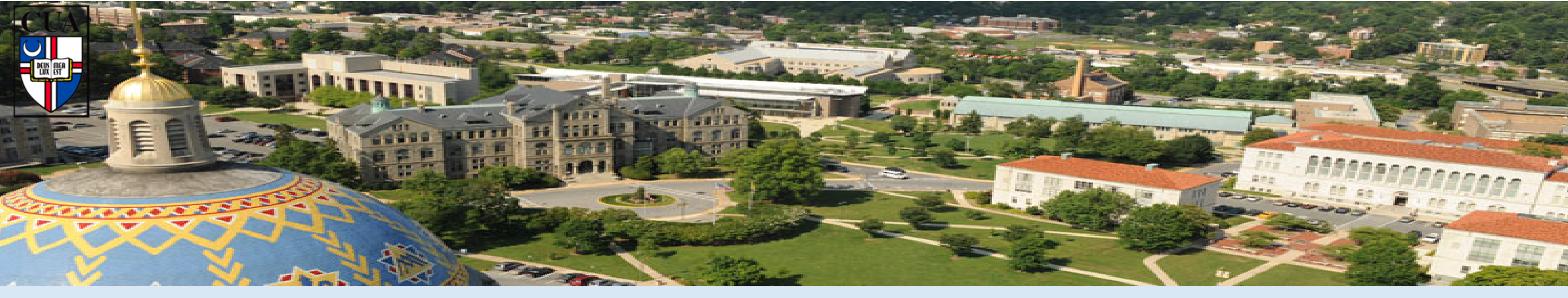

Telehealth and Suicide Safer Care (and the CAMS Approach)

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Professor of Psychology
Associate Director of Clinical Training
Director, Suicide Prevention Laboratory
The Catholic University of America

Vermont Program for Quality in Health Care Webinar
September 29, 2023

Disclosures

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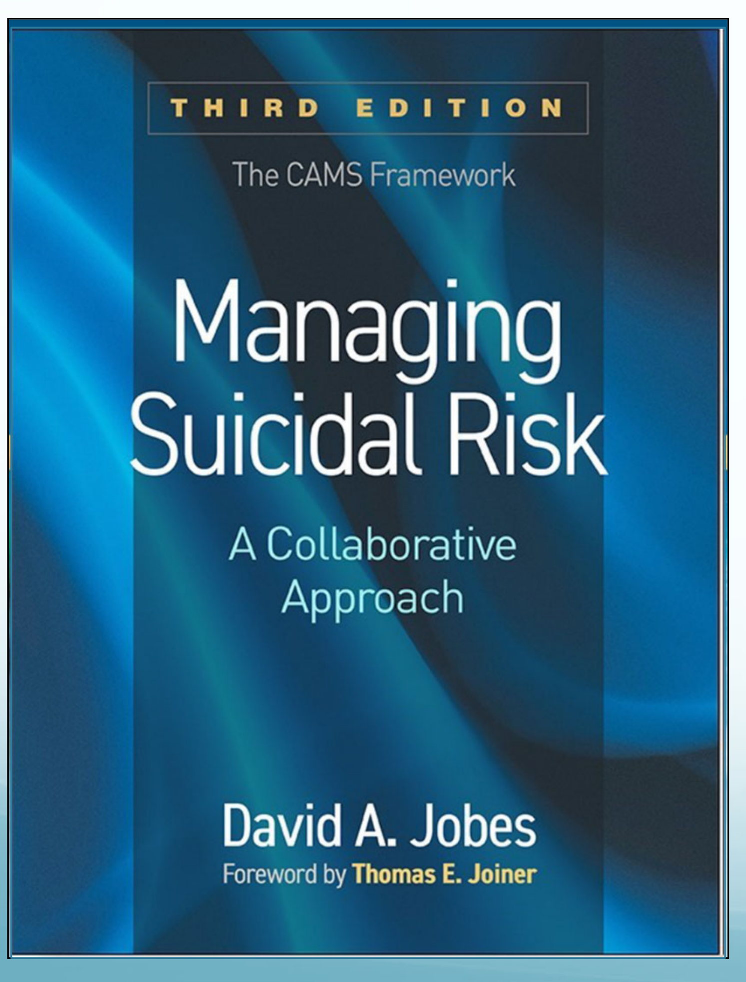
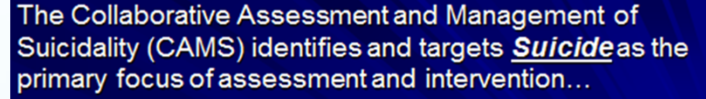
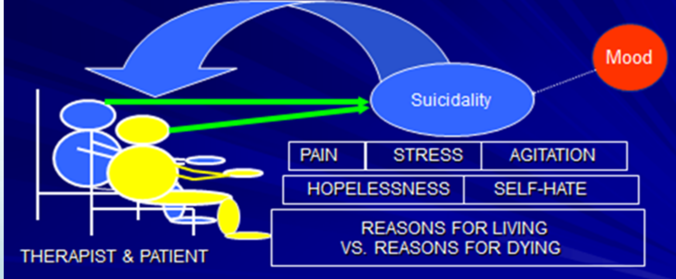
- Founder and Partner, CAMS-care, LLC (a professional training and consultation company)
- The views expressed in this presentation are those of the author and do not necessarily reflect the official policy of the Department of Defense, the Department of the Army, the US Army Medical Department, Veteran’s Affairs, or the United States Government.

The Collaborative Assessment and Management of Suicidality (CAMS)







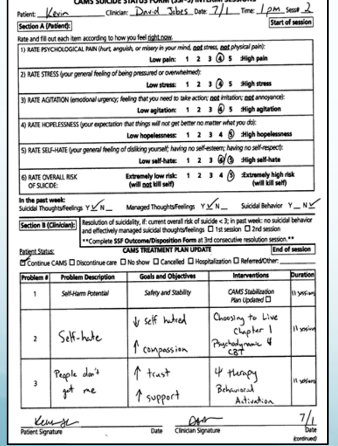
CAMS assessment uses the Suicide Status Form (SSF) as a means of deconstructing the "functional" utility of suicidality; CAMS as an intervention emphasizes a problem-focused intensive outpatient approach that is suicide-specific and "co-authored" with the patient…

The four pillars of the CAMS framework:

1) Empathy
2) Collaboration
3) Honesty
4) Suicide-focused

Goal: Build a strong therapeutic alliance that increases patient-motivation; CAMS targets and treats *patient-defined* suicidal "drivers"

