NAViGO's Implementation of CAMS System of Care in the UK: Preliminary Positive Outcomes

by Professor Zaffer Iqbal, Mike Reeve, Sophie Brown, Vicki Ayres and Dr. Aamer Sajjad

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Executive Summary

In 2017, NAViGO Community Interest Company (CiC) implemented CAMS (Collaborative Assessment and Management of Suicidality) as part of their National Health Service-commissioned health and social care services in the United Kingdom, for a highly deprived ward with a population of over 165,000 people.

Within two years of implementing this system of care for Mental Health, the following preliminary outcomes have been realized:

- Increased healthcare clinicians' confidence in assessing and treating suicidal patients
- Greatly reduced waiting time for care
- Reduced number of individuals requiring a Crisis contact
- Lower average of Crisis total contacts and fewer individuals requiring subsequent inpatient admissions
- Reduced local suicide rates (preliminary data suggest a reduction of 80%)

While data is preliminary at this early stage of the implementation, the short-term trends observed are expected to be replicated over the full term of the project.

The article below, published with permission, describes the processes and outcomes of NAViGO's custom implementation of CAMS as their primary system of care for suicidality among the mentally ill in this community. It is the hope of all of us at CAMS-care that more communities around the world can replicate a similar system of care for similar positive outcomes in reducing the number of suicides in their own health care systems.

For information about how CAMS-care can help you develop and implement a CAMS-based mental health system of care in your community, please contact us.

Introduction

North East Lincolnshire (NEL) is in the top 20 electoral wards in the UK with the highest proportion of deprived neighbourhoods (English Indices of Deprivation, 2019). Rates of violent crime, long-term unemployment and opiate use are significantly worse than the national average (Public Health England, 2018). Alongside the high deprivation in this population of over 165,000 people, as with many other socioeconomically challenged areas, there has been a historic failure from mental and public health services to meet the challenge of managing life-threatening and suicidal behaviours as reflected in the data produced by the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH, 2018). One potential exacerbating factor may be through the lack of timely mental health provision, which would suggest a greater prevalence for crisis presentations and undesirable pathways to care such as via self-harm and expressed suicidality (Kapur et al., 2016). Despite at least a satisfactory historical provision from Clinical Psychiatry, Nursing and allied professions, a key NEL deficit in provision was identified as the previous three decades waiting list for referrals of Serious Mental Illness (SMI) to Clinical Psychology. This resulted in a wait of up to 4 years for evidence-based therapy, sometimes with little support in the interim, which has often led to additional comorbid problems.

Introduction (cont'd)

NAViGO Community Interest Company (CiC) provide National Health Service (NHS) commissioned health and social care services to a population of 158,000, extending from primary care through to acute inpatient services for all adults and older adults in the NEL catchment area. As a commissioned NHS service it is no different to other NHS organisations in terms of its operational provision and delivery structures and employs NHS staff on identical terms and conditions. As a progressive and ambitious organisation that aims to support those living with a mental health illness, their carers and families in the most effective ways, NAViGO is about working together with local people to create services that are owned by the community and supported by it.

Since its inception in April 2011, there has been a positive drive for providing better mental health services locally. Waiting times for evidence-based therapy have reduced to 2 weeks from referral to having a scheduled appointment. A targeted programme has ensured that the inherited waiting list of 300+ referrals has been eradicated (Iqbal et al., in prep), with significant positive treatment outcomes and reduction of therapeutic need at follow-up. There has been significant investment in training for a range of clinical skills, referral pathways and mental health needs, including embedding of national guidelines and quality standards, evaluation of service impact through research and audit, diagnostic training, as well as evidenced therapies such as Eye Movement Desensitisation and Reprocessing Therapy (EMDR), Cognitive Behavioural Therapy (CBT) and Dialectical Behaviour Therapy (DBT).

These organisational development and operational processes have ensured that evidence-based standards and therapies are widely accessible in line with guidance from the National Institute for Health and Care Excellence (NICE).

