

Running title: Consensus on Digital Monitoring

Consensus Statement on Ethical & Safety Practices for Conducting Digital Monitoring Studies with People at Risk of Suicide and Related Behaviors

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Abstract

Objective: Digital monitoring technologies (e.g., smartphones, wearable devices) provide unprecedented opportunities to study potentially harmful behaviors such as suicide, violence, and alcohol/substance use in real-time. The use of these new technologies has the potential to significantly advance the understanding, prediction, and prevention of these behaviors.

However, such technologies also introduce myriad ethical and safety concerns, such as deciding when and how to intervene if a participant's responses indicate elevated risk during the study? **Methods:** We used a modified Delphi process to develop a consensus among a diverse panel of experts on the ethical and safety practices for conducting digital monitoring studies with those at risk for suicide and related behaviors. Twenty-four experts including scientists, clinicians, ethicists, legal experts, and those with lived experience provided input into an iterative, multi-stage survey and discussion process. **Results:** Consensus was reached on multiple aspects of such studies, including: inclusion criteria, informed consent elements, technical and safety procedures, data review practices during the study, responding to various levels of participant risk in real-time, and data and safety monitoring. **Conclusions:** This consensus statement provides guidance for researchers, funding agencies, and institutional review boards regarding expert views on current best practices for conducting digital monitoring studies with those at risk for suicide – with relevance to the study of a range of other potentially harmful behaviors (e.g., alcohol/substance use, violence). This statement also highlights areas in which more data are needed before consensus can be reached regarding best ethical and safety practices for digital monitoring studies.

Key words: ethics, safety, guidelines, suicide, ecological, digital

The development of new technologies such as smartphones and wearable biosensors has provided unprecedented opportunities to study a wide range of mental health concerns and to improve their understanding, prediction, and prevention. The newfound ability to monitor people's thoughts, affect, and behavior in real-time has the potential to significantly advance the understanding of potentially harmful behaviors that occur episodically in natural environments and to develop new just-in-time adaptive interventions¹ to help mitigate them. Perhaps the most concerning of such clinical high-risk behaviors are suicide and its immediate precursors – suicidal thoughts and behaviors (STBs). Studies using digital monitoring of those at risk for STBs are increasing exponentially in number in recent years.² However, these newly available methods also present unprecedented scientific, methodological, clinical, ethical, and legal concerns. There has been no consensus among scientists, clinicians, and other stakeholders about best practices for conducting real-time monitoring studies of those at risk for suicide and related behaviors, leaving these parties on their own to work through these issues and propose solutions.

Prior papers have provided valuable guidance for researchers, funding agencies, and institutional review boards (IRBs) in planning and carrying out research with those at risk for suicide.³⁻⁵ Digital monitoring methods present a host of new factors for consideration. Whereas traditional assessment approaches ask participants to retrospectively report on the presence, characteristics, and risk of STBs over a period of weeks or months at a time, digital monitoring approaches and studies assess such outcomes *at that very moment* at which they occur and can do so repeatedly over periods of minutes, hours, days, and weeks. Moreover, some digital monitoring apps also allow the passive collection of data on participants' exact geolocation (e.g., GPS). This means that digital monitoring studies often can tell us not only *when* someone is at risk, but *where* someone is at the time of risk. Given these considerations, funding agencies, IRBs, and researchers commonly raise important participant safety and privacy questions to be considered and decided before, during, and after the conduct of such studies. For instance,

what should researchers do when a participant's response suggests that they are at high or imminent risk for suicide at that very moment? Is an automated response sufficient to manage participant risk, or should there be a follow-up by phone, text or e-mail by a member of the research team to conduct a more thorough risk assessment to ensure appropriate and timely treatment?

Here we report on a consensus meeting that included leading scientists, clinicians, ethicists, legal experts, those with lived experience, and other interested stakeholders regarding the safe and ethical conduct of digital monitoring studies of those at risk for suicide and related behaviors. Our goals were to outline areas of consensus to provide guidance for those using digital monitoring to study suicidal and related behaviors, and to discover and discuss areas where there is not yet consensus to point toward key questions for future research on this topic.

