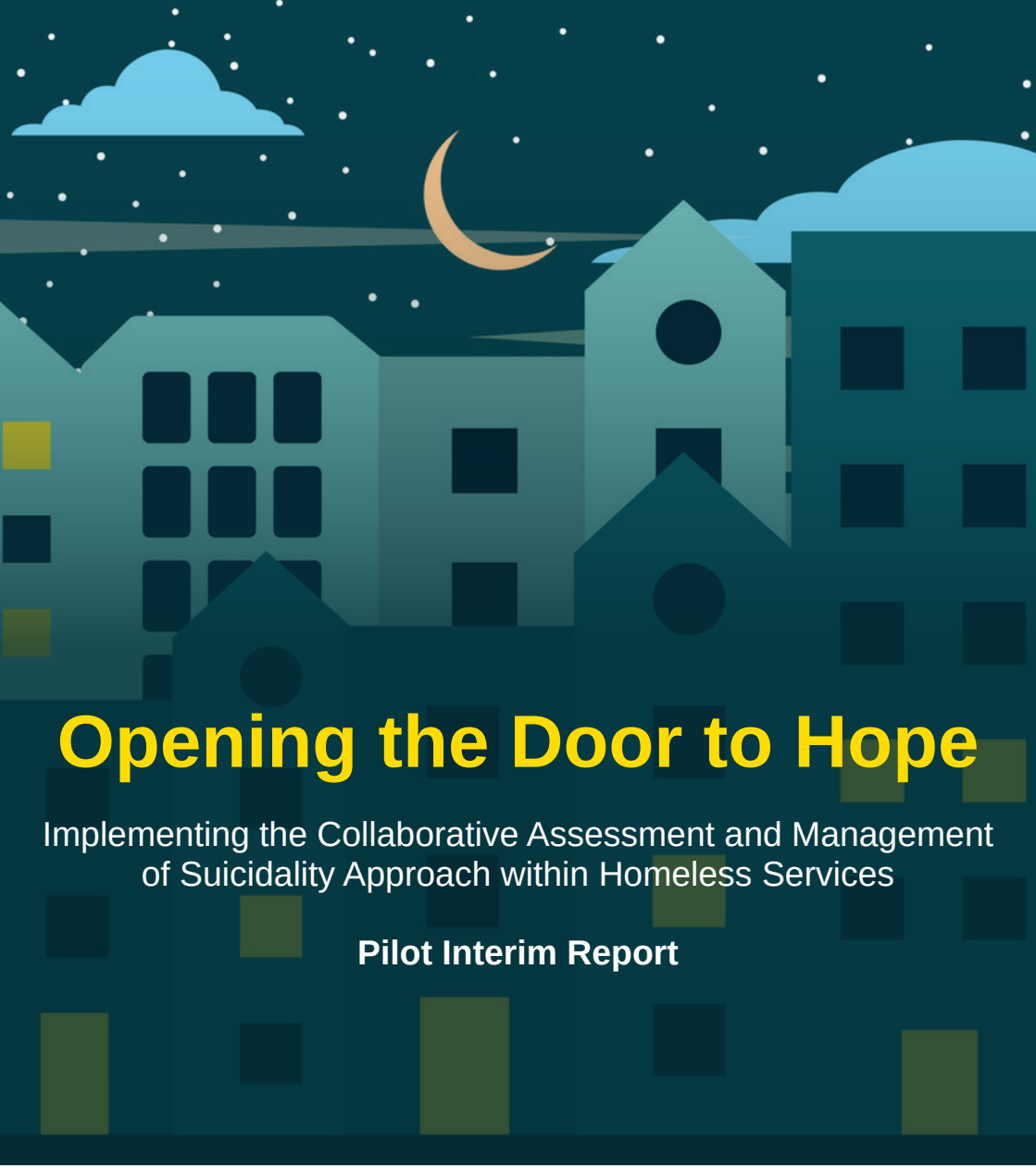

Opening the Door to Hope

Implementing the Collaborative Assessment and Management of Suicidality Approach within Homeless Services

Pilot Interim Report

Dublin Simon Community

Sure Steps Counselling
2018

Acknowledgements

We wish to thank all the authors of *Opening the Door to Hope* and the staff, volunteers and clients of Dublin Simon Community for their support and co-operation in making this report possible.

Our sincere appreciation goes to Dr. Eoin Galavan for his ongoing support and consultation.

Thank you to the Communications team for their work on designing and launching the report and to Andrea Koenigstorfer for co-ordinating.

Thank you to the Animate Social Innovation Ireland Fund and to all the donors of the Sure Steps Counselling Service who make our work possible.

Contributors

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Contributors

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Rachael is a third-year psychology undergraduate student attending Dublin City University. She has volunteered with Dublin Simon Community for the past three years. She began working on the Soup Run for one year and then moved to the position of administrative officer for the Sure Steps Counselling Service. She has a strong interest in the field of psychology and has many research interests. She has completed three years of research method modules which has given her confidence in both qualitative and quantitative research methods. She has just completed an internship in Beaumont Hospital in the neuropsychology and the liaison psychiatry services under the supervision of two clinical psychologists. Currently she is undertaking a summer research internship alongside a professor in Dublin City University which has been externally funded. She wishes to pursue a career as a Clinical Psychologist.

Michael Condron

Michael has been involved with Dublin Simon Community since 2013 and is a former member of the Client Action Group (CAG). He has participated as a peer researcher in the Mental Health Reform report, in conjunction with Trinity College. In 2016 Simon and Focus Ireland came together to attend the Feantsa European homeless conference in Brussels. Michael was a member of the group that participated in that conference.

Michael recently completed a degree in Social Care in DIT and hopes to work with people experiencing homelessness and addiction. In the future Michael may consider getting his Masters in Drug and Alcohol Policy in Trinity College.

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Part One: Introduction

Foreword

Since its establishment in 2012, Sure Steps Counselling has been to the fore in providing emotional support to people in our community experiencing homelessness. As the homeless emergency has deepened, we have also seen an increase in suicidality in this population group.

Suicide is the ultimate and final act a person may consider to escape the unbearable emotional pain and suffering they experience. The care and support we provide at this time to help them cope with such crises is crucial.

It was for this reason that in 2016 we recognised the need within the organisation for a specific suicide management approach that would meet the sometimes complex needs of our clients who have expressed suicidal ideation. After comprehensive research we adopted the Collaborative Assessment and Management of Suicidality (CAMS) Approach. This model was chosen because of its extensive empirical research demonstrating a decrease in suicidal ideation in clients. An equally important factor in adopting this approach was how it is a collaboration between therapist and client, thus empowering the client who because of their current homelessness can often feel totally disempowered.

It is with tremendous pride that we are presenting this preliminary report *Opening the Door to Hope*, evaluating the first results of implementing the CAMS Approach within Dublin Simon Community. We are very much looking forward to continuing to collaborate with our clients and support them at critical crisis times in their life.

Derek Dempsey
Sure Steps Counselling Service Manager

Opening the Door to Hope

Hopelessness and shame go hand in hand with the despair that comes from homelessness. This is the hardest for people to overcome. There is no door to close, no escape from fear or judgment. You feel alone, isolated and worthless. These feelings often become so intense, so overwhelming, you lose any sense of yourself...and start to disappear.

When I speak to clients about the most important part of their journey out of homelessness, they tell me that getting a sense of hope back made the biggest difference. For many, it saved their life. The volunteer who spoke to them when they were struggling, the cook who ensured they had enough to eat each evening, or the keyworker there at every step until they secured their own home, all made them believe there was hope.

Working across our services, our Sure Steps Counselling provides vital emotional support, building a therapeutic relationship with our clients. They create a safe, informal and confidential space where they can feel secure and listened to, many who may have never have experienced counselling before. Sure Steps continuously improves and adapts to meet the needs of clients. Having identified an increased risk of vulnerability to suicide, from the trauma of homelessness and its causes, over the past year they have worked with our staff, volunteers and clients to implement new training, procedures and approaches. These innovations mean that, for clients at risk, our staff and volunteers will be better prepared to meet them where they are at and provide a supportive environment within the services they are already accessing.

Across all the services we provide at Dublin Simon Community, from outreach, to housing, to treatment, prevention and employability services, our role will always be to help our clients and residents realise their own potential, giving them the hope that brighter days lie ahead. We are all a part of the Simon Community and our clients deserve a future, just like the rest of us.
From all of us at Simon, thank you to our donors and funders for continuing to be a valued part of our community of kindness. Our life changing work would not be possible without you.

Sam McGuinness
Dublin Simon Community CEO

The Pilot Project

Participants

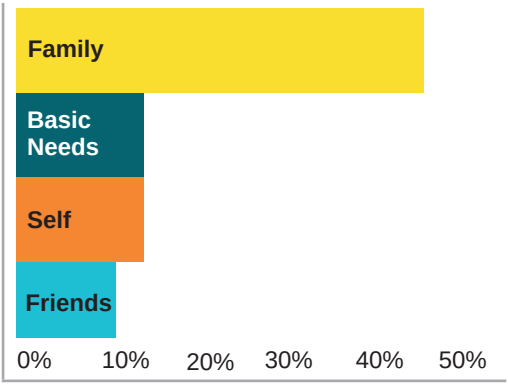
17 Sure Steps Counselling Clients

30 Simon Staff receiving CAMS training

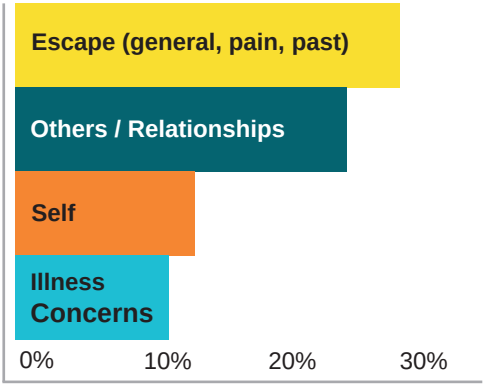
Clients' Suicide Attempt History

64.7% of participants reported at least one previous suicide attempt

Reasons for Living



Reasons for Dying



The Pilot Project

Staff Training and Implementation

- Increased confidence in having skills to address suicide ideation.
- Fewer beliefs of inevitable hospitalisation / sole principal role of medical professionals.
- Increased self-rated knowledge, skills and competencies.
- Unanimous agreement that CAMS training achieved intended learning outcomes.