CAMS Research Proposal

The presentation of the initial CAMS research proposal generated interest across the organisation and was unanimously agreed at executive board level in 2017. Service user involvement was a key component of the proposal and refinements were made based on feedback from the independent service user/carer forum representatives. It was important to ensure that pathways to care and treatment components for self-harm and life-threatening behaviours were in place prior to testing the CAMS model (see Figure 1). The "fast tracking" for cases presenting with life-threatening behaviours was a key precursor to the project. As shown in the figure, life-threatening cases in Navigo are able to access a range of inpatient and outpatient treatment options, which include access to a next-day Psychology appointment. Additionally, it was agreed across all services in the organisation that access to the Care Program Approach (CPA) including Care Coordination, medication reviews and referrals anywhere within Navigo would be fast-tracked for CAMS cases requiring these. This ensures that the most high-risk cases are able to receive urgent care to ensure the established confidence and trust from the service user is not lost due to delays.

With these provisions in place, the next major challenge was to manage the high rates of suicidality and self-harm within NEL. A range of risk factors observed in the locality including socioeconomic deprivation, unemployment and substance misuse exacerbates vulnerability for suicidality (Bambra & Cairns, 2017; Webb & Kapur, 2015). Each month, there are approximately 150 referrals to Crisis and Acute services and mental health workers are faced with the challenging task of assessing some of the most serious cases of acute mental illness in this population.

The need to target service users presenting with self-harm and life-threatening behaviours requires substantive and expert skill from clinicians to ensure effective engagement of people who are considering killing themselves. As Slee et al. (2008) have noted, dealing with patients who self-harm and/or are suicidal, is perhaps one of the most difficult challenges faced by clinicians. Jahn, Quinnett and Ries (2016) reported that 88% of mental health professionals expressed at least some fear relating to a patient dying by suicide as well as discomfort working with suicidal patients. The limited training that mental health professionals receive relating to the assessment and management of suicidality may contribute to the burden felt by

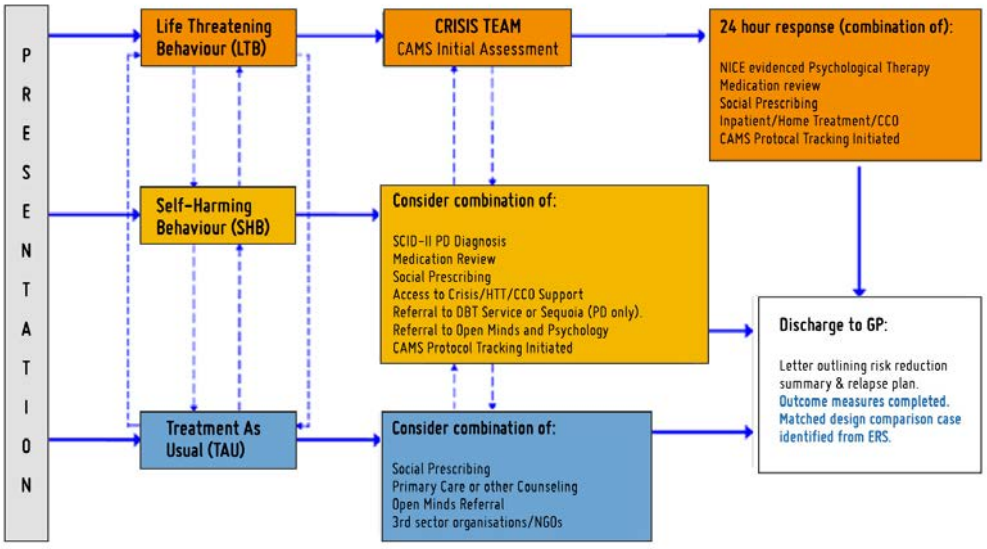

Figure 1:
Pathways to care for service users as part of the CAMS triage framework with rapid access to treatment available for CAMS cases.

clinicians working in these settings (Pope & Tabachnick, 1993).Negative experiences with suicidal patients can impact on clinical decision-making (Rothes, Henriques, Leal, & Lemos, 2014). Research suggests that losing a patient by suicide can impact professional practice in a number of ways including increased vigilance when dealing with future suicidal patients and avoiding treating suicidal patients (Séguin, Bordeleau, Drouin, Castelli-Dransart, & Giasson, 2014). However, evidence highlights that delivery of training to clinicians focusing specifically on the management of suicidal behaviours can have a positive effect on confidence and clinical practices (Oordt, Jobes, Fonseca, & Schmidt, 2009). As such, it became an organisational priority to implement a service-wide approach to suicidality in order to improve clinical risk decision-making and effective management of suicide risk presentations.

