Patient and Provider Outcomes of e-Learning Training in Collaborative Assessment and Management of Suicidality (CAMS)

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Acknowledgements

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- Disclaimer: The contents of this presentation do not represent the views of the Department of Veterans Affairs or the United States Government.

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Objectives

- To describe an HSR&D funded study of VA provider and Veteran outcomes of e-Learning training
- To describe empirical support and use of a systematic method for managing suicidality, the Collaborative Assessment and Management of Suicidality (CAMS)
- To describe nurse-led initiatives, implementation, and collaboration in VA suicide prevention
- To identify opportunities for nursing collaboration, training, and leadership in suicide prevention
Suicide in the US

- Suicide is the 10th leading cause of death and 2nd leading for young (15-24)
  - 44,193 suicides in the U.S. (rate 13.8%)
  - Males: 33,994 (rate 21.5%)
  - Whites 39,796 (rate 15.8%)
  - Midlife (45-64): 16,490 (rate 19.6%)
  - One suicide every 11.9 minutes

- Homicide is the 16th leading cause
  - 2 victims of homicide for every 3 suicides

- Twice as many deaths are due to suicide than due to HIV/AIDS

- 1.4 million suicide attempts per year
  - 25 attempts:1 completion
  - Youth 100-200:1
  - Elderly 4:1
  - 4 females:3 males

Highest rates
- Whites
- Men
- Midlife
- Young
- Elderly
- W/Firearms

and Veteran Subgroups

AAS, 2015
VHA has identified suicide in Veterans as priority area

The risk for suicide in Veterans is:
- Higher than non-Veterans
- Higher for younger Women Veterans
- Higher for rural than urban Veterans
- Higher for Veterans receiving services outside the VA
- Highest for subgroups of Veterans with depression, psychiatric treatment, and medication change

Risk in military populations is highest in Army and the Marines

Shoenbaum et al., 2009; Valenstein et al., 2009
VA EBP Synthesis on Suicide Risk & Tools

- 3 updates, underscored methodological weaknesses

- 37 studies of suicide
  - Veteran suicide accounts for 20% of all suicides
  - Veteran suicide increased between 2000-2010
  - Rates in female Veterans are increasing

- Risk and tools
  - Not clear evidence for clinical risk assessment
  - Suicide Potential Index high sensitivity/specificity
  - Army STARRS study risk algorithm
  - Brief CBT for active duty & DBT for women
  - Computer-assisted Implicit Association Test

Helson et al., DVA, 2015
Trends in the Suicide Prevention Field for Clinician Scientists

- Midlife men (45-64 years) have the highest suicide rate (19.6%)
- Determining level of risk does not predict death by suicide
- Nock is opening new frontiers in technology and intervention
- rTrans Magnetic Stimulation (TMS) may reduce suicidality
- Care for suicidality costs $40 billion per year

DID YOU KNOW?

AAS, 2015; Pisani et al., 2016
Exemplars: Suicide Prevention Policy

- 2012 National Strategy for Suicide Prevention
- Clinical Task Force
- SAMSHA National Assessing and Managing Suicide Risk Competencies/Curriculum
- Federal Officers in SAMSHA, NIMH, CDC, VA for suicide
- Suicide Prevention Resource Center (SPRC)
- Garrett Smith state grants
- DOD/VA strategic plans/systematic reviews
- Suicide Research Agenda
- The Joint Commission

Bagley et al., 2010; HHS, 2014; The Joint Commission, 2016; Shoenbaum et al., 2009
Veteran-Specific Suicide Prevention

Janet A. York · Dorian A. Lamis · Charlene A. Pope · Leonard E. Egede

Abstract  Suicide rates have been increasing in some subgroups of Veteran populations, such as those who have experienced combat. Several initiatives are addressing this critical need and the Department of Veterans Affairs (VA) has been recognized for its leadership. This integrative review adopts the Research Impact Framework (RIM) to address suicide-specific prevention activities targeting Veterans. The RIM is a standardized approach for developing issue narratives using four broad areas: societal-related impacts, research-related impacts, policy-related impacts, and service-related impacts. The questions addressed in this review are: (1) What are the major initiatives in Veteran-specific suicide prevention in four areas of impact—society, research, policy, and services? (2) Are there gaps related in each impact area? and (3) What are the implications of this narrative for other strategies to address suicide prevention targeting Veterans? Systematic application of the RIM identifies exemplars, milestones, gaps, and health disparity issues.

