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The COVID-19 Pandemic and Treating Suicidal Risk:

The Telepsychotherapy Use of CAMS

David A. Jobes, Ph.D. and Jennifer A. Crumlish, Ph.D.

The Catholic University of America

Andrew Evans

CAMS-care, LLC

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jobes@cua.edu

Abstract

The COVID-19 pandemic has created profound challenges for healthcare systems worldwide. The exponential spread of COVID-19 has forced mental health providers to find new ways of providing mental health services that maintain physical distance and keeps providers and patients at home limiting possible exposure to the deadly virus. The pandemic has thus sparked a sudden interest in providing mental health services via telepsychotherapy (otherwise known as telehealth or telemedicine). Telepsychotherapy care has some inherent challenges that must always be mastered by providers to render effective care. Previous research and professional guidelines understandably note possible concerns about providing telepsychotherapy care to high risk suicidal patients in a remote location. The coronavirus pandemic now poses all new ethical concerns about the routine practice of having acutely an suicidal patient go to an emergency department and/or admitting such patients to an inpatient psychiatric unit (if the public health goal is to limit the spread of this deadly virus). To this end, this article describes a pandemic-driven effort to rapidly provide support, guidance, and resources to providers around the world to use a suicide-focused and evidence-based intervention called the Collaborative Assessment and Management of Suicidality (CAMS) within a telepsychotherapy. Additional suicide-relevant resources are being made available to provide further guidance and support to mental health professionals worldwide. In the midst of a worldwide pandemic, there are emerging ways to help reduce further loss of life to suicide through the medium of telepsychotherapy to provide effective clinical care that is suicide-focused and evidence-based.

Keywords: COVID-19, Telepsychotherapy, Suicide Treatment, CAMS

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Suicide is the 10th leading cause of death in the United States accounting for 48,344 lives lost in 2018 (Drapeau & McIntosh, 2020). Increasing rates of suicide deaths over the past 50 years are alarming (refer to Fig 1). While there was a flickering hope of perhaps lowering the rate of suicide in the late 1990's, the past twenty years have seen a marked increase in suicides with no clear understanding as to why these deaths continue to increase. Notably the field of suicide prevention has grown markedly over these twenty years in terms of research and policy initiatives, but these efforts do not seem to be having an impact on the overall rate of suicide.

The public health challenge of suicide is even more troubling when we consider that in 2017 approximately 1,400,000 adult Americans made suicide attempts and a staggering 10,600,000 American adults had *serious* thoughts of ending their lives (SAMHSA, 2018). As noted by Jobes and Joiner (2019), there is insufficient attention paid to suicidal ideation in terms of treatment research, clinical practice, and mental health policy that primary focuses on suicidal behaviors. Suicidal behaviors are understandably a major public health and mental health focus, but these populations are dwarfed by those struggling with serious suicidal ideation. If suicidal children and teenagers are added to the mix, the population of those with serious suicidal thoughts may well approach 13,000,000. While we are noting American data, similar trends exist worldwide (refer to https://www.who.int/mental_health/prevention/suicide/suicideprevent/en/).

In terms of treating suicidal risk it is important to note that the most common clinical responses to suicidality (e.g., the use of medication or inpatient hospitalization) have limited to no empirical support (Jobes, 2017; Jobes & Chalker, 2019). Interestingly, suicide-focused psychological treatments with *replicated* randomized controlled trial (RCT) support (e.g.,

Dialectical Behavior Therapy, Cognitive Therapy for Suicide Prevention, Brief Cognitive Behavioral Therapy, and the Collaborative Assessment and Management of Suicidality) are not widely used within routine clinical practice. To this end Jobes (2017) has hypothesized that countertransference issues related to working with suicidal patients, fears about malpractice litigation, and a lack of knowledge about effective suicide assessment and treatment may lead to defensive clinical practices (e.g., the potential overuse of inpatient hospitalization). Nevertheless, the RCT research has begun to influence major suicide-specific policy initiatives from The Joint Commission (2016) and the National Action Alliance for Suicide Prevention which may ultimately help transform clinical practices over time by emphasizing the importance of directly treating suicidal ideation and behaviors with evidence-based practices independent of psychiatric diagnoses (refer to “Zero Suicide” <https://zerosuicide.edc.org/>).

