Dissemination of Therapeutic Frameworks vs. Specific Treatments

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Overview

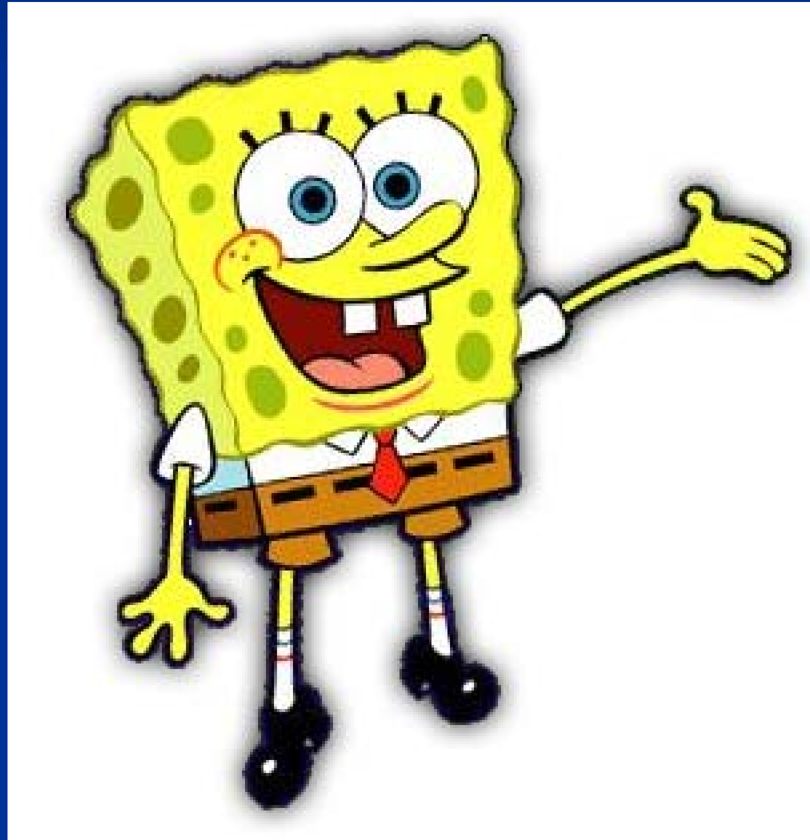
- The problem
- Treatment frameworks
- CAMS as an example
- Limitations
- Next steps

What are clinicians afraid of doing?

- Multiple barriers to treatment implementation, including uptake by clinicians
- Clinicians are concerned that adopting treatment manuals will make them less effective
  - Worried that standardized therapy may negatively affect care
    - treatment rapport
    - individualized case conceptualization
  - Worried that standardized therapy may reduce autonomy in decision making

From Borntrager, Chorpita, Higa-McMillan, Weisz, 2009;
Addis & Krasnow, 2000; Addis, Wade, Hatgis, 1999; Nelson & Steele, 2007

What are clinicians afraid of becoming?



Alternative to Treatment Manuals

- Modular assembly of treatment procedures
  - Provides clinicians with ownership in determining use of evidence based approaches based upon algorithm
  - But in reality, clinicians are mixing and matching elements of treatment manuals, which ultimately requires them to replace conceptualization and intervention approaches

(Wetherell et al., 2009; Borntrager et al., 2009)

Taking It One Step Further

Rather than providing clinicians with

1. Structured psychotherapy, or
2. Modules of structured psychotherapy…

… We could encourage clinicians to integrate evidence based strategies into their customary and preferred practices.

