

INFORMED CONSENT FOR SUICIDE PREVENTION TRIALS

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*I have no relevant
personal/professional/financial
relationship(s) with respect to this
educational activity.*

Objectives:

1. How the nature of suicidality uniquely influences research design and informed consent for suicide prevention RCTs
2. How NIMH guidelines for informed consent for suicide RCTs address these unique aspects
3. How clinical care practices can inform consent procedures in ways that protect both participant autonomy and welfare

Suicidality: High Risk – Low Base Rate

Suicide attempts and mortality are low base-rate events (CDC, 2017)

- Suicide is the 10th leading cause of death in the U.S: 2nd leading cause of death for adolescents
- In 2017 there were 47,173 suicide deaths; 6,252 15 – 24 years

To capture sufficient prevalence rates in research requires

- Extended data collection periods
- Post-experimental follow-up
- Multisite studies

Long-term Follow-up: Implications for IC

Informed consent should explain that suicide attempts and suicide death are low base-rate events requiring long term follow-up (NIMH, 2019)

- Re-consent during the course of the study and post-treatment follow-up.
- Re-consent/consent procedures for youth who reach age of majority at different study points

Multisite Studies: Implications for IC

Informed consent should explain how low-base rates require multisite studies and consent for sharing data across sites (NIMH, 2019)

- Avoid or define terms “de-identified” i.e. what identifying information may be removed or retained
- Clarify the researcher’s, institution’s or data repository’s role in ensuring confidential information will not be misused by other’s

Inclusion Criteria

Prospective studies are not feasible

- Depression, co-morbid psychiatric disorders, life stress predict suicide attempts only slightly better than chance

Critical Risk Periods for Suicide

- 3 - 12 months following hospitalization for a suicide attempt
- 6 months following hospitalization for serious non-suicidal self-harm (NSSI)

To obtain sufficient power recruitment often occurs shortly following a suicide related hospitalization

(Grandcler et al., 2016; King et al., 2010)

Inclusion Criteria: Implications for IC

- *You are being asked to participate in this study because you were recently hospitalized for a suicide attempt or serious self-injury which increases your risk of a suicide attempt in the future.*

Death is an Expected Research Outcome

As in other potentially terminal medical conditions, in suicide prevention research suicide attempts and mortality are baseline research risks and expected RCT treatment outcomes

(Fisher, Pearson, Kim, & Reynolds, 2002)

Outcome Measures: Implications for IC

If you agree to be in this research, at the beginning and at different points in the study we will ask you to participate in clinical assessments of your mental health including:

- Suicidal thoughts and behaviors
- Authorization to review your health records in the event you are hospitalized for a suicide attempt
- Written consent to obtain information from the National Death Index in the event of a suicide resulting in your death (NIMH, 2019)

Autonomy-Welfare Paradox

Autonomy

An informed consent decision requires the participant's appreciation of participation risks and benefits on their own situation (Applebaum & Grisso, 2001)

Welfare

How does discussion of participant's future suicide risk and death as an anticipated study outcome affect how they respond to study treatment conditions?

Welfare: Clinical Care Best Practice

Talking about suicide risk with patients

- Does not increase risk
- Routine in prescribing psychotropic medications for depression

Health Beliefs Model: Treatment adherence requires that patients' believe they are *at risk* for a negative outcome *serious enough to warrant treatment*

Discussing Suicide Risk with Participants Clarifies

- Suicide treatment is a high risk endeavor in which suicide attempts are probable and routinely occur.
- Treatment compliance and crises management are vital to maximize treatment efficacy

(Gipson & King, 2013; Reynolds et al, 2006; Rudd et al., 2009)

**“Involvement in this study does not
provide protection against suicide”
(NIMH 2019)**

Suicide Treatment is a High Risk Endeavor

- 33% of suicide completers had contact with mental health services within a month of suicide
- Several treatments (e.g. CBT, DBT) demonstrate significant improvement in suicidality compared with TAU
- The longer term treatments (e.g. 12 months) have better comparative outcomes to TAU, *but difficulty with retention*
- Treatment effectiveness ranges from 5% - 37% reduction in suicide attempts

(Goldston, 2015; Iyengar et al., 2018; McCauley et al., 2018; Mendez-Bustos, 2019; Rudd et al., 2004)

Participation Does Not Protect Against Suicide Risk: Implication for IC

Health Beliefs Model: For individuals to remain in and adhere to treatment they need to believe it will be beneficial (Gipson & King, 2013)

The Autonomy-Welfare Paradox

What are the implications for treatment adherence and efficacy of informing individuals that RCT participation does not offer protection against suicide risk?

