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

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Professional and ethical challenges for clinicians…

FOCUS ON ETHICS
Jeffrey E. Barnett, Editor

Ethical and Competent Care of Suicidal Patients: Contemporary Challenges, New Developments, and Considerations for Clinical Practice

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Clinical work with suicidal patients has become increasingly challenging in recent years. It is argued that contemporary issues related to working with suicidal patients have come to pose a number of considerable professional and even ethical hazards for psychologists. Among various concerns, these challenges include providing sufficient informed consent, performing competent assessments of suicidal risk, using empirically supported treatments/interventions, and using suitable risk management techniques. In summary, there are many complicated clinical issues related to suicide (e.g., improvements in the standard of care, resistance to changing practices, alterations to models of health care delivery, the role of research, and issues of diversity). Three experts comment on these considerations, emphasizing acute versus chronic suicide risk, the integration of empirical findings, effective documentation, graduate training, maintaining professional competence, perceptions of medical versus mental health care, fears of dealing with suicide risk, suicide myths, and stigma/blame related to suicide. The authors' intention is to raise awareness about various suicide-related ethical concerns. By increasing this awareness, they hope to compel psychologists to improve their clinical practices with suicidal patients, thereby helping to save lives.

Keywords: suicide, informed consent, risk assessment, treatment, risk management

Clinical Work With Suicidal Patients: Emerging Ethical Issues and Professional Challenges

David A. Jobes

Clinical work with suicidal patients is fraught with professional challenges. Some of these challenges include psychologists' inability to predict behaviors with low base rates (such as suicide attempts and completions), the decision to commit a person to an inpatient setting, intense countertransference issues, and the potential life-or-death implications of treatment (Jobes & Berman, 1993; Jobes & Maltsberger, 1995; Maltsberger & Buie, 1974). Although these concerns continue, additional challenges have recently emerged, which make providing this care even thornier. In this article, I examine various present-day issues that clinicians face with suicidal patients, with an eye to ultimately enhancing the ethical and effective clinical care of suicidal patients. The following fictitious cases capture a sampling of current concerns.

