18 May 2022

Steven Davey
University of Auckland

WHANGANUI
DISTRICT HEALTH BOARD
Te Poari Hauora o Whanganui

Via email: steven.davey@auckland.ac.nz

100 Heads Road, Private Bag 3003
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Tēnā koe Steven

Official Information Act Request – OIA 14266 Suicide Risk Assessments

On 19 April 2022, under section 12 of the Official Information Act, you requested the following information from Whanganui District Health Board (WDHB):

Official information request (on behalf of colleagues Dr. Sarah Fortune; Dr. Sarah Hetrick; Prof. Roger Mulder): information on how the DHB undertakes suicide risk assessment to inform decisions on access to services (which may also be known as the "triage process")

Please supply the following information under the Official Information Act (OIA):

1. Full descriptions and/or a copy of the *measurement tool(s), procedure(s) or method(s)* used to assess the *risk* of *suicide or self-harm*, informing decisions on providing access to the *DHB's services*.

    a) By "measurement tool(s), procedure(s) or method(s)", I mean how risk is determined, which may also involve any of the following (but not limited to these): surveys; protocols; checklists; questionnaires; scales; instruments; screening tools; inventories; evaluation tools; scores; an index or indices; psychometric tools; psychological tests; psychiatric tests; ratings; interviews; items; forms; status forms; decision trees; pathways; safety plans; template; risk stratification; formulation or risk formulation; action plan; risk banding; risk categorisation. These may feed into a "traffic light system" that categorises individuals according to varying degrees of risk.

    b) By "risk", I mean the probability (of suicide or self-harm occurring). The measurement tool(s)/procedure(s)/method(s) in question may refer to any of the following terms (but not limited to these): likelihood; possibility; potential; prediction; danger; hazard.

    c) By "suicide" I mean an individual taking their own life. By "self-harm" I mean an individual intentionally damaging their body, with or without suicidal intent. The measurement tool(s)/procedure(s)/method(s) in question may use other terms, including the following (but not limited to these): attempted suicide/suicide attempt; suicidality; self-injury; self-injurious behaviour; parasuicide.

    d) By "the DHB's services", I mean those services related to all ages, all teams, all specialities, including but not limited to mental health, inpatient and outpatient, Emergency Department, EIS/Early Intervention, maternal mental health, cultural teams, youth forensic services, older adult, dual disability, liaison psychiatry, emergency psychiatric service, crisis team. Hence, I request information regarding *any* DHB service where suicide risk is assessed during decisions on service access.

I seek this information for a research project addressing the role of risk factors in informing service access decisions. We seek to understand current practices in Aotearoa/New Zealand.

Whanganui District Health Board's response:

Full descriptions and/or a copy of the *measurement tool(s), procedure(s) or method(s)* used to assess the *risk* of *suicide or self-harm*, informing decisions on providing access to the *DHB's services*.

Whanganui DHB Mental Health and Addiction Service provides a 24-hour urgent response to severe mental health and addiction calls from a free 0800-number and get referrals via e-mail. Initial responses are triaged using the UK Mental Health Triage Scale (code and description) as a guideline to identify the time which the type of response best suits. The response varies from between one hour to 72 hours, depending on the triage and situation.

There are various screening tools that assist to measure the risk, such as the Edinburgh Postnatal Depression Scale (EPDS) or the PHQ-9 Patient Depression Questionnaire that are used to help baseline a measure that will be helpful for the person and the patients general practitioner.

The Mental Health Assessment and Home Treatment (MHAHT) team has a brochure that explains the types of services and support it provides to the community that includes a list of local agencies and their contact details.

When a referral has been accepted then a standardised risk assessment formulation is completed that identifies serious risk problems that need addressing.

There are three mental health specific Whanganui hospital wide cards in circulation that provide the community with traffic light numbers from 1737 green, 0800653358 (MHAHT) amber and 111 (Police) in red. The wellbeing resource card provides members of the community with community resources including the MHAHT 0800 number and the police 111. The Mental Health Risk Screen card is a lanyard card designed to assist DHB staff to follow procedures when screening for risk.

The following documents are attached to the end of this document:

Copy of Risk Assessment.pdf

MHAHT Triage.pdf

Transition recovery plan.pdf

uk-mental-health-triage-scale1.pdf

preventing-suicide-guidance-emergenc

Suicide Prevention Pathway draft.pdf

pink lanyard.pdf

Cue cards suicide assessment WDHB.(

Maternal Infant Child Adolescent Mental Health and Addictions Service (MICAMHAS) discuss new referrals each working day with a small team which consists of the clinical nurse manager, clinical coordinator, the infant therapist, a psychologist, psychiatrist, a member of the addictions team and a member of the youth mental health team.

