Collaborative assessment and management of suicidality at Menninger (CAMS-M): An inpatient adaptation and implementation

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In this article, the authors describe CAMS-M, a novel approach to working therapeutically with suicidal psychiatric inpatients, with the goal of reducing the likelihood of future suicidal crises. CAMS-M, developed at The Menninger Clinic, is an adaptation of the Collaborative Assessment and Management of Suicidality (CAMS), a novel framework with promising early research findings in outpatient settings (Jobes, 2006). Here, we provide a detailed description of CAMS-M, describe how it differs from CAMS in its original form, and discuss issues around implementation in a hospital setting. We conclude that CAMS-M holds considerable promise in risk management and therapeutic intervention with suicidal patients in the inpatient environment. (Bulletin of the Menninger Clinic, 76[2], 147–171)

When a mental health professional encounters a patient in the midst of a suicidal crisis, hospitalization is generally viewed as a means of ensuring safety until the patient has been stabilized and the crisis resolved. Indeed, in this situation, hospitalization is viewed by some as standard of care (Bongar, 1991). However,

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it is important for clinicians to be aware that hospitalization is no guarantee of safety; indeed, of the more than 30,000 deaths by suicide that occur in the U.S. each year (Centers for Disease Control and Prevention, 2008), between 4% and 7% occur while the patient is in the hospital (Wolfersdorf, 2000). Moreover, the weeks and months following discharge from a psychiatric hospital stay are recognized as a period of particularly high risk (Deisenhammer, Huber, Kemmler, Weiss, & Hinterhuber, 2007; Kan, Ho, Dong, & Dunn, 2007).

Clinicians treating suicidal patients, whether hospitalized or not, face a number of challenges. Foremost among these is developing a collaborative working alliance around shared goals. Simply put, the clinician's most fundamental goal (the patient's survival) may not be shared by the patient. These patients often are convinced that their future is hopeless and that death is their only avenue to relief from intolerable suffering. Thus they may lack the motivation needed for productive participation in treatment (Britton, Patrick, Wenzel, & Williams, 2010). The therapeutic alliance becomes more salient because collaboration is essential for patients to begin to feel a sense of competence in their recovery (Britton et al., 2010).

A number of empirically supported treatments for suicidal patients have been introduced and tested in recent years (Ellis & Rutherford, 2008). These include Dialectical Behavior Therapy (DBT; Linehan, 1993), cognitive therapy for suicidal patients (Wenzel, Brown, & Beck, 2009), and Mentalization Based Therapy (e.g., Bateman & Fonagy, 2008, 2009). All of these approaches to working with suicidal individuals have shown promise in terms of both symptom improvement and reduction of risk for future suicidal behavior.

The study of suicide at The Menninger Clinic has an extensive history, dating back as far as Karl Menninger's (1938) groundbreaking book, *Man Against Himself*. More recently, work at Menninger has addressed such topics as hospital suicide (e.g., Conroy & Smith, 1983) and personality assessment in the prediction of suicide (e.g., Eyman & Eyman, 1992). In this article, we describe an adaptation and implementation of the Collaborative Assessment and Management of Suicidality (CAMS), a novel approach to suicide risk that has shown promise in outpatient settings (e.g., Jobes, Wong, Conrad, Drozd, & Neal-Walden, 2005), but that has not yet been evaluated in the inpatient environment. As notedin what follows, the thrust of CAMS does not dictate what therapeutic approach is used, but rather it functions as a framework for developing and maintaining the collaborative relationship as an agent of change (Jobes, 2006). With its several-week lengths of stay and twice-weekly individual psychotherapy, The Menninger Clinic provides a rare opportunity to implement a protocol designed to decrease long-term vulnerability to suicidal states. Yet the eclectic version of CAMS developed and researched in this setting also has potentially wide applicability.

What is CAMS?

CAMS is a structured, collaborative approach to risk assessment, treatment planning, alliance-building, and risk reduction with suicidal patients (Jobes, 2006). It facilitates the management of suicidality and serves as a "platform" for therapeutic treatment aimed at reducing vulnerability to future suicidality. CAMS is compatible with a variety of therapeutic approaches, depending upon clinical indications and the background of the individual therapist.

The CAMS procedure places special emphasis on cultivating a spirit of collaboration with the patient on tasks such as developing a shared understanding of the suicidal episode and creating a safety plan to be implemented both during the hospital stay and after discharge. It also directly addresses specific psychological vulnerabilities to suicidality, such as perceived reasons for dying exceeding perceived reasons for living.