Methods

Delphi Process

We used a modified Delphi process to obtain expert opinions about the conduct of digital monitoring studies with those at risk for suicide and related behaviors. This approach has been used to obtain expert opinion and consensus across the medical and social sciences in areas where none yet exists.⁶⁻⁹ Essential elements of the Delphi process include: assembling a team of experts representing a broad range of perspectives, receiving iterative and anonymous assessments from these experts to obtain their candid and unbiased input, and group discussion of key issues facilitated by review of the anonymous and aggregated results to allow the group to consider all perspectives before final assessment of individual experts views on the key issues.

Identification of Key Issues/Questions on this Research Topic. The first step in this modified Delphi process was to generate a list of key issues and questions on this research topic about which expert consensus was lacking. This was done via a thorough literature review followed by a series of discussions between two university-based clinical scientists (MKN, EMK)

and National Institute of Mental Health (NIMH)-based scientists (JP, GS, AO) who planned and organized the rest of the process. Our approach was to cast a broad net and to generate issues/questions at each phase of the research process (outlined below).

Panel Selection. The second step was to generate a diverse list of experts who could provide guidance on the range of issues/questions produced. The experts invited to participate represent the perspectives of those working in the areas of: science, clinical practice (inpatient/outpatient, child/adolescent/adult), bioethics/legal/IRB, computer science, statistics, funding agencies (federal and private), and those with personal/lived experience with STBs. We invited 23 experts to participate in this process. To increase the diversity of perspectives included, we also invited four post-doctoral and two pre-doctoral research fellows, each of whom had multiple years of experience working in this area, for a total of 29 invitees.

Survey: Round 1. The third step was to develop and send a 19-item survey to all invited participants. These questions focused on two time periods: (1) issues to consider before data collection begins (described in detail in **Table 1**) and (2) issues to consider during data collection (described in detail in **Table 2**). Consistent with suggested guidelines for Delphi surveys,^{8,9} this survey was conducted anonymously to get participants' unbiased responses to each question. When possible, questions included response options that could be easily quantified (e.g., no/yes, check all that apply) to facilitate efforts to reach a consensus. All questions also included an open-ended response option so that participants could provide more nuanced responses if the response options did not adequately capture their perspective. Administration of this survey and all procedures described here were approved by the Harvard University IRB. An anonymous link to the survey was e-mailed to all 29 invitees. Twenty-four (82.8%) participants completed the survey.

Consensus Meeting. In the fourth step, all invitees were invited to attend a day-long, face-to-face meeting co-hosted by researchers from Harvard University and NIMH. Twenty-seven of the 29 invitees attended (93.1%). Each invitee presented information about their

experience and/or perspectives in this area. We then shared the aggregated results of the Survey: Round 1 and talked through each topic assessed in the survey in detail.

Survey: Round 2. In the fifth and final step in this process, we modified the survey based on the previous round of responses (e.g., clarifying questions in places where there was confusion about what was being asked) and on the discussion at the face-to-face meeting. The updated survey re-administered the first 13 items of the prior survey (because we had complete consensus on the final 6 items) with several modifications. We sent this version of the survey to the 27 people who participated in the face-to-face meeting (and had the benefit of the extended discussion about these issues), of whom 21 (77.8%) participants completed the survey.

Data Analysis

Here we report the results from each of the final questions asked of this panel of experts. There currently is no agreed upon standard regarding what constitutes a “consensus” using the Delphi process (irony noted: no consensus on consensus). Given the standard convention in the social and health sciences for considering agreement of 70% or higher to represent an acceptable level of agreement for inter-rater reliability, response rates, validity, etc., we considered agreement of 70% or higher to represent “agreement” (i.e., consensus) and 80% or higher to represent “strong agreement.”