From this meeting a determination is made to acuity and urgency of assessment. Those referrals deemed to be urgent are seen same day by members of the team on an urgent roster. As Whanganui is a small DHB we do not have the resources to run a youth crisis team. MICAMHAS runs an urgent roster, the roster is a rotation of MICAMHAS clinicians. An urgent assessment requires the cancellation of regular appointments.

An urgent assessment can also be arranged via a self-referral, Police, ED, or any other concerned party via phone contact, email with MICAMHAS. These are triaged by the clinical coordinator and in general any mother or young person who expresses suicidal intent is seen same day. MICAMHAS arranges that mothers and young people are seen with a whanau member or carer who will be part

of the developed plan. The agreement and participation of whanau is important in the success of the plan. The adult mental health service will see any new urgent maternal mental assessments, but current maternal clients are seen by MICAMHAS.

Risk of suicide and self-harm is assessed by clinical observations as well as having discussions with the mother (in regard to maternal mental health), the young person and whanau. MICAMHAS will also have discussions with concerned parties including schools, Police, Oranga Tamariki, other health professionals and outside agencies. These discussions will determine the development of a plan to manage risk. The plan may include the involvement of community agencies or may be a whanau lead plan.

Help in determining risk may include the use of genograms, (family history) timelines (previous history), and current history. Having a rapport with the young person, mother and whanau is essential to ensure the information shared is as accurate as possible.

MICAMHAS has developed a Transition Risk Assessment Plan (TRAP). This plan is the maternal mental health mother's or young person's plan, it is developed collaboratively with the mother, young person, and whanau and the clinician. The plan is easy to read and is written in the mother's, young person's words. The plan is given to the young person, mother and whanau and also any other agency that the young person, mother may want involved.

If admission either voluntary or under the Mental Health Act is determined as required the mother, young person will be seen by the psychiatrist for further assessment.

There is no designated mental health bed for young people in Whanganui and admission requires negotiation and referral to the Rangatahi Unit in Wellington. If there is no bed available in Wellington, then the young person can be admitted with carer support to the adult mental health unit if over 15, the Paediatric Ward if under 15. Admission locally relies on the availability of beds which is not always possible. In this case the plan will be altered to include home treatment management. See attached document.

WH MH MICAMHAS TRAP form.pdf

Instruments, procedures, methods and tools used as part of triage/screening

Our assessment is based on clinical interviewing and adapted to the needs of tangata whai ora. Requests and referrals are assessed on a case by case basis. Team members are taught interviewing using materials from the following sources and attend courses from Annette Beautrais as well as the Zero suicide initiative, Barry Taylor's workshops and other regional and international approaches (e.g Gold Coast - Australia).

The following are some of the frameworks and interviewing techniques which inform our clinical interviewing:

a) Antony Pisani et al, CARE Framework (Connect, Assess, Respond, Extend) from Zero Suicide (Safe Side)
https://safesideprevention.com/approach/care-framework

b) From Ministry of Health 2016 publication, *Preventing suicide – guidance for Emergency Departments*
https://www.health.govt.nz/system/files/documents/publications/preventing-suicide-guidance-emergency-departments-apr16.docx

EDSRA

Brief EDSRA

These may be used by junior medical staff and others in assessing tangata whai ora, whether presenting acutely or in other situations (see attached cue cards).

c) Shawn Shea (TISA) – The CASE (Chronological evaluation of suicide events) approach - https://www.psychiatrictimes.com/view/suicide-assessment-part-2-uncovering-suicidal-intent-using-case-approach

d) Elements from Galynker, I "The Suicidal Crisis: Clinical Guide to the assessment of Imminent suicidal risk":
Suicidal crisis syndrome: - 3 primary components:

i) Frantic hopelessness
ii) Ruminative flooding
iii) Panic-dissociation

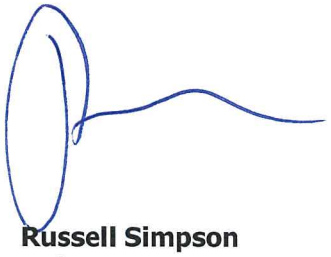
Plus emotional pain, fear of dying/sudden death/losing control over planned death by suicide, acute anhedonia (these, plus another construct, implicit attitude, are also part of the MoH guidance mentioned in b). above).

Key staff have attended workshops by Annette Beautrais and this training is about to be re-offered in August 2022 (postponed from May 2022 due to COVID).

Under section 28(3) of the Act you have the right to ask the Ombudsman to review any decisions made under this request. The Ombudsman may be contacted by email at: **info@ombudsman.parliament.nz** or by calling 0800 802 602.