Beyond the emphasis on collaborative process, CAMS endeavors to keep the suicidal response at the forefront of therapy. Suicide is framed fundamentally, not as a symptom of an illness, but rather as a coping response in the face of extreme distress and in the absence of an available means of gaining relief from that distress. A major agenda item for the therapy is developing a shared understanding of how the suicidal experience unfolds for the patient, in terms of the psychological factors contributing

to the suicidal state, as well as typical situational triggers, cognitions, impulses, behaviors, and emotions. Particular attention is paid to identifying skill deficits and psychological vulnerabilities that play roles in suicidal episodes.

The other primary therapeutic focus is on development of alternate coping responses. Here, an assortment of interventions are used, many borrowed from other therapeutic approaches, including DBT and cognitive therapy. Examples include coping cards, the safety plan, the Hope Kit, and self-soothing techniques (Linehan, 1993; Wenzel et al., 2009). CAMS patients also receive the usual array of treatments delivered at The Menninger Clinic, including psychiatric medications, various psychoeducational groups, family therapy sessions as appropriate, and participation in a therapeutic milieu.

Inpatient application

"CAMS-M" was developed at The Menninger Clinic as a variant of CAMS, adapted to an inpatient population characterized by complex, treatment-refractory problems. Compared to CAMS, CAMS-M functions a bit less as a risk management strategy (risk management at The Menninger Clinic is shared throughout the institution, notably residing with nursing) and takes on more psychotherapeutic characteristics by virtue of its effort to partner with the patient to explore and address psychological and situational vulnerabilities that initially set the stage for suicidality and that may place the patient at future risk if not addressed.

The general objectives of CAMS-M include the following:

(a) ongoing assessment of level of suicide risk (imminent and long-term)
(b) resolution of acute suicidality
(c) education of the patient through functional analysis of suicidal episodes and sharing of a therapeutic formulation based on that analysis
(d) development of coping responses as adaptive alternatives to suicidal behavior

(e) amelioration of suicide vulnerability factors ("drivers" such as psychological pain and self-hate)
(f) relapse prevention, using such devices as the safety plan

The following are central aspects of CAMS-M. These are considered basic to the nature of CAMS-M; to the extent that they are present, it can be assumed that the intervention differs from "therapy as usual."

General approach

Collaborative relationship

Collaboration is cultivated in the same manner as described in *Managing Suicidal Risk* (Jobes, 2006). This begins with the initial administration of the Suicide Status Form (SSF; Jobes, 2006), in which clinician and patient literally sit side-by-side while conjointly filling out the form. The SSF serves both to assess suicide risk and to promote treatment planning (Jobes, Jacoby, Cimbolic, & Hustead, 1997). It is derived from an integration of various theories of suicidal behavior. It assesses the patient's subjective experience of various forms of negative emotion, which comprise the drivers for the suicidal state (Pain, Stress, Agitation, Hopelessness, and Self-Hate); current wish to live and wish to die; reasons for living and dying; subjective judgment of probability of eventually dying by suicide; and a question about the "one thing" that would enable the patient to no longer be suicidal. An alternate (tracking) form of the SSF allows the clinician to follow the patient session-by-session on several of these variables.

Exploration of issues, identification of contributors to suicidality, and setting of the treatment agenda all are done collaboratively. Of central importance, suicidality is regarded by the clinician in a nonjudgmental fashion. Rather than delivering the message that suicidality is unacceptable and must stop, the clinician validates the patient's pain and seeks to make sense with the patient of the process by which that pain led to suicidal ideation and behavior. This shared understanding, characterized by a nonjudgmental stance, is a fundamental enabling objective for an effective working relationship.

More generally, the practice of CAMS-M entails an attitude on the part of the therapist that both parties make essential contributions to the process, and that neither party is "in charge" of the therapy. More specifically, the CAMS-M therapist, while committed to suicide prevention, rejects the role of the savior or enforcer who endeavors to change the patient's mind or take the suicide option away from the patient. Rather, the therapist recognizes that suicide is, in fact, an option for the patient, and endeavors to help the patient to identify and pursue options to reduce emotional pain and make life more worth living.

Suicide focus

CAMS-M, by definition, places suicide "front-and-center" in therapeutic work with the patient. This is explained to the patient during the process of informed consent. Recognizing that patients often are highly sensitized to the message, "You have to get rid of your suicidality," and are understandably resistant to accepting this foreign agenda as their own, CAMS-M is presented as an option rather than a mandate. The clinician seeks to meet the patient empathically, in his or her emotional space, recognizing that his or her suffering has been so severe that it has nearly proven fatal. The clinician observes that he or she is committed to helping the patient find relief from that suffering, and is most concerned that the patient might not survive to allow this to occur. The agenda is posed as a question: "Would it make sense to you to make survival the first order of business—to gain a clear, mutual understanding of what generates the pain and find ways of obtaining relief from that pain without endangering your life?"