The COVID-19 Pandemic and Suicidal Risk

The worldwide pandemic spread of a novel coronavirus (referred to as COVID-19 or SARS-CoV-2 by the World Health Organization) has led to hundreds of thousands of Americans getting sick and tens of thousands more dying (as of this writing) from this extremely contagious virus. There is evidence within the suicidology literature that previous public health crises (e.g., SARS in Hong Kong) can be significantly associated with increased suicide risk among certain sub-samples (Yip, Cheung, Chau, & Law, 2010). Social isolation, economic downturn, and unemployment have also long been associated with increased suicidal risk (refer to Maris, 2019 for an extensive review). Given the profound impact of this pandemic worldwide, there is reason to believe that we will see significant increases in stress and anxiety in the face of an uncertain future. Needless to say, people who struggle with underlying anxiety disorders, certain phobias

(e.g., a germ phobia), and obsessive-compulsive disorder (e.g., repetitive handwashing behavior) will likely be disproportionately impacted by the COVID-19 pandemic.

Beyond turning personal and professional lives upside down, the pandemic has suddenly created a crisis as to how we now effectively provide clinical services, as well as train and appropriately supervise trainees and unlicensed providers within a physical distancing reality that is needed to “flatten the curve” of the spread of COVID-19. Professional organizations, licensure boards, and leaders within mental health community have scrambled to respond to existing and future needs for mental health providers to deliver clinical services, training, and supervision when mental health professionals are being required to ensure physical distance, to stay at home, and to avoid potential exposure to avert viral transmission. The pandemic crisis has suddenly led to an explosion of interest in providing professional services through telepsychotherapy (also called telehealth, telemedicine, telepsychology, etc.). It is possible that years from now when we will look back at this time, we may see that this pandemic created a major turning point in the delivery of healthcare around the world wherein face-to-face clinical care becomes displaced by initial and routine use of virtual telehealth in medicine and telepsychotherapy in mental health.

Mental health care with suicidal patients has long been known to have many inherent clinical and professional challenges (Jobes & Maltzberger, 1995). But these inherent challenges are further complicated when mental health care for suicidal risk must be provided through telepsychotherapy. In a study conducted by Gilmore and Ward-Ciesielski (2019) with 52 mental health providers, three perceived risks related to using “telemedicine” with suicidal patients were found. These perceived risks include: (a) remote assessment challenges, (b) lack of control over patient, and (c) difficulties triaging patients if that is needed. While working with suicidal patients is not explicitly excluded in telepsychotherapy recommendations (e.g., APA, 2013;

Yellowlees, Shore, & Roberts, 2010), expert guidance does nevertheless appropriately emphasize the importance of being prepared through thorough informed consent for a suicidal emergency with a remotely located suicidal patient. In the Gilmore and Ward-Ciesielski (2017) study, it is noteworthy that only 21.2% of the sample endorsed the use of telemedicine for patients at high risk for suicide which reflects a general wariness to using telemedicine with suicidal patients.

Within a post-pandemic reality, there is yet another major complication related to the routine clinical practice of routing an acutely suicidal person to an emergency department (we will refer to “ED” which is the preferred term by providers vs. “emergency room” or “ER”). Indeed, the ubiquitous practice of recommending that a patient “go to their nearest emergency department if this is a mental health emergency” on one’s professional voice message is now suddenly ill-advised in the midst of the global coronavirus pandemic. From an ethical perspective, how can we argue that such a professional recommendation is now in the patient’s best interest if it means putting the patient and others—including other patients and overtaxed ED providers—at increased risk of contracting or spreading the virus? Moreover, is a psychiatric inpatient hospitalization similarly putting a suicidal patient at increased risk given the highly contagious nature of this novel coronavirus? While the relative merits and limits of inpatient care has been hotly debated in the field pre-pandemic (e.g., Large, Ryan, Walsh, Parbury & Patsfield, 2013), the exponentially deadly transmission of COVID-19 must give us pause to reconsider the value of such an intervention if the overall public health goal is to maintain physical distance, to stay at home, and limit potential exposure, all of which are needed public health interventions to flatten the curve of viral transmission and spread. Whether or not mental health providers are prepared to embrace the pandemic implications for suicidal risk, major politicians (including the United States President) are readily talking about the

implications of the pandemic fueling dramatic increases in suicides secondary to unemployment and a pandemic-related economic recession or depression (<https://abcnews.go.com/Politics/fact-checking-trumps-claim-suicide-thousands-economic-shutdown/story?id=69790273>).

Given these various and considerable challenges wrought by the pandemic, a timely and decisive response to the potential loss of life to both the novel coronavirus and to suicide risk is needed. An “either/or” position is not acceptable; a “both/and” approach is required to save as many lives as possible from the virus and from suicide. In the midst of a global pandemic, it is ethically or morally indefensible to refuse to see or turn away a suicidal person who is seeking care. But modifications to our mindset about that care is urgently needed to help save lives from suicide and avert further “collateral damage” secondary to the coronavirus global pandemic.

