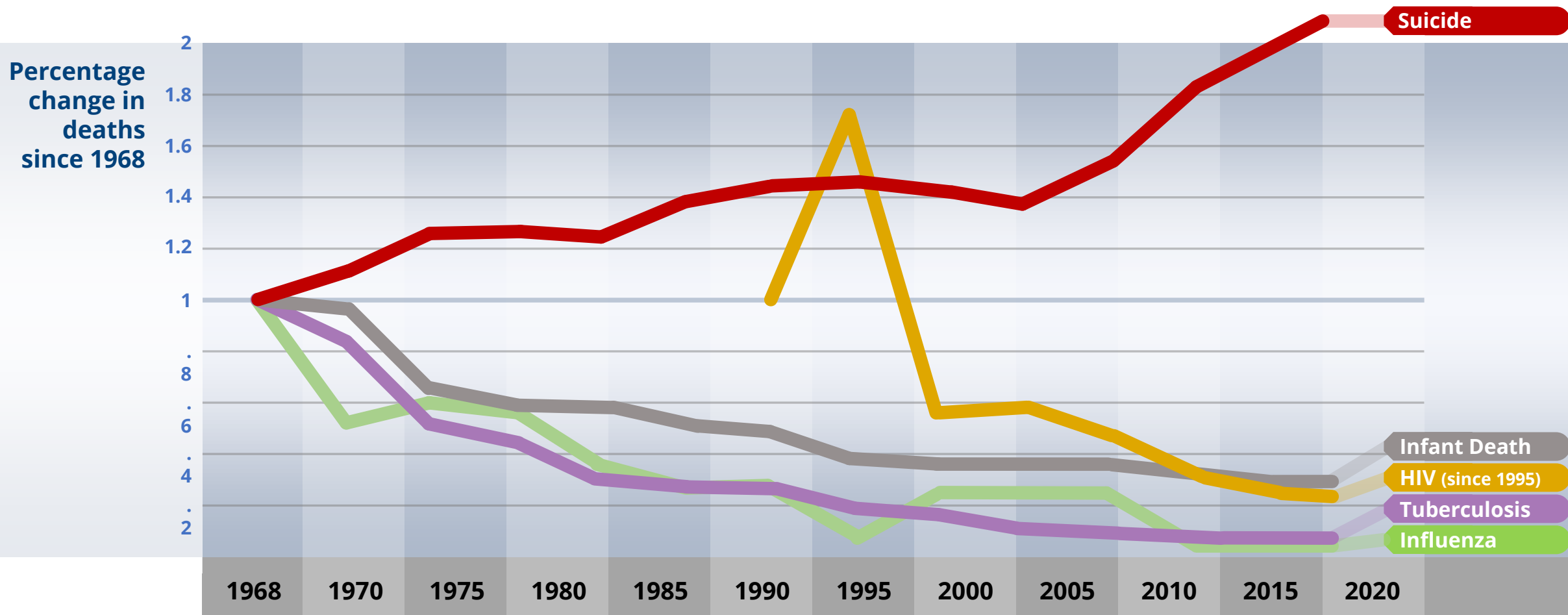CAMS-care
Preventing Suicide

Zero Suicide and the Role the Collaborative Assessment and Management of Suicidality (CAMS) Can Play

Raymond P. Tucker, Ph.D.
Associate Professor of Psychology
Louisiana State University
Clinical Assistant Professor of Psychiatry
LSU Health Sciences Center/Our Lady of the Lake

50 Years Addressing the Leading Cause of Death

United States 2018

Percentage change in deaths since 1968

Suicide

Infant Death

HIV (since 1995)

Tuberculosis

Influenza

1968 1970 1975 1980 1985 1990 1995 2000 2005 2010 2015 2020

12 Leading Causes of Death in 2020

All Ages

1	Diseases of heart (heart disease)	696,962
2	Malignant neoplasms (cancer)	602,350
3	COVID-19	350,831
4	Accidents (unintentional Injuries)	200,955
5	Cerebrovascular diseases (stroke)	160,264
6	Chronic lower respiratory diseases	152,657
7	Alzheimer Disease	134,242
8	Diabetes Mellitus)	102,188
9	Influenza & pneumonia	53,544
10	Nephritis, nephrosis (kidney disease	52,547
11	Chronic Liver Disease and cirrhosis	51,642
12	SUICIDE (INTENTIONAL SELF-HARM)	45,979

All Ages

Leading Cause 12	Suicide 45,979
	Rate 14.0

Age 15-24

Leading Cause 3	Suicide 6,062
	Rate 14.2

WISQARS™

Produced by: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention
Data source: National Center for Health Statistics (NCHS), National Vital Statistics System

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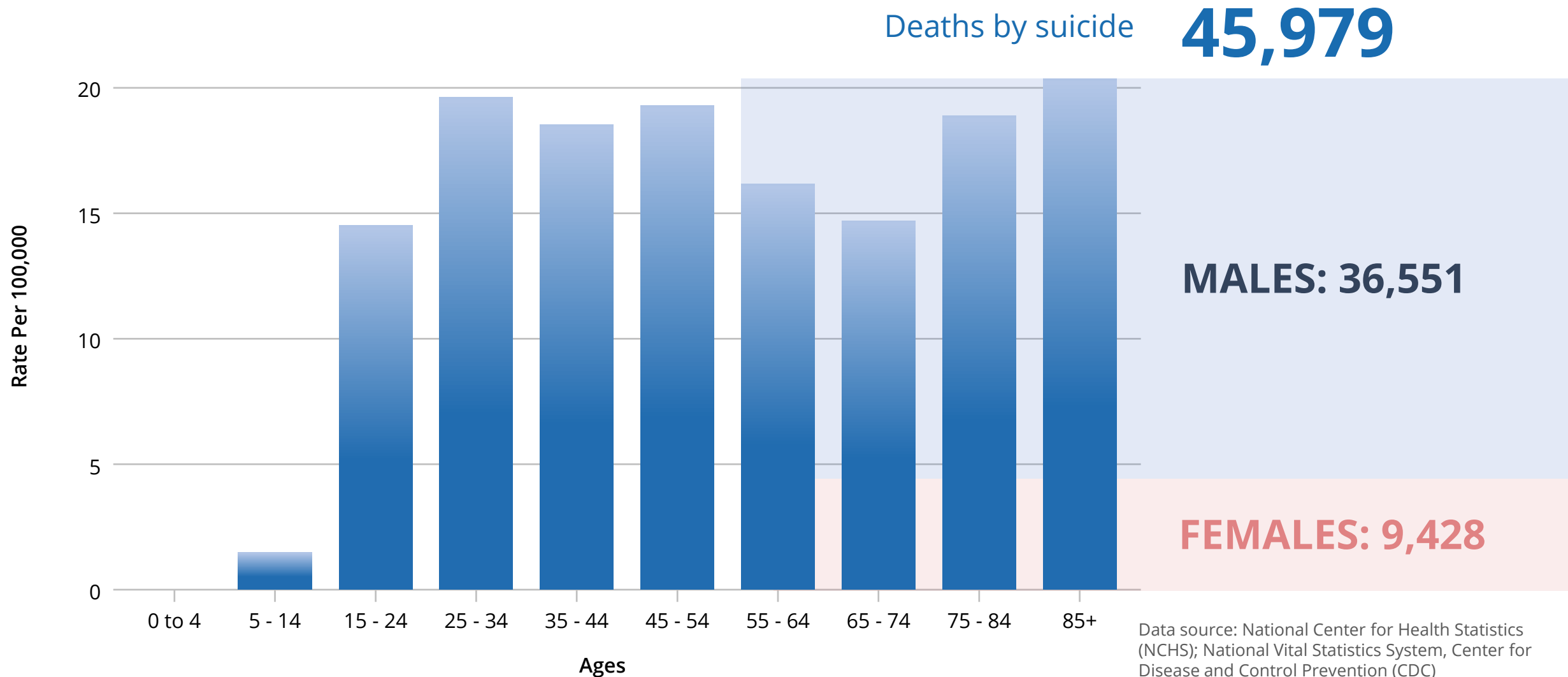
Deaths by suicide   **45,979**