Staff experience of CAMS training

- Content, format and delivery
- Perceived training benefits
- Application of CAMS in practice
- Future direction of CAMS in the context of the organisation

Counsellor experience of CAMS training and implementation

- Positive experiences of using CAMS
- Training / Use: A 'gradual' process
- Issues with completing CAMS forms
- Process-driven care beyond CAMS sessions
- Concerns over resources and funding

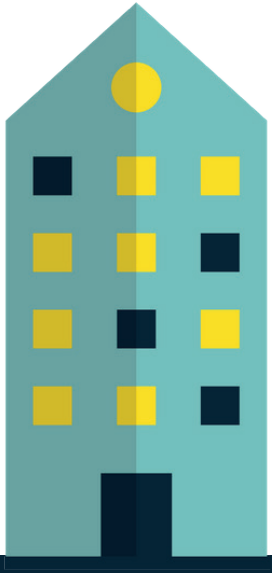
1.1 Executive Summary

The Current Project

Individuals experiencing homelessness are often exposed to various risk factors that increase their vulnerability towards suicide. With high rates of documented suicidal attempts, ideation and behaviours among this population, and recent initiatives pushed by our own national strategies, there is an ever-growing need for evidence-based assessment and management of suicide among individuals experiencing homelessness. However, there is a substantially limited evidence-base of such practices in an Irish context.

It was for these reasons that Dublin Simon Community's Sure Steps Counselling Service established a pilot project from November 2016 to February 2018 with clients and staff to evaluate one such evidence-based approach, the Collaborative Assessment and Management of Suicidality (CAMS).

This report assesses the CAMS Approach in terms of ease of training, implementation into practice and its effectiveness for reducing suicidal thoughts and behaviour among the homeless population. It is the hope that such a report will inform practices and guidelines both within Dublin Simon Community as well as among homeless services nationally and internationally.



Summary of Findings

Clinical Interventions

For the administered CAMS interventions, 17 participants were recruited. Completion of CAMS sessions included examinations of core suicidal beliefs, reasons for living and dying, explorations of related suicidal behaviour and symptoms, as well as the development and implementation of individualised treatment and stabilisation plans.

Successful completion was illustrated by consistent reductions in suicidal ideation and behaviour over several CAMS sessions through collaborative tracking, assessment and judgement of their suicidal status with their respective counsellor over the course of intervention.

Results indicated a reduction of core suicidal beliefs (Psychological Pain, Stress, Agitation, Hopelessness, Self-Hate), as well with self-rated suicidal risk from pre to post intervention among completed cases, however none of these reductions were statistically significant. In addition, the extent to which clients wanted to die was positively correlated across all the above ratings at pre-intervention sessions. Most clients reported either single or multiple suicide attempts in the past using a variety of methods. High rates of risk variables were also indicated by clients, including reports of shame, impulsivity, significant loss, substance abuse, relationship problems and personal feelings of burdensomeness.

Qualitative responses illustrated a range of factors influences clients' core suicidal beliefs. Such factors include relational issues, unpleasant internal states, external behaviours and homelessness. When asked to specify reasons for living and dying, participants noted family and relationships, depictions of one's self, health outcomes and basic needs such as shelter and food as key reasons for both living and dying dependent on each client.

Pre-Post Frontline Staff Training Evaluation

Thirty CAMS training participants were initially recruited for the training evaluation. Most participants were support, project or key workers, while psychotherapists, counsellors, social workers and managers also participated. A group of seven Dublin Simon Community Sure Steps Counsellors had been previously trained in CAMS and were not participating in this training. Apart from two participants, all participants had received some form of prior suicide prevention training.

Self-reported confidence in having skills to address suicidal ideation increased from before to after the training. Findings also demonstrated that fewer participants felt after the training that hospitalisation is inevitable and that the medical professions would have the principal role in suicide prevention. Finally, participants tended to agree more with the notion of not being at fault should a client take their own life.

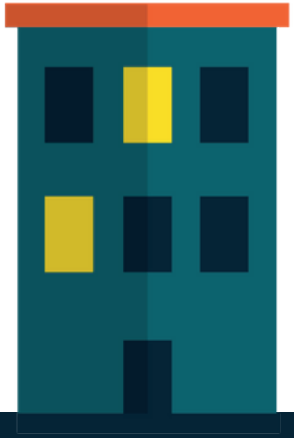
Findings from the follow-up interviews supported the positive experiences reported as part of the pre-post-training evaluation. Thematic analysis of the feedback resulted in the emergence of four main themes with accompanying subthemes; Training Content, Format and Delivery, particularly relating to the online training and workshops; Perceived Training Benefits, with regard to greater general confidence, as well as experiences with risk assessment and management; Applications of CAMS in practice, highlighting the importance of service integration as well as concerns over complexity and diagnose among clients, and; Future Development of CAMS in the Context of the Organisation, highlighting the need for a full-service implementation as well as improvements to the CAMS training.

Post-Implementation Counsellor Focus Group

Following the implementation of the CAMS model, a focus group of four counsellors explored a variety of topics related to training and implementation, including the usefulness of CAMS. Perceptions of training efficacy of CAMS, the content, language and overall use of the CAMS forms, as well as barriers and solutions to adhering to and implementing the CAMS process.

Thematic analysis resulted in the emergence of five main themes and accompanying sub themes; Positive experience of using CAMS, including the benefits of training and using a detailed, suicide-specific model of care; Training and use of CAMS as a 'gradual' process, with the importance of consistent and repeated use; Issues with completing SSF Forms, including when and how to include forms into sessions; Process driven, integrated care beyond CAMS sessions, including collaborative understanding across all professionals involved in the care pathway as well the availability of round-the-clock, client-tailored care, and; Concerns over funding and resources, in terms of both training and staff availability required for this process-driven approach.

It is important to note that this analysis is preliminary in nature, and a more robust and comprehensive review is required. Strengths, limitations as well as implications for the use of CAMS and the overall approach to suicide management and treatment are discussed for each component as well as for the project as a whole.



1.2 Literature Review

Context, Prevalence and Risk

According to the World Health Organisation approximately 800,000 people die by suicide each year, equating to one person every 40 seconds (World Health Organisation, 2017). Suicide can be defined as the act of intentionally ending one's own life and has become a global cause for concern. Suicidal thoughts and behaviours can include suicidal ideation, suicide planning and suicide attempts (Nock et al., 2008). The risk factors for suicide have been relatively well documented among the literature; these include, but are not limited to, psychiatric illnesses, substance abuse, relationship issues, loss of a significant other or unemployment/financial issues (Evans, Scourfield & Moore, 2016; Dragisic, Dickov, Dickov & Mijatovic, 2015; Saxby & Anil, 2012; Windfuhr & Kapur, 2011; Bhatia et al., 1987). Lack of connectedness, shame and hopelessness have also been highlighted as psychological risk factors for suicidal thoughts and behaviour (Daniel & Goldston, 2012; Beck, 1986).

Many of these risk factors have also been identified as root causes of homelessness and are therefore highly prevalent among this population. Psychotic disorders, substance abuse and financial issues for example are all more prevalent among the homeless population compared to the housed population (Crane et al., 2005; Teesson, Hodder & Buhrich, 2003). For example, the prevalence of psychotic disorders ranges from 3-42% among the homeless population compared to 3-3.5% for the general population (Fazel, Khosla, Doll & Geddes, 2008; Perälä et al., 2007). In Ireland specifically, reports from individual homeless services found that 71% of clients had received a formal psychiatric diagnosis, with approximately 22% receiving a diagnosis of schizophrenia or psychosis (Murphy, Mitchell & McDaid, 2017). Large-scale cross-sectional data in two Irish cities found at least half of all individuals experiencing homelessness received a diagnosis of depression, while over half reported having a mental health difficulty that limited them in their daily functioning (O'Reilly et al., 2015). In a report for the National Advisory Committee on drugs, the primary substance of abuse was alcohol, with 51% of the homeless sample scoring as problematic drinkers on the AUDIT screening tool (Lawless & Corr, 2005). With such a high prevalence of suicidal risk factors, it is evident that individuals experiencing homelessness are particularly vulnerable to the risk of suicide.

Homelessness and Suicide

However, based on the existing research, the prevalence of suicidal ideation or suicide attempts among this group is startlingly high. In a study conducted by Eynan et al. (2002) with 330 homeless individuals, 61% reported suicide ideation, with 34% indicating a previous suicide attempt. Similar results were found by Desai, Liu-Mares, Dausey & Rosenheck (2003) who conducted research among a homeless population with a mental illness. It was reported that 66% of the sample had a lifetime prevalence of suicide ideation and 51% had attempted suicide at some point in their lives. In an observational study of suicide deaths in Toronto, the homeless and precariously housed population were over represented in suicidal deaths 10-fold (Sinyor, Kozloffa, Reis, Schaffer & Kozloff, 2017).

Recent national research has been conducted by the registry of deliberate self-harm in Ireland who monitors the incidence and repetition of self-harm presentations to hospital accident and emergency departments (A&E) with the aim of identifying high-incidence groups for suicide. Self-harm has been identified as a high indicator of suicide vulnerability and is startlingly high among the homeless community. The researchers reported that homeless individuals were 22 times more likely to present in A&E for self-harm than domiciled individuals (Arensman, Mhuircheartaigh & Corcoran, 2014). In addition, the previously cited cross-sectional study showed that among the presenting mental health difficulties, a third of homeless individuals had self-harmed or attempted suicide (O'Reilly et al., 2015). It is clear that the prevalence of suicide and suicidal behaviours among the homeless population both nationally and internationally far exceeds the average for the non-homeless population, and therefore emphasises the need for proper risk assessment and treatment for of suicide for individuals experiencing homelessness.

Current Intervention Practice

The current protocol and most common practice among organisations working with homeless individuals presenting with suicidal behaviour or thoughts is to call an ambulance followed by immediate admission to A&E. Homeless individuals are 30 times more likely to present in emergency departments compared to those with fixed abode (Barrett et al., 2018). Despite this being the current practice, there is little to no evidence to suggest that hospitalisation is an effective form of treatment for suicidal patients. In fact, research has indicated that suicidal ideation can increase after hospitalisation (Gaudiano, Andover & Miller, 2008). Hospitalisation can ultimately worsen the patient's situation and therefore should only be used sparingly, as a crisis management strategy or in emergency situations (Galavan & Repper, 2017). Within Dublin Simon Community, clients have expressed that going to A&E was not meeting their needs when suicidal. The urgent need to provide homeless clients who have expressed suicidal ideation with evidence-based interventions as an alternative to A&E for the client was identified by the Homeless Mental Health Action Group (HMHAG) which is chaired and hosted by Dublin Simon Community. This was established by reviewing critical and serious incidents relating to suicide ideation. To this end, a sub group of the HMHAG was established to research and identify a suitable, well established and proven intervention for the management of suicidal ideation.

