Catalogue of

EAAD evaluation materials

This collection of evaluation material has been prepared in the context of the "*European Alliance Against Depression*", an international project funded by the European Commission.

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Evaluation level:

Surveys of the general public and specific target groups

Introductory remarks

The core items in this section should form the basis for all surveys conducted among the general population or special target groups.

In particular, the minimum requirements concerning socio-demographic information have been kept very short. Age, gender and occupational status should be sufficient to allow basic stratifications. However, some additional demographic information may be particularly important to your region and could be important in accounting for variations among your given target groups or among the general population in your area. Therefore each region should feel free to add any additional socio-demographic items or to ask any additional questions, as needed.

Following the "core item" section, we have provided you with a number of additional optional items and other instruments covering similar areas of information, attitudes and knowledge. Not all of these instruments cover the core items completely, so please make sure that you include the core items making any additions in a second step.

Certain target groups will require additional items to be covered (e.g. GPs). These additional fields, items and topics can be added by each partner. From the Nuremberg Alliance Against Depression, we have learned that interesting comparisons concerning, for example, differences in perceived treatment options among the general population and professionals can be made. Thus, the more overlap between different questionnaires, the more interesting comparisons we will be able to make.

Assessment of Socio-demographic information: Core variables

1.1. Gender
- 1_Male
- 2_Female

1.2. Age (in years)

1.3. Occupational status
- 1_Still in training (full time student)
- 2_Full-time employed (incl self-employed)
- 3_Part-time employed (incl self-employed)
- 4_Unemployed
- 5_Military service
- 6_Housewife/-man
- 7_Retired
- 8_Disabled
- 9_Other, specify ____________________

1.4. Are you working in the health care sector?
- 1_yes
- 2_no

1.5. Occupation ____________________

Assessment of Socio-demographic information: Optional variables

1.1. Nationality ____________________

1.2. Family status
- 1_Married, lives with partner
- 2_Lives with partner, not married
- 3_Divorced or separated, lives apart and without partner
- 4_Widowed and without partner
- 5_Lives alone, has never been married or lived with partner

1.3. Number of children __________, of those under-aged (under 16 years) __________

1.4. Educational status
- 1_No education
- 2_Primary education
- 3_Secondary education
- 4_Non-university higher education
- 5_University higher education
- 6_Other, specify ____________________

Surveys – Core Items

1. Opinions and attitudes to depression[1]

The following are eight short statements about depression, which you may answer if you, totally disagree, partially disagree, partially agree or totally agree.

	Strongly Agree	***Agree***	***Undecided***	***Disagree***	***Strongly Disagree***
Depression is a real disorder	1	2	3	4	5
Depression can be treated	1	2	3	4	5
Use of antidepressants can change someone's personality	1	2	3	4	5
The causes of depression are unknown	1	2	3	4	5
If somebody is suffering from depression, it is his/her own fault	1	2	3	4	5
If you are suffering from depression, you have to pull yourself together for getting over it	1	2	3	4	5
Antidepressants have side-effects	1	2	3	4	5
Antidepressants are addictive	1	2	3	4	5

2. Causes of depression

If you suffer from depression, this can be due to different causes. To what extent do you agree or disagree that the following causes are related to the development of depression?

	Strongly Agree	***Agree***	***Undecided***	***Disagree***	***Strongly Disagree***
Wrong lifestyle	1	2	3	4	5
Problems with other individuals	1	2	3	4	5
Disorder of brain metabolism	1	2	3	4	5
Stroke of fate (e.g. death of relative)	1	2	3	4	5
Heredity	1	2	3	4	5
Environmental poisons	1	2	3	4	5
Influence by the mass media (television, papers)	1	2	3	4	5
Today's achievement-orientated society	1	2	3	4	5
Loss of self-discipline	1	2	3	4	5
Weakness of character	1	2	3	4	5

[1] Generally the term "depression" should reflect "depressive disorder" being understood as a mental disease.