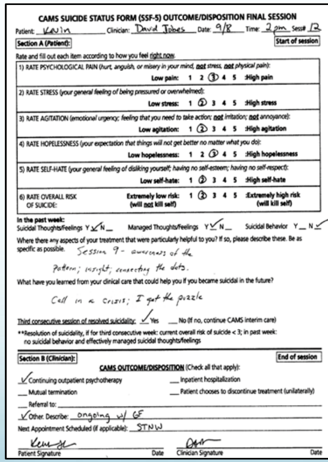
First session of CAMS—SSF-5 Assessment, Stabilization Planning, Driver-Focused Treatment Planning, and HIPAA Documentation



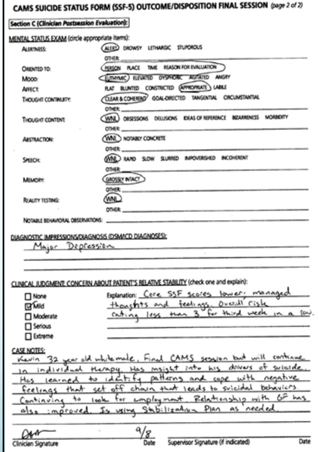
CAMS SUICIDE STATUS FORM (SSF-5) INTERIM SESSIONS

CAMS SUICIDE STATUS FORM (SSF-5) INTERIM SESSIONS (page 2 of 2)

CAMS Interim Sessions

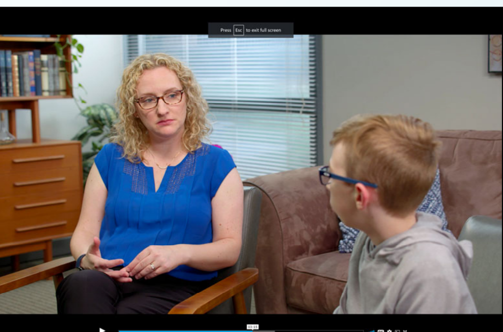


CAMS SUICIDE STATUS FORM (SSF-5) OUTCOME/DISPOSITION FINAL SESSION



CAMS SUICIDE STATUS FORM (SSF-5) OUTCOME/DISPOSITION FINAL SESSION (page 2 of 2)

CAMS Outcome/Disposition Final Session



Correlational and Open Clinical Trial Support for SSF/CAMS

Authors	Sample/Setting	n =	Significant Results
Jobes et al., 1997	College Students	106	Pre/Post SSF Core Assessment and symptom distress
Jobes et al., 2005	USAF Outpatients	56	Between-group suicidal ideation; ED/PC appts reductions
Arkov et al., 2008	Danish CMC Outpatients	27	Pre/Post SSF Core Assessment and qualitative findings
Jobes et al., 2009	College Students	55	Linear reductions in suicidal ideation and distress
Nielsen et al., 2011	Danish CMH Outpatients	42	Pre/Post SSF Core Assessment reductions
Ellis et al., 2012	Psychiatric Inpatients	20	Pre/Post SSF Core Assessment; reduced suicidal ideation, depression, hopelessness
Ellis et al., 2015	Psychiatric Inpatients	52	Reduced suicide ideation; changes in SI cognitions
Ellis et al., 2017	Inpatients (& post-discharge)	104	Impacts suicidal ideation, depression, hopelessness, functional impairment, well-being, psychological flexibility
Graure et al., 2021	Outpatients—CMH/SME	61	Pre/post SSF Core Assessment reductions
Adrian et al., 2021	Teenage outpatients	22	Pre/post suicidal ideation reductions; benchmark results

Randomized Controlled Trials Supporting CAMS

Authors	Sample/Setting	n =	Significant Experimental Results
Comtois et al., 2011	CMH Outpatients Harborview—Seattle, WA	32	Reduced Suicide Ideation and Symptom Distress, Increased Hope, Patients Preferred CAMS
Andreasson et al., 2016	CMH Outpatients Copenhagen Denmark	108	Mixed findings: CAMS was as effective as DBT for Self Harm and Suicide Attempts
Jobes et al., 2017	Soldier Outpatients Ft. Stewart, GA	148	Reduced Suicide Ideation in 6-8 sessions; Moderator findings: Resiliency, Symptom Distress, Decreased ED visits; Cost-Effective
Ryberg et al., 2019	Inpatients/Outpatients Oslo Norway	78	Reduced Suicide Ideation and Symptom Distress Moderator finding: CAMS improves poor working alliance
Pistorello et al., 2020	College Student Outpatients University of Nevada, Reno	62	Reductions in Suicide Ideation and Depression Moderator finding: Reductions in Hopelessness
Comtois et al., 2022	CMH Outpatients (SME)	150	Mixed findings: TAU worked better early, CAMS worked better later in terms of Suicidal Ideation and Symptom Distress; Clinicians were more satisfied with CAMS
Santel et al (2023)	Psychiatric Inpatients Bielefeld Germany	88	Decreased Suicide Ideation, Symptom Distress, and Suicide Attempts Post-D/C; Stronger Alliance

ORIGINAL ARTICLE

The effectiveness of the Collaborative Assessment and Management of Suicidality (CAMS) compared to alternative treatment conditions: A meta-analysis

Joshua K. Swift PhD, Associate Professor | Wilson T. Trusty MS, Doctoral Candidate | Elizabeth A. Penix MS, Doctoral Candidate

Swift et al's (2021) meta-analysis of nine CAMS clinical trials: CAMS is a "well supported" intervention for suicidal ideation as per CDC criteria

