, lucid
- Somnolent
- Alcoholic
- Drowsy
- Lethargie
- Stuporous
- Other:
- Oriented to:
- Person
- Place
- Time
- Other:
- Mood:
- Euphoric
- Elevated
- Diffused
- Somber
- Mournful
- Anxiet
- Other:
- Affect:
- Flat
- Blunted
- Constricted
- Anxious
- Labile
- Other:
- Thought Content:
- Ideas of reference
- Blasphemy
- Morbid
- Other:
- Abstraction:
- Notably concrete
- Other:
- Speech:
- Slow
- Rapid
- Slurred
- mumbling
- Incoherent
- Other:
- Memory:
- Blunted
- Other:
- Reality Testing:
- Other:
- Other:
- Notable Behavioral Observations:

DIAGNOSTIC IMPRESSION/IMPRESSION (DSM-5/C Diagnosis):

Deferred - Rlo Major Depression

PATIENT’S OVERALL SUICIDE RISK LEVEL (check one and explain):
- Low (WTL/AF):
- Explanation:
- Moderate (AMH): Multiple attempt history, high SSF score
- Assessment ratings, long history of suicidal ideation - but willing to try CAMS for 3 months
- High (WTD/RPD):

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

Next Appointment Schedueled: Thurs
Treatment Modality: Individual, insight and CBT

Clinician Signature: Date: 6/25
**CAMS Interim Tracking/Update Session**

### Section A (Patient)
- **Patient:** Kevin
- **Clinician:** David Jones
- **Date:** 21
- **Time:** 11pm

**CAMS Suicide Status Form: Tracking/Update Interim Session**

<table>
<thead>
<tr>
<th>Problem Description</th>
<th>Goals and Objectives</th>
<th>Intervention</th>
<th>Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Self-Harm Potential</td>
<td>Safety and Stability</td>
<td>Stabilization</td>
<td>1 month</td>
</tr>
<tr>
<td>2. Self-Hate</td>
<td>Self-hatred &amp; compassion</td>
<td>Choosing to Live &amp; Cognitive-Behavioral Therapy</td>
<td>1 session</td>
</tr>
<tr>
<td>3. People don't get me</td>
<td>Trust &amp; support</td>
<td>Therapy &amp; Behavioral Activation</td>
<td>1 session</td>
</tr>
</tbody>
</table>

### Section B (Clinician)
- Resolution of suicidality: current overall risk of suicide: C1 in past week: no suicidal behaviors and effectively managed suicidal thoughts/feelings C2 in session.

### Section C (Clinician Post-Session Evaluation)
- **Mental Status Exam:**
  - **Alertness:** Normal
  - **Orientation:** Lateral Thinking
  - **Relevant Information:**
    - **Thoughts:**
      - Current: C1: ideation of suicide
      - Content: C1: depression, hopelessness, worthlessness
      - **Activity:**
        - **Thought Process:** C1: goal-oriented, tangential, circumstantial
        - **Thought Content:** C1: depression, hopelessness, emptiness, worthlessness
      - **Abstraction:** Notably concrete
    - **Mood:** Depressed
    - **Speech:** Rapid, jargon, incoherent, pressured
    - **Memory:** Grossly intact
    - **Reality Testing:** Poor
    - **Notable Behavioral Observations:**

- **Diagnostic Impression/Diagnosis (DSM-5):**
  - Major Depression

- **Patient’s Overall Suicide Risk Level:** MILD (WIL/RFL)
  - Explanation:
    - Continues to have high SIS score
    - Assessment ratings: managing suicidal thoughts and feelings

- **Case Notes:**
  - Kevin, 35-year-old white male, unemployed for 6 months
  - **Current:** Classified CAMS Therapeutic, presenting today and discussed history of abuse that contributes to self-hate.
  - **Self-hate** as a primary driver of suicide for him.
  - Updated his treatment plan to note self-hate related to trauma history.
  - Discussed Behavioral Activation for goal setting.

**Next Appointment Scheduled:** Thus., Treatment Modality: Individual, CBT, Insight
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
  - 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-Guided 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 of CAMS-guided care, we are seeking:

Completion of Sections A-B of the SSF Outcome/Disposition

- 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

- Patient’s CAMS-guided care comes to an end; the patient is appropriately debriefed and referred to further care if indicated.

