

The Collaborative Assessment and Management of Suicidality (CAMS) Approach with Suicidal Military and VA Populations

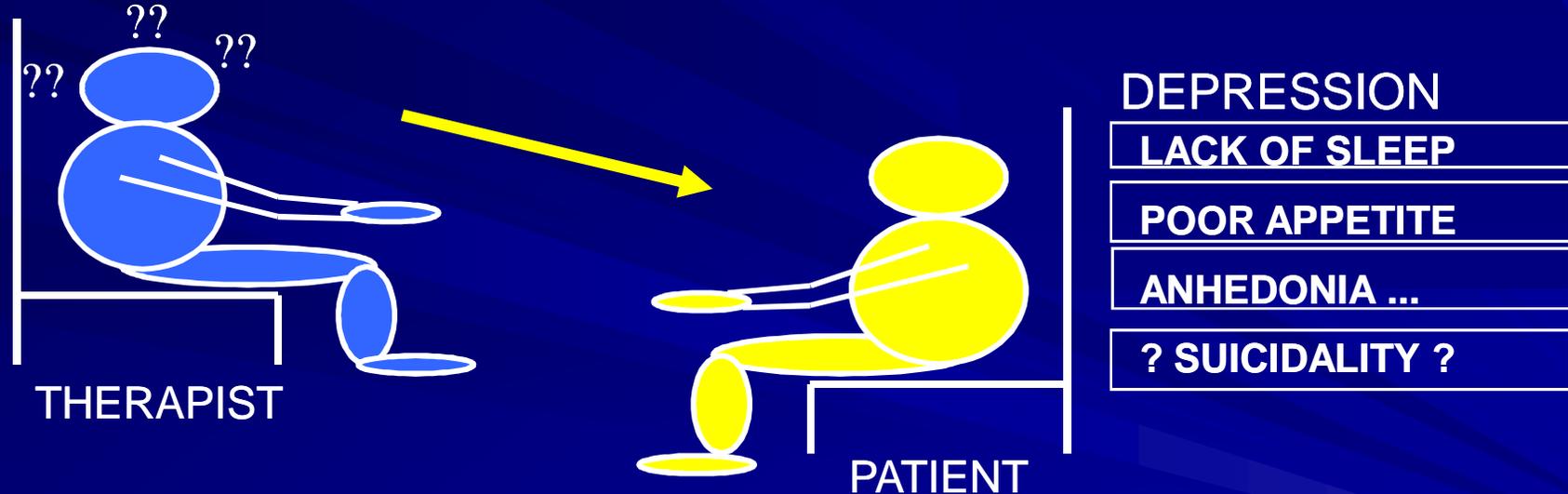
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Clinical Work with Suicidal Patients:
Emerging Ethical Issues and Professional Challenges
(*PPRP*: Jobes, Rudd, Overholser, & Joiner, 2008)

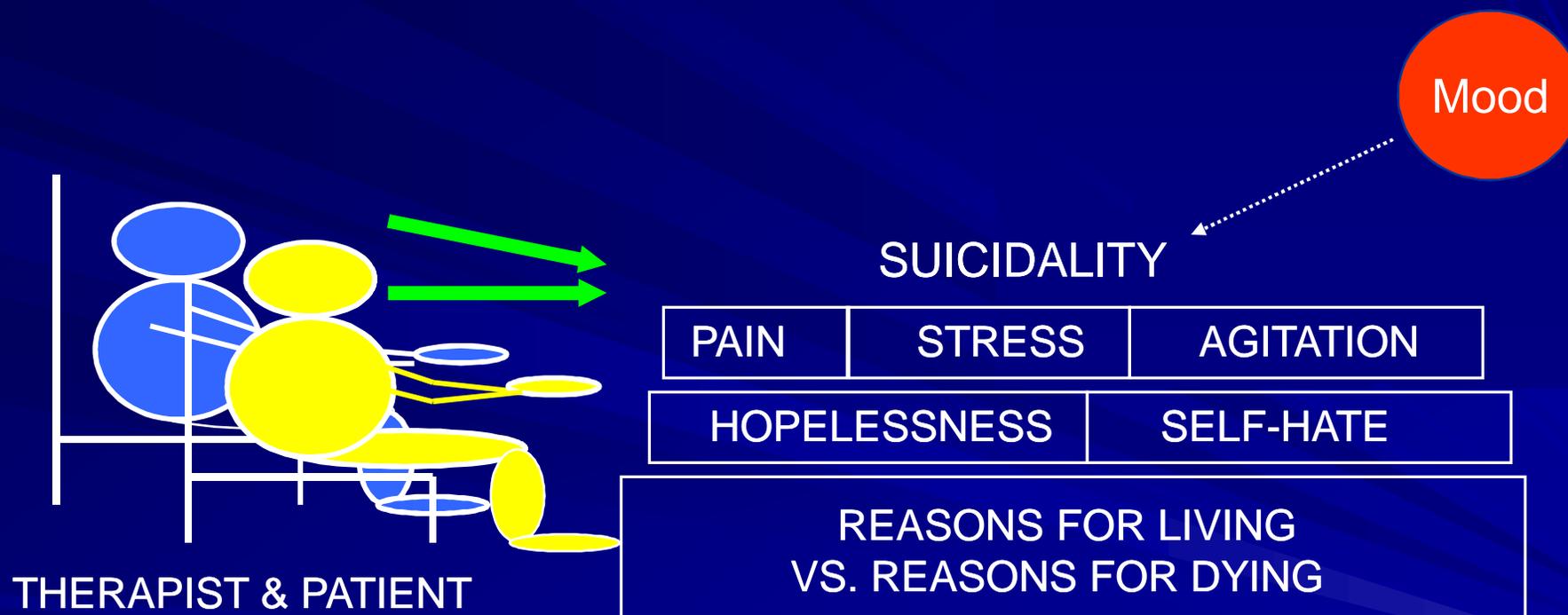
1. Issues of sufficient informed consent.
2. Issues of competent assessment of risk.
3. Need for empirically-oriented treatments.
4. Appropriate risk management (liability issues).