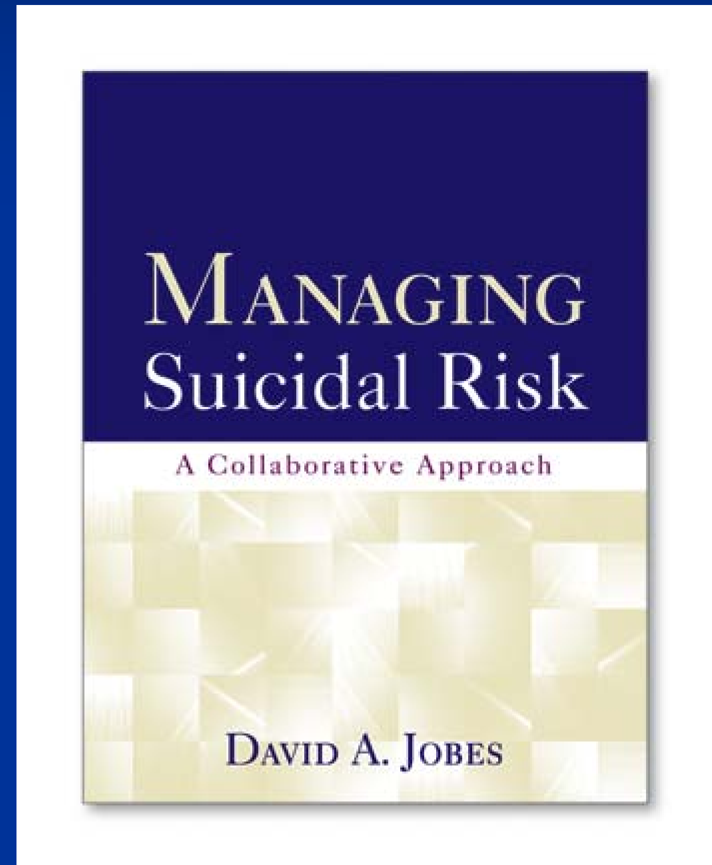
<u>This is what we are referring to as a therapeutic framework</u>

What a Therapeutic Framework Offers

- Guidance on the most important aspects related to a targeted problem/behavior
- Allows clinicians (and patients) the ability to remain flexible in their beliefs/theories regarding behavior and personality
- Fewer criteria for adherence – most notably, not getting dinged for intervention strategies that fall outside the purview of an underlying theory
- Potentially lower training costs than other flexible, principle focused therapies

CAMS as an Example

- Collaborative Assessment and Management of Suicidality (CAMS)



