

## CHAPTER 1

# Collaborative Assessment and Management of Suicidality

---

### *A Suicide-Specific Clinical Intervention within Contemporary Health Care*

Bill is a middle-aged white male who arrives for the first therapy session at a private-practice outpatient setting. He is a highly successful architect who runs a large firm. For 30 years Bill has been married to his wife, Kathy, and they have four successful young-adult children. Despite his many successes in life, Bill reports an extensive history of depression, anxiety, intermittent bouts of insomnia, and periods of binge drinking. He further describes recent marital distress and reports that his life is “generally adrift.” Bill has sought mental health care on two previous occasions, dropping out each time after a handful of sessions. Bill endorsed various symptoms related to stress, depression, and anxiety on a screening tool that he completed in the waiting room prior to his appointment. On a screening item related to suicidal thoughts, Bill checked that he “frequently” has thoughts of ending his life. While it is unbeknownst to the clinician, Bill is an avid gun owner with many firearms in his home, and he has selected his “favorite” handgun to use for his suicide. In addition, Bill has put his affairs in order and he has written drafts of suicide notes to his wife and children.

Bill’s case poses many challenges to a mental health clinician in contemporary clinical practice. Both demographically and diagnostically, Bill presents as the modal suicide completer in the United States (Centers for Disease Control and Prevention [CDC], 2014). Given his cluster of psychiatric symptoms, his poor history of mental health treatment compliance, and his chosen method of a readily accessible handgun, Bill’s potential objective risk is alarmingly high. In addition, Bill’s

wife Kathy is a trial lawyer, and any clinician treating the spouse of an attorney might have anxiety about a malpractice lawsuit if the patient ends his or her life.<sup>1</sup>

Given all these considerations, it is fair to say that most mental health providers (across disciplines and theoretical orientations) encountering a patient like Bill would experience some worry. For some clinicians, such a clinically challenging case may actually be a terrifying prospect because they feel ill equipped to care for someone as potentially lethal as Bill. Sitting with Bill in our first session, I was worried and anxious about him. As a career suicidologist, I quickly appreciated the serious objective risk for suicide that he presented. But my worry and anxiety were lessened because I knew that I had a therapeutic approach that could be the exact life-saving remedy for him.

\* \* \*

When I first worked in the field of mental health more than 30 years ago, a clinical presentation like Bill's would have prompted an immediate hospitalization to a psychiatric unit, even if he was not necessarily deemed to be in "clear and imminent" danger. Back in the early 1980s, such an inpatient psychiatric stay would likely last many weeks; with especially good insurance, such a stay might last for months. (In those days with some cases, inpatient stays sometimes lasted for years!) However, these days, a patient like Bill (while undoubtedly worrisome) might not be "suicidal enough" to earn a precertification from an insurer for an inpatient admission. Some insurance companies require *both* "clear and imminent" danger *and* an actual suicide attempt to have occurred before they will approve an inpatient psychiatric admission. In any case, in the event of such an admission, a typical contemporary length of an inpatient psychiatric stay is 7–8 days (Stranges, Levit, Stocks, & Santora, 2011); many stays are brief as 24–48 hours. Moreover, in most contemporary inpatient settings, typical "treatment" may consist only of prescribing some psychotropic medications, and perhaps some brief psychoeducationally oriented groups (National Alliance on Mental Illness, 2014). It is a far cry from the days when psychiatric inpatient care routinely included individual psychotherapy, group therapy, various activity therapies, psychological testing, and a full psychiatric work-up as the standard of care.

So how does one best proceed with a case as daunting as Bill's? Upon reflection, there are two noteworthy factors in his case. First, despite his considerable suffering and objective suicide risk factors, Bill is nevertheless still *alive*. Second, despite his poor history of seeking mental health care, Bill is nonetheless apparently seeking treatment from yet another mental health professional. In fact, Bill

---

<sup>1</sup>Survey data confirm that suicide-related malpractice litigation is a commonly considered by surviving family when a suicide occurs while a loved one is engaged in mental health care (Peterson, Luoma, & Dunne, 2002).

is sitting with a clinical psychologist who is skilled in the use of a suicide-specific innovation called the Collaborative Assessment and Management of Suicidality (CAMS) approach—the evidence-based intervention described throughout this book.