Autonomy

- A reasoned participation decision requires understanding the potential risks and benefits of participation (45CFR46...116)
- Avoid *therapeutic misconception* (conflation of research goals with goals of clinical care) by explaining that the advantage of one treatment over the other is unknown.
- “While being optimistic and hopeful, IC for suicide research must not collude with participants’ unrealistic expectation for the treatment under investigation” (King & Kramer. 2011)

Welfare: Clinical Best Practices

*“Informing patients that suicide treatment is a high risk endeavor increases their understanding that participation requires compliance and risk management”
(Rudd et al, 2009)*

IC should communicate and encourage questions regarding:

- Percent of patients whose suicidal symptoms on average decreased or increased when receiving the study treatments or alternative treatments
- How treatment adherence and risk management strategies can increase treatment effectiveness and safety

Participation Does Not Protect Against Suicide Risk: Autonomy

Hypothetical IC for Hypothetical Study comparing a more intensive 6 month treatment X to 12 months of treatment X.

Currently available 6-month treatments (e.g. X, Y, Z) help reduce suicidality for up to 25% of patients; *although approximately 5% report their symptoms increase.*

Prior research indicates 12 months of treatment X reduced suicidality by 35% --*However most people dropped out of treatment before the end of 12 months.*

Participation Does Not Protect Against Suicide Risk: Welfare

Hypothetical IC

It is important to know that participation in this study does not guarantee protection against suicide risk (NIMH).

Attending study treatment sessions and complying with the study clinician's recommendations can increase the potential benefits of participating in this study.

In addition, to increase participant protections, we have put in place safety management procedures to identify and address when participants may be at imminent suicide risk.

**Describe risk management plans to participants and families for addressing imminent risk
(NIMH, 2019)**

Risk Management: Hospitalization

Autonomy

- Imminent risk may require involuntary psychiatric hospitalization
- Who are the persons to contact in case of emergency

Welfare

- Fear of hospitalization can reduce participants' willingness to accurately report suicidal symptoms
- *Reporting of suicidal thoughts during treatment does not automatically result in hospitalization*

(Hom et al., 2017)

Risk Management: Self-Monitoring

How to evaluate “Imminent Risk”

- Suicidal thoughts, a suicide plan, means of carrying out that plan
- Balanced by protective factors including social support, reasons for living (Chu et al., 2015)

Understanding when NSSI is a Risk Factor for Suicide

- Cutting arms or legs vs. cutting close to carotid artery
- Body piercing versus cutting atypical areas (e.g. face, eyes, genitals) which can be a sign of decomposition

Assessment Procedures

IC should address potential role confusion between a participant's clinical care research staff provider and independent staff conducting assessments (NIMH, 2019)

- Staff conducting formal assessments of suicidality are different from your study clinicians
- Assessment staff are blind to the treatment condition
- Your study clinician may (or may not) be provided information gained from these assessments.
- IC should clarify who participants should turn to if they believe treatment is not working or other guidance.

Competence to Consent

Depression and Hopelessness Associated with Suicidality

- Research refutes assumption that depression decreases participant understanding of consent information
- However, hopelessness may diminish concern regarding participation risks and interfere with a reasoned consent decision.
- Post-hospital distress may lead to an over or under-estimation of research risks and benefits.