Should you have any further queries about the above information, please contact our OIA co-ordinator Anne Phoenix at anne.phoenix@wdhb.org.nz

Ngā mihi



Russell Simpson
Kaihautū Hauora – Chief Executive
Whanganui District Health Board

Additional Patient Information

Ethnicity

Assessor Details

Assessor Name

Assessor Service/Unit

Assessor Title

Assessor Telephone

After Hours Acute Management Plan

Date

Time

Date of expiry (max 3 months)

Reason for Review

Clinical Concern

Current Diagnosis

Legal Status

Supporting Parents, Healthy Children Screening

Are there any children / young people who may be affected by mental health and / or addiction issues?

Yes /No Clear the selection Full names and DOBs of children /young persons potentially affected Full names and DOBs of children /young persons potentially affected Children Children Name and Date of Birth Name and Date of Birth Remove this section

Name

Date of Birth

Has a referral been made to MH and wellbeing support?

Yes/ No Clear the selection Has a referral been made to other agencies? Which agencies?

Declined referral for support at this time

Yes /No Clear the selection Education about Supporting Parents, Healthy Children given?

Yes /No Clear the selection FV FV FV question asked

Yes /No Clear the selection FV + - Clear the selection If FV question not asked, give reason

Statement in clinical notes

Yes /No Clear the selection If a positive enquiry, an FVID form must be completed and sent to the VIP co-ordinator.

Document Current and / or Potential Risks

Risk to who? Means?

Static factors of importance (e.g. History of substance abuse, childhood abuse, etc.)?

Internal dynamic factors of importance - what are they?

Who noticed the changes first - patient/family/whanau/others? Is victim notification required?

What are the early warning signs, or triggers of these internal dynamic risk factors? Are there other relapse factors?

What can be done to influence and manage the early warning signs, triggers or relapse indicators?

What situational dynamic factors may affect the risk (e.g. substance abuse, living conditions, relationship problems, not taking medication, access to weapons, etc.)?

What interventions help address the situational dynamic factors?

Risk Behaviours

Document here if the risk behaviour is reinforcing (e.g. self harm reducing tension, violence or threats being effective?). What interventions help the patient learn other ways of expressing themselves?

Which staff / family / friends, etc. are involved in the treatment and care of the patient?

Name and Relationship Contact details

Protective factors (e.g. insight into illness, supportive family, stable accommodation, etc.)

Acute interventions required

Risk Statement, After Hours & Acute Management Plan

Risk assessment copied to

Patient GP Keyworker NGO Family / Whanau ED Police Accommodation provider Other

Alert to MHAHT / Keyworker (enter name)

Plan completed in collaboration with

Signature:

NB: Have you put enough information in this form to help a colleague treat and care for this patient in an emergency?

Psychoeducation given to client on the potential for increased risk to self and others when under the influence of alcohol and/or other substances?

Yes No Clear the selection

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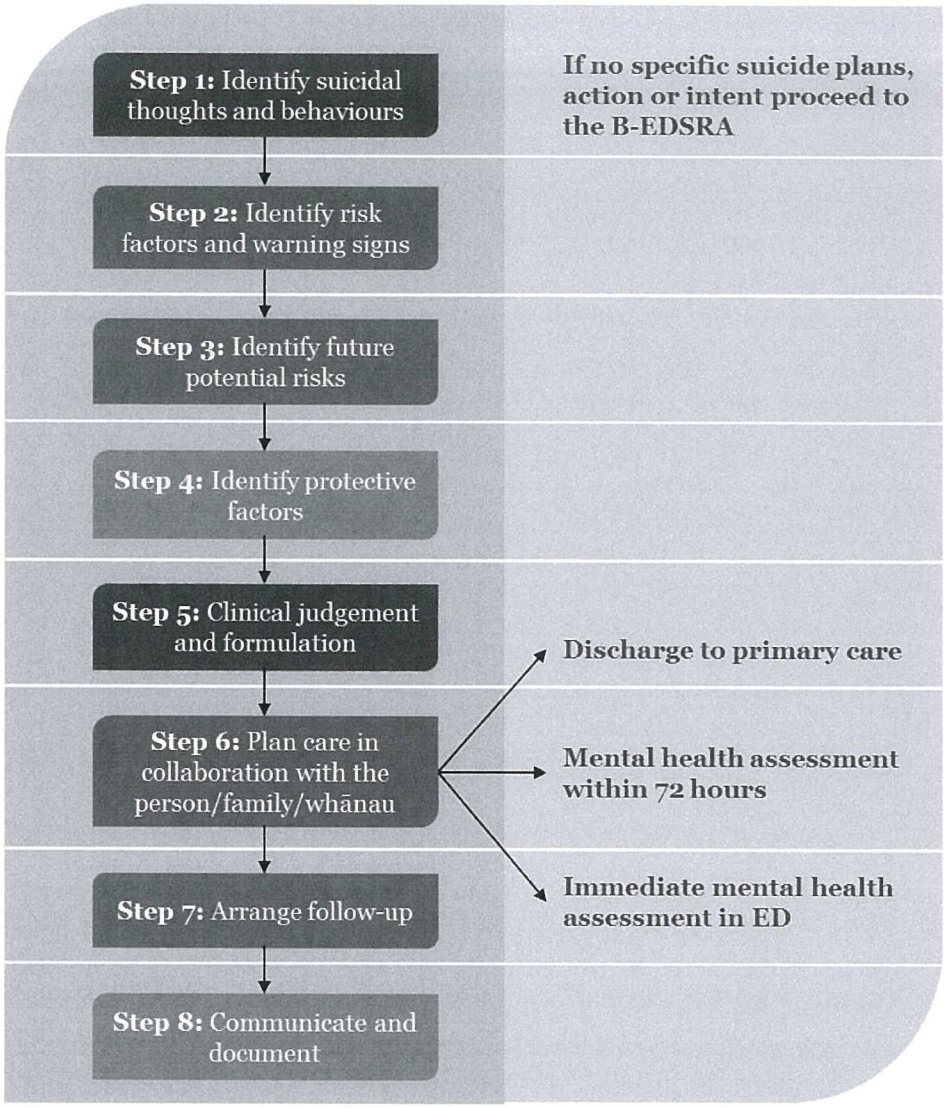
Emergency Department Suicide Risk Screening Assessment (EDSRA)