Rate of suicide   **14/100,00**

Suicide by Self-Identified Race/Ethnicity

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White
40,155
15.7

People of Color
5,824
7.8

American Indian/Alaska Native
14.6

Black/African American
7.5

Hispanic/Latin
7.5

Data source: CDC

Crude Rates of Suicide

United States 2020
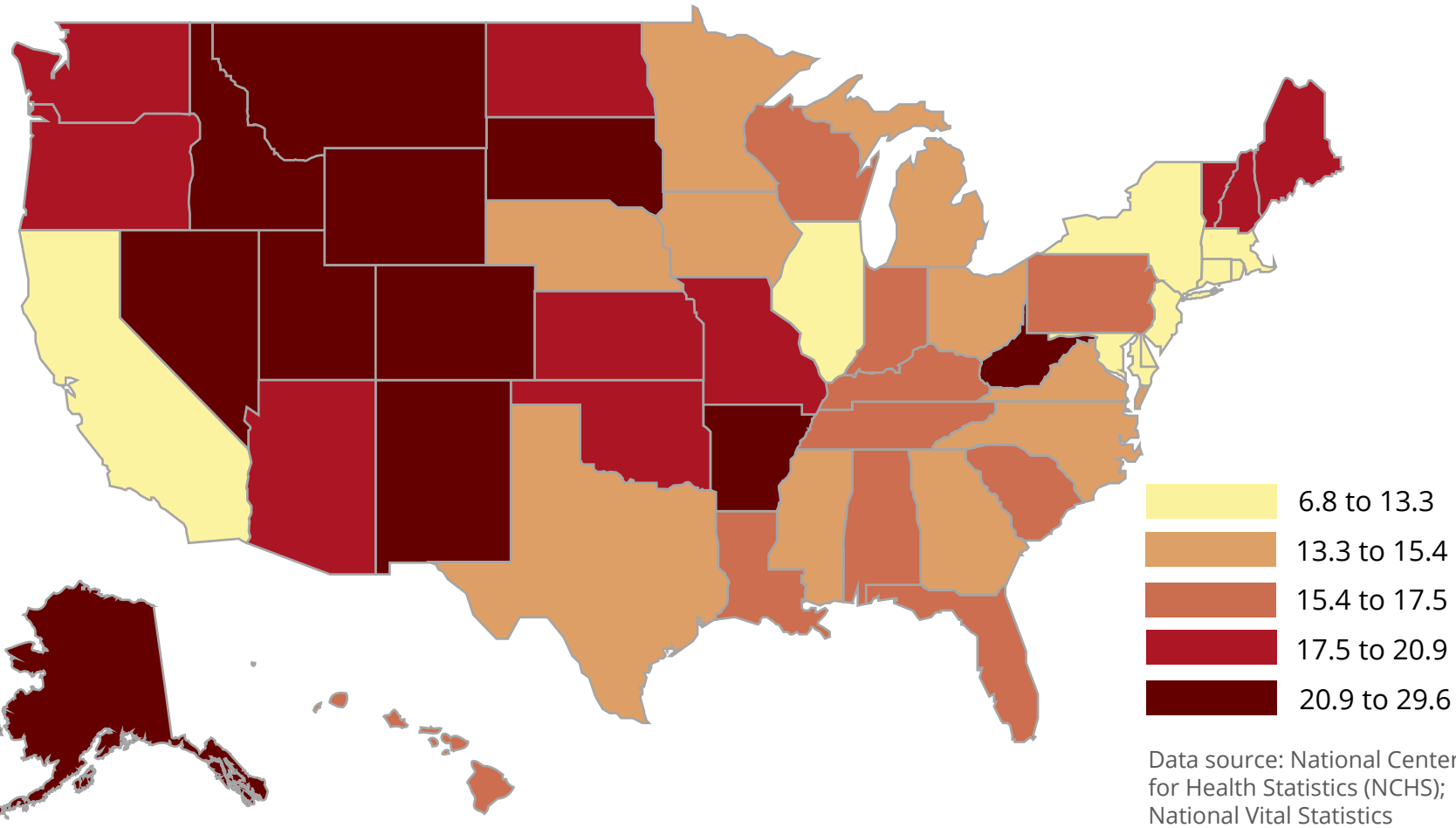
States with **lowest** rate per population:

Washington, D.C.