Nationally mental health organisations have improved their ability to quantify the nature and extent of such presentations (NCISH, 2018). However, attempts to reduce the number of suicides has been less than satisfactory (NCISH, 2018). In Navigo, the utilisation of the Collaborative Assessment and Management of Suicidality (CAMS) model combined with a bespoke suicide risk triage has had a positive impact on service user outcomes and clinician confidence. CAMS is a highly promising RCT

evidence-based intervention that aims to target and treat the problems that lead to suicidal risk (Comtois et al., 2011; Ellis et al., 2012; Jobes et al., 2009). Clinicians who receive CAMS training report decreased anxiety and increased confidence in dealing with patients who self-harm and/or are suicidal (Crowley et al., 2014; Jobes, 2016). The main objectives of the CAMS research project were to reduce the number of suicides in the locality, improve outcomes for individuals presenting as high-risk of suicide (and offering rapid access treatment options) and improve clinician confidence when dealing with such cases.

The organisation's unique risk decision-making process supporting the CAMS intervention includes a supervision hierarchy (see Figure 2). A 4-level hierarchical structure was set up across the organisation to support clinicians if they were unsure about the level of suicidal risk a service user presented with, or if they felt that the risk was potentially life-threatening and therefore needed escalation for a CAMS assessment. Thus, joint "ownership" of risk decisions is available whenever a clinician believes this is required and extends to senior and executive clinical and managerial staff. Departmental champions received additional training to help differentiate between life-threatening and self-harming behaviours to provide supervision within their teams. The Crisis and Hospital Liaison teams are the first-line assessors of service users presenting with self-harm and suicidality and the majority have now undertaken CAMS intervention training.

The initial phase of the project has focused on the training and supervision of mental health staff across the organisation (see Figure 3). All qualified staff were required to undertake a 1-day 'Risk triage training' to understand the core components of the CAMS project and using the CAMS triage decision-making framework. To date, over 280 staff have undertaken this training and it is delivered on a rolling 3-monthly basis for new starters. During these sessions, clinicians expressed a range of concerns relating to suicide risk decision-making including the impact of serious investigations, obtaining the information required to make objective decisions around suicide risk and support from other colleagues/managers when making these decisions. The supervision hierarchy was implemented to mitigate the effects of these concerns by ensuring that any serious incidents relating to suicidal behaviours within the organisation are the collective responsibility of all levels of the hierarchy. Pre and post training surveys were under-