(Horwitz et al, 2017; King & Kramer, 2011)

Addressing Consent Vulnerabilities

Requires Staff Training in Skills in:

- Stress identification and reduction
- Addressing over or underestimation of treatment benefits and risks
- Enhancing risk appreciation during discussion of inclusion criteria and outcome measures
- Enhancing safety through emphasis on treatment adherence and risk management
- Use of supportive decision-making
- Opportunity to consider consent information over a period of time

Protecting Autonomy & Welfare through Informed Consent

- Honest discussion of suicide risk and the limitations of treatment to reduce such risks
- Attention to psychological factors that may influence consent decision-making.
- Consideration of ways in which consent can influence participant responses to treatment
- Development of consent procedures that promote both autonomous decision-making and treatment adherence and efficacy.

THANK YOU QUESTIONS?

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References

- Appelbaum, P. S., & Grisso, T. (2001). *MacArthur competence assessment tool for clinical research (MacCAT-CR)*. Sarasota, FL, US: Professional Resource Press/Professional Resource Exchange.
- Center for Disease Control (2017). *QuickStats: Suicide Rates for teens aged 15 – 19 years by sex – United States, 1975-2015*. <https://www.cdc.gov/mmwr/volumes/66/wr/mm6630a6.htm>
- Chu, C., Klein, K. M., Buchman-Schmitt, J. M., Hom, M. A., Hagan, C.R., & Joiner, T. E. (2015). Routinized assessment of suicide risk in clinical practice: An empirically informed update. *Journal of Clinical Psychology*, 71, 1186–1200. doi: 10.1002/jclp.22210
- Fisher, C. B., & Mast, J. K. (2006). A goodness-of-fit ethic for informed consent to pediatric cancer research. In R. T. Brown (Ed.), *Comprehensive handbook of childhood cancer and sickle cell disease* (pp. 205–217). New York: Oxford University Press
- Fisher, C. B., Pearson, J. L., Kim, S., & Reynolds, C. F. (2002) Ethical issues in including suicidal individuals in clinical research. *IRB, Sep-Oct;24(5):9-14*.
- Fisher, C. B., & Wallace, S. A. (2000). Through the community looking glass: Re-evaluating the ethical and policy implications of research on adolescent risk and psychopathology. *Ethics & Behavior*, 10(2), 99–118. DOI: 10.1207/S15327019EB1002_01. PMID: 1184110.
- Grandcler, S., De Labrouhe, D., Spodenkiewica, M., Lachal, J., & Mora, M. (2016). Relation between non-suicidal self-injury and suicidal behavior in adolescence: A systematic review. *PLoS One*, 11, e0153760.

- Gipson, P., & King, C. (2012). Health Behavior Theories and Research: Implications for Suicidal Individuals' Treatment Linkage and Adherence. *Cognitive and behavioral practice*, 19(2), 209–217. doi:10.1016/j.cbpra.2010.11.005
- Hedegaard, H., Curtin, S.A., & Warner, M. (2018) Suicide mortality I the United States 1999 – 2017. *NCHS Data Brief No. 330*, November 2018. <https://www.cdc.gov/nchs/products/databriefs/db330.htm>
- Hein, I. M., Troost, P. W. Broersma, A., de Vries, M. C., Joost, G. D. & Lindauer, R. J. L. (2015). Why is it hard to make progress in assessing children's decision-making competence? *BMC Medical Ethics*, 16, Retrieved October 1, 2019 from <http://www.biomedcentral.com/1472-6939/16/1>.
- Hom, M.A., Podlogar, M. C., Stanley, I. H., & Joiner, t. E. Ethical Issues and Practical Challenges in Suicide Research. (2017). *Crisis*. Mar;38(2):107-114. doi: 10.1027/0227-5910/a000415. Epub 2016 Aug 26. clinical research. *IRB: Ethics & Human Research*, 24, 9–14. DOI: 10.2307/3563804. PMID: 12737170.
- Horwitz, A.G., Berona, J., Czyz, E.K., Yeguez, C.E., King, C.A. (2017). Positive and Negative Expectations of Hopelessness as Longitudinal Predictors of Depression, Suicidal Ideation, and Suicidal Behavior in High-Risk Adolescents. *Suicide Life Threat Behav*. Apr;47(2):168-176. doi: 10.1111/sltb.12273. Epub 2016 Jul 2.
- Icenogle, G., Steinberg, L., Duell, N., Chein, J., Chang, L., et al. (2019). Cognitive capacity reaches adult levels prior to their psychosocial maturity: Evidence for a 'maturity gap' in a multinational, cross-sectional sample. *Law and Huma Behavior*, 43, 69-85. doi: 10.1037/lhb0000315
- Iyengar, U., Snowden, N., Asarnow, J. R., Moran, P., Tranah, T., & Ougrin, D. (2018). A Further Look at Therapeutic Interventions for Suicide Attempts and Self-Harm in Adolescents: An Updated Systematic Review of Randomized Controlled Trials. *Frontiers in psychiatry*, 9, 583. doi:10.3389/fpsy.2018.00583