New York

New Jersey

Rhode Island

Massachusetts

Legend:
- 6.8 to 13.3
- 13.3 to 15.4
- 15.4 to 17.5
- 17.5 to 20.9
- 20.9 to 29.6
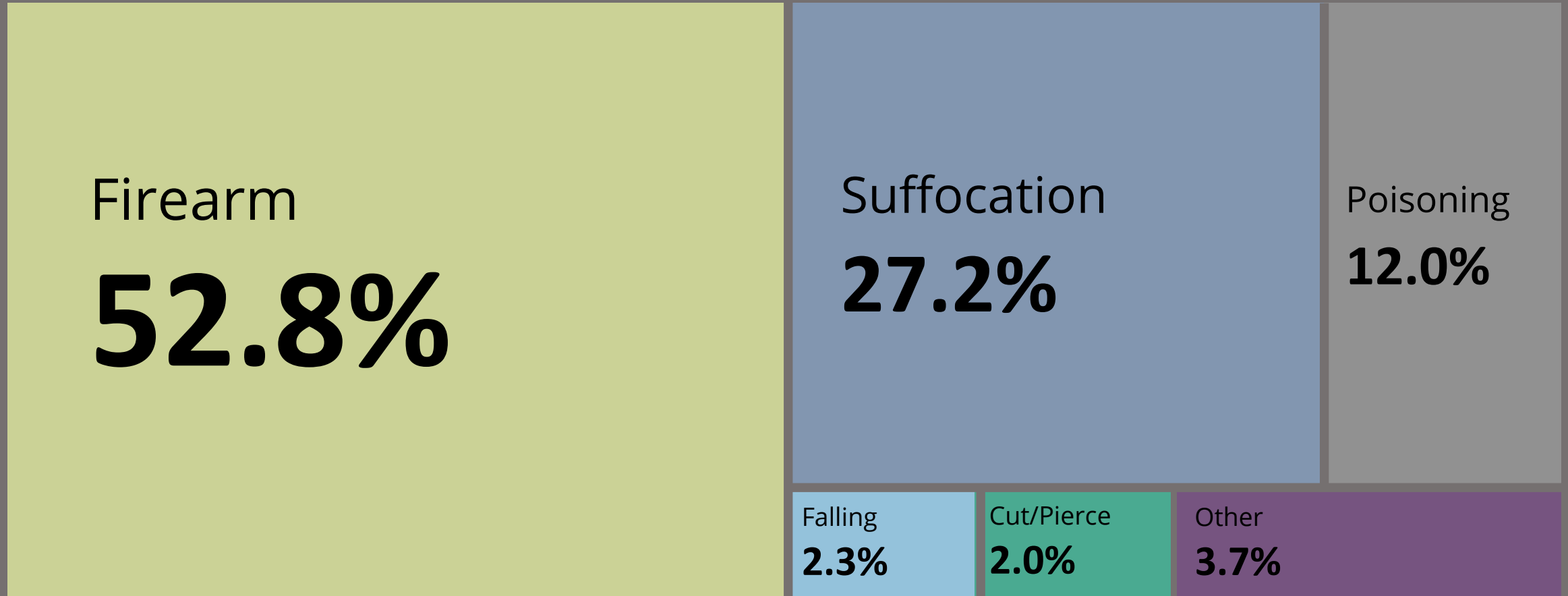
Data source: National Center for Health Statistics (NCHS); National Vital Statistics System, Center for Disease and Control Prevention (CDC)
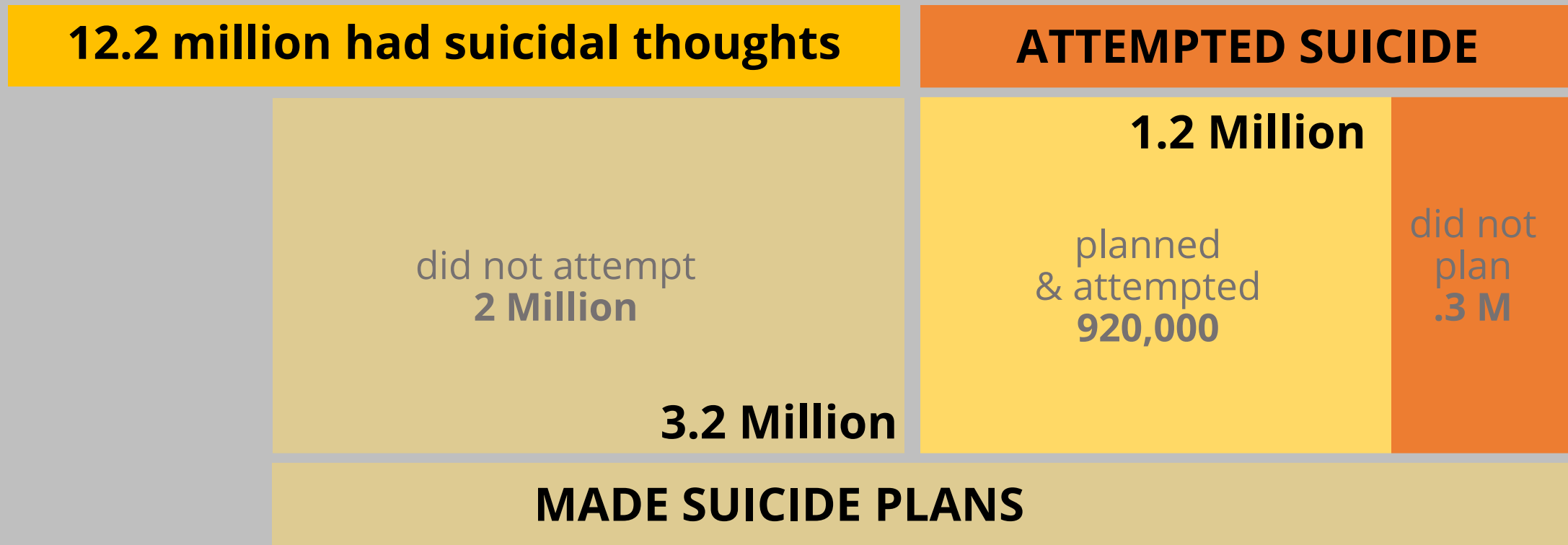
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Methods for Suicide

Related Deaths (2020)

Firearm
52.8%

Suffocation
27.2%

Poisoning
12.0%

Falling
2.3%

Cut/Pierce
2.0%

Other
3.7%

Data source: National Center for Health Statistics (NCHS); National Vital Statistics System, Center for Disease and Control Prevention (CDC)

Suicidal Ideation and Behavior in the US in 2019

Approximately 1.2M Adults Attempted Suicide and 12.2M Experienced Serious Suicidal Thoughts

12.2 million had suicidal thoughts

ATTEMPTED SUICIDE

did not attempt
2 Million

1.2 Million

planned
& attempted
920,000

did not plan
.3 M

3.2 Million

MADE SUICIDE PLANS

Data source: Substance Abuse and Mental Health Services Administration. (2018). *Key substance use and mental health indicators in the United States: Results from the 2020 National Survey on Drug Use and Health* (HHS Publication No. SMA 18-5068, NSDUH Series H-53). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration

Suicidal Ideation and Behavior in the US in 2019

Approximately 1.2M Adults Attempted Suicide and 12.2M Experienced Serious Suicidal Thoughts