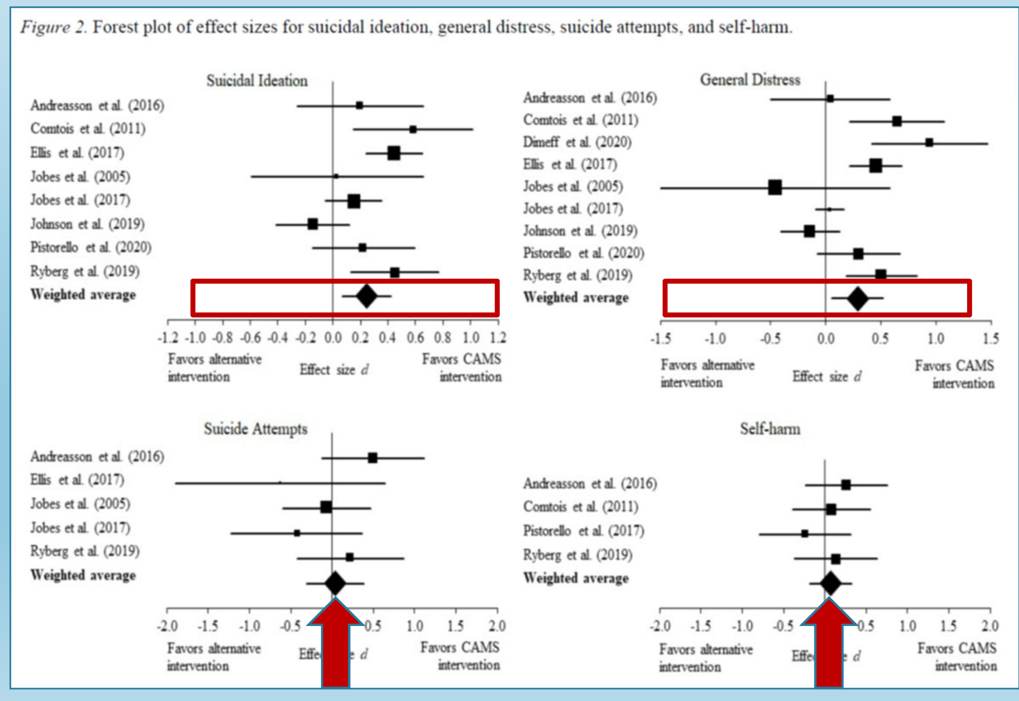


Figure 2. Forest plot of effect sizes for suicidal ideation, general distress, suicide attempts, and self-harm.

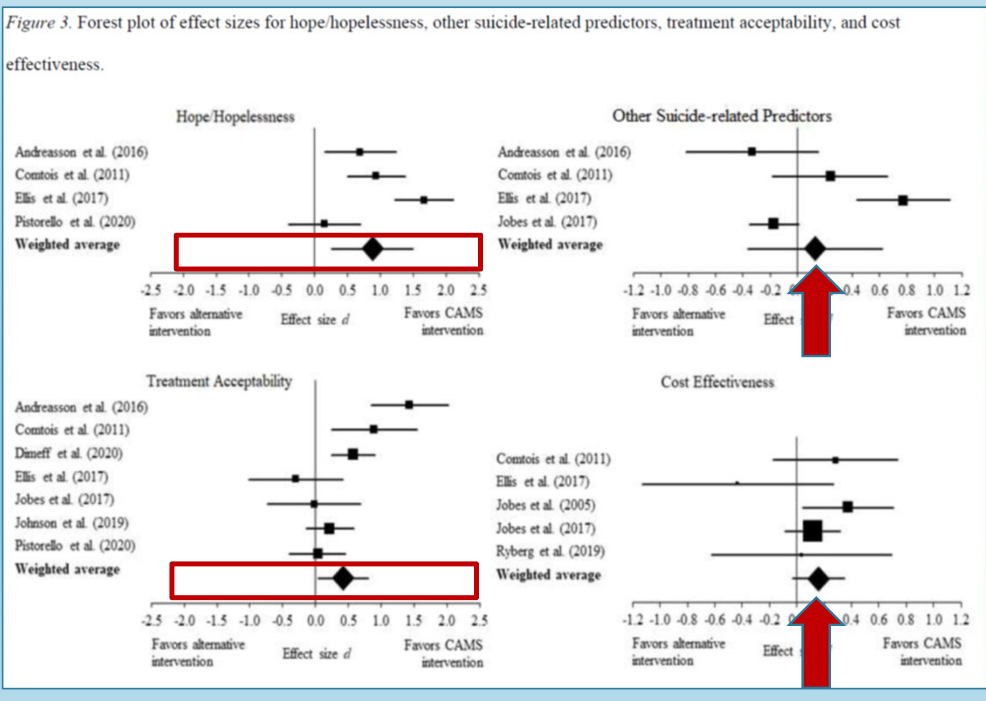


Figure 3. Forest plot of effect sizes for hope/hopelessness, other suicide-related predictors, treatment acceptability, and cost effectiveness.

The Impact of COVID-19 on Mental Health

SAMHSA

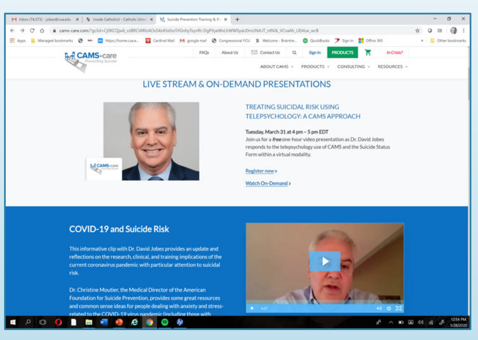
Disaster Technical Assistance Center Supplemental Research Bulletin

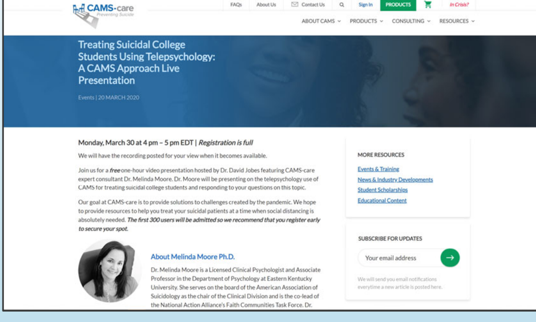
A Preliminary Look at the Mental Health and Substance Use-related Effects of the COVID-19 Pandemic

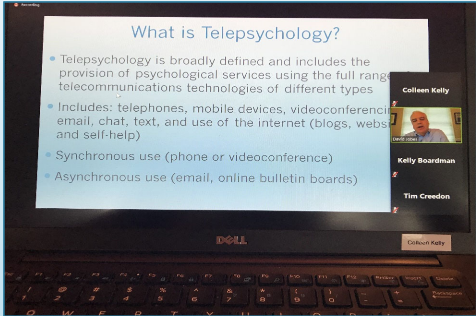
May 2021

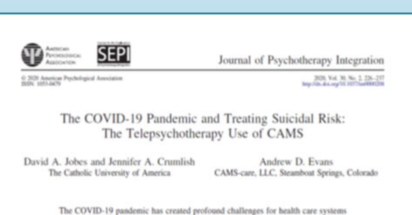
An apparent impact on mental health overall—but the impact on completed suicides and increased suicidal risk is still not entirely clear…

On-line training and telehealth use of CAMS Spring 2020









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The COVID-19 Pandemic and Treating Suicidal Risk: The Telepsychotherapy Use of CAMS

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The Catholic University of America

Andrew D. Evans
CAMS-care, LLC, Steamboat Springs, Colorado

The COVID-19 pandemic has created profound challenges for health care 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 an acutely 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 modality. Additional suicide-relevant resources are being made available to provide further guidance and support to mental health professionals worldwide. In the midst of a global 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, Collaborative Assessment and Management of Suicidality

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 Figure 1). Whereas there was a flickering hope of perhaps lowering the rate of suicide in the late 1990s, the past 20 years have seen a marked increase in suicides with no clear understanding as to why these deaths continue to increase. Notably the field

Editor's Note. This article received rapid review due to the time-sensitive nature of the content, but our standard high-quality peer review process was upheld.