Keywords  Suicide · Veterans · Suicide prevention

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VA Suicide Prevention Strategy

- VA Strategy for Suicide Prevention
- Suicide Prevention Coordinators
- Crisis Line, press 1 for Veteran
- Environmental Safety
  - MHEOCC, environmental rounds
  - Anti-ligature slanted doors
- VA tools and computerized record templates
  - Suicide Behavior Report
  - VA Suicide Risk Assessment Guide

Bagian et al., 2002; Stanley & Brown, 2008; Mills et al., 2011; Schoenbaum et al., 2009
VA Suicide Prevention Strategy (cont.)

- **Patient Risk Flag (PRF)**
  - 30-90 days Enhanced Care Services-7 days, weekly
  - VA Safety Plan template
  - High Risk IP Discharge Meeting
  - Suicide-specific discharge planning

- **Root Cause Analysis-adverse events, close calls**
  - Peer reviews, Behavioral Autopsy, Aggregate Review
  - National Center for Patient Safety

- **Nomenclature, Clinical Tool**

- **Computer algorithm to identify at risk Veterans from CPRS analysis of risk/ protective factors & provide services**
## Self-Directed Violence

<table>
<thead>
<tr>
<th>Type</th>
<th>Sub-Type</th>
<th>Definition</th>
<th>Modifiers</th>
<th>Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Thoughts</strong></td>
<td>Non-Suicidal Self-Directed Violence Ideation</td>
<td>Self-reported thoughts regarding a person's desire to engage in self-inflicted potentially injurious behavior. There is no evidence of suicidal intent. For example, persons engage in Non-Suicidal Self-Directed Violence Ideation in order to attain some other end (e.g., to seek help, regulate negative mood, punish others, to receive attention).</td>
<td>N/A</td>
<td>Non-Suicidal Self-Directed Violence Ideation</td>
</tr>
<tr>
<td></td>
<td>Suicidal Ideation</td>
<td>Thoughts of engaging in suicide-related behavior. For example, intrusive thoughts of suicide without the wish to die would be classified as Suicidal Ideation, Without Intent.</td>
<td></td>
<td>Suicidal Ideation, Without Suicidal Intent</td>
</tr>
<tr>
<td></td>
<td>Preparatory</td>
<td>Acts or preparation towards engaging in Self-Directed Violence, but before potential for injury has begun. This can include anything beyond a verbalization or thought, such as assembling a method (e.g., buying a gun, collecting pills) or preparing for one's death by suicide (e.g., writing a suicide note, giving things away). For example, hoarding medication for the purpose of overdosing would be classified as Suicidal Self-Directed Violence, Preparatory.</td>
<td></td>
<td>Non-Suicidal Self-Directed Violence, Preparatory</td>
</tr>
<tr>
<td></td>
<td>Non-Suicidal Self-Directed Violence</td>
<td>Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is no evidence, whether implicit or explicit, of suicidal intent. For example, persons engage in Non-Suicidal Self-Directed Violence in order to attain some other end (e.g., to seek help, regulate negative mood, punish others, to receive attention).</td>
<td></td>
<td>Non-Suicidal Self-Directed Violence, Without Injury</td>
</tr>
<tr>
<td></td>
<td>Undetermined Self-Directed Violence</td>
<td>Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. Suicidal intent is unclear based upon the available evidence. For example, the person is unable to admit positively to the intent to die (e.g., unconsciousness, incapacitation, intoxication, acute psychosis, disorientation, or death); OR the person is reluctant to admit positively to the intent to die for other or unknown reasons.</td>
<td></td>
<td>Undetermined Self-Directed Violence, Without Injury</td>
</tr>
<tr>
<td></td>
<td>Suicidal Self-Directed Violence</td>
<td>Behavior that is self-directed and deliberately results in injury or the potential for injury to oneself. There is evidence, whether implicit or explicit, of suicidal intent. For example, a person with the wish to die cutting her wrists with a knife would be classified as Suicide Attempt, With Injury.</td>
<td></td>
<td>Suicide Attempt, Without Injury</td>
</tr>
</tbody>
</table>

