The Collaborative Assessment and Management of Suicidality (CAMS)

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Evidence-Based Treatments for Suicidality

With n=50 studies (in the world literature), there are remarkably few evidence-based treatments and interventions for suicidal risk.

- We mostly know what does not work (e.g., medication only).

What does work:

- Dialectic Behavior Therapy (DBT)
- Cognitive Therapy
- Brief interventions with non-demand follow-up
The Collaborative Assessment and Management of Suicidality (CAMS)

MANAGING Suicidal Risk
A Collaborative Approach

DAVID A. JOBES
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…
**Suicide Status Form-ISR**

**Suicide Status Form-ISR (Initial Session—Page 2)**

<table>
<thead>
<tr>
<th>Section</th>
<th>Description</th>
<th>Goals and Objectives</th>
<th>Interventions</th>
<th>Estimated Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Self-harm Potential</td>
<td>Depression Safety</td>
<td>Cognitive Behavioral Therapy</td>
<td>1 month</td>
</tr>
<tr>
<td>2</td>
<td>Suicide plan</td>
<td>Access to means</td>
<td>Medication Management</td>
<td>1 month</td>
</tr>
</tbody>
</table>

**Problem List**

1. Self-harm Potential
2. Suicide plan
3. Access to means

**Mental Status Exam**

- **Cognitive Status**: Superior memory, clear thinking, good judgment.
- **Affective Status**: Mild depression, elevated tension, occasional crying.
- **Behavioral Status**: Somewhat withdrawn, avoids eye contact, dressed in casual clothes.

**Vital Signs**

- **Blood Pressure**: 120/80
- **Heart Rate**: 80
- **Respiratory Rate**: 18
- **Temperature**: 98.6°F

**Current Medications**

- **Antidepressants**: Sertraline 100mg daily
- **Antihypertensives**: Amlodipine 5mg daily

**Past Medical History**

- **History of Depression**: 1 episode of depression 5 years ago
- **Family History**: No history of mental illness

**Social History**

- **Support System**: Living with parents, no significant others
- **Employment Status**: Unemployed
- **Educational Status**: High school graduate

**Differential Diagnosis**

- **Axis I**: Major Depressive Disorder
- **Axis II**: None
- **Axis III**: None

**Treatment Plan**

- **Therapeutic Approach**: Cognitive Behavioral Therapy
- **Interventions**: Medication Management, Therapeutic Alliance Building
- **Estimated Duration**: 1 month

**Signatures**

- **Patient Signature**: [Signature]
- **Clinician Signature**: [Signature]
- **Date**: [Date]

**Suicide Status Form-ISR (Last Session)**

**Problem List**

1. Self-harm Potential
2. Suicide plan
3. Access to means

**Mental Status Exam**

- **Cognitive Status**: Improved memory, clear thinking, good judgment.
- **Affective Status**: No depression, tension reduced.
- **Behavioral Status**: More engaged, eye contact improved, dressed in casual clothes.

**Vital Signs**

- **Blood Pressure**: 120/80
- **Heart Rate**: 70
- **Respiratory Rate**: 16
- **Temperature**: 98.6°F

**Current Medications**

- **Antidepressants**: Sertraline 100mg daily
- **Antihypertensives**: Amlodipine 5mg daily

**Past Medical History**

- **History of Depression**: Same as previous session
- **Family History**: Same as previous session
- **Social History**: Same as previous session

**Differential Diagnosis**

- **Axis I**: Major Depressive Disorder
- **Axis II**: None
- **Axis III**: None

**Treatment Plan**

- **Therapeutic Approach**: Cognitive Behavioral Therapy
- **Interventions**: Medication Management, Therapeutic Alliance Building
- **Estimated Duration**: 1 month

**Signatures**

- **Patient Signature**: [Signature]
- **Clinician Signature**: [Signature]
- **Date**: [Date]
Psychometrics of the Core SSF (Jobes et al., 1997; Conrad et al., 2009)

