CHAPTER 1

The Collaborative Assessment and Management of Suicidality

"Carmen," a 16-year-old in her second year of public high school, has been distraught by her parent's bitter divorce. Carmen's mother is from Puerto Rico and her father is Asian American of Chinese descent. As a mixed-race, only child, Carmen struggles with loneliness and with her cultural identity. Like many high school teens, Carmen has also struggled to find a close group of friends. To this end, Carmen is extremely active on social media in her determined effort to connect with peers. Following a difficult first year, Carmen began to develop friends in the drama club. Carmen then fell in love with a Eric, a popular boy in his last year of high school, who was often the lead in school plays and musicals. Her interest in Eric was unrequited. At a party where her friends were drinking, Carmen got drunk and had sex with Eric. Carmen subsequently announced through social media that she and Eric were a couple. Eric denied this notion on social media and noted that Carmen was "a pathetic loser and crappy in bed." A series of Instagram and Snapchat messages ensued, and Carmen's drama club peers began taunting her about Eric's characterization of her. After a few days of online bullying, Carmen posted a Snapchat message about "ending it all" and she promptly overdosed on all the prescription medications in her mother's medicine cabinet. One member of the drama club who was alarmed by the post told her mother, who called Carmen's mom. Carmen's distressed mother raced to Carmen's bedroom and found her seizing on the floor of her room in a pool of vomit.

Carmen was rushed to the emergency department where her stomach was immediately lavaged. She spent 2 days in an intensive care unit where she was medically stabilized before being transferred to an inpatient psychiatric unit for 3 days. Carmen's school principal visited with Carmen's mother prior to her

discharge and suggested a referral to my private practice. Shortly following Carmen's discharge from the hospital, I held an initial consultation meeting with her and her distraught parents. In the course of this consultation, I proposed using the Collaborative Assessment and Management of Suicidality (CAMS)® to address Carmen's ongoing thoughts of suicide. Carmen's terrified parents quickly concurred, and with encouragement Carmen grudgingly agreed to try it.

A case like Carmen's poses many challenges for a mental health provider. Carmen is demographically the prototype of an American adolescent with serious thoughts of suicide (Curtin, 2020; Substance Abuse and Mental Health Services Administration [SAMHSA], 2020b). While her overdose suicide attempt was quite serious, Carmen does not have a history of multiple (two or more) suicide attempts. Nevertheless, Carmen harbors serious suicidal ideation, not unlike 18.8% of teenage high school students according to 2020 Youth Risk Behavior Survey research (Ivey-Stephenson et al., 2020). Other survey research obtained by SAMHSA (2020b) would further suggest that as a person of color within a marginalized community, Carmen incurs additional risk for serious thoughts of suicide. While statistically Carmen is less at risk for dying by suicide in comparison to a middle-aged White male, she is nevertheless still at risk for continued suicidal thoughts and additional suicide attempts. As a further consideration, Carmen's father is an experienced trial lawyer, and any provider might understandably harbor fears about a malpractice lawsuit for wrongful death if Carmen were to take her life while actively engaged in mental health treatment.[1]

Given all these considerations, many mental health providers (across disciplines and theoretical orientations) might have misgivings about taking on Carmen as a patient. As I have previously noted (Jobes, 2017), mental health providers often feel ill-equipped to care for someone like Carmen on an outpatient basis. While these concerns are not lost on me, I nevertheless approached her case with some measure of reassurance because, as a clinician and clinical trial researcher over many years, I have come to know that using CAMS should help decrease Carmen's suicide-related suffering and may even help save her life.

The CAMS Framework within Contemporary Mental Health Care

When I first worked in the field of mental health over 40 years ago, a common clinical response for an adolescent like Carmen with relatively well-off parents might have been an admission to an inpatient psychiatric facility that would last for weeks, often months, and in some cases even years. I first worked as member of a psychiatric nursing staff as a psych-tech in a locked, private, inpatient psychiatric hospital outside of

[1]Survey data confirm that suicide-related malpractice litigation is commonly considered by surviving family when a suicide occurs while a loved one is engaged in mental health care (Peterson et al., 2002).

Washington, DC. While I worked primarily on the adult unit, I often did shifts on the adolescent unit, and patients just like Carmen were routinely admitted for lengthy stays. In those days inpatient care was quite different, consisting of a comprehensive therapeutic milieu that included community meetings (with all staff and patients in attendance) every morning and a level-system that afforded different on-unit privileges that were indexed to a patient's relative progress within the milieu. Each morning after the community meeting, every patient had an extensive schedule of appointments with various members of the multidisciplinary treatment team, including daily meetings with their psychiatrist and regular meetings with their psychologist, and their clinical social worker. Well-trained clinicians provided small-group therapy that was offered every other day along with psychoeducational groups and activity therapies including psychodrama, art therapy, and music therapy. Moreover, teenagers who were on the adolescent unit also attended an in-house therapeutically oriented "school" that was a signature feature of this particular inpatient adolescent program.

While I enjoyed much of my work as a psych-tech, the most disagreeable part of my job was responding to emergency codes (i.e., "code reds" signaling that a patient was behaviorally out of control and in need of seclusion and restraint). One memorable code red was called on the adolescent unit where a "riot" had apparently broken out. I left the adult unit with a familiar mix of anticipatory anxiety and adrenaline, and the elevator doors opened on the adolescent unit that was indeed out of control. Staff were struggling with a number of patients near the nurse's station. I spotted a friend and coworker with an adolescent girl on his back who was flailing and screaming and pulling his hair. I sprinted out of the elevator to help disengage him from her grip, and after a harrowing struggle we finally got her and the other patients under control. In the weeks following this horrifying experience, I came to know this teenager better. She was a rather remarkable and gifted Latina (quite similar to Carmen). After her rocky start on the unit (the riot had occurred just days after her admission), this impressive young woman made steady and excellent progress, and was ultimately discharged after a *10-month* stay. When I reflect back on my experiences as a psych-tech in the trenches of inpatient care all these years later, I have many positive memories of patients that we clearly helped who got well by the time they were discharged. Nevertheless, I am still haunted by the patients who did not do well, and I remember with sadness some dreadful struggles in the seclusion rooms. While seclusion and restraint interventions were a necessary evil of my job in those days, it often did not feel therapeutic at all.