Brenner et al., 2011
Patient & Provider Outcomes of e-Learning Training in CAMS

- HSR&D funded, 2010-2014, part of REAP (Veteran disparities research, Egede)

- Interprofessional Study Team
  - Janet York & Kathryn Magruder (Co-I’s)
  - Elizabeth Marshall & Mark L. DeSantis (SPC)
  - Rebecca Knapp & Derik Yeager
  - David A. Jobes
  - Lisa Sternke & Charlene Pope & Louisa Burris (nurse researchers)
  - Mary Mauldin & Stan Sulkowski (education/technology)
  - Ron Acierno (Assoc Dean Nsg Res) & Ken Ruggerio (VA researchers)
  - SPC’s in 4 other sites
The Collaborative Assessment & Management of Suicidality

Managing Suicidal Risk
A Collaborative Approach

David A. Jobes
Foreword by Marsha M. Linehan

CAMS assessment uses the Suicide Status Form (SSF) as a means of deconstructing the "functional" utility of suicidality; CAMS as an intervention emphasizes a problem-focused intensive outpatient approach that is suicide-specific and "co-authored" with the patient.
What is CAMS?

- CAMS is a suicide-specific therapeutic framework, emphasizing five core components of collaborative clinical care (over 10-12 sessions/3 months)
  - Collaborative Assessment of Suicidal Risk
  - Collaborative Treatment Planning
  - Collaborative Deconstruction of Suicidogenic Problems
  - Collaborative Problem-Focused Interventions
  - Collaborative Development of Reasons for Living

- Goal of CAMS:

  To provide a novel, comprehensive, multidisciplinary clinical assessment, treatment planning, and clinical management approach for reducing suicidal thoughts, feelings, and behaviors in outpatient settings.

Jobes, 2016
Why CAMS?

- Over 25 years of studies supporting feasibility & clinical use of CAMS & SSF tool with suicidal outpatients
  - 6 RCT, 7 nonrandomized, 1 inpatient & 2 training studies, others in process
  - VA, DOD, Menninger’s, Harborview, & international trials,

- Recommended in systematic reviews for military persons, Veterans and other clinical populations, also JACHO

- Core multipurpose risk assessment (SSF4)

- Roadmap for guiding the clinician and patient

- The VA has purchased SSF & developing templates for computerized patient record & e-CAMS for training on TMS

- Fit with Affordable Health Care
Suicide Status Form (SSF-4)

- 8 page form
- Collaborative and Interactive (side by side and pass clipboard)
  - Initial session (Assessment, Treatment Planning)
  - Tracking/Update Interim Sessions
  - Outcome/Disposition Final Session

Jobes, 2016
1. Refine a CAMS e-learning course that covers the same material and meets the same learning objectives of CAMS in-person training

2. Compare the effectiveness of the CAMS e-learning, the CAMS in-person modality, and non-CAMS training control in terms of provider evaluation and behavior

3. Compare the effectiveness of the CAMS e-learning, the CAMS in-person delivery, and non-CAMS training control in terms of patient outcomes

4. Assess factors that facilitate or inhibit adoption of CAMS through e-learning or in-person

**HYPOTHESES**

Equivalence for CAMS conditions
Superiority for CAMS conditions over no-intervention control
Implementation: Create e-Learning Platform

Keith

- OEF/OIF returning Veteran
- Trauma exposure during war
- 31 years old
- Alcohol abuse
- Married
- Marital distress
- Catholic
- Isolation
Session 8: Setback
Keith reveals a serious setback which he and Dave explore
Methods

- Pilot w/10 MH providers (Aim 1)

- 3 arm RCT w/ provider & patient follow-up (Aims 2 & 3)
  - CAMS in-person plus coaching & manual
  - CAMS e-learning plus coaching & manual
  - No suicide training & ED psychiatry text