A number of alternative training programs are available in the context of treating suicide. The STORM (Skills Training on Risk Management) training provides skills to aid in the assessment and management of self-harm risk to frontline staff and staff specifically working with vulnerable populations through workshops on suicide-prevention and self-injury mitigation (Appleby, Morriss, Gask & Green 2000). SafeTALK is a half-day suicide alertness training allowing participants to notice the presence of suicidal thoughts, recognise invitations to help, welcome discussion of suicide with the person(s) in question, and inform them of relevant community resources for further assistance. While safeTALK provides an initial basis for suicide alertness, the Applied Suicide Intervention Skills Training (ASIST) is a two-day course exploring invitations for help, discussing suicide, reviewing risk, developing safe-plans and the appropriate referral. It is described as a type of mental health first aid, focusing on helping an at-risk person stay safe and seek further assistance as needed rather than an intervention or comprehensive risk assessment in its own right. Despite the merits of each of these approaches, a more comprehensive and appropriate intervention was chosen; the Collaborative Assessment and Management of Suicidality (CAMS).

The Collaborative Assessment and Management of Suicidality (CAMS)

CAMS is a flexible therapeutic framework in which clients who are experiencing suicidal ideation work collaboratively with the practitioner to assess the client's suicidal risk and use that information to plan and manage suicide-specific, "driver-oriented" treatment (Jobes et al., 2007). It is a philosophy of clinical care that can be used for a wide range of suicidal clients across outpatient and inpatient treatment settings and in the context of various psychotherapies and treatment modalities.

The focus of the CAMS collaborative approach to create a therapeutic alliance between the client and the practitioner has long standing evidence for effective clinical outcomes. It is universally known and accepted among the literature that the quality of the client therapist alliance is a reliable predictor of positive clinical outcomes independent of the psychotherapeutic approach (Ardito & Rabellino, 2011; Hall, Ferreira, Maher, Latimer & Ferreira, 2010). Further evidence of its effectiveness is based on an expanding body of literature which has shown significant effects in reducing suicide ideation using CAMS among a variety of populations in several different settings. Such studies have been conducted with college students in an outpatient setting (Jobes, Jacoby, Cimbolic & Hustead, 1997), in randomised control studies in a mental health clinic, with patients in an inpatient setting (Ellis, Rufino, Allen, Fowler & Jobes, 2015; Ellis, Green, Allen, Jobes & Nadorff, 2012; Ellis, Allen, Woodson, Frueh & Jobes, 2009) and among suicidal service members and veterans (Archuleta et al., 2014; Jobes, Lento & Brazaitis, 2012; Bryan, Jennings, Jobes & Bradley, 2012; Nademin et al., 2008).

At the core of the CAMS Approach is the Suicide-Status form (SSF), which is a measure of the client's current suicide risk and potential for suicide behaviour. The SSF collects both qualitative and quantitative data from the client and is informed by strong theoretical foundations. The first three SSF items which were derived from Shneidman's (1995) cubic model of suicide, aim to assess psychological pain, pressure (stress) and perturbation (agitation). The fourth item assesses the patient's level of hopelessness which was based on Beck's (1986) theorising that hopelessness is a prominent predictor of suicide ideation which has since been supported by robust evidence from research studies (Qiu, Klonsky & Klein, 2017; Kuo, Gallo & Eaton, 2004).

The fifth SSF item assesses level of self-hate, taken from Baumeister's theory that suicide is an escape from oneself and one's disapproval that they have fallen below their expected personal standards (Baumeister, 1990). The final item assesses the overall risk of suicide at present. Both clients and clinicians rate these items collaboratively in every session. High scores of validity and reliability in several studies have highlighted the strong psychometric value of the tool in comparison to other assessment techniques (Jobes, Kahn-Greene, Greene & Goeke-Morey, 2009; Conrad et al., 2009; Jobes et al., 1997).

The SSF has been referred to as 'gold standard' in clinical evaluation (Harris et al., 2015, p. 21). The qualitative element of the assessment has been criticised for its use for screening and research applications, however is actually a valuable addition and an essential component to the overall clinical assessment in order to document in the client's own words what it feels like to be suicidal (Jobes et al., 2004). These include qualitative responses relative to each of the SSF items, as well as space for open-ended responses for clients to indicate their own reasons for living (RFL) and reasons for dying (RFD) (Jobes & Mann, 1999). The qualitative approach lends compliment to the quantitative, providing a more valid, rich and insightful overall view of the client's situation which is absent from many other suicide risk assessment tools. These elements are combined to develop treatment and stabilisation plans to be implemented over the course of the CAMS intervention and beyond. Such plans include establishing goals and interventions for specific problems, ways to cope during moments of crises and reduce access and use of lethal means.

Regarding professional training, research has demonstrated that CAMS training can result in pre-post training differences in knowledge and attitudes towards working with suicidal patients, including changes in clinician's conduct at follow-up with clients (Oordt, Jobes, Fonseca & Schmidt, 2009). This would suggest an increase in clinician's perceived ability to work with suicidal clients. However, certain factors may act as barriers to the implementation of CAMS, such as time-constraints among clinicians, or the amount of paperwork required in sessions (Jobes, 2006).

Service and National Context

It is clear that the CAMS Approach has been clinically driven with a strong theoretical basis. The framework allows space for other therapeutic interventions to be used during the sessions to work on the suicidal drivers such as Dialectical Behaviour Therapy (Linehan et al., 2015). For Sure Steps, it was important to introduce an evidence-based intervention for suicide into the service in order to standardise the way in which clients with suicidal ideation are referred and treated. The CAMS Approach would allow for each counsellor to use the therapies they are most comfortable with or the therapy which is most appropriate for the client while adhering to the CAMS model in order to track and evaluate the client's progress.

Connecting for Life is Ireland's national strategy to reduce suicide between 2015-2020. Among the strategy's primary goals are the improvement and implementation of effective approaches for those vulnerable to suicide, to provide safe and high-quality services and to improve surveillance, evaluation and high-quality research relating to suicidal behaviour. It was also highlighted that targeted approaches are essential for the assessment and prevention of suicide among vulnerable groups. However, the research to evaluate suicide interventions and evidence-based treatments specific to the homeless population is limited.

Therefore, in line with the national strategy's goals for reducing suicide, Dublin Simon Community's Sure Steps Counselling Service aim to evaluate the CAMS Approach in terms of ease of training, implementing the intervention and most importantly its effectiveness for reducing suicidal thoughts and behaviour among the homeless population. This preliminary report covers the data drawn from a pilot project which implemented CAMS in three pilot sites within Dublin Simon Community – two residential short-term accommodations and one medium supported housing unit. It will discuss three aspects;

1. **Evaluation of the clinical data from the CAMS interventions.**

2. **The frontline staff's experience of the CAMS training they received.**

3. **The counsellors' experience of implementing the CAMS Approach.**

Part Two: Findings from the Pilot Project

2.1 Clinical Interventions

This section reports on the analysis of the clinical data from the implementation of the Collaborative Assessment and Management of Suicidality (CAMS) intervention model by Dublin Simon Community's Sure Steps Counsellors. The aim of the data is to provide an initial evidence base for the use and efficacy of CAMS as an appropriate suicide intervention model within the Sure Steps Counselling Service.

Aim

The analysis examined the following research questions:

- Is there a reduction from pre-post evaluations of Core SSF suicidal risk self-ratings?
- Are there any trends in previous suicidal behaviour and risk variables among clients?
- Do clients' core SSF ratings predict the extent to which they want to commit suicide?
- How can clients' core SSF ratings, as well as their indicated reasons for living and dying be categorised in terms of their personal experiences?

Method

A chart review of routine collected data from the pilot intervention was undertaken in relation to the pilot implementation of the CAMS intervention.

Participants

A criterion-based sampling method was employed. Individuals identified within the Dublin Simon Community's services as having a suicidal risk or who had had previously indicated suicidal ideation and behaviour were subsequently referred to the CAMS Intervention Team.

As this was a chart review of the collected data, no other specific inclusion or exclusion criteria was employed. A total of 17 participants were recruited for the pilot intervention.

Instrument

The Suicide Status Form (SSF) was used for the clinical assessment and tracking of suicidal clients from the initial to the final intervention session. As described previously, the SSF provides a means to record the nature of one's current suicidality informed by their initial assessment. Of interest in the current analysis were the SSF ratings themselves and their supplementary qualitative responses, Reasons for Living and Reasons for Dying indicated by clients, as well as indications of previous suicidal behaviour.

Procedure

Clients attended sessions in various locations attached to the Sure Steps Counselling Service across Dublin city. Initial sessions included the completion of pre-session SSF forms as well as the construction of stabilisation and treatment plans for each client to be developed and implemented over the course of treatment. Clients engaged in CAMS sessions with their respective counsellors over several months, with the range of completed sessions and time between sessions varying for each participant.

While clients engaged with one of four members of the counselling team, the same intervention model was used across all clients. Successful completion of the intervention and the resolution of suicidal risk is indicated by three consecutive sessions of no suicidal thoughts, feelings, and behaviours. This was done through collaborative assessment, tracking and judgement between counsellors and clients throughout the course of their respective interventions.

Results

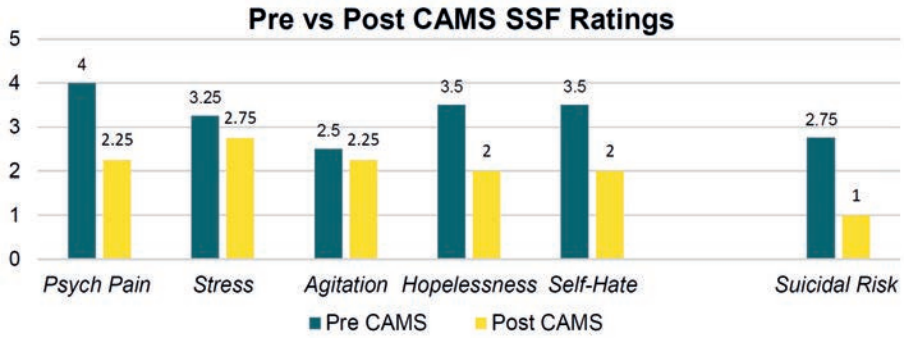
Pre-Post Core SSF ratings

Despite an initial total of 17 participants, only 4 participants completed their respective interventions for inclusion in the pre-post intervention comparisons. Sessions required for completion of the intervention ranged from 3 to 13 for each client.

Figure 2.1 shows a clinical reduction in self-reported SSF and suicidal risk ratings at final CAMS sessions in comparison to initial sessions. However, Wilcoxon Signs Tests as shown in **Table 2.1** found no statistically significant reductions for any of the five core SSF ratings or for self-rated risk. It is important to note that such a small sample size may have likely influenced the outcome of such inferential tests, and that discrepancies between clinical significance and statistical significance are not uncommon.

