

**PROCEDURES FOR MANAGING SUICIDALITY IN THE  
NIMH TREATMENT OF ADOLESCENT DEPRESSION STUDY (TADS)**

**Version 2**

**© 2005 Duke University Medical Center, The TADS Team**

**Contact:** John S. March, M.D.  
Department of Child and Adolescent Psychiatry  
Department of Psychology – Soc & HLTH  
718 Rutherford St Durham, NC 27705  
Box 3527 Med Ctr Durham, NC 27710  
(p) 1-919-416-2404  
(f) 1-919-416-2420  
[jsmarch@acpub.duke.edu](mailto:jsmarch@acpub.duke.edu)

**Adapted from (1) Cognitive Therapy Treatment Manual for Depressed and Suicidal Youth;  
the AACAP Practice Parameters For The Assessment And Treatment Of Children And  
Adolescents With Suicidal Behavior; and (3) PROSPECT: High Risk Management  
Guidelines for Suicidal Patients in Primary Care, Version 6.2**

## I. Rationale

In a study of teenagers with depression where suicidality is not an absolute exclusion criterion, it is necessary to delineate specific procedures for managing suicidal behavior that may arise during TADS. The TADS Suicidality Prevention Manual extends the no suicide contract procedure introduced at the gate C2 orientation visit (pre-randomization) to the treatment and follow-up portions of TADS.

**All TADS clinical staff are expected to be familiar with the *Practice Parameters For The Assessment And Treatment Of Children And Adolescents With Suicidal Behavior* developed by the American Academy of Child and Adolescent Psychiatry<sup>1</sup>, which provides a detailed summary of the causes, assessment and treatment of the suicidal child. In addition, all TADS staff are expected to be familiar with the procedures for managing the suicidal child presented in *Cognitive Therapy Treatment Manual for Depressed and Suicidal Youth* by David Brent and Kim Poling<sup>2</sup>, aspects of which are central to the TADS psychosocial treatment intervention.**

## II. Relationship to Adverse Event Monitoring

Procedures for recording suicidality fall within the general area of AE/ASAP reporting. By definition, suicidality associated with an AE or that threatens premature termination or that results in SAE reporting will be managed and documented via ASAP procedures. This manual supplements the TADS AE/ASAP Manual, which specifies types and indications for AE/SAE/ASAP reporting only one of which involves suicidality.

When suicidality triggers ASAP, the reason for ASAP referral, the decision of the ASAP Panel and the outcome of the ASAP intervention will be recorded on the ASAP Form. A specific section of the ASAP Form addressing suicidality should be completed. When suicidality triggers a severe adverse event (SAE)—for example, with a suicide attempt leading to medical hospitalization—the SAE form also should be completed.

## III. Clinical Principles For Dealing With Suicidal Patients

Drawn from PROSPECT<sup>3</sup>, the following comments provide a general approach for dealing with patients who report suicidal thinking or behavior.

---

<sup>1</sup> AACAP Practice Parameters For The Assessment And Treatment Of Children And Adolescents With Suicidal Behavior developed by David Shaffer, M.D., Cynthia R. Pfeffer, M.D., and the Work Group on Quality Issues: William Bennet, M.D., Chair

<sup>2</sup> Brent D and Poling K (1997), *Cognitive Therapy Treatment Manual for Depressed and Suicidal Youth*, Pittsburgh:Starwood Publications

<sup>3</sup> PROSPECT is a collaborative research study funded by the National Institute of Mental Health using the Interrelated Research Grant Program mechanism for the following sites: Coordinating Center at Cornell University (R01MH59366), G.S. Alexopoulos (PI) and M. L. Bruce (Co-PI); University of Pennsylvania (R01MH59380), I. Katz (PI) and T. TenHave (Co-PI); and University of Pittsburgh (R01MH59381), C. F. Reynolds (PI) and H. C. Schulberg (Co-PI).

**Be very attentive.** Patients need to have someone listen and take their suicidal ideation seriously. The belief that someone is paying close attention and is trying to understand their level of distress may be sufficient to decrease the immediate threat. Attentive listening can also help dispel stigma and fear that having suicidal thoughts is “crazy” or shameful. Lack of attention may lead the patient to believe that people are ignoring or minimizing the threat and that no one cares if they do die. The patient may escalate the danger in order to communicate the seriousness of his or her pain.

