**Standard Operating Procedure for Assessment of Suicidal and Homicidal Ideation over the Phone**

**Purpose:** The purpose of this Standard Operating Procedure (SOP) is to describe the clinical steps lab staff must take when assessing suicidal ideation (SI) and homicidal ideation (HI) over the phone. Staff who do not feel comfortable implementing the SOP should notify their clinical support contact to request that they assist with implementation of SOP.

**Clinical Support Team:**

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| --- | --- | --- |
| Chris Gioia | 608-235-3659 (cell)  608-262-6352 (office) | Assistant Director of PRTC |
| John Curtin | 608-217-6221 | Principal Investigator |
| Susan Schneck | 608-293-2412 | Lab Manager |

**Critical Rule:** When in doubt, begin contact with the clinical support team. Clinical support team is available to assist if needed, but in order to maintain rapport and trust with the caller, whoever answered the call should be the only one directly communicating with the caller.

**Things to keep in mind/tips:**

1. The caller is the only person who can solve this problem. Please refrain from trying to fix his/her problem. You may offer suggestions, but for the most part, try to get the caller to come up with a solution.
2. When caller is ready to find a solution, start with the easiest problem and move up to the more difficult ones.
3. Focus on what the client has control over.
4. Work with caller to make small “pacts” to ensure temporary safety while on the call.
   1. Helps to “buy” additional time.
   2. Example: ask them to put the lethal means away/in another room (lock a gun up, put the pills in a cabinet and leave the room)
5. Ask clarifying questions, which is a good tool when needing to keep the caller on the line.
6. Take notes while taking the call.
7. Try to find out if caller has an existing support system (friends, family, co-workers).
8. DO NOT say everything will be alright or offer false reassurances.

Crisis Resources

If you believe that the caller is not in immediate danger and will be okay after the call, consider recommending some of the following resources:

1. **UnityPoint Health Meriter Hospital 24 Hour Emergency Care**: (608) 417-6206
2. **St. Mary’s Hospital Medical Center 24 Hour Emergency**: (608) 258-6800
3. **University of Wisconsin Hospital and Clinics Emergency:** (608) 262-2398
4. **Journey Mental Health Center Suicide Prevention Hotline**: (608) 280-2600
5. **For UW Students ONLY**:
   1. Mental Health Crisis Services (608) 265-5600, Select option 9

If you believe that the caller is in immediate danger and a welfare check needs to be made, depending on the situation, call one of the following numbers:

1. **City of Madison Non-Emergency Dispatcher**: (608) 255-2345
   1. If individual should be checked on, but not immediately (non-emergency police can take up to 30-45 minutes to respond)
2. **City of Madison Police/Ambulance**: 911
   1. Ask for a Crisis Intervention Trained (CIT) police officer
   2. If individual reports that they’ve already ingested a lethal substance, etc.

When contacting either number, it is important to remember that we are still required to maintain confidentiality to a certain degree, meaning that we provide the minimum amount of information necessary to facilitate our goal. **The minimum amount of information includes (1) name, (2) phone number, and (3) address.**

If the caller does not believe he/she can keep himself/herself safe while you make this call, consult a fellow staff member to make the call for you either by text or email. Here would be a good place to show a staff member any relevant notes that they would need to make the call. If you don’t have any notes, summarize the caller’s situation to the caller so that your fellow staff member can get the necessary information. Remember: whoever takes the call needs to finish it.

After the call:

1. Remember that you are not responsible for any actions the caller decided to take.
2. If you’d like, please schedule a time to meet with Chris Gioia to debrief about the call.

**When is it necessary to begin contact with the clinical support team?**

1. Any indication of **intent** to harm self or others
   1. Example: Participant reports suicidal/homicidal ideation, with a clear plan and **intent**
   2. Example: Participant reports suicidal/homicidal ideation, with a vague plan and **intent**
2. Any indication with a clear plan, regardless of intent
   1. Example: Participant reports suicidal/homicidal ideation, with a **clear plan** and intent
   2. Example: Participant reports suicidal/homicidal ideation, with a **clear plan** but no intent
3. Suicidal/homicidal thinking with no clear plan or intent, but involves psychosis or is confusing, concerning, or strange
   1. Example: Participant reports voices in his head are telling him to kill a family member, despite participant not wanting to harm family member
   2. Example: Participant reports suicidal thinking only after talking to his ex-wife; engages in daily contact with his ex-wife
4. Generally speaking, if participant reports suicidal thinking **but no plan or intent**, it is not necessary to take additional steps (e.g., contact Chris). However, there may be exceptions to this (noted above in 3), so follow the CRITICAL RULE when necessary.