It is important to convey to the patient (and—importantly—to referring clinicians) that "suicide focus" does not mean "talking only about suicide and nothing else." The suicidal state is viewed as a window into the patient's core psychological and interpersonal problems. Thus, in CAMS-M, suicide becomes the context for all other matters of significance to the patient: relationship failure as an antecedent to suicidal ideation; self-harm behavior as a means of eliciting caring from others; thoughts of death as a reflection of poorly articulated personal values and reasons for

living; and suicidality as an example of an array of behaviors reflecting a pattern of experiential avoidance. Problems such as substance abuse, infidelity, emotional dysregulation, and search for meaning all are grist for the mill against the backdrop of psychic pain, self-hate, and suicidality.

Suicide framed as a coping response

Following the lead of Jobes (2006) and Linehan (1993), the therapist offers the patient an alternate attributional framework for suicidal ideation and behavior. Conventional views include suicidality as a symptom of an illness, attention-getting, personal weakness, spiritual failure, and other derogatory meanings. In CAMS-M, the therapist presents his or her view that, from an objective standpoint, suicidality is a sign of severe distress and is nothing more or less than an effort to find relief from that distress. Rather than the behavior (or the patient) being "bad," it is viewed as the best course of action the patient has been able to identify. In this context, the clinician wonders aloud whether the patient would be considering suicide or self-harm if he or she were aware of less harmful ways of feeling better. Suicide is framed as merely a means to an end; and in this respect, no patient wants to die so much as to find relief from suffering. Hence, the agenda offered by the clinician is no less than to find alternate pathways to relief.

None of this is to deny the multidetermined nature of suicidality, views of which vary according to theoretical orientation and among members of the multidisciplinary team. Thus various hypotheses may exist about motivations behind suicidality, whether hostile, despairing, aggressive, or even altruistic. However, the starting point for intervention, especially with the patient experiencing shame or self-criticism regarding his or her suicidality, is the view that suicide is fundamentally about relief from suffering, and the therapy agenda is about finding alternate paths to relief.

Treatment guided by ongoing psychometric assessment

Systematic, ongoing assessment has been a hallmark of CAMS from the beginning (e.g., Jobes & Eddins, 1992). The SSF serves multiple functions, not only providing information for risk as-

sessment, but also serving as a vehicle for building the collaborative relationship and a platform for treatment planning.

Use of the SSF differs in an inpatient setting relative to conventional usage. The SSF was originally developed to facilitate management of suicidal individuals in outpatient settings. The Initial Form was used during the first session, and the SSF Tracking Form was used in all subsequent sessions until three consecutive sessions resulted in a determination of "no suicidality," at which time the SSF Outcome Form would be administered (Jobes, 2006). Because psychotherapy patients are generally seen more than once per week in inpatient settings, we administer the SSF Tracking Form once per week rather than at every session. As in outpatient settings, the SSF Initial form is used for the first session (following informed consent). However, rather than utilizing the "three-session rule," CAMS-M stipulates continued administration throughout treatment, with the Outcome Form used just prior to discharge.

When providing ratings on suicide drivers (Pain, Stress, etc.), hospitalized patients often ask whether this pertains to now (since hospitalization) or during their suicidal episode. For this reason, we have found it desirable to obtain both current and "worst point" ratings. This is done by asking the patient first to rate all items according to how he or she felt during the recent suicidal episode by circling the appropriate numbers, and then to go back and use an X to show current ratings on each item. At this time, the patient also enters statements regarding the content of the rating (e.g., What I find most painful is ________). In other words, for the purposes of inpatient treatment, we are most interested in content with respect to *current* distress.

Similarly, it is desirable to obtain two ratings for the item asking for the patient's self-assessed risk for dying by suicide. The first rating is for "in the near term," loosely defined as during hospitalization or within weeks after discharge. The second rating is for lifetime: "your sense that your life will ultimately end by suicide."

Other assessment instruments

In addition to the SSF, CAMS-M utilizes the following self-administered measures on a biweekly basis: the Beck Depression Inventory (BDI-II; Beck, Steer, & Brown, 1996), the Beck Hopelessness Scale (BHS; Beck & Steer, 1993a), the Beck Scale for Suicidal Ideation (BSS; Beck & Steer, 1993b), and the Suicide Cognitions Scale (SCS; Rudd et al., 2008). These provide for ongoing assessment of the patient's affective state with norms to allow for comparisons to established population benchmarks. In addition, use of the SCS permits assessment of two constructs thought to be associated with "trait" hopelessness: unbearability and unlovability (self-hate).

Content

Central foci

As described above, although CAMS in its original form is not viewed as a form of psychotherapy per se, CAMS-M has a prominent therapeutic aspect. In other words, in addition to being utilized as a means of assessing and understanding suicide risk, CAMS-M is also viewed as an approach (or "platform") for treating underlying vulnerabilities to suicide. Indeed, it is an explicit goal of CAMS-M that the patient leaves the hospital not only having resolved a suicidal episode, but also having addressed underlying vulnerabilities, such that the probability of future suicidal episodes is significantly reduced. Described below are various vehicles for achieving this goal.