REDUCTIONISTIC MODEL: Suicide = Symptom



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

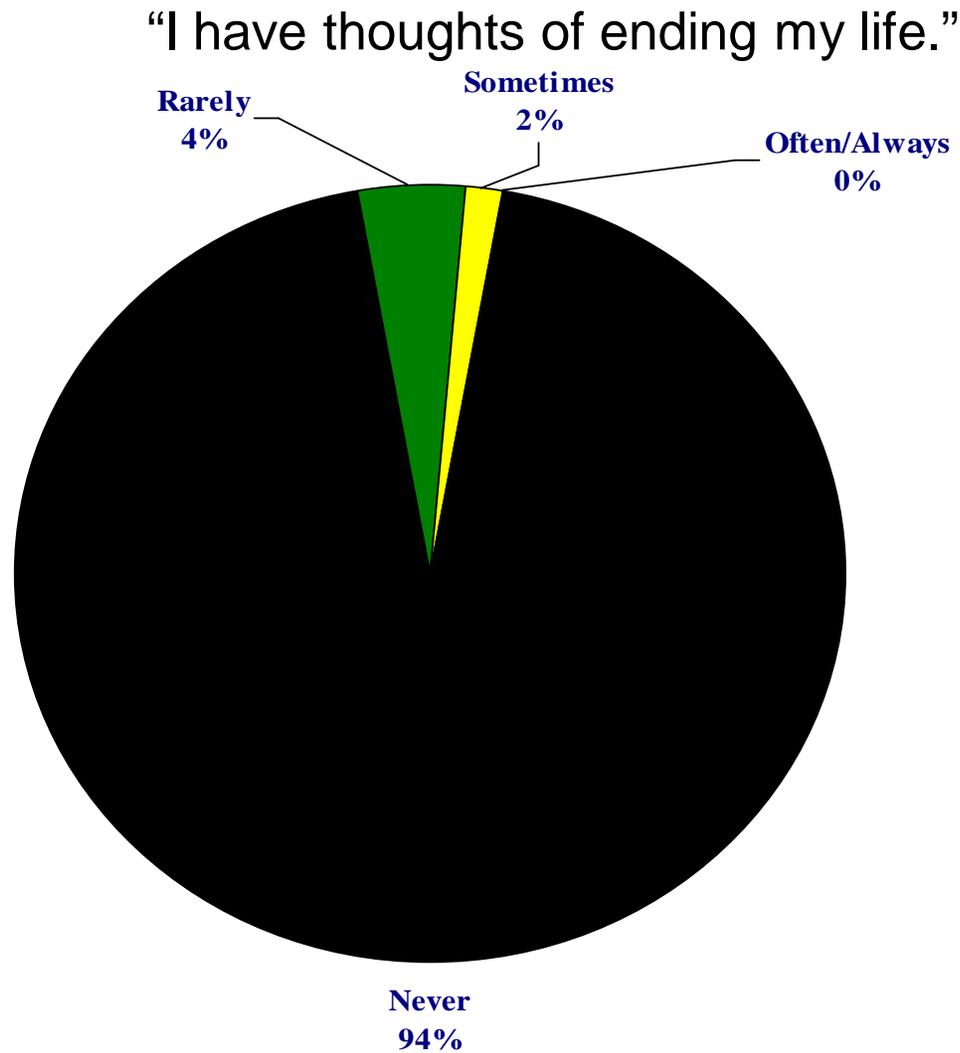
COLLABORATIVELY ASSESSING RISK: Targeting Suicide as the Focus of Treatment



CAMS Treatment = Intensive outpatient care that is suicide-specific, emphasizing the developing of other means of coping and problem-solving thereby systematically eliminating the need for suicidal coping...