Results

Issues to Consider Before Data Collection Begins

The panel of experts raised and discussed a range of issues that encompass decisions about, and interactions with, potential study participants before data collection begins. These included issues regarding who to enroll in a study, under what conditions, what information to include in the informed consent process, how much contact information to collect from participants, and what technical and safety procedures to set in place.

Exclusion of participants. The first question addressed by the panel was whether any potential participants should be excluded from real-time monitoring studies due to elevated risk

of suicide. There was strong agreement that researchers should aim to collect data from those even at the highest levels of risk, and thus that potential participants should not be excluded solely due to high level of suicide risk. This perspective was endorsed by 19/21 experts (90.5%). Two people (9.5%) thought that those at very high risk of STBs should be excluded because they might be “unable to agree to seek crisis care” or “unable to respond to ecological momentary assessment prompts.”

Conditions for enrolling in the study. There also was strong agreement (85.7% of experts) that there should not be any conditions that participants must agree to in order to enroll in a real-time monitoring study, such as agreeing to be in treatment or call a hotline when at high risk. Experts also indicated that such contingencies would be difficult to enforce, would not increase participant safety, and seem intended to protect the researcher/institution more than the participant. The 14.3% of experts who indicated that participants should agree to some conditions to enter or remain in the study all endorsed that those should include: (a) agreeing to call a hotline or seek other help when at high risk, (b) agree to access a clinician when at imminent risk, and (c) agree to provide data with some frequency. At least one expert also endorsed each of the following: agreeing to have a safety plan, providing collateral contact information, and getting permission from their current clinician (if they have one) to participate.

Informed consent. The panel reached consensus on 10 elements that should be conveyed to participants during the consent process (i.e., written in the consent form and conveyed to the participant verbally when possible). There was strong consensus for nine of these elements (**Table 1**), with consensus, but some divergence of opinion, regarding whether participants should be informed about what risk monitoring activities and interventions may be taking place in the study. Some experts believed that efforts to monitor and intervene during high-risk situations may be compromised if participants are made aware of the specifics of potential monitoring approaches or interventions, whereas others did not share this concern.

Contact information. There was strong agreement that investigators conducting digital monitoring studies should have some method of contacting participants in the event of elevated risk, including: participant phone number, parent contact information (in the case of child/adolescent participants), home address, and email address. There also was agreement that investigators should obtain contact information for at least one collateral person who could help reach the participant in times of increased risk. There was not a consensus on a requirement for multiple collaterals, participants' clinicians' contact information, or having access to participants' social media accounts as a means of communicating. Two notable exceptions to the need for participant or collateral contact information are studies of hospital inpatients and those recruited anonymously online. In the former, hospital staff should be alerted if a participant reports elevated risk. In the latter, referrals to higher levels of care may be made in an automated message/referral.

Technological and Safety Procedures. There was strong agreement on seven different technological and safety procedures that investigators should conduct before beginning a digital monitoring study in this area (**Table 1**). Several experts suggested that investigators should solicit feedback from participants about their desired response from the investigative team for various levels of risk; however, there was not a consensus on this point, as other experts did not believe that having individual-level risk responses is feasible for larger studies.

Issues to Consider During Data Collection

The most challenging aspects of conducting digital monitoring research with people at elevated risk for suicide and related behaviors involve determining when and how to monitor participant data and manage suicide risk. The panel of experts spent most of its time discussing issues in this area, including how frequently to check participant data, how quickly to respond to those at elevated risk, how to define and respond to elevated risk, as well as issues of study monitoring and data security.

Frequency of reviewing participant data. Investigators may have access to software platforms that allow for continuous, real-time monitoring of study data. In some instances, real-time monitoring of data is not possible (e.g., a survey app does not have the ability to automatically alert the research team when a participants' response crosses a specified threshold, or if data are only uploaded when a Wi-Fi connection is available). Regardless, the panel agreed that the research team should have a protocol specifying the frequency with which a team member would check the data for high-risk responses. There was strong agreement (89.5%) that in such instances data should be reviewed at least every weekday (**Table 2**). There was not consensus regarding how frequently data should be reviewed within shorter windows.

