**Determining Human Subject Suicide Risk: Risk Assessment Flowchart and Brief User Guide**

The following flowchart was designed to help research personnel make thoughtful decisions regarding the level of a research participant’s suicidal risk. This flowchart can be used to help the research personnel 1) organize their process of asking questions and making decisions regarding risk level, 2) communicate effectively with clinical supervisors and research participants regarding safety concerns and next steps, and 3) determine and initiate appropriate action steps based on risk level to ensure participant safety.

The flowchart is designed to evaluate three main components of suicide risk: 1) current suicidal thoughts, 2) intent to act on suicidal thoughts, and 3) development of a plan to act on suicidal thoughts.

This flowchart is designed as a guide and may be adapted for individual research studies based on the study population and specific risk identification protocols. *Please be sure to refer to your study protocols for additional details and action steps. It is also highly recommended that you collaborate with your facility Suicide Prevention Coordinator to determine the most appropriate risk assessment procedures.*

**1) Initial endorsement of suicidal thoughts (Box 1)**: During a participant interaction, actively listen for indicators of increased risk for suicide. The participant may state suicidal thoughts **explicitly** (e.g., “I’m thinking of killing myself”), but more often, statements about suicidal thoughts will be mentioned **implicitly** (e.g., “I’m such a failure, I don’t think I want to try anymore”). It is important for the research personnel to determine if the thoughts are current and/or chronic (days, weeks – as determined by your protocol). *In this specific flowchart example, Box 1 indicates an observation of suicidal thoughts (what the participant says or how they behave). Depending on the study design, you may also decide to put a specific measure item in this box that would trigger a suicide risk assessment (e.g., participant endorses item #\_\_ on our suicide assessment questionnaire).*

Indicators of risk may include (but are not limited to):

* Endorsement of thoughts of suicide
	+ Passive thoughts (e.g. “I wish I could go to sleep and not wake up”, “Sometimes I just wish I wasn’t here anymore”), or
	+ Active thoughts (e.g. “I want to die”, “I can’t do this anymore”, “I want to make the pain stop”)
* Endorsement of intent to end their life, with or without a plan
* Endorsement of increase in risk factors for suicide
	+ Talking about wanting to die, great guilt or shame, being a burden to others
	+ Feeling empty, hopeless, trapped, or having no reason to live
	+ Feeling extremely sad, anxious, agitated, or full of rage
	+ Experiencing unbearable emotional or physical pain
	+ Researching ways to die
	+ Increase in substance use or dangerous behaviors
	+ Withdrawing from friends, saying goodbye, giving away important items, or making a will

***Note:*** Identification ofsuicide risk triggers may be challenging for research personnel, even those with a clinical background.It is highly recommended that research personnel practice role plays with other study personnel to help them practice their active listening skills and ability to identify both explicit and implicit indicators of suicidal thoughts.

**Action Steps for Box 1:**

* If the participant DOES NOT endorse any current suicidal thoughts - No Current Risk
	+ - No formal documentation (risk assessment note) is typically necessary.
		- There is no need to provide a resource brochure or risk resources to the participant at this time.
	+ If the participant DOES endorse current suicidal thoughts, research personnel must move to Box 2 to determine intention to act.

**2) Determination of suicidal intent (Box 2):** If the participant endorses suicidal thoughts,the next step is to determine whether the participant has any intention to act on their suicidal thoughts. Some participants will have ongoing thoughts of wanting to die but will have no intention of acting on these thoughts (e.g., “I have thought about overdosing but I would never do it”). It is important for the research personnel to determine if the participant has any current intention of acting on their thoughts (e.g., “I have thoughts of ending my life and I might do it”).

***Note:*** Intent to act can sometimes be seen as a desire or want to act on the thought to end their life.Assessing intent to act is one of the more important pieces of suicide risk assessment because it shows a shift in thinking from inaction towards action. Research personnel may gather information regarding current intent to act in several ways during a research visit. If study protocols include either researcher administered interviews (e.g. C-SSRS) or self-report questionnaires that collect data regarding current intent to act, research personnel may use this information to assess for current intent. Research personnel should actively listen for the presence of any indication of intent, including statements that show ambiguity towards life (e.g., “I don’t care if I live or die at this point”). It is important to remember intent does not need to be definite; any indication of intent to act on suicidal thoughts is relevant and should be explored.

**Action Steps for Box 2:**

* If the participant has current thoughts, but NO current intent to act on thesethoughts - Low Risk
	+ Formal documentation (risk assessment note) is recommended
	+ Research personnel must provide participant with study specific risk resources that contains information on for available help
* If the participant has current thoughts AND some current intent to act, the research personnel must continue to Box 3, to assess whether the participant has a plan for acting on their suicidal thoughts.