Figure 2.1

Comparison of SSF and suicidal risk ratings across participants Pre and Post Intervention



Note: N = 4 for Pre-Post intervention calculation

Table 2.1

Measure	*Median*	*Z*	*p*
Pysch Pain - Pre	4		
Psych Pain - Post	2.5	-1.63	.102
Sress - Pre	3		
Stress - Post	2.5	-.45	.655
Agitation - Pre	2.5		
Agitation - Post	2.5	-.45	.655
Hopelessness - Pre	3.5		
Hopelessness - Post	1.5	-.13	.194
Self-Hate - Pre	4		
Self-Hate - Post	1.5	-1.41	.157
Suicidal Risk - Pre	2.5		
Suicidal Risk - Post	1	-1.84	.066

Previous Suicidal Behaviour

Table 2.2 below illustrates that the majority of participants (11 / 17) specified at least one previous attempt on their own life. Six out of these were single attempts, while 4 were multiple and one not specified. While various methods can be seen, the most common method was attempted overdose, followed by self-harm to the wrists. In cases of overdose, some cases specified drugs used, while others did not. While there appear to be 6 non-attempters, form incompletion may have been an issue, and it is therefore difficult to differentiate between non-attempters and those whose histories are not accounted for.

Table 2.2

Frequencies and methods of previous suicidal attempts (N=17)

Previous Attempts (f)				
Single	Multiple	Unknown but attempted	Total attempted	No attempt / no response
6	4	1	11	6

Methods of suicidal attempts (f)			
Overdose	Self-Harm	Indirect Suicide	Not Specified
5	4	3	2

Related Risk Variables

Clients were also asked to indicate the presence of a variety of related symptoms and concerns as illustrated in **Table 2.3** below. The presence of shame was indicated by all clients who filled out this section of the form, with high rates of impulsivity and significant loss (84.61%) as well as substance abuse, relationship problems and a person feeling of a burden to others (76.92%).

Table 2.3
Frequencies and percentages of clinical symptoms reported pre-intervention

Item	*f*	*%*	*N*
Shame	13	100%	13
Impulsivity	11	84.61%	13
Significant Loss	11	84.61%	13
Substance abuse	10	76.92%	13
Relationship problems	10	76.92%	13
Burden to others	10	76.92%	13
Health Problems	9	69.23%	13
Sleep Problems	7	77.77%*	9
Physical Pain	6	46.15%	13
Legal / Financial Issues	5	38.42%	13
Interpersonal isolation	4	100%*	4
Current intent	0	0%*	4
Non-completed forms	4	23.5%	

Note: Total number of responses and subsequent frequencies were different across each symptom due to the presence and absence of symptoms in different versions of the form.

Desire to Commit Suicide as a Predictor of Client Ratings

Clients also indicated their present desire to commit suicide prior to interventions. The extent to which one wanted to die was positively correlated with all five SSF and suicidal risk ratings at initial sessions. More specifically, Spearman's Rank correlations found moderate positive significant correlations for both Psychological Pain ($r = .602$ (1,13), $p = .030$) and Suicidal Risk ($r = .620$ (1,13), $p = .024$), while no significant correlations were found for Stress, Agitation or Hopelessness.

Qualitative SSF Responses

Responses for core SSF and suicidal risk ratings were coded into distinct categories. These categories were taken from those developed from a previous CAMS study in which responses were coded under one of twelve possible categories. Independent coding in this study illustrated high levels of interrater reliability (Jobes et al., 2004). In addition, Accommodation / Homelessness was added as a category based on responses in the current study (please see Appendix 1 for descriptions of individual categories).

Table 2.4
Frequency and percent of categories across all five core SSF ratings.

Category	*Frequency*	*%*
Relational	21	29.2
Unpleasant Internal States	14	19.4
External Descriptors	9	12.5
*Homelessness / Accommodation	8	11.1
Global / General	5	6.9
Self	3	4.2
Helpless	3	4.2
Compelled to Act	3	4.2
Situation Specific	2	2.8
Internal Descriptors	2	2.8
Future	1	1.4
Role Responsibilities	1	1.4

Note: * = Newly generated coding category from current study. Total number of Core SSF responses N = 72

Table 2.4 indicates that the most frequent response across all five SSF ratings were Relational (29.2%), Unpleasant Internal States (19.4%), External Descriptors (12.5%) and Homelessness / Accommodation (11.1%). A more specific breakdown of responses is illustrated by those given within each SSF rating. The most common responses were Relational for psychological pain (40%), stress, (43.8%) and self-hate (33.3%), Unpleasant Internal States for agitation (53.3%) and Homelessness / Accommodation for hopelessness (33.3%).

Reasoning for Living and Dying

Qualitative responses for reasons for living and dying were also coded into distinct thematic categories. These categories were either generated through independent judging or taken from a previous CAMS study in which responses were commonly coded across two independent coders with high levels of inter-rater reliability (Jobes & Mann, 1999). For a full breakdown of categories from the original study, as well as those newly-generated, please see Appendix 2.

A total of 51 responses were given for both RFL and RFD, with an average of 3 RFL and RFD responses provided by each client. Eight RFL and ten RFD categories were generated. **Table 2.5** overleaf shows that most reasons for living pertained to Family (f = 22). The most frequent category generated uniquely from this study related to obtaining basic needs such as accommodation, food and sanitation (f = 7). Reasons for Living showed a similar trend with Others / Relationships appearing most frequently (f = 13), with newly-generated categories regarding illness concerns and accommodation / homelessness appearing less frequently.

Table 2.5
Category response frequencies for Reasons for Living (RFL) and Reasons for Dying (RFD)

Category		
Reasons for Living	**Frequency**	**%**
1. Family	22	43.14
2. *Basic needs	7	13.73
3. Self	7	13.73
4. Friends	6	11.76
5. *Personal health outcomes	3	5.88
6. *Financial / Career	3	5.88
7. Enjoyable things	2	3.92
8. Future – vague	1	1.96
Reasons for Dying	**Frequency**	**%**
1. Others / Relationships	13	25.49
2. Escape - general	11	21.57
3. General Descriptors of self	7	13.73
4. *Illness concerns	6	11.76
5. *Accommodation / Homelessness	4	7.84
6. Hopelessness	2	3.92
7. Escape - pain	2	3.92
8. Escape - past	2	3.92
9. Feeling alone	2	3.92
10. Feeling stressed / worried	2	3.92

Note: * Categories newly generated for current study. Total number of RFL responses = 51. Total number of RFD responses = 51

Table 2.6
Sample stabilisation plan from a completed intervention case.

CAMS Stabilisation Plan	
Ways to reduce access to lethal means	No plan at present
Things I can do to cope differently when I am in a suicide crisis	Playing guitar, writing songs, listening to music, get a CD player, watching television
Life or death emergency contact number	112 / 999
People I can call for help or to decrease my isolation	Staff members, Pieta House 1800 247 247
Potential Barrier / Solutions I will try	None / NA

Table 2.7
Sample treatment plan and subsequent updates from a completed intervention case.

Treatment Plan

Problem #	Problem Description	Goals / Objectives	Interventions	Duration
1	Loneliness, Isolation, Depression	Playing guitar, talking to peers, writing songs	Counselling	NA
2	Self-Harm	Looking at other ways of releasing emotion	Counselling	NA

Treatment Plan Update

Problem #	Problem Description	Goals / Objectives	Interventions	Duration
1	Isolation	Talk to the night nurse	Client to approach night nurse	NA
2	Depression	Contact Doctor in *location*	Client has contacted receptionist	NA

The above figures illustrate a sampling of stabilisation and treatment plans among the completed clinical interventions. The case above illustrates the extensive procedures put in place in order to keep the client both safe and stable under the CAMS model, while also tailoring these procedures to individual circumstances. This individuality can also be seen in relation to the accompanying treatment plans, which as can be seen above are updated over time to address specific issues as they arise for each client.

2.2 Pre-Post Frontline Staff Training Evaluation

A preliminary pre-post evaluation of the Collaborative Assessment and Management of Suicidality (CAMS) training delivered to frontline staff at Dublin Simon Community was undertaken.

Aim

The aim of the evaluation study was to explore potential self-perceived knowledge and skills gains among training participants and to identify areas of improvement for CAMS training and implementation.

Methods

Training Overview

Training involved participants engaging in a 3-hour online learning module, a one-day live role play workshop, and follow up case consultation phone calls. Training detailed the Collaborative Assessment and Management of Suicidality model and had the following learning goals:

- Have an introduction to and practiced the CAMS Approach.
- Be able to identify suicidal risk early in the clinical engagement and use the Suicide Status Form (SSF) to collaboratively assess suicidal risk.
- Develop SSF-based suicide specific outpatient treatment plans that emphasise the development of a stabilisation plan and the identification of suicidal 'drivers' as a focus of treatment.
- Clinically track, assess and treat drivers with problem-focused interventions.
- Be able to prepare a stabilisation or crisis response plan.

All training participants consented to take part in the preliminary service development and training evaluation.

Evaluation

The evaluation comprised a set of pre-post questions that were presented to participants via an online questionnaire (prior to the training) and an on-site questionnaire (following immediately after completion of the one-day training). The questionnaire contained items on demographic characteristics, prior suicide prevention training and confidence to work with clients with suicidal ideation. The questionnaire-based evaluation was followed up with brief semi-structured in person interviews two months after the training.

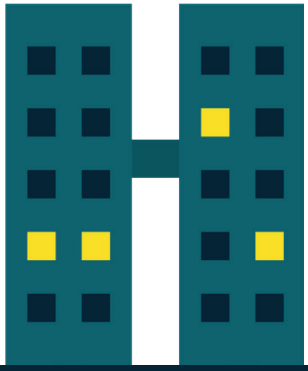
Data analysis

Simple descriptive analyses (e.g. frequencies; means and standard deviations) were conducted as participants were not matched on participant ID for statistical analysis of differences between pre-and post-tests).

Results

Evaluation Participants

The sample included the total of n=30 CAMS training participants, 24 women and 6 men (across age categories 18-24 to 55-64) at one training event. 30 respondents completed the baseline questionnaire (before the training) while 29 completed the questionnaire after the training. Most participants were support, project or key workers (n=19), while five were psychotherapists, counsellors or social workers, four were managers, and two indicated other roles. Apart from two participants, all others had received some form of prior suicide prevention training, with 19 participants indicating having been trained in ASSIST, 15 in SAFETALK, 1 in STORM and 2 in Training for Life Helpline.