Surveys – Core Items (continued)

3. Symptoms of depression

A depression can affect experience and behaviour in different ways. Which symptoms do you think are typical of depression?

	Strongly Agree	***Agree***	***Undecided***	***Disagree***	***Strongly Disagree***
Compulsive grooming	1	2	3	4	5
Physical complaints (e.g. sleeping disturbances)	1	2	3	4	5
Hallucinations	1	2	3	4	5
Feelings of guilt	1	2	3	4	5
Loss of pleasure	1	2	3	4	5

4. Treatment of depression

There are different ways of treating depression. To what extent do you agree or disagree that the following are effective in the treatment of depression?

	Strongly Agree	***Agree***	***Undecided***	***Disagree***	***Strongly Disagree***
Talk to friends	1	2	3	4	5
Go on holiday	1	2	3	4	5
Take barbiturates and sedatives [2]	1	2	3	4	5
Contact a psychotherapist[3]	1	2	3	4	5
Contact a doctor	1	2	3	4	5
Pull yourself together	1	2	3	4	5
Eat chocolate or sweet things	1	2	3	4	5
Light therapy[4]	1	2	3	4	5
Take antidepressants	*1*	*2*	*3*	*4*	*5*
Activities (e.g. sports)	1	2	3	4	5
Contact a non-medical practitioner/ alternative medical practitioner[5]	1	2	3	4	5

[2] Barbiturates are medicines that act on the central nervous system and cause drowsiness and can control seizures. Although barbiturates have been used to treat nervousness and sleep problems, they have generally been replaced by other medicines for these purposes. Sedative - Medicine that has a calming effect and may be used to treat nervousness or restlessness.

[3] Psychotherapist - An individual, who practices psychotherapy. Psychotherapy - The treatment of mental and emotional disorders through the use of psychological techniques designed to encourage communication of conflicts and insight into problems, with the goal being relief of symptoms, changes in behaviour leading to improved social and vocational functioning, and personality growth. A Psychotherapist can be a psychiatrist (only therapists who can prescribe drugs), psychologist, psychiatric nurse, or psychiatric social worker.

[4] Light therapy - the use of strong light for the treatment of depression and gloom (as in seasonal affective disorder) called also light treatment.

[5] A non-medical professional practising holistic medicine such as homeopathy or Chinese medicine.

Surveys – Core Items (continued)

5. Treatment by expert
How successfully can a depression be treated by a:

	Very successful	***Quite successful***	***Moderately***	***Less successful***	***Not successful at all***
A) Family Doctor/GP	1	2	3	4	5
B) Psychiatrist[6]	1	2	3	4	5
C) Psychotherapist	1	2	3	4	5

6. Have you, a close member of your family or close friend ever suffered from any form of depressive disorder?

Yes – self		***Yes – close member of family***		***Yes – close friend***		***No – none***		***Don´t know***

7. Have you heard of the "European Alliance Against Depression" (resp. local name) **Campaign? If so from**

	Yes	***No***
Television		
Radio		
Newspapers		
Magazines		
GP/doctor/doctor´s surgery		
Hospitals/clinics		
Friends		
Spouse/partner/relatives		
Work colleagues		
Chemist/pharmacist		
Posters (not at hospital/clinic/doctor´s surgeries)		
Leaflets (not at hospital/clinic/doctor´s surgeries)		

End of core items

6 A physician who specializes in psychiatry. The branch of medicine that deals with the diagnosis, treatment, and prevention of mental and emotional disorders. A main aspect of their profession is that they can prescribe drugs.

Surveys: Other instruments – Defeat Depression Campaign

DEFEAT DEPRESSION CAMPAIGN - MORI POLL QUESTIONNAIRE
- EAAD ADAPTATION -

1. How strongly do you agree or disagree with each of the following things that have been said about depressive disorders?

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don´t know
Depressed people are often mad or mentally unstable						
Depressive disorders are a medical condition like other illnesses (e.g. bronchitis or arthritis)						
Anybody can suffer from depressive disorders						
Depressive disorders mainly affect women						
Children are very unlikely to suffer from severe depressive disorders						

2. And how strongly do you agree or disagree with the following things that have been said about people suffering from depressive disorders?

	Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don´t know
People suffering from depressive disorders deserve more understanding and support from their family and friends than they get at present						
People suffering from depressive disorders should be treated with anti-depressant tablets						
People suffering from depressive disorders should be offered counselling						

3. Have you, a close member of your family or close friend ever suffered from any form of depressive disorder?

Yes – self		Yes – close member of family		Yes – close friend		No – none		Don´t know

Surveys: Other instruments *(Continuation of Mori Poll – EAAD Adaptation)*

4. Who if anyone would you approach if you suffered from a depressive disorder?

Spouse		GP/doctor		Community psychiatric nurse		Colleagues at work	
Parents		Psychiatrist		Health visitor		Other	
Other relatives		Psychologist		Social worker		None	
Friends				Counsellor		Don´t know	

5. If you suffered from depressive disorder would you be happy to consult your GP?

Yes	**No**	**Don't know**

6. How strongly do you agree or disagree with the following things?

	Strongly agree	**Tend to agree**	**Neither agree nor disagree**	**Tend to disagree**	**Strongly disagree**	**Don´t know**
People with depressive disorders feel embarrassed to consult their GP						
People with depressive disorders are afraid that that will be regarded by their GP as unbalanced or neurotic						
GPs feel irritated and annoyed when people suffering from depressive disorders consult them						
GPs are too busy to deal with depressive disorders						
GPs are well trained to deal with depressive disorders						
GPs are generally understanding and sympathetic towards people with depressive disorders						
When GPs see a depressed patient, they just tend to give them pills						

Surveys: Other instruments *(Continuation of Mori Poll – EAAD Adaptation)*

7. How addictive would you say the following drugs are – very addictive, fairly addictive, not very addictive or not at all addictive?

	Very addictive	Fairly addictive	Not very addictive	Not at all addictive
Tranquilisers				
Antidepressant tablets				
Aspirin				

8. How effective would you say the following are in the treatment of depressive disorders - very effective, fairly effective, not very effective or not at all effective?

	Very effective	Fairly effective	Not very effective	Not at all effective
Antidepressants				
Tranquilisers				
Counseling and/or talking about the problem				

9. Which of the following things are likely to cause depressive disorders - yes/no?

	Yes	No
Virus infections		
Stress		
Bereavement		
Illness		
Biological changes in the brain		
Redundancy		
Unemployment		
Financial problems		
Post-natal depression		
Premenstrual tension		
Menopause		
Loneliness / isolation		
Divorce/end of relationship		
Other		
Don´t know		

Surveys: Other instruments *(Continuation of Mori Poll – EAAD Adaptation)*

10. Have you heard of the "Alliance Against Depression" (resp. local name) Campaign? If so from

	Yes	No
Television		
Radio		
Newspapers		
Magazines		
GP/doctor/doctor´s surgery		
Hospitals/clinics		
Friends		
Spouse/partner/relatives		
Work colleagues		
Chemist/pharmacist		
Posters (not at hospital/clinic/doctor´s surgeries)		
Leaflets (not at hospital/clinic/doctor´s surgeries)		

11. If you were receiving treatment for a depressive disorder which one of the following would you think would be most important to you?

To be able to think clearly		To be able to perform manual tasks without difficulty		None of these
To remain calm and not become aggressive		Not to suffer from drowsiness		Don´t know

Surveys: Other instruments – NSRF[7] Baseline questionnaire

Notes on the questionnaire
The following are notes that were drafted following experience of the interviewers involved in the pilot run of this study and are offered as references for potential interviewers.

Contacting & interviewing
After the person has been contacted 3 times and still would like to be rung back at a better time, it is appropriate to ask if:

- Firstly they could suggest a suitable time

Or

- Secondly would prefer if the questionnaire was posted out to them with a SAE

Or

- Finally would prefer not to participate

Occupation
With regard to the occupation, it is common for the individual to mention their **job title,** if so, please note this (e.g. nurse) and find out if there are in the **public or private sector** etc.

