Appendix 1 Assessment of suicide risk (NZGG)

Assessment of suicide risk				
Suicide assessment				
Have you had thoughts that life isn't worth living?			☐ Yes	☐ No
Have you thought of harming yourself?			☐ Yes	☐ No
Are you thinking of suicide?			☐ Yes	☐ No
Have you tried to harm yourself in the past? If yes, how many times?			☐ Yes	☐ No
When was the most recent time? ☐ in the last day	☐ in the last week	☐ last month	☐ longer ago (specify)	
How often are you having these thoughts?				
Have you thought about how you would act on these (is there a plan)? (Does this plan seem feasible? Are the methods available? Is it likely to be lethal?)				
Have you thought about when you might act on this plan?				
Are there any things/reasons that stop you from acting on these thoughts?				
Do you know anyone who has recently tried to harm themselves?				
If any answer is 'yes' prompt with: 'Tell me more about that' as discussion will help to convey the extent of risk.				
If a suicide attempt has been made				
What did you hope would happen as a result of your attempt? (Did they want to die, or end their pain?)				
Do you still have access to the method used?			☐ Yes	☐ No
Did you use alcohol or drugs before the attempt?				
What did you use?				
Do you have easy access to a weapon?			☐ Yes	☐ No

Commentary

Consider whether the person is safe to be alone

Risk factors include:

- definite plan
- hopelessness
- severe depression
- psychotic symptoms
- recent discharge from a psychiatric unit
- use of alcohol, street drugs, particularly recent escalation
- recent suicide attempt
- single men: young, older people
- homelessness
- medical illness
- history of childhood abuse
- recent suicide attempt by a whänau/family member or a friend.

Adapted with permission from:
RAPID assessment of patients in distress. In Centre for Mental Health. Mental Health for emergency departments: a reference guide. NSW Department of Health; 2001.

A guideline on the "Assessment and Management of People at Risk of Suicide" can be found at **www.nzgg.org.nz** – enter the guideline title into the search box, then select the publication.

Appendix 2 Assessment of suicide risk (NZGG)

Table 1: Assessment tool to determine the level of risk of suicide for a young person

During the interview with the young person, investigate each of the areas in the column on the left and CIRCLE THE RELEVANT DESCRIPTION OF THE YOUNG PERSON'S CURRENT SITUATION. In investigating any suicide plan (note 4 below), it is important to use direct questions as the young person is likely to be reluctant to volunteer the information. Direct questioning will not aggravate the risk of suicide but failure to fully investigate, categorise the risk and respond appropriately may result in a suicide that could have been avoided. On the basis of the young person's responses, determine which of the three risk levels: LOW, MODERATE or HIGH, best describes the situation. If there is any risk then proceed with the management plan (Table 2).