In this first chapter, we begin our consideration of CAMS in relation to three important organizing concepts that directly bear on using it effectively. We will first explore the CAMS philosophy and then examine it as a clinical framework. The chapter ends by situating the use and application of CAMS within the context of contemporary mental health care.

## CAMS PHILOSOPHY

As I have described elsewhere in depth with some of my key research collaborators (Jobes, Comtois, Brenner, & Gutierrez, 2011; Jobes, Comtois, Brenner, Gutierrez, & O'Connor, 2016), CAMS is first a clinical *philosophy* of care. The success of CAMS rests firmly on a foundation of a particular philosophical orientation to clinically working with suicidal risk. In many ways, this approach to suicidal risk proposes some significant departures from conventional clinical practices about how best to understand and clinically assess and treat a person with suicidal risk. What follows are key features of the CAMS philosophical approach to caring for suicidal patients.

### ***Empathy for Suicidal States***

In 2001, the late Israel Orbach published an influential article in the field of suicidology that focused on *empathy with the suicidal wish*. Orbach and I were charter members of the Aeschi Group, a cadre of clinician-researchers who were fed up with conventional clinical approaches to working with suicidal risk involving diagnostic reductionism that emphasizes the primacy of mental disorders over the phenomenology of suicidal states (Michel et al., 2002). In an intentional effort to chart a new course, the members of the Aeschi Group championed an empathic, narrative, and noncoercive approach to working with suicidal patients. At the heart of this orientation is a core tenet that clinicians must truly *listen* to the patient's suicidal story in an empathic and nonjudgmental fashion. As I have written about for years (Jobes, 1995a, 2000, 2012), the nature of clinical work with suicidal patients often unravels into a patient versus clinician adversarial relational dynamic. We in the Aeschi Group felt compelled to propose a range of alternative ways of forming a therapeutic alliance in the presence of suicidal risk; an entire book is dedicated to this particular approach (Michel & Jobes, 2010). Marsha Linehan once told me that the default professional response to a suicidal patient throughout mental health settings was to *shame and blame* such patients. In my experience, particularly in

emergency departments, this has been all too true. I once sat in a hospital emergency department (ED) into the wee hours of the morning with a patient of mine who had overdosed. She was shackled to a gurney and awaited a charcoal treatment. We were both shocked to overhear her ED nurse say to a colleague, “Yeah, we have another overdoser. I wish we could work with *real* patients!” Within CAMS we never shame or blame; we endeavor to enter the mind of the suicidal person respectfully, and to understand the phenomenology of suicidal suffering from an empathic, nonjudgmental, and intrasubjective perspective.

### **Collaboration**

Collaboration is perhaps the most important ingredient to successful CAMS-guided clinical care. Through collaboration we engage in a highly interactive assessment process and we directly solicit patient input to their treatment plan. Moreover, every session of CAMS actively considers the patient’s feedback and sense about what is and is not working within their treatment. All CAMS assessment work is collaborative; all treatment-related aspects of CAMS are collaborative. When conducting assessments, we never interrupt or talk over the patient; instead we endeavor to draw them out and seek their input at every opportunity. In terms of treatment planning, the patient is actively engaged and is said to be a “coauthor” of their suicide-specific treatment plan. From the treatment research literature, all good clinical outcomes are defined by the quality of the therapeutic alliance (Horvath & Symonds, 1991). In CAMS we foster that alliance through a consistent emphasis on collaboration and interactivity over the course of care. From beginning, to middle, to end—collaboration is the key.