Changes in Self-Rated Confidence and Views

The questionnaire asked participants about their confidence to assess and manage suicidal ideation. The Figure below shows median pre- and post-test ratings on the 5-point scale (1=strongly disagree; 2=disagree; 3=neutral; 4=agree; 5=strongly agree). Self-ratings after the training were more positive than before the training.

Figure 2.2

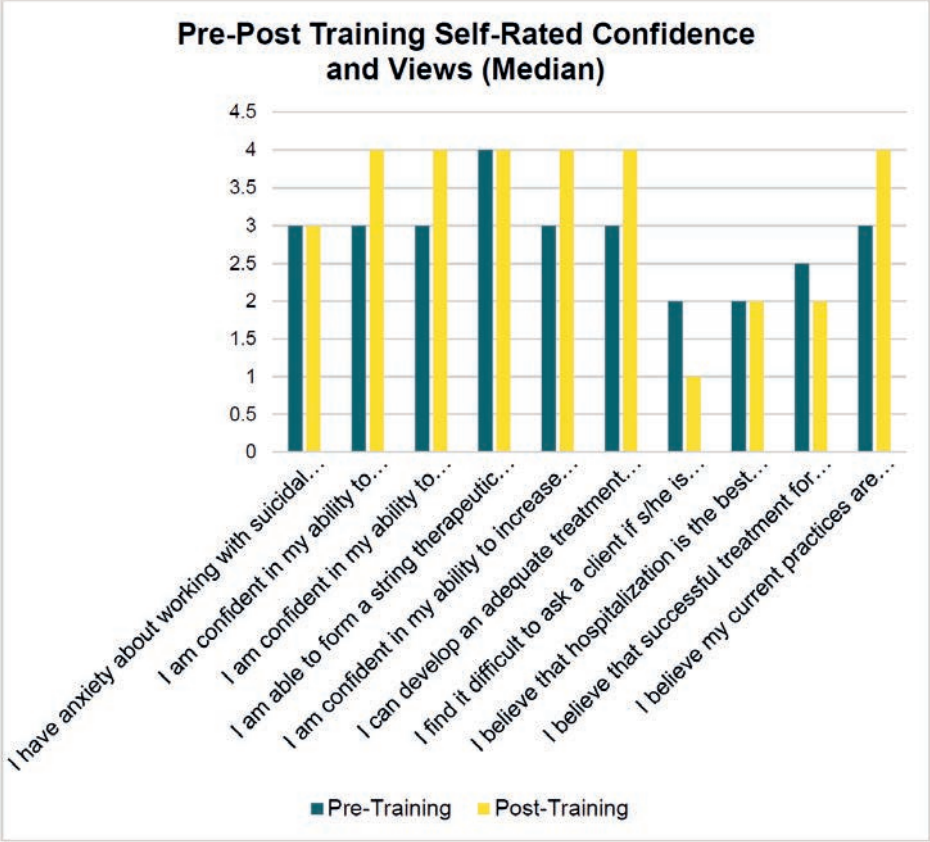


Figure 2.2 Changes in mean scores before and after the CAMS training on the 5-point scale (1=strongly disagree; 2=disagree; 3=neutral; 4=agree; 5=strongly agree).

Training Content, Format and Delivery (After the Training Event)

The bar chart in **Figure 2.3** shows that the training was well received by participants.

Figure 2.3

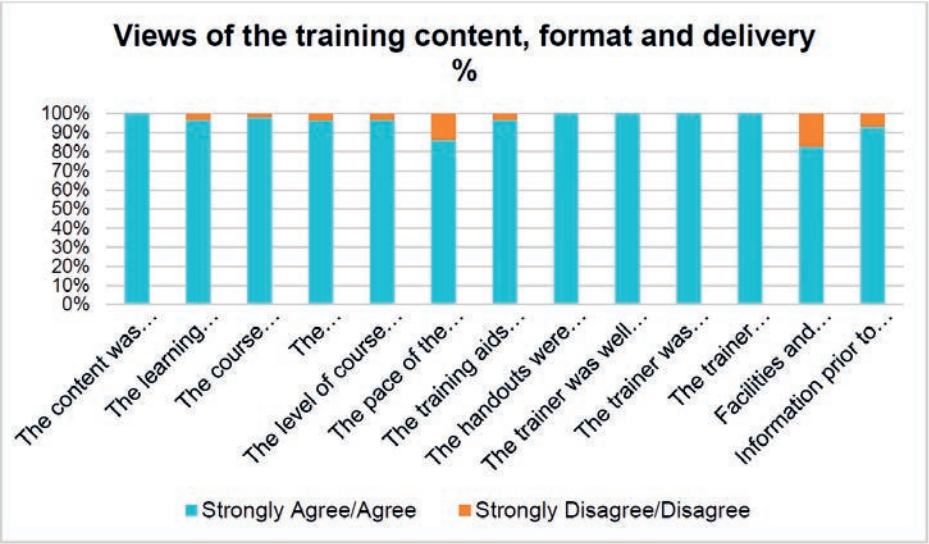
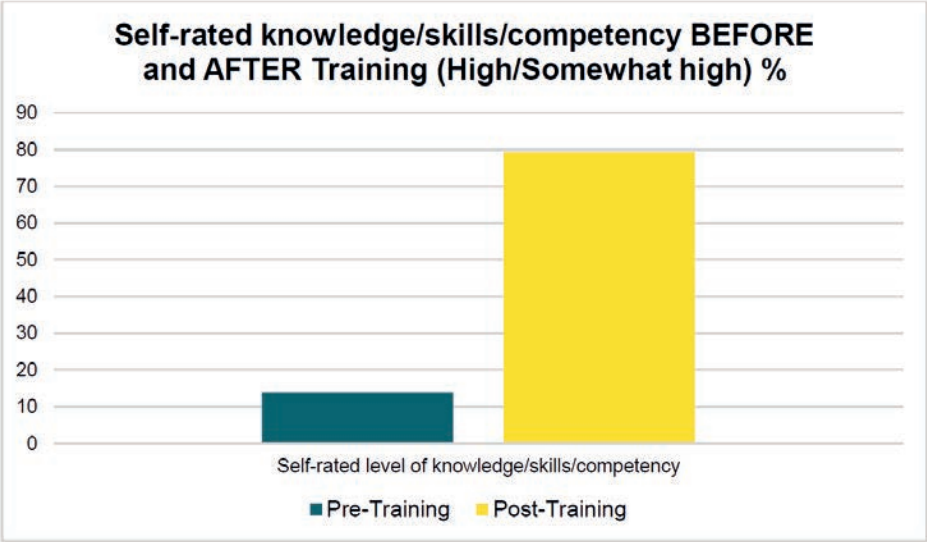


Figure 2.3 Course content, format and delivery views (n=29).

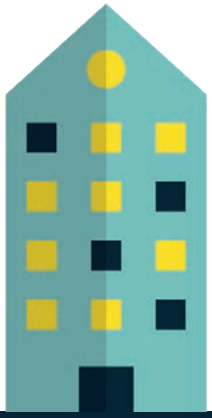
All participants also strongly agreed or agreed (100%; n=29) that the course achieved intended 'learning outcomes'.

Training participants were also asked to retrospectively self-rate their level of knowledge/skills/competency pre and post training (see **Figure 2.4**). The figure shows self-ratings point towards self-perceived knowledge/skills and competency gains after training.

Figure 2.4



Finally, participants were asked to describe two 'things learnt' from the training event. The majority mentioned that the training had helped them with better 'risk assessment' and the development of stabilisation plans.



2.3 Principal Findings From the Semi-structured Telephone Interviews

Conduct of Interviews

All interviews were conducted in person by a skilled and trained volunteer of Dublin Simon Community and co-author of the report. The interviewer was not involved in the delivery or implementation of the programme.

Interview Participants

The sample of the semi-structured follow-up interviews consisted of 10 randomly chosen CAMS training participants. Interview questions focused on experiences with using the training content in practice as well as the strengths and limitations of the training itself.

Data Management and Analysis

The interviews were audio-recorded with permission, subsequently transcribed independently and anonymised by a co-author of this report. Interviews were content coded in relation to **(1) Training Content, Format and Delivery; (2) Perceived Training Benefits; (3) Application of CAMS in Practice and (4) Future Development of CAMS in the Context of the Organisation.**

Results

Findings from the qualitative interviews supported the positive experiences reported as part of the pre-post-training evaluation. Interview participants made helpful suggestions for further improvements of the CAMS training and the structural implementation of the CAMS approach in the organisation. **Table 2.8** overleaf provides a summary of the findings from the telephone interviews.

Table 2.8: Experiences with the CAMS Training

1. Training Content, Format and Delivery	Specific Issues	Sample quotes
1.1 Online training	• American voice – degree of alienation • Flexibility of use • CAMS forms easy complete	*"I found the online training…very informative …it was very clear …and it gave great insight into what was expected as a participant."* (P7)
1.2 Workshop	• Good mixture of participants • Presenter expertise • Role play scenarios (not adapted to client group) • Role play interaction – positive to observe; immediacy • Emotionality of role play participants - negative • Facilities not conducive (noise, temperature)	*"I thought the format was quite good…I think there was some group work which I thought was very good I learned the most from and a chance to actually put the CAMS forms into practice."* *"I think definitely need to include something with homelessness even in a scenario or in a role-play but definitely in some aspect and see how the facilitator handles that… that's the only extra thing."* (P10)
2. Perceived training benefits	**Specific Issues**	**Sample quotes**
2.1 Psychological	• Confidence and acceptance • Reduced anxiety	*"When I use CAMS I get a lot of material and it's in a straightforward way of how to get it and it means I've asked all the questions… if somebody asks me …did I ask them this question …I can say well these are the questions that I've asked… and it gives me a reason to say what level of suicide risk the client has.. so yeah it would give me much more confidence making the right decision…"* (P10)

2.2 Risk assessment	• Risk assessment tools	*"I think the CAMS training has done that for me it is to make me aware there is a path the client can go on you know when doing a risk assessment that they have tried to commit suicide it made me more aware that we need to put some sort of plan in place and then I think the CAMS is the way forward."* (P1)
2.3 Risk management	• Having a standardised scripted format to follow • Alternatives to hospitalisation for clients and local management of suicide ideation • Structured, standardised approach positive	*"we try to reduce the risk locally...and that has worked for our clients you know individual risk assessments, assessing the environment so I think probably being more positive about it that as impacted on our team is something I've definitely seen."* (P9) *"…not only like preventing him from you know attempting suicide or self-harm but you know keeping him out of hospital, and coming up with a contract and a verbal contract."* (P7)
3. Application of CAMS in practice	**Specific Issues**	**Sample quotes**
3.1 Value consistency	• Consistency with values, especially in relation to choice	*"I think it did integrate very well into my current way I would work and in terms of everything else like I could relate CAMS back to the way we like our kind of culture of interacting with clients."* (P9)
3.2 Service integration	• Crisis phase and emergency settings – no time to sit down and complete forms; difficult to use • Greater appropriateness for recovery • Greater alliance with Sure Steps	*"I'd to see a snap kind of piece on emergency so eventually you could talk to them about going to Sure Steps or go through the form but it's that initial stage… that initial period, the emergency kind of piece I'd love to do a little more work on that…"* (P1) *"you have a tool in your bag to use and it sort of brings in a closer association with Sure Steps so you're building more of an alliance…"* (P2)