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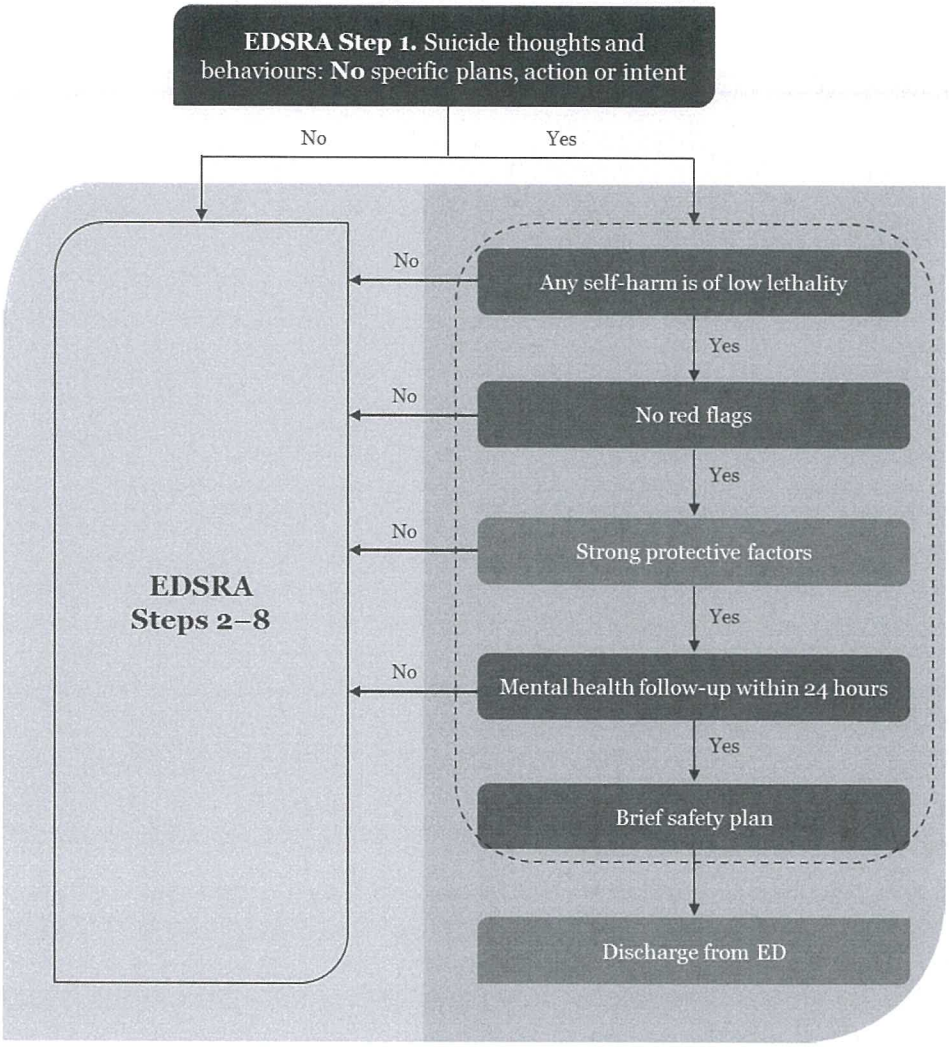
Brief Emergency Department Suicide Risk Screening Assessment (B-EDSRA)