- Formative evaluation using RE-AIM framework (Aim 4)
Eligibility to Participate

- Outpatient mental health provider
  - Psychiatrist
  - Psychologist
  - APRN
  - Social Worker
  - PA
  - Case Manager

- No previous CAMS training
Randomization

<table>
<thead>
<tr>
<th>Site</th>
<th>Charleston</th>
<th>Atlanta</th>
<th>Tuscaloosa</th>
<th>Augusta</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of providers randomized N = 268</td>
<td>67</td>
<td>67</td>
<td>67</td>
<td>67</td>
</tr>
<tr>
<td>10% Provider drop out N = 240</td>
<td>20 22 23</td>
<td>20 22 23</td>
<td>20 22 23</td>
<td>20 22 23</td>
</tr>
<tr>
<td>Two high risk pts per provider (est.) N = 480</td>
<td>40 40 40</td>
<td>40 40 40</td>
<td>40 40 40</td>
<td>40 40 40</td>
</tr>
</tbody>
</table>

We estimate that 240 providers will contribute two high risk patients each, for a total of 480 patients across three equal-sized treatment arms (n = 160 patients and 80 providers) as follows:

ARM₁ = CAMS (In person); n = 160 patients and 80 providers.
ARM₂ = CAMS (E-learning); n = 160 patients and 80 providers.
ARM₃ = non-intervention (Control); n = 160 patients and 80 providers.
### Characteristics of Providers Randomized to Training

<table>
<thead>
<tr>
<th>Characteristics</th>
<th>e-Learning (n=69)</th>
<th>In-person (n=70)</th>
<th>Total (n=139)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age (n, %)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>&lt;50</td>
<td>39 (56.5 %)</td>
<td>41 (58.6 %)</td>
<td>80 (57.6 %)</td>
</tr>
<tr>
<td>≥50</td>
<td>30 (43.5 %)</td>
<td>29 (41.4 %)</td>
<td>59 (42.4 %)</td>
</tr>
<tr>
<td><strong>Gender (n, %)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>20 (29.0 %)</td>
<td>23 (32.9 %)</td>
<td>43 (30.9 %)</td>
</tr>
<tr>
<td>Female</td>
<td>49 (71.0 %)</td>
<td>47 (67.1 %)</td>
<td>96 (69.1 %)</td>
</tr>
<tr>
<td><strong>Race (n, %)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Caucasian</td>
<td>45 (67.2 %)</td>
<td>45 (68.2 %)</td>
<td>90 (67.7 %)</td>
</tr>
<tr>
<td>African American</td>
<td>19 (28.4 %)</td>
<td>15 (22.7 %)</td>
<td>34 (25.6 %)</td>
</tr>
<tr>
<td>Hispanic</td>
<td>2 (3.0 %)</td>
<td>0 (0.0 %)</td>
<td>2 (1.5 %)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (1.5 %)</td>
<td>6 (9.1 %)</td>
<td>7 (5.3 %)</td>
</tr>
<tr>
<td><strong>Profession (n, %)</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatrist</td>
<td>12 (17.4 %)</td>
<td>12 (17.1 %)</td>
<td>24 (17.3 %)</td>
</tr>
<tr>
<td>Psychologist</td>
<td>13 (18.8 %)</td>
<td>16 (22.9 %)</td>
<td>29 (20.9 %)</td>
</tr>
<tr>
<td>Midlevel provider</td>
<td>44 (63.8 %)</td>
<td>42 (60.0 %)</td>
<td>86 (61.9 %)</td>
</tr>
</tbody>
</table>

**Completed pre-survey**

*Participants ≥50 group would have 20+ years of clinical experience*
Implementation of Online Suicide-Specific Training for VA Providers

Elizabeth Marshall • Janet York • Kathryn Magruder • Derek Yeager • Rebecca Knapp • Mark L. De Santis • Louisa Burriss • Mary Mauldin • Stan Sułkowski • Charlene Pope • David A. Jobes

Abstract

Objective Due to the gap in suicide-specific intervention training for mental health students and professionals, e-learning is one solution to improving provider skills in the Veterans Affairs (VA) health system. This study focused on the development and evaluation of an equivalent e-learning alternative to the Collaborative Assessment and Management of Suicidality (CAMS) in-person training approach at a Veteran Health Affairs medical center.