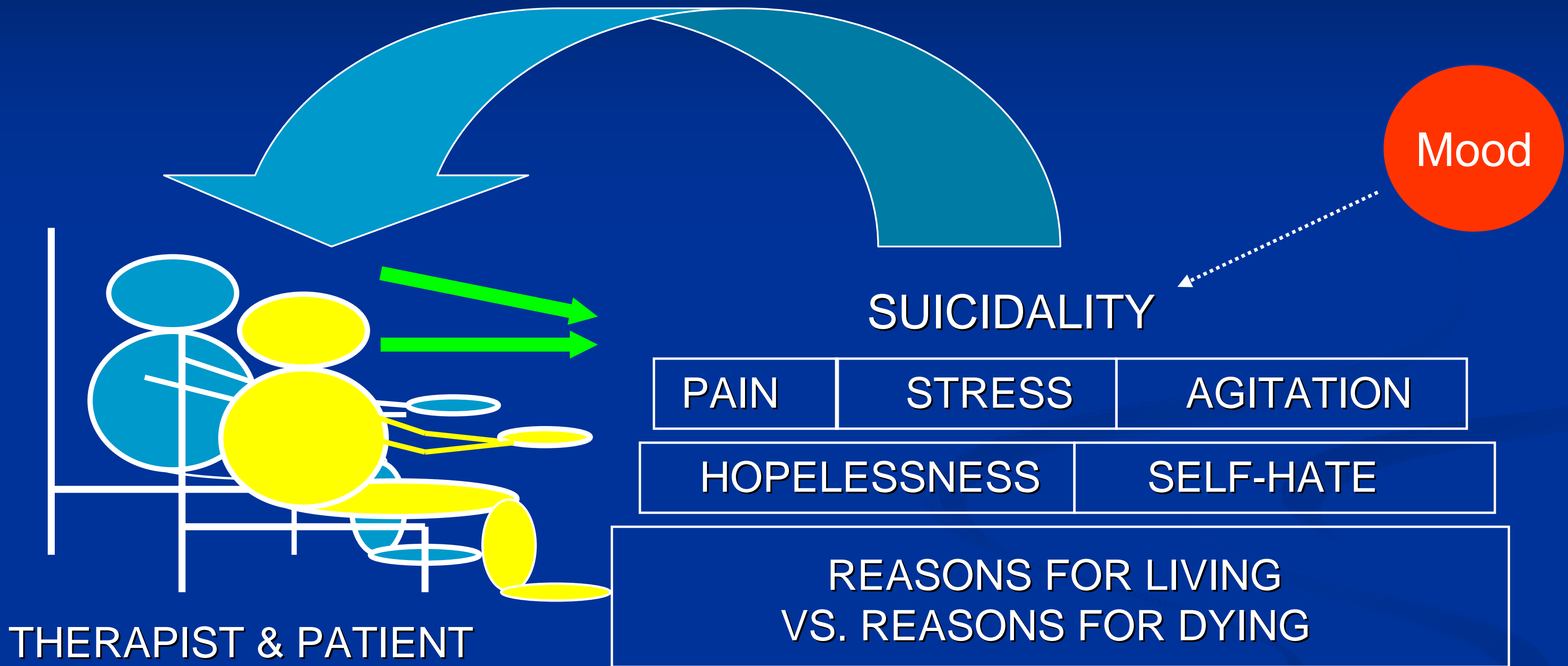
CAMS Development

- Began as semi-structured approach to managing suicide risk in outpatient settings
  - Formalized assessment compiled aspects of the suicidology literature in a useful, innovative way
  - Emphatically non-prescriptive in terms of intervention approach
  - Focus was on management of suicide through clear, concise documentation of the assessment and treatment planning process

- CAMS has evolved into more of a defined structure as efforts to test and disseminate have increased
  - Series of quasi-experimental and correlations studies showing CAMS may be useful in treating suicidal patients

    (Jobes et al., 2005; Arkov et al., 2008; Jobes et al., 2009; Nielsen et al., 2011)

COLLABORATIVELY ASSESSING RISK: Targeting *Suicide* as the Focus of Treatment



CAMS Treatment = Weekly outpatient care that is suicide-specific, emphasizing the development of other means of coping and problem-solving thereby systematically eliminating the need for suicidal coping…

CAMS SSF: First understand the experience of suicidality

Section A (*Patient*):

I have thoughts of ending my life: **0 1 2 3 4**
(0=Never; 1=Rarely; 2=Sometimes; 3=Frequently; 4=Always)

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	
____	1) RATE PSYCHOLOGICAL PAIN (*hurt, anguish, or misery in your mind, **not** stress, **not** physical pain*): **Low pain: 1 2 3 4 5 :High pain** What I find most painful is: ____
____	2) RATE STRESS (*your general feeling of being pressured or overwhelmed*): **Low stress: 1 2 3 4 5 :High stress** What I find most stressful is: ____
____	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: ____
____	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: ____
____	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: ____
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 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

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

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

CAMS SSF: Then review other important suicide risk factors.

Section B (*Clinician*):

Y N Suicide plan: When: ______________________
Where: ______________________
How: ______________________ Y N Access to means
How: ______________________ Y N Access to means

Y N Suicide Preparation Describe: ______________________

Y N Suicide Rehearsal Describe: ______________________

Y N History of Suicidality

- Ideation Describe: ______________________
  - Frequency _____ per day _____ per week ____ per month
  - Duration _____ seconds _____ minutes ____ hours
- Single Attempt Describe: ______________________
- Multiple Attempts Describe: ______________________

Y N Current Intent Describe: ______________________

Y N Impulsivity Describe: ______________________

Y N Substance abuse Describe: ______________________

Y N Significant loss Describe: ______________________

Y N Interpersonal isolation Describe: ______________________

Y N Relationship problems Describe: ______________________

Y N Health problems Describe: ______________________

Y N Legal problems Describe: ______________________

CAMS SSF: Toward end of session, develop a treatment plan that targets key drivers of suicidality.

Section C (*Clinician*):

OUTPATIENT TREATMENT PLAN (Refer to Sections A & B)

Problem #	Problem Description	Goals and Objectives Evidence for Attainment	Interventions (Type and Frequency)	Estimated # Sessions
1	*Self-Harm Potential*	*Outpatient Safety*	***Crisis Response Plan:***	
2				
3				

YES ____ NO _____ Patient understands and commits to outpatient treatment plan?
YES ____ NO _____ Clear and imminent danger of suicide?