A Pandemic-Driven Effort to Provide Effective Suicide-Focused Care

As the COVID-19 pandemic exponentially spread in the U.S. in March of 2020, there was an emergent need for mental health professionals to modify their provision of mental health services (with clear implications for professional training, as well as supervising unlicensed providers). Fully realizing that suicidal people would continue to be suicidal (and if anything risk would likely increase given the worldwide increase in anxiety, fear, and the existential threat posed by the pandemic), there was a pressing need for decisive action to help providers save lives from suicide. To this end, we moved briskly to provide a range of free professional resources to rapidly help provide support and guidance to providers who are in a position to care for suicidal patients in the midst of the pandemic. What follows is an overview of one evidence-based suicide-focused intervention and our recent pandemic-driven efforts to modify the standard use of this intervention to accommodate its delivery via telepsychotherapy.

The Collaborative Assessment and Management of Suicidality (CAMS)

As described by Jobes (2006, 2016), CAMS is a suicide-focused therapeutic framework that uses a multi-purpose assessment, treatment planning, tracking, and clinical outcome tool called the Suicide Status Form (SSF—refer to Figure 2). The SSF “Core Assessment” items (i.e., ratings of psychological pain, stress, agitation, self-hate, hopelessness, and overall risk of suicide) are repeatedly assessed across every phase of CAMS-guided care. The SSF Core Assessment has excellent validity and reliability with suicidal college students (Jobes et al., 1997), high-risk suicidal inpatients (Conrad et al., 2009), and suicidal teenagers (Brausch et al., 2019). Within the CAMS framework the first session version of the SSF has various qualitative assessments to comprehensively assess risk (Brancu, Jobes, Wagner, Greene, & Fratto, 2016; Hamadi et al., 2019; Jobes & Mann, 1999; Jobes et al., 2004) and an assessment-oriented meta-analysis has previously showed that the SSF functions as a *therapeutic assessment* (Poston & Hanson, 2010). A signature feature of CAMS is a side-by-side seating arrangement (always with a patient’s permission) at the start of each CAMS session for collaborative assessment and at the end of each session to facilitate suicide-focused treatment planning “co-authored” by the dyad.

Within its clinical research evolution, CAMS has developed into proven a suicide-focused intervention, that treats patient-defined “suicidal drivers”—self-identified problems that make the patient suicidal (Jobes, 2016). CAMS is not a new psychotherapy; rather it functions as a therapeutic framework that is theoretically “non-denominational” and integrative. Within this suicide-focused framework, CAMS providers can employ the full spectrum of possible clinical interventions (e.g., CBT, insight-oriented work, behavioral activation, and medication) using different treatment modalities to effectively target and treat patient-identified suicidal drivers. CAMS can be effectively used across a range of outpatient and inpatient treatment settings with different suicidal populations (community mental health, counseling center, private practice, or

inpatient care). CAMS can be effectively used within a stepped-care approach to suicidal risk that emphasizes the use of suicide-focused care that is evidence-based, least-restrictive, and cost-effective for achieving optimal clinical outcomes (Jobes, Gregorian, & Colborn, 2018).

There are now five RCT's with various suicidal samples showing replicated support for CAMS. Across RCT's, CAMS significantly reduces suicidal ideation in 4-8 sessions (Comtois et al., 2011; Jobes et al., 2017; Pistorello et al., in press), overall symptom distress at 12-month follow-up (Comtois et al., 2011; Ryberg, Zahl, Diep, Landro, & Fosse, 2019), and depression (Pistorello et al., in press). CAMS also significantly increases hope, patient satisfaction, and retention to care relative to treatment as usual (Comtois et al., 2011). In non-randomized comparison-controlled trials, CAMS was significantly associated with decreases in suicidal ideation (Jobes, Wong, Conrad, Drozd, & Neal-Walden, 2005; Ellis, Rufino, & Allen, 2017; Ellis, Rufino, Allen, Fowler, & Jobes, 2015), emergency department and primary care visits (Jobes et al., 2005), depression, hopelessness, and functional disability (Ellis et al., 2017) relative to treatment as usual (TAU). Statistically significant increases in subjective well-being and psychological flexibility, in addition to changes in suicidal cognitions, have also been associated with CAMS when compared to TAU care (Ellis et al., 2017). While there are encouraging trending data that CAMS may help reduce self-harm and suicide attempts on par with DBT (Andreasson et al., 2016), definitive RCT data on the impact of CAMS on suicidal behaviors is lacking but is still being investigated in three on-going CAMS RCTs with suicide-attempting patients discharged from inpatient psychiatric care, suicidal veterans in outpatient care, and suicidal inpatients in Germany. Although RCT's are the "gold standard" in science for studying the *causal* impact of an intervention, there are also eight published trials reporting *correlational* data providing additional supportive data for using CAMS—see Jobes (2012) for a full review.