Suicidality in a Community ADAF Sample

N = 200

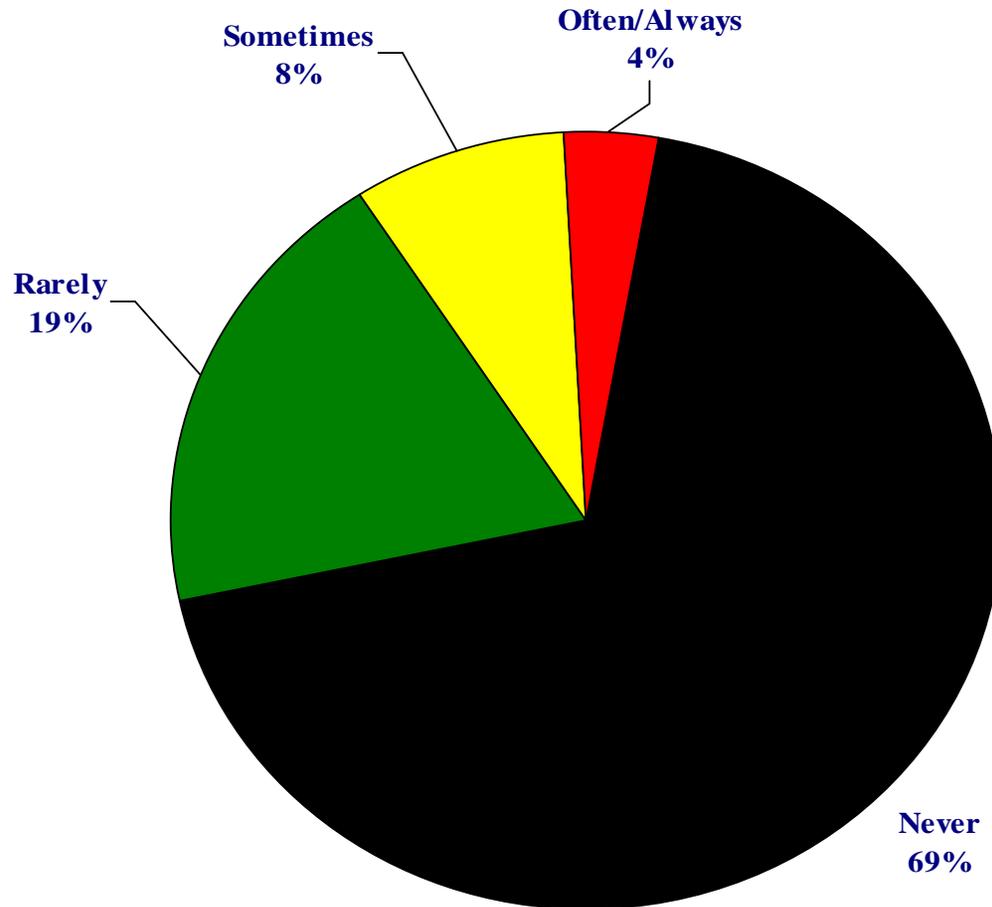


Source: Drozd, J. F., Lancaster, D. P., Zak, M. L., and Peters, K.R.L. (unpublished data)
Thule AB, Greenland, 2001