Suicidal Ideation

If a participant reports current suicidal ideation or a past suicide attempt, a risk assessment is required. Please follow the instructions outlined below.

1. **Current** suicidal ideation
   1. At a **minimum**, the following questions are **required**:
      1. What do you actually think about (i.e., assess for content)?
         1. Alternative: When you think about harming yourself, are you more likely to think about wishing you were dead or actively thinking about how to harm yourself?
      2. How often do you think about killing yourself?
         1. Examples of questions that assess frequency/duration of suicidal ideation
            1. Over the last two weeks, on average, how many days per week did you think about killing yourself?
            2. On the days that you thought about killing yourself, how many times per day did you think about it?
            3. During the times when you thought about killing yourself, on average, how long did it last (e.g., seconds, minutes, or hours)?
      3. Do you have a plan?
         1. If so, what is it? (*assess for specificity of plan*)
         2. Do you have more than one plan?
            1. If so, what other plans have you thought of?
      4. Do you have any intent (or commitment) to kill yourself?
      5. Do you have access to any means to kill yourself (e.g., guns, pills, other weapons, close proximity to bridge or a body of water)?
      6. What are some things you do (coping strategies) to help you manage your thoughts?
      7. Have you ever had thoughts about killing yourself?
      8. Have you ever made a suicide attempt? (*If YES, move to “2. Past suicide attempt*)
   2. Questions that may be asked to gather additional information:
      1. Is there anything, anyone, or any other reason that makes you want to keep living?
         1. How important is that to you?
      2. Is there anyone you feel comfortable talking to about your thoughts?
         1. If so, have you talked to them recently about your thoughts?
      3. What is your current living arrangement [e.g., alone, friend(s), significant other]?
         1. If you go home after this appointment, is there anybody at home that will be there with you?
      4. Are you currently taking any prescription medications for a mental health reason?
      5. Are you currently attending psychotherapy (talk therapy)?
2. **Past** suicide attempt
   1. When was it?
   2. How did you try to kill yourself?
      1. Cutting
         1. Did you intend to kill yourself or just harm yourself?
      2. Pills
         1. What pills did you take?
         2. How many did you ingest?
         3. Were the pills prescribed to you?
         4. Did you ingest anything else (e.g., alcohol, other drugs) with the pills?
   3. Were you under the influence of any substance at the time of your attempt?
   4. Tell me why you selected this method and how did you prepare for it.
      1. Indication of skill in or level of planning
   5. What happened after your attempt?
      1. Listen for any indication of guilt or fear (e.g., I swallowed twenty Xanax pills, felt nauseous after an hour, got scared, and called my mother)
         1. How did you feel after your attempt knowing that you were still alive?
      2. Listen for admission to a psychiatric hospital, as a result of the attempt
         1. Were you admitted to a hospital as a result of your attempt?
   6. **If Unknown:** Does anyone know about this attempt?

Homicidal Ideation

If a participant reports current homicidal ideation, a risk assessment is required. Please follow the instructions outlined below.

1. **Current** homicidal ideation
   1. At a **minimum**, the following questions are **required**:
      1. Is there a specific person (or group of persons) that you want to kill?
      2. What do you actually think about (i.e., assess for content)?
      3. How often do you think about killing others?
         1. Examples of questions that assess frequency/duration of homicidal ideation
            1. Over the last two weeks, on average, how many days per week did you think about killing others?
            2. On the days that you thought about killing others, how many times per day did you think about it?
            3. During the times when you thought about killing others, on average, how long did it last (e.g., seconds, minutes, or hours)?
      4. Do you have a plan?
         1. If so, what is it? (*assess for specificity of plan*)
         2. Do you have more than one plan?
            1. If so, what other plans have you thought of?
      5. Do you have any intent (or commitment) to kill others?
      6. Do you have access to any means to kill others (e.g., guns, other weapons)?
      7. What are some things you do (coping strategies) to help you manage your thoughts?
   2. Questions that may be asked to gather additional information:
      1. Is there anything, anyone, or any other reason that makes you not want to harm others?
         1. How important is that to you?
      2. Is there anyone you feel comfortable talking to about your thoughts?
         1. If so, have you talked to them recently about your thoughts?
      3. What is your current living arrangement [e.g., alone, friend(s), significant other]?
         1. If you go home after this appointment, is there anybody at home that will be there with you?
      4. Are you currently taking any prescription medications for a mental health reason?
      5. Are you currently attending psychotherapy (talk therapy)?