**3) Determination of suicidal planning (Box 3):** If a participant endorses current intent to act on suicidal thoughts, the research personal must assess whether the individual has started to formulate a plan for taking their life, and whether they intend to carry out their plan.

***Note:*** Research personnel should clearly understand the difference between an identified suicide METHOD and a suicidal PLAN.

* **Method** is defined as any means by which a person chooses to end their life. Types of methods/means include poisoning (e.g. taking pills or overdosing), hanging, using a gun, crashing a car, etc.
	+ Having an identified method is common among participants who have either attempted suicide in the past or who have chronic suicidal ideation.
	+ Having an identified method does not necessarily mean a person has a plan for suicide.
* **Plan** is defined as a clearly articulated series of events that include details of how the method of suicide would be carried out.
	+ Plans usually involve details that have been thought out and often include preparatory behaviors (e.g., moving a gun out of a locked cabinet, stockpiling pills to take at once, etc.)

**Action Steps for Box 3:**

* If the participant has current thoughts, some current intent to act, and no plan – MODERATE RISK
	+ Participants at this level may have a method/means for suicide identified, but no active planning has taken place and there are no plans to develop or begin plans in the near future (please refer to study protocols for the number of days that fall into the definition of “near future.” In some study populations, this could be 3 days, or some study teams may decide to extend this to a week or even longer).
	+ Formal documentation (risk assessment note) is needed.
	+ Research personnel must provide participant with study specific risk resources that contains information for available help
	+ Consultation with a clinical supervisor is recommended at this level, especially for ambiguous situations
		- If current risk level is between MODERATE/LOW, clinical consultation can occur after the participant leaves the study visit.
		- If current risk level is between HIGH/MODERATE, it is recommended that the clinical consultation occur while the participant is present at the study visit in case a warm handoff to clinical care resources is necessary.
* If the participant has current thoughts, some current intent to act, and a current plan and/or preparatory behaviors – ACUTE HIGH RISK
	+ If the participant is in **immediate, life-threatening danger** (e.g., an injury has already occurred or is about to happen) research personnel should call 911. This should be done prior to contacting a clinical supervisor if the participant needs immediate, emergency medical services.
		- Research personnel should be prepared to contact emergency services (i.e., 911, crisis line) for imminent risk situations when indicated or if a clinical supervisor is not immediately available.
		- Examples of imminent risk situations will be discussed during suicide risk assessment trainings.
	+ Consultation with a clinical supervisor is **required**, however the timing of the consultation may vary based on the situation.
		- If the participant is in **immediate, life-threatening danger** or a suicide event is imminent, research personnel should contact an emergency resource (e.g., 911) **immediately**, prior to consulting with a clinical supervisor to ensure participant safety.
			* Situations requiring immediate emergency services will be discussed during risk assessment trainings.
			* Once an emergency resource has been contacted and the participant’s safety has addressed, research personnel should immediately contact the clinical supervisor to debrief.
		- Emergency protocols should be developed for each research project based on the study population and available emergency resources within the area.
	+ Research personnel should always remain with the participant at this risk level until connected with a clinical resource.
		- If a participant chooses to leave the assessment at this risk level, research personnel should remind participants of the limits of confidentiality and that they will be contacting emergency services on their behalf.
		- Research personnel should contact a clinical supervisor to discuss next steps should an acute high-risk participant leave the study assessment. If a clinical supervisor is not immediately available, or if you believe a participant is in immediate danger, the research personnel should contact emergency services themselves.
	+ If the participant is at acute high risk (but NOT in immediate danger), a clinical supervisor should be contacted for consultation prior to involving emergency services. The clinical supervisor will discuss options for connecting to clinical care resources with the research personnel. They may request to speak directly to the participant for further assessment. Participants may be connected to clinical care resources (crisis line, counselor, etc.) at this level if warranted.
		- If a participant is unwilling to self- disclose their current thoughts, a clinical supervisor will instruct the research personnel on next steps if breaking confidentiality is necessary.
			* In instances where a clinical supervisor is not readily available for consultation, research personnel should be prepared to contact clinical care resources themselves and should follow study protocols related to breaking confidentiality when necessary to protect participant safety.
		- As a reminder, family / friends do not count as a clinical resource.
	+ Formal documentation (risk assessment note) is needed. It is suggested that this document is reviewed by all parties (e.g. research personnel, clinical supervisor) involved in the risk assessment process for accuracy.
	+ Research personnel must provide participant with study specific risk resources that contains information for available help

**Risk Assessment Flowchart**

**Important:** For assessments that are conducted remotely (e.g. over the phone, via telehealth, etc.) research personnel should verify the research participant’s current location at the beginning of the study visit in case emergency services must be sent to the participant’s location.