Suicidality in a Clinical ADAF Sample

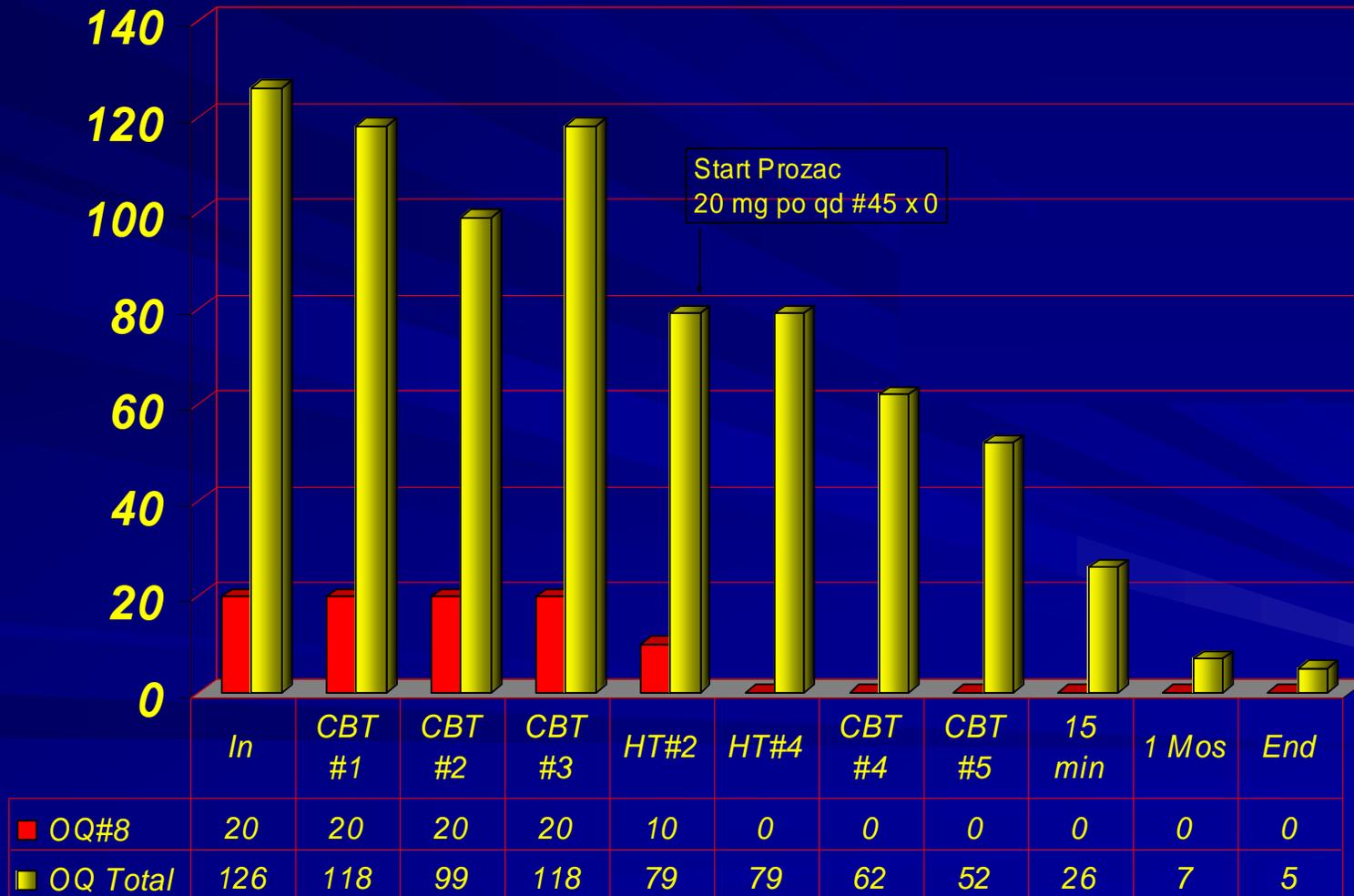
N = 1105

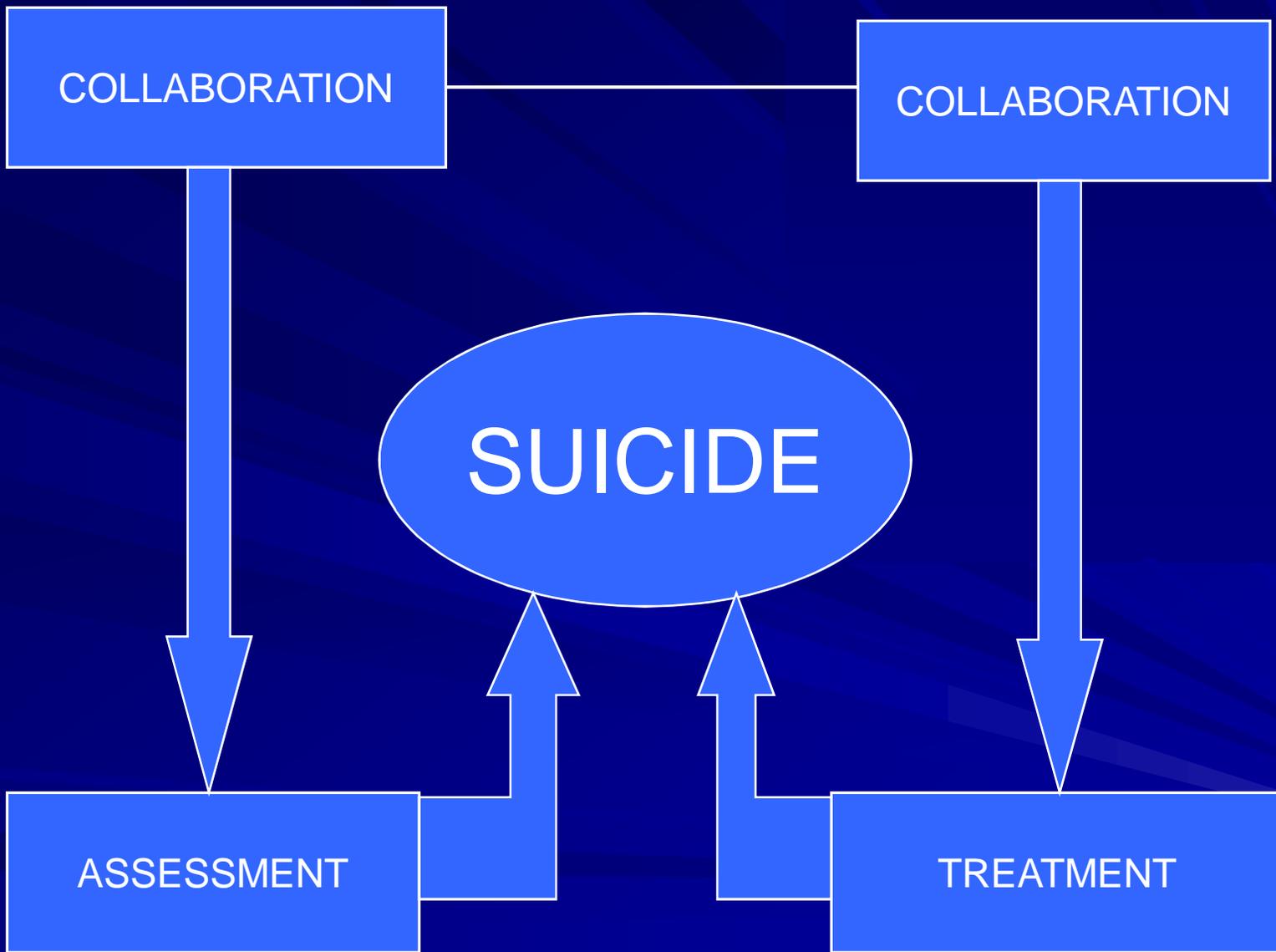
“I have thoughts of ending my life.”