**TABLE 3**
Convergent Validity: Correlations Between SSF-II Items and Established Measures of Similar Constructs

<table>
<thead>
<tr>
<th>SSF-II Item</th>
<th>Measure</th>
<th>n</th>
<th>Spearman rho</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pain</td>
<td>BHQ-20</td>
<td>113</td>
<td>-.35*</td>
</tr>
<tr>
<td></td>
<td>OQ-45.2</td>
<td>127</td>
<td>.45*</td>
</tr>
<tr>
<td></td>
<td>OMMP</td>
<td>110</td>
<td>.43*</td>
</tr>
<tr>
<td>Stress</td>
<td>PI-III</td>
<td>129</td>
<td>.12</td>
</tr>
<tr>
<td></td>
<td>STICSA-S</td>
<td>130</td>
<td>.36*</td>
</tr>
<tr>
<td></td>
<td>STICSA-T</td>
<td>136</td>
<td>.27*</td>
</tr>
<tr>
<td></td>
<td>STICSA-Total</td>
<td>121</td>
<td>.31*</td>
</tr>
<tr>
<td>Agitation</td>
<td>STICSA-S</td>
<td>128</td>
<td>.42*</td>
</tr>
<tr>
<td></td>
<td>STICSA-T</td>
<td>134</td>
<td>.28*</td>
</tr>
<tr>
<td></td>
<td>STICSA-Total</td>
<td>119</td>
<td>.36*</td>
</tr>
<tr>
<td></td>
<td>BIS</td>
<td>133</td>
<td>.36*</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>BHS</td>
<td>140</td>
<td>.52*</td>
</tr>
<tr>
<td>Self-hate</td>
<td>BST</td>
<td>141</td>
<td>-.37*</td>
</tr>
<tr>
<td>Overall Risk</td>
<td>L-RFL</td>
<td>137</td>
<td>-.51*</td>
</tr>
</tbody>
</table>

*Correlation is significant at p < .01 (one-tailed).

**TABLE 2**
Factor Analysis Results: Spearman Promax Rotated Factor Pattern

<table>
<thead>
<tr>
<th>SSF-II Item</th>
<th>Factor 1</th>
<th>Factor 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Self-hate</td>
<td>.88***</td>
<td>-.09</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>.85***</td>
<td>.05</td>
</tr>
<tr>
<td>Pain</td>
<td>.74***</td>
<td>.10</td>
</tr>
<tr>
<td>Agitation</td>
<td>-.07</td>
<td>.92***</td>
</tr>
<tr>
<td>Stress</td>
<td>.12</td>
<td>.78***</td>
</tr>
</tbody>
</table>

*Note. ***Value is greater than 0.4

**TABLE 5**
Comparison of Suicidal Patients to Nonsuicidal Patients on SSF-II Items

<table>
<thead>
<tr>
<th>SSF item</th>
<th>Suicidal patients</th>
<th>Nonsuicidal patients</th>
<th>Univariate F</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
<td>M</td>
</tr>
<tr>
<td>Pain</td>
<td>3.82</td>
<td>1.24</td>
<td>3.44</td>
</tr>
<tr>
<td>Stress</td>
<td>3.87</td>
<td>1.25</td>
<td>3.78</td>
</tr>
<tr>
<td>Agitation</td>
<td>2.90</td>
<td>1.24</td>
<td>2.93</td>
</tr>
<tr>
<td>Hopelessness</td>
<td>3.81</td>
<td>1.29</td>
<td>2.83</td>
</tr>
<tr>
<td>Self-hate</td>
<td>3.74</td>
<td>1.31</td>
<td>2.88</td>
</tr>
<tr>
<td>Overall risk</td>
<td>2.68</td>
<td>1.27</td>
<td>1.55</td>
</tr>
<tr>
<td>OQ-45 total</td>
<td>125.22</td>
<td>23.13</td>
<td>130.47</td>
</tr>
</tbody>
</table>

*Note. **F statistic is significant at p < .001.