For better and for worse, times have dramatically changed since the early 1980s in relation to routine mental health care for people at risk of suicide. There is perhaps no more dramatic example of practice change than what we have seen in relation to inpatient psychiatric care. For example, seclusion and restraint practices have plummeted in recent years, mostly due to more effective use of chemical restraints (Muir-Cochrane, Grimmer, et al., 2020; Muir-Cochrane, Oster, et al., 2020). However, lengths of inpatient stays have also plummeted from many months to a matter of days. Indeed,

a typical contemporary length of an inpatient psychiatric stay for mental health and substance use treatment is 6–7 days (Healthcare Cost and Utilization Project [HCUP], 2021) and many stays are as brief as 24–48 hours. Within most contemporary inpatient settings, typical "treatment" may only include prescribing psychotropic medications, and perhaps some brief psychoeducational groups (National Alliance on Mental Illness [NAMI], 2014). All things considered, contemporary practice is a far cry from what some consider the "golden era" of comprehensive inpatient psychiatric care, when patients were admitted, extensively evaluated, and then treated with many modes of therapy during extensive lengths of time. Such typical inpatient stays ideally enabled patients to leave the facility in a meaningfully different and often markedly better state of mental health than they were in when they were first admitted. We cannot say the same now, with contemporary inpatient stays that may last for only a few days.

CAMS Philosophy

We begin our initial consideration of the CAMS framework by focusing on important organizing concepts that directly bear on using the intervention with patients who are suicidal. We will initially explore the key philosophical underpinnings of CAMS and then further examine the intervention as a clinical framework. We will also situate the use and application of CAMS within the broader context of recent developments within contemporary mental health care.

What is the best way to clinically proceed with an adolescent like Carmen? As I reflect back on the start of my work with her, a few noteworthy facts readily come to mind. First and foremost, Carmen was *alive.* And despite her obvious reluctance, and with some degree of persuasion by her parents, she tentatively agreed to work with me, complaining, "Like I really have a choice?" One particularly important aspect of this case was that her bitterly estranged parents were able to find common ground and established a tentative truce because of their love for Carmen and their fear of losing her to suicide. I remember her glaring resentfully at me for "making" her do a course of care that she clearly did not want to pursue. In turn, I did my best to reassure her parents, and I carefully endeavored to do nothing to further upset Carmen, who was prickly and eager to leave my office.

As I have described in the two previous editions of this book (Jobes, 2006, 2016b) and elsewhere with some of my key research collaborators (Jobes et al., 2011, 2016), the effective use of CAMS requires embracing a certain *philosophy* of clinical care. I believe the proven success of CAMS as an evidence-based suicide-focused intervention largely rests on a foundation of a particular set of philosophical ideas and a particular orientation to clinically working with people who are at risk for suicide. In recent years, I have argued that effective CAMS-guided clinical care *must* be supported by four pillars: (1) empathy, (2) collaboration, (3) honesty, and (4) a suicide-focus. Eighteen years ago, when I wrote the first edition of this book, these key philosophical underpinnings

were unusual and even provocative in some quarters. Despite all the evidence now supporting CAMS, the overall philosophical approach that we take when using CAMS nevertheless reflects some major departures from conventional clinical practices about how we best understand, assess, and treat a person at risk for suicide. I am, however, pleased to note that the essential elements that fundamentally define CAMS have now been more broadly embraced by international colleagues who emphasize the importance of therapeutic assessments, clinical formulations, the management of suicidal risk, and the use of risk reduction interventions within clinical care (Hawton et al., 2022). So, progress is being made in relation to these key philosophical ideas. What now follows is an elaboration of the essential pillars that define the CAMS framework.

Empathy for Suicidal States

Over two decades ago my friend and colleague the late Israel Orbach published an influential article (2001) in the field of suicidology that focused on *empathy with the suicidal wish*. Orbach and I were both charter members of the Aeschi Group, a small cadre of clinician-researchers who were critical of the conventional clinical approaches of that time for working with suicidal risk that relied on diagnostic reductionism and an emphasis on the primacy of mental disorders over the importance of appreciating the phenomenology of suicidal states (Michel et al., 2002). In a deliberate effort to chart an alternative course of action, the members of the Aeschi Group, who first convened in 2000, championed an empathic, narrative, and noncoercive approach to working with patients who were suicidal. That small gathering of experts was the beginning of what became a series of international meetings; the first six meetings were held in Aeschi, Switzerland, and the next four meetings were held in Vail, Colorado, in the United States (with the final conference in 2019). Simply stated, a central tenet of the Aeschi approach is that providers must truly *listen* to their patient's narrative story of being suicidal—the verbalization of their suicidal journey so to speak—in an empathic and nonjudgmental manner.

For decades I have been writing about how clinical work with patients who are suicidal can often rapidly unravel into a patient versus clinician adversarial relational dynamic (Jobes, 1995a, 2017; S. S. O'Connor, Jobes, Comtois, et al., 2012). Those of us in the Aeschi Group felt compelled to propose a range of alternative ways of forming a therapeutic alliance in the presence of suicidal risk; consequently an entire book was dedicated to this particular approach, which I coedited with Konrad Michel (Michel & Jobes, 2010). My clinical treatment research mentor, Marsha Linehan (the developer of Dialectical Behavior Therapy [DBT], who attended multiple Aeschi meetings), once told me that the default professional clinical response to suicidal risk throughout mental health settings has been to *shame and blame* such patients. The contemporary lived experience (aka "lived expertise") of people who have been suicidal and who have made suicide attempts confirms this critique, based on firsthand experiences of encountering conventional mental health care (SAMHSA, 2022).

For example, a number of years ago, I had a patient overdose on her antidepressant medication. I personally drove her to the emergency department (ED) of a nearby medical center and sat with her into the wee hours of the morning. She was unnecessarily and ignominiously shackled to a gurney and awaited a charcoal treatment for hours. And to our mutual horror we overheard her ED nurse loudly say to a colleague, "Yeah, we have another OD, I wish we could work with *real* patients!" My patient burst into tears of shame as I ruefully glared at the nurse. Within CAMS we never shame or blame. Instead, we endeavor to enter into the mind of a person who is suicidal with respect, taking great care to understand the phenomenology of the person's suicidal suffering from an empathic, nonjudgmental, and intrasubjective perspective. A person who struggles with serious thoughts of suicide deserves nothing less when engaging in professional care. It follows that empathy is the first critical pillar of all CAMS-guided care. We thus always enter into the suicidal struggle with genuine interest and humility as we endeavor to understand the struggle from the patient's perspective.