- SSF Outcome Form HIPAA page is completed after final CAMS session (Section C).
### CAMS Outcome-Disposition Final Session

**Patient:** Kevin  
**Clinician:** Edward Jones  
**Date:** 9/18  
**Time:** 2:45 pm

#### Section A (Patient):

<table>
<thead>
<tr>
<th>Rate (1 item answering how you feel right now)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) RATE PSYCHOLOGICAL IMPAIRMENT (Lack of cognitive capacity, mood, or motivation)</td>
</tr>
<tr>
<td>Low imp. 1 2 3 4 5 High imp.</td>
</tr>
<tr>
<td>2) RATE ANXIETY (general feeling of uneasiness)</td>
</tr>
<tr>
<td>Low anxiety 1 2 3 4 5 High anxiety</td>
</tr>
<tr>
<td>3) RATE AGITATION (tension, energy, feeling that things are not going your way)</td>
</tr>
<tr>
<td>Low agitation 1 2 3 4 5 High agitation</td>
</tr>
<tr>
<td>4) RATE HOPELESSNESS (your expectation that things will not get better no matter what you do)</td>
</tr>
<tr>
<td>Low hopelessness 1 2 3 4 5 High hopelessness</td>
</tr>
<tr>
<td>5) RATE SELF-DEST (your general feeling of having to eliminate, meaning, or purpose)</td>
</tr>
<tr>
<td>Low self-dest 1 2 3 4 5 High self-dest</td>
</tr>
<tr>
<td>6) RATE OVERALL RISK OF SUICIDE (N.Y.C. Health and Hospitals Corporation)</td>
</tr>
<tr>
<td>Extremely low risk 1 2 3 4 5 Extremely high risk</td>
</tr>
</tbody>
</table>

**In the past week, thoughts of killing yourself?** Yes  
**Thoughts of killing self?** No  
**Specific plans or behavior?** No

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#### Section B (Clinician):

- **Final assessment of suicide risk:** Yes  
- **Suicidal ideation:** Low

**ACCOMMODATION/Disposal:**

- Continuing outpatient psychotherapy  
- Initial hospitalization  
- Mutual termination  
- Patient chooses to discontinue treatment (unilaterally)  
- Referral to:**

**Diagnosis:** Major Depression

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#### Section C (Clinician Post-Session Evaluation):

**Mental Status Exam (circle appropriate item):**

- Alertness: Clear  
- Orientation: Time, Place, Person  
- Speech: Slow and slurred  
- Reality Testing: Poor

**Thought Content:** Somatic delusions  
**Behavior:** Suicidal ideation  
**Antidepressant:** Yes  
**Homicidal ideation:** Yes

**Current suicidal plan:** Self-harm  
**Next Appointment Scheduled:** 9/18
<table>
<thead>
<tr>
<th>Authors</th>
<th>Sample/Setting</th>
<th>n</th>
<th>Significant Results</th>
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</thead>
<tbody>
<tr>
<td>Jobes et al., 1997</td>
<td>College Students, Univ. Counseling Ctr.</td>
<td>106</td>
<td>Pre/Post Distress, Pre/Post Core SSF</td>
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<tr>
<td>Jobes et al., 2005</td>
<td>Air Force Personnel Outpatient Clinic</td>
<td>56</td>
<td>Between Group Suicide Ideation, ED/PC Appts.</td>
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<tr>
<td>Arkov et al., 2008</td>
<td>Danish Outpatients, CMH Clinic</td>
<td>27</td>
<td>Pre/Post Core SSF Qualitative findings</td>
</tr>
<tr>
<td>Jobes et al., 2009</td>
<td>College Students, Univ. Counseling Ctr.</td>
<td>55</td>
<td>Linear reductions Distress/Ideation</td>
</tr>
<tr>
<td>Nielsen et al., 2011</td>
<td>Danish Outpatients, CMH Clinic</td>
<td>42</td>
<td>Pre/Post Core SSF</td>
</tr>
<tr>
<td>Ellis et al., 2012</td>
<td>Psychiatric Inpatients</td>
<td>20</td>
<td>Pre/Post Core SSF Suicidal Ideation, depression, hopelessness</td>
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<tr>
<td>Ellis et al., 2015</td>
<td>Psychiatric Inpatients</td>
<td>52</td>
<td>Suicide ideation and cognitions</td>
</tr>
<tr>
<td>Ellis et al., 2017</td>
<td>Inpatients (&amp; post-discharge)</td>
<td>104</td>
<td>SI, cognitions, depression, hopelessness, funct. impare, well-being, psych flexibility</td>
</tr>
</tbody>
</table>
# Randomized Controlled Trials of CAMS