Methods The study used a multicenter, randomized, cluster, and three group design. The development of e-CAMS was an iterative process and included pilot testing. Eligible and consenting mental health providers, who completed a CAMS pre-survey, were randomized. Provider satisfaction was assessed using the standard VA evaluation of training consisting of 20 items. Two post training focus groups, divided by learning conditions, were conducted to assess practice adoption using a protocol focused on experiences with training and delivery of CAMS.

Results A total of 215 providers in five sites were randomized to three conditions: 69 to e-learning, 70 to in-person, 76 to the control. The providers were primarily female, Caucasian, midlife providers. Based on frequency scores of satisfaction items, both learning groups rated the trainings positively. In focus groups representing divided by learning conditions, participants described positive reactions to CAMS training and similar individual and institutional barriers to full implementation of CAMS.

Conclusions This is the first evaluation study of a suicide-specific e-learning training within the VA. The e-CAMS appears equivalent to the in-person CAMS in terms of provider satisfaction with training and practice adoption, consistent with other comparisons of training deliveries across specialty areas. Additional evaluation of provider confidence and adoption and patient outcomes is in progress. The e-CAMS has the potential to provide ongoing training for VA and military mental health providers and serve as a tutorial for psychiatrists in preparation for specialty boards.

Keywords Suicide • Intervention training • Mental health students • Mental health residents • Veteran Health Affairs medical center

Received: 27 August 2013 / Accepted: 9 January 2014 © Academic Psychiatry 2014
Background

Implementation process

Sample: 215 randomized providers (female, White, <50, psychologists)

Methods: VA Satisfaction Scale & Focus Group protocol, only treatment

Findings: Equivalency of e-learning and in person CAMs
  - Satisfaction with training
  - Practice adoption

Findings consistent with studies of training deliveries across other specialties (most predominantly depression training)
Fig. 1 Study flow chart

Study Flow Chart

Marshall et al., 2014
<table>
<thead>
<tr>
<th>Survey Question</th>
<th>Agree (%)</th>
<th>Neutral (%)</th>
<th>Disagree (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall</td>
<td>89.6 (93.6)</td>
<td>3.4 (4.3)</td>
<td>6.8 (2.1)</td>
</tr>
<tr>
<td>Learning</td>
<td>87.5 (92.3)</td>
<td>5.7 (3.9)</td>
<td>6.8 (3.9)</td>
</tr>
<tr>
<td>Content</td>
<td>88.9 (91.0)</td>
<td>3.2 (1.3)</td>
<td>7.9 (7.7)</td>
</tr>
<tr>
<td>Objectives</td>
<td>87.9 (90.3)</td>
<td>3.0 (0.0)</td>
<td>9.1 (9.7)</td>
</tr>
<tr>
<td>Job impact</td>
<td>75.0 (83.0)</td>
<td>15.0 (12.8)</td>
<td>10.0 (4.3)</td>
</tr>
<tr>
<td>Enablers &amp; barriers</td>
<td>70.0 (74.6)</td>
<td>23.3 (11.1)</td>
<td>6.6 (14.2)</td>
</tr>
<tr>
<td>Logistics</td>
<td>78.3 (70.9)</td>
<td>13.3 (21.0)</td>
<td>8.3 (8.0)</td>
</tr>
<tr>
<td>Environment</td>
<td>82.4 (87.8)</td>
<td>10.1 (7.7)</td>
<td>7.4 (4.5)</td>
</tr>
</tbody>
</table>
Manuscript #2

RCT evaluating provider outcomes by suicide prevention training modality: in-person vs. e-learning

Kathryn Marley Magruder, Janet Ann York, Rebecca G. Knapp, Derik Edward Yeager, Elizabeth Marshall and Mark DeSantis

Abstract

Purpose – The purpose of this paper is to evaluate provider outcomes in response to two modes of suicide prevention training (e-learning and in-person) and a control group. The Collaborative Assessment and Management of Suicidality (CAMS) was adapted for e-learning delivery to US Veterans Administration mental health providers. Outcomes include: self-evaluated beliefs, ability, and self-efficacy in managing suicidal patients.