Collaboration

The second philosophical pillar of CAMS is the notion of collaboration. Indeed, collaboration is built into the name of the intervention. It is through respectful clinical collaboration that we initially engage the patient at the start of every CAMS session in a highly interactive assessment experience. In turn, at the end of each session of CAMS we actively collaborate with the patient to craft, further modify, and improve their suicide-focused treatment plan. It follows that in every session of CAMS we actively and intentionally elicit and consider the patient's sense about what is and is not working within the treatment. All CAMS assessment work is entirely collaborative; all treatment-related aspects of CAMS-guided care are fundamentally defined by active collaboration. When conducting any CAMS-based assessment, we never interrupt or talk over the patient; instead, we endeavor to draw them out and solicit their input at every opportunity. In terms of CAMS treatment planning, the patient is actively engaged and is said to be a "coauthor" of their own suicide-focused treatment plan (which is revisited at the end of every session). One look at the treatment research literature tells us that optimal clinical outcomes across approaches depends on the quality of the therapeutic alliance (Horvath & Symonds, 1991; Martin et al., 2000). In CAMS we actively foster that alliance through a consistent emphasis on collaboration and interactivity over the course of care. From beginning, to middle, to end—vigorous and earnest clinical collaboration is crucial for success.

Honesty

A third pillar of CAMS philosophy is honesty. This means being candid, transparent, and forthright with the patient at all times. For any patient teetering between life and

death, there can be no more important component of care than direct and respectful honesty about the entire situation. Clinical honesty related to suicidal risk begins with thoughtful and thorough informed consent (Jobes et al., 2008; Rudd et al., 2009) and candid discussions about the law and your duty as a licensed provider in relation to clear and imminent danger to self and others. In my experience, people who are suicidal invariably struggle with issues related to control, trust, betrayal, coercion, their civil liberties, shame and blame, and abject paternalism. I therefore always present some version of informed consent to my patients who are suicidal that goes like this:

> "Let's begin our discussion about suicide with something obvious: You can of course kill yourself, and in the grand scheme of things there is remarkably little I, or anyone else, can do about it. To be frank, it is your life and ultimately up to you whether you choose to live it. However, from a clinical standpoint, we have a dilemma because state laws and my profession's standard of care require me to not permit you to take your life if you pose a 'clear and imminent' danger to yourself. This duty can create a serious strain between your personal autonomy and my professional obligation, which could mean that I might have to consider committing you to an inpatient hospital setting, even against your will. While I do not want any of my patients to die by suicide, I nevertheless understand that to some people at times it seems there is no other way to cope with their situation. By the end of the day on average 130 Americans will die by their own hand, and about 30% of them will be engaged in mental health care. So the majority of people who die are not doing what you are doing with me right now. But honestly, I would rather not debate with you whether you can kill yourself. Instead, I would propose that we consider a proven treatment that is designed to decrease your suffering and help save your life. The clinical treatment research shows that most people who are suicidal quickly respond to this treatment across various clinical trials. So why not give it a try? In truth, you have everything to gain and really nothing to lose. You can, of course, kill yourself later when you are no longer in treatment. After all, it is your life to live or not as you see fit. But then, what is the hurry? One day we all die, and would it not be comforting before you take your life to know that you turned over every possible stone of help, including this one? Let me be clear: I do hear you, and that you may see suicide as the best way to deal with your situation. Yet I am glad you are still alive, and I applaud you for being here. Perhaps it is not yet your time to die, and maybe we should endeavor to pursue a suicide-focused treatment to see if we can make your life worth living?"

Too provocative? Over the years some mental health professionals have bluntly said that to me. When I present some version of this suicide-specific informed consent to groups of mental health providers that I train, I usually expect to see some raised eyebrows and sometimes hear direct objections from certain audience members. Some

believe this version of informed consent is akin to reverse psychology, a kind of intentional baiting, challenging the patient to take their life. Others are clearly uncomfortable by my candid admission about the limits of my influence and lack of control over any patient. Still others object to my acknowledgment that a patient can kill themselves later when they are no longer in treatment. When such objections are raised, I encourage audience members to pause and reflect, and place themselves into the mindset of a person who is profoundly suffering with suicidal thoughts. Then I repeat this version of suicide-related informed consent. Usually most clinicians then get it, and the training proceeds.

In truth, we cannot stop people from taking their lives through coercion, intimidation, or even involuntary commitment. And patients do take their lives on inpatient units (de Santis et al., 2015; James et al., 2012). In my experience, this candid form of suicide-related informed consent shows respect and that we take them seriously and it can actually *comfort* and *reassure* the person who is suicidal, compelling them to see me not as an adversary but as a potential clinical ally. By giving up any illusion of control and power *over* the patient, I actually earn more credibility and influence *with* and *for* the patient. I believe we should play the metaphorical poker game of clinical work with suicidal risk with our cards placed face-up on the table. In other words, we should give patients a copy of the clinical playbook, so to speak, so that they do not feel misled or tricked into situations (e.g., commitment against their will to an inpatient unit can feel like a betrayal that all too often traumatizes the patient and may only intensify their determination to end their life).

I endeavor to be crystal clear about my professional duty, which enables me to propose a viable path forward so that we may intentionally avoid an adversarial and nontherapeutic dynamic. Moreover, this line of informed consent has the distinct virtue of being the *truth* about contemporary clinical demands and the law as it relates to suicidal risk. When I was in graduate school one of my favorite professors once told us, "The truth is highly underrated in psychotherapy." Now decades later, I could not agree with her more. In fact, this kind of clinical truth-telling and transparency has become fundamental to CAMS philosophy of care and is indispensable to ethical and effective clinical practice (Jobes, 2011a, 2020).