Source: (unpublished data)
Peterson AFB
Schriever AFB
Cheyenne Mountain Air Force Station
Andrews AFB
United States Air Force Academy (AD)
Kirtland AFB

Case Example





Factor analysis from Conrad et al (in press) Mayo Clinic psychometric study of the Core SSF assessment (n=140)

(Spearman Promax Rotated Factor Pattern)

SSF Theoretical Variable	Factor 1	Factor 2
Self-Hate	.88*	-.09
Hopelessness	.85*	.05
Pain	.74*	.10
Agitation	-.07	.92*
Stress	.12	.78*

Note: * Values greater than 0.4

- Factor 1: “Chronic” Suicidal Risk Profile accounted for 53% of variance
- Factor 2: “Acute” Suicidal Risk Profile accounted for an additional 19% of variance
- Therefore the robust two factor solution accounted for 72% of the total variance

Studies of the SSF Core Assessment

- Jobes et al (1997) demonstrated the quasi-independence of the six rating scales as well as the validity and reliability of the SSF Core Assessment with a sample suicidal college students (n=102).
- Conrad et al (in press) have replicated and extended the psychometrics of the SSF Core Assessment in a study of suicidal inpatients (n=140) at the Mayo Clinic.
- Jobes et al (2009) have shown using HLM analyses that index SSF ratings can be used to discriminate differential reductions in suicidal thinking over the course of clinical care with suicidal college students (n=60)—replicating data from the preceding studies.

Empirical research from USAF 10th Medical Group (n=55) has shown that CAMS patients reach complete resolution of suicidality about 4-6 weeks more quickly than treatment as usual patients (Jobes et al., 2005; Wong, 2003)