Please note that the **Health care and Educational sectors** are both important sectors in relation to the results. Therefore, it is advisable to clarify if an individual is in either of these sectors.

[7] National Suicide Research Foundation, Irish EAAD partner

Surveys: Other instruments (Continuation of NSRF Baseline questionnaire)

Baseline questionnaire for the General Public

(Via telephone and estimated time to complete: average 15 minutes
Pilot study showed a min. 8minutes & max. 80 minutes)

Call record

[The respondent shall be called 5 times before considering the call N/A]

Call outcome codes:
CI = Competed Interview
PC = Partially Completed
RI = Refused Interview
II = Impossible: e.g. Language Barrier, hard of earing
BNCI = Business Number Completed Interview
BNPC = Business Number Partially Completed
BNRI = Business Number Refused Interview
NA = No Answer
BS = Busy Signal
LD = Line Disconnected
WN = Wrong Number
NC = Number Changed
MM = Message Machine
CB = Call Back (Write Date, Time & Respondent's First Name)

Date	Call Outcome Code	Date & Time for Call Back
Day 1 _______	_______________	_____________________
Day 2 _______	_______________	_____________________
Day 3 _______	_______________	_____________________
Day 4 _______	_______________	_____________________
Day 5 _______	_______________	_____________________

Interview name: __________

Time interview started: _____________ **ended:** ____________________

Person actually interviewed (Respondent named in Directory)	
County of residence	
Gender (please circle)	MALE FEMALE NOT KNOWN
AGE (please circle or fill in) a) Ensure what age the caller is over 18 years of age b) Age	 YES NO _______YEARS OLD / NOT KNOWN

Surveys: Other instruments (Continuation of NSRF Baseline questionnaire)

Do you mind me asking what type of sector are you working in? (Please tick/fill in job/position)
Voluntary Sector
Public (Govt.) Sector
Private Sector
Student
Volunteer
Other
Don't Know
Missing Answer

Question 1.

The following are eight short statements about depression, which you may answer if you, totally disagree, partially disagree, partially agree or totally agree.

[Ensure the participant understands and continue]

Opinions and attitudes to depression

	Strongly Agree	***Agree***	***Undecided***	***Disagree***	***Strongly Disagree***
Depression is a real disorder	1	2	3	4	5
Depression can be treated	1	2	3	4	5
Use of antidepressants can change someone's personality	1	2	3	4	5
The causes of depression are unknown	1	2	3	4	5
If somebody is suffering from depression, it is his/her own fault	1	2	3	4	5
If you are suffering from depression, you have to pull yourself together for getting over it	1	2	3	4	5
Antidepressants have side-effects	1	2	3	4	5
Antidepressants are addictive	1	2	3	4	5

Surveys: Other instruments (Continuation of NSRF Baseline questionnaire)

Question 2
If you suffer from depression, this can be due to different causes. To what extent do you agree or disagree that the following causes are related to the development of depression?

	Strongly Agree	***Agree***	***Undecided***	***Disagree***	***Strongly Disagree***
Wrong lifestyle	1	2	3	4	5
Problems with other individuals	1	2	3	4	5
Disorder of brain metabolism	1	2	3	4	5
Stroke of fate (e.g. death of relative)	1	2	3	4	5
Heredity	1	2	3	4	5
Environmental poisons	1	2	3	4	5
Influence by the mass media (television, papers)	1	2	3	4	5
Today's achievement-orientated society	1	2	3	4	5
Loss of self-discipline	1	2	3	4	5
Weakness of character	1	2	3	4	5

Question 3.
Depression can affect experience and behaviour in different ways. Which symptoms do you think are typical of depression?