CAMS as a Suicide-Focused Therapeutic Framework

The final pillar of CAMS philosophy deserves its own particular emphasis: being singularly, unabashedly, and unwaveringly focused on suicide. Some years ago, I remember a conversation I had with my research mentor Marsha Linehan. At the time I was doing assessment research on the Suicide Status Form (SSF) and starting to clinically investigate what would evolve into CAMS. Linehan bluntly quizzed me about what CAMS is. "Is it an assessment? Is it a treatment? Or is it a new psychotherapy?" she queried. "You better figure it out pretty soon, if you want anyone to actually use this!"

She was right to ask (as usual), and since that moment I have set about figuring out and then articulating what CAMS is and, perhaps just as critically, what it is not.

Many people think of CAMS as an assessment or screening tool, emphasizing the first page of the SSF. This perception is understandable in that the first edition (Jobes, 2006) was heavily focused on the assessment aspects of using the SSF. In effect, CAMS was a particular method of administering the SSF as a suicide-focused assessment; the treatment implications were only starting to emerge. With the second edition (Jobes, 2016b), CAMS was fully developing into a promising suicide-focused clinical intervention with a clear emphasis on suicide-focused treatment and emerging supportive data from the initial randomized controlled trials (RCTs) that were getting published. Now, with this third edition, CAMS has matured into a full-blown proven clinical intervention for suicidal risk. At the time of this writing there are 10 published nonrandomized clinical trials of CAMS and seven published supportive RCTs. In addition, an independent meta-analysis of nine CAMS clinical trials has shown its robust efficacy and effectiveness as a *well-supported* intervention for suicidal risk (Swift et al., 2021).

To answer Linehan's question: CAMS is a suicide-focused *therapeutic framework*. While assessment is a key element across the course of CAMS-guided care, CAMS is now much more than a mere assessment. CAMS is a clinical intervention that is now properly thought of as a suicide-focused treatment. No matter the diagnosis, the bullseye in CAMS is suicide.

As a suicide-focused therapeutic framework, CAMS is fundamentally guided by the unique multipurpose SSF. The SSF basically functions as a clinical roadmap within the CAMS framework that guides all assessments, treatment planning, the tracking of ongoing risk over interim care, as well as clinical outcomes and dispositions when the use of CAMS is discontinued. As is discussed at length in this book, the SSF has been extensively studied for over three decades in a broad range of clinical settings around the world. The SSF Core Assessment has excellent and replicated validity and reliability (Brausch et al., 2020; Conrad et al., 2009; Jobes et al., 1997) and has been used extensively across a range of settings, clinical populations, and various applications (Jobes et al., 2018). The assessment portion of the first session version of the SSF includes a unique blend of both quantitative and qualitative assessment responses. It is noteworthy that the collaborative completion of the assessment portions of the SSF is experienced as a therapeutic exercise for the patient. Indeed, Poston and Hanson (2010) empirically demonstrated that the CAMS-based SSF assessment functions as a "therapeutic assessment" experience within their meta-analysis of 17 published studies of psychological assessments. By definition, therapeutic assessments have positive and clinically meaningful effects on treatment, including the improvement of the treatment process.

As is discussed in the coming chapters, other portions of the SSF focus on the development of a suicide-focused treatment plan that initially features the CAMS Stabilization Plan and identification and treatment of *patient-identified* suicidal "drivers,"

which are issues or problems that make suicide compelling to the patient (Jobes et al., 2016). The development of the CAMS Stabilization Plan (CSP) in the first session is a critical first step within initial CAMS-guided treatment that highlights the importance of identifying and treating patient-defined suicidal drivers. After the first session and across ongoing CAMS-guided care, an interim version of the SSF is used to start each session with a quick review of the SSF Core Assessment and each of these sessions ends with further crafting the CSP and updating the CAMS Treatment Plan so as to optimally treat the patient's drivers of suicide. Importantly, all CAMS interim sessions end by thoughtfully reconsidering the driver-focused treatment plan based on developments and progress that occurs in each session. The more dynamic (i.e., changing and evolving vs. static) this treatment plan update process is, the better the treatment outcomes will be (Gregorian, 2021). The course of CAMS-guided care concludes with a final version of the SSF that accounts for the full range of treatment outcomes and helps guide an optimal disposition.

What Else Is CAMS?

In addition to the four philosophical pillars underpinning CAMS, there are some additional signature features that need to be emphasized.

How We Focus on Suicide

CAMS clinicians are singularly focused on clinically preventing their patient's suicide and decreasing suicide-related suffering. Within CAMS, the inherent clinical orientation is that there is nothing more important to consider about a patient's mental health treatment than the prospect of the patient's suicide. To this end, there is a certain persistence—even doggedness—in our primary focus on endeavoring to save the patient's life. In other words, within CAMS we continually work together to reduce or eliminate suicide as a means of coping, by effectively treating the problems (or modifying the perceptions of such problems) that compel the patient to consider suicide. Within CAMS we thus strive to treat, ameliorate, modify, and potentially eliminate suicidal drivers that imperil the patient's life. For example, over the course of a session a patient may want to talk about their kids, politics, or the economy. While the CAMS clinician may find these topics interesting, we nevertheless resist the temptation to focus on topics unrelated suicide. Unless such topics are relevant to the patient's suicidal risk, a CAMS clinician gently redirects the discussion back to those issues that threaten the patient's life. If the patient is frustrated with the singular emphasis on suicide, we will comment on how we would love to talk about other non-suicide-related topics *after* the patient has become behaviorally stable and effectively learned to manage any suicidal thoughts/feeling or ultimately eliminated suicide as an option within their coping repertoire.

Given the considerable success of CAMS, many have suggested to me that the CAMS model could perhaps be used to assess and treat homicidal risk, substance abuse, or eating disorders. My routine rejoinder is to appreciate the suggestion but underscore that CAMS is for treating suicide-related suffering, full stop. While various concepts within the CAMS model might apply to other problems, it is designed (and has been tested) for treating suicidal risk. A common related question is whether CAMS is effective for treating nonsuicidal self-injury (NSSI), otherwise referred to as self-harm behavior. While there is an overlap between those who struggle with suicidal thoughts and those who self-harm, what we know for sure is that CAMS is optimal for suicidal ideation. That said, there is some evidence that CAMS may also be effective for reducing self-harm behaviors on par with DBT, as seen in one RCT conducted in Copenhagen, Denmark (Andreasson et al., 2016). But from my perspective, CAMS will remain unwaveringly focused on suicide in the pursuit of decreasing suicide-related suffering and always endeavoring to help save lives and make those lives more worth living.

