Collaborative Assessment and Management of Suicidality (CAMS) Applied in a School Mental Health Program

Overview

1. Collaborative Assessment and Management of Suicidality (CAMS)
2. Counseling on Access to Lethal Means (CALM)
3. Prevention of Escalating Adolescent Crisis Events (PEACE)
4. The Assessment, Support, and Counseling (ASC) Center
5. Integration of CAMS, CALM, and PEACE at the ASC Center
6. Future Directions
7. Questions

Common Suicide Treatment Approaches

- Hospitalization
  - No evidence hospitalization prevents suicide in period following discharge (Knoll, 2000)
  - Pervasive ideation is indicative of future risk (Pruitt, 2008)
  - Risk of suicide is highest immediately following discharge (Crawford, 2004)
- No-Suicide Contract (Knepper, 2011)
- Treating underlying psychopathology
  - Short-term relief (Ellis, 2011)
CAMS as an Alternative

- 3 Cornerstones of CAMS:
  - Empathy
  - Honesty
  - Collaboration

What Makes CAMS Different?

- Easy to learn and implement
- Flexible and adaptable
- Focus on therapeutic alliance increases client motivation and treatment compliance
- Least-restrictive and cost-effective clinical approach to suicide risk
- Tracks and manages ongoing risk
- Recovery-oriented

What CAMS Is and Is Not

- A clinical philosophy of care
- A therapeutic framework and a clinical platform
- Suicide-focused
- Adaptable
- CAMS is not a new psychotherapy
CAMS Overview

1. Early Identification of Risk
2. Collaborative Assessment Using the Suicide Status Form (SSF-IV)
3. Coauthor a collaborative Treatment Plan
4. Clinical Tracking of Suicide Status
5. Clinical Resolution of Suicide Status

CAMS Procedures

1. Risk assessment - Section A & B
2. Collaborative Treatment Plan - Section C
3. Stabilization Plan
4. Clinician postsession evaluation - Section D

Risk Factors & Reduce Access to Lethal Means
Clinical Tracking of Suicide Status
- Self-report - Section A of SSF
- Adjust treatment and stabilization plan as needed
- Resolution of suicide status
  - Concludes when overall risk is ranked less than a 3
  - No suicidal behaviors and effectively managing suicidal thoughts/behaviors

Tracking and Resolution of Suicide Status

Support for CAMS
- Within-group treatment of suicidal college students (Jobes, 2009)
  - SSF and CAMS associated with reductions in suicidal thoughts and overall symptom distress
- Non-randomized control group design with active duty Air Force outpatient sample (Jobes et al., 2005)
  - CAMS care correlated with more rapid reductions of SI and less utilization of non-mental health care compared to TAU
  - Small sample size limitation

Support for CAMS
- Small feasibility study of CAMS care in a hospital outpatient clinic using random assignment
  - CAMS participants decreased suicidal ideation more rapidly with low rates maintained throughout treatment
  - CAMS care resulted in better treatment retention and high patient satisfaction compared to E-CAU
  - CAMS group had greater improvement in suicidal ideation, overall symptom distress, and increased hope at 12-month assessment compared to E-CAU group
  
  (Comvis et al., 2011)
Support for CAMS with Children

- No current systematic study of CAMS use with children
  - Potential feasibility supported by findings that elementary-aged children did not significantly differ from older adolescents in self-report quantitative ratings on SSF (Romanowicz et al., 2013)
- No research supporting psychometric value of SSF with young children (Ridge Anderson, Keyes, Jobes, 2016)
- Several clinical case studies support use of modified CAMS care with young children (Ridge Anderson, Keyes, Jobes, 2016)
  - Need for empirical research

Support for CAMS with Adolescents

- Exploratory research
  - No sex differences in SI report using SSF with large sample of adolescents receiving inpatient psychiatric treatment (Ridge Anderson, Keyes, Jobes, 2016)
  - Use of modified CAMS in Department of Juvenile Justice in Georgia judged effective by staff in clarifying suicidal thinking and providing structure to management of suicidal risk and self-harm (O’Connor et al., 2014)