Moderator analyses from three CAMS RCTs have yielded additional supportive data. Among subsets of highly suicidal Soldiers (Huh et al., 2018), CAMS significantly increased resiliency while decreasing overall symptom distress and emergency department visits. In subsets of community-based suicidal outpatients and inpatients in Oslo Norway (Ryberg, Diep, Landrø, & Fosse, 2019), CAMS improved care when there was a poor working alliance at baseline. Pistorello and colleagues (in press) have recently found that CAMS significantly reduced hopelessness among “less complex” suicidal college students (i.e., those without a multiple suicide attempt history or borderline personality disorder features).

The clinical use of CAMS can be supplementary to other mental health treatments, or it can be used as a means to optimally stabilize a suicidal patient for further treatments. CAMS can be initiated with new patients with current suicidal risk and it can always be used for cases within on-going care if suicide emerges as a source of concern. In our experience, CAMS with a new patient can expedite the formation of the therapeutic alliance because it is patient-centered, empathic, and collaborative—the CAMS engagement can often be quite bonding. If CAMS is used within on-going care, the framework and collaborative use of the SSF provides valuable structure and guidance for the clinical dyad to maintain and even further deepen their alliance. In other words, within on-going care, a patient’s emerging suicidality does not have to become a divisive issue for the clinical relationship. Finally, across clinical trial studies and routine use of CAMS, the approach appears to be effective for a wide range of patients including those with varying degrees of suicidal intensity as well as those with and without significant intent or plans.

The Telepsychotherapy Use of CAMS

As previously noted, while providers may have some reluctance to render mental health treatment to suicidal patients via telepsychotherapy, the global pandemic demands an open mind

to the virtues of this approach. To this end, CAMS has already been piloted and used effectively in a range of clinical settings. The CAMS protocol for telepsychotherapy was first developed for use with suicidal active-duty U.S. Army Soldiers. For example, mental health providers at the Warrior Resiliency Program located in San Antonio Texas have successfully used CAMS within a telepsychotherapy modality for several years (Waltman, Landry, Pujol, & Moore, 2019). These experienced telepsychotherapy providers use the modality to provide a range of evidence-based treatments for various mental health issues (e.g., PTSD and insomnia) and they have effectively mastered the provision of CAMS using telepsychotherapy to suicidal Soldiers serving in remote locations across the United States.

CAMS has thus been used via telepsychotherapy at other military installations, within Veterans Affairs, and within community mental health centers. The protocol has also been further adapted to use in correctional settings where therapy may be provided on both sides of a Plexiglas barrier. To date, the telepsychotherapy use of CAMS has mostly been used with the clinician in one clinical setting and the patient in a separate remote mental health clinic. But increasingly CAMS telepsychotherapy is being used with patients who are in their homes or residential settings (a trend that is markedly increasing because of the COVID-19 pandemic).

Using CAMS in a telepsychotherapy session is relatively easy and anecdotal reports indicate that patients readily adapt and may even prefer it to office-based sessions. The main difference is that instead of collaboratively completing the SSF sitting side-by-side, the clinician and patient both have a blank SSF and take turns dictating, transcribing, and comparing content for accuracy as the document is collaboratively completed in parallel using telepsychology. For example, during the Initial Session CAMS assessment, the patient writes their ratings and qualitative responses and either simultaneously or just after will dictate their responses so the

therapist can complete their copy of the SSF. The therapist and patient then verify and affirm that the therapist's version is consistent with the patient's intended responses. The SSF can thus be completed in the same amount of time as an in-person session. Reports from clinicians regarding this parallel completion of the SSF actually may *increase* rapport as this collaborative process becomes a joint endeavor and patients sometimes enjoy clarifying their responses for the therapist's version. Moreover, the repetition of information as it is being dictated, transcribed, double-checked and re-affirmed appears to increase the patient's retention of the information about their SSF assessment rating and key aspects of their CAMS Stabilization Plan as well as their driver-focused treatment plan. The clinician's version of the SSF serves as the official medical record progress note; the patient retains their copy for between-session reference (i.e., for therapeutic guidance and various resources in case of crisis).