Outpatient Oriented

In the first edition of this book, I firmly asserted that CAMS should be stridently oriented toward keeping a person who is suicidal *out* of an inpatient psychiatric hospital setting (if at all possible). Eighteen years ago, this assertion was somewhat novel, if not controversial. It would be misleading to say I was alone in this assertion, as people like Marsha Linehan (Coyle et al., 2018; Linehan & Coyle, 2016) and Matthew Large (Bruer et al., 2018; Large, 2016; Large & Kapur, 2018) have long been strongly critical of contemporary inpatient psychiatric care. Indeed, Large and colleagues (2014) have even argued that there are "nosocomial" suicides that are *caused* by inpatient psychiatric hospitalizations. While I see a place for inpatient care in certain cases, for me it is plain that a psychiatric inpatient admission should *always* be the last possible option for responding to a person who is considering suicide. See Ward-Ciesielski and Rizvi (2021) for an excellent critical review of the potential iatrogenic effects of inpatient care. Despite the various issues related to inpatient care, 70% of 613 mental health clinicians surveyed favorably endorsed hospitalization as their option for suicidal risk (Rozek et al., 2022)

While this outpatient-emphasis is perhaps not as controversial as it once was, I sense many (perhaps even most) mental health clinicians continue to harbor a strong inclination toward inpatient care whenever they clinically face a patient with suicidal risk. This may be particularly true among psychiatrists and nurse practitioners who have traditionally been more attached to a "medical model" approach to suicide. But even for providers who are inclined toward outpatient care, hearing a patient talk about suicide can prompt a sudden thought: "Uh-oh, where can I admit this patient?" As described elsewhere (Jobes & Chalker, 2019), some of our inpatient bias has a long history, dating back to 18th-century notions of asylum in which various

deviants—mentally unstable "lunatics"—were routinely institutionalized. For many people in civil society such troubled individuals were better off effectively being put out of sight and out of mind.

Certainly, there may still be a need for an inpatient admission if a clinical dyad is unable to negotiate the CAMS Stabilization Plan (and secure lethal means) or otherwise develop a mutually acceptable treatment plan with care focused on patient identified drivers of suicide. As well, a notable exception to the general outpatient predisposition of CAMS is when CAMS is being used as part of *inpatient* care (refer to Chapter 9). Inpatient CAMS still focuses on developing an effective CAMS Stabilization Plan and driver-oriented treatment plan, both of which can play a pivotal role in optimal discharge planning and a successful post-hospital discharge and disposition (cf. Ellis, Green, et al., 2012; Ellis, Rufino, Allen, et al., 2015; Santel et al., 2023).

Flexible and Nondenominational

As a therapeutic framework, CAMS is designed for flexibility and adaptation. In a mental health world where providers passionately adhere to and defend particular theoretical approaches, I have asserted that CAMS is theoretically nondenominational. CAMS is meant to incorporate the full spectrum of clinical treatments and interventions. Whenever I train mental health providers in CAMS, I emphasize that I want clinicians to retain their own clinical skill sets, their own clinical judgment, and their own familiar treatment approaches. We do not want a clinician to transform into a different provider. Consequently, CAMS has been successfully used by mental health clinicians of all theoretical orientations (psychoanalytic, humanistic, interpersonal, cognitive-behavioral, etc.) and across professional disciplines (psychologists, psychiatrists, social workers, counselors, nurses, marriage and family therapists, case managers, substance-abuse clinicians, etc.) and across settings (private practice, counseling centers, community mental health settings, Veterans Affairs clinics, forensic settings, etc.). We consequently encourage providers to practice as they typically do, but to do so *within* the flexible and highly adaptive CAMS therapeutic framework.

As I have just mentioned, CAMS has primarily flourished in a range of outpatient settings. Moreover, as is discussed in more depth in Chapter 9, CAMS has been effectively used in emergency departments, psychiatric inpatient settings, crisis settings, and as part of a post-inpatient discharge group therapy. It would be naïve to think a single clinical approach will work with every kind of patient who is suicidal, in every possible clinical setting, across every culture and personal identity around the world. Nevertheless, CAMS does seem to work remarkably well for many patients who are suicidal across a range of settings where care is rendered worldwide (Schembari, 2017). As is discussed in the next chapter, there is evidence of CAMS being effective with active-duty military, Veterans, college students, crisis-care patients, inpatients, in adults, and increasingly with adolescents. While there is unquestionably a need for effective and highly structured manualized evidence-based treatments that embrace a particular

theoretical approach, there is an obvious demand for the theoretical flexibility and the ability to adapt that CAMS is able to afford.

Evidence-Based

Given the ubiquity of suicidal risk in mental health practice, it may be surprising to hear that empirically proven interventions for suicidal risk are remarkably limited. When we consider clinical science, it is important to note that RCTs are the gold standard of what is proven effective in a *causal* manner. Beyond RCTs, *replication* of key outcome findings is essential (i.e., independent replication and validation of RCT findings) (Chambless & Ollendick, 2001). With these criteria in mind, there are but a handful of suicide interventions that meet this highest level of scientific rigor. By far, DBT (Linehan et al., 2006, 2015) has the most replicated and independent RCT support for reliably reducing suicide attempt and self-harm behaviors (refer to DeCou et al.'s [2019] meta-analysis of 18 DBT RCTs) as well as the adapted version for adolescents (DBT-A) demonstrating reductions in self-harm (McCauley et al., 2018; Mehlum et al., 2014; Santamarina-Perez et al., 2020). There are two forms of suicide-focused Cognitive-Behavioral Therapy (CBT) that have been shown to impressively reduce suicide attempt behaviors based on two related but independent RCTs. Brown and colleagues (2005) were the first to show that 10 sessions of a Cognitive Therapy for Suicide Prevention (CT-SP) reduced repeat suicide attempts by *half* in comparison to treatment as usual. Using a briefer version of CT-SP, the suicide-focused intervention called Brief Cognitive-Behavioral Therapy (BCBT) by Rudd and colleagues (Rudd et al., 2015) demonstrated a 60% decrease in suicide attempts for those receiving BCBT in comparison to usual treatment. BCBT also has shown reductions in self-harm for youth in a pilot RCT (Sinyor et al., 2020). Furthermore, various forms of Problem-Solving Therapy (PST) for individuals with increased suicidal risk has been shown to reliably reduce suicidal ideation (Choi et al., 2016; Fitzpatrick et al., 2005; Gustavson et al., 2016; Stewart et al., 2009).