Legend: ■ 18 or Older ■ 18-25 ■ 26-49 ■ 50 or Older

Categories: Serious Thoughts of Suicide, Suicide Plan, Attempted Suicide

Responding to Suicidal Ideation
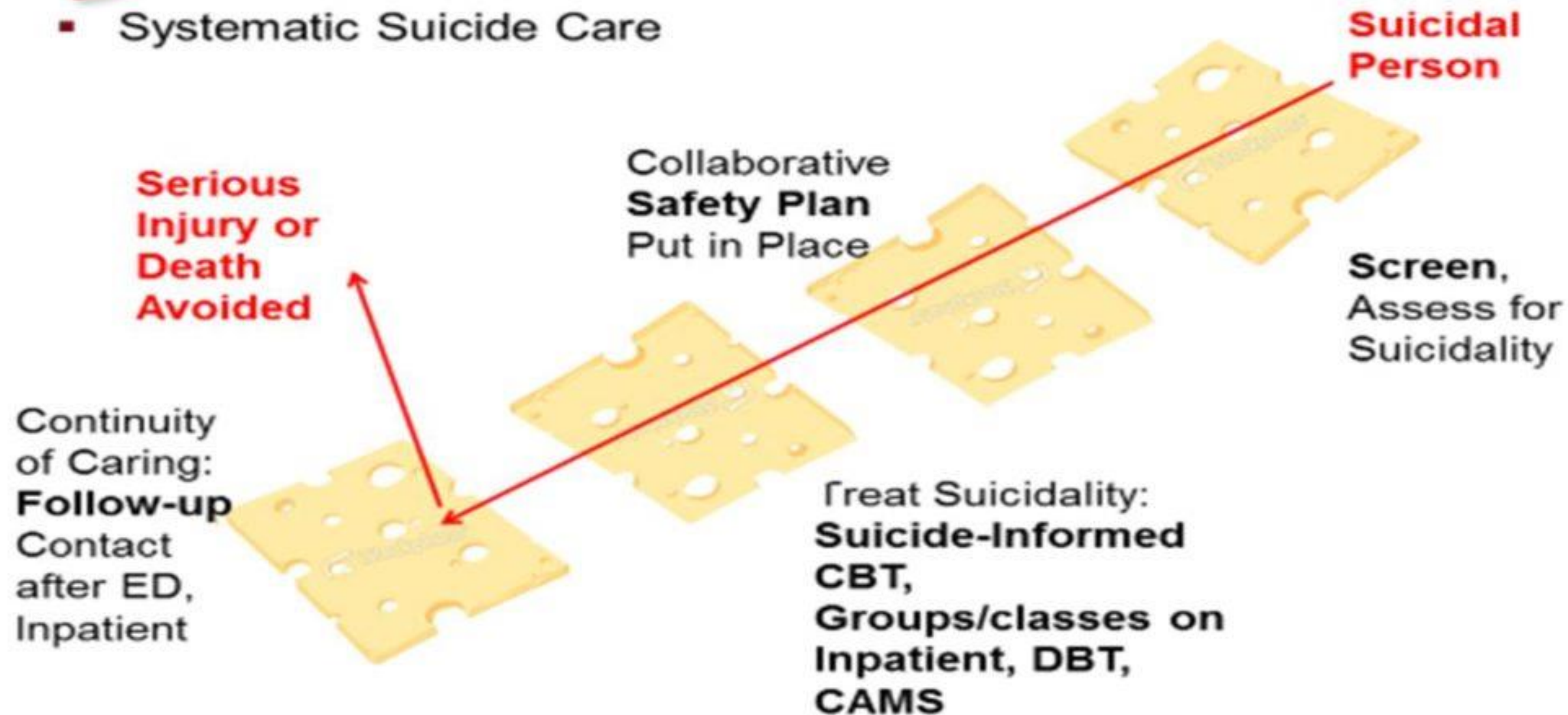
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If **12.2 million** adult Americans are experiencing **serious suicidal thoughts each year**

Systematic Suicide Care Plugs the Holes in Health Care

- Systematic Suicide Care

Suicidal Person

Serious Injury or Death Avoided

Collaborative **Safety Plan** Put in Place

Screen, Assess for Suicidality

Continuity of Caring: **Follow-up** Contact after ED, Inpatient

Treat Suicidality: **Suicide-Informed CBT**, Groups/classes on Inpatient, DBT, CAMS

Seven elements to create a standard of suicide-specific care

© 2020 Zero Suicide Institute at EDC.

Administration Focused

Lead

system-wide culture change committed to reducing suicides

Learn More

Train

a competent, confident, and caring workforce.

Learn More

Improve

policies and procedures through continuous quality improvement

Learn More

Patient Focused

Identify

individuals with suicide risk via comprehensive screening and assessment

Learn More

The Patient's Journey

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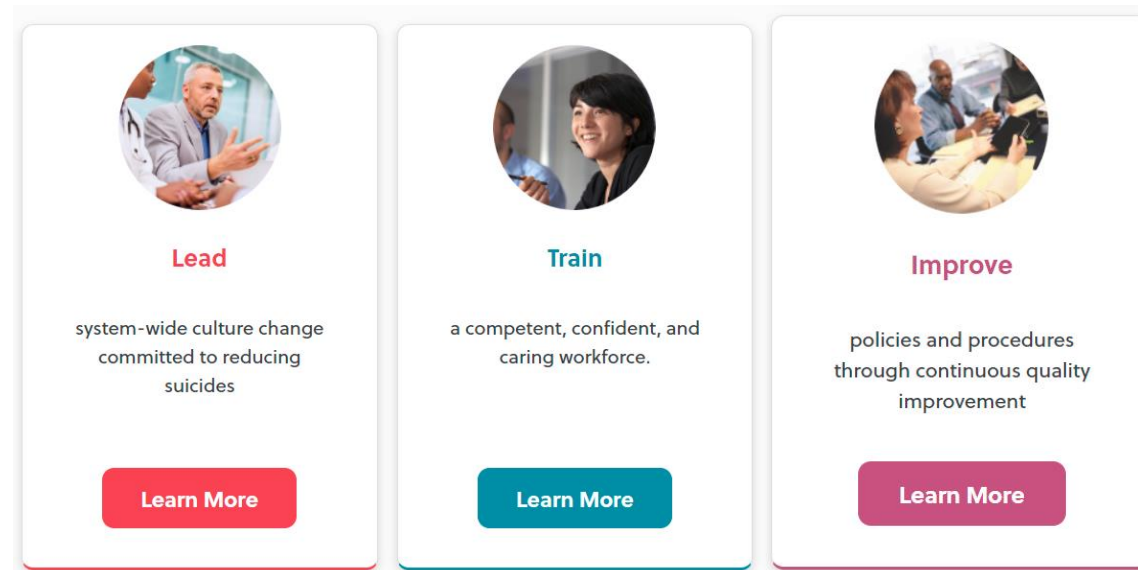
Learn More

Engage

all individuals at-risk of suicide using a suicide care management plan

Learn More

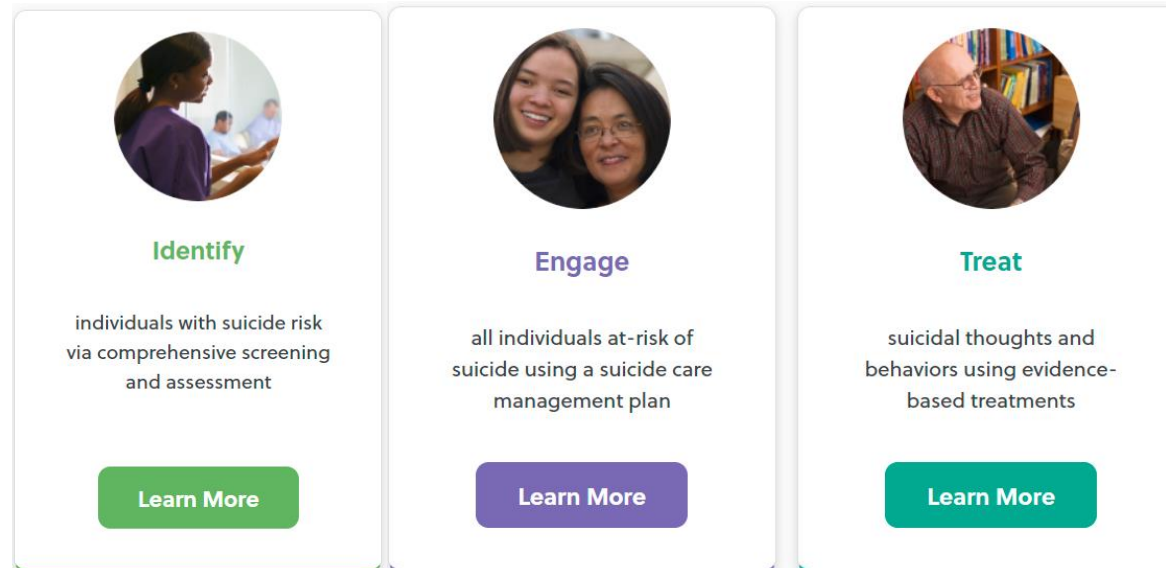The Patient's Journey

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individuals through care with warm hand-offs and supportive contacts
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Making Sense of the Options