### **Honesty**

Finally, in terms of CAMS philosophy, honesty and forthrightness are essential. 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 created when suicidal risk is present. Clinical honesty related to suicidal risk begins with thoughtful and thorough informed consent (Jobes, Rudd, Overholser, & Joiner, 2008; Rudd et al., 2009). Suicidal patients usually struggle with issues pertaining to control, trust, betrayal, coercion, civil liberties, shame and blame, and abject paternalism. I therefore present some version of informed consent to a suicidal person that goes as follows:

“Let’s begin our discussion about suicide with something plain: 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 the clinical 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 commit 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 for some people there is no other way to cope with their situation. By the end of the day on average 100-plus Americans will die by their own hand, and about 30% of them will be in concurrent mental health care. I therefore have no illusions that mental health care will necessarily save your life. That said, I would rather not debate with you whether you can kill yourself; instead I would propose an evidence-based treatment designed to save your life. The research shows that most suicidal people respond to this treatment within 3 months. So why not give it a try? You have everything to gain and really nothing to lose. You can of course kill yourself later, when you are no longer in treatment. It is your life to live or not as you see fit. But then, what is the hurry? One day we all die. Finally, if suicide is the best way to do to deal with your situation, then what are you doing here with me? Perhaps it is not yet your time to die?"

Perhaps this is too provocative? Some mental health professionals think so. When I present some version of this suicide-specific informed consent to mental health professionals, I routinely see some raised eyebrows and sometimes even overt objections among certain audience members. Some believe I am baiting the patient to take his or her life. Others are uncomfortable by my frank admission about the limits of my influence and control. Still others object to my acknowledgment that a patient can kill him- or herself later when he or she is 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 truly suicidal person. Then I repeat this line of informed consent. Usually most clinicians "get it"—we cannot make people not take their lives through coercion, intimidation, or inpatient commitment. In my experience, this kind of informed consent actually *comforts* and *reassures* the suicidal person, making the patient less inclined to see me as a potential adversary and more likely to see me as an ally. By giving up any illusion of control and power *over* the patient, I have actually gained more credibility and influence *with* the patient. While I am clear about my professional duty I still propose a viable path to avoid an adversarial dynamic. Moreover, this line of thinking has the noble virtue of being the absolute *truth* about contemporary clinical demands related to suicidal risk. When I was in graduate school one of my favorite professors once told me, "The truth is highly underrated in psychotherapy." All these years 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 clinical care and is indispensable to ethical and effective clinical practice (Jobes, 2011).

## CAMS AS A SUICIDE-FOCUSED THERAPEUTIC FRAMEWORK

CAMS is emphatically *not* a new psychotherapy. Rather, it is a suicide-focused therapeutic framework—a clinical platform—guided by a unique multipurpose clinical tool called the Suicide Status Form (SSF). The SSF functions as a clinical roadmap within CAMS, guiding all assessments, treatment planning, tracking of ongoing risk, and, ultimately, clinical outcomes. As is discussed at length in this book, the SSF has been extensively studied for over 25 years in a broad range of clinical settings around the world. It has excellent psychometrics and extensive clinical utility (see Jobes, 2012, for a review). The SSF is in part an assessment tool that provides a unique blend of quantitative and qualitative assessment data. Collaboratively completing the assessment portions of the SSF is often a therapeutic experience for the patient in itself. Indeed, Poston and Hanson (2010) have empirically demonstrated that the CAMS-based SSF assessment functions as a “therapeutic assessment” in their meta-analysis of 17 published studies of psychological assessments that have positive and clinically meaningful effects on treatment, including treatment processes. Other portions of the SSF focus on the development of a suicide-specific treatment plan that features a stabilization plan and targeting and treatment of *patient-defined* suicidal “drivers”—those issues or problems that make suicide compelling to the patient (Jobes et al., 2016). Successful stabilization work in CAMS and ongoing treatment of suicidal drivers is further guided by the use of interim and then outcomes versions of the SSF. As discussed in Chapter 8, the use of the SSF can help to significantly decrease the risk of malpractice liability by creating an extensive documentation trail. Let us now further consider some of the key features of this therapeutic framework for suicidal risk.