Areas to Consider	Low Risk	Moderate Risk	High Risk
1. Personal difficulties	▪ No significant stress	▪ Moderate reaction to loss or environmental change	▪ Severe reaction to loss or environmental change
Stressful events Presence of mental disorders depression, substance abuse, conduct disorder, psychosis	▪ Mild: feels slightly down	▪ Moderate: some moodiness, sadness, irritability, loneliness and decrease of energy	▪ Many recent social/personal crises ▪ Overwhelmed with hopelessness, sadness and anger (verbal/ physical), feelings of worthlessness ▪ Extreme mood changes ▪ Delusions, paranoia, lost touch with reality
Ongoing life difficulties Significant trauma Sexual identity issues Family difficulties	▪ Minimal impact but aware of some potential difficulties	▪ Having some impact on everyday life	▪ Major concerns, impacting on many areas of their life
Cultural issues	▪ Minimal impact	▪ Having some impact on everyday life	▪ Major concerns, impacting on many areas of their life
Coping behaviour	▪ Only occasional thoughts about suicide ▪ Daily activities continue as usual with little change	▪ Recurring thoughts of suicide ▪ Intentional self-harming without expressed suicidal intent eg: cutting ▪ Some daily activities disrupted; disturbance in eating, sleeping, school work	▪ May resist help ▪ Constant suicidal thoughts ▪ Significant disturbances in daily functioning ▪ Participation in high risk behaviours (ie: alcohol and drug abuse, potential for accidents etc)
2. Positive resources Family and friends	▪ Help available; significant others concerned and willing to help	▪ Family and friends available but unwilling to help consistently	▪ Family and friends not available or hostile, exhausted, injurious ▪ Significant self neglect
Lifestyle	▪ Stable family relationships, personality and school performance	▪ Recent acting out behaviour and substance abuse ▪ Acute suicidal behaviour in stable personality	▪ Suicidal behaviour in unstable personality; emotional disturbance; repeated difficulty with peers, family
Communication	▪ Direct expression of feelings and suicidal thoughts associated with distress and active help seeking	▪ Interpersonalised suicide goal ("They'll be sorry", "I'll show them", "I don't deserve to live" or "I want to be with someone who has died")	▪ Very indirect or non-verbal expression of internalised suicide goal (guilt, worthlessness)
3. Previous suicide attempts	▪ None or one of low lethality (see 4.4 for lethality)	▪ Multiple of low lethality or one of medium lethality; history of repeated threats (see 4.4 for lethality) ▪ Suicide among family or friends	▪ One of high lethality or multiple of moderate lethality ▪ Several attempts over the last weeks and/or suicide among family or friends
4. Suicide plan 1. Details 2. Availability of means 3. Time 4. Lethality of method 5. Chance of intervention	▪ Vague ▪ Not available ▪ No specific time or in the future ▪ Pills or slash wrists ▪ Others present most of the time	▪ Some specifics ▪ Available, has close by ▪ Within a few hours ▪ Drugs and alcohol, and car accident ▪ Others available if called on	▪ Well thought out; knows when, where, how ▪ Has means at hand ▪ Immediately ▪ Gun, hanging, jumping, carbon monoxide ▪ No one nearby; isolated

Table 2: Managing suicide risk in young people

Select column relevant to level of risk identified in assessment. Suicide risk fluctuates and management needs to be adjusted accordingly.

Action	Low Risk	Moderate Risk	High Risk
Reduce risk	▪ Remove means to harm themselves ▪ Establish an appropriate regime to monitor young person ▪ Check on family's/friends' support as appropriate, provide information on resources centred around the needs of the young person ▪ In collaboration with young person and support people, write a clear action plan	▪ Remove means to harm themselves ▪ Ensure young person has appropriate support eg: family/whānau, friends ▪ Arrange back-up support which is available 24 hours a day ▪ In collaboration with young person and support people, write a clear action plan	▪ Remove means to harm themselves (in extreme circumstances this may mean calling the police) ▪ Involves all management outlined in moderate risk, but urgent action is required ▪ Support and supervise at all times until responsibility is passed to another agency or individual ▪ Make urgent referral to mental health team
Consultation and Referral	▪ Consider discussing case with a colleague or specialist mental health provider ▪ Children, Young Persons and their Families Agency (CYPFA) must be ▪ informed where care and protection are required (under 17 years)* ▪ Check if any other services are involved and who has responsibility for coordination eg: school counsellor, Specialist Education Services, CYPFA or mental health services ▪ Network with school or educational institution	▪ Consult with or refer to specialist cultural health service prior to other agency consultation for Māori ▪ Consult with or refer to mental health services on the same day ▪ Involve family/whānau, friends if permission given or arrange alternative support** ▪ CYPFA must be informed where care and protection are required (for 17 years and under) ▪ Recommend to young person and support people appropriate agencies or other resources, and assist them in accessing these services ▪ Ensure there is a management plan in collaboration with all services involved	▪ If immediate referral is not possible, mobilise professional networks to assist in the management, support and supervision of the young person in consultation with mental health professional ▪ Contact family/whānau, friends if not already present and involve as appropriate ▪ CYPFA must be informed where care and protection are required (for 17 years and under) ▪ Consider arranging assessment under the Mental Health Act if appropriate ▪ Ensure there is a management plan in collaboration with all services involved with explicit handover of responsibility between agencies or professionals
Manage underlying factors	▪ Initiate/optimise treatment of any underlying mental disorders or problems ▪ Assist the young person and family to address any immediate precipitating factors and ongoing life difficulties	▪ Must initiate/optimise treatment for any underlying mental disorders or problems ▪ Assist the young person and family to address any immediate precipitating factors and ongoing life difficulties	▪ Must initiate/optimise treatment for any underlying mental disorders or problems ▪ Assist the young person and family to address any immediate precipitating factors and ongoing life difficulties (undertaken in most cases by the specialist mental health services)
Monitor and follow up	▪ Make regular follow-up appointments ▪ Monitor changes in suicide risk ▪ Telephone contact may suffice ▪ If no improvement in one to two weeks treat as moderate risk	▪ Make regular follow-up appointments ▪ Contact regularly ▪ Monitor changes in suicide risk ▪ Check outcome of any agency referrals	▪ Ensure the following processes are in place and working effectively ▪ Make regular follow-up appointments ▪ Contact regularly ▪ Monitor changes in suicide risk ▪ Check outcome of any agency referrals