Patient Signature Date Clinician Signature Date

CAMS SSF: Rest is standard treatment note… with suicide risk level explicitly described.

Section D (*Clinician Post-Session Evaluation*):

MENTAL STATUS EXAM (circle appropriate items):

ALERTNESS:	ALERT DROWSY LETHARGIC STUPOROUS
	OTHER: ________
ORIENTED TO:	PERSON PLACE TIME REASON FOR EVALUATION
MOOD:	EUTHYMIC ELEVATED DYSPHORIC AGITATED ANGRY
AFFECT:	FLAT BLUNTED CONSTRICTED APPROPRIATE LABILE
THOUGHT CONTINUITY:	CLEAR & COHERENT GOAL-DIRECTED TANGENTIAL CIRCUMSTANTIAL
	OTHER: ________
THOUGHT CONTENT:	WNL OBSESSIONS DELUSIONS IDEAS OF REFERENCE BIZARRENESS
	MORBIDITY OTHER: ________
ABSTRACTION:	WNL NOTABLY CONCRETE
	OTHER: ________
SPEECH:	WNL RAPID SLOW SLURRED IMPOVERISHED INCOHERENT
	OTHER: ________
MEMORY:	GROSSLY INTACT
	OTHER: ________
REALITY TESTING:	WNL
	OTHER: ________

NOTABLE BEHAVIORAL OBSERVATIONS: ________

PRELIMINARY DSM-IV-R MULTI-AXIAL DIAGNOSES:

Axis I ________

Axis II ________

Axis III ________

Axis IV ________

Axis V ________

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

- ☐ No Significant Risk
- ☐ Mild
- ☐ Moderate
- ☐ Severe
- ☐ Extreme

CASE NOTES (diagnosis, functional status, treatment plan, symptoms, prognosis, and progress to date):

____

Next Appointment Scheduled: ________ Treatment Modality: ________

Clinician Signature Date Supervisor Signature Date

CAMS Ongoing Session Ratings

Section A (*Patient*):

I have thoughts of ending my life: **0 1 2 3 4**
(0=Never; 1=Rarely; 2=Sometimes; 3=Frequently; 4=Always)

Rate each item according to how you feel right now.

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**
2) RATE STRESS (*your general feeling of being pressured or overwhelmed*):		
	Low stress: 1 2 3 4 5	**:High stress**
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**
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**
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**
6) RATE OVERALL RISK OF SUICIDE:	**Extremely low risk: 1 2 3 4 5** **(will not kill self)**	**:Extremely high risk** **(will kill self)**

CAMS Ongoing Treatment Planning

Section B (*Clinician*):

"I have thoughts . . ." # of sessions at "0" or "1" ☐ 1st sess ☐ 2nd sess ☐ 3rd sess
Complete **Suicide Tracking Outcome Form after 3rd consecutive session at "0" or "1"

Y __ N __ Suicidal Thoughts?
Y __ N __ Suicidal Feelings?
Y __ N __ Suicidal Behaviors?

Patient Status:
☐ Discontinued treatment ☐ No show ☐ Referral to: ______________
☐ Hospitalization ☐ Cancelled ☐ Other: ______________

TREATMENT PLAN UPDATE

Problem #	Problem Description	Goals and Objectives Evidence for Attainment	Interventions (Type and Frequency)	Estimated # Sessions
1	*Self-Harm Potential*	*Outpatient Safety*	***Crisis Response Plan:***	
2				
3				

Patient Signature Date

Clinician Signature Date

CAMS Final Session: Evaluate what has worked and explicitly summarize disposition.

Section A (*Patient*):

Rate each item according to how you feel right now.