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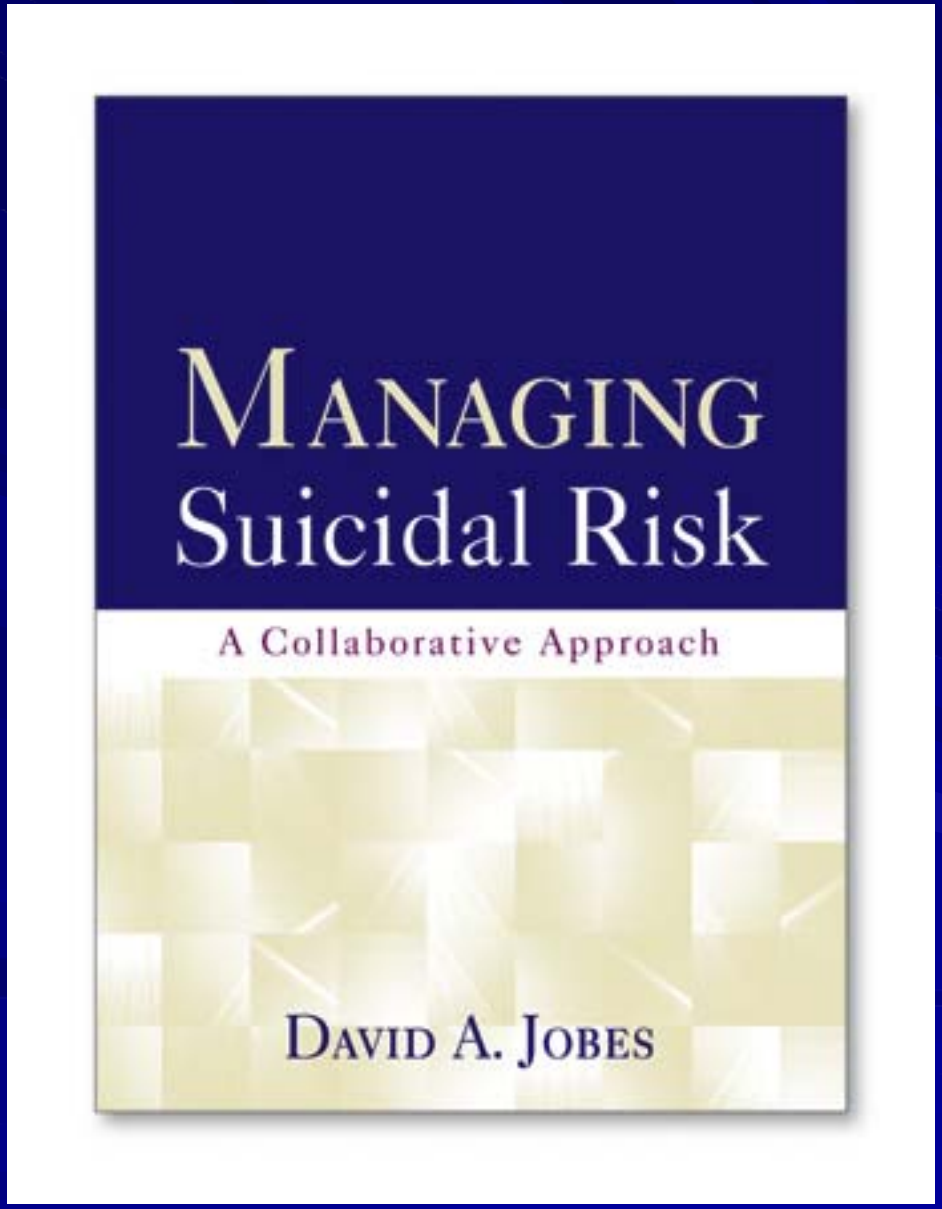
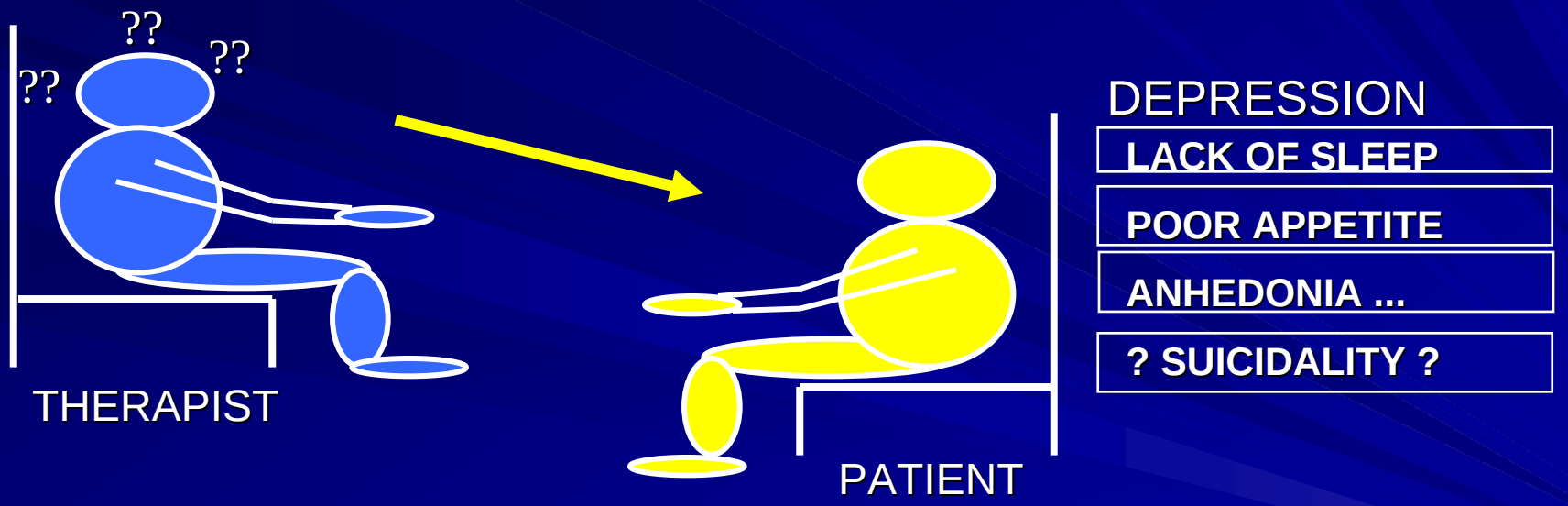
Challenges in Clinical Suicidology (Jobes et al., 2008)

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).