(Adapted from Ministry of Education, 1997 Young People at Risk of Suicide: A Guide for Schools)

* This may include family's inability or unwillingness to provide care, support and monitoring.

** If there is serious or imminent threat to the young person's life, permission to contact family/support people is not required, decisions must be made in the interests of safety.

Appendix 3 Strengths and Difficulties Questionnaire (SDQ)

The Strengths and Difficulties Questionnaire is copyrighted so we are unable to reproduce it in this Appendix. To access individual copies for printing please visit the web site: **www.sdqinfo.com**

The SDQ tool in the *bestpractice* decision support module links out to an external resource and does not record the information to the PMS. A hard copy can be printed out and kept on record.

What is the SDQ?

The Strengths and Difficulties Questionniare (SDQ) is a brief behavioural screening questionnaire about 3–16 year olds. It exists in several versions to meet the needs of researchers, clinicians and educationalists. Each version includes between one and three of the following components:

A) 25 items on psychological attributes.
All versions of the SDQ ask about 25 attributes, some positive and others negative. These 25 items are divided between 5 scales:

1) emotional symptoms (5 items)
2) conduct problems (5 items)
3) hyperactivity/inattention (5 items)
4) peer relationship problems (5 items)
5) prosocial behaviour (5 items)

added together to generate a total difficulties score (based on 20 items)

- The same 25 items are included in questionnaires for completion by the parents or teachers of 4–16 year olds.
- A slightly modified informant-rated version for the parents or nursery teachers of 3 (and 4) year olds. 22 items are identical, the item on reflectiveness is softened, and 2 items on antisocial behaviour are replaced by items on oppositionality.
- Questionnaires for self-completion by adolescents ask about the same 25 traits, though the wording is slightly different. This self-report version is suitable for young people aged around 11–16, depending on their level of understanding and literacy.

B) An impact supplement
Several two-sided versions of the SDQ are available with the 25 items on strengths and difficulties on the front of the page and an impact supplement on the back. These extended versions of the SDQ ask whether the respondent thinks the young person has a problem, and if so, enquire further about chronicity, distress, social impairment, and burden to others. This provides useful additional information for clinicians and researchers with an interest in psychiatric caseness and the determinants of service use.

C) Follow-up questions
The follow-up versions of the SDQ include not only the 25 basic items and the impact question, but also two additional follow-up questions for use after an intervention. Has the intervention reduced problems? Has the intervention helped in other ways, e.g. making the problems more bearable? To increase the chance of detecting change, the follow-up versions of the SDQ ask about 'the last month', as opposed to 'the last six months or this school year', which is the reference period for the standard versions. Follow-up versions also omit the question about the chronicity of problems.

Appendix 4

Substances and choices scale

The SACS is only to be used by health professionals working with young people who are engaged in a treatment agency.

The questions in part A) and B) are about your use of alcohol and drugs over the last month. This does not include tobacco or prescribed medicines. Please answer every question as best you can, even if you are not certain. Tick only one box on each row.