	Strongly Agree	***Agree***	***Undecided***	***Disagree***	***Strongly Disagree***
Compulsive grooming	1	2	3	4	5
Physical complaints (e.g. sleeping disturbances)	1	2	3	4	5
Hallucinations	1	2	3	4	5
Feelings of guilt	1	2	3	4	5
Loss of pleasure	1	2	3	4	5

Surveys: Other instruments (Continuation of NSRF Baseline questionnaire)

Question 4.
There are different ways of treating depression. To what extent do you agree or disagree that the following are effective in the treatment of depression?

	Strongly Agree	***Agree***	***Undecided***	***Disagree***	***Strongly Disagree***
Talk to friends	1	2	3	4	5
Go on holiday	1	2	3	4	5
Take barbiturates and sedatives [8]	1	2	3	4	5
Contact a psychotherapist[9]	1	2	3	4	5
Contact a doctor	1	2	3	4	5
Pull yourself together	1	2	3	4	5
Eat chocolate or sweet things	1	2	3	4	5
Light therapy[10]	1	2	3	4	5
Take antidepressants	1	2	3	4	5
Activities (e.g. sports)	1	2	3	4	5
Contact a non-medical practitioner/alternative medical practitioner[11]	1	2	3	4	5

Question 5.
How successfully can a depression be treated by a:

	Strongly Agree	***Agree***	***Undecided***	***Disagree***	***Strongly Disagree***
A)Family Doctor/GP	1	2	3	4	5
B) Psychiatrist[12]	1	2	3	4	5
B) Psychotherapist	1	2	3	4	5

[8] Barbiturates are medicines that act on the central nervous system and cause drowsiness and can control seizures. Although barbiturates have been used to treat nervousness and sleep problems, they have generally been replaced by other medicines for these purposes. Sedative - medicine that has a calming effect and may be used to treat nervousness or restlessness.

[9] Psychotherapist - An individual, who practices psychotherapy. Psychotherapy - the treatment of mental and emotional disorders through the use of psychological techniques designed to encourage communication of conflicts and insight into problems, with the goal being relief of symptoms, changes in behaviour leading to improved social and vocational functioning, and personality growth. A psychotherapist can be a psychiatrist (only therapists who can prescribe drugs), psychologist, psychiatric nurse, or psychiatric social worker.

[10] Light therapy - the use of strong light for the treatment of depression and gloom (as in seasonal affective disorder) called also light treatment.

[11] A non-medical professional practising holistic medicine such as homeopathy or Chinese medicine.

[12] A physician who specializes in psychiatry. The branch of medicine that deals with the diagnosis, treatment, and prevention of mental and emotional disorders. A main aspect of their profession is that they can prescribe drugs.

Surveys: Other instruments – Nuremberg Alliance Against Depression: General population survey

General population survey
to assess the effectiveness of a local awareness programme
targeting suicide prevention

The Nuremberg Alliance Against Depression, a sub-project of the German Research Network on Depression and Suicidality, targets the optimisation of diagnosis and therapy of depression and suicidality on primary care level in Nuremberg. As one of several measures, a comprehensive public information campaign comprised of press releases, public events, advertisement aims to achieve the following goals:

(1) To enhance the acceptance of the awareness programme
(2) To sensitise medical practitioners
(3) To realise the knowledge transfer to the broad public

Knowledge to be transferred refers to the following depression related topics:

(1) Prevalence
(2) Severity
(3) Causes
(4) Symptoms
(5) Treatment methods of depressive disorders
(6) Regional help offers and support measures

The information campaign aims to impart the following core messages:

(1) Many people suffer from depression.
(2) Depressive disorders also have somatic causes.
(3) Depression is a severe disease.
(4) When suffering from depression, it is helpful to consult a doctor.
(5) Depression can successfully be treated.
(6) Antidepressants are not addictive, do not change one´s personality, have only minor side effects and take effect in the long run.

The evaluation of the awareness programme takes place by assessing changes in comparison with the initial situation both in Nuremberg (intervention region) and Wuerzburg (control region) and in comparison of the two regions with each other. Particularly, the effectiveness of the information campaign is to be measured by a telephone survey of representative samples of the population in Nuremberg and Wuerzburg.