Triage acuity levels

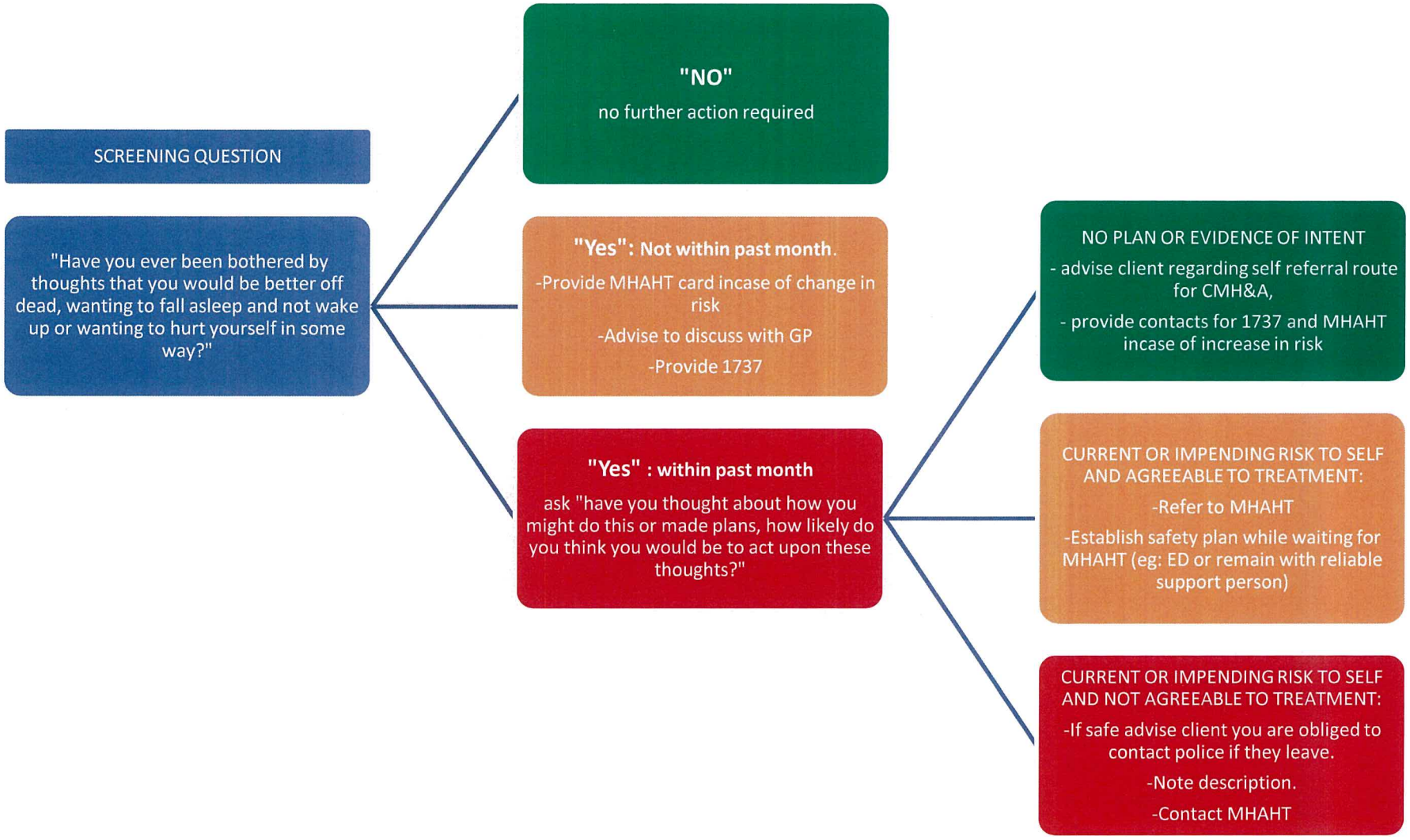
Level of urgency	**Level I = Emergency**	**Level II = Urgent**	**Level III= Acute**	**Level IV = Non-urgent**
Entry	Fulfils entry criteria and eligibility	Fulfils entry criteria and eligibility	Fulfils entry criteria and eligibility	Fulfils entry criteria and eligibility
Assessment	Is an imminent threat to physical safety of self, service user/tangata whaiora and/or others. Is making threats Is actually causing harm to self, others or property. Person has a weapon There is evidence of high lethality	There are immediate concerns about physical safety and wellbeing of the service user/tangata whaiora or others May fulfil the definition of mental disorder under the Mental Health Act There is evidence that if response is not timely negative outcomes for the service user/tangata whaiora or others will occur	Is acutely unwell or deteriorating but not at an imminent risk of harm to self and/or others Has reasonable support systems The service user /tangata whaiora , their supports, are able, willing, to contact the service if their situation changes	Does not fulfil criteria for acute assessment but will benefit from mental health assessment Does not fulfil criteria: give information/ advice re Primary Providers
Action	▯ Contact Emergency Services (Police, Ambulance) immediately ▯ Keep caller on line until emergency services arrive	▯ Contact the service user /tangata whaiora /referrer within 15 minutes ▯ MHtriage assess or ▯ Key worker/duty person of CMHAS / Specialist Service to conduct a crisis assessment as soon as possible and/or access MHtriage for assistance ▯ Put contingency plans in place to ensure safety of the service user/tangata whaiora until crisis assessment can occur ▯ Keep service user /tangata whaiora /referrer informed about processes and time frames ▯ May require police input	▯ Allocation process will be undertaken daily ▯ Assess the situation as soon as possible, 24-48 hours. Key worker for current service user /tangata whaiora. Duty Worker for new referrals, or access MHtriage for assistance. ▯ Contact the service user /tangata whaiora /referrer and inform them about processes, timeframes ▯ Put contingency plans in place to ensure safety of the service user /tangata whaiora until this assessment can occur.	▯ MH triage refer straight to SPOE CMHAS ▯ To the CMHAS SPOE allocation system ▯ Contact the service user/tangata whaiora/referrer and inform them about processes and approximate time frames ▯ Refer to, or give service users /tangata whaiora information re contacting primary/secondary providers.
Follow up	▯ Whether further assistance and assessment is required	▯ Ensure service user /tangata whaiora was assessed	▯ Ensure service user /tangata whaiora was assessed	▯ Ensure service user /tangata whaiora was assessed and/or referred to the appropriate service