Overview to CAMS

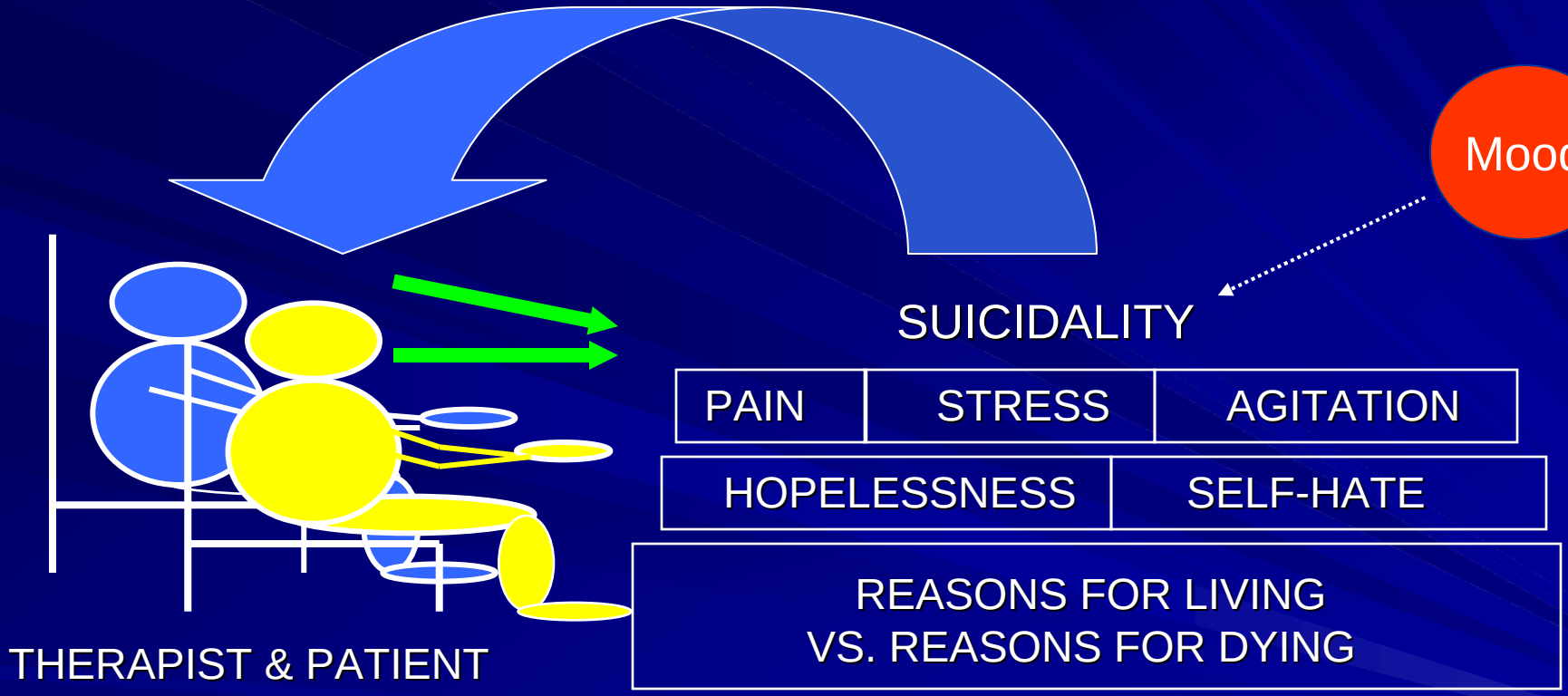


REDUCTIONISTIC MODEL:
Suicide = Symptom



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

COLLABORATIVELY ASSESSING RISK: Targeting *Suicide* as the Focus of Treatment

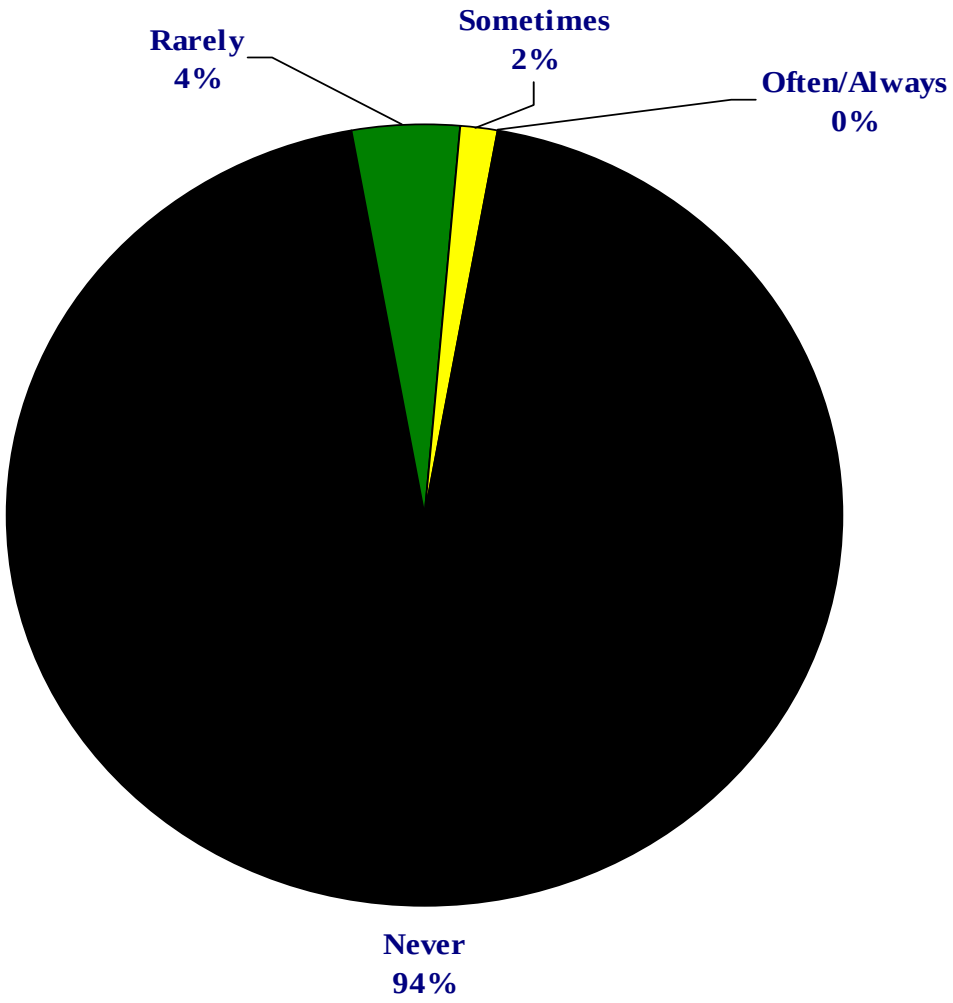


CAMS Treatment = Intensive outpatient care that is suicide-specific, emphasizing the developing of other means of coping and problem-solving thereby systematically eliminating the need for suicidal coping…

Suicidality in a Community ADAF Sample

N = 200

"I have thoughts of ending my life."