- Joffe, S., Fernandez, C.V., Pentz, R.D., Ungar, D.R., Mathew, N.A., Turner, C.W., Alessandri, A.J., Woodman, C.L., Singer, D.A., Kodish, E. (2016). Involving children with cancer in decision-making about research participation. *J Pediatr. Dec*;149(6):862-868.
- King, C.A., and Kramer, A.C. (2011). Intervention Research with Youths at Elevated Risk for Suicide: Meeting the Ethical and Regulatory Challenges of Informed Consent and Assent. *Suicide Life Threat Behav.*; Mar 20 doi: 10.1521/suli.2008.38.5.486 PMID: PMC3061222, NIHMSID: NIHMS112839, PMID: 19014301
- Lakeman, r., & Fitzgerald, M. (2009). Ethical suicide research: A survey of reserchers. *International Journal of Mental Health Nursing*, 18, 10 – 17.
- McCauley, E., Berk, M.S., Asarnow, J.R., et al.(2018) Efficacy of Dialectical Behavior Therapy for Adolescents at High Risk for Suicide: A Randomized Clinical Trial. *JAMA Psychiatry*. 75(8):777–785. doi:10.1001/jamapsychiatry.2018.1109
- Mendez-Bustos, P., Calati, R., Rubio-Ramirez, F., Olie, E., Courtet, P., & Lopez-Castroman, J. (2019). Effectiveness of psychotherapy on suicidal risk: A systematic review of observational studies.
- NIMH (2019). Conducting research with participants at elevated risk for suicide. Study. <https://www.nimh.nih.gov/funding/clinical-research/conducting-research-with-participants-at-elevated-risk-for-suicide-considerations-for-researchers.shtml>
- Pearson, J. L., Stanley, B., King, C., & Fisher, C. B. (2001). Intervention research for persons at high risk for suicidality: Safety and ethical considerations. *Journal of Clinical Psychiatry Supplement*, 62, 17–26. PMID: 11765091

- Reynolds, S.K., Lindenboim, N., Comtois, K.A., Murray, A., & Linehan, M. M. (2006). Risky assessments: Participant suicidality and distress associated with research assessments in a treatment study of suicidal behavior. *Suicide Life Threatening Behavior*, 36, 19 -34.
- Rudd, M. D., Joiner, T., Brown, G. K., Cukrowicz, K., Jobes, D. A., Silverman, M., & Cordero, L. (2009). Informed consent with suicidal patients: Rethinking risks in (and out of) treatment. *Psychotherapy: Theory, Research, Practice, Training*, 46(4), 459-468. <http://dx.doi.org/10.1037/a0017902>
- Rudd, M. D., Joiner, T. E., & Rajab, M. H. (2004). *Treating suicidal behavior: An effective time-limited approach*. NY: Guilford
- Walsh, B. (2008). Strategies for responding to self-injury: When does the duty to protect apply? In J. L. Werth, E. R. Welfel, & G. A. H. Benjamin (Eds.), *The duty to protect: Ethical, legal, and professional considerations for mental health professionals* (pp. 181–193). Washington, DC: American Psychological Association.
- Walter, J.K., Ross, L.F. (2014). Relational autonomy: moving beyond the limits of isolated individualism. *Pediatrics*. Feb;133. Suppl 1:S16-23. doi: 10.1542/peds.2013-3608D.