Collaborative understanding of key drivers of suicidality. Utilizing the SSF, as well as exploration during therapy, therapist and patient endeavor to understand the underlying psychological and interpersonal processes that account for the suicidal response to adversity. This exploration begins with the SSF core items, which call for repeated (weekly) ratings of Psychological Pain, Stress, Agitation, Hopelessness, and Self-Hate. The patient's profile on these measures creates the context for psychotherapeutic work, especially as the therapist seeks to understand fluctuations on the measures over time, thoughts and feelings driving them, and developmental origins. The patient's response to the "one thing" item also fig-

ures importantly in clarifying the processes fueling the patient's suicidality.

Suicide formulation. The suicide formulation seeks to remove all mystery from the suicidal process, replaced with the shared understanding developed by the therapist and patient. It is presented in the context of the CAMS philosophy of objectivity, curiosity, and nonjudgment of suicidality. The formulation may take the form of a diagram or a brief narrative (generally only two or three paragraphs), including the following components:

- Developmental influences (e.g., chronic, abusive criticism from father)
- Likely trigger events (e.g., interpersonal rejection)
- Key thoughts and feelings (e.g., "I'll always be alone," leading to hopelessness)
- Risk-escalating behaviors (e.g., drinking, arguing)
- Suicidal behaviors
- Alternate pathways/coping devices (consistent with therapy work and safety plan)

Reasons for living and dying/key values in service of improved quality of life. This section of the SSF Initial form sets the stage for later work on helping the patient to articulate what has "kept me going" through the years, as well as what has driven the suicidality, both in the past and in the present. It is important to note that any lack of reasons for living is a *perception* on the part of the patient. The patient's experience of having no reasons for living is regarded as a state-dependent phenomenon, created by negative filtering, a cognitive feature of depressed mood that blocks access to positive perceptions and memories. Reasons for dying also provide fertile ground for exploration, in particular because this discussion almost always boils down to an understanding that the suicidal wish is about alleviation of pain and that if relief can be obtained by other means, reasons for dying tend to fade away. Other reasons for dying, such as "my family will be better off without me," can be explored collaboratively for validity.

Values-based living is a relatively new form of intervention, introduced by "third-wave" behavior therapies such as Acceptance and Commitment Therapy (ACT; Hayes, 2006) and the positive psychology movement (e.g., Peterson, 2006). In this approach, the patient is helped to better articulate his or her personal values (whether spiritual, interpersonal, vocational, societal, or political) and begin to think about reasons for living in a new way, based less on circumstances beyond one's control (e.g., the economy or one's mate's behavior) and more on general directions (e.g., cultivating compassion for self and others) expressed via specific goals and activities (e.g., volunteer work or political involvement).

Development of alternate coping strategies. As indicated above, CAMS approaches suicidality first and foremost as a coping response to adversity and/or negative emotion. To this extent, development of alternate coping strategies is an indispensible cornerstone of CAMS-M. Overlap here with cognitive therapy and DBT is substantial. Emotional regulation strategies loom especially large in this context. Therapeutic pathways for improving emotional regulation are not dictated by CAMS-M because these vary considerably from one therapeutic orientation to another. However, it is generally agreed that DBT skills, such as mindfulness and self-soothing activities (Linehan, 1993), as well as improved mentalizing capacity (Allen, 2011), are effective and well worth acquiring. As such, DBT is a core therapy group on all the specialty units of the hospital.

CAMS-M specifically includes the use of various devices developed via Beck and associates' cognitive therapy for suicidal patients, as described by Wenzel et al. (2009). The authors describe one such device, the Hope Kit, as follows:

> *The Hope Kit is a memory aid consisting of a collection of meaningful items that remind patients of reasons to live and that can be reviewed during times of crisis. Patients often locate something as simple as a shoebox, and they store mementos such as pictures, postcards, and letters. During the course of constructing a Hope Kit, patients often find that they identify reasons for living that they had previously overlooked. Sometimes using a shoebox for the Hope Kit is impractical or uninteresting to patients. In these in-*

stances, the Hope Kit can be implemented in other ways to identify reasons for living (e.g., a scrapbook, a collage, a painting, a Web page). (p. 192)

Patients are encouraged to create their Hope Kit while in the hospital. Participation in arts and crafts activities has led some to become quite creative with this project.

Another important device is the Coping Card (Wenzel et al., 2009), also known as the Crisis Card. This is a convenient, portable memory device, utilizing a 3×5 card, designed to be readily accessible and useful at times when the patient is too distressed to bring to mind coping strategies or resources developed in therapy. One useful form of Coping Card is a laminated card containing an abbreviated version of the Safety Plan (see below) for the patient to use when he or she does not have access to the safety plan. This device is described in detail by Jobes (2006, pp. 80–83). A few examples of coping cards can be found in Wenzelet al. (2009, p. 194).