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**
2) RATE STRESS (*your general feeling of being pressured or overwhelmed*):	**Low stress: 1 2 3 4 5 :High stress**
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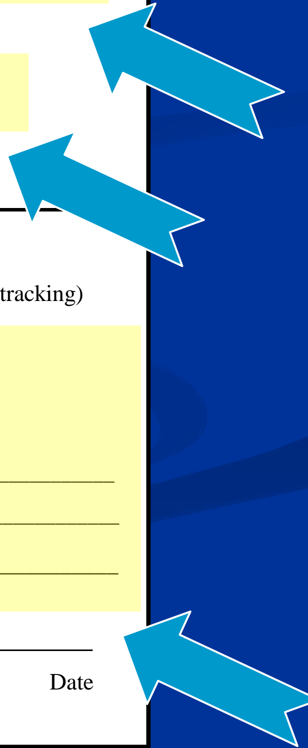
6) RATE OVERALL RISK OF SUICIDE:	**Extremely low risk: (will not kill self) 1 2 3 4 5 :Extremely high risk (will kill self)**

Were there any aspects of your treatment that were particularly helpful to you? If so, please describe these. Be as specific as possible.

What have you learned from your clinical care that could help you if you became suicidal in the future?



Section B (*Clinician*):

Third consecutive session of resolved suicidality: ____ Yes ____ No (if no, continue Suicide Status tracking)

OUTCOME/DISPOSITION (Check all that apply):