Please visit [http://cams-care.com/?pgnc=1](http://cams-care.com/?pgnc=1) to see how you can sign up for the online CAMS training.
### Counseling on Access to Lethal Means (CALM)
- Means restriction
  - Removing firearms from the home, locking medication(s) in a lockbox
- Means restriction counseling
- Increase number of mental health care providers utilizing CALM
  - Provide education about risk of access
  - Plan to reduce access
- Increase skills and confidence in reducing access to lethal means
- Utilize in behavioral health and outpatient settings

(Stone & Rudd, 2015)

### Why Means Restriction?
- The decision to attempt suicide occurs in a short amount of time (Drum et al., 2009; Simon et al., 2001)
- The lethality of an attempt is contingent upon mean
  - Firearm
  - Suffocation
  - Medication
- The majority of those who attempt suicide, do not die by suicide (Owens et al., 2002)

### Restriction of Access to Lethal Means Support
- Suggested to strongly reduce likelihood of attempting and completing suicide (Barber & Miller, 2014)
- Firearm regulation in the United States (Andrés & Hempstead, 2010; Anestis & Anestis, 2015)
- Switzerland (Reisch et al., 2013)
- Israeli Defense Forces (Cox et al., 2007; Lubin et al., 2010)
- Sri Lanka (Edleston et al., 2006)
- Australia (Studdert et al., 2010)
Firearm availability has been associated with a significant increase in individual and overall suicide rates (Kposowa, 2013; Miller et al., 2015) • Has not been associated with other means (Miller et al., 2013) • Firearms have been associated with risk for completed suicide (Anglemyer et al., 2014) • Firearms are the leading suicide method in the United States (Miller et al., 2013) • Most fatal • Culturally acceptable • Easily accessible

**Why Firearms?**

- Importance of talking about reducing child’s access to lethal means
- Perceptions of effectiveness in discussing reducing access to lethal means
- Gun knowledge
- Comfort talking to parents about means reduction
- Belief that suicide can be prevented by restricting access to lethal means
- Information from the CALM workshop helped in counseling clients and families about firearm safety

**CALM Support**

- 89% of eligible patients received means-restriction counseling
- Parents reported favorable impression
- 10% initially had medications secured
  - After, 76% reported securing medications
- 67% of guns were locked initially
  - After, all guns were reported to be secure

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(Johnson, Frank, Ciocca, & Barber, 2011)

(Ranyan et al., 2016)
Increased self-reported confidence in resident advisors’ ability to conduct means restriction following CALM gatekeeper training and at follow-up with large effect sizes

Increased self-reported confidence in resident advisors’ ability to address suicide prevention following CALM gatekeeper training and from pre-training to follow-up with small to medium effect sizes

Repeated measures ANOVA (with Greenhouse-Geisser corrections)

- Suicide Prevention: \((F[1.448,115.814]=14.047, p=.001, \eta^2=0.149)\)
- Means Restriction: \((F[1.592,128.924]=86.527, p=.001, \eta^2=0.516)\)

(Cowan, Michael, & Jameson, in prep)

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Post-Training Follow-Up

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Prevention of Escalating Adolescent Crisis Events
(PEACE; Sale et al., 2014)

- Crisis intervention protocol
- Developed to establish a common language across school personnel and increase efficiency
- Systematic evidence-based procedure to assess and intervene according to level of suicidal and/or homicidal risk and protective factors
- 4 levels of risk:
  - Green, Yellow, Orange, Red
  - Each level associated with set of action steps, suggested consultation, and follow-up procedures

Green:
- Current feeling, superficial irritation
- Some past escalation or intent
- No current risk of plan

Plan of action:
- Document time and extent of past or feeling irritation
- Assess coping skills

Yellow:
- Current thoughts of hurting self or others, but mildly
- Risk factors for suicide are present but not immediately to external circumstances
- High risk of escalation to more severe act or alteration
- Risk factors for suicide are present, but escalation not evident in means to express suicidal thoughts
- High risk of suicide, no specific method, recent expressions of suicidal ideation, or specific type of persons or situations identified, suicidal interaction
- No specific plan or weapon available, immediate plan of action