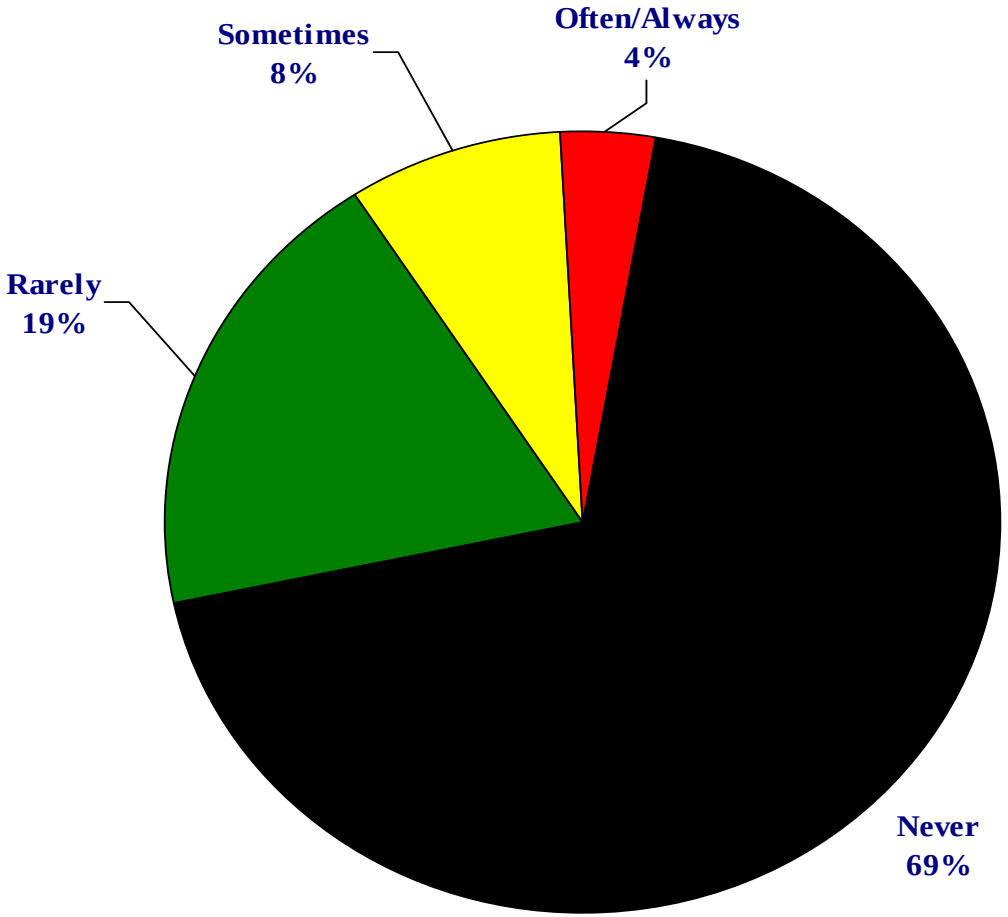


Source: Drozd, J. F., Lancaster, D. P., Zak, M. L., and Peters, K.R.L, (unpublished data) Thule AB, Greenland, 2001