Reliability

The first three test-retest t-test analyses yielded correlations that were statistically significant (Pain = .33, Stress = .23, Agitation = .35); however, the findings were more robust for the latter three variables (Hopelessness = .46; Self-Hate = .57, Overall Risk = .51). All correlations were significant at the p < .001 level, except the SSF stress correlation, which was significant at p < .05.
Index SSF Overall Risk rating differentially predicted four different reductions in suicidal thoughts…

BHQ10A Ordinal Analysis
QUPLESS = 0, QUSHATE = 0

(n = 55)
## RFL/RFD Cross Sectional Results (n=108) (Jobes, Stone, & Wagner, 2010)

### Measures

<table>
<thead>
<tr>
<th>Measures</th>
<th>RFL</th>
<th>AMB</th>
<th>RFD</th>
<th>Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beck Hopelessness Scale</td>
<td>10.17</td>
<td>12.62</td>
<td>15.01</td>
<td>$F = 5.23^{**}$</td>
</tr>
<tr>
<td>Reasons for Living Inventory</td>
<td>179.00</td>
<td>141.88</td>
<td>148.53</td>
<td>$F = 5.14^{**}$</td>
</tr>
<tr>
<td>WTL/WTD Suicide Index Score</td>
<td>3.49</td>
<td>1.83</td>
<td>-2.03</td>
<td>$F = 18.24^{***}$</td>
</tr>
</tbody>
</table>

### Suicide Attempts

<table>
<thead>
<tr>
<th>Suicide Attempts</th>
<th>RFL</th>
<th>AMB</th>
<th>RFD</th>
<th>Test</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-1 Attempts</td>
<td>15</td>
<td>10</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>2 or more Attempts</td>
<td>5</td>
<td>11</td>
<td>15</td>
<td>Chi-Sq = 7.83*</td>
</tr>
</tbody>
</table>

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*p < .05, ** p < .01, *** p < .001*
Adherence to CAMS as an Intervention: (Jobes, Comtois, Brenner, & Gutierrez, 2011)

CAMS is a therapeutic framework, used until suicidality resolves. Adherence to CAMS requires thorough suicide assessment and problem-focused interventions that are designed to target and treat direct and indirect “drivers” of suicide risk.

**CAMS as a 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**

**CAMS as a 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
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
<table>
<thead>
<tr>
<th>Authors</th>
<th>Sample/Setting</th>
<th>n</th>
<th>Significant Results</th>
</tr>
</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>
</tr>
<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>
</tr>
<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, Ideation, Depression, Hopeless, Suic. Cog.</td>
</tr>
</tbody>
</table>
Approached by Clinician (N=49)

Rejected at Screening (N=8)
- leaving the country = 1
- currently had provider = 3
- denied SI = 3
- wanted different treatment = 1

Assessor Screen (N=49)

Did not attend first session (N=9)

Accepted into Study (N=41)

Randomization Sample (N=32)

Started CAMS (N=16)

Started ECAU (N=16)

Withdrawn from study
Required intensive services (N=2)

Dropped treatment (N=2)

Completed treatment (N=12)

Completed treatment (N=10)

Dropped treatment (N=5)

Withdrawn from study
Court-ordered to treatment (N=1)

Completed Study Assessments (N=11)

Completed Study Assessments (N=9)
CAMS RCT at Ft. Stewart, GA

Consenting Suicidal Soldiers (n=150)

Control Group
E-CAU
3 months of outpatient care (n=75)

Experimental Group
CAMS
3 months of outpatient care (n=75)

Dependent Variables: Suicidal Ideation/Attempts, Symptom Distress, Resiliency, Primary Care visits, Emergency Department Visits, and Hospitalizations.

Measures: SSI, OQ-45, SHBQ, SASIC, CDRISC, PCL-M, SF-36, NFI, THI (at 1, 3, 6, 12 months)
Some Next Steps for CAMS

- VA E-Learning training of CAMS
  (Magruder, York, Marshall, & De Santis)

- VAMC use of CAMS-Groups
  (Johnson, Jobes, & O’Connor)

- CAMS Brief Intervention
  (Jobes, O’Connor, & Jennings)

- Web-based electronic version of
  CAMS and SSF (Koerner & Jobes)