There are also several promising RCT-supported interventions that either have two or more RCTs by the same investigators with replicated findings or two or more RCTs by independent investigators without replicated findings. There is an RCT-supported intervention called Attempted Suicide Short Intervention Program (ASSIP) with an RCT (Michel & Gysin-Maillart, 2015) and a pilot RCT with the developers of the intervention (Conner et al., 2021), both of which show reductions in suicide attempts for those in the ASSIP condition. There are additional ASSIP trials underway, one with the important focus on including those with lived expertise (Stapelberg et al., 2021). Other RCT-supported interventions include Mentalization-Based Therapy (MBT; Bateman & Fonagy, 2006, 2009; Ougrin et al., 2015) and Attachment-Based Family Therapy (ABFT; Diamond et al., 2016). These two excellent suicide-related approaches still require replicated RCT support conducted by independent investigators to reach the highest tier of rigor proving the reliable and causal positive impact of these approaches.

Acceptance and Commitment Therapy (ACT) is another RCT-supported intervention for numerous diagnoses. In terms of suicide-related outcomes, this promising therapy has mixed RCT findings by independent investigators (Ducasse et al., 2018; Tighe et al., 2017; Walser et al., 2015) perhaps due to the unique protocols utilized in the RCTs (e.g., group therapy, ACT for depression, mobile health app). Of note for ACT, a systematic review reported two studies with a pre–post design demonstrating a reduction in suicidal ideation (Tighe et al., 2018). A RCT using a direct suicide-focused protocol of ACT is underway as of this writing (Barnes et al., 2017, 2021).

More broadly, it is worth noting that there are additional interventions that are broadly classified as cognitive-behavioral-based psychotherapy (e.g., Cognitive-Behavioral and Problem-Solving Therapy), CBT, and various other forms of CBT for Suicide Prevention (commonly followed by the acronym CBT-SP). These various CBT approaches have been shown to be effective for reducing self-harm for adolescents in meta-analyses (Hawton et al., 2016; Ougrin et al., 2015), reducing self-harm and repeated suicide attempts for teens and adults in a systematic review (Gøtzsche & Gøtzsche, 2017), and reducing suicidal behavior for adults in individual CBT when compared to minimal treatment or treatment as usual (Tarrier et al., 2008). Cognitive-Behavioral Suicide Prevention Therapy (CBSP) has pilot RCT-support for reductions in suicidal behavior in a prison sample (Pratt et al., 2015), and Safe Alternatives for Teens and Youths (SAFETY)—a CBT/DBT-informed family treatment designed to promote safety—was found to be effective at reducing suicide attempts in adolescents who self-harmed in an RCT (Asarnow et al., 2017). While CBT has empirical support, there is nevertheless inconsistent language used to define these CBT interventions as well as the opaqueness of what modules or protocols are being utilized in CBT. These considerations result in challenges for the field to know the exact skill set being taught in these types of therapies that garner such positive results.

Across all the effective and independently replicated treatments, there is a clear expectation of close adherence to highly structured treatment manuals in order to effectively deliver these interventions faithfully with adherence. For example, in the case of DBT one must be able and willing to practice behavior therapy, whereas to use the two CBT suicide-focused approaches one must practice cognitive therapy to effectively deliver each intervention. As adherence to an evidence-based approach is a critical component of effective delivery of that manualized care, the extensive training necessary to achieve reliable adherence to a proven treatment protocol is an extremely important consideration. For each of these excellent approaches to treating suicidal risk, the amount and duration of both didactic and experiential training can be considerable. Moreover, as noted by one of my CBT colleagues, "If you don't take the time to learn to carefully and faithfully follow the recipe, it's not really a cake." And as previously noted, and in marked contrast to such approaches, the CAMS framework accommodates different types of chefs who appreciate a more flexible approach to baking.

Relatively Easy to Learn

In contrast to some independently replicated RCT-supported approaches I have just described, CAMS is relatively easier to learn and use with adherence. Previous training research has shown that CAMS can be effectively learned in live-didactic forums (Pisani et al., 2011) as well as within e-learning training approaches (Bowers, 2021; Jobes, 2015, 2016a; Marshall et al., 2014). In an unpublished dissertation investigating 120 providers with training in CAMS ranging from simply reading the first edition of this book to a daylong live intensive training plus role playing, Crowley and colleagues (2014) found moderate to high self-report adherence to the CAMS framework across the range of learning experiences. Within our large randomized controlled trial of using CAMS with U.S. Army Soldiers who were suicidal (Jobes et al., 2017), it is noteworthy that CAMS clinicians in the RCT achieved adherence to CAMS within *four sessions* of their first use with a suicidal patient. Generally speaking, by their third CAMS case, these providers were relatively expert at using the intervention and they did not later fall out of adherence in follow-up fidelity and adherence reviews of their work (Corona et al., 2019a, 2019b). We have seen when providers fall out of adherence in an RCT that we can quickly remediate them back to adherence with some focused consultation. And to this end, adherence to an intervention matters because we have shown that better adherence to CAMS is significantly associated with better clinical treatment outcomes (Chalker, Gallop, et al., 2021).

The Integrated Training Model (ITM) developed and offered by CAMS-care LLC (the only source for authorized training in CAMS) includes three training components: (1) this book and a 3-hour foundational online demonstration of CAMS, (2) a day of role-play training (live or using an online platform), and (3) six to eight consultation calls/online video meetings. The ITM has been shown to be highly effective when delivered either live or online (Bowers, 2021). Also, in a statewide training study conducted by a team of researchers in the U.S. state of Georgia (LoParo et al., 2019), CAMS training was found to be significantly superior to training in DBT, AMSR (Assessing and Managing Suicide Risk), and QPR (Question, Persuade, and Refer) for effectively impacting the implementation of evidence-based suicide-focused care. In comparison to the other three training approaches, CAMS training was significantly better at increasing provider confidence for delivering effective suicide-focused clinical care.