Determining Risk Level. Much of the in-person meeting was spent discussing how to determine a participant's level of current risk (e.g., low, moderate, high, imminent) at a given assessment point. Although there was no consensus on how to do this – as is the case with suicide risk assessment more generally¹⁰ – there was strong agreement on the pieces of information that researchers should collect to determine risk level: current level of desire to die, level of intent to die, presence of a suicide plan, and access to the planned method. Importantly, the group noted that self-report of each of these aspects of suicidal thinking/intention is not necessarily indicative of high probability of suicidal behavior; determining a given participant's probability of suicidal behavior at a given point in time is one of the desired goals of research of this type. In the meantime, self-reported level of suicidal thinking/intention is used as a best estimate of participant level of risk.

Length of Response Window. Once the research team receives indication that a participant is at "imminent risk," how quickly should they respond? The simple answer is 'as quickly as possible.' However, what if the indication comes at 2 am or while the team member responsible for responding is conducting a therapy session or otherwise not monitoring their phone or computer for messages? There was strong consensus (94.4%) that the team should respond within 24 hours of receiving an "imminent risk" indication, and consensus (72.2%) that

such a response should be made within 12 hours. For instance, a team may not have the resources (e.g., person-power) to monitor responses overnight (e.g., 9pm-9am), but in such a case should respond no longer than 12 hours after the imminent risk indication was received.

Potential Interventions. The majority of experts (>61.1%) believed that for those currently at low/moderate risk, an automated message suggesting that the participant contact a crisis line, support person, or clinician is a sufficient response by the research team. For those at high risk, there was consensus that participants should receive a personalized safety plan and/or an automated additional risk assessment (77.8%), and some experts suggested that best practice should be to always have a safety plan (and associated call numbers) readily available to participants within the survey app. There was strong consensus that in cases of high risk the research team should reach out to the participant directly to conduct a risk assessment (94.4%). There was not consensus about the need to call 911 to request a wellness check, with 50% of experts endorsing such an action. Some experts suggested this “should be the last possible option” and noted potential negative consequences to doing so in cases of working with potentially vulnerable participants, such as racial/ethnic minority participants, who experience significantly higher rates of physical force and death in police-initiated contacts.^{11,12}

The group also discussed the extent to which an automated intervention (e.g., pop-up with safety plan or one-touch call to clinician or hotline) versus human outreach (e.g., call, text, or email from member of the research team) should be used. There was strong consensus that automated interventions are sufficient for low risk and moderate risk situations, but that human outreach is preferred for high-risk situations and in studies of minors. Experts noted that automated outreach is sufficient in studies where participation is anonymous. There was strong consensus that researchers should formulate a personalized risk plan with each participant before the monitoring portion of the study begins to guide procedures for responding to instances in which participants do not respond to initial calls, texts, or emails from the research

team (**Table 2**). There also was strong consensus that in studies involving youth, a parent should be contacted in instances of non-response by high-risk adolescents.

Participant Removal. An important question in the current context is whether participants should be removed (temporarily or permanently) from the study by the research team (vs an individual participant's wish to discontinue), due to elevated risk of suicide or clinical severity or worsening. There was strong consensus among experts that no participants should be removed from real-time monitoring studies – as it is important to understand and be able to predict harmful behavior among those at all levels of risk, particularly those at highest risk.

Data Safety and Monitoring. Data and Safety Monitoring Boards (DSMBs) and Independent Safety Monitors (ISMs) often are required for NIMH-supported clinical trials “to assure the safety of research participants, regulatory compliance, and the data integrity,”^{3,13} but could be used in any study. One of their main functions is to review adverse events. There was not consensus on the requirement for DSMBs or ISMs in the case of real-time monitoring assessment studies. Approximately one-third (31.6%) of experts indicated that they are not needed for such studies, one-half (47.4%) indicated they are needed but only for studies where participants are recruited because they are at high risk, and a smaller percentage (21.1%) indicated they should be required of all such studies. For those indicating that such studies should have a DSMB/ISM, there was strong consensus that there should be a requirement that such oversight is provided by someone with expertise managing suicide risk (**Table 2**).