Community mental health centers that have implemented CAMS using telepsychotherapy to remote rural clinic locations have anecdotally reported that patients often do not need to be hospitalized. Patients in turn are often relieved to learn that this suicide-focused treatment does not necessarily require hospitalization, and they may therefore be more motivated and engaged in participating in an outpatient suicide prevention within telepsychotherapy use of CAMS. A pilot study is now underway with a community mental health center in an intermountain western state in the United States with patients in remote rural and frontier locations. Early feasibility use of telepsychotherapy use of CAMS has thus far revealed a reduced need for hospitalization. In addition, the number of sessions to achieve CAMS resolution is comparable to results from randomized controlled studies of CAMS using in person standard use of CAMS. It should be noted that within standard CAMS there is an overt goal of trying to work with a suicidal patient

safely on an *outpatient* basis if at all possible. Within the mindset and philosophy of CAMS-guided care, inpatient care should be the last possible response versus the first response.

Finally, in a university-based psychology clinic there has been clear success in the telepsychotherapy use of CAMS wherein suicidal patients are effectively engaged in their homes. The preliminary outcomes from the telepsychotherapy use of CAMS have shown that no hospitalizations have been required since initiation of CAMS using telepsychotherapy within this university-based clinic. Though clinicians may feel hesitant to use CAMS in telepsychotherapy modality with patients in their homes, thus far anecdotal clinical use of CAMS telepsychotherapy is very promising no matter where the patient is located. Indeed, a clinician in this setting noted that one of their best CAMS sessions to date occurred with an on-going patient who was located in her study with her beloved dog in her lap. While we may assume that something is lost within telepsychotherapy, our experience thus far suggests that there may be unexpected gains as well.

Real Time Response to Provide Telepsychotherapy Resources

As the COVID-19 virus transmission in the United States began increasing exponentially in mid-March and early-April 2020, CAMS-care (a limited liability company that provides CAMS-oriented professional training and consultation), moved to quickly to provide *free* resources and guidance for providing CAMS through a telepsychotherapy modality. Starting the week of March 15, initial brief videos were posted to the company's website (www.cams-care.com) discussing the need for telepsychotherapy in times of physical distancing in order to flatten the curve of coronavirus transmission. As state and local governments ordered citizens to stay at home and maintain physical distance, mental health care professionals were abruptly thrust into an uncertain professional position wherein perforce they needed to provide alternatives to face-to-face in-office care. Moreover, specific to suicide risk, the prospect of

sending a suicidal patient to an emergency department was now suddenly problematic as ED resources were so desperately needed for COVID-19 patients that quickly overwhelmed the U.S. healthcare system. Beyond two brief overview videos on the telepsychotherapy use of CAMS, an entire webpage dedicated to the topic was quickly posted on the website. The website page provided various telepsychotherapy resources that could be downloaded for clinical use, including an American Psychological Association (APA, 2013) overview checklist for doing telepsychotherapy, an APA-generated informed consent template for doing telepsychotherapy, a protocol for using CAMS within a telepsychotherapy modality, and a CAMS Quick Reference Guide. A major emphasis in this guidance was on the importance of thorough preparation and the need for comprehensive and thoughtful informed consent, particularly related to laws about clear and imminent danger to self (and others) and the duty of licensed mental health professionals to protect patients therein. To be sure, these are thorny issues in general made even more complex and challenging within a global pandemic.

Beyond practical resources and guidance, four free video conference presentations were offered to interested providers to help facilitate their use of CAMS within our new pandemic reality. Two initial hour-long presentations about telepsychotherapy and CAMS were offered on the teleconference platform “Zoom” during the week of March 23, 2020; two additional talks were held the following week of March 30, 2020. There were 458 registrants (from five countries) seeking access to the first Zoom presentation; another 382 applicants from around the world tried to register for the second presentation that week. Since our Zoom account is limited to 300 participants, recordings of these talks were made and posted (along with PowerPoint slides) for free on the website (and it is worth noting that these materials have been downloaded almost 1300 times at the time of this writing). A more specialized Zoom presentation on the

topic of “Treating Suicidal College Students Using Telepsychotherapy: A CAMS Approach” generated a tremendous amount of interest with registration quickly meeting the 300 person limit the first day it was available; an additional 383 interested providers were unable to register but were routed to the website for free access to the recorded presentation video and slides later the same day. Needless to say, there is an apparent worldwide demand for guidance and resources as to how to appropriately use suicide-focused care within a telepsychotherapy modality.