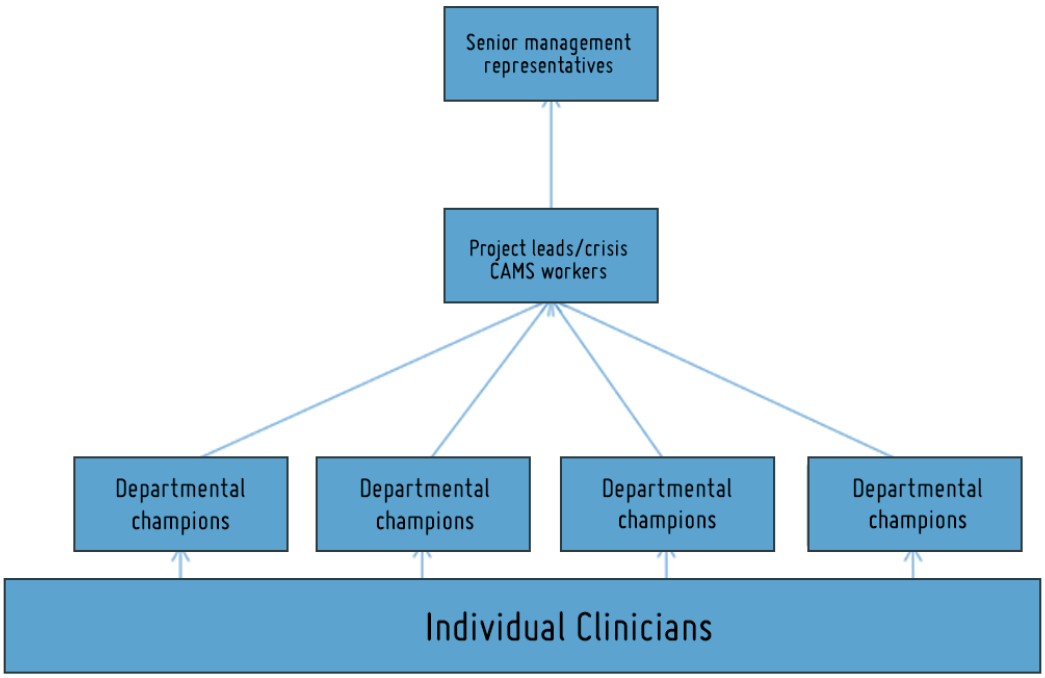

Figure 2:
Supervision hierarchy structure set up across the organisation over four levels.

taken when clinicians attended the triage training which will be analysed to quantify the extent of the impact on clinician confidence. Anecdotal feedback from the training highlighted the positive impact of a clear, structured approach to help clarify the most appropriate pathways to care for suicide risk presentations and the benefit of having support available for decision-making around challenging risk cases. Consequently, a psychometric tool with items utilised from the triage training of 280+ clinical staff is being developed as a bespoke measure of clinician confidence.

Early quantitative data from the first 12 months of the project suggests a positive impact of the implementation of the CAMS project compared with an archival cohort of matched individuals from the electronic record system. Key outcomes include a reduction in the number of individuals requiring a Crisis contacts, a lower average of Crisis total contacts and fewer individuals requiring a subsequent inpatient admissions, as well as a reduction in local suicide rates. Based on qualitative feedback, the evidence suggests that the anxiety clinicians experience when assessing such high-risk cases reverts to confidence as they gain a full understanding of suicidality which helps them to successfully engage with the service user. Key themes emerging from service user interviews was an appreciation of the fast-tracking aspect of CAMS and the SSF questions that encouraged them to be open and honest about their suicidality.

Complete data for suicides and undetermined deaths in North East Lincolnshire is available for 2012-16, with 64 inquests in total recorded (nelincs.gov.uk, 2018). Of these, 25 had a diagnosed mental health condition and 17 had been in contact with mental health services in the 12 months prior to their suicide. The CAMS research project commenced in April 2018 and has been embedded within services since the start of 2019. Since this time, preliminary data would suggest a reduction of over 80% equating to 1 suicide since January 2019. However, this short-term trend has to be replicated over the full-term of the project.

Navigo has a 24/7 open-access Crisis service including self-referrals, hence presentations to the service include individuals not presenting with a mental health problem. The data presented here is produced by a national body reporting on patient suicides and does not take into account whether the individual had a mental health problem. Therefore, it is likely that the figures for Navigo would reduce further if it only included those presenting to Crisis with a mental health difficulty.

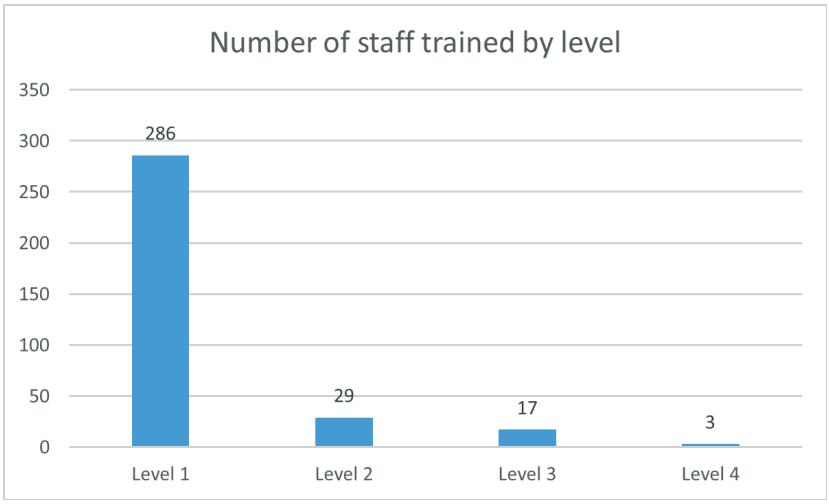

Figure 3:
Number of staff trained at Levels 1,2,3 and 4 of the supervision hierarchy.