David A. Jobes and Jennifer A. Crumlish, Department of Psychology, The Catholic University of America; Andrew D. Evans, CAMS-care, LLC, Steamboat Springs, Colorado.

David A. Jobes discloses the following potential conflicts: grant support for clinical trial research from the American Foundation for Suicide Prevention and the National Institute of Mental Health; book royalties from American Psychological Association Press and Guilford Press; founder and partner of CAMS-care, LLC (a clinical training/consulting company). Jennifer A. Crumlish is consultant to CAMS-care, LLC, and Andrew D. Evans is President of CAMS-care, LLC.

Correspondence concerning this article should be addressed to David A. Jobes, Department of Psychology, The Catholic University of America, 314 O'Boyle Hall, Washington, DC 20064. E-mail: jobes@cua.edu

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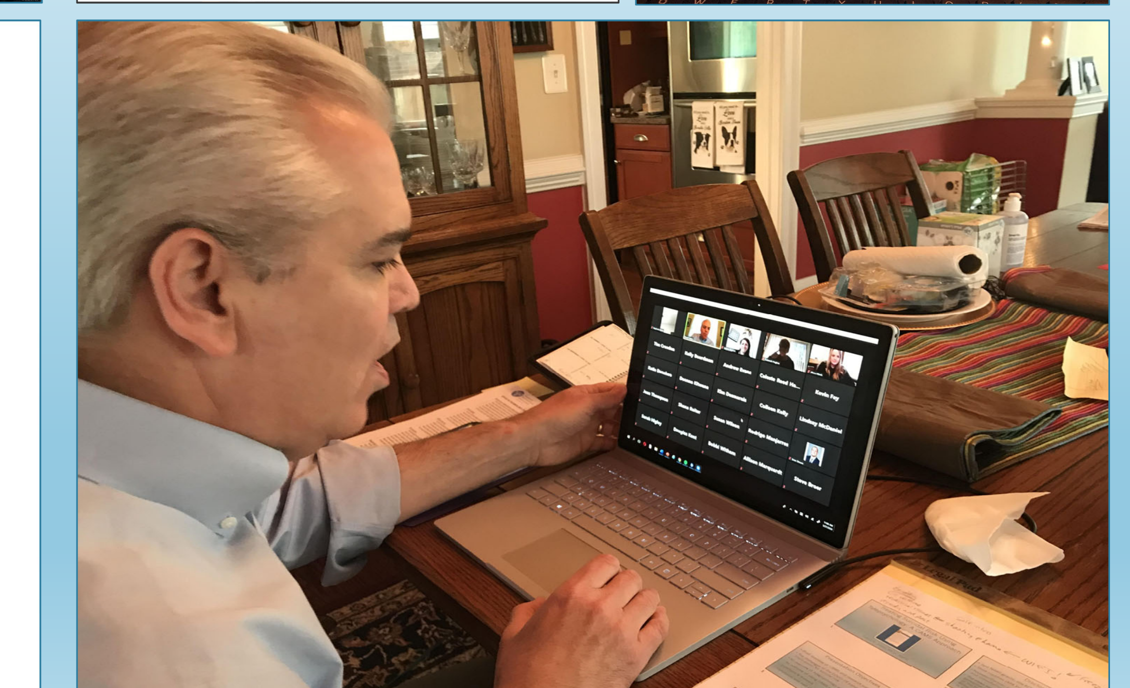

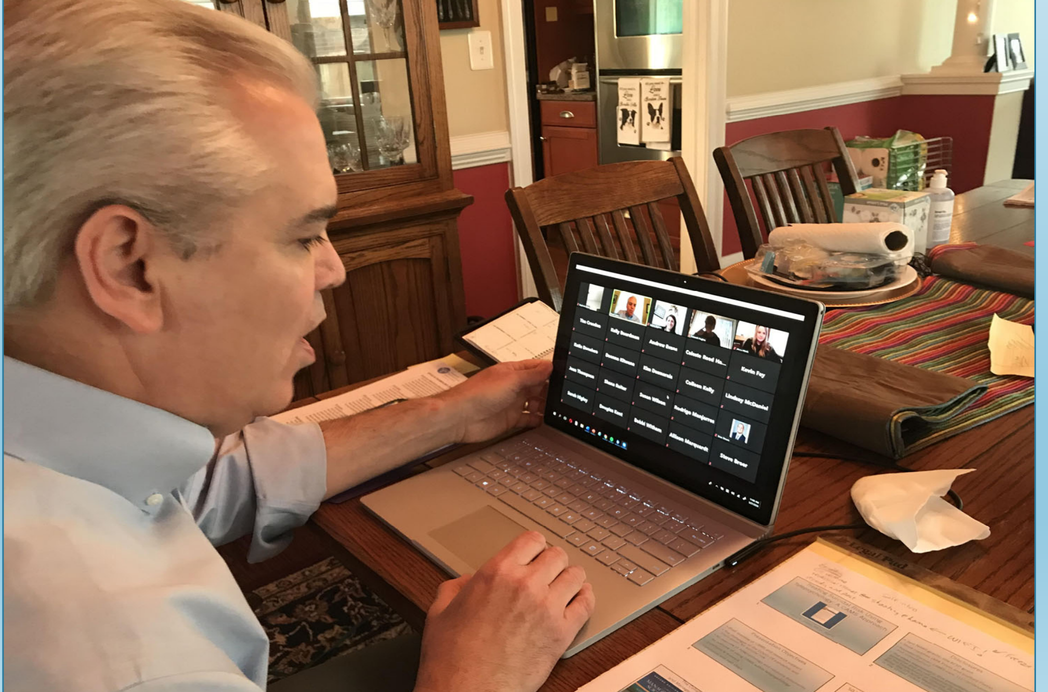

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Online Suicide-Focused Treatment:

The Telehealth Use of CAMS

Mary V. Tipton, B.A.[1], Josh Brenner M.A.[1], Jennifer Crumlish, Ph.D.[1], Melinda Moore, Ph.D.[2], and David A. Jobes, Ph.D.[1]

[1]Department of Psychology, The Catholic University of America, Washington, D.C., USA [2]Department of Psychology, Eastern Kentucky University, Richmond, KY, USA.

Free online webinars are a corona virus pandemic silver lining!

The form-fillable PDF of the Suicide Status Form is available, and it works well!