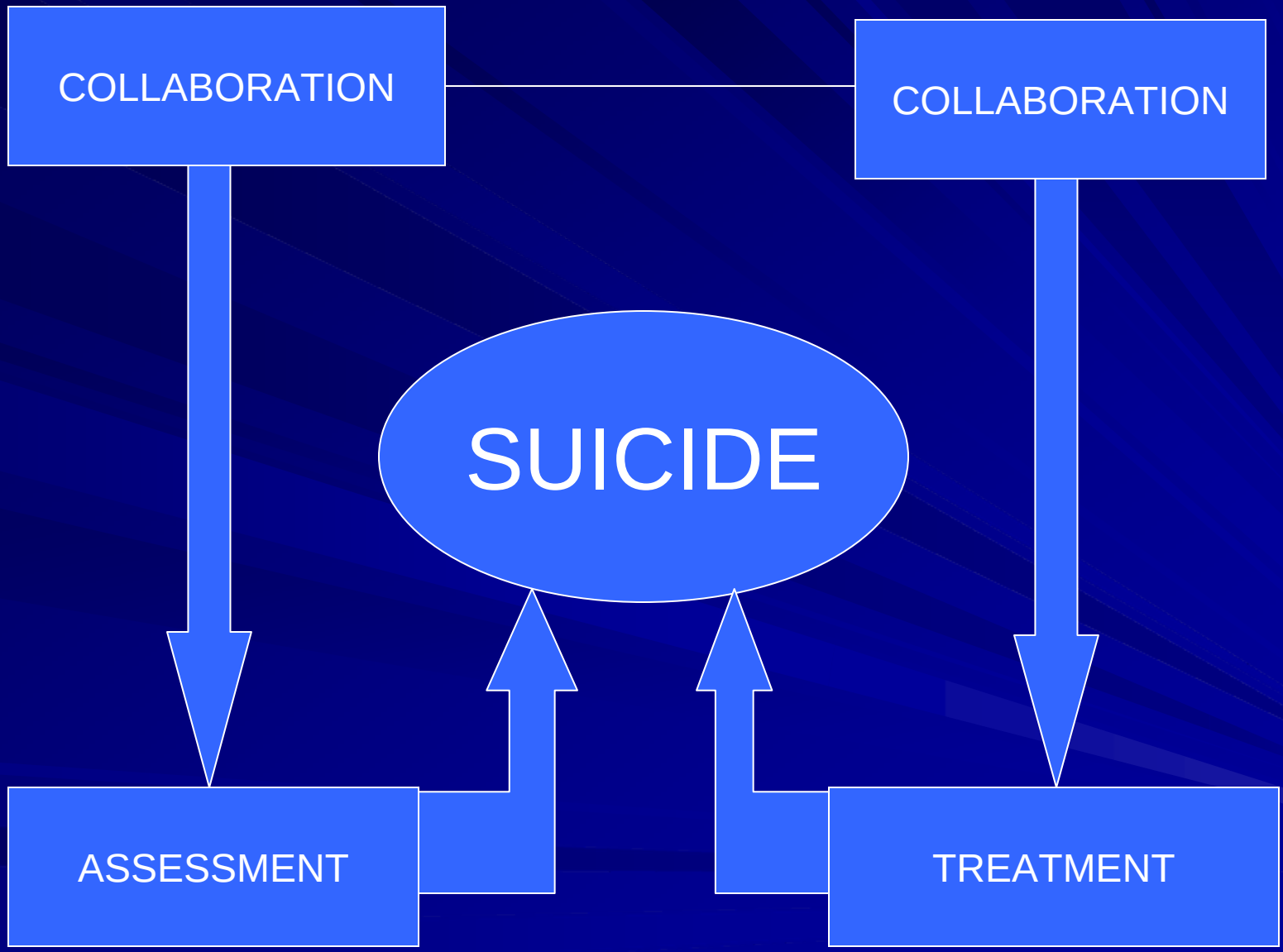
Suicidality in a Clinical ADAF Sample

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


COLLABORATION
COLLABORATION
SUICIDE
ASSESSMENT
TREATMENT

Factor analysis from Conrad et al (2009) 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 (2009) 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)