Data Security. There was strong consensus that researchers conducting such research use secure web-based platforms and de-identified data storage, and consensus that HIPAA compliant platforms also should be used in such research.

Discussion

Digital monitoring technologies provide unprecedented opportunities to advance the understanding of suicide and related behaviors. However, there are not yet accepted guidelines regarding ethical and safety practices for conducting research studies in this area. We

convened a panel of experts to attempt to reach consensus about key considerations in this area based on currently available data and perceived best practices. This panel of experts reached consensus on a number of key issues regarding ethical and safety practices for conducting digital monitoring studies with those at high clinical risk (**Table 3**). Many of these aspirations reflect the need to expand study inclusion to participants with significant suicide risk, since historically they have been typically excluded from research. In many cases these aspirations also reflect the need for significant resources to enable researchers to conduct intensive longitudinal monitoring and real-time risk management and intervention, which is not always possible. This consensus statement can help to guide researchers, funding agencies, and IRBs involved in the planning, conduct, and oversight of research studies in this area. Notably, the panel of experts discussed and endorsed the fact that these views are based on currently available data and thinking, and that these views may evolve over time as additional data and considerations become available – highlighting the need to revisit these ethical and safety considerations iteratively over time.

There also were several areas in which the panel did not reach consensus. These included: (a) determination of what constitutes low, moderate, high, and imminent risk for suicide and related behaviors; (b) determination of the most effective intervention for each risk level; and (c) the requirements for using DSMBs and ISMs for monitoring studies of this type. Reaching consensus on the first two areas requires additional empirical data. Historically, determinations about level of risk for suicide and related behaviors and the most appropriate response (e.g., hospitalization) have been made primarily based on clinical judgment and decision-making. Recent advances in electronic record-keeping and machine learning have significantly enhanced the ability to predict suicidal and related behaviors,¹⁴⁻¹⁶ and similar innovations are needed in studies of real-time digital monitoring. Still absent from all such studies are data on the most effective intervention for a particular person at a particular time point – a long-standing question in mental health research and practice.¹⁷ Efforts to address

questions such as this are currently underway^{18,19} and hopefully will provide guidance that can be used to update the current consensus at that time.

This panel of experts considered, but did not sufficiently discuss, several related topics that require further attention. These include further incorporation of research participants' perspectives; consideration of issues unique to children and adolescents; issues unique to other behaviors such as substance use (e.g., if/how to intervene if the research team believes a person may operate an automobile while intoxicated?); and issues unique to other digital platforms such as social media apps. The current effort represents a key step toward providing consensus guidance on safety and ethical practices for conducting digital monitoring studies with those at high clinical risk. Additional, iterative efforts are needed to provide ongoing guidance on these important topics.

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Table 1. Issues to Consider Before Data Collection Begins in Digital Monitoring Studies of those at Risk for Suicide and Related Behaviors

| Issue | Question | Answer | |
|---------------------------|--|--|-------|
| Exclusion of participants | | No, we should be collecting data from everyone, even those at the highest levels of suicide risk | 90.5% |
| | Should any potential participants be excluded due to elevated risk of suicide? (select one) | Yes, people who are too high risk should not participate in research | 9.5% |
| | Should there be certain conditions participants must <u>agree</u> to in order to enter/stay in a study, such as agreeing that they will go to treatment sessions or call a hotline when at high risk? (select one) | No, we can encourage people to do these things but should not set any such conditions | 85.7% |
| | Yes, there should be conditions participants must agree to enter/stay in the study | 14.3% | |