<table>
<thead>
<tr>
<th>Principal Investigator</th>
<th>Setting &amp; Population</th>
<th>Design &amp; Method</th>
<th>Sample Size</th>
<th>Status Update</th>
</tr>
</thead>
<tbody>
<tr>
<td>Comtois (Jobes)</td>
<td>Harborview/Seattle CMH patients</td>
<td>CAMS vs. TAU Next-day appts.</td>
<td>32</td>
<td>2011 published article</td>
</tr>
<tr>
<td>Andreasson (Nordentoft)</td>
<td>Danish Centers CMH patients</td>
<td>DBT vs. CAMS superiority trial</td>
<td>108</td>
<td>2016 published article</td>
</tr>
<tr>
<td>Ryberg (Fosse)</td>
<td>Norwegian Centers Outpatient/inpatient</td>
<td>CAMS vs. TAU</td>
<td>78</td>
<td>2019 published article</td>
</tr>
<tr>
<td>Pistorello (Jobes)</td>
<td>Univ. Nevada (Reno) College Students</td>
<td>SMART Design CAMS/TAU/DBT</td>
<td>62</td>
<td>Manuscript in preparation</td>
</tr>
<tr>
<td>Comtois (Jobes)</td>
<td>Harborview/Seattle Suicide attempters</td>
<td>CAMS vs. TAU Post-Hosp. D/C</td>
<td>150</td>
<td>ITT complete; on-going assess</td>
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<tr>
<td>Santel et al</td>
<td>German Crisis Unit Inpatients</td>
<td>CAMS vs. TAU</td>
<td>110</td>
<td>ITT complete; on-going assess</td>
</tr>
<tr>
<td>Depp et al</td>
<td>San Diego VAMC Walk-in Veterans</td>
<td>CAMS vs. Outreach Same day services</td>
<td>176</td>
<td>RCT preparation on-going</td>
</tr>
</tbody>
</table>
AFSP-Funded CAMS vs. TAU RCT (Comtois & Jobes et al., 2011)

Significantly higher patient satisfaction ratings and better clinical retention...
Figure 1. Odds ratio with 95% confidence intervals of non-suicidal self-injury and suicide attempts, favoring CAMS treatment.

At 28 weeks: DBT Self Harm = 21; CAMS = 12
DBT Attempts = 12; CAMS = 5
DoD-Funded Operation Worth Living (OWL) Project: CAMS vs. E-CAU RCT at Ft. Stewart, GA
CAMS significantly reduced suicidal ideation and overall symptom distress among inpatients and outpatients (n=78)
NEWS FLASH: NIMH R01 has been funded!!!

Stage 1

**CAMS (8 Weeks)**
- Assessment: Adequate Response? (YES)
  - Monitoring, Post and Follow-Up
  - CAMS (16 Weeks)
- Random Assignment (NO)
  - DBT (16 Weeks)

**TAU (8 Weeks)**
- Assessment: Adequate Response? (YES)
  - Monitoring, Post and Follow-Up
  - CAMS (16 Weeks)
- Random Assignment (NO)
  - DBT (16 Weeks)

Significant Stage 1 findings for CAMS on depression and suicidal ideation...

CAMS = Collaborative Assessment and Management of Suicidality
DBT = Comprehensive Dialectical Behavior Therapy
TAU = Treatment as Usual
Summary of CAMS Research Findings to Date

- Across 8 published non-randomized clinical trials of CAMS, 1 meta-analysis, and 4 published randomized controlled clinical trials, and 1 unpublished RCT (a total of 70+ publications):
  - CAMS quickly reduces suicidal ideation in 6-8 sessions
  - CAMS reduces overall symptom distress, depression, hopelessness, and changes suicidal cognitions
  - CAMS increases hope and improves clinical retention to care
  - Patients like CAMS and the process of doing CAMS
  - CAMS works better with less severe patients at baseline presentation (impact with borderline patients is mixed)
  - CAMS decreases ED visits among certain subgroups
  - CAMS appears to have a promising impact on self-harm behavior and suicide attempts (but replication is needed)
  - CAMS is relatively easy to learn (adherence is typically attained with first patient)
Patients admitted to hospital with suicide attempt in past month referred by inpatient/ER staff

Study assessor conducts informed consent and conducts baseline, randomizes, provides patient and clinical team with ‘Next Day Appointment’

CAMS ‘Next Day Appt’ and Aftercare

1, 3, 6 & 12 month blind outcome assessments

State hospital and death certificate records

TAU ‘Next Day Appt’ and Aftercare

1, 3, 6 & 12 month blind outcome assessments

State hospital and death certificate records

Funded by AFSP from 2015-2019
Target sample size = 150

Primary Aims:
1. Evaluate whether CAMS for suicidal NDA patients results in a significant reduction in suicidal behavior compared to TAU.
2. Evaluate whether CAMS for suicidal NDA patients results in significant reductions in suicidal ideation and intent as well as related improvements in other mental health markers compared to TAU.
3. Evaluate whether CAMS for suicidal NDA patients is more satisfactory to patients than TAU.

For more information, contact mhsr@uw.edu
Rapid Referral Study: Randomized Controlled Trial

PEC Clinic/Same Day/Transition Clinic Visit

Randomization

CAMS Intervention

SPC Telephone Outreach (Standard Care)

Ongoing Mental Health Care

Colin Depp, Ph.D.
Principal Investigator

VA Health Services Research and Development (HSRD) Merit Grant; VA IRB H180055
NIMH-Funded R43 and R44 V-CAMS SBIR ED Projects
Thank You!