### **Focus on Suicide**

CAMS clinicians are singularly focused on preventing their patient’s suicide. Within CAMS the inherent clinical bias is that there is nothing more important to consider in mental health treatment than the prospect of the patient’s suicidal death. To this end, there is persistence—sometimes even doggedness—in our primary focus on saving the patient’s life. In other words, we continually work together to eliminate suicide as a coping option as we endeavor to treat, ameliorate, or eliminate the suicidal drivers that imperil the patient’s life. We therefore make no apologies for this emphatic focus: We are trying to save a life. For example, over the course of a session a patient may want to talk about her kids or the economy. While the CAMS clinician may find these topics interesting, we still resist the temptation to focus on unrelated topics; unless these topics are relevant to the patient’s suicide risk the CAMS clinician must gently redirect 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 the kids or economy *after* suicide has been eliminated from the patient’s coping repertoire. As noted



earlier, when using CAMS we should remain unwaveringly focused on helping to save the patient's life and assisting in the development of purpose and meaning.

### ***Outpatient Oriented***

In the first edition of this book, I asserted that CAMS as a clinical approach to suicidal risk is fundamentally oriented toward keeping a suicidal person *out* of an inpatient psychiatric hospital setting, if at all possible. Ten years ago this approach was a somewhat novel idea. But based on my experiences training thousands of clinicians, I still get a strong impression that many (if not most) mental health clinicians continue to harbor a strong inpatient focus to care. In other words, when a typical clinician encounters suicidal risk their approach often *begins* with an a priori hospitalization bias: "Uh-oh, where can I get a bed?" Using CAMS as a therapeutic framework, we earnestly endeavor to find ways to keep a suicidal patient *out* of the hospital. We achieve this through our collaborative development of a suicide-specific outpatient treatment plan that includes a carefully developed stabilization plan and a problem-focused treatment of the patient's idiosyncratically defined suicidal drivers. Consequently an inpatient psychiatric hospitalization is the ultimate *last* resort in CAMS-guided care. The need for inpatient care naturally emerges only when the dyad is not able to collaboratively develop a satisfactory outpatient plan that includes stabilization and driver-focused treatment options. A notable exception to this general outpatient bias of CAMS-guided care is when CAMS is used as an *inpatient* intervention. In this case the proper course of inpatient CAMS care still focuses on stabilization planning and driver-oriented treatment that becomes central to effective discharge planning and successful post-hospital disposition (cf. Ellis, Green, Allen, Jobes, & Nadorff, 2012; Ellis, Rufino, Allen, Fowler, & Jobes, 2015).

### ***Flexible and Nondenominational***

As a therapeutic framework, CAMS is designed for flexibility and adaptation; we think of CAMS as theoretically "nondenominational." While there are not many replicated evidence-based treatments for suicidal risk, two excellent exceptions clearly do stand out: dialectical behavior therapy (DBT) and cognitive-behavioral therapy (CBT). As Marsha Linehan has shown in rigorous clinical trials, DBT effectively treats both suicide attempt behaviors as well as self-harm behaviors (Linehan et al., 1999, 2006, 2015). In addition, Brown and colleagues (2005) have shown that 10 sessions of a suicide-focused cognitive therapy for suicide prevention (CT-SP) can significantly reduce repeat suicide attempts by *half* in their randomized controlled trial. Using a similar brief cognitive-behavioral therapy (B-CBT) approach for suicide risk, Rudd and colleagues (2015) found a 60% decrease in suicide attempt behaviors for those receiving B-CBT in comparison to usual treatment.

Across these effective and replicated treatments, there is a clear expectation of close adherence to highly structured treatment manuals in order to effectively deliver these interventions faithfully. In the case of DBT one must be able and willing to practice behavior therapy, and in the case of the CBT approaches one must practice cognitive therapy to effectively deliver the intervention. As adherence to an evidence-based approach is a critical component of effective delivery of that care, the training necessary to achieve reliable adherence to a manualized treatment is an important consideration. For both 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 really not a cake.”