Patient →

Gatekeeper Training (examples):
- QPR
- SafeTalk
- Umatter
- Sources of Strength

Identify

individuals with suicide risk via comprehensive screening and assessment

Learn More

Engage

all individuals at-risk of suicide using a suicide care management plan

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Treat

suicidal thoughts and behaviors using evidence-based treatments

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individuals through care with warm hand-offs and supportive contacts

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Evidence based options

Create a plan to keep the person out of the hospital

Use EVIDENCE BASED Treatments

Transition to optimal case disposition

Make connections to social services

CAMS

ASQ	CALM	DBT	Caring Contacts
C-SSRS	Safety Planning	CT-SP/BCBT	Structured Case management calls
SBQR			

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Evidence Base for CAMS

Across 8 published non-randomized clinical trials of CAMS, 1 meta-analysis, and 5 published randomized controlled trials (with 1 unpublished 5 on-going RCT's)

CAMS

Reduces suicidal ideation

Changes suicidal cognitions

Increases hope

Positive patient experience

Reduces ED visits

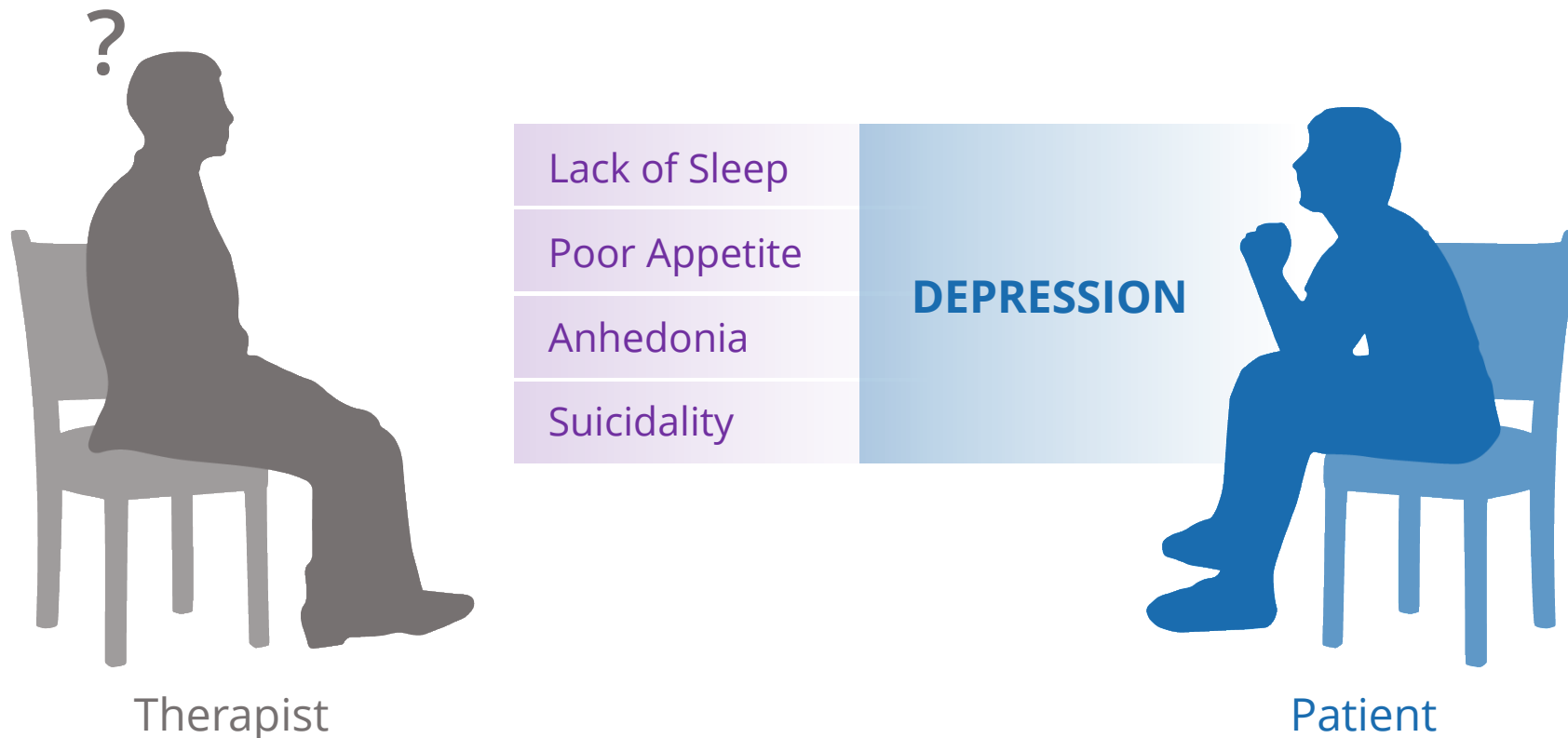Positive impact on self-harm/attempts

Relatively easy to learn

Per CDC criteria: "Well supported" in reducing suicidal thoughts

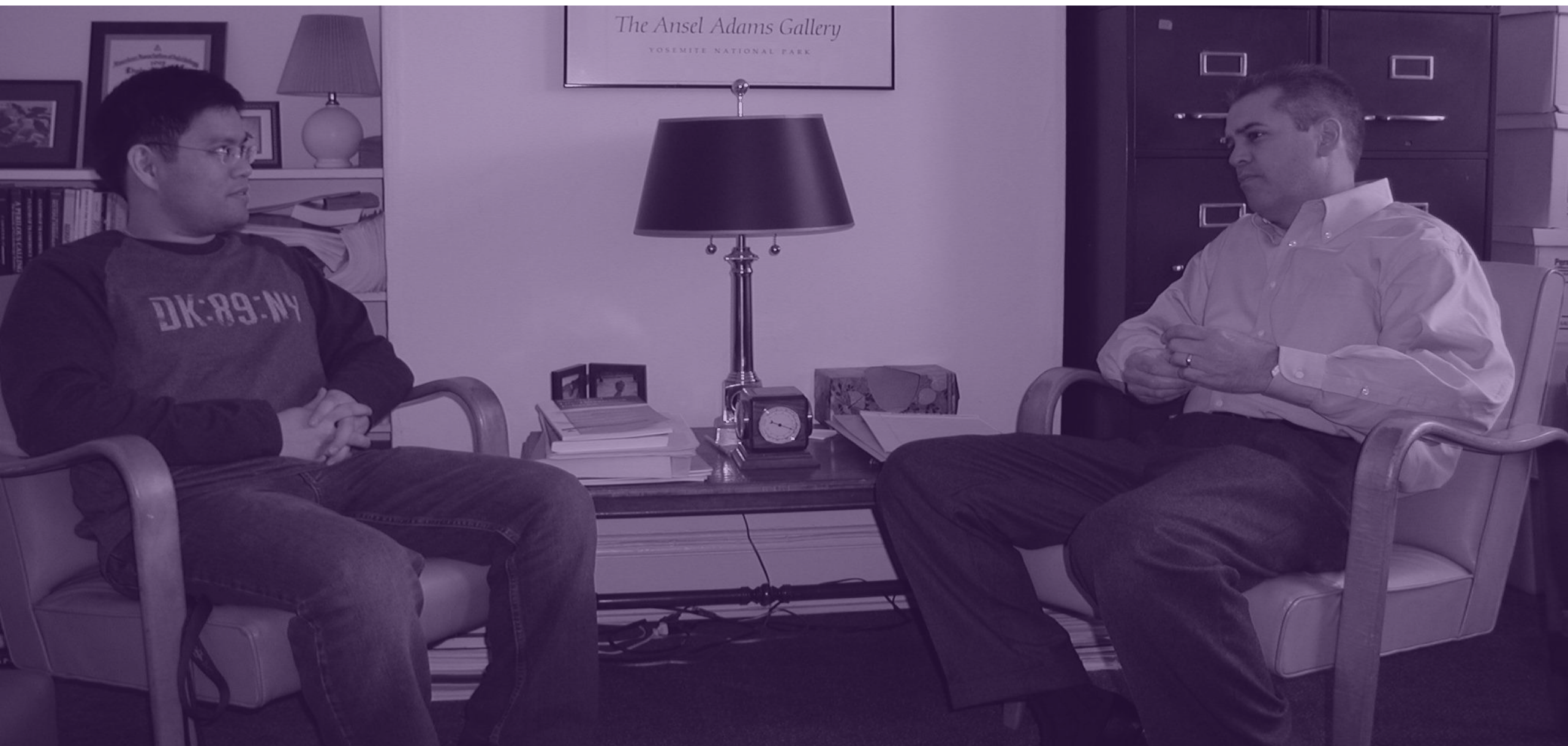# The CAMS Philosophy within Clinical Practice
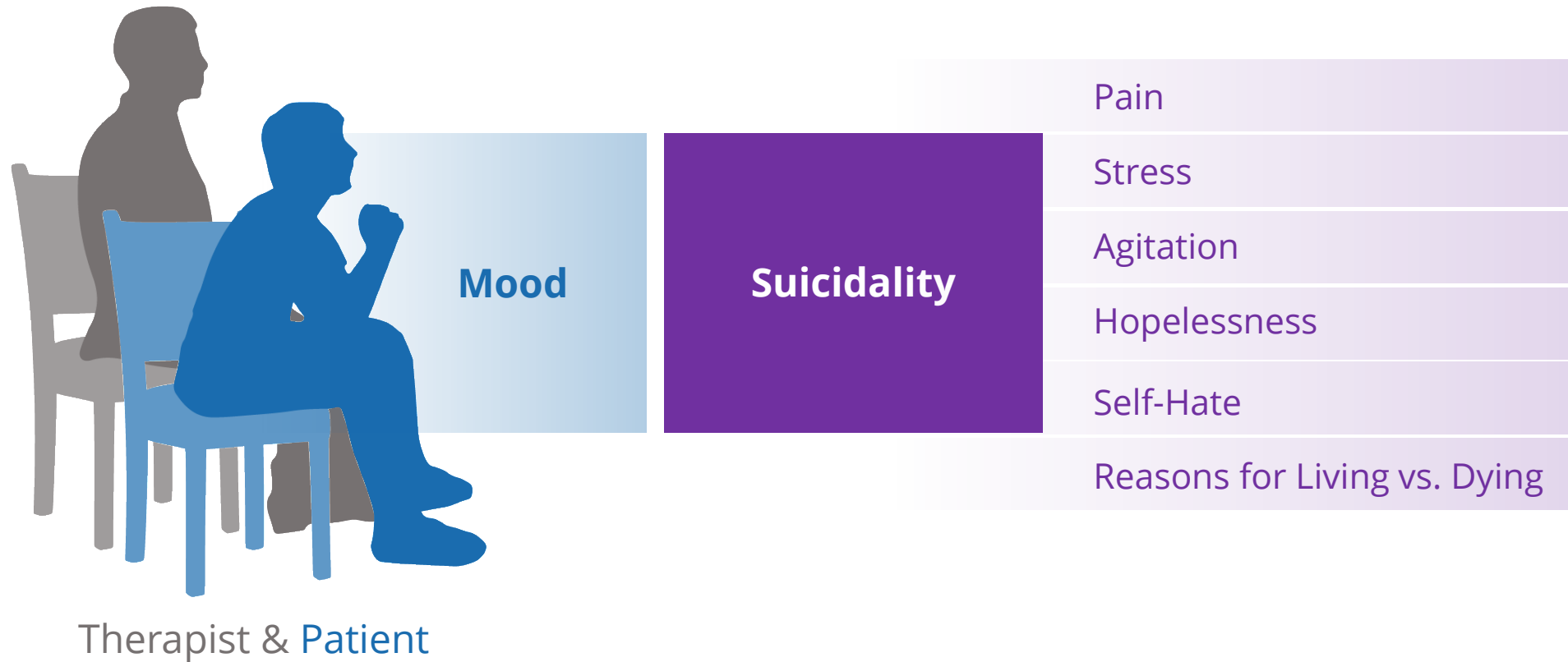
The CAMS Approach:

Building a Strong Alliance and Increasing Patient Motivation

The CAMS Philosophy Theoretical Foundation

Shneidman's Ten Commonalities of Suicide

1 Psychological Pain	2 Psychological Needs	3 Seek a Solution	4 Cessation of Consciousness	5 Hopeless-Helpless
6 Ambivalence	7 Constriction	8 Communication	9 Escape	10 Coping Patterns

(Shneidman, 1985)

Theoretical Foundation of the Suicide Status Form (SSF)