Form-fillable PDF of the SSF for telehealth CAMS sessions

Home Tools test-result.pdf Danny Johnson SS... Using a Tablet-Base... NIH_NOA_1R44AA... retreat.pdf

You are screen sharing | Stop Share

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

Patient: Danny Johnson Clinician: Dr. Jobes Date: 9/11/2021 Time: 10AM

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)

Rank	
3	1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*): **Low pain:** 1 2 3 4 5 **:High pain** What I find most painful is: dealing with covid, having no friends, dealing with my parents
4	2) RATE STRESS (*your general feeling of being pressured or overwhelmed*): **Low stress:** 1 2 3 4 5 **:High stress** What I find most stressful is: not having a job, being dependent on my parents
5	3) RATE AGITATION (*emotional urgency; feeling that you need to take action; **not** irritation; **not** annoyance*): **Low agitation:** 1 2 3 4 5 **:High agitation** I most need to take action when: I get in a fight with my parents
1	4) RATE HOPELESSNESS (*your expectation that things will not get better no matter what you do*): **Low hopelessness:** 1 2 3 4 5 **:High hopelessness** I am most hopeless about: The earth is dying and I have no sense of direction
2	5) RATE SELF-HATE (*your general feeling of disliking yourself; having no self-esteem; having no self-respect*): **Low self-hate:** 1 2 3 4 5 **:High self-hate** What I hate most about myself is: don't know where I am going, what is next for me
N/A	6) RATE OVERALL RISK OF SUICIDE: **Extremely low risk: (will *not* kill self)** 1 2 3 4 5 **:Extremely high risk (will kill self)**

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 feeling 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
4	something good might happen	1	I hate this limbo
2	my dog	3	the earth is dying
3	rock climbing	4	racial and political injustice
1	my family	5	politics
		2	escape

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

Danny Johnson

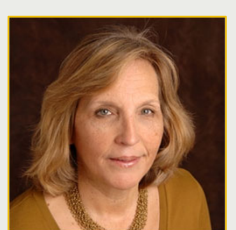
Dr. Jobes

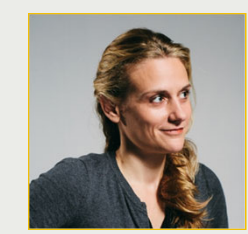
Type here to search 77°F 5:22 PM 9/20/2021

Guilford Press has authorized CAMS-care LLC to negotiate licenses with major electronic medical record companies to install the SSF on their default EMR platforms

Treating Suicidal Patients During COVID-19: Best Practices and Telehealth

April 14, 2020





@SPRCTweets

Presenter: Dr. Barbara Stanley

Barbara Stanley, PhD
Director, Suicide Prevention: Training, Implementation and Evaluation Program, New York State Psychiatric Institute;
Professor of Medical Psychology, Columbia University

Telehealth with Suicidal Clients

- Treating individuals at risk for suicide is anxiety producing under the best of circumstances.
- Using telehealth with **suicidal individuals present unique challenges.**
- People who have been suicidal before **could have a spike** in suicidal risk under the current circumstances.
- The purpose of this presentation is to provide pragmatic guidance for **evaluating and managing suicide risk via telehealth.**

Overview of Suicide Prevention Approaches Adapted for Telehealth and COVID-19

- **Basic guidelines** for initiating remote contact with an at-risk individual
- Adaptations for conducting **remote screening and risk assessment**
- Remote **clinical management** of suicidal individuals
- **Safety planning** adaptations for COVID-19
- Use of ongoing **check-ins and follow-up** to avert ED visits and hospitalization
- Documentation
- Support for yourself

Initiating contact when your client may be suicidal: *Basic guidelines*

- Request the person's **location (address, apartment number)** at the start of the session in case you need to contact emergency services.
- Request or make sure you have **emergency contact information.**
- **Develop a contact plan** should the call/video session be interrupted.
- Assess **client discomfort** in discussing suicidal feelings.
- **Secure the client's privacy** during the telehealth session as much as possible.
- **Prior to contact, develop a plan** for how to stay on the phone with the client while arranging emergency rescue, if needed.

Adaptations for Suicide Risk Assessment

- In addition to standard risk assessment, **assess for the emotional impact of the pandemic on suicide risk.**
- Possible **COVID-related risk factors**: social isolation; social conflict in sheltering together; financial concerns; worry about health or vulnerability in self, close others; decreased social support; increased anxiety and fear; disruption of routines and support.
- **Inquire about increased access to lethal means** (particularly stockpiles of medications, especially acetaminophen (Tylenol) and psychotropic medications).

Adaptations for Clinical Management

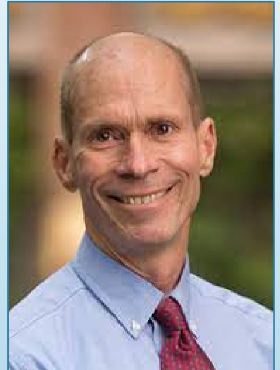
Given the strain on hospitals and EDs and the importance of remaining home for health reasons, identifying ways of staying safe short of going to the ED is critical.

- Make provisions for **increased clinical contact** (even brief check-ins) until risk de-escalates; remember risk fluctuates.
- Provide **crisis hotline (1-800-273-8255)** and **crisis text (Text "Got5 to 741741)** information.
- **Identify individuals in the client's current environment** to monitor the client's suicidal thoughts and behaviors in-person or remotely; seek permission and have direct contact with those individuals.
- **Develop a safety plan** to help clients manage suicide risk on their own.
- **Collaborate** to identify additional alternatives to manage risk.

In case of unmanageable imminent risk…

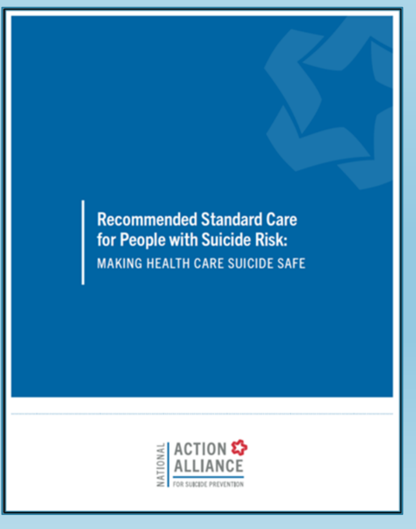
- If risk becomes imminent and cannot be managed remotely or with local supports, arrange for client to **go to the nearest ED or call 911.**
- **If risk is imminent, stay on the phone if possible** until the client is in the care of a professional or supportive other person who will accompany them to the hospital.

Suspending the screening of suicidal risk?



Gregory E. Simon, MD, MPH

- Dr. Simon noted to members of our Task Force in the fall of 2020 that large healthcare systems were suspending suicide screenings due to remote access online telehealth.
- So…don't ask, don't tell?
- Is this anyway to save lives from suicide?