In contrast, CAMS is designed to be highly flexible and can be adapted to a range of theoretical approaches and the spectrum of clinical treatments. As a suicide-specific clinical framework, clinicians across the gamut of theories can equally and effectively use CAMS when working with suicidal patients. Whenever I train providers in CAMS, I emphasize that I want clinicians to retain their own clinical skills, their own clinical judgment, and their own treatment approaches; we do not want a clinician to transform into a different provider, someone he or she does not recognize. Consequently, CAMS has been successfully used by mental health clinicians of all theoretical orientations (psychoanalytic, humanistic, interpersonal, cognitive-behavioral, etc.) and professional disciplines (psychologists, psychiatrists, social workers, counselors, nurses, marriage and family therapists, case-managers, substance-abuse clinicians, etc.). We thus encourage providers to practice as they typically do, but to do so *within* the flexible and highly adaptive CAMS therapeutic framework. As discussed in depth in Chapter 9, CAMS has been extensively adapted for brief use in emergency departments and crisis settings, as a post-inpatient discharge group therapy (Johnson, O’Connor, Kaminer, Jobes, & Gutierrez, 2014), and modified for different populations (e.g., military, college students, suicidal youth). While there is undoubtedly a need for effective and highly structured manualized evidence-based treatments, there is an obvious need for highly flexible and adaptive interventions like CAMS as well.

Unlike other replicated evidence-based approaches, CAMS is relatively easy to learn, and achieving adherence can be quick and enduring. Training research has shown that CAMS can be learned in live-didactic forums (Pisani, Cross, & Gould, 2011) as well as within an e-learning training approach (Jobes, 2015, 2016; Marshall et al., 2014). Interestingly, in an online study of 120 providers whose training in CAMS ranged from merely reading the first edition of this book to a daylong live training plus role playing, Crowley, Arnkoff, Glass, and Jobes (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 suicidal U.S. Army Soldiers, it is noteworthy that all CAMS clinicians in the



study 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, 2015).

## CONTEMPORARY MENTAL HEALTH CARE

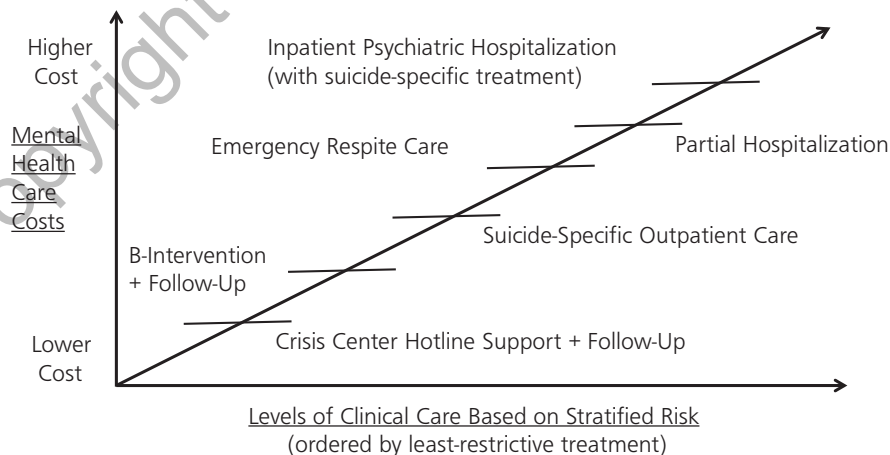
As I have previously noted, within my 30-year professional lifetime there have been extraordinary changes in the delivery of mental health care in relation to suicide risk. In the United States, even more change is currently under way as a result of the passage and enactment of the Affordable Care Act (Patient Protection and Affordable Care Act; Public Law No. 111-148, March 23, 2010). Among all the challenges of the highly politicized issues associated with American health care reform, there is a rather blunt truism that has the power to meaningfully shape and influence the treatment of suicidal risk for years to come. The sheer costs of mental health care related to suicide risk and behaviors are extremely high. For example, inpatient psychiatric care has become quite expensive (Stranges et al., 2011) with an average cost of \$5,700 per inpatient stay (ranging from \$2,900 to \$13,300). Yang and Lester (2007) estimate a typical inpatient stay for suicide risk averages \$13,690, with a range from \$1,997 to \$68,150. Moreover, the use of emergency departments by suicidal people, more specifically attempters, has become costly as well (Owens, Mutter, & Stocks, 2010; Stensland, Zhu, Ascher-Svanum, & Ball, 2010; Valenstein et al., 2009). The collective expense of suicide-related medical procedures such as sewing up “cutters,” surgeries related to self-inflicted gunshot wounds, and lavaging stomachs following intentional drug overdoses is considerable (Bennett, Vaslef, Shapiro, Brooks, & Scarborough, 2009). Add costly attorney’s fees to defend against suicide wrongful death malpractice lawsuits, and the overall expensive of suicide-related care and management is plain. While it is perhaps a tactless consideration in a discussion of life or death, within a “fee-for-service” approach to health care, one can understand why insurers are struggling to shoulder mounting expenses created by mental health patients in general, and patients with suicide-related morbidity and mortality in particular.