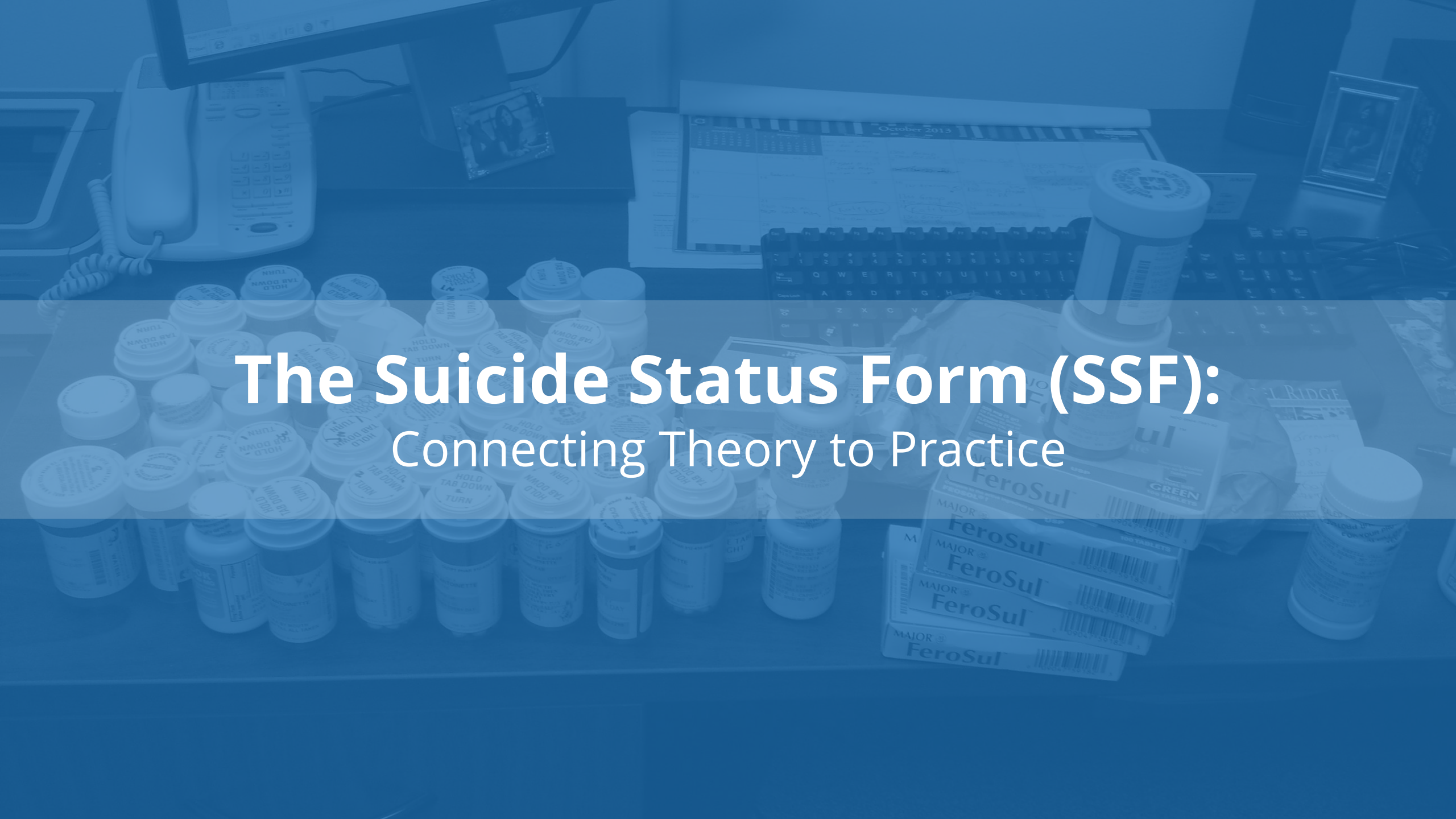| Shneidman's Cubic Model Theory	Beck's Cognitive Theory	Baumeister's Escape Theory
Psychological Pain	Hopelessness	Intense self-hate
Press	The Cognitive Triad	Escaping intolerable experience of self
Perturbation		

The Suicide Status Form (SSF):
Connecting Theory to Practice

CAMS SSF Initial Session

Section A:
Completed by Patient

CAMS SUICIDE STATUS FORM–4 (SSF-4) INITIAL SESSION

Patient: _____ Clinician: _____ Date: _____ Time: _____

Section A (*Patient*):

Rank	
	Rate and fill out each item according to how you feel <u>right now</u>. Then rank in order of importance 1 to 5 (1 = most important to 5 = least important)
_____	1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind,* **not** *stress,* **not** *physical pain*): **Low pain:** 1 2 3 4 5 :High pain What I find most painful is: _____

2) RATE STRESS (*your general feeling of being pressured or overwhelmed*):

1) How much is being suicidal related to thoughts and feelings about <u>yourself</u>? **Not at all:** 1 2 3 4 5 : completely

2) How much is being suicidal related to thoughts and feeling about <u>others</u>? **Not at all:** 1 2 3 4 5 : completely

Please list your reasons for wanting to live and your reasons for wanting to die. Then rank in order of importance 1 to 5.

Rank	REASONS FOR LIVING	Rank	REASONS FOR DYING

I wish to live to the following extent: **Not at all:**   0   1   2   3   4   5   6   7   8   : Very much

I wish to die to the following extent: **Not at all:**   0   1   2   3   4   5   6   7   8   : Very much

The one thing that would help me no longer feel suicidal would be: _____

CAMS SSF Initial Session

Section B (*Clinician*):

Y N Suicide ideation   Describe: _____

      • Frequency   _____ per day   _____ per week   _____ per month

      • Duration   _____ seconds   _____ minutes   _____ hours

Y N Suicide plan   When: _____

                      Where: _____

                      How: _____ Access to means Y N

                      How: _____ Access to means Y N

Y N Suicide preparation   Describe: _____

Y N Suicide rehearsal   Describe: _____

Y N History of suicidal behaviors

      • Single attempt   Describe: _____

      • Multiple attempts   Describe: _____

Y N Impulsivity   Describe: _____

Y N Substance abuse   Describe: _____

Y N Significant loss   Describe: _____

Section C (*Clinician*):   **TREATMENT PLAN**

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	*Self-Harm Potential*	*Safety and Stability*	*Stabilization Plan Completed* ☐	
2				
3				

YES _____ NO _____ Patient understands and concurs with treatment plan?

YES _____ NO _____ Patient at imminent danger of suicide (hospitalization indicated)?

_____   _____

Patient Signature   Date   Clinican Signature   Date

Stabilization Plan

Treatment Plan

Direct Drivers:

Internal experiences, behaviors, and external situations that are associated with **this person's own** acute suicidal crises (what is the "straw that breaks the camel's back?" leading to suicidal behavior).

Indirect Drivers:

Factors that make **this person** feel vulnerable to direct drivers being activated.