One Size Does Not Fit All

In Appendix A I review a range of contemporary mental health care developments related to suicide prevention that have been driven by increasing public health concerns about suicide. Taken together, these recent developments within contemporary

mental health care, particularly as it relates to suicide, are trailblazing and increasing exponentially. I would argue that there has been more change and progress within the field of suicide prevention in the last decade than we collectively saw in the previous 50 years. The field of suicide prevention is exploding; research is booming, clinical innovations are being developed and studied, and major suicide-related policy initiatives are well underway with the potential for making far-reaching differences for saving lives. Along these lines, I would highly recommend the important work of Rory O'Connor (2021) and Craig Bryan (2021), who have thoughtfully integrated the state of the field with sensible considerations about where we need to go to realize success. The dramatic headway in suicide prevention is exciting and gratifying to see; having now been in the field for several decades, I particularly relish this hard-earned and unmistakable progress. My own fairly long-term view of the field may provide some unique perspectives on suicide prevention.

In 1995 I received the Edwin S. Shneidman Award from the American Association of Suicidology (AAS) for my early career contributions that were mostly focused on the early development and use of the SSF (years before the advent of CAMS). In those days as part of receiving this award, the recipient was invited to submit a manuscript to the AAS journal, *Suicide and Life-Threatening Behavior*. I excitedly jumped at the chance to write a manuscript fashioned after my Shneidman Award speech that was ultimately published (Jobes, 1995a) after a bit of an editorial tussle. The issue was centered on my proposing that one day we might be able to reliably identify different suicidal states that could be matched to different suicide-specific clinical treatments, what I called "prescriptive treatments" for different suicidal populations. One particularly critical reviewer of my submitted manuscript took issue with this concept, calling it a naive "pipe dream" as they harshly reviewed the manuscript. Nevertheless, I was not deterred but fought for the inclusion of this concept, and it was ultimately included in the published article. Now some 28 years later, I am pleased to note that my dismissed pipe dream of matching different suicide-specific treatments to different suicidal states is now emerging as a clinical reality. My colleague Ronald Kessler has proposed the compelling idea of "precision treatment rules" (Kessler, Bossarte, et al., 2019). And my lab has done a study with Kessler using clinical trial data from our Army RCT (Kessler, Chalker, et al., 2019). This study used a machine-learning methodology to create an algorithm that would route 78% Soldiers who were better suited to benefit from CAMS while 22% were routed to be better treated receiving control care. As described in depth elsewhere, we are beginning to see the potential merits of matching different treatments to different needs (Jobes & Chalker, 2019).

Figure 1.1 depicts this potential. From the proverbial 10,000-foot perspective, our consideration of suicide prevention begins on the bottom half of Figure 1.1, with the 70% of people who are suicidal but do not seek mental health care at the time of their death (Jobes & Chalker, 2019); as per U.S. statistics this may account for over 32,000+ of U.S. deaths. For such people, we must find ways to make mental health care more compelling. In the meantime, we can take a public health approach and aspire to

educate, provide access to the national Lifeline and Crisis Text Line, and if they touch health care systems, endeavor to provide caring contact follow-up (Luxton et al., 2013; National Action Alliance for Suicide Prevention: Transforming Health Systems Initiative Work Group, 2018). But beyond these largely public health-oriented approaches, we do not yet know how to best reach this group. Perhaps the evolving lived-experience perspective and peer-support movement or social media can provide a safer form of support that is more accessible and less stigmatizing for this population as noted in the lower portion of Figure 1.1.

Considering the upper half of Figure 1.1, for people who are suicidal and willing to seek mental health care, within an ideal mental health care delivery model, such people would be matched to evidence-based approaches for which they are best suited. For example, the 1.2 million adults who attempt suicide would most benefit from safety planning-type interventions (Nuij et al., 2021) and/or DBT, CT-SP, BCBT, PST (or perhaps ACT, ASSIP MBT, or a CBT). For the 12.3 million adults with serious thoughts of suicide, such people would be optimally referred to CAMS. For youth with suicidal thoughts, an optimal referral might be to DBT-A (or perhaps ABFT or a CBT) or CAMS-4Teens (Jobes et al., 2019). Finally, the upper right corner of Figure 1.1 simply suggests that similar mechanisms are "baked" into the existing evidence-based approaches (e.g., stabilization planning and lethal means safety discussions) and are common across suicide-focused interventions proven to be effective through RCTs (Rudd et al., 2022).

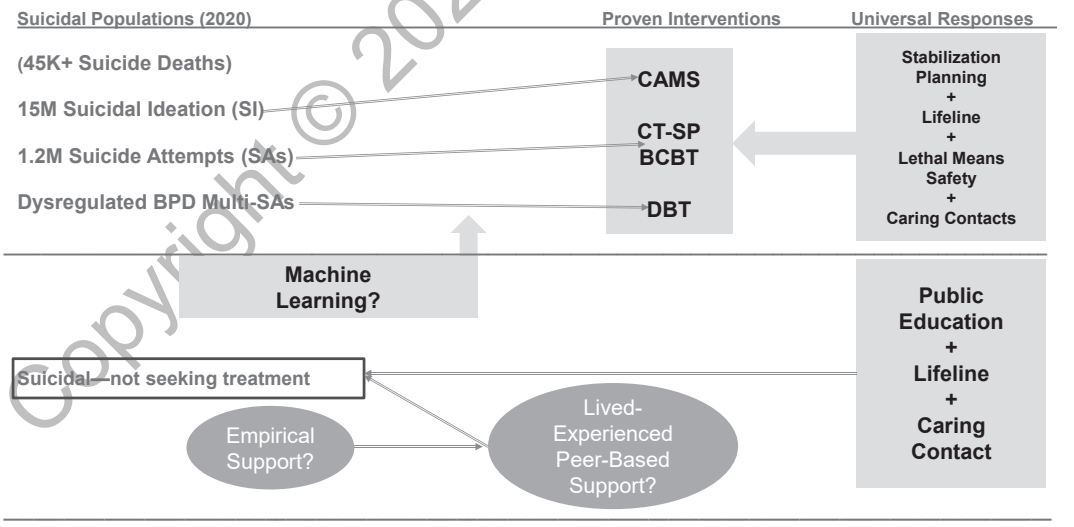

FIGURE 1.1. Matching interventions to different suicidal states. CAMS, Collaborative Assessment and Management of Suicidality; CT-SP, Cognitive Therapy for Suicide Prevention; BCBT, Brief Cognitive-Behavioral Therapy; DBT, Dialectical Behavior Therapy; BPD, borderline personality disorder. From Jobes and Chalker (2019).