**Remain calm and non-threatened.** The threat of suicide by a patient does not mean that you have lost control of the situation. It may indicate that the patient is trying desperately to communicate how badly he or she feels. If the provider appears confident in the face of such a crisis, it can have a stabilizing effect for a labile patient.

**Give the patient some space and time to vent.** If you assess for suicidality (or follow up on suicidal hints) early in the visit, you will provide yourself and the patient with enough time to fully describe how he or she is feeling. By allowing enough time to hear the patient’s whole story (and not just jumping in to try and solve the problem), you will assist the patient to feel an important sense of validation. Empathic listening (e.g., “It sounds like you must be going through a really tough time right now” with appropriate eye contact) will also help to validate the patient’s feelings. These techniques often facilitate the patient to be more receptive to your feedback.

**Stress a team approach to the problem.** Freely use the collaborative pronoun “we” when discussing the suicidality, e.g., “We have to find a way for you to get some relief when you feel deeply depressed.” Let the patients know that the responsibility for how treatment progresses is a shared responsibility between you and the patient, and that there are a number of treatment alternatives that can be tried.

**Be willing to say the word “suicide” without flinching.** Do not avoid the word “suicide,” as that gives the impression that we find the concept stigmatic. To the contrary, it is important to discuss the issue directly, without dread or negative judgment, in order to promote an open discussion. Clearly stating that feelings of suicide are symptoms of a treatable illness or disorder may also give the patient a sense of hope.

#### **IV. Routine Monitoring for Suicidality**

##### *Clinical Assessment*

At every office and phone visit, it is expected that the responsible clinician will inquire about suicide risk.

##### *Tracking Forms for Monitoring Suicidality*

As shown in Table 1, TADS includes four forms that provide an opportunity to track suicidal risk from the point of view of the patient and the parent. Other measures are available (c.f. the Beck Hopelessness Scale), but these four measures were chosen because they tap each potential informant (patient, parent, clinician and IE) on a reasonably frequent basis.

The ADS includes two suicide items addressing ideation and behavior. Since the Affective Disorders Screen (ADS) is routinely completed at each office visit, this provides a prompt for reviewing of the extent of suicidality in the context of routine clinical care.

In contrast, the SIQ and RADS are completed as part of the patient-reported core assessment battery and reviewed in real time by the study coordinator for suicide risk. Each has suicide items, which if endorsed, will prompt reconsideration of suicidality if not already addressed in the clinical visit as prompted by the ADS and clinical inquiry. Similarly, the CDRS suicide item if endorsed will prompt the IE to alert the study coordinator that a clinical inquiry regarding suicide risk is necessary.

## V. Table 1: Tracked Measures

| INSTRUMENT | ITEM(s)  | CRITERION  | REVIEWER |
|------------|--|--|----------|
| ADS        | Item 18  | Score of 3   | CBT/PT   |
| ADS        | Item 19  | Score of 2 or 3  | CBT/PT   |
| RADS       | Item 14  | Score of 4 or greater  | SC       |
| CDRS       | Item 13  | Score of 6 or 7  | IE/SC    |
| SIQ        | Items 1-15<br>Critical items<br>(2, 3, 4, 7, 8, 9) | Score of 5 or 6 on <u>two</u> of six critical items (2, 3, 4, 7, 8, 9) | SC       |

CBT = CBT Therapist; IE = Independent Evaluator; PT = Pharmacotherapist; SC = Study Coordinator

|       |  |                     |
|-------|--|---------------------|
| ADS:  | <b>Affective Disorders Screen</b>                  | (treatment visits)  |
| RADS: | <b>Reynolds Adolescent Depression Scale</b>        | (assessment visits) |
| CDRS: | <b>Children's Depression Rating Scale, Revised</b> | (assessment visits) |
| SIQ:  | <b>About My Life: Grades 7-9</b>                   | (assessment visits) |