It should be further noted that beyond our multi-focused response to provide resources to providers for the telepsychotherapy use of CAMS with suicidal patients, other suicide prevention colleagues in the field have also endeavored to provide additional resources as well. For example, Dr. Barbara Stanley at the Center for Practice Innovations at Columbia Psychiatry and the New York State Psychiatric Institute developed a 3-page handout entitled “Telehealth Tips: Managing Suicidal Clients During the COVID-19 Pandemic” <https://practiceinnovations.org/I-want-to-learn-about/Suicide-Prevention>. This useful guide talks about adaptations for assessment and management of suicidal patients emphasizing the use of Safety Planning. From the Dialectical Behavior Therapy (DBT) perspective, Dr. Shireen Rizvi at Rutgers University developed “DBT Crisis Survival Skills” and posted these videos to YouTube for anyone to access (<https://www.youtube.com/watch?v=seKJvjCiT4w>). This interesting series of videos provides an overview to learn about effective DBT Skills (e.g., “Wise Mind,” “IMPROVE,” and “PLEASE”). These skills are valuable evidence-based techniques that can be used to help deal with any crisis, which certainly applies to the COVID-19 global pandemic (as Dr. Rizvi notes in her narration). Similarly, another DBT expert, Dr. Ursula Whiteside, offers free resources and guidance on her website: <https://www.nowmattersnow.org/skills>. The National Suicide Prevention Lifeline (1-800-273-TALK) and the Crisis Text Line (<https://www.crisistextline.org/>)

are both excellent resources for suicidal people in crisis. Finally, there is an outstanding book that is thoughtfully written for suicidal people called *Choosing to Live: How to Defeat Suicide Through Cognitive Therapy* by Ellis and Newman (1996) that is a superb resource as well.

Given increased anxiety, uncertainty, and disruption to life caused by the COVID-19 pandemic, there is a need for many more resources for managing mental health issues. This is particularly true for suicidal people for whom the pandemic may increase despair and hopelessness further fueling suicidal thoughts and behaviors. While the various resources noted here will undoubtedly help those who struggle, to our knowledge the use of CAMS within a telepsychotherapy modality is the only suicide-focused evidence-based clinical *treatment* being offered to help save lives from suicide in the midst of the worldwide coronavirus pandemic.

Conclusion

Suicide is a major public health concern as a leading cause of death in the United States and around the world; millions of Americans struggle with serious suicidal thoughts each year. In the spring of 2020, the COVID-19 pandemic created a sudden and urgent need to provide effective mental health care services that can accommodate the public health need for physical distancing and reducing face-to-face exposure so as to avert possible transmission of the highly contagious and deadly coronavirus. Mental health providers have perforce been compelled to rapidly embrace the use of online technologies to provide mental health care services through various telepsychotherapy modalities. While there is a general need to provide services for a range of mental health concerns, the need for potentially life-saving care is even more urgent with people who are suicidal. As a general matter, telepsychotherapy care of suicidal patients can be challenging given the increased risk of managing a patient who is in a remote location. The COVID-19 pandemic has also created a whole new set of ethical/clinical challenges around the

routine practice of routing a suicidal person to an emergency department or inpatient unit for a psychiatric admission. The potential risk of transmission and/or exposure to this highly contagious and deadly novel coronavirus makes this routine practice potentially dubious.

The Collaborative Assessment and Management of Suicidality (CAMS) has been developed to provide an effective clinical response to the challenges of suicidal risk. CAMS is an evidence-based clinical framework for providing effective suicide-focused care that is supported by five randomized controlled trials. CAMS is designed to build a strong therapeutic alliance while increasing motivation in the patient to save their life. CAMS-guided treatment targets patient-articulated problems that compel them to consider suicide (i.e., suicidal “drivers”) which can be effectively treated with a range of clinical techniques across theoretical orientations (e.g., CBT, insight-oriented work, behavior activation, etc.). Prior to the COVID-19 pandemic, there was a growing use of CAMS using telepsychotherapy with active duty Soldiers, suicidal outpatients in rural communities, and suicidal Veterans.

In response to the sudden need to provide telepsychotherapy services our training company quickly developed and offered free resources, clinical guidance, and synchronous and asynchronous access to on-line presentations to hundreds of mental health providers around the world. The demand for this information has been striking; mental health providers worldwide are urgently seeking effective ways to work with suicidal risk within a physical distancing pandemic reality. It is encouraging to note that other resources are being made available to help support mental health professionals and suicidal people themselves including the use of Safety Planning and DBT Skills. Considering the scope of the challenge at hand, even more resources are needed.

COVID-19 has killed thousands and destroyed lives and impacted economies worldwide; the actual magnitude of virus-related tragedies would have been utterly unimaginable in our pre-

pandemic world. But in the face of this pandemic we are being asked to profoundly change our behaviors to help flatten the curve of transmission for the greater good of all. However, even if we do these public health measures well, thousands of lives will still be lost. It is therefore up to us to not make the scourge of this virus a double tragedy. We already know that far too many will succumb to a deadly virus that we cannot yet treat. Yet there is an emerging knowledge and the means to potentially effectively treat suicidal people to avert further loss of life. It is our contention, that we can maintain physical distance, stay at home, and not expose ourselves or our patients to increased risk of a viral transmission while we simultaneously provide effective care to suicidal people. As a worldwide mental health workforce, we therefore need to mobilize, innovate, and think outside the box—and perhaps outside our comfort zones—for the greater good so that evidence-based care can be safely and effectively provided to help save lives.