As a member of the National Action Alliance Clinical Care and Intervention Task Force, I had the opportunity to explore in depth the many and various challenges connected to contemporary suicide-related health care. As part of our charge, we were directed to pay particular attention to these suicide-related cost issues as it would pertain to the Affordable Care Act. The task force report entitled “Suicide Care in Systems Framework” (National Action Alliance, 2011) thus strongly emphasized a *systems* approach to clinical suicide prevention. Key health care systems-related phrases such as “evidence-based approaches” and “least-restrictive treatments” and “cost-effective care” were frequently mentioned

during our deliberations and ultimately within our report focusing on systems-level issues.

Inspired by the work of the task force, I presented a model at an international suicide prevention conference of a potential spectrum of care for suicidal risk (Jobes, 2013a). I argued in this presentation that potential changes in suicide-related care (largely driven by purely economic forces) do not necessarily have to have a negative impact if we can pursue the goal of reliably differentiating (i.e., “stratifying”) suicidal states and then matching our best evidence-based interventions in a least-restrictive manner to each level of risk. I also talked about exciting innovations in suicide interventions that are increasingly focused on brief (one to four sessions of contact) interventions (e.g., Gysin-Maillart, Schwab, Soravia, & Michel, 2016). We also know the potential therapeutic power of follow-up letters, postcards, phone calls, and other means of caring outreach such as texting and e-mails are being studied as well (see Luxton, June, & Comtois, 2013). Follow-up contacts are often referred to as “nondemand” or “caring-contacts,” and the data that support their use are impressive. Moreover the potential value of crisis center suicide hotlines has been proven (Gould, Kalafat, Harris-Munfakh, & Kleinman, 2007), and crisis center workers can also provide caring-contact follow-up calls that are typically well received by suicidal people (Gould, 2013).

Figure 1.1 shows the model I am describing of an array of suicide-specific interventions that are both least restrictive and cost effective. Along the *x*-axis there are graduated steps of interventions that reflect different types and intensities of care. For example, a relatively “low-risk” suicidal person with ideation might be effectively supported and managed purely through a crisis hotline level of intervention. For someone who needs more intensive contact, a brief suicide-specific intervention with follow-up may be sufficient. Persons with more serious risk may require



**FIGURE 1.1.** Stepped model for suicide interventions.

suicide-specific outpatient care, respite crisis care, or partial hospitalization. For someone who is imminently at high risk, an inpatient admission may be necessary (with suicide-specific care provided during the stay). As you follow the arrow that transects the figure, you can see a full continuum of care with increasing steps of intensity and focus. Note that on the  $y$ -axis there is the corresponding consideration of mental health care costs.