## VI. Clinical Assessment

### Overview

Assessment of suicidal child or adolescents requires an evaluation of the suicidal behavior and determination of risk for death or repetition as well as of the underlying diagnosis or promoting factors. Evaluating the presence and degree of suicide intent is a complicated matter. Suicide intent involves a balance between the wish to die and the wish to live. Some aspects of this address severity of the behavior, the efforts made to conceal the behavior and avoid discovery, and also the formulation of specific plans (e.g., "Did you do anything to get ready to kill yourself? Did you think what you did would kill you?"). However, children and adolescents systematically overestimate the lethality of different suicidal methods, so that a child or adolescent with a significant degree of suicidal intent may fail to carry out a lethal act. Another

approach in assessing suicidal intent is to evaluate motivating feelings, for example, the wish to gain attention, to effect a change in interpersonal relationships, to rejoin a dead relative, to avoid an intolerable situation, or to get revenge. If these motivations have not been satisfied by the time of the evaluation, serious suicidal intent may still be present. Similarly, it is important to determine the type of method employed in the suicide attempt (more unusual attempts, i.e., method other than cutting or small ingestion, carry a worse prognosis), potential medical lethality (not always a reliable predictor, some seriously suicidal children and teens are a poor judge of lethality), the degree of planning involved, and the degree to which the chance of intervention or discovery was minimized (signifying higher intent). Previous suicide attempts make a further attempt more likely; a pervasive and frequent degree of current suicidal ideation also denotes greater seriousness and a greater likelihood of an associated mental illness. Availability of firearms or lethal medications should be ascertained, and, if available, a recommendation for removal or more secure storage should be made as an imperative part of assessment. Likewise, drugs and alcohol increase suicide risk perhaps by increasing mood dysphoria and impulsivity. Finally, the capability of the child's environment to insure safekeeping is critical in the evaluation of the suicidal teenager. Of specific importance are the presence of abuse, parental mental illness, family conflict/hostility and willingness to negotiate and sign a no suicide agreement.

#### *Steps in the ASAP evaluation of a suicidal teen*

The following steps are required TADS procedures.

- Step 1:** Review the most recent administration of the measures specified in Table 1.
- Step 2:** Complete a suicidality interview following the outline presented below.
- Step 3:** Arrange an appropriate intervention dictated by the patients clinical circumstances.
- Step 4:** Complete AE, ASAP and SAE forms as required.
- Step 5:** Update the Patient Safety Monitoring Log (PSML)

#### *Interview of the suicidal teen*

Specific topics to be covered during the evaluation of the suicidal teen include the following, which will directly inform coding the extent of suicidality on the ASAP Log.

1. **What is the degree of suicide risk?** Determine the extent of suicidality, by asking about ideation, method/plan, the presence of threats (e.g. suicide note) and actual behaviors. A suicidal gesture means the method is in hand, but the patient didn't actually do anything, c.f., threatened to take pills he/she was holding but didn't actually do it. An attempt means acted on suicidal ideation, c.f. took pills. In an ideator, determine the risk that patient will move from low to higher risk. If an attempt has already occurred, determine its nature and assess future risk.
2. **Was a precipitant present?** Ask whether anything triggered the suicidal ideation, e.g. break up with boyfriend or death of a loved one or fight with parent. Carefully, ask whether the primary motivation was to escape the pain associated with this stressor, to communicate distress, ask for help, make someone change his/her mind or to exact revenge. Determine whether these circumstances still hold.