| | | | |
|--|---|---------------|--------------------|
| | Whether responses can trigger follow-up and/or intervention actions by the research team and/or clinicians, which may include breaking of confidentiality | 100% | |
| | Information that the participant should not rely on the study monitoring to keep them safe/alive | 100% | |
| | Information about who will have access to their data including third party software developers to improve their app product | 100% | |
| | How often researchers will check participants' responses | 95.2% | |
| Should participants be explicitly informed of the following during informed consent? (select all that apply) | Circumstances under which the subject's participation may be terminated by the investigator without regard to the subject's consent | 95.2% | |
| | Who to contact in case of crisis | 95.2% | |
| | Information that there can be technology failures | 95.2% | |
| | Information that the participant won't be automatically hospitalized if their responses trigger a follow up assessment by the research team | 90.5% | |
| | How and what information will be shared with participants and others if confidentiality is breached | 90.0% | |
| | What risk monitoring activities and interventions will be taking place | 76.2% | |
| | What contact information, including collateral contact information, | | |
| | Participant cell phone number | 100% | 95.2% |
| | | Adults | Adolescents |

t should studies be required to
a collect? (select all that apply)

| | | |
|---------------------------------------|-------|-------|
| Parent contact information | - | 90.5% |
| Participant home address | 88.9% | 76.2% |
| Participant email address | 83.3% | 71.4% |
| Collateral contact | 72.2% | 61.9% |
| Multiple collateral contacts | 38.9% | 33.3% |
| Participant's clinician | 27.8% | 28.6% |
| Participant's social media account(s) | 11.1% | 9.5% |
| None | 14.3% | 0% |

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Which issues should researchers
address BEFORE data collection
begins in a
real-time monitoring study?

| | | |
|------------------------------------|--|-------|
| | Figure out what to do when technology fails | 100% |
| | Test the alert system | 100% |
| Technology (select all that apply) | In a standardized manner, go over items of incidental data collection (medical information, voice, video) being obtained and the process of alerting and collecting data | 100% |
| | Determine how to store and potentially share location data | 95.2% |
| | Provide the participant with emergency contact information | 100% |
| | Determine what criteria should be used to delineate specific criteria for triggering further risk assessment or intervention | 100% |
| Safety (select all that apply) | Train study staff with risk assessment protocol for assessing and responding to participant suicidal ideation and behavior | 100% |
| | Solicit feedback from participant about their desired response from research team for varying levels of risk | 55.0% |

Table 2. Issues to Consider During Data Collection in Digital Monitoring Studies of those at Risk for Suicide and Related Behaviors

| Issue | Question | Answer | |
|--|---|-------------------------------|-------|
| Frequency of reviewing participant data | If available technology is not able to alert researchers in real time, how often should participant data be reviewed by a human on the research team for risk assessment purposes? (select one) | More than two times a day | 5.3% |
| | | Twice every day | 21.1% |
| | | Once every day | 31.6% |
| | | Every weekday | 31.6% |
| | | Less than once a day | 10.5% |
| Determining risk level | What key pieces of information should researchers collect to determine a participant's level of risk? (select all that apply) | Level of intent to die | 94.4% |
| | | Presence of suicide plan | 94.4% |
| | | Access to suicide plan/method | 88.9% |
| | | Level of desire to die | 83.3% |