___ Continuing outpatient psychotherapy ___ Inpatient hospitalization

___ Mutual termination ___ Patient chooses to discontinued treatment (unilaterally)

___ Referral to: ____

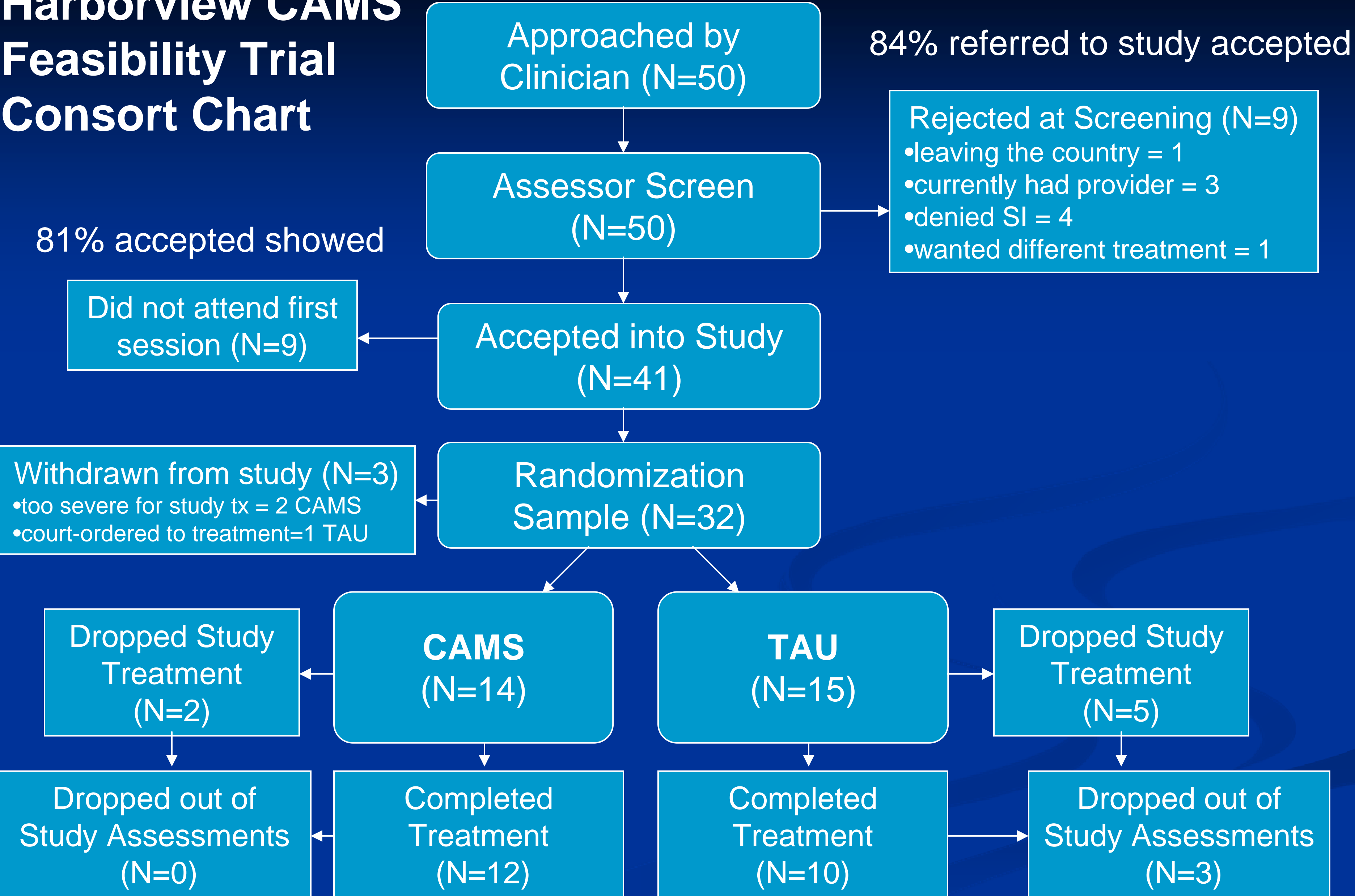
___ Other. Describe: ____

Next Appointment Scheduled (if applicable): ____

______________________________ ______________________________

Patient Signature Date Clinician Signature Date

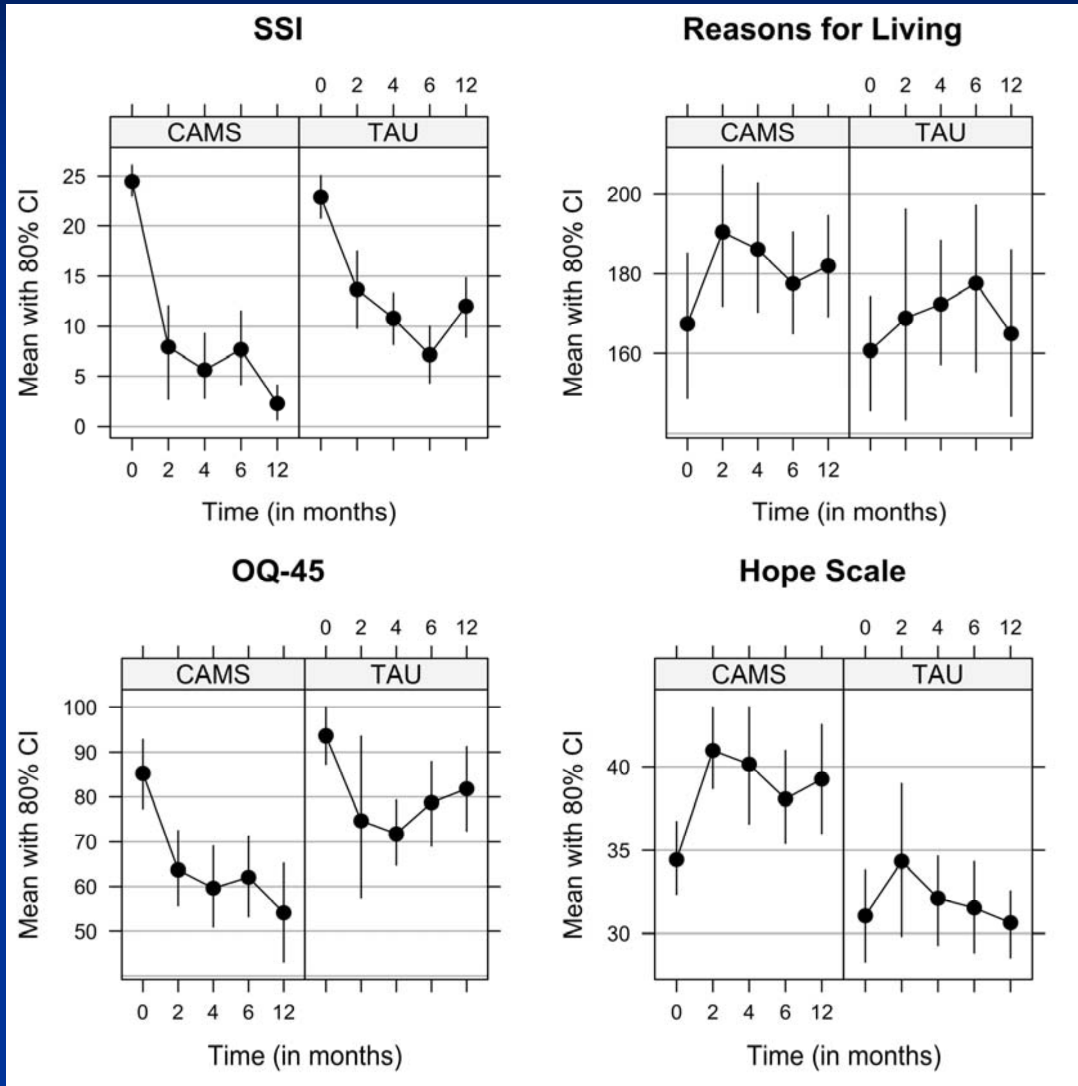
Harborview CAMS Feasibility Trial Consort Chart