Within this model of stratified risk and stepped care, evidence-based and suicide-specific interventions can be provided at each level of intervention. CAMS itself can be adapted and used at almost every level of stratified clinical care model—from brief crisis intervention, to standard outpatient CAMS, to adapted brief versions of CAMS used in respite care, partial hospitalization, and within inpatient settings (see Chapter 9). CAMS is thus well positioned for use in our evolving health care environment (Jobes & Bowers, 2015).

Another major consideration alluded to earlier pertains to anxieties that many providers have about the risk of malpractice lawsuits should a suicide occur. As I discuss in depth in Chapter 8, using CAMS may actually significantly *decrease* such risk because of the central use of the SSF that creates an extensive clinical documentation trail. Risk of liability is further reduced because CAMS is evidence based and suicide specific; any potential ongoing suicidal risk is monitored and treated until optimal clinical outcomes are ultimately realized.

Having said all this, it would be naive to suggest that there is a “one-size-fits-all” evidence-based intervention that will work in every clinical environment, with every suicidal patient, for every type and kind of mental health provider. CAMS has nevertheless proven to be an effective and adaptive approach in range of clinical environments, with a diverse spectrum of suicidal patients around the world. Providers across professional disciplines and theoretical orientations have been able to effectively use CAMS as a suicide-specific therapeutic framework that can make a meaningful difference in their clinical practice with suicidal patients.

If we truly aspire to clinically save lives we must use practices that have been proven to be effective for working specifically with suicidal risk. But as a trainer of mental health providers for decades, I have the strong impression that evidence-based practices are often not reliably used in the “trenches” of mental health care (these impressions are further confirmed by literature on the topic; e.g., McHugh & Barlow, 2010; Shafran et al., 2009). As I have reflected on this elsewhere (Jobes, 2015), there are various reasons why any clinician might be willing to change practice behaviors to embrace a proven treatment for suicidal risk. While these are in no particular order, some of these considerations may include:

- A genuine desire to help patients do better.
- Empirical support for the treatment.
- Directives or mandates by leadership (i.e., being forced to do it).
- Fear of losing a patient to suicide and then being blamed.

- Fear of litigation for malpractice wrongful death.
- Different incentives to change practices (e.g., money or comp time).
- Everyone else is doing it and feeling left behind.
- Seeing is believing (being convinced that a treatment could actually work).

Even with all these potential motivators, I am still circumspect about the willingness of many clinicians to change their practice behaviors to use an intervention that works. As you read these words, where do you stand in terms of *your* willingness to change your practice behaviors? It is my hope that by the end of this book you will be convinced that CAMS is both a sensible and compelling approach for effectively working with any suicidal patient you may encounter.

In closing this chapter I would hasten to add that as this book was going into production, a landmark document was released by The Joint Commission (2016), which is *the* accrediting body within U.S. health care. On February 24, 2016, The Joint Commission released a “Sentinel Event Alert” titled “Detecting and Treating Suicide Ideation in All Settings.” This extraordinary document has the power to shape and influence mental health assessment and treatment of suicide risk for decades to come within medical institutions accredited by The Joint Commission. And to this end, DBT, CT-SP, and CAMS were specifically mentioned as evidence-based clinical approaches that help reduce suicidal thoughts and behaviors for at-risk patients. This is indeed a most noteworthy development for the cause of clinical suicide prevention.

\* \* \*

Within the first 10 minutes of my initial session with Bill, I proposed the use of CAMS. In the true spirit of informed consent, I talked plainly about suicide and my duties as a licensed mental health professional. We discussed the DC Mental Health Act and what the law says about “clear and imminent danger” to self. This discussion both raised Bill’s anxiety but also intrigued him about the possibilities of doing a suicide-specific intervention, and with some wariness Bill agreed to proceed with CAMS. But our potentially life-saving treatment began in earnest when I asked for permission to take a seat next to Bill. I did so and handed Bill a copy of the SSF, saying, “Here is an assessment tool that will help me understand in depth the nature of your pain and suffering so I can see how things are going for you right now. The first page here is for you to complete with my help. But you are the expert of your own struggle—please help me understand what it is like to be you so we can pursue a treatment together that may just help save your life.”