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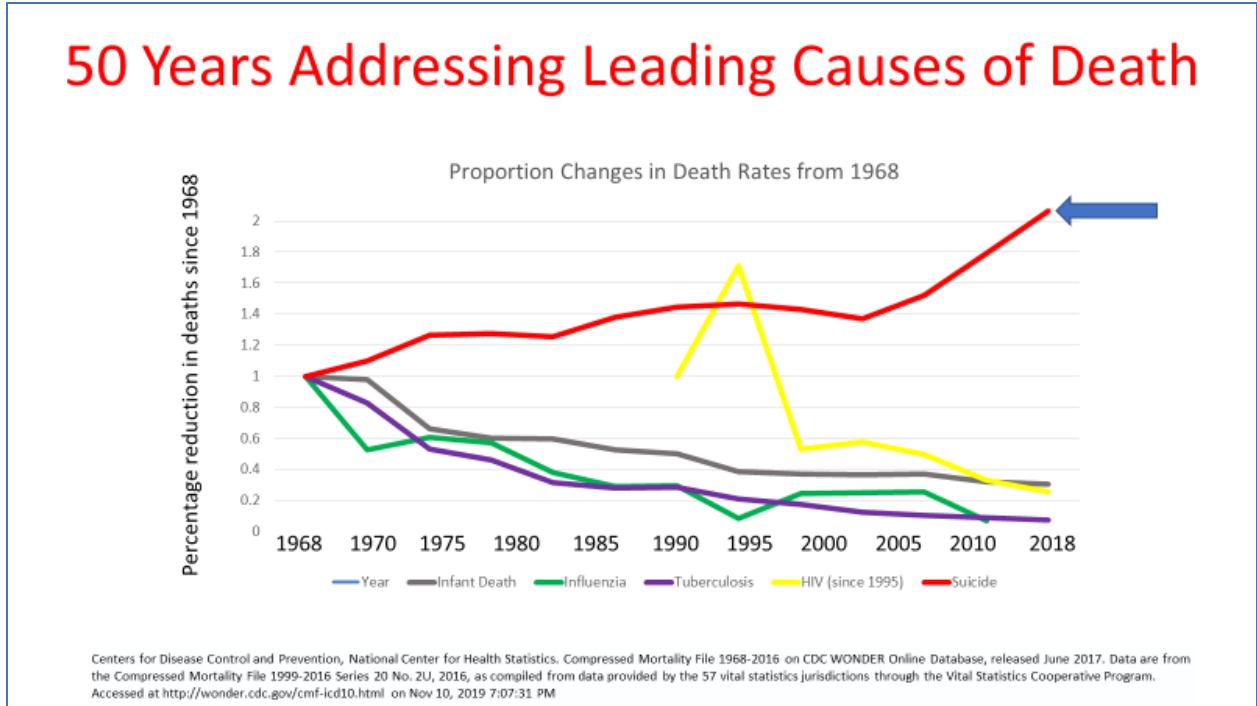


Figure 1. Rates of leading causes of death in the United States from 1968 to 2018.

CAMS Suicide Status Form Initial Session

Patient: Kevin Clinician: David Jobs Date: 6/23 Time: noon

Section A (Patient):

Rate and fill out each item according to how you feel right now. 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):
 Rank: 3 Low pain: 1 2 3 4 5 High pain

What I find most painful is: being stuck in my own skin

2) RATE STRESS (your general feeling of being pressured or overwhelmed):
 Rank: 5 Low stress: 1 2 3 4 5 High stress

What I find most stressful is: being here

3) RATE AGITATION (emotional urgency, feeling that you need to take action; not irritation; not annoyance):
 Rank: 4 Low agitation: 1 2 3 4 5 High agitation

I most need to take action when: someone does something untrustworthy

4) RATE HOPELESSNESS (your expectation that things will not get better no matter what you do):
 Rank: 1/5 Low hopelessness: 1 2 3 4 5 High hopelessness

I am most hopeless about: anything changing

5) RATE SELF-HATE (your general feeling of disliking yourself; having no self-esteem; having no self-respect):
 Rank: 1 Low self-hate: 1 2 3 4 5 High self-hate

What I hate most about myself is: everything

6) RATE OVERALL RISK OF SUICIDE:
 Rank: N/A Extremely low risk: 1 2 3 4 5 Extremely high risk: 1 2 3 4 5