3. **Irrespective of intent, what is preferred method for suicide?** Begin with an open ended question, but consider asking hanging, jumping, drowning, stabbing, carbon monoxide, car accident and cutting. *Always ask about the availability of firearms and pills not only at home but at relatives' and friends' houses.* When asking about firearms or pills, ask specifically about type, how many, how stored (e.g. locked up or not) and for, firearms, availability of ammunition.
4. **Was the attempt planned or impulsive?** If the teen made a suicide gesture or attempt, to what extent was it planned versus impulsive. Inquire about how long she/he had been thinking about it. Ask about indicators about planning such as leaving a suicide note or making preparations for what would happen after she/he dies. Determine insight into vulnerability to act impulsively again and intent to avoid precipitants that might provoke impulsive actions.
5. **Intoxication?** In the context of the teen's drug and alcohol history, ask whether drugs or alcohol are involved either through worsening mood or decreasing behavioral self control (e.g. impulsivity). If present, ask about future intent to use and availability.
6. **Suicidal intent?** Ask specifically about whether the teen has a desire to die. If yes, consider the degree and type of motivation: actually wants to die, doesn't particularly want to die but rather wants to escape an intolerable situation or wants to communicate something, such as asking for help, getting attention, making someone feel sorry or change their mind. In the teen who has made an attempt or gesture, ask whether these motivating factors still exist. If yes, this indicates increased risk. In this context, inquire specifically about the extent of *hopelessness* and *irritability/anger*. Both increase risk before an attempt and, if not resolved by or after an attempt, increase risk of another attempt or completed suicide. Ask about what the teen thinks will happen after he/she dies. Ask about personal fate and impact of suicide of family and friends. Ask specifically, what keeps him/her from committing suicide, including reasons for living and adverse impact on other people. Ask about regret for what happened. Finally, ask about the chances that the teen will make a suicide attempt: less than 50%, equal or more than 50%.
7. **How lethal is/was the method used or proposed?** Irrespective of intent or the teen's judgment about lethality, how dangerous is/was the teen's preferred method?
8. **What is/was the potential for discovery?** Inquire about whether or not early intervention for suicidality is/was possible in the context of whether or not a suicide attempt will be discovered in time to do something to preserve life.
9. **How effective is the environment for keeping the teen safe?** In the context of negotiating and adhering to a no suicide contract, including the contract negotiated at the start of TADS treatment and the renewal or renegotiation of this contract as part of ASAP, can the parent(s) and, most importantly, the primary caregiver, provide for safekeeping. Consider availability to the teen, the quality of their relationship, whether abuse/neglect, parental mental illness or substance abuse is present and the ease of working out the no suicide contract.

## **VIII. Intervention**

It is impossible to pre-determine the outcome of an ASAP evaluation. However, three general principles must apply to all interventions: (1) the teen's safety is the paramount consideration; (2) continuing TADS treatment is only appropriate if it contributes in a meaningful way to the child's clinical care and does not conflict with other necessary interventions; and (3), other interventions within or outside the TADS protocol must be implemented if clinically appropriate.

In every case, the following conditions should obtain before discharging a suicidal patient to home.

1. There is a supportive and responsible person at home.
2. A no suicide contract is in place.
3. Firearms and lethal medications are effectively secured or removed
4. Patient and family have been cautioned about disinhibiting effects of drugs or alcohol.
5. A follow-up appointment has been scheduled and teen/family understand how to contact the TADS team at any time for emergencies.

If these five conditions cannot be met, then hospitalization for safekeeping should be considered.

## **IX. Primary Caregiver/Parent Suicidality**

If suicidal, family members other than the teen may require referral for mental health evaluation or services during the course of TADS treatment for the identified patient. Such referrals are coded as ASAP 8, and listed on the ASAP Form.

At each assessment point, the study coordinator will review the primary caregiver BDI within 24 hours of the assessment. If item nine (suicidality) is endorsed at a level of 2 or 3 (indicating ideation and/or intent), the primary therapist and the PI will be notified immediately. The primary therapist (in consultation with the team and PI as needed) will intervene using the ASAP 8 mechanism as appropriate.

Note that the TADS AE/ASAP manual already requires consideration of referral of either parent for treatment of depression if the baseline BDI for either parent is > 20 and at any other point in the study when referral appears indicated on clinical grounds. The above rule for identifying and managing parental suicidality will apply to the BDI from either parent when obtained at baseline.

Note also that in no instance should referral for treatment include treatment that overlaps TADS treatment, e.g. a referral for behavioral family therapy unless the recommendation is made in the context of ASAP indications 2-5.

## **X. Summary**

This manual provides a consistent vehicle for sites to handle situations involving suicidality that require additional evaluation and/or intervention beyond that provided for in the study protocol. Since this treatment study is being conducted at nine different sites, it is important that there be consistency and agreement in the manner in which these situations are handled, so as not to bias treatment results or to invite site-by-treatment interactions. Above all, this manual is intended to provide compassionate and competent care to suicidal teens and their families in TADS so that risk

to the patient is minimized and the benefits of treatment from TADS or though ASAP procedures can be maximized.