Addressing sources of emotional dysregulation. In addition to learning to cope better with emotional distress, CAMS-M also educates patients about how negative emotions are produced and how this process can be interrupted, or the "fuel taken from the fire" altogether. Here, the CAMS-M therapist pursues treatment according to his or her own theoretical perspective. For example, *mentalization-based therapy* helps the patient develop a balanced and flexible awareness of mental states in self and others. This approach focuses on emotional awareness and emotion regulation in attachment relationships, with the aim of helping the patient to move from insecure to secure attachment patterns. *Psychodynamic psychotherapy* enhances awareness of intrapsychic and interpersonal emotional conflicts with an eye toward repetition and reenactment of early relationship problems in current relationships, including the patient–therapist relationship. The *cognitive-behavioral* approach alerts the patient to dysfunctional beliefs and meaning-making processes that create vulnerability to severe emotional reactions to schema-relevant events. Options for improving emotional regulation are many and varied; the (generally welcome) message to the patient is that healing is more than just learning to

"bear" or cope with strong negative emotion, but that well-focused therapy (continued after discharge) can target the sources of such feelings such that they are not generated in the first place. This message requires a balance of hope, encouragement, and realism regarding the commitment to therapy that will be required to bring it about.

Safety planning. As distinct from how it is applied in CAMS in outpatient settings, safety planning in an inpatient setting is done in two phases. During the inpatient phase, ensuring patient safety rests less with the individual therapist than with the nursing staff and treatment team. At The Menninger Clinic, a safety plan is created by nursing staff in collaboration with every at-risk patient soon after admission. CAMS-M, on the other hand, includes development of a postdischarge safety plan, using Stanley and Brown's form (2012). Useful guidelines for the development and implementation of safety plans (including dealing with possible obstacles to their use) are provided by Wenzel et al. (2009).

Imaginal rehearsal. In the same vein as relapse prevention for addictions and other disorders, CAMS-M follows the lead of Wenzel et al. (2009) in utilizing imaginal rehearsal as a way to help the patient anticipate future coping scenarios and to provide the therapist with an assessment of the patient's *ability* to draw upon the therapeutic learning experience and apply it in a stressful situation. Moreover, because of its implications for discharge timing, the therapist endeavors to conduct this exercise during middle sessions of therapy because feedback to the team regarding the patient's experience of this exercise may have implications for readiness for discharge.

Descriptions of other interventions recommended for use in CAMS-based therapy have been given by Jobes (2006, chapter 5). These include means restriction (e.g., reducing access to firearms or medication), enhancing social support, behavioral activation, future thinking, and addressing the SSF "one thing" via problem-solving.

Other interventions for suicidal patients
Beyond those described by Jobes (2006), a variety of interventions with suicidal individuals are supported by outcome research. They are not fundamental to CAMS-M, but are compatible and facilitative of its goals and processes. These interventions are described in detail by Ellis (2006) and include the following:

Behavioral "chain analysis" for understanding suicidal episodes. Chain analysis (also known as behavioral analysis or functional analysis) is used in DBT to help the patient understand how problem behaviors are triggered and maintained. Stimulus events (internal and external), cognitive processes, and outcomes are all examined with an eye toward the patient's developing a greater sense of control. In CAMS-M, chain analysis is importantly used as a means of helping the patient make sense of suicide-related events (including nonsuicidal self-injury). Conducted in an environment of validation and nonjudgment, chain analysis has the goal of diminishing any sense of mystery or shame around suicidal behavior and of moving the patient more in the direction of an internal locus of control and an appreciation of an array of nonsuicidal options.

Mindfulness and acceptance-focused interventions. "Third-wave" therapies such as DBT and ACT rely heavily upon the Buddhist-inspired view that much of human suffering is created by the failure to accept the inevitability of pain, whether physical or emotional. Mindfulness-based therapies therefore teach patients that the combination of present-moment awareness (mindfulness) and nonjudgmental acceptance of what one becomes aware of are essential to mental health. In this context, suicide is viewed as the ultimate example of nonacceptance of the conditions of one's existence. Therefore treatment of the suicidal individual entails not only finding ways to alleviate suffering, but also cultivating skills that allow one to reduce the struggle with emotions (acceptance) and reduce suffering in the process. Resources in this area include contributions by Hayes (2006), Williams, Teasdale, Segal, and Kabat-Zinn (2007), and Germer (2009).