Risk factor:
- Further discussion in absolutely necessary
- Assess and discuss alternative coping skills
- Refer for services or modify treatment if unable to help
- Continue to monitor suicidal ideation
- Notify school personnel
- Seek consultation from colleague who broaches risk
- Document all steps taken

Follow up with student within the week, preferring next day

Orange:
- Current suicidal or homicidal situation and intent
- Realistic and specific plan of hurting self or others
- Severe intuitive behaviors that are resistant to intervention
- Risk factors for at least 1 protective factor

Plan of action:
- Take consultation from colleague, preferably a licensed mental health professional
- Contact parents of student for emergency meeting
- Consult with community provider’s mobile crisis team

Notify school personnel & set up meeting with school personnel to be present in parent meeting
- School principal involvement is optional
- Homicidal situation, Student Resource Officer (SRO) is optional

Intervention: assistance is important in student's life (e.g., school) but not those who may project guilt

During family meeting:
- Complete Safety Plan w/ student & Parent Confirmation Form
- Homicidal: absent Duty to Harm = notify individual who has been threatened & patients of treatment
- Document all events and those involved
- Follow up with student before class begins the following morning
- Send for psychological services if not already
Effectiveness of PEACE

- 2012-13 year (Sale et al., 2014)
  - (2% base rate) with success in all 33 events (20 students)
- 2015-14 year (Michael, Jameson et al., 2015)
  - (4% base rate) with success in all 68 events (42 students)
- 2014-15 (Michael, Jameson, Lichiello, in prep)
  - (2% base rate) with success in ~ 30 events
- 2015-16 (in prep)
  - (3% base rate) with success in ~ 53 events (33 students)
- 2016-17 (in progress)
  - (5% base rate) with success in all 63 events (48 students)

The Assessment, Support, and Counseling (ASC) Center

- SMH program serving three North Carolina high schools
- Services
  - Individual CBT
  - Group therapy (DBT Skills)
  - Case management
  - Crisis intervention
- Effective in significantly reducing psychological symptoms in students served (Albright et al., 2013; Michael et al., 2013)
- Improvements in attendance and school discipline incidents (Michael et al., 2013)
- In collaboration with USC, reduced mood disorder symptoms over an average of nine 45 min. sessions of modularized intervention (Michael et al., 2016)
Integrating CAMS, CALM, and PEACE in SMH: An Overview

- SSF
  - Systematic assessment for level of risk
  - Assessing access to means
  - Practical implementation issues for students who present during crisis vs. non-crisis
- Stabilization Plan
  - Reducing access to lethal means
  - Communication with parents
  - Addressing issue of continued treatment
- Action steps guided by PEACE and in communication/collaboration with school personnel

Integrating CAMS, CALM, and PEACE: Crisis Intervention

- 2016-2017 suicidal crisis events
  - 48.21% (n = 27) of crisis response involved lethal means restriction (CALM)
  - Since CAMS/ASC research partnership, 15 crisis events
    - 46.67% (n = 7) of crisis response involved CAMS SSF and stabilization plan
- Limitations of SSF:
  - Time constraints
  - ASC clients versus drop-in students who may not become ASC clients
  - Missing information (i.e., family hx of suicidality and self-injury)
Integrating CAMS, CALM, and Peace: Individual Therapy

- 2016-2017 year (in progress)
  - Approximately 10 individual therapy clients utilizing CAMS
  - Advantages:
    - Targeting drivers of suicidality in treatment
    - CAMS Therapeutic Worksheet
    - Collaboration with parents
    - Automated texting rating scales of suicidality
    - Communication with mobile crisis

Future Directions

- Increasing contextual relevance of SSF for crisis interventions through updated integration of PEACE and CAMS
- Consideration of:
  - Risk factors such as self-injury and family history of suicidality
  - Time limits of school setting
  - Collaboration with school personnel
  - Completion of Section B and relevant information from Section A during crisis events
- Validation of updated integration of PEACE and CAMS

Questions?
## Learning Objectives

1. Understand CAMS
2. Be oriented to the CAMS modules
3. Apply the CAMS model in a school mental health program

## References

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