| | | | | |
|---|--|--|------------------|-------------------|
| | | Presence of any suicidal ideation (no/yes) | 66.7% | |
| Length of response window | When the research team learns that the participant is at "imminent risk," what is the longest acceptable time window to respond? (select one) | Within 6 hours | 22.2% | |
| | | Within 12 hours | 50.0% | |
| | | Within 24 hours | 22.2% | |
| | | Within 48 hours | 0% | |
| | | Within 72 hours | 5.6% | |
| | | | | |
| | | | Low/ Moderate | High |
| Potential interventions | What action/intervention should be taken in each case? (select all that apply) | Pop up message with suggestions to call a suicide hotline/crisis line | 66.7% | 66.7% |
| | | Pop up message with suggestion to contact participant's supports such as family | 66.7% | 50.0% |
| | | Pop up message with suggestion to call clinician | 61.1% | 61.1% |
| | | Pop up message with personalized safety plan instructions | 61.1% | 77.8% |
| | | Pop up automated/interactive risk assessment | 44.4% | 77.8% |
| | | Research team contacts participant for risk assessment | 11.1% | 94.4% |
| | | Research team calls 911 to request wellness check | 5.5% | 50.0% |
| | | | | |
| | At what level is an automated intervention sufficient and at which level of risk is human out-reach required? (select one option for each row) | Low risk | 100% | 0% |
| | | Moderate risk | 80.0% | 20.0% |
| | | High/imminent risk | 20.0% | 80.0% |
| | | | Adult | Adolescent |
| Steps for reaching out to participants | If you believe that human outreach is required, what steps should be taken if a participant is not reachable by the research team? (select all that apply) | Formulate a personalized risk plan beforehand that is agreed upon during consent process | 85.0% | 80.0% |
| | | Notify parent | 20.0% | 90.0% |
| | | Notify collateral contact | 65.0% | 65.0% |
| | | Contact clinician | 20.0% | 30.0% |

| | | | | |
|--|--|--|-------|-------|
| | | Call 911 and send ambulance team to participant | 30.0% | 30.0% |
| | | Do nothing | 5.0% | 5.0% |
| Participant removal | Should participants be removed from the study due to elevated risk or clinical severity? (select one) | No, we should be collecting data from everyone. Even those at the highest levels of risk | | 100% |
| | | Yes, people who are too high risk should not participate in research | | 0% |
| Data and Safety Monitoring Boards & Independent Safety Monitors | Should all real-time monitoring studies have a DSMB or ISM? (select one) | No, DSMBs or ISMs are not needed for such studies | | 31.6% |
| | | Yes, but DSMBs or ISMs should be required only for such studies with participants at high risk for suicide | | 47.4% |
| | | Yes, DSMBs or ISMs should be required for all such studies | | 21.1% |
| DSMB/ISM members | What DSMB members should be <u>required</u> for real-time monitoring type studies? (select all that apply) | Expert in managing suicide risk | | 91.7% |
| | | Someone with an understanding of the technology | | 58.3% |
| | | Licensed clinician | | 41.7% |
| | | Community member (someone with lived experience) | | 33.3% |
| | | Legal expertise in the field of psychiatry | | 25.0% |
| Data security | What are minimal standards for data security? (select all that apply) | Secure web-based platforms | | 94.4% |
| | | Deidentified data storage | | 83.3% |
| | | HIPAA compliant platform | | 77.8% |

Table 3. Main Points of Consensus in Digital Monitoring Studies of those at Risk for Suicide and Related Behaviors

Researchers conducting real-time monitoring studies of those at risk for suicide and related behaviors should strive to:

- (1) Not exclude participants solely on the basis of elevated clinical severity or suicide risk.
 - (2) Not exclude or remove participants who are not willing or able to meet pre-specified conditions for participant or help-seeking (e.g., remaining in treatment or calling a hotline when at high risk).
 - (3) Provide participants with explicit information about key elements of study procedures during the informed consent process.
 - (4) Collect and retain (during the real-time monitoring period) contact information (phone, email, and home address) from both the participant and at least one collateral to facilitate contacting participants during periods of perceived elevated risk.
 - (5) Address key aspects of technology use and participant safety before proceeding with data collection.
 - (6) Review participant survey responses at least once every weekday.
 - (7) Respond to those determined to be at “imminent risk” for suicide within 12 hours of learning of this risk.
 - (8) Collect data about suicidal desire, intent, plan to determine participants’ level of risk.
 - (9) Respond to participants determined to be at high or “imminent” risk for suicide with automated risk assessments, safety plans, and human outreach (depending on risk and type of study) as soon as possible.
 - (10) Store data in de-identified form, in secure servers, and in compliance with HIPAA guidelines. In cases in which Data Safety and Monitoring Boards are used they should include at least one person with expertise managing suicide risk.
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