Mentalization-based therapy. A mentalizing approach to psychotherapy with suicidal patients (Allen, 2011) overlaps extensively with the CAMS approach in its collaborative endeavor to understand and empathize with the patient's suicidal state of mind. Indeed, an overriding goal of mentalizing is to help the patient maintain a sense of the difference between a state of mind and action. The mentalizing approach also aims to help the therapist maintain a mentalizing stance (i.e., a curious and nonjudgmental inquiry) as contrasted with an anxious and controlling stance. The premise of a mentalizing approach to treatment is this: *Mentalizing begets mentalizing*, in psychotherapy as in development. If the therapist can maintain mentalizing, the patient is more likely to move into a mentalizing stance, an essential aspect of psychotherapy.

The mentalizing approach envisions a strong parallel between traumatized states of mind and suicidal states: Both entail an experience of being in a state of unbearable emotional pain in conjunction with a sense of being alone in the sense of lacking a mentalizing relationship. From this standpoint, attachment plays a key role in suicide and in treatment of suicide. The central thesis: The experience of being left psychologically alone in unbearable emotional states is potentially traumatic owing in part to the absence of mentalizing, and treatment entails creating a secure attachment context conducive to mentalizing in which previously unbearable emotional states can be experienced, expressed, understood, and reflected upon—and thus rendered meaningful and bearable. This thesis runs parallel to Linehan's (1993) emphasis on the combination of emotional dysregulation and an invalidating environment as pillars of the development of borderline personality disorder.

Problem-solving training. Numerous studies have shown that suicidal patients' hopelessness is commonly fueled by poor problem-solving skills. Such problems are typically interpersonal or social in nature, although they may also be around financial, legal, vocational, or other issues. As described by D'Zurilla and Nezu (2010), patients should be trained to approach problems in five steps: identifying the problem, generating alternatives, weighing pros and cons, implementing a solution, and evaluating and revising. Importantly, a problem-solving "orientation" (the extent to which problems are accepted and conceptualized as problems to be solved) may be especially germane to suicidal processes.

"Products" with which the patient leaves the hospital

In most inpatient settings, there is a sharp demarcation between patient status and nonpatient status. An intense treatment relationship is developed over a short period of time, with the end of that relationship occurring abruptly at discharge. Such "termination" is especially stark at facilities such as The Menninger Clinic, where 70% of patients are referred from out-of-state. Therefore considerable attention is paid to the question of what specific knowledge, skills, and materials patients take with them so as to minimize the probability of relapse. The importance of relapse prevention around the issue of suicidal behaviors is especially salient. This has led us to the concept of CAMS-M "products," which we endeavor to provide to patients over the course of treatment. These are described in the paragraphs that follow.

Tangible resources. CAMS-M places major emphasis on providing practical, concrete resources to suicidal patients that can be used during times of crisis or emotional distress. These are times when memory and problem-solving processes tend to malfunction and emotion arousal can spiral into a suicidal crisis. Examples of these resources were described above, including the Hope Kit, coping (crisis) cards, and the postdischarge safety plan.

Skill set (competency) to replace suicidal coping response. Although less tangible than the products described above, this one is in many ways the "bottom line" objective of CAMS-M. Beyond the typical inpatient criterion of "no longer suicidal," CAMS-M seeks to provide the patient with a *competency* that he or she did not have at admission and that he or she will be able to apply in future situations such that a different (nonsuicidal) outcome is obtained. Although this competency will take many forms, depending upon the characteristics of both the patient and the therapist, the objective is a response to adversity that enhances, rather than diminishes, life and well-being. The criterion for achievement of this goal is the imaginal rehearsal exercise discussed above.

Flow of sessions

Psychiatric hospitalization, by nature, is somewhat unpredictable, especially with respect to length of stay. An assortment of

variables have influence, including the patient's symptom course, his or her preferences and economic resources, and the treatment team's perspectives regarding discharge. Treatment decisions with respect to individual therapy must take this unpredictability into account, and flexibility is needed. However, it is helpful for the therapist to have a rough idea of the order and timing of various aspects of CAMS-M, so that therapy can proceed in a smooth and predictable manner for the patient. A rough time frame for treatment from a CAMS-M perspective follows:

Early sessions

Introduction. The priority for the initial session is to ensure that the patient has sufficient information to make a fully informed decision on participation. As noted above, this conversation about committing to the CAMS approach is necessarily collaborative, as well as providing information about the approach to help the patient to make a fully informed choice.

Suicide Status Form (SSF). Administration of the SSF, a key foundation stone for the treatment, is fully described by Jobes (2006). Any gaps in the knowledge base (such as regarding prior attempts) should be completed at this time. The goal is an individualized, fully shared understanding of the suicidal process for the patient.

Goals for therapy. Given the relatively brief time frame of a psychiatric hospitalization, it is advisable to keep goals for CAMS-M straightforward, few in number, and directly related to suicidality. Depressed mood, severe anxiety, and sleep disturbance are typically high on this list for inpatients. The clinician might refer back to the "one thing" item for further guidance regarding identification of goals.