3.3 Specific Challenges	• Literacy issues, dual diagnosis and complexity of client population – clients may 'close up' when confronted with forms	*"…some of our guys have literacy issues and they won't say they do but you sit down with a form either they'll fake their way through it or they will get really anxious and you know it will defeat the purpose…"* (P2)
4. Future development of CAMS in the Context of the Organisation	**Specific issues**	**Sample quotes**
4.1 Implementation in Dublin Simon Community	• Whole system service integration • Ensuring safe hand over (all staff trained in CAMS)	*"you could even have like a working group to develop it further and to integrate it and to maybe see what the barriers are and maybe starting with each department first and maybe looking at people's individuals roles because I mean I don't use it at the moment but I can definitely see how it could be very beneficial… maybe looking at cases where it has been implemented and seeing what kind of outcomes people got from that."* (P3)
4.2 Improvement of the CAMS Training	• Whole system approach of training needed • Implementing follow-up systems – refresher and booster sessions • Supervision (contact for debriefing) • Spread workshop over 2 days • Extend access to online training beyond one week • Revise slides for better readability and accessibility.	*"But I'd just like to be using it more and maybe have more refreshers and more governance around the use of it."* (P4) *"…maybe some debriefing sessions you know for when with staff and groups and if they're using it and how are they finding it and same with residents you have."* (P4)

2.4 Post-Evaluation Counsellor Focus Group

A focus group was conducted with counsellors who were responsible for the implementation of the CAMS interventions. The group discussed topics related to both training and implementation.

Aim

The aim of the focus group was to assess the experiences of Dublin Simon Community's Sure Steps Counsellors in the introduction and implementation of the CAMS model.

Method

Participants

Participants included members of the Sure Steps Counselling Service at Dublin Simon Community. These counsellors were previously trained in the CAMS intervention model, in a two day offsite training, and subsequently implemented this model with several clients within the service. The focus group was facilitated by a skilled and trained volunteer of Dublin Simon Community and co-author of the report. The interviewer was not involved in the delivery or implementation of the programme.

Procedure

Participants were invited to attend the focus group within a suitable location attached to the Sure Steps Service. A topic guide was generated to cover various aspects of the CAMS training and implementation process, which included: usefulness of the CAMS training; perceptions of efficacy of the CAMS process; format / presentation of CAMS forms; content/language of CAMS forms; barriers / solutions to adhering to the CAMS process measures that tend to have poor adherence; barriers / solutions to implementing the CAMS process. The focus group was audio recorded and digitally transcribed for analysis.

Analytic Approach

Thematic analysis was conducted as per in Braun and Clarke (2006) to identify, analyse and report themes emerging from the focus group. Although emerging themes were somewhat separated due to the influence of a previously developed topic guide, inductive analysis was still exercised as themes emerged directly the data itself. Questions were deliberately left open-ended whenever possible, and emerging themes were derived from the data directly rather than from themes favourable to previous research, thus addressing concerns of reflexivity.

The focus group was audio-recorded and transcribed for subsequent analysis. Responses were first coded individually, with similar or matching codes merged and placed under themes covering various aspects of the CAMS training process. Five main themes and accompanying sub-themes emerged. Themes were analysed further to evaluate for any triangulation across aspects of the training and implementation process as well as whether such findings gave any reflections on those found in the intervention data, as well as those from the post-training evaluation data.

Results

Five main themes and accompanying sub-themes emerged from the analysis:

- **Positive experience of using CAMS**
- **Training / Use of CAMS as a 'gradual' process**
- **Issues with completing SSF Forms**
- **Process driven, integrated care beyond CAMS sessions**
- **Concerns over funding and resources**

Table 2.8 overleaf shows a breakdown of each merging theme, along with descriptions of the specific issues emerging, and sample quotations as supportive evidence.

Table 2.9: Experiences of training and implementation.

1. Positive experiences of using CAMS	Specific Issues	Sample quotes
1.1 Increased confidence in working with suicide	• Being able to provide clear evidence of the treatment work • Confidence in leaving the client in safer circumstances	*"it gives you some sense of security that you have done something that there is proof that it's there, and you have…I would feel that I have a much more … Confidence in what I have done."* (P1) *"in the moment I'm leaving the client, he's either safe … or I'm passing on the fact that they are at high risk and there is the appropriate intervention done."* (P4).
1.2 Providing Suicide-specific intervention	• A clear focus on addressing and tracking suicidality	*"you are actually doing an intervention… intervening purely on the suicidality and that's what CAMS is about, is purely that intervention."* (P4). *"it's a wonderful tracking tool … you cut to the chase really quickly, you get to see what the core issues are the drivers."* (P3).
1.3 Positive Training experiences	• Importance of two-day training workshop • Ability to explore solutions to specific situations experienced	*"the two days, I thought were really essential with the role it plays."* (P4). *"stuff that has come up that I'd like to be able to discuss and when it arises be able to bounce off."* (P3)

2. Training / Use of CAMS: A 'gradual' process	Specific Issues	Sample quotes
2.1 The importance of constant / repeated use	• The need for constant and repeated use of the model • Importance of constant trainer feedback to maintain quality of skills and care	*"I think the more you use it, the more comfortable you get with it ... It's like a language if you stop using your French you are going to lose the language."* (P3) *"someone that gives us feedback regularly …this is what is going on, this is what happens, you are hitting a road block there or you may be scared there in how you integrate it, because you are uncomfortable the client is uncomfortable."* (P4)
2.2 Increased comfort in form use over time.	• Increased comfort in using SSF forms effectively	*"For me using it for the first time, I was uncomfortable and as time went on with the clients I found a way of integrating it."* (P2).
3. Issues with completing SFF forms	**Specific Issues**	**Sample quotes**
3.1 Prioritising the therapeutic relationship and work first.	• Prioritising safety and comfort of the client • How to integrate paperwork into the therapeutic process	*"it's completely off-putting when they are coming in traumatised. Number one priority is to settle them down and that can take a while."* (P3) *"not the paperwork as such, the paperwork is helpful it's integrating it nicely in the therapeutic process."* (P4)
3.2 Concern for the 'reaction' of clients to the forms.	• Can affect therapeutic relationship • Forms may instil elements of fear or discomfort for clients • Feelings of being restricted to addressing issues specific to the form	*"clients find it very hard to trust, so even I found when you do settle them down with paperwork comes back up again, suddenly … you can see fear with them."* (P3) *"It might also remind them of hospitals and checklists."* (P4) *"I felt that the clients shut down when they see paperwork. I just felt that they felt limited in what they could talk about, because it is very direct if we are asking them questions in relation to what's in the form."* (P2)

3.3 Resulting effects on form completion	• Client reactions and time constraints lead to form incompletion	*"I have seen where there is a reaction I'll leave that, put it away and it's to continue on with general focusing on what's in the CAMS form."* (P1) *"I was uncomfortable with paperwork. But, I didn't get it finished … So I was uncomfortable leaving the session as well, because I felt I hadn't filled out the form correctly."* (P2)
4. Process-driven care beyond CAMS sessions	**Specific Issues**	**Sample quotes**
4.1 Care as 'process-driven'	• Specific knowledge to allow other staff to handle out of hour situations • Establishing decision-making across workers	*"linking in and connecting with the client, … is there an emergency there or not, and can I hold that person until the counsellor gets here. Because what if it is 10 at night … because there is no counsellor there at 10 at night."* (P4) *"it's not a formal process, but something that could give them the power to be able to make a decision."* (P1)
4.2 Care as 'round the clock'	• Using CAMS to enhance out of hours care	*"we work 9 to 5. So that wraparound support that knowing the stabilisation plan that off the hoof how do I calm the client down, how do I connect with them fearlessly that needs to be there, it needs to be around the clock."* (P4)
4.3 Care as 'collaborative'	• Awareness of carers regarding clients' care plans / current state • An interdisciplinary 'dialogue'	*"it works really well… if everybody else departmentally is on the same page. I always give a copy of the stabilisation to the key worker and they look at it and go …we know about some of those already, but we didn't know about that. So really getting everyone else on the same page it can go from strength to strength."* (P3) *"Opening up a dialogue with hospitals and clinicians, … I think it is where we want to go with it, is that right in terms of the homeless, addiction, mental health? … all of us singing from the same hymn sheet."* (P3)

4.4 Extension of training to other workers	• Providing other staff with similar CAMS training	*"it's very important we are trying to develop a training, … where we train key workers in the principles of CAMS and they can use it in an ad-hoc way."* (P1)
5. Concern over funding and resources	**Specific issues**	**Sample quotes**
5.1 Staff availability	• Staff availability in potential crises in various units	*"because say if it is 11 at night and there is one key worker on and one support worker, and you need to sit with someone for 6 hours."* *"back to resources with, they don't really have the resources to keep the 24 hour vigil on him."* (P3)
5.2 Additional training	• Funding implications on type and extent of training access	*"And again we are bringing it back to funding and resources, … the online training is a fraction of the price of what the 2 day training is and that funding just isn't there to train everyone that needs to be trained."* (P4)
5.3 Inability to roll out national strategies	• Lack of funding to roll out guidelines set by national strategy for suicide prevention	*"they have identified that they need to be treated a special way … But when we went back and checked is there any funding, so we can roll out this process more, there wasn't any money there as of yet anyway."* (P4)

Part Three: Discussion of Findings

The sections that follow outline discussion of each component of the pilot project. Triangulation of data is noted where appropriate, as well as the studies strengths and limitations, and resulting recommendations for future practice and evaluation are outlined.