TRANSITION RECOVERY PLAN

Tangata whaiora Name (or place label here) NHI DATE HUB # Presenting Health Care Professional:	Tick or cross below to evidence areas discussed in transition meeting and add comments where appropriate.
1. Reason for transition meeting presentation (circle one) • Initial assessment • Routine review/ update • Treatment planning/ change in circumstances (includes risk) • Transition planning	
2. Tangata whaiora goals and presenting problem relevant for presentation - Goal 1. - Goal 2. - Goal 3.	
3. Physical –medications (and its effectiveness/ tangata whaiora adherence), health conditions, head injury, metabolic monitoring, diet etc	
4. Environmental – housing, social circumstances/ influences, financial, employment etc	
5. Family/Whānau – family dynamics, separation from family, violence, abuse, supportive family, additional supports etc - *Parent? –how are the children doing?* - *VIP Q's*	
6. Mental health and Addiction – depression, anxiety, addiction, suicidal ideation etc	
7. Protective factors –what is going well? Strategies utilised? Strengths?	
8. Treatment progress/ plan (include measures) • Include HONOS/ADOM/K10 or other	
9. Outcome of transition meeting • k/w follow up (note urgency) • NGO referral request • Rehab • Detox • COPMIA • MHAHT alert • Dr review • Psychology referral • Transition from service • Other (specify)	
10. Safety plan – client directed - Warning signs: - People I can contact: - Places I can go: - Brief tool I can use: - Validating statement:	Does the client have a copy?
11. transition plan (from secondary to primary care) – client directed - I achieved ... - I am still working on... - I plan to... - If I relapse I will... - Validating statement...	Does the client have a copy?
12. Signed by presenting clinician:	Co-signed by: signature:

UK Mental Health Triage Scale				
Triage Code /description	**Response type/ time to face-to-face contact**	**Typical presentations**	**Mental health service action/response**	**Additional actions to be considered**
A Emergency	**IMMEDIATE REFERRAL Emergency service response**	Current actions endangering self or others Overdose / suicide attempt / violent aggression Possession of a weapon	**Triage clinician to notify ambulance, police and/or fire service**	Keeping caller on line until emergency services arrive / inform others Telephone Support.
B Very high risk of imminent harm to self or to others	**WITHIN 4 HOURS Very urgent mental health response**	Acute suicidal ideation or risk of harm to others with clear plan or means Ongoing history of self harm or aggression with intent Very high risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Urgent assessment under Mental Health Act Initial service response to A & E and 'front of hospital' ward areas	**Crisis Team/Liaison/ face-to-face assessment AND/OR Triage clinician advice to attend a hospital A&E department** (where the person requires medical assessment/ treatment)	Recruit additional support and collate relevant information Telephone Support. Point of contact if situation changes
C High risk of harm to self or others and/or high distress, especially in absence of capable supports	**WITHIN 24 HOURS Urgent mental health response**	Suicidal ideation with no plan or ongoing history of suicidal ideas with possible intent Rapidly increasing symptoms of psychosis and / or severe mood disorder High risk behaviour associated with perceptual or thought disturbance, delirium, dementia, or impaired impulse control Overt / unprovoked aggression in care home or hospital ward setting Wandering at night (community) Vulnerable isolation or abuse	**Crisis Team/Liaison/ Community Mental Health Team (CMHT) face-to-face assessment**	Contact same day with a view to following day review in some cases Obtain and collate additional relevant information Point of contact if situation changes Telephone support and advice to manage wait period
D Moderate risk of harm and/or significant distress	**WITHIN 72 HOURS Semi-urgent mental health response**	Significant patient / carer distress associated with severe mental illness (but not suicidal) Absent insight /early symptoms of psychosis Resistive aggression / obstructed care delivery Wandering (hospital) or during the day (community) Isolation / failing carer or known situation requiring priority intervention or assessment	**Liaison/CMHT face-to-face assessment**	Telephone support and advice Secondary consultation to manage wait period Point of contact if situation changes
E Low risk of harm in short term or moderate risk with good support/ stabilising factors	**WITHIN 4 WEEKS Non-urgent mental health response**	Requires specialist mental health assessment but is stable and at low risk of harm during waiting period Other services able to manage the person until mental health service assessment (+/- telephone advice) Known service user requiring non-urgent review adjustment of treatment or follow-up Referral for diagnosis (see below) Requests for capacity assessment, service access for dementia or service review / carer support	**Out-patient clinic or CMHT face-to-face assessment**	Telephone support and advice Secondary consultation to manage wait period Point of contact if situation changes
F Referral not requiring face-to-face response from mental health	**Referral or advice to contact alternative provider**	Other services (outside mental health) more appropriate to current situation or need	**Triage clinician to provide advice, support Advice to contact other provider and/or phone referral to alternative service provider** (with or without formal written referral)	Assist and/or facilitate transfer to alternative service provider Telephone support and advice
G Advice, consultation, information	**Advice or information only OR More information needed**	Patient or carer requiring advice or information Service provider providing information (collateral) Initial notification pending further information or detail	**Triage clinician to provide advice, support, and/or collect further information**	Consider courtesy follow up telephone contact Telephone support and advice

Sands, N. Elsom, E, Colgate, R & Haylor, H. (2016) Development and inter-rater reliability of the UK Mental Health Triage Scale (In Press). *International Journal of Mental Health Nursing.*


SCREENING QUESTION
"Have you ever been bothered by thoughts that you would be better off dead, wanting to fall asleep and not wake up or wanting to hurt yourself in some way?"
"NO"
no further action required
"Yes": Not within past month.
-Provide MHAHT card incase of change in risk
-Advise to discuss with GP
-Provide 1737
"Yes" : within past month
ask "have you thought about how you might do this or made plans, how likely do you think you would be to act upon these thoughts?"
NO PLAN OR EVIDENCE OF INTENT
- advise client regarding self referral route for CMH&A,
- provide contacts for 1737 and MHAHT incase of increase in risk
CURRENT OR IMPENDING RISK TO SELF AND AGREEABLE TO TREATMENT:
-Refer to MHAHT
-Establish safety plan while waiting for MHAHT (eg: ED or remain with reliable support person)
CURRENT OR IMPENDING RISK TO SELF AND NOT AGREEABLE TO TREATMENT:
-If safe advise client you are obliged to contact police if they leave.
-Note description.
-Contact MHAHT

Mental Health Risk Screen

"I am going to ask you some questions that we ask everyone who comes here, no matter what the reason they are coming for. It helps us to ensure we are not missing anything important"

1) *"In the past few weeks have you felt down, depressed or hopeless?"*

2) *"Have you felt that you, or your whanau, would be better off it you were dead?"*

"Situations and risk can change quickly. We want people to know how to access assistance at these times" (Provide everyone screened with 1737 & MHAHT cards)

If "YES" to question 2 screen for immediate safety:

3) *"Are you having thoughts of killing yourself right now?" (if "no" response as per previous statement)*

If "yes" plan for immediate safety/ contact MHAHT 0800 653 358

Immediate safety in the event of disclosure of imminent risk (hospital setting):

- Ensure safety of environment (note description, minimise access to means, offer support, be aware of location, utilise ED).
- Contact MHAHT 0800 653 358 for advise or to discuss assessment.

Useful Numbers & Supports:

Social Supports: consider whanau/family, friends and faith based supports.