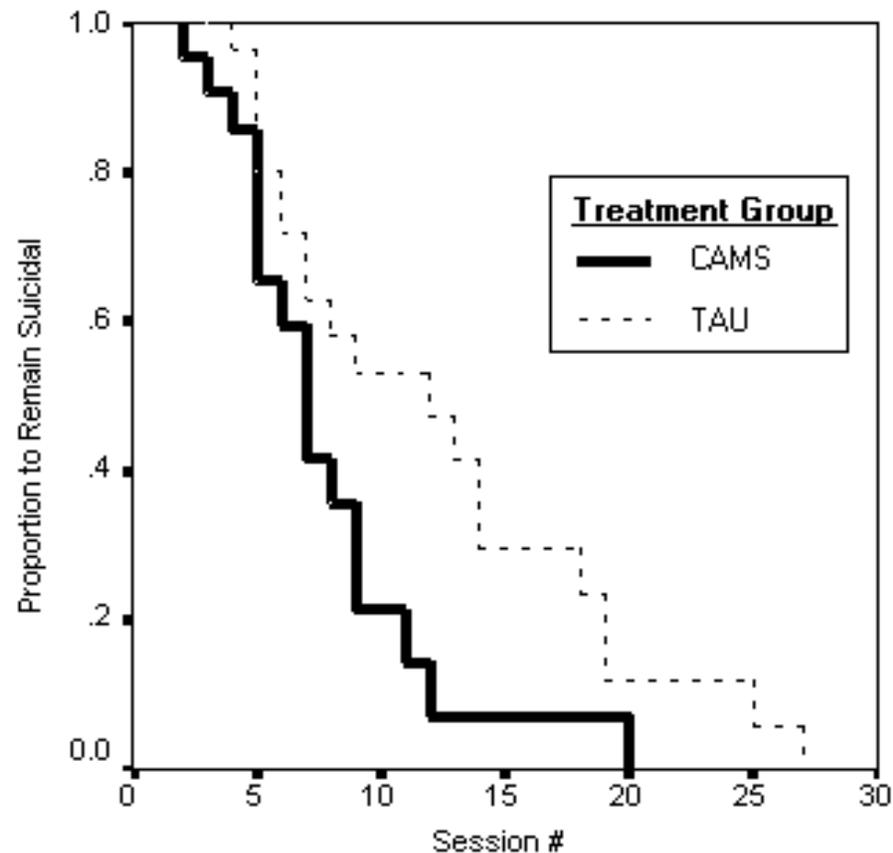
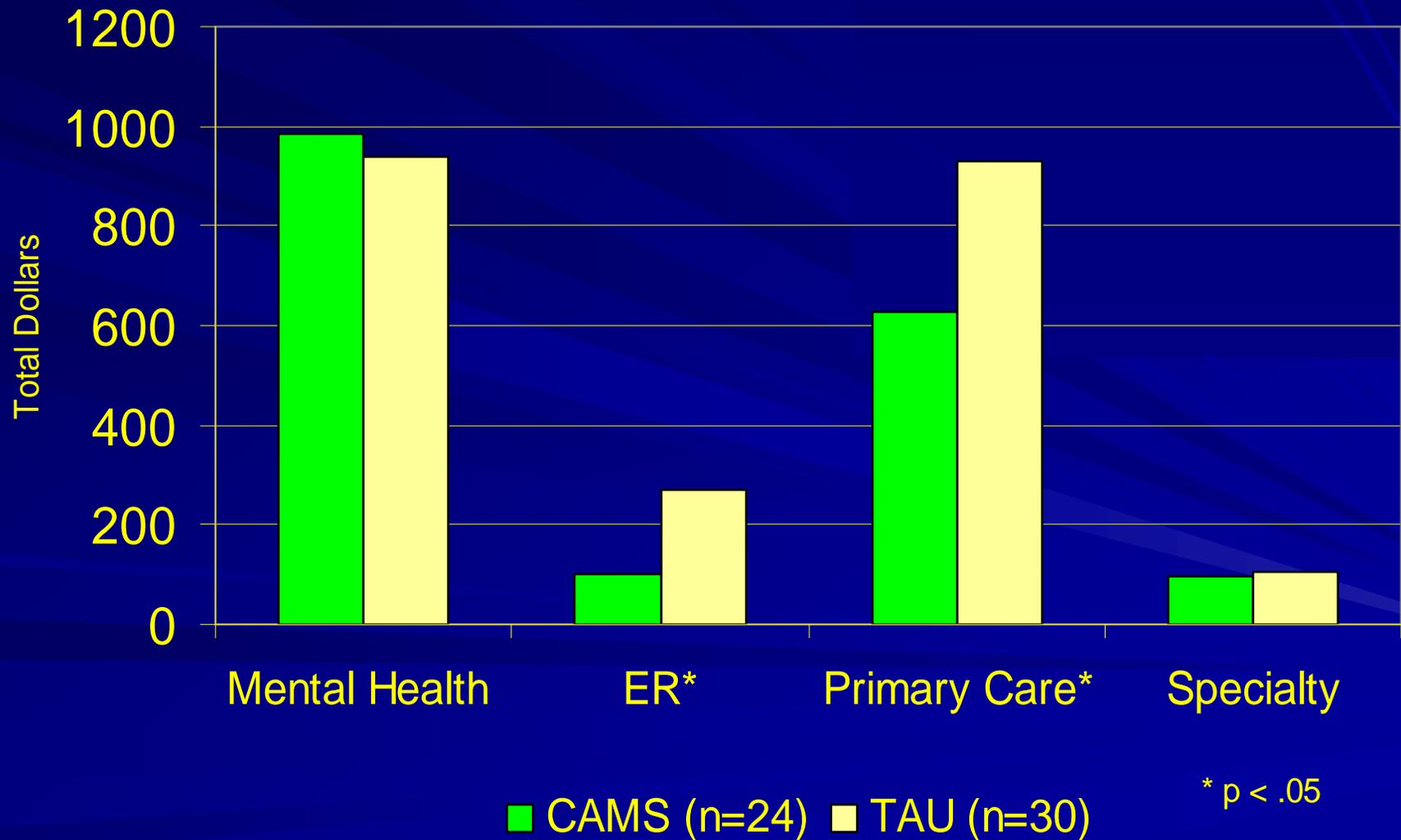
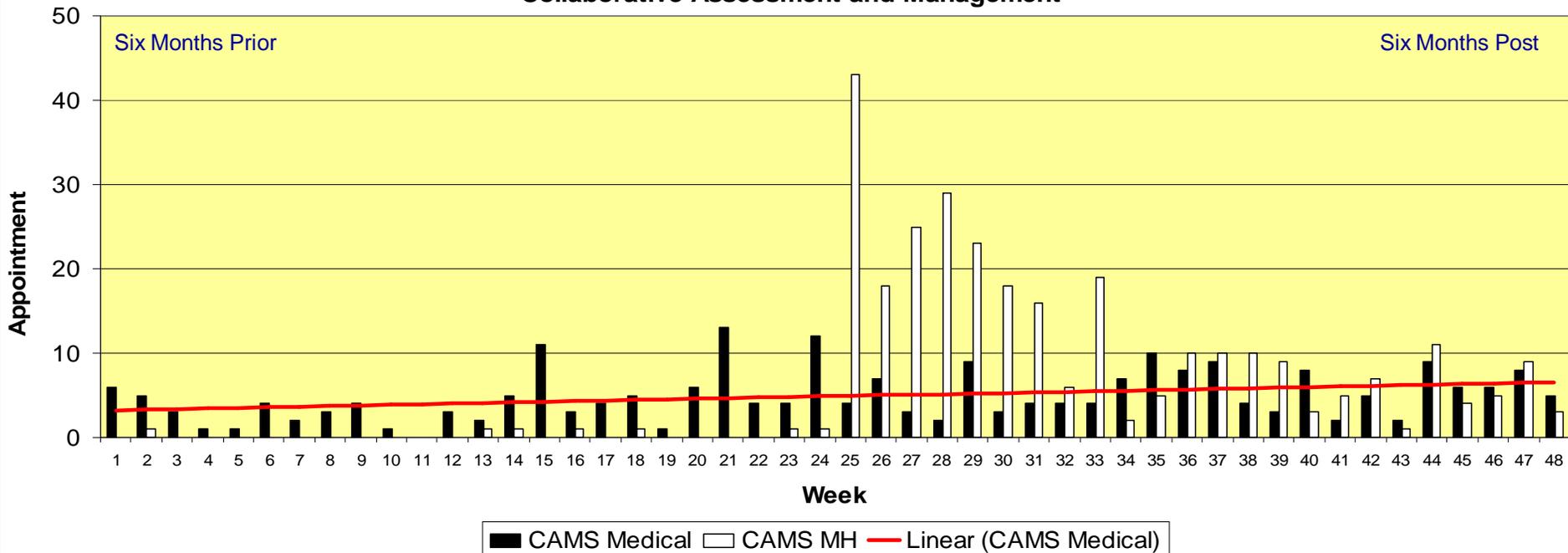


Figure 1. Estimated proportion of patients in the CAMS and TAU group to remain suicidal as a function of session number.