3.1 CAMS Intervention Data

In terms of statistical analysis, clinical reductions in suicidal ratings adds to the pertinent literature supporting CAMS interventions, with this study contributing uniquely with the representation of homeless individuals. It is important to note that such reductions were not statistically significant. However, due to the small sample size at baseline as well as an even lower number of completed cases, inferential statistics such as repeated sample analyses are inevitably limited, and the evidence of clinical reductions are still a legitimate finding. High reports of risk factors indicated by participants support previous findings of suicide-related risks, such as substance abuse, relationship issues, loss of a significant other and financial issues (Evans, Scourfield & Moore, 2016; Dragisic, Dickov, Dickov & Mijatovic, 2015; Saxby & Anil, 2012; Windfuhr & Kapur, 2011; Bhatia et al., 1987), as well as studies that highlight the high prevalence of such factors among homeless individuals (Crane et al., 2005; Teesson, Hodder & Buhrich, 2003). The finding that each of the SSF ratings was associated with the extent to which clients wanted to die supports the theoretical rationale for the inclusion of such items (Shneidman, 1995; Baumeister, 1990; Beck, 1986).

The high rate of pre-existing categories found in the current study shows a commonality of SSF-related factors across multiple populations (Jobes et al., 2004). However, the present study also highlights the importance of accommodation as a unique circumstance among homeless individuals that contribute to suicidal risk. A similar trend can be found in relation to indicated reasons for living and dying. While certain categories relate to previous studies (Jobes & Mann, 1999), there was also the presence of unique circumstances, including basic needs of accommodation, food and sanitation as well as personal health outcomes.

It is important to note also that whether each category was a reason for living or dying was dependant on each client.

Limitations of Intervention studies

As mentioned previously, the current study contained a very small sample in comparison with other CAMS studies, as well as with typically recommended sample sizes. As a result, any statistical inferences are inherently limited. For future studies, increased sample sizes would increase both the legitimacy of the findings, as well as the scope of potential analyses. In addition, correlational analyses of SSF ratings as predictors of wanting to die cannot infer causality.

In addition, since this was a preliminary analysis, the reliability of how responses for both core SSF responses as well as reasons for living and dying were categorised is not accounted for. To gain further empirical legitimacy, inter-rater reliabilities of the response coding is required with at least two coders, as implemented in previous studies.

3.2 Staff training and Implementation

The resulting trends from both the focus group and follow-up interviews show a broad range of positive experiences, issues of concern and suggestions for future improvement in relation to the training and implementation of the CAMS model among staff members. Below is an integration of these findings to create an overall reflection of staff perspectives.

Positive Experiences of CAMS Training and Implementation

In the counsellor focus group, participants noted the positive experience of being able to clearly illustrate progress within sessions and being left with a sense of understanding for the clients' current state, resulting in an increase in confidence in staff members' ability to work with suicidal clients. This was also highlighted in the frontline staff follow-up interviews, as well as supported by the evident increases in knowledge and confidence from the pre-post evaluations. Interviewees also noted the flexibility and clarity was highlighted in relation to both online and workshop-based training. This shows the importance of all components of the training process required for developing competency and consequently the need for sufficient resources for such training to be provided.

In addition, a clear focus on suicidality within CAMS sessions provided a very objective treatment experience among participants. The quality of direct training received as noted previously as well as the ability to work out case-specific situations was crucial to pre-intervention training. This benefit was seen at all stages of intervention, from training, to risk assessment to management.

A Process-Driven Approach

Focus group members felt the CAMS process should be a core part of a wider collaborative and process-driven system of care. Awareness of specific knowledge and procedures around suicidal cases was the core of this, with the need for both interdisciplinary collaboration to implement these practices fully. This whole-system approach was also endorsed by the follow-up interviews of the frontline staff, emphasising the need for appropriate handovers of care between staff members.

Round-the-clock Care

This process-driven incentive was also dependant on having the availability of such care at any hour of the day when potential crises and subsequent care are warranted. Specifically, there is a need for staff to not only be informed of the processes, but also for CAMS-trained staff to be available at hours outside of when the majority of practitioner's work.

CAMS Form Completion

Concerns were raised in the counsellor focus group regarding administration and completion of the SSF forms with clients, supportive of previous research findings (Jobes, 2006). Counsellors felt the need to prioritise the therapeutic relationship as well as the safety of clients perhaps hindered this process and considered how form completion may 'fit' adequately into the therapeutic process. These concerns were also raised in relation to the clients' 'reaction' to these forms, as it may affect the relationship as well as potentially restricting the scope of conversation to items solely on the forms. This is somewhat of a contradiction to the follow-up interviews of frontline staff, in which participants noted the ease at which forms can be completed in training. This would suggest a discrepancy between training and practice in terms of form administration and completion. This has specific implications on the resulting clinical data, as certain aspects of the data were not accounted for due to incompletion and / or omittance of data.

Consistency and Repetition of Practice

Implementation of the CAMS model was described as a gradual experience among focus group participants. The importance of consistency and repetition was noted as a fundamental aspect of both the training and the subsequent use of the CAMS model as effectively as possible, with examples including learning how to integrate form filling into sessions appropriately as mentioned above. This related closely to the individual follow-ups of frontline staff, which noted the suggestion of future supervision and revision of training.

Concerns over Resourcing for Future CAMS Training and Implementation

Further integration of staff perspectives highlighted that certain concerns and potential improvements linked back to issues of resourcing and funding. The counsellor focus group emphasised a lack of staff availability that prevents services from providing crucial round the clock care for individuals at risk of suicide as recommended previously. In terms of staff training required to implement this process driven care, a lack of funding limits both the quality and scope of those reached in training. These findings relate similarly to the recommendations made in both sets of frontline staff post-training follow-ups, highlighting the need for a whole-system approach by training all relevant staff members, as well as repeated training and supervision for themselves over time to adhere to the 'gradual' process of optimal implementation of the CAMS training. In addition, as noted in the focus group analysis, the rolling out of important evidence based national strategies to supplement such training and intervention are limited due to a lack of dedicated resourcing within the service.

Limitations of Staff Training and Implementation Studies

For the pre-post training evaluation of frontline staff, the measures included in the evaluation are self-report tools that have not been validated. Moreover, there is a risk of a 'response shift bias', which has been reported for self-assessed knowledge and experiences in pre-post designs where participants' self-ratings change as a result of the programme content. In addition, the service evaluation did not include control participants. A Hawthorne Effect cannot be ruled out in that participants simply changed their responses as they knew they participated in a training programme that intended to change their experiences and skills. In addition, the preliminary evaluation data cannot determine 'effectiveness' of the training. Limited sample sizes and resources for implementing more empirical evaluations hinder a more sophisticated analysis of the inferential data. Nevertheless, the results point into a promising direction and should be followed up with a more robust evaluation at a later stage.

In terms of the follow-up interviews, the analysis was limited to description and extraction of participant experiences with the training. The data cannot provide information on what specifically was learned and how the learning has been implemented in the participants' practice. However, the counsellor focus group data partially assists in complimenting these findings, as counsellors cited specific examples of how their training directly translated into intervention practice. This would suggest that specific examples of applying theory into practice is better explored with in-depth discussions among staff.

In conclusion, the use of several mixed methods components to evaluate staff training and implementation provides a multifaceted, multi-layered evidence base. When taken together, staff evaluations and perspectives provide crucial insight into developing such training and implementation further, both within the CAMS model and in terms of general suicidal care and intervention. However, it is important to be aware of the preliminary nature of these results, and the need for more robust analyses for a sounder empirical evidence base going forward.

3.3 Recommendations for Future Research and Practice

Based on the evaluations above, five key recommendations are proposed for future practice and evaluation, both in the context of the CAMS model, as well as general practice for the treatment of suicidality among individuals experiencing homelessness:

- Implementation of CAMS and similar interventions should adapt a process-driven approach, with an integration of services and knowledge across a variety of stakeholders.

- Restricted availability of such provisions is of particular concern within the homeless population, who are often limited to the use of A&E in moments of crises. It is recommended that services are available 24x7 to serve as a viable alternative to A&E.

- To further the process-driven, round the clock service provision, CAMS training must adapt a whole-service approach with an incentive towards consistent and gradual development of service workers. As a result, there is a need for training of all staff members involved in the management and treatment of suicidal clients, as well as the inclusion of ongoing and progression training to increase staff knowledge, confidence and competency over time.

- Our intervention findings illustrate the variety of concerns and factors related to each client's suicidal presentation. To this end, we endorse the need for training and implementation of suicide-specific interventions such as the CAMS model to tailor towards individual client needs and concerns.

- To contribute to the evidence base of suicide intervention within the homeless population, a broader and more robust set of evaluations of such interventions is required. An increase in population samples from both a client and staff base as well as increased research resources can allow for more sophisticated statistical inferences, a broader set of mixed method analyses, as well as greater scope for the validity, reliability and generalisability of findings.

3.4 Concluding Thoughts: Our Proposed Framework for Suicide Intervention

This report highlights the increased risk of suicide experienced within the homeless population, and the potential benefits of implementing an evidence-based, suicide-specific intervention such as the CAMS model. Despite the presence of mental health services during working hours, the expression of suicide ideation and level of intent does not limit itself to these working hours.

There currently is no 24x7 intervention for the ongoing assessment and management of suicide ideation other than A&E for the homeless population. As Dublin Simon Community provides on-going support services 24x7 to the homeless population, suicide ideation and intent is prevalent to different degrees at any given time across all Dublin Simon Community services irrespective of the type of service being provided.

The present situation in terms of provision of support to clients who have expressed suicide ideation leads itself very much towards A&E presentations, which in many cases are deemed unnecessary and unsuitable in terms of meeting the therapeutic needs of the client.

There is ultimately a need to provide an alternative therapeutic intervention for people who are homeless who are expressing suicide ideation, which is fully funded, to allow a 24x7, round-the-clock service as an alternative to A & E for clients. However, there are a variety of aspects of service provision required to accomplish this. To this end, with the inclusion of the current pilot project, Dublin Simon Community's Sure Steps Counselling Service has implemented a framework to establish such provisions within our services.

Concluding Thoughts: Our Proposed Framework for Suicide Intervention

This proposed framework will concentrate on developing and rolling out a Suicide Specific Treatment Track (SSTT), including an SSTT training course for Dublin Simon Community staff, as a pathway into a CAMS based intervention provided by the Dublin Simon Community's Sure Steps Counsellors. Funding will be sought to provide a new out-of-hours service for clients expressing suicidal ideation.

With this new framework in place, it is envisaged that staff will be better equipped to deal with incidents of suicidal ideation and clients will have a viable alternative to presenting in A&E, particular outside the regular working hours. It is anticipated that adapting the implementation of the CAMS model into our services will provide an alternative, evidence-based, round-the-clock set of support services for clients, with the intent to reduce the rate of suicide among individuals experiencing homelessness.