Middle sessions

Ongoing assessment. The SSF Tracking Form should be completed once per week, although therapy sessions may occur more often.

Session content. Middle sessions should address issues derived from the SSF, particularly ratings of the "drivers" (Pain, Stress, etc.), as well as reasons for living and dying, the "one thing," etc. It is to be expected that other issues will arise in the context of therapy, including those brought up spontaneously by the patient. It is the therapist's role to find an appropriate middle ground, neither rigid nor passive, weaving issues and concerns of the patient together with the suicide formulation, to remain faithful to the primary objectives of CAMS.

Safety plan. Timing of the work on the safety plan is flexible, depending upon the judgment of the therapist and the patient. Note that the safety plan is conceptualized as a collaborative project, not to be simply assigned to the patient as a solitary homework assignment (although the patient might be asked to complete some work on it, such as finding phone numbers, independently).

Competency assessment. Sometimes referred to as the "final exam," the competency assessment consists of the imaginal rehearsal exercise described above, in which the therapist helps the patient to vividly imagine being in a situation similar to that which triggered the suicidal episode prior to admission, and seeks a nonsuicidal, effective coping strategy. This exercise ideally should be conducted well before a discharge date is set; indeed, the outcome of the assessment should be presented to the patient and the treatment team as information germane to the determination of discharge timing. Of course, this is not always possible, given the unpredictable nature of many patients' courses in the hospital, including premature, sudden discharges.

Concluding sessions

Relapse prevention. The primary agenda for the final few sessions of CAMS-M prior to discharge is review and reinforcement of knowledge and skills that will provide alternatives to suicidality in the face of adverse events after discharge. Anticipation of possible future "triggering" events, practicing with guided imagery, role playing, use of coping cards, and reminders to use the safety plan and other devices all may be pursued in the interest of providing "rehearsals" for dealing with real-world stressors.

Patient education. The suicide formulation is collaboratively developed during the concluding sessions, perhaps offered as a draft during the next-to-last session and revised according to feedback provided by the patient.

Final assessment. The SSF Outcome form is completed, including patient feedback with respect to helpful aspects of the therapeutic experience.

Documentation

Routine documentation of individual therapy is greatly enriched by the addition of information gleaned from CAMS-M procedures. Information obtained from repeat administrations of the SSF not only documents progress (or lack thereof) but also adds to the knowledge base available to the multidisciplinary team in service of treatment decisions. It is also important to integrate the therapeutic process with information from other outcome measures, with attention paid to depression, hopelessness, suicidal ideation, suicide cognitions, and the therapeutic alliance. Finally, documentation of the suicide formulation, in addition to the benefits listed here, also can prove invaluable to future providers who receive records of the inpatient treatment.

Discussion

Implementation Issues

As described in a prior article (Ellis, Allen, Woodson, Frueh, & Jobes, 2009), implementation of CAMS-M at The Menninger Clinic has occurred relatively smoothly. Clinic administrators have strongly supported the initiative as part of a comprehensive process improvement program aimed at maximizing patient safety. Resources have been devoted to the process of training and introducing clinicians to the culture of the CAMS-M approach. Regular consultation has been obtained from CAMS creator David Jobes, and large numbers of staff across disciplines have attended his lectures and demonstrations. Clinicians recruited to

the CAMS study team attended a day-long workshop with Dr. Jobes, and video recordings of their sessions with suicidal patients were reviewed by his research laboratory for adherence to CAMS protocol. CAMS clinicians thus received an overall "satisfactory" rating using this approach; feedback was provided to CAMS providers when there was a need to increase adherence.

The team continues to meet biweekly to review use of the approach and to discuss specific cases using CAMS. In addition to enhancing the skills of the clinicians, these meetings also have served to identify and address a number of implementation issues. For example, team clinicians initially struggled to arrive at a shared definition of CAMS-M beyond the initial stages of assessment and collaborative process. Specifically, after the first few sessions, therapy sometimes evolved into a "therapy as usual" mode, and suicide was lost as the focus of treatment. Review of video recordings at team meetings helped clinicians to remain more focused on a suicide-specific agenda. Moreover, work during team meetings to develop a checklist of "necessary ingredients" of CAMS-M, to be completed with each SSF, was instrumental in reaching a shared understanding among team members of how CAMS-M differs from conventional therapy.

Another challenge for team clinicians has been implementing CAMS-M with patients whose suicidality has faded in intensity since admission. Patients are often admitted for being actively suicidal, but once hospitalized, the structure and dynamics of the therapeutic milieu produce emotional relief and subsequent decrease in suicidal ideation. The patient may continue to have passive thoughts but no longer have an active plan for completing suicide. Such patients are often reluctant to discuss suicide, preferring to "let the past stay in the past." They hope that by avoiding the topic, the desire to end their life will dissipate. In this situation, the challenge to the therapist is to remain responsive to the patient's perceived needs while continuing to attend to the suicidal themes and vulnerabilities.