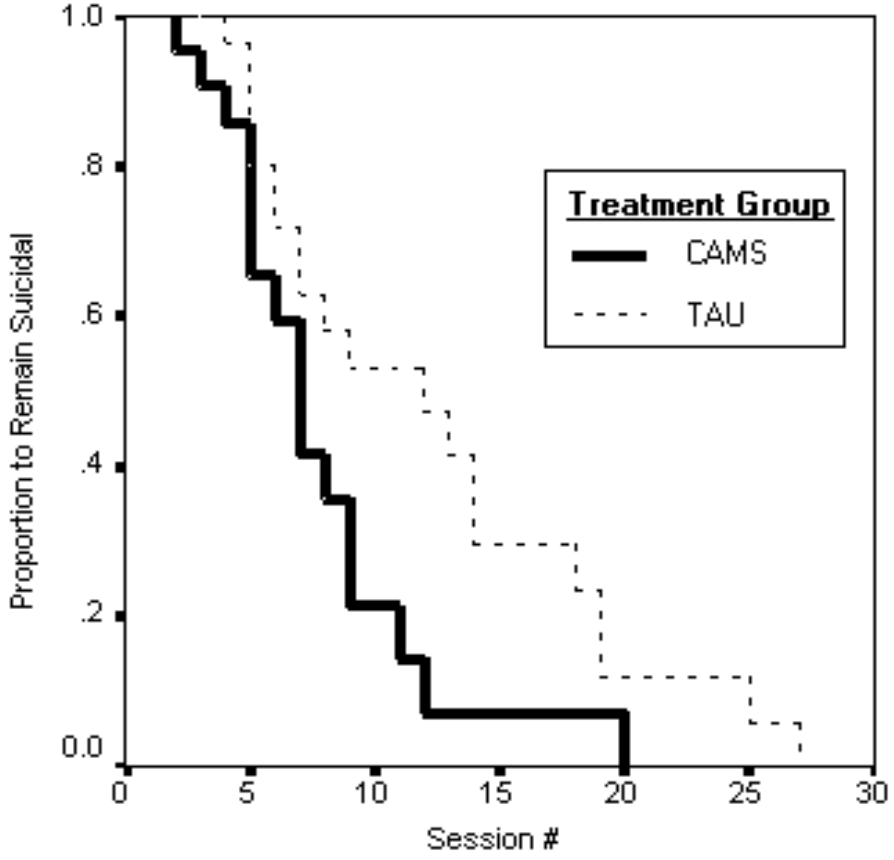
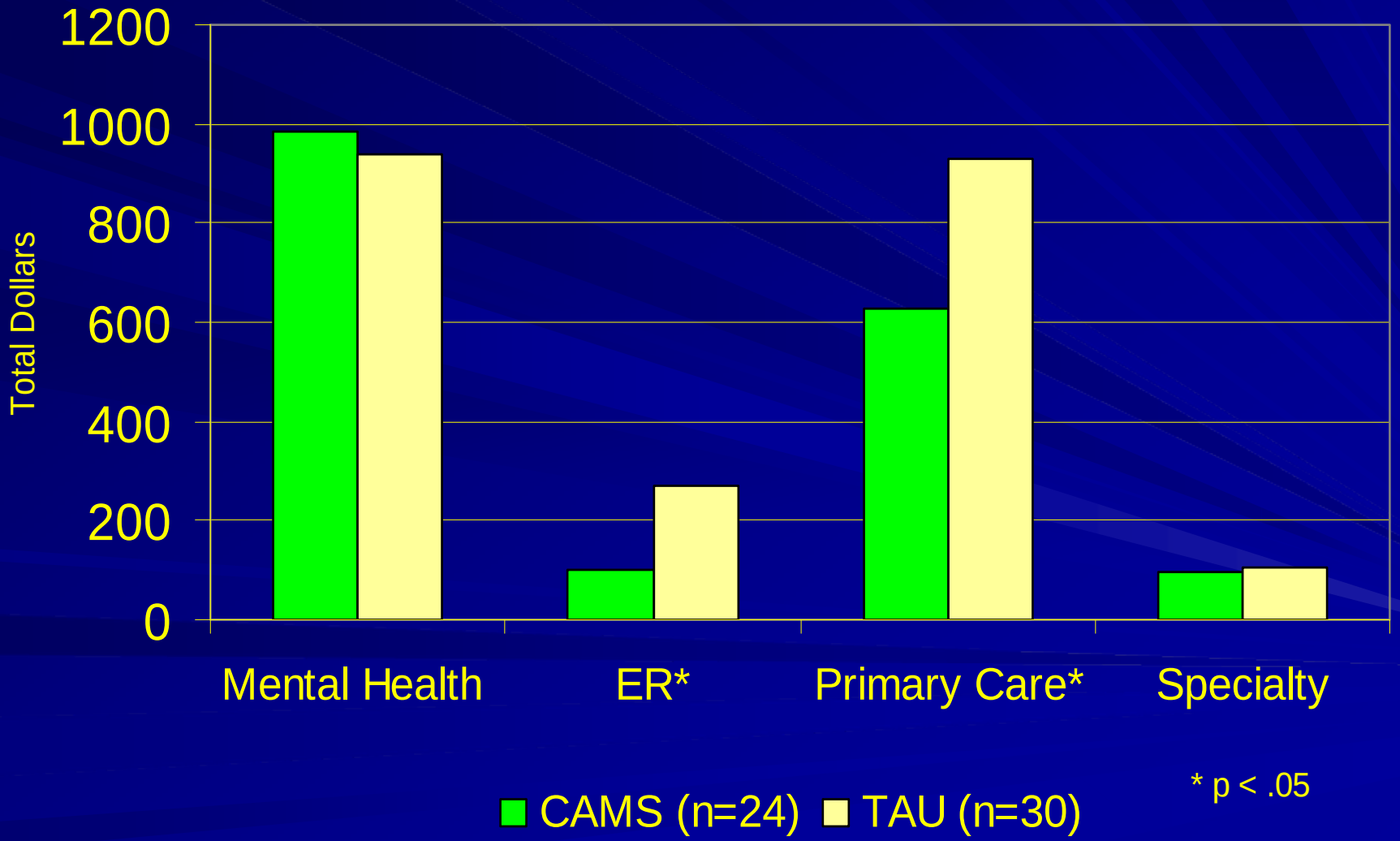