NATIONAL ACTION ALLIANCE FOR SUICIDE PREVENTION

THE NATION'S PUBLIC-PRIVATE
PARTNERSHIP FOR SUICIDE PREVENTION

COVID GUIDANCE:
Screening for Suicide Risk during Telehealth Visits

An Addendum to the 2018
Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe

Background

The COVID-19 pandemic has prompted a rapid shift from traditional face-to-face health care encounters to various forms of virtual care, including telephone encounters, video encounters, asynchronous or "chat" meetings, and mHealth or eHealth tools. In 2018, the National Action Alliance for Suicide Prevention (Action Alliance) published *Recommended Standard Care for People with Suicide Risk: Making Health Care Suicide Safe*. The report suggested suicide screening, with indicated care as needed, for all individuals receiving care for behavioral health conditions as a core responsibility for health care organizations. In 2019, both CARF and The Joint Commission included these recommendations in their accreditation requirements. Increasingly, more health care systems have worked to improve suicide risk detection and consequent workflows to reduce patients' suicide risk. However, with the pandemic, screening for or assessment of suicide risk must now occur virtually in addition to face-to-face interactions. Some of this shift to virtual or online care will likely persist after the pandemic subsides, based on expanded access to care and patient preferences.

As health care organizations work to adapt their practices to telehealth, continuing to screen for suicide risk in the same manner as face-to-face visits has raised some concerns. For example, some health system leaders have expressed concern that screening for or assessment of suicide risk outside of a face-to-face encounter might create liability risk. The perceived concern is greatest for asynchronous screening, such as a questionnaire including questions related to suicidal ideation sent in advance of a telephone or video visit.

Principles

According to SAMHSA survey data,[1] 12 million adult Americans had serious suicidal ideation in 2019.[2] Recent CDC data indicated that 40% of Americans reported mental health or behavioral health problems, and 11% seriously considered suicide in the past 30 days.[3] Given the mental health impacts of the COVID-19 pandemic, identifying people at increased risk of self-harm or suicide is a higher priority than ever. More people are at risk, and those who have been under care may find their care interrupted or altered.

1 Substance Abuse and Mental Health Services Administration. (2020). Key substance use and mental health indicators in the United States: Results from the 2019 National Survey on Drug Use and Health (HHS Publication No. PEP20-07-01-001, NSDUH Series H-55). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

2 Czeisler, M. E., et al. (2020). Mental health, substance use, and suicidal ideation during COVID-19 pandemic — United States, June 24–30, 2020. Morbidity and Mortality Weekly Report, 69, 1049–1057. DOI: http://dx.doi.org/10.15585/mmwr.mm6932a1

Key Ideas: Telehealth with Suicide Risk

- Informed consent has never been more critical—use telehealth-specific consent
- Make arrangements for any imminent risk—3rd party involvement critical!
- Develop plan for contact—cell, text, email, phones numbers for key people
- Anticipating technology challenges (Wi-Fi failures) update software/platforms
- Use secure HIPAA-complaint platforms, be clear about recording sessions
- Verifying private space for the session—patients should use headphones
- Provide back up resources—National Lifeline/Textline, access to clinician?
- Consider increased follow-up and check-ins (e.g., phone, email, text)
- Ensure your competence with using technology—get trained or consult!

Getting back to “normal” post-pandemic?

Check for updates

Received: 14 February 2021 | Revised: 26 March 2021 | Accepted: 27 March 2021
DOI: 10.1002/cpp.2594

RESEARCH ARTICLE

WILEY

Live psychotherapy by video versus in-person: A meta-analysis of efficacy and its relationship to types and targets of treatment

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Funding information
University of Texas at San Antonio

Abstract
In-person psychotherapy (IPP) has a long and storied past, but technology advances have ushered in a new era of video-delivered psychotherapy (VDP). In this meta-analysis, pre-post changes within VDP were evaluated as were outcome differences between VDP versus IPP or other comparison groups. A literature search identified $k = 56$ within-group studies ($N = 1681$ participants) and 47 between-group studies ($N = 3564$). The pre-post effect size of VDP was large and highly significant, $g = +0.99$ 95% CI [0.67–0.31]. VDP was significantly better in outcome than wait list controls ($g = 0.77$) but negligible in difference from IPP. Within-groups heterogeneity of effect sizes was reduced after subgrouping studies by treatment target, of which anxiety, depression, and posttraumatic stress disorder (PTSD) (each with $k > 5$) had effect sizes nearing 1.00. Disaggregating within-groups studies by therapy type, the effect size was 1.34 for CBT and 0.66 for non-CBT. Adjusted for possible publication bias, the overall effect size of VDP within groups was $g = 0.54$. In conclusion, substantial and significant improvement occurs from pre- to post-phases of VDP, this in turn differing negligibly from IPP treatment outcome. The VDP improvement is most pronounced when CBT is used, and when anxiety, depression, or PTSD are targeted, and it remains strong though attenuated by publication bias. Clinically, therapy is no less efficacious when delivered via videoconferencing than in-person, with efficacy being most pronounced in CBT for affective disorders. Live psychotherapy by video emerges not only as a popular and convenient choice but also one that is now upheld by meta-analytic evidence.

KEYWORDS
affective disorders, cognitive-behavioural therapy (CBT), face-to-face, meta-analysis, online treatment, video-delivered psychotherapy

1 | TRADITIONAL DELIVERY OF PSYCHOTHERAPY

The traditional mode for delivering psychotherapy is through a meeting of therapist and client in-person and in close physical proximity, whether in a clinical, educational, or forensic setting. This has been variously referred to as in-person psychotherapy (IPP), in vivo therapy, or face-to-face therapy, and it can be formatted for use with individuals, dyads, or groups. As Kazdin (2015) recently stated, “one-to-one in-person treatment has remained as the dominant model of delivery” (pp. 7–8). This established mode of delivery has, however, come under criticism for failing to reach many of those in need, especially in

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- 56 within-group studies (*N*=1,681)
- 47 between-group studies (*N*=3,564)
- Psychotherapy is no less efficacious when delivered via telehealth than in-person/face-to-face therapy
- Effects are most pronounced for CBT with affective disorders
- “Live psychotherapy by video emerges as not only a popular and convenient choice but also one that is now upheld by meta-analytic evidence.”

The great democratization of mental health?