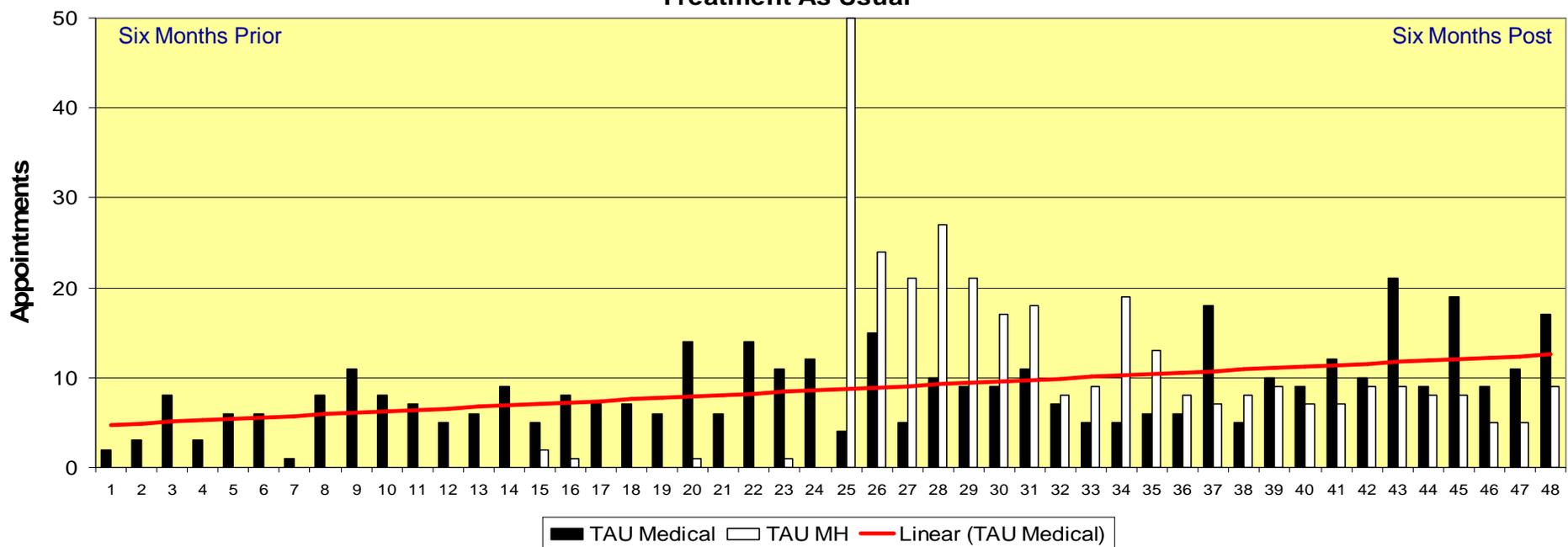
10th Medical Group Research: Six Month Period After the Start of Mental Health Care—Mean Health Care Costs