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Appendices

Appendix 1

Newly generated and original coding category descriptions from Jobes et al., (2004) for core SSF responses

Category	Definition
Newly generated category	
Homelessness / Accommodation	Any references to issues regarding homelessness or general housing issues
Categories taken from original study	
Relational	Any references to specific relationship problems or issues with family, friends, significant others or any other social interaction. Any responses that speak to being hurt by others, hurting others or being alone and isolated go here as well.
Unpleasant Internal States	Statements referring to discrete descriptions of hurting, distress, suffering, pain, and other negative emotions.
External Descriptors	Some external, outer aspect of him/herself such as his/her personal appearance, body or behaviours in which he/she is engaging.
Global / General	Any nonspecific, broad statements that are completely inclusive and therefore vague. These responses indicate a general overarching sense of being overwhelmed and/or unable to cope.

Category	Definition
Self	Responses that are specific to one's self, or when a reference ot one's self is clearly inferred. These can be statements about feelings of qualities about the self. These tend to be descriptors of core attributes or harsh self-critiques or eternal descriptors.
Helpless	Any implied or specific references to being out of control, lost, trapped, or directionless. Includes statement about hopelessness about one's ability to cope, function or achieve in the future.
Compelled to Act	Explicit desire to urgently change their life; a quick solution; a need to act; being stuck.
Situation Specific	Any reference made about a specific situation or circumstance, or any reference made to a certain place, time or events.
Internal Descriptors	Lack of positive qualities or the presence of negative qualities in him/herself; feelings about the self; inner descriptors of the self.
Future	Specific dreams, skills, events or experiences (except career or school, see Role / Responsibilities) with a clear reference to the future.
Role Responsibilities	Common adult role expectations including the roles of the worker, homemaker, or student. Responses such as academic concerns, financial burdens, or job concerns are included here. Specific future-orientated

Appendix 2

Newly-generated and original coding category descriptions from Jobes and Mann, (1999, pg. 100) for Reasons for Living and Reasons for Dying

Description of coding categories for Reasons for Living (RFL)

Category	Definition
Newly-Generated Categories	
Basic Needs	Any mention of desire for basic human needs (food, shelter, sanitation)
Personal Health outcomes	Any mention of the desire to improve current health issues (addiction / sobriety)
Financial / Career	Any mention of the desire to seek improvements relating to finances or jobs.
Categories taken from original study (Jobes & Mann, 1999)	
Family	Any references to family such as marriage or children (e.g., “my parents,” “my husband”, or “my family loves me”).
Friends	Any mention of friends, including specific names (e.g., “my friends”, or “Dick and Jane”).
Self	Specific reference to self or feelings or qualities about the self (e.g., “myself,” or “I don’t want to let myself down”).
Enjoyable things	Any mention of activities or objects that are enjoyed (e.g., “Chinese food,” or “playing the piano”).
Future – vague	Future-orientated statements that deal with vague abstract yearnings, expressing a hopeful attitude or curiosity of how the future will be (e.g. “I hope I’ll stop feeling bad,” or “There’s much I still want to do”).

Description of coding categories for Reasons for Dying (RFD)

Category	Definition
Newly-Generated Categories	
Illness Concerns	Any mention of desire for basic human needs (food, shelter, sanitation)
Accommodation / Homelessness	Any mention of the effect of issues concerning housing or homelessness
Stressed / Worried	Any mention of experiencing feelings of stress or worry
Categories taken from original study (Jobes & Mann, 1999)	
Others / Relationships	Any reference to other people (e.g., "I want to stop hurting others" or "retribution").
Escape – general	General statements about escape as well as references to a general attitude of giving up (e.g., "Escape" or "I need a rest").
Escape – pain	Statements about pain and a desire to stop the pain (e.g., No more pain" or "I want to stop the pain").
Escape – past	Statements about the past or getting away from past experiences and feelings (e.g. "I would like to start over" or "I want to break from the past").
General descriptors of Self	Statements of feelings about the self as well as general references to self (e.g., "Myself," or "I'm not worth anything", or I feel awful").
Feeling hopeless	Statements referring to hopelessness (e.g., "thing may never get better," or "I may never reach my goals").
Feeling alone	Any mention of loneliness (e.g. "I don't want to feel lonely anymore," or "feeling alone).

Appendix 3

CAMS - Pre-Post Training Questionnaire for Participants

Q1. What is your gender?

Answer Choices	Responses
Female	
Male	

Q2. What is your age?

Answer Choices	Responses
18 to 24	
25 to 34	
35 to 44	
45 to 54	
55 to 64	
65 to 74	
75 or older	

Q3. What is your job title?

Answered	
Skipped	

Q4. Type of site you presently work at (e.g. private practice, treatment service, emergency accommodation, supported housing): other

Answer Choices	Responses
Private practice	
Treatment service	
Emergency accommodation	
Supported Housing	
Counselling agency	
Other (please specify)	

Q5. Number of hours of formal suicide training you have received:

Answered
Skipped

Q6. What did your suicide training entail? (Check all that apply below) Answer Choices Responses

ASSIST
SafeTalk
STORM
Other (please specify)

Q7. I have anxiety about working with suicidal clients.

Strongly disagree Disagree Agree Strongly Agree Neutral

Total Weighted Average

Q8. I am confident in my ability to successfully assess suicidal clients.

Strongly disagree Disagree Agree Strongly Agree Neutral

Total Weighted Average

Q9. I am confident in my ability to successfully manage suicidal clients.

Strongly disagree Disagree Agree Strongly Agree Neutral

Total Weighted Average

Q10. I am able to form a strong therapeutic alliance with a suicidal client.

Strongly disagree Disagree Agree Strongly Agree Neutral

Total Weighted Average

Q11. I am confident in my ability to increase motivation and hope in a suicidal client.

Strongly disagree Disagree Agree Strongly Agree Neutral

Total Weighted Average

Q12. I can develop an adequate treatment plan with clients who are at-risk of suicide.

Strongly disagree Disagree Agree Strongly Agree Neutral

Total Weighted Average

Q13. I find it difficult to ask a client if s/he is suicidal.

Strongly disagree Disagree Agree Strongly Agree Neutral

Total Weighted Average

Q14. I believe that hospitalization is the best response for suicidal clients.

Strongly disagree Disagree Agree Strongly Agree Neutral

Total Weighted Average

Q15. I believe that successful treatment for suicidal clients should be by medical professionals.

Strongly disagree Disagree Agree Strongly Agree Neutral

Total Weighted Average

Q16. I believe my current practices are sufficient to protect me from liability in the event one of my clients should complete suicide.

Strongly disagree Disagree Agree Strongly Agree Neutral

Total Weighted Average

Q17. Do you have any other comments, questions, or concerns?

Answered
Skipped

Appendix 4

FOCUS GROUP DISCUSSION
CAMS – Participating Counsellors

FOCUS GROUP:
DEMOGRAPHIC DETAILS QUESTIONNAIRE

Please answer the following questions in the spaces provided, circle or tick the most appropriate options.

1. Age:……

2. Are you: (please tick as necessary) □ Male □ Female

3. What is your professional background?
□ Qualified Counsellor / Psychotherapist
□ Pre-accredited Counsellor / Psychotherapist
□ Staff Counsellor / Psychotherapist
□ Other: (please describe) _____

4. How many CAMS interventions have you carried out since the pilot began (approximately)? _____

5. How many years of experience have you had in this current job?
□ <1 Year □ 1-2 Years
□ 2-5 Years □ 5-10 Years
□ >10 Years

6. How many years of experience have you had in this profession (since qualification):
□ <1 Year □ 1-2 Years
□ 2-5 Years □ 5-10 Years
□ >10 Years

7. Which CAMS Training have you received:
□ Online Training □ On-site training □ Off-site training
□ Online and off-site □ On-site and off-site

Thank you for taking the time to complete this questionnaire.

FOCUS GROUP: TOPIC GUIDE

Topics for the Discussion
The topics that will be covered during the discussion are as follows:

Your experience with suicide prevention models in general
Your experience of using the CAMS model
Your experience of using the CAMS process within your work with homeless clients within the overall Dublin Simon Community structure / processes
Any improvement opportunities for the CAMS process within Sure Steps going forward

Guiding questions

1. Your experience with suicide prevention models
   a. Which models?
   b. Which populations? (homeless, addiction, general)
   c. Challenges, benefits, efficacy

2. Your experience of using the CAMS model
   a. Which populations have you used it?
   b. Comparison to others? Benefits/Challenges/User-friendly or not

3. Your experience of using CAMS with homeless/addiction population within Dublin Simon Community?
   a. Your experience – and why?
      i. Has it made a difference and why
      ii. Has it changed your way of working with suicidal clients and why
      iii. Has it changed your attitude towards working with suicidal clients and how
      iv. Did you feel you had sufficient information around the pilot to be able to work efficiently
   b. Other staff members' attitude who were involved in the client's care – and why?
   c. Clients' attitudes – and why?
   d. Clients' presenting issues/comorbitities/population-specific circumstances influencing process? How?

3.

e. Your thoughts on the Clinical Forms – format (amount of forms, content – detail – what should be on forms what not for this population, applicability, adapted to clients' cognitive abilities – language used on forms?, filing), client safety, outcomes, user-friendliness, best practice, treatment planning – and why?

f. Training
    i. amount and quality of training received – did it cover everything you needed to know
    ii. What could be improved for both you or clients?

g. Post training support
    i. amount and quality of support received
    ii. What could be improved for both you or clients?
    iii. Did you feel your input was valued / received?
    iv. What other supports might you need?

h. What are the benefits of CAMS?
    i. Process and forms?
    ii. For clients?
    iii. Examples of where you found it really effective / why?
    iv. How could the benefits be enhanced further
    v. If no benefits, why?

i. What are the challenges around the CAMS process and the forms?
    i. barriers before, during, after sessions (completion of forms, time, client disengagement)
    ii. incomplete treatments
    iii. factors influencing treatment completion/drop out
    iv. administrative barriers
    v. challenges for other staff involved in the care of the client
    vi. accessibility, client motivation, factors outside of control
    vii. how does it integrate within existing Dublin Simon Services and care the clients receive
    viii. how can you / did you overcome the challenges?

j. How comfortable do you feel with the CAMS process and the forms? – training, support, how and where?

4. Any improvement suggestions to the use of CAMS within Simon Sure Steps?
   a. Ease of use / experience for clinician (forms and process)
   b. Integration within existing processes, other care clients may receive both within and outside Dublin Simon in terms of their mental health and addiction issues
   c. Client experience
   d. Treatment completion

Concluding question

- Of all the things we've discussed today, what would you say are the most important issues you would like to express about the CAMS process within Sure Steps?

- Any other comments or issues you would like to mention that haven't already been covered?

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CHY5963
www.dubsimon.ie

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Funding for the creation and publication of this report was made possible by the Animate Social Innovation Fund Ireland of which Sure Steps Counselling was a 2017 award winner.