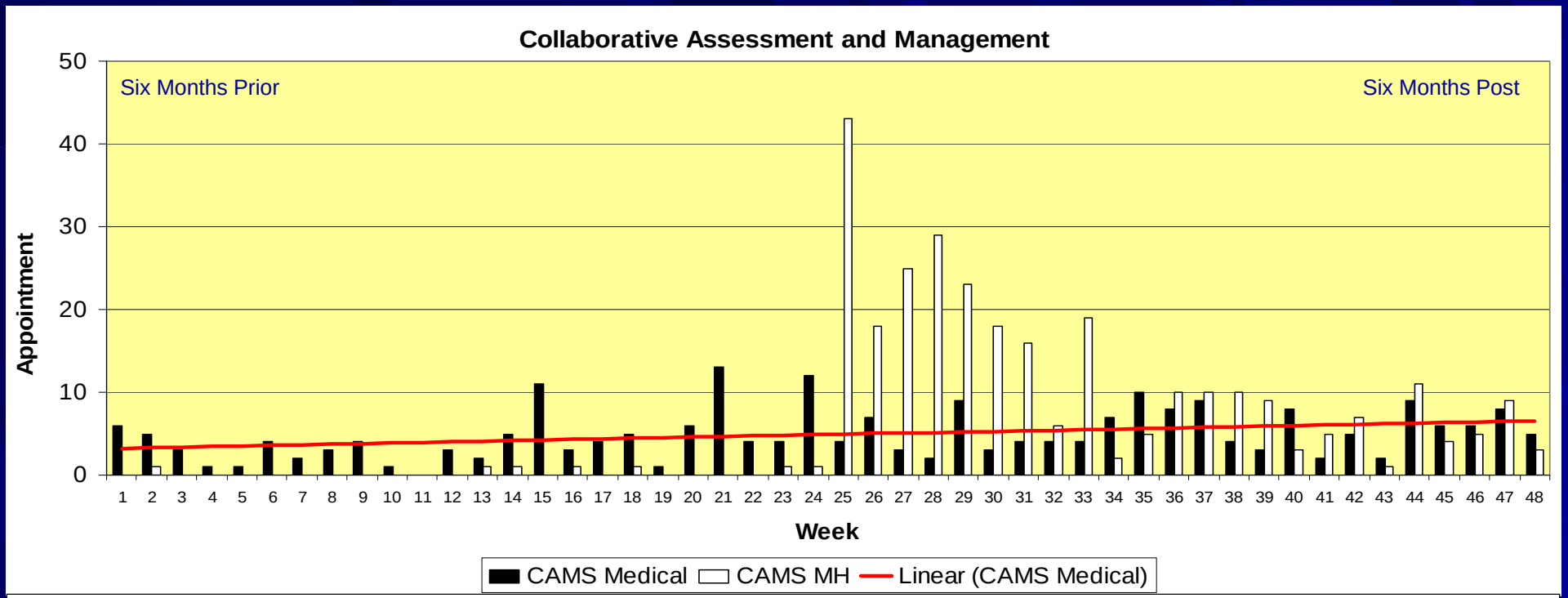
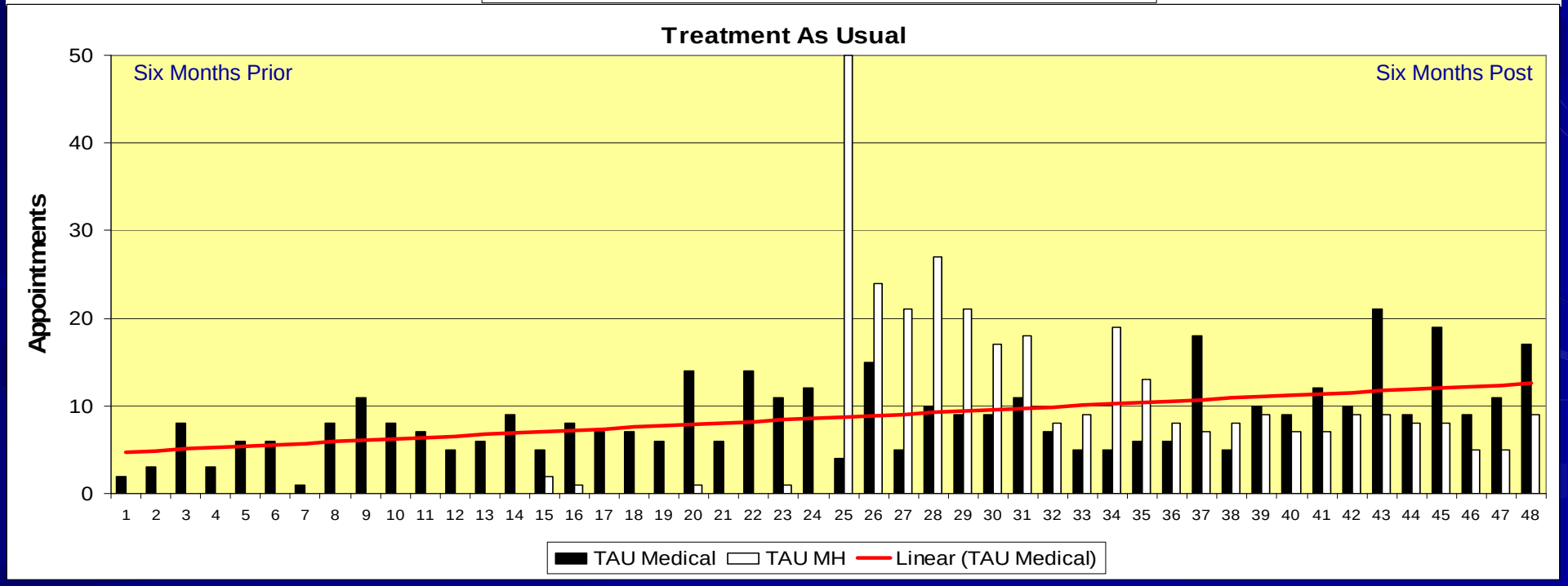