- With proper infrastructure and secure internet access, telehealth may potentially extend the reach of mental health care making it much more accessible to:
  - Rural populations
  - Remote populations
  - Underserved and marginalized populations
  - Not seen walking into clinics—avoiding stigma
  - Not fighting traffic
  - Pets can join telehealth psychotherapy
  - Retention to care is better with fewer missed sessions
  - Lethal means safety can be done remotely—securing lethal means
  - PSYPACT—more provider options across state lines (for psychologists)

Limitations of Telehealth with Suicide Risk

- Basic issue: access to hardware and the internet
- Privacy—patients in a closet or next to co-workers!
- A distinct loss of intimacy and missing nuance
- Signing documents and sharing materials
- Seeing a teen at home in crisis and parents are gone (not as previously negotiated and expected)
- Patients may have challenges using technology
- Cell phone telehealth sessions can be problematic
- Technology routinely fails
  - Poor Wi-Fi connectivity—freezing or getting dropped
  - External hacks—“Zoombombing”

The Washington Post *Democracy Dies in Darkness*

Patients and doctors who embraced telehealth during the pandemic fear it will become harder to access

By Frances Stead Sellers

September 15, 2021 at 12:00 p.m. EDT

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When the pandemic hit, the little health center on Vinalhaven, an island 15 miles off the coast of Maine, was prepared in ways many larger facilities were not. The Islands Community Medical Services had long been using telehealth to provide primary and behavioral care to its 1,500-strong year-round community, relying on grants to cover costs. As the public health emergency lifted many restrictions on virtual care, the clinic ramped up its offerings.

“We were able to pivot pretty quickly,” said former operations director Christina R. Quinlan, describing a scramble to add specialized medical and social care.

Across the country, in urban and suburban settings, the same pattern played out as federal and state regulators issued scores of waivers to telehealth access and coverage rules, making it easier for hospitals, health centers and clinics to offer a wider range of remote services and be reimbursed for delivering them.

A question that remains to be answered, experts say, is how many rules will tighten once the public health emergency is over. This summer, more than 430 health-related organizations, including hospitals, professional bodies and patient-advocacy groups, urged congressional leaders to keep open the gateways to telehealth. They argued that much of health-care delivery has moved online “not only to meet COVID-driven patient demand, but to prepare for America’s future health care needs.”

Lawmakers on both sides of the aisle have shown support for making the shift to telehealth permanent through mechanisms such as the Connect for Health Act. But many states have already rescinded the licensing waivers that allowed clinicians and some other providers to practice across state lines, or are preparing to do so. Other decisions at the state, federal and individual health-care system levels remain uncertain.

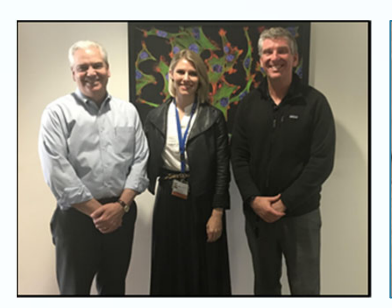
“It’s frustrating,” said Steven A. Epstein, chair of psychiatry at Georgetown University School of Medicine, who said the pandemic not only fixed logistical challenges for physicians treating patients in adjoining states, but offered many clients welcome convenience when they were able to connect with therapists without having to show up at a clinic.

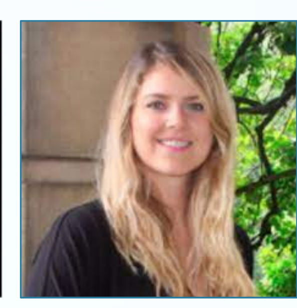
“The no-show rates dropped off significantly,” said Epstein, who has heard of patients who now drive across state lines to talk to therapists from their cars.

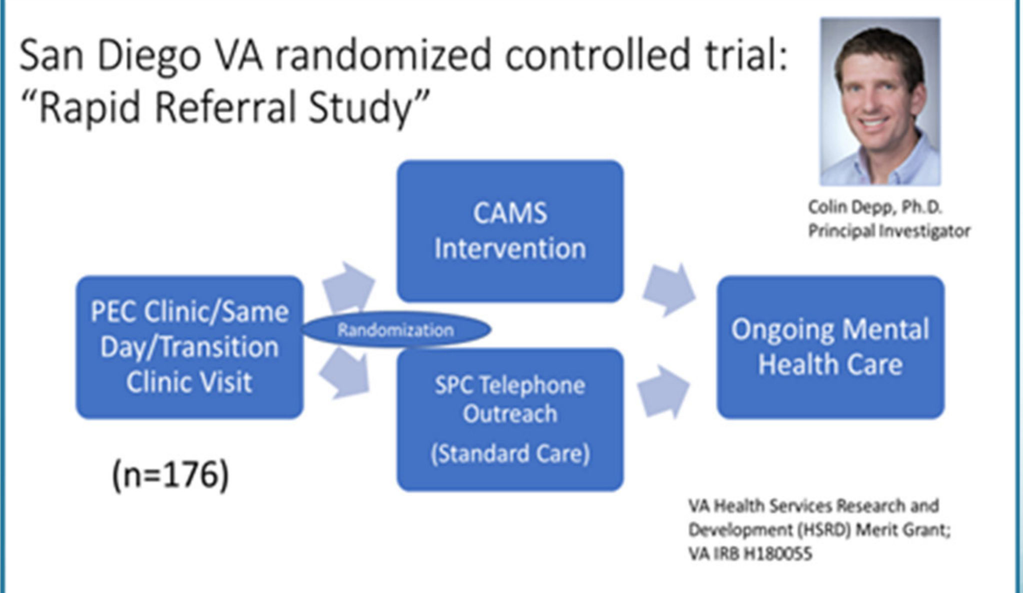
Over the past 18 months, providers have revamped their practices, taking advantage of the pandemic-fueled flexibility that allows consultations in people’s homes rather than in approved clinical settings and via phone instead of only on video. Some have been using platforms that did not meet pre-pandemic standards for privacy and security. Many have invested in new computer systems and signed up for training in a new skill for the modern tech-savvy physician – a good webside manner. (Rx for doctors: Look into the laptop camera, not at the screen.)

“The floodgates opened during covid,” said Danielle Louder, program director for the Northeast Telehealth Resource Center, which supports the growth of telehealth in New England and New York.