Training Outcomes

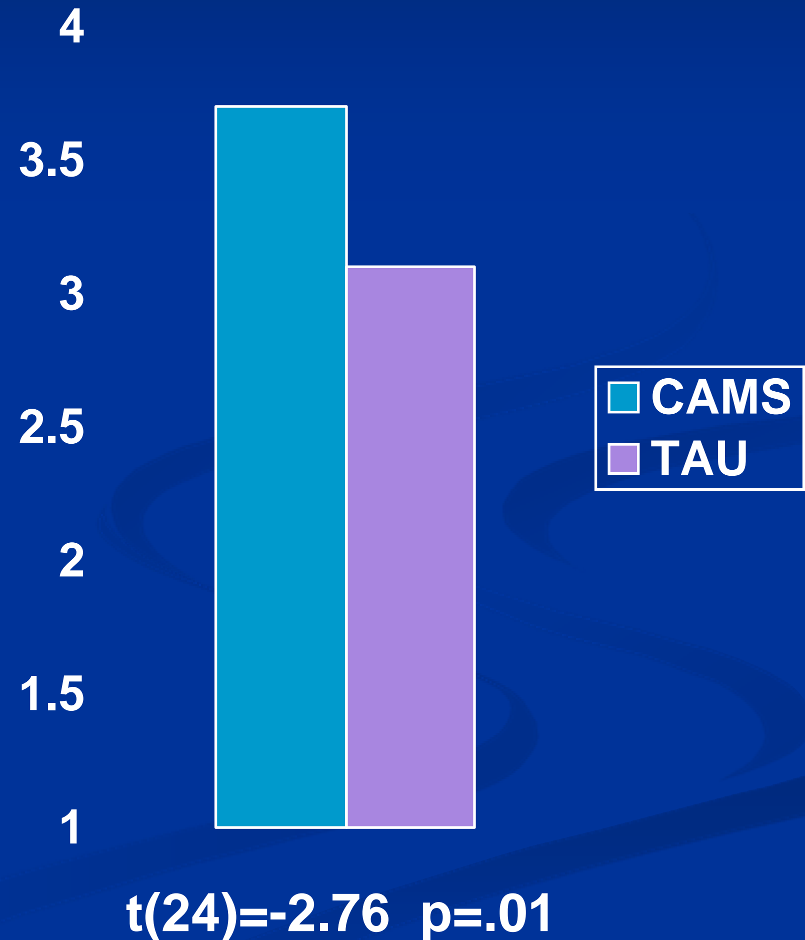
- Acceptable to therapists
- Most therapists adherent after first training client based on one day of training and weekly group supervision
  - M = 4.75 sessions, with 4 consecutive sessions being the minimum for establishing adherence
- More previous therapy experience associated with ease of training