Design/methodology/approach – This study used a multicenter, randomized, cluster design to test the effectiveness of e-learning vs. in-person conditions CAMS for changes in provider outcomes.

Findings – Survey scores showed significant improvements for both the e-learning vs control and the in-person vs control between pre-intervention and post-intervention; however, the e-learning and in-person conditions were not significantly different from each other.

Research limitations/implications – Limitations of the study include that there were drop-outs over the study period and the survey questions may not have captured all of the aspects of the CAMS training.

Practical implications – Results suggest that e-learning training modules can provide comparable outcomes to in-person training for suicide prevention.

Social implications – More providers may have accessible training materials for managing suicidal patients.

Originality/value – Currently practicing providers now can choose between two equivalent training modalities for improving the management of suicidality in their patients.

Keywords Suicide, e-Learning, CAMS, Intervention training, Suicide management, Suicide prevention training

Paper type Research paper

Magruder et al., 2016
Manuscript #2: Provider Outcomes

Research Questions
1. Is CAMS e-learning inferior or superior to CAMS in-person?
2. Are both CAMS treatment arms superior to control?

Corresponding Hypotheses
- There will be a difference in participants’ survey responses for the e-learning compared to the in-person training groups.
- Participants’ survey responses for the CAMS (e-learning and in-person) will be superior to those of the control treatment

Sample
- Same as Manuscript 1
- 2 intervention groups plus control

Measures
- CAMS Provider Survey- self report, baseline-modality preference, experience, demographics
- 11 items-beliefs, motivations, attitudes, competence, self-efficacy
- 3 intervals: T1-baseline, T2-post training, T3-3 months

Magruder et al., 2016
Analysis

- Descriptive statistics for the total and individual item scores (means, standard deviations, frequency distributions)
- Generalized Linear Mixed Models (GLMM) approach to model the longitudinal data

Findings

- T1 scores not significantly different in intervention groups, T2 scores significantly improved for treatment groups but differed from control
- Some items significant differences (e.g., belief about hospitalization, liability)
- T3 no significant differences except one item (e.g., hospitalization)

Conclusions

- No clear differences between the e-learning and in-person modalities, suggesting that either method could be used,
- Both need enhancements to boost and sustain knowledge, consistent with literature

Magruder et al., 2016
Manuscript #3: Patient Outcomes (in process)

Sample
- 176 Veterans on PRF treated with study provider within year of training
- 5 sites

Methods
- Chart review, Patient Outcome Form (e.g., military status, dxs, SSF, hx, episodes, PHQ, completion of therapy)
- Health services utilization (MHS, PC, ED), suicidal behavior, mortality

Analysis
- Multivariable modeling strategy, GLMM
- Hypothesis testing

Preliminary Findings
- Groups equivalent-male, White or Black, unmarried, enlisted, Army, disability
- No deaths by suicide, only one provider put SSF in CPRS
- Intervention groups equivalent in PO and differ from Control
Inpatient Suicide Prevention in our VAMC

Suicide-specific Safety in the Inpatient Psychiatric Unit

Mark L. De Santis, PsyD
Ralph H. Johnson VAMC, Mental Health Service Line, Charleston, South Carolina, USA

Hugh Myrick, MD
Medical University of South Carolina, Psychiatry and Behavioral Sciences, Charleston, South Carolina, USA

Dorian A. Lamis, PhD
Emory University School of Medicine, Atlanta, Georgia, USA

Christopher P. Pelic, MD, Collete Rhue, MS, RN, and Janet York, PhD, PMHCS, BC, FAAN
Ralph H. Johnson VAMC, Mental Health Service Line, Charleston, South Carolina, USA