Figure 1. Estimated proportion of patients in the CAMS and TAU group to remain suicidal as a function of session number.

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




Collaborative Assessment and Management
Six Months Prior
Six Months Post
Appointment
Week
CAMS Medical
CAMS MH
Linear (CAMS Medical)


Treatment As Usual
Six Months Prior
Six Months Post
Appointments
TAU Medical
TAU MH
Linear (TAU Medical)

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 (existential purpose and meaning)

Adherence to CAMS: PI Collaboration (Denver/Seattle)

CAMS is a therapeutic framework, used until suicidality resolves. Adherence to CAMS requires thorough suicide risk assessment and problem-focused interventions that are designed to directly and indirectly decrease suicide risk (Jobes, Comtois, Brenner, & Gutierrez, in press).

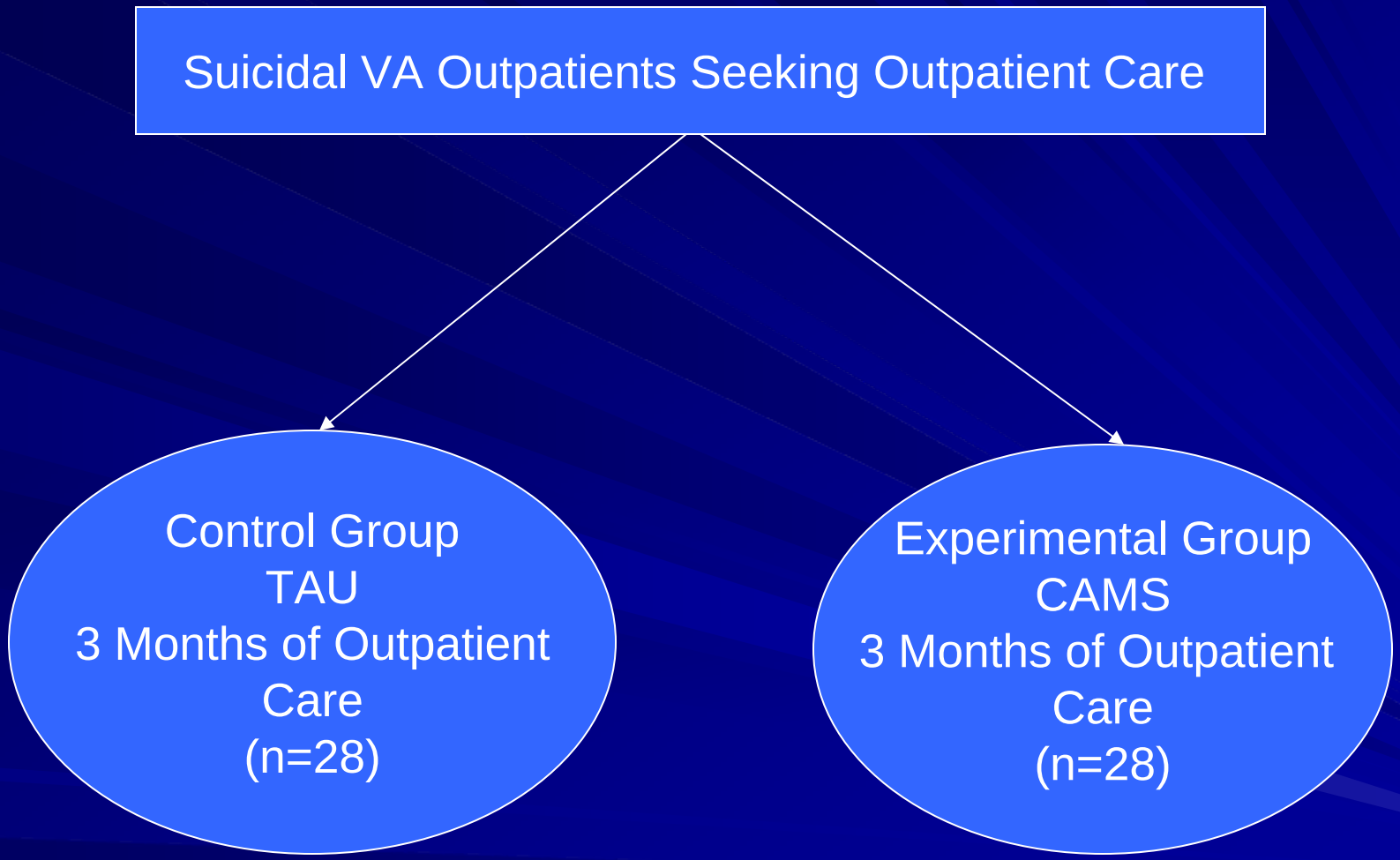
Therapeutic Philosophy

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 every clinical contact
2. All SSF-guided interventions are meant to eliminate direct or indirect causes of suicidal risk (so called “drivers” of suicide 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 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.

CAMS Clinical Trial Feasibility Studies

Warrior Resiliency Program

Process Improvement for Suicide Risk Management

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"Building & Restoring Resiliency"

Aims for Process Improvement at BAMC

- **Aim 1**: To evaluate existing procedures for clinical assessment and treatment of suicidal risk
- **Aim 2:** Pilot an evidence-based program (i.e., CAMS) at BAMC to enhance clinical assessment / intervention with suicidal military patients
- **Aim 3:** Evaluate the effectiveness of an enhanced model for possible dissemination to similar Military Treatment Facilities within the Southern region

Goal: To return soldiers to functional and deployable status as soon as possible…