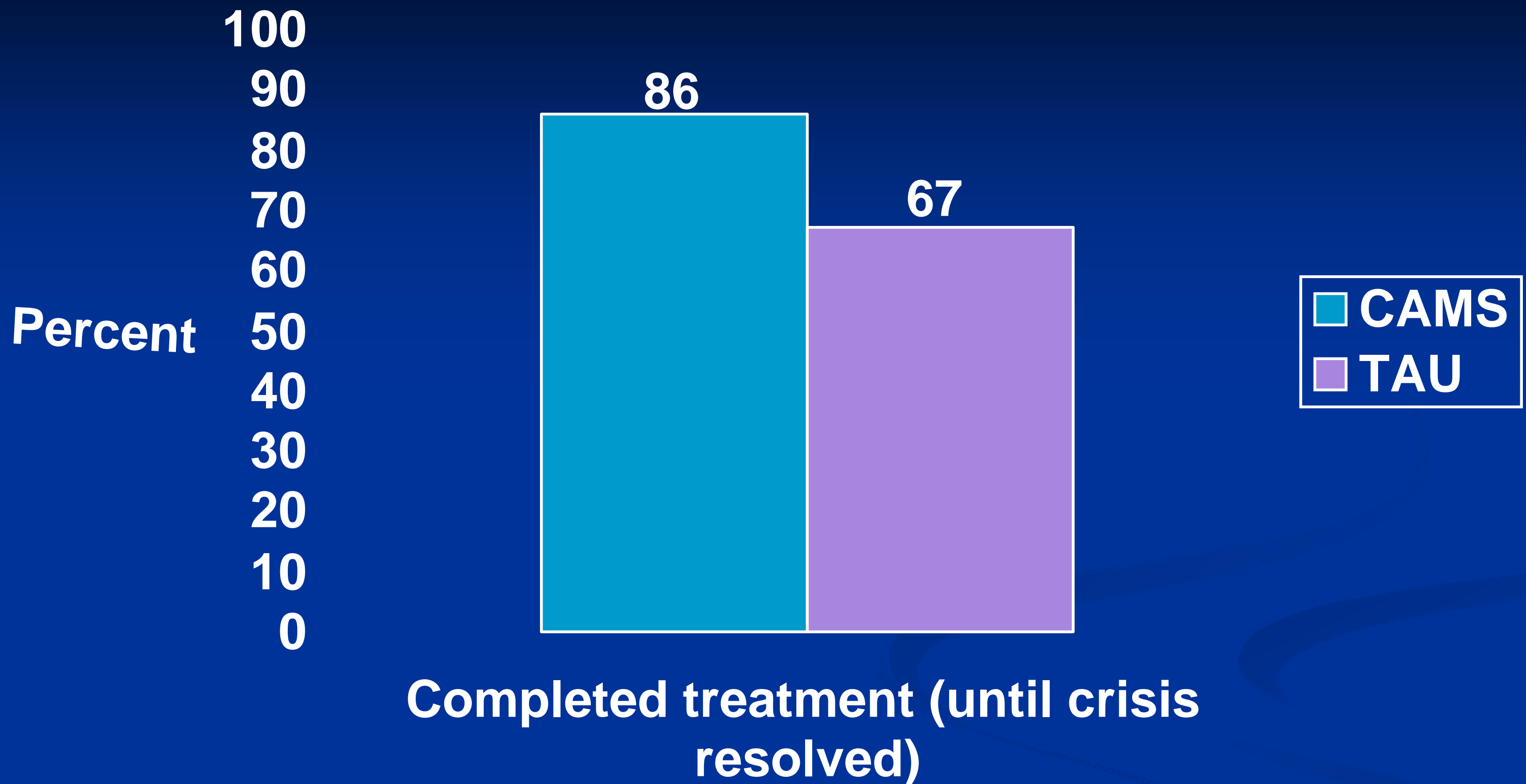
Treatment Outcomes



Client Satisfaction

- Average client satisfaction was high for both treatments (range 1-4).
- Satisfaction higher for the CAMS treatment condition





Total sessions ranged from low of 1 to high of 16 sessions:

CAMS = 2 to 16 sessions (mean = 8.5), 7% subject had < 3 sessions

TAU = 1 to 11 sessions (mean = 4.5), 53% subjects had < 3 sessions

Limitations to Exporting Treatment Frameworks

- Unlike manualized treatments or modular approaches, it's tough to drill down on the mechanisms that lead to change.
  - Collaboration? Focus on suicide drivers?
- Can this approach be replicated for other mental health issues, including larger constructs like depression and anxiety?
- How much is related to the existing skills of the practicing clinician?

Next Steps

- Ongoing randomized clinical trial of CAMS for suicidal active duty military personnel.
  - Mediation analyses
  - Clinicians are not CAMS treatment developers
  - Moderators of treatment outcomes
    - Diagnoses
    - Suicidal ambivalence

Thank you