A On how many times did you use each of the following in the last month?	Never	Once a week or less	More than once a week	Most days or more
1. Alcoholic drinks (e.g. beer, wine, spirits etc.)	☐	☐	☐	☐
2. Cannabis (e.g. weed, marijuana, pot, skunk etc.)	☐	☐	☐	☐
3. Other drug. Name_____	☐	☐	☐	☐
4. Other drug. Name_____	☐	☐	☐	☐
5. Other drug. Name_____	☐	☐	☐	☐

B Mark one box (on each row), on the basis of how things have been for you over the last month.	Not True	Somewhat True	Certainly True
1. I took alcohol or drugs when I was alone.	☐	☐	☐
2. I've thought I might be hooked or addicted to alcohol or drugs.	☐	☐	☐
3. I've wanted to cut down on the amount of alcohol and drugs that I am using.	☐	☐	☐
4. Most of my free time has been spent getting hold of, taking, or recovering from alcohol or drugs.	☐	☐	☐
5. My alcohol and drug use has stopped me getting important things done.	☐	☐	☐
6. My alcohol or drug use has led to arguments with the people I live with (family, flatmates or caregivers etc.).	☐	☐	☐
7. I've had unsafe sex or an unwanted sexual experience when taking alcohol or drugs.	☐	☐	☐
8. My performance or attendance at school (or at work) has been affected by my alcohol or drug use.	☐	☐	☐
9. I did things that could have got me into serious trouble (stealing, vandalism, violence etc) when using alcohol or drugs.	☐	☐	☐
10. I've driven a car while under the influence of alcohol or drugs (or have been driven by someone under the influence).	☐	☐	☐
			SACS difficulties scale ☐

C Finally, how often have you used tobacco (e.g. cigarettes, cigars) over the last month?	Never	Once a week or less	More than once a week	Most days or more
	☐	☐	☐	☐

Appendix 5

CRAFFT Tool

CRAFFT Tool	
1. Have you ever ridden in a **C**ar driven by someone (including yourself) who was high or had been using alcohol or drugs ?	◯
2. Do you ever use alcohol or drugs to **R**elax, feel better about yourself, or fit in ?	◯
3. Do you ever use alcohol or drugs while you are by yourself, **A**lone?	◯
4. Do you ever **F**orget things you did while using alcohol or drugs?	◯
5. Do your **F**amily or **F**riends ever tell you that you should cut down on your drinking or drug use ?	◯
6. Have you ever got in to **T**rouble while you were using alcohol or drugs ?	◯

Scoring:

Two or more positive items indicate the need for further assessment

Appendix 6

Patient health questionnaire for depression				
Over the last 2 weeks, how often have you been bothered by any of the following problems? For each question select the option that best describes the amount of time you felt that way.				
In the last 2 weeks	Not at all	Several days	More than half the days	Nearly every day
	0	1	2	3
1. Little interest or pleasure in doing things	○	○	○	○
2. Feeling down, depressed, or hopeless	○	○	○	○
3. Trouble falling or staying asleep, or sleeping too much	○	○	○	○
4. Feeling tired or having little energy	○	○	○	○
5. Poor appetite or overeating	○	○	○	○
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	○	○	○	○
7. Trouble concentrating on things, such as reading the newspaper or watching television	○	○	○	○
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	○	○	○	○
9. Thoughts that you would be better off dead, or of hurting yourself in some way	○	○	○	○

PHQ-9 provisional diagnosis

Scoring — add up answers to questions on PHQ-9

Not at all = 0; Several days = 1; More than half the days = 2; Nearly every day = 3

Total Score	Depression Severity
10–14	Mild
15–19	Moderate depression
≥ 20	Severe depression

See **www.nzgg.org.nz/CMD-assessmenttools** for more information

Appendix 7

Management of depression in young people in primary care

Immediate referral* !

Refer at any stage if:

- serious suicidal intent
- psychotic symptoms
- severe self-neglect.