- Examples include: negative life events, psychosocial stressors, psychiatric illnesses, isolating, not sleeping enough

- These may be profoundly painful, they **do not necessarily trigger acute crises but increase vulnerability**

(Jobes et al., 2011; Tucker et al., 2015)

?

| Indirect Driver(s)* | → | Suicide as an Option |

* Some examples of indirect drivers that inserted above include:

Depression	Substance Abuse	Pending Deployment
Marital Conflict	Financial Difficulties	Chronic Medical Issues
Homelessness	Relationship Problems	Unemployment
PTSD Symptoms	Bad Grades	Incarceration

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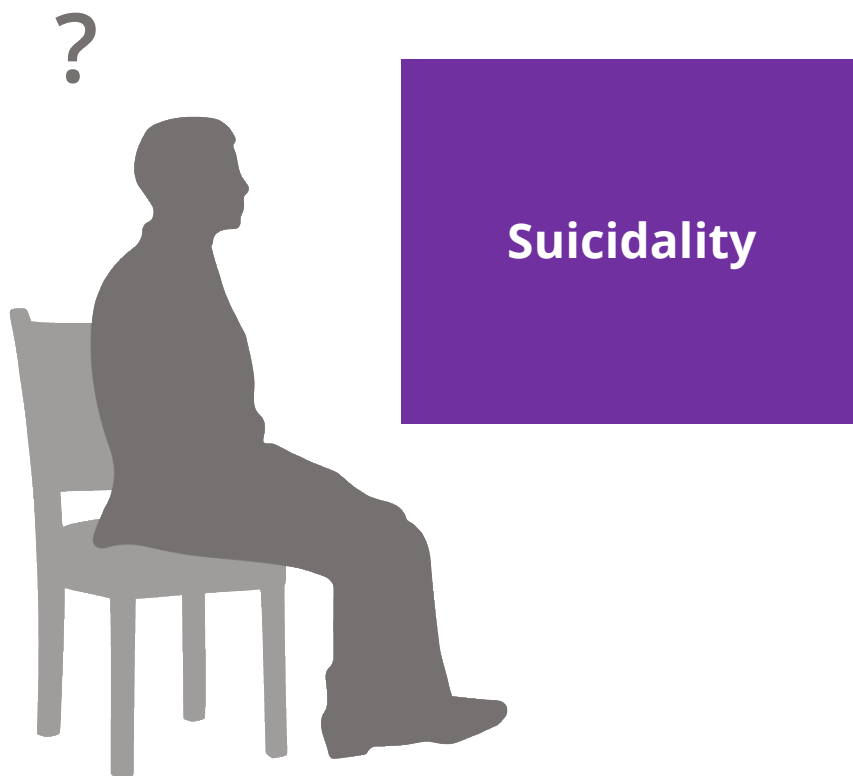| Indirect Driver	Direct Driver(s)*	Suicide as an Option

* **Direct drivers bridge the gap. They explain how this person gets from indirect drivers to considering/choosing suicide as an option.**

"A lot of people struggle with X, but not everyone who does wants to kill themselves. How are you seeing X that makes you feel like suicide is an option or the only option for dealing with it?"

- Frank and Frank (1991)

- 4 components

  1. Sanctioned healer (and demoralized sufferer)

  2. Healing relationship

  3. Special rationale that explains the difficulty

  4. Rituals or learning experiences that promise relie

- Mid-30s White cisgender woman

- Delivered her first child on 04/12/2022 at Woman's hospital

- Screened for concerns related to misuse of opioids and post-partum depression at first aftercare appointment

Case Study: Ronnie

- Referral made to opioid dependence program
- Initial data
  - Overall risk: 4/5
  - WTL = 2 and WTD = 7
  - Plan = use husband's hunting rifle

- Management plan
  - More time spent with mother in-law
  - Re-engage in value driven activity despite guilt
  - Husband agreed to carry firearm on his person, but not lock at night
  - Slow ween from opioid and husband held medication

Identify

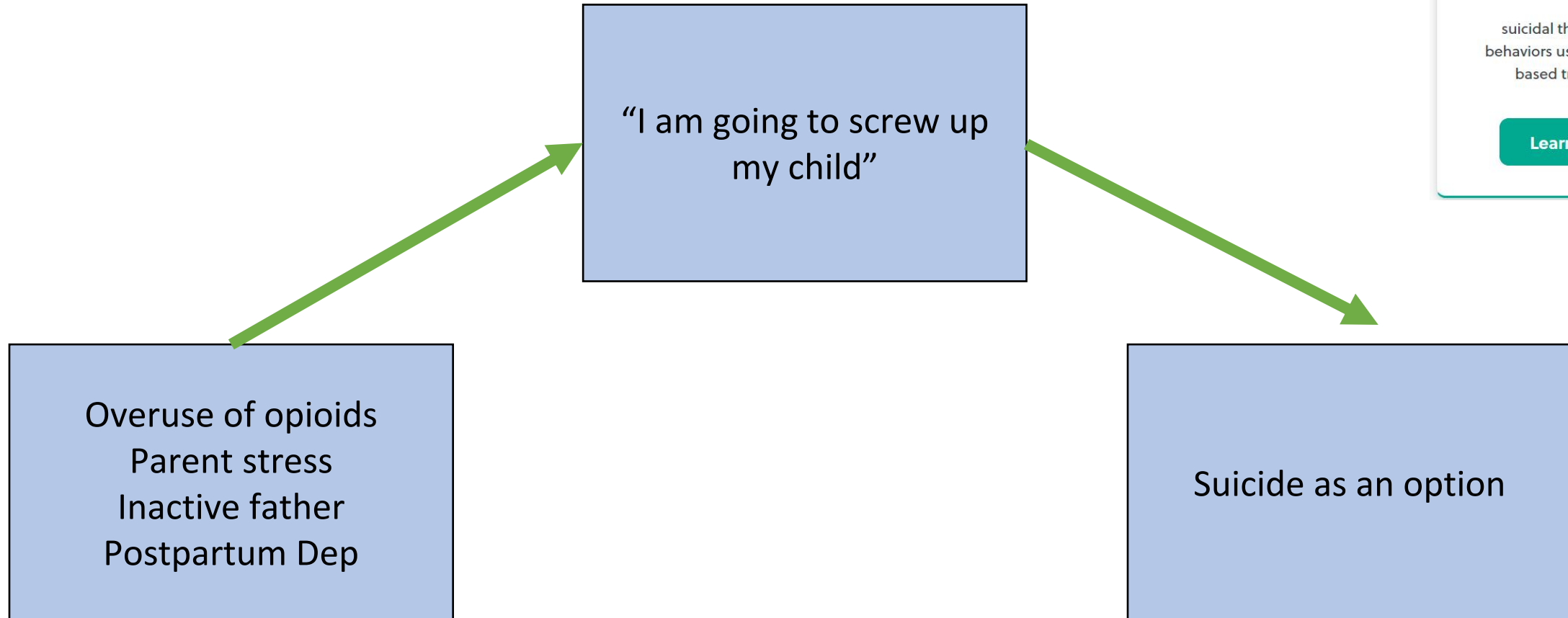individuals with suicide risk via comprehensive screening and assessment

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Engage

all individuals at-risk of suicide using a suicide care management plan

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Case Study: Ronnie

```
                    ┌─────────────────────┐
                    │ "I am going to      │
                    │  screw up           │
                    │  my child"          │
                    └─────────────────────┘
         ↗                                    ↘
┌──────────────────┐                  ┌──────────────────┐
│ Overuse of       │                  │                  │
│ opioids          │                  │ Suicide as       │
│ Parent stress    │                  │ an option        │
│ Inactive father  │                  │                  │
│ Postpartum Dep   │                  │                  │
└──────────────────┘                  └──────────────────┘
```

Case Study: Ronnie

- Parental support group

- Anti-depressant medication

- Cognitive behavioral therapy integrating
  - Pain management
  - Depression

- Husband joined therapy session 1x a month

Treat

suicidal thoughts and behaviors using evidence-based treatments

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Final Thoughts
Questions and Answers

Raymond Tucker, PhD
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