In total, 75% of suicides reported to the Joint Commission as sentinel events since 1995, have occurred in psychiatric settings. Ensuring patient safety is one of the primary tasks of inpatient psychiatric units. A review of inpatient suicide-specific safety components, inclusive of incidence and risk; guidelines for evidence-based care; environmental safety; suicide risk assessment; milieu observation and monitoring; psychotherapeutic interventions; and documentation is provided. The Veterans Health Administration (VA) has been recognized as an exemplar system in suicide prevention. A VA inpatient psychiatric unit is used to illustrate the operationalization of a culture of suicide-specific safety. We conclude by describing preliminary unit outcomes and acknowledging limitations of suicide-specific inpatient care and gaps in the current inpatient practices and research on psychotherapeutic interventions, observation, and monitoring.
Hope Kits and CAMS

by Janet York, Ph.D., APRN, B.C., FAAN

The Collaborative Assessment and Management of Suicidality (CAMS) is a therapeutic framework that provides a structured approach to assess, treat, and track suicidal risk for optimal clinical outcomes (Jobes, 2006). The system encourages mental health providers to collaborate with patients and develop a shared understanding of suicidal risk that informs specific interventions and ensures safety and stability.

CAMS is consistent with the National Consensus Statement on Mental Health Recovery (2004) and eight of SAMHSA’s fundamental components of recovery: self-direction, individualized and person-centered, empowerment, non-linear, strengths-based, respect, responsibility, and hope.

At the Ralph H. Johnson VA Medical Center in Charleston, South Carolina, nurse leaders were involved in a clinical pilot called “Collaborative Nursing Clinic for Hope.” The intervention combined CAMS with Susan Gingerich and Kim Mueser’s Illness Management and Recovery (IMR) program to target suicide, recovery, homelessness, and frequent inpatient readmission. Programs were delivered in separate weekly inpatient groups.

The majority of our homeless veterans experience addiction and personality difficulties, which is why the veteran-specific IMR group focuses on substance abuse and behavior problems. Suicidality can be an expression of the desperation of survival on the streets, the panic of running out of money for the month, or the troubled socialization of peers. We believe feigning suicidality in the Emergency Department can be an indicator of this desperation and hopelessness. Hopelessness is a strong predictor of suicide, and building hope is an important part of CAMS treatment.

We learned many lessons from our veterans during the pilot. One that was particularly poignant emerged as the group leader prepared content for a CAMS group on hope. She faced several dilemmas designing the Hope Kits, as the materials had to comply with the unit’s environmental safety policies. Although the leader was quite taken with red, white, and blue wooden boxes from the Dollar Store, she considered the potential for mishandling (boxes could be used as weapons for self-inflicted pain or to harm others) as well as portability, thus selecting small envelopes with multicolored paper squares for the kits.

Next, she addressed a critical issue for homeless veterans: restricted access to their most cherished items. She developed instructions for the hope session that entailed writing an item’s name on one side and recording its whereabouts—“in storage,” “at my sister’s house.” “Lost but not forgotten”—on the other. For future sessions, we suggested taking a picture of the item with a cell phone. In the end, lessons learned related to safety, practicality, and empathy for the pain of losing treasured possessions. The collaborative process of CAMS not only enhances the recovery of our veterans, but also facilitates ongoing learning, cultural awareness, and creativity for providers in suicide-specific care.

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York et al., 2012
Psychiatric-Mental Health Nurse Essential Competencies for Assessment and Management of Individuals at Risk for Suicide

- Adapted from Suicide Prevention Resource Center & American Association of Suicidality, Assessing and Managing Suicide Risk: Core Competencies for Mental Health Professionals.

Endorsed by the APNA Board of Directors February 27, 2015

National Expert Review & Veteran consumer voice

Background manuscript (Puntil, York, Greene, et al., 2014)
On-line training + live role-playing + coaching calls = CAMS adherence

www.cams-care.com

Jobes, 2016
Conclusions

- CAMS is recommended by JACHO and other policy groups
- CAMS is a proven EBP
- CAMS SSF4 is available in VA CPRS
- CAMS approach consistent with nursing interventions
- VA MH APRN’s should be CAMS trained
- Nurse researchers can collaborate, disseminate, and study CAMS implementations

Jobes, 2016
References

CAMS


Suicide and Veterans


Suicide Prevention and VA Inpatient Care


Suicide & Technology


Policy Reports


Policy Reports (cont.)


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