1) How much is being suicidal related to thoughts and feelings about yourself? Not at all: 1 2 3 4 5 : completely
 2) How much is being suicidal related to thoughts and feelings about others? 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
3	my mom	1	people don't get it / they don't care
2	maybe something will get better	3	nothing is going to change
1	See how "Breaking Bad" ends	4	I don't contribute to society
		1	people would be better off if I was dead

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: MB flash thing on everyone and then myself

CAMS Suicide Status Form Initial Session

Section B (Clinician):

Suicide ideation Describe: I think about it a lot since 7
 Frequency: per day per week per month all the time
 Duration: seconds minutes hours

Suicide plan When: At home before GF comes home
 Where: At home
 How: knife Access to means:
 How: Belt Access to means:

Suicide preparation Describe: think about death scene, tried out belt

Suicide rehearsal Describe: Put belt around neck

History of suicidal behaviors
 Single attempt Describe: _____
 Multiple attempts Describe: Bx hanging

Impulsivity Describe: GF says yes

Substance abuse Describe: _____
 Significant loss Describe: _____

Relationship problems Describe: GF/GF's mom/mother

Burden to others Describe: _____

Health/pain problems Describe: _____

Sleep problems Describe: Only sleeps 3-4 hours a night

Legal/financial issues Describe: _____

Shame Describe: everything

Section C (Clinician): TREATMENT PLAN (Refer to Sections A & B)

Problem #	Problem Description	Goals and Objectives	Interventions	Duration
1	Self-Harm Potential	Safety and Stability	Stabilization Plan Completed <input checked="" type="checkbox"/>	3 months
2	Self-hate	↓ self-hate	Insight 4tx BA Voc counseling	3 months
3	People don't get it / Betrayal	Find ways to help others get it increase trust	Psychodynamic tx CBT BA CT?	3 months

YES NO Patient understands and concurs with treatment plan?
 YES NO Patient at imminent danger of suicide (hospitalization indicated)?
 Patient Signature: Kevin Clinician Signature: David

CAMS Suicide Status Form STABILIZATION PLAN

Ways to reduce access to lethal means:

- Conversation with girlfriend about knife
- Remove the belt
- _____

Things I can do to cope differently when I am in a suicide crisis (consider crisis card):

- Exercise
- Watch "Breaking Bad"
- Write in journal
- Read "Choosing to Live"
- Walk to local Best Buy

Life or death emergency contact number: 555-750-1093
1-800-273-TALK

People I can call for help or to decrease my isolation:

TBD (1) _____
 (2) _____
 (3) _____

Attending treatment as scheduled:

Potential Barrier: _____ Solutions I will try:
 1. N/A
 2. _____

Section D (Clinician Post-Session Evaluation):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS: OTHER: BROWSY LETHARGIC STUPOROUS

ORIENTED TO: REASON FOR EVALUATION: _____

MOOD: ELEVATED DEGRADED ANGRY

AFFECT: FLAT BLUNTED CONSTRICTED APPROPRIATE LABILE

THOUGHT CONTINUITY: CLEAR & COHERENT GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL

THOUGHT CONTENT: OTHER: _____
 OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS MORBIDITY

ABSTRACTION: OTHER: _____
 NOTABLY CONCRETE

SPEECH: OTHER: _____
 RAPID SLOW SLURRED IMPOVERISHED INCOHERENT

MEMORY: OTHER: _____
 GRASPING INSTANT

REALITY TESTING: OTHER: _____
 WILD

NOTABLE BEHAVIORAL OBSERVATIONS: _____

DIAGNOSTIC IMPRESSIONS/DIAGNOSIS (DSM/ICD DIAGNOSES):
Deferred - R/o Major Depression

PATIENT'S OVERALL SUICIDE RISK LEVEL (check one and explain):

LOW (WTL/RFL) Explanation: _____
 MODERATE (AMB) Multiple attempt history, high SSF score, assessment ratings, long history of suicidal ideation - but willing to try CAMS for 3 months
 HIGH (WTD/RFD)

CASE NOTES:
Kevin is a 32 year old white male who is unemployed and living with his girlfriend at her mom's house. He is isolated, hopeless and hates himself. He has few resources and limited coping skills. But he is verbal and somewhat intrigued by the treatment being offered. He reports high risk, but based on compliance and CAMS stabilization plan, can be managed on an outpatient basis.
 Next Appointment Scheduled: Thurs Treatment Modality: Individual, insight + CBT

Clinician Signature: David Date: 6/23

Figure 2. Case example of the first session version of the CAMS Suicide Status Form.