San Diego VAMC CAMS RCT—Depp et al (data collection ends in Spring 2024)

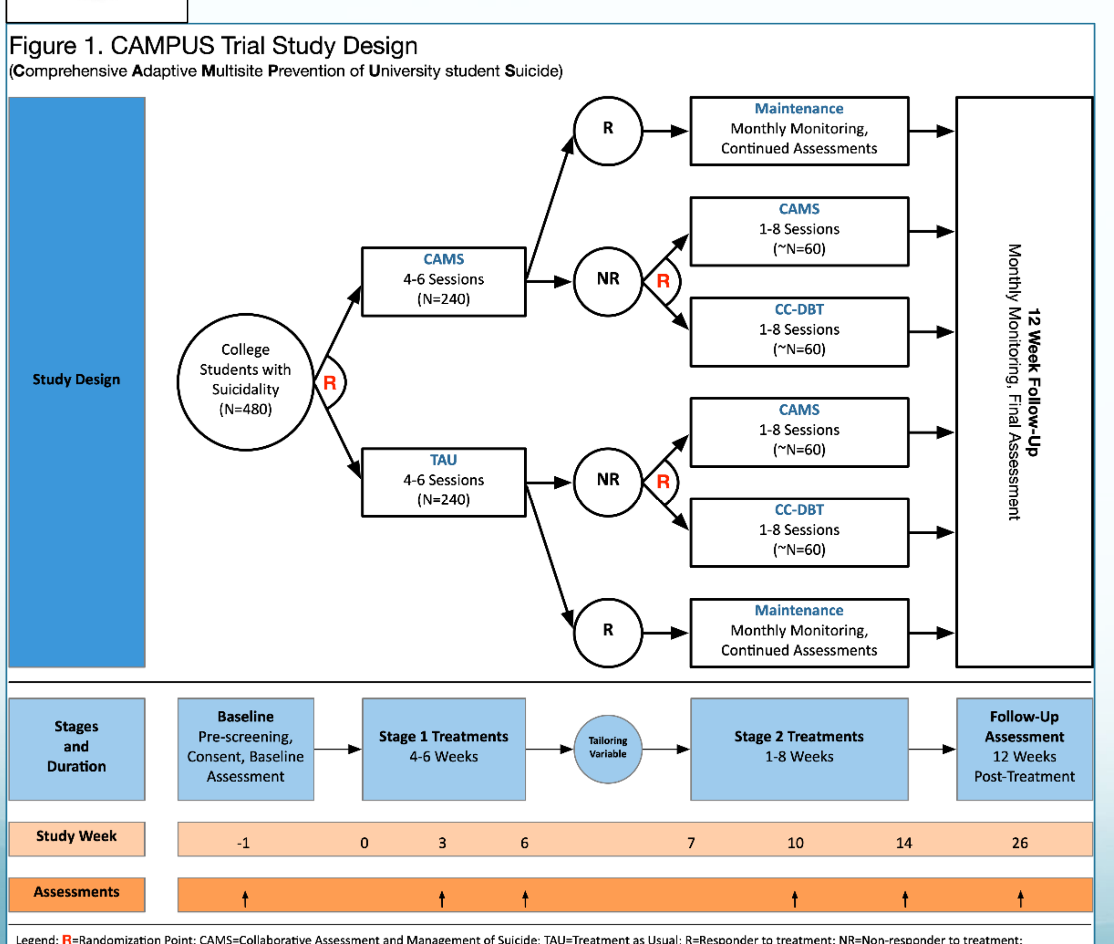






Now standing up a "Suicide Stabilization Clinic" at SD VAMC focused on suicide-specific care, training young clinical providers, and cost-effectiveness!

Comprehensive Adaptive Multisite Prevention of University student Suicide



The CAMPUS Study

NIMH-funded ($11M) multisite SMART of n=480 college students who are suicidal at four university counseling centers (University of Oregon, University of Nevada-Reno, Duke University, and Rutgers University).

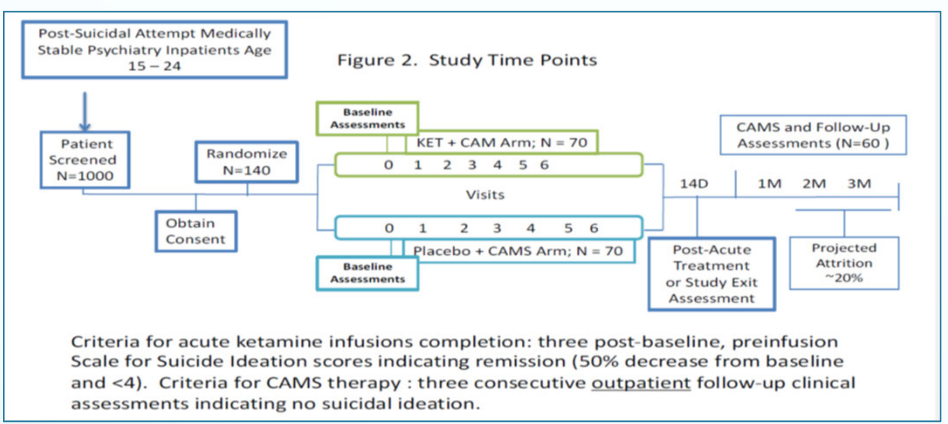
Authorized to do a feasibility trial for academic years 2020-2022 to study online training and online treatment.

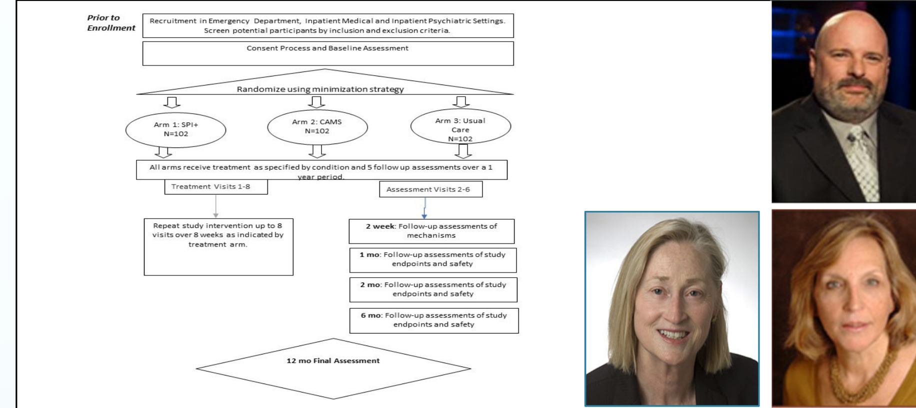
The actual trial (finally) began Fall 2022; one more year of data collection (2023-2024)

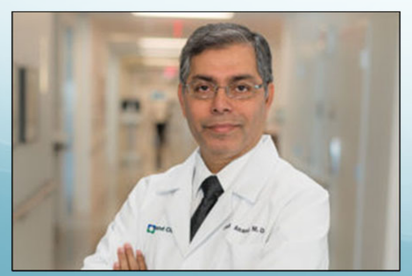
NIMH R01 Funded “CAMS-4Teens” RCT’s

CAMS & Ketamine RCT
Cleveland Clinic & Mass General Hospital
(PI’s: Anand & Falcone)

CAMS-4Teens vs. SPI+ vs. TAU
Seattle Children's & Nationwide
(PI’s: Adrian & Bridge)







A new PCORI grant has been funded: ECT vs IV Ketamine plus CAMS post D/C

Thank You CatholicU SPL and CAMS-care!