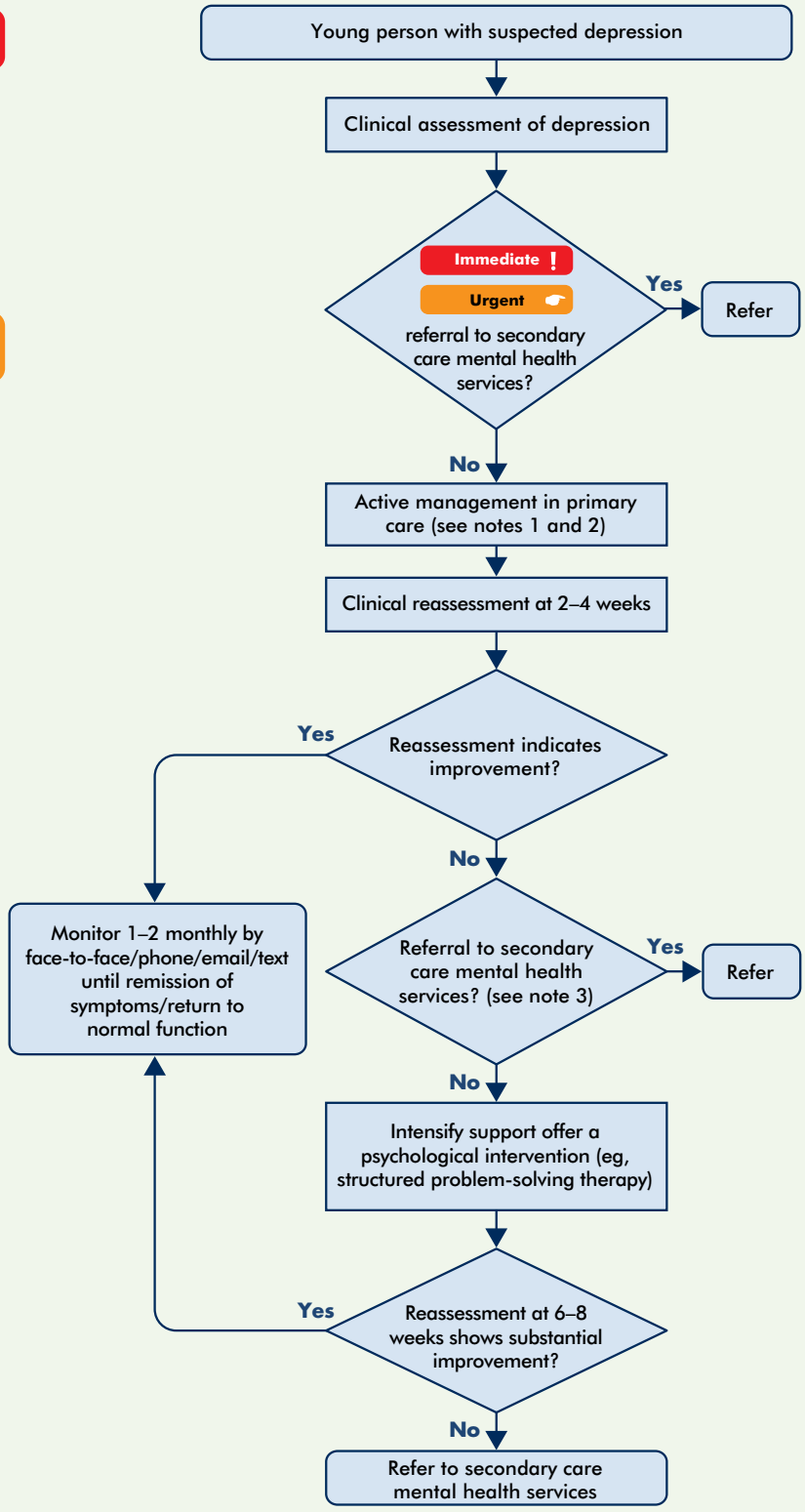
* **Immediate referral:** referral is to be made by the primary care practitioner that day with the expectation of a same-day response to the referral

Urgent referral†

Refer at any stage if:

- severe depression
- persistent symptoms
- profound hopelessness
- other serious mental or substance use disorders
- significant functional impairment (eg, unable to do most daily activities)
- suspected bipolar disorder.

† **Urgent referral:** referral is to be made by the primary care practitioner within 24 hours, with the expectation that the person referred will be seen within 7–10 days, or sooner depending on secondary care service availability



Note 1

Initial management should include active listening, problem identification, advice about simple self-management strategies and active follow-up (2-weekly monitoring by face-to-face/phone/text/email).

Note 2

Consider involving support services such as school guidance counsellors or family services.

Note 3

Review whether referral is indicated at this point given lack of improvement or other concerns.