A Suicide-Focused Stepped-Care Approach

From an even larger macro-level perspective, Figure 1.2 depicts a "stepped-care" model for suicide care (Jobes et al., 2018). This pyramid model was originally developed for a plenary session at the 2013 Congress of the International Association for Suicide Prevention held in Oslo, Norway. Figure 1.2 notes health care costs on the *y*-axis, which is probably the single biggest force that shapes health care practices around the world. It follows that the top of this pyramid of suicide-focused care corresponds to the most expensive systems-level interventions that we have in the form of inpatient psychiatric hospitalization. As we move down each level of the pyramid model, we observe increasingly less-expensive systems-level interventions. Accordingly, the bottom level of the pyramid reflects an obvious need to grow and develop a massive paraprofessional workforce because there are not enough licensed mental health providers to effectively care for upwards of 15.6 million adults and teens with serious thoughts of suicide. Such a paraprofessional workforce of caring people could be well trained and appropriately supervised to effectively work with people who have serious thoughts of suicide. I have previously called for the development in the United States of a "National Mental Health Service Corp" (comparable to the U.S. Peace Corp founded in the 1960s) (Jobes & Chalker, 2019). While this may be another "pipe dream" idea, such things can only happen if we dare to imagine them in the first place and advocate for them to happen.

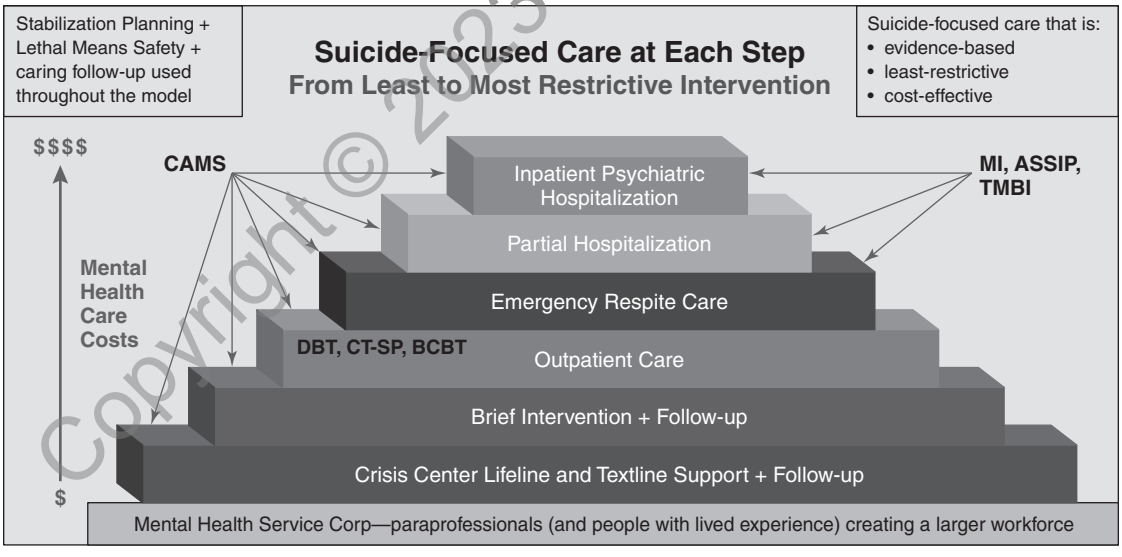

FIGURE 1.2. A stepped-care model for suicide care. CAMS, Collaborative Assessment and Management of Suicidality; DBT, Dialectical Behavior Therapy; CT-SP, Cognitive Therapy for Suicide Prevention; BCBT, Brief Cognitive-Behavioral Therapy; MI, Motivational Interviewing; ASSIP, Attempted Suicide Short Intervention Program; TMBI, Teachable Moment Brief Intervention. From Jobes and Chalker (2019).

In any event, the use of different evidence-based suicide-focused treatments described in this chapter could be provided at each level of clinical care. Note that CAMS (and the SSF) can be adapted and used in each level of the care pyramid. Bottom line, this stepped-care model provides a way of thinking broadly about providing *cost-effective*, *least-restrictive*, and *evidence-based* care for those who are at risk for suicide. If we aspire to make a lifesaving difference, both public health and mental health policy need to be adapted in such ways to help reduce suicide-related suffering, suicide attempts, and ultimately suicides, which cause so much heartbreak among those who survive these deaths. But if we do not imagine a world with cost-effective, least-restrictive, and evidence-based care that reduces suicidal risk, it is hard to make such concepts our reality.

* * *

A few days after our initial family meeting, I greeted Carmen, who anxiously sat with her mother in my practice waiting room. In my office, Carmen was skittish and upset and, as part of CAMS, I asked her for permission to take a seat next to her to complete the Suicide Status Form together. She gave me a long and hesitant look before nodding nervously. But as Carmen began to complete the various SSF ratings and wrote out her responses to the qualitative prompts on the first page, she seemed surprised by my ability to understand and validate her emotional struggles and feelings about suicide. Having done this countless times with patients over the years, I soon recognized in her quick glances and the slightest trace of a guarded smile that she was becoming less anxious and a bit less leery of me. I sensed that she sensed that I was actually getting what it was like to be her, particularly in relation to her suicidal thoughts. Carmen could see that I was familiar with feelings like hers, and she seemed gradually reassured by my steady and certain approach to this sensitive topic. I noted her subtle and nuanced cues over the course of that first session of CAMS, and I then began to see slight flickers of hope, which is the most important and essential ingredient in the pursuit of clinically saving lives from suicide. And despite her lability and tentativeness, I began to feel that I could become a clinical ally to Carmen and her struggle with suicide and life.

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