Community Mental Health & Addictions 06 348 1207 ***1737 Need to Talk?*** *Txt or call 1737,* ***Alcohol Drug Helpline*** *0800 787 797,* ***The Lowdown*** *(young people) 5626 txt,* ***Safe to Talk*** *(sexual harm) 0800 044 334*

Emergency in the community:
Police/Ambulance 111 (for immediate/unfolding risk)

(No guideline can cover all variations required for specific circumstances. The advice provided here is not intended to replace clinical judgement)

To re-order cards and resources contact:

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Brief sample question sets to assess suicidal thinking

Question set I	Guide
Q1) In the past month, have you ever wished you were dead, or could fall asleep and not wake up? (Y/N)	Y/N Ask Q2, regardless of the answer to this question.
Q2) In the past month, have you actually had any thoughts of ending your life?	(Y/N)

Question set II	Prompts
Q1) In the past two weeks, have you been bothered by thoughts that you: • would be better off dead • want to hurt yourself in some way?	• No, not at all • Several days • More than half the days • Nearly every day

Key:

- A positive response to any of the above three sample assessing questions about suicidal thinking, especially in the presence of any of the indicators outlined in Step 1 above, should initiate *safety planning* using a tool like the Emergency Department Mental Health Triage Scale.
- To facilitate engagement and to help develop the best clinical impression for triage, briefly explore those thoughts with the person: "What sort of distress do these thoughts cause?"; "What sort of distress are these thoughts connected with?"; "How frequently do these thoughts occur to you?"; "Are they fleeting thoughts or do you tend to dwell on them?"; "How long?"

Questions for assessing suicidal thoughts or ideation

Questions	Person who presents with self-harm behaviour or a suicide attempt	Person who presents with suicidal thoughts or ideation
What did you do?	✓	
Did you do that as a way to end your life?	✓	
Did you want to die? or Did you think it was possible you could have died?	✓	
Why didn't it work?	✓	

How do you feel about it not working? or How do you feel about still being alive?	✓	
Do you intend to try again? If so, how?	✓	
How often are the suicidal thoughts occurring?	✓	✓
How intense are they?	Ask if needed	✓
How long do they last?	Ask if needed	✓
How recent (e.g. in the past month, in the past two weeks, in the past two days)?		✓

Questions for assessing suicide plans

Questions	**Person who presents with self-harm behaviour or a suicide attempt**	**Person who presents with suicidal thoughts or ideation**
Have you been thinking about how you might kill yourself?	Ask about any further attempts (e.g. "Are you still thinking about how you might kill yourself?")	✓

What have you thought of doing? (Note: be as specific as possible. For example, if someone says they would hang themselves, ask: When would you do it? Where would you get the rope? Do you think it would hold your weight? Where would you hang it from? Do you know how to make a noose? Have you researched it? Where (e.g. on the internet, in books, television programmes)?	Ask about any further attempts	✓
Do you think it would work?		✓
Have you tried to do this in the past?		✓

Important factors for short-term suicide risk

Factors
Implicit attitudes
Ruminative flooding and frantic hopelessness
Insomnia
Psychotic symptoms
Past suicide attempts
Substance intoxication
Depression

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Suicide Trigger Scale 3 (STS-3)

STS-3

I would like to ask you some questions about the way you were feeling over the last several days, when you were dealing with thoughts, feelings and events that brought you to this emergency department. Is that okay?	*In the past several days ...* 1 Did you feel trapped? 2 Did you feel there was no exit? 3 Did you feel your head could explode from too many thoughts? 4 Did you feel bothered by thoughts that did not make sense? 5 Did you feel your thoughts were confused? 6 Did you feel like you were getting a headache from too many thoughts in your head?	1 Not at all 2 Somewhat 3 Very much

Key:

- A response of 'somewhat' or 'very much' to any of the questions should weight the decision towards referring the person for a comprehensive specialist mental health assessment.
- Two 'very much' responses is considered positive for this state.

Personal Health Questionnaire (PHQ-2)

PHQ-2

Stem question:	Question items:	Response options and scoring:
In the past two weeks, how often have you been bothered by either of these problems?	a. little interest or pleasure in doing things b. feeling down, depressed, or hopeless	• Not at all • Several days* • Half the time* • Nearly every day*

* These responses are indicative of the presence of depression.

Transition/Risk Assessment Plan

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Title and Full Name:	
NHI:	DoB:
Address:	Ph: (H) Cell:

Date of Plan: **Person completing the Plan:**

What's happening for you right now?

Risk to self/others?

What have we agreed to work on?

What are we going to do about it?

Medication, what's it for?

Who can I ask for help?

1. ***Name*** ***Phone***
2. ***Name*** ***Phone***
3. ***Name*** ***Phone***

ICAMHAS or SUPP office hours number 06 348 1901
Keyworkers name ***Phone***
Need to Talk? Call/Text : 1737
MHAHT (out of hours urgent mental health support) 0800 653 358
Police/Ambulance 111 (If unsafe)

Date created: 28/01/2019