The vagaries of inpatient hospitalization also have presented a set of challenges, especially in terms of premature discharges. Because The Menninger Clinic is a voluntary facility, patients can discharge at any time provided they are not a threat to themselves

or others. This complicates the ability to sequentially administer the CAMS-M protocol. For example, it may be difficult to gauge when to introduce the "final exam" (e.g., imaginal exposure to the suicide event). Ideally this occurs toward the end of treatment but with sufficient time to process emotions or thoughts that were elicited by this exercise. Clinicians shared their frustrations when patients impulsively requested discharge, or discharge was unexpectedly scheduled by the treatment team, precluding the completion of the treatment protocol.

Dissemination issues

Widespread dissemination of CAMS-M to other inpatient facilities is likely to present an assortment of challenges. Length of stay is perhaps the most obvious issue. Patient length of stay at The Menninger Clinic averages 6–8 weeks, which permits a careful exploration of the suicidal process and possible solutions over the course of around a dozen sessions. Of course, few psychiatric inpatient facilities nowadays are able to keep patients more than a few days. Further work is needed to determine whether meaningful suicide-specific interventions can take place over briefer periods of time. One interesting line of research is currently being conducted by Ghahramanlou-Holloway and colleagues, examining a 5-session version of Beck et al.'s protocol (Ghahramanlou-Holloway, Cox, & Greene, 2012). In addition, Jobes et al. (2010) report work currently taking place in Copenhagen testing a 1–3 session version of the CAMS framework for working with suicidal adolescent outpatients. This is obviously an area for continued innovation and testing.

Another challenge to dissemination efforts (which applies to most efforts to introduce new and innovative procedures) has to do with acceptability to clinicians. Despite recent advances in theory and research, many clinicians still balk at the idea of focusing so directly on suicide, concerned that such an emphasis might actually reinforce or trigger more suicidal thinking and urges. A related concern is that the focus on suicide might preclude addressing other significant psychological issues in therapy. Our experience has been that neither concern is justified; a pilot study of 21 patients has produced effect sizes (Cohen's *d*) between 0.7

and 2.2 on a variety of outcome measures, including suicidal ideation and suicide-related cognitions (Ellis, Green, Allen, Jobes, & Nadorff, 2012). Furthermore, we have learned that talking about triggers for suicidality quickly leads to the most profoundly important issues for patients, such as maladaptive interpersonal patterns and dysfunctional thinking processes such as harsh self-criticism.

Yet another dissemination issue is the objection of many clinicians to manualized therapies, which are often perceived as inflexible "cookbooks" that eliminate the human, interpersonal element from therapy. It is hoped that reading this article relieves this concern somewhat; and we are confident that a quick read of *Managing Suicidal Risk* (Jobes, 2006) will go further toward addressing this concern.

Conclusion

Although hospitalization is a common response to suicide risk, clinicians often feel limited in their ability to mitigate that risk beyond standard procedures of crisis stabilization. This article has described one approach—CAMS-M—that seeks to move beyond stabilization measures to begin to address psychological vulnerabilities that may predispose a patient to future suicidal episodes. We have worked with administrative and clinical staff to achieve acceptability and resolve obstacles to implementation, while modifying the standard CAMS protocol (Jobes, 2006) to better accommodate the realities of the hospital environment.

Preliminary outcome data indicate that patients enrolled in CAMS-M show significant improvement on an assortment of measures, including suicidal ideation, and no adverse outcomes have been encountered to date. Anecdotally, it can be said that CAMS-M enjoys high levels of acceptability by both patients and clinical staff. The latter, in particular, report much lower levels of anxiety and a higher degree of self-efficacy in working with suicidal patients. At this early stage, it is reasonable to conclude that CAMS-M represents a promising new innovation in the treatment of suicidal psychiatric inpatients.

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Appendix A

CAMS-M Checklist

(to be completed bi-weekly)

Patient:______________________________Date:__________________

Clinician:____________________________

Please check the CAMS-M strategies that you have used with this patient.

_____SSF (first session and once weekly thereafter)
_____Regularly exploring intensity and content of Pain, Stress, Hopelessness, etc.
_____Hope Kit
_____Crisis card(s)
_____Safety plan
_____Consistently teaching and practicing alternate coping responses
_____Imaginal rehearsal
_____Exploring reasons for living and dying
_____Exploring the "one thing"
_____Clarifying personal values to help inform reasons for living
_____Other: ____

Other strategies
_____Means restriction
_____Development of social support
_____Behavioral activation
_____Future thinking
_____Problem-solving