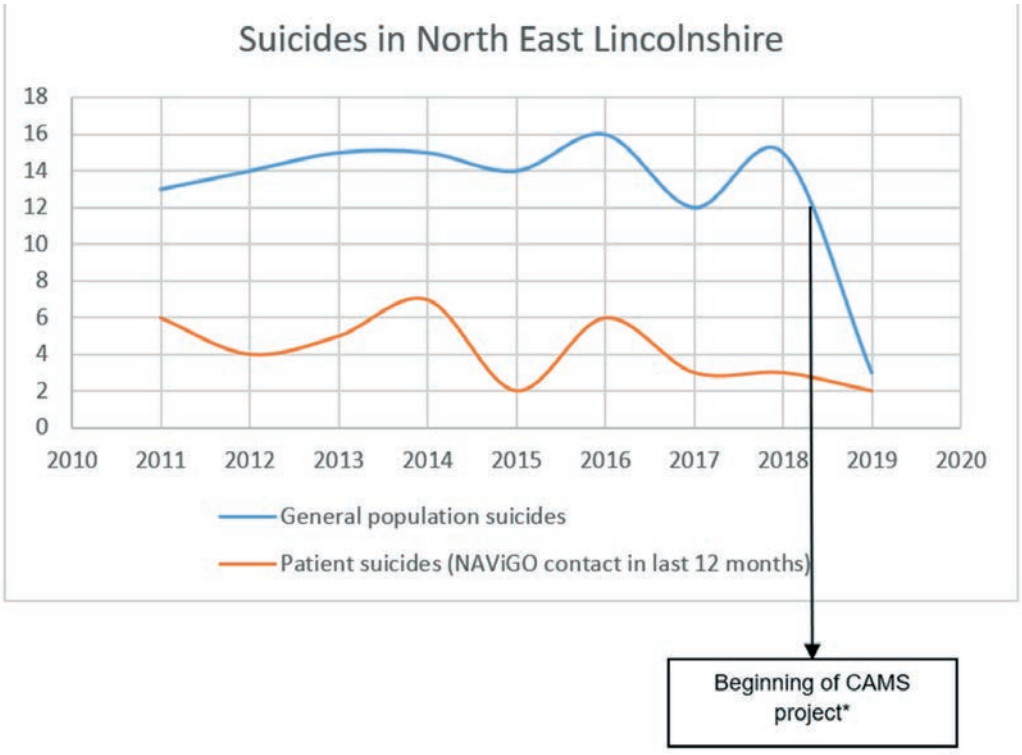

Figure 4:
North East Lincolnshire suicide data 2011-2019. (Note: 2018 and 2019 data subject to ratification by the Coroner's Court and data for suicides in 2019 is incomplete.)

The Future

The first year of Navigo's CAMS project has had a powerful impact on how the NHS tackles the national problem of suicide prevention. Given that preliminary results in 2019 show an 80% reduction in suicide numbers, and although caution is advisable given a 12-month trend would need to be continued into 2020/21, there are many reasons to be optimistic. The rate reflects not only the clinical cohort of those with mental health problems but also the general population with the catchment area. Additionally, clinician confidence, positive risk taking and effective treatment/care planning are all positives that are being observed.

The dissemination of the project through regional and national NHS bodies and third-sector organisations has begun, and additional interest from other NHS trusts has resulted in approaches to commence discussions to locate and work with CAMS partners. The Navigo approach allows for CAMS to be embedded optimally, (i.e. 100% compliant with the evidenced intervention), within an NHS organisation and the processes to do this seamlessly can be tailored to an individual organisation's needs. The dissemination through academic publications and presentations at conferences will culminate with the Royal College of Psychiatrists congress in July 2020, at which time we will be ready to meet the needs of NHS organisations who will form the roll-out of CAMS within the United Kingdom. The opportunity to commence CAMS clinical trials with NHS partners will be a priority and academic institutional support for this is being sought from a number of areas including universities and the National Institute of Health Research. ●

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