Collaborative Assessment and Management



Treatment As Usual

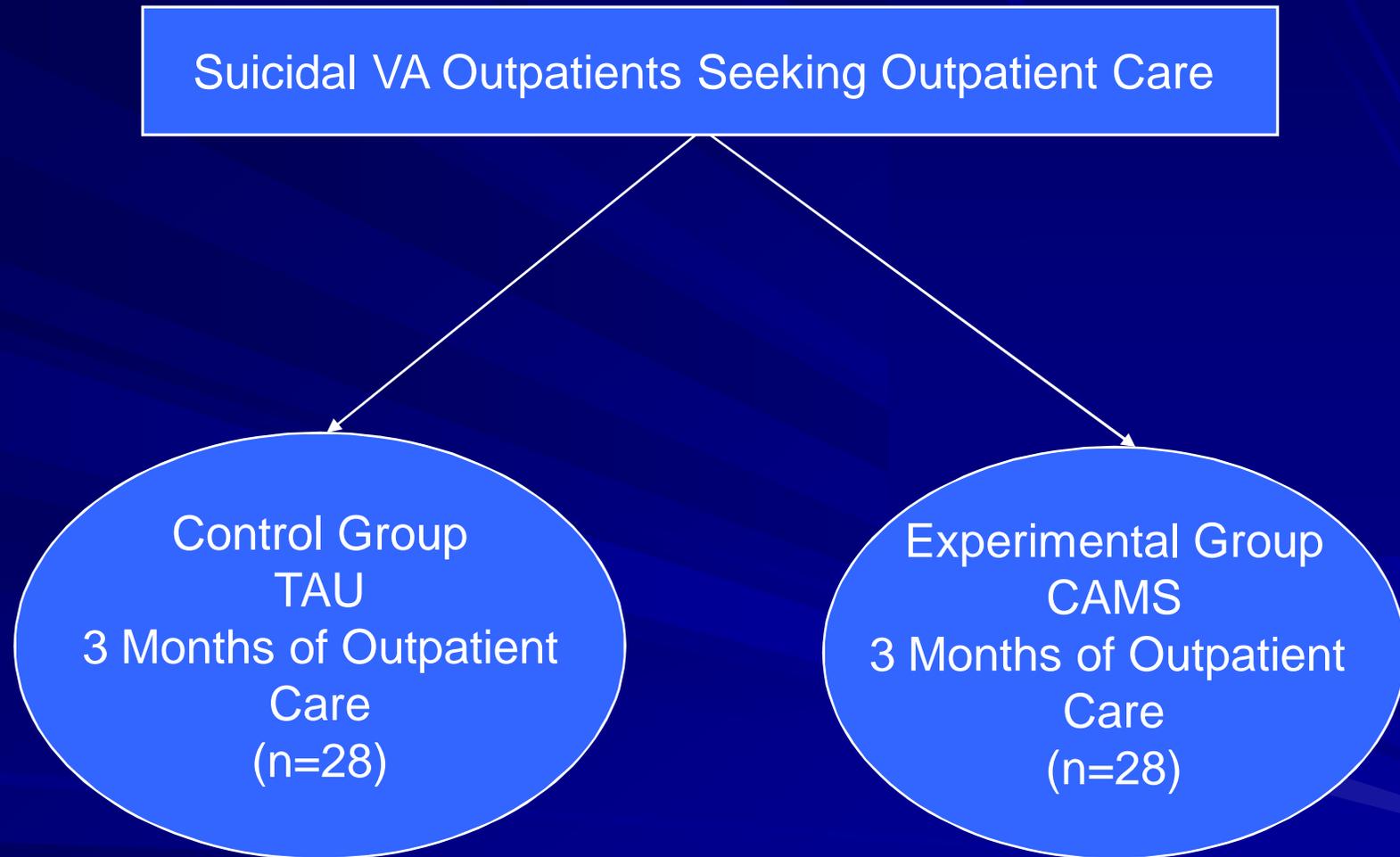


Overview to CAMS Assessment and Care

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 Deconstruction of Suicidogenic Problems
 - 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
- 

CAMS Feasibility Trial—Denver VA Medical Center



Dependent Variables: Suicidal Ideation/Attempts, Symptom Distress, Depression, Primary Care/ ED Visits, and Hospitalizations.

Measures: SSI, RFL, BDI, OQ-45.

Harborview “Next Day Appointment” (NDA) CAMS Clinical Trial

- Dr. Kate Comtois at the University of Washington is the PI on an AFSP-funded CAMS feasibility randomized clinical trial with patients referred out of the emergency department at a large urban medical center in Seattle.
- The project is designed to create a cost-effective alternative to expensive inpatient hospitalization of suicidal patients.
- We successfully developed our procedures through a pilot phase and CAMS vs. TAU care of study patients is on-going.
- We are treating a very challenging population (e.g., issues of unemployment, homelessness, and substance abuse).

Developing an Inpatient Version of CAMS at the Menninger Clinic in Houston Texas

- CAMS was successfully used in a Swiss inpatient psychiatric setting (Schilling et al., 2006), but there was no comparison control group.
- There is ongoing SSF/CAMS work at the Mayo Clinic and the University of Washington.
- We are now developing a randomized clinical trial of a new inpatient version of CAMS at the Menninger Clinic (administered over 30-50 days).
 - This new inpatient version of CAMS will feature a mentalizing component for chronic suicidal self-hatred.
 - There will also be a group component at discharge.
 - Discharge would be *contingent* on demonstrating competency in CAMS-acquired problem-solving, help-seeking, coping, and self-soothing skills (after Brown et al., 2005).
 - Disposition planning and active family/support system involvement and post-discharge follow-up will be a crucial component of the treatment.

Adherence to CAMS:

PI Collaboration (from Denver/Seattle CAMS trials)

CAMS is a therapeutic framework, used until suicidality resolves. Adherence to CAMS requires thorough suicide assessment and problem-focused interventions are designed to directly and indirectly decrease suicide 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 direct or indirect causes of suicidal risk
 - A suicide-specific treatment plan with Crisis Response/Safety Plan
 - Reduce access to lethal means
 - Insure treatment attendance
 - Make referrals to address indirect causes of suicide

CAMS RCT Collaborators

- Denver VA MIRECC: Lisa Brenner, Ph.D., Peter Gutierrez, Ph.D., Larry Adler, M.D., Herbert Nagamoto, M.D., and Jan Kemp, Ph.D.
- Seattle Harborview NDA: Kate Comtois, Ph.D., Karin Hendricks, B.A., and Stephen O'Connor, M.A.
- Menninger Inpatient Study: Tom Ellis, Psy.D., Chris Frueh, Ph.D., Pam Greene, Ph.D., Jon Allen, Ph.D., Harrell Woodson, Ph.D., and John Oldham, M.D.
- Clinical Trial Consultants: Greg Brown, Ph.D., Marsha Linehan, Ph.D., and David Rudd, Ph.D.