Surveys: Other instruments *(Continuation of NAAD – General population survey)*

DATE OF INTERVIEW

☐☐.☐☐.☐☐☐☐

Day Month Year

REGION OF SURVEY

1 ☐ *Nuremberg*
0 ☐ *Wuerzburg*

People get ill from time to time. Sometimes it´s a minor illness, but sometimes a more severe disease. How do you estimate the following diseases? Do you perceive this disease as very severe *(4)*, ***severe*** *(3)*, ***less severe*** *(2)* ***or not servere at all*** *(1)****?***

☐ ***influenza***
☐ ***hay fever***
☐ ***backache***
☐ ***diabetes***
☐ ***cancer***
☐ ***caries***
☐ ***depression***
☐ ***AIDS***

Do you think that the topic depression is currently more talked about in public?

1 ☐ *yes*
0 ☐ *no*

There are different opinions regarding depression. To what extent do you agree to the following statements? Please indicate in each case whether you agree completely *(3)*, ***in parts*** *(2)* ***or not at all*** *(1).*

☐ ***"In fact, depression isn´t a real disease."***

☐ ***"If somebody is suffering from depression, it is his/her own fault."***

☐ ***"If you are suffering from depression, you have to pull yourself together for getting over it."***

☐ ***"Without external support you are at the mercy of a depression."***

☐ ***"Depression is a disease, such as asthma or diabetes, which ought to be treated by a doctor or psychotherapist."***

Surveys: Other instruments *(Continuation of NAAD – General population survey)*

***If you suffer from depression, this can be due to different causes. Which of the following causes do you regards as very important** (5), **quite important** (4), **moderately** (3), **less important** (2) **or not important at all** (1).*

- ☐ ***wrong lifestyle***
- ☐ ***interpersonal problems***
- ☐ ***disorder of brain metabolism***
- ☐ ***stroke of fate (e. g. death of relative)***
- ☐ ***heredity***
- ☐ ***poor nutrition***
- ☐ ***environmental poisons***
- ☐ ***stimulus satiation by media***
- ☐ ***today´s achievement-orientated society***
- ☐ ***loss of self-discipline***
- ☐ ***weakness of character***

A depression can affect experience and behaviour in different ways. What do you think, which symptoms are typical for a depression?

compulsive grooming?

1 ☐ *yes*
0 ☐ *no*

physical complaints (e. g. sleep disturbances, loss of appetite)?

1 ☐ *yes*
0 ☐ *no*

hallucinations?

1 ☐ *yes*
0 ☐ *no*

feelings of guilt?

1 ☐ *yes*
0 ☐ *no*

loss of pleasure?

1 ☐ *yes*
0 ☐ *no*

Surveys: Other instruments *(Continuation of NAAD – General population survey)*

There are different ways of treating depression. Which of the following possibilities do you regard as very appropriate *(3)*, ***moderately*** *(2)* ***or not appropriate*** *(1)*.

- ☐ ***talk to friends***
- ☐ ***go on holiday***
- ☐ ***take barbiturates and sedatives***
- ☐ ***contact a psychotherapist***
- ☐ ***contact a doctor***
- ☐ ***pull yourself together***
- ☐ ***eat chocolate or sweet things***
- ☐ ***light therapy***
- ☐ ***take antidepressants***
- ☐ ***autogenic training***
- ☐ ***a lot of sports***
- ☐ ***contact a non-medical practitioner***

REMARK: ONLY IN THE FIRST INTERVIEW

Do you think that you can talk frankly about mental problems to your doctor?

1 ☐ *yes*
0 ☐ *no*

What do you mean: How successfully can a depression be treated by a doctor or psychotherapist? Do you think very good *(5)*, ***quite good*** *(4)*, ***moderately*** *(3)*,***less good*** *(2)* ***or not good at all*** *(1)****?***

☐

Among other treatment methods, the doctor treats depression with special drugs called antidepressants. What do you think:

Do antidepressants have side-effects?

2 ☐ *strong*
1 ☐ *moderate*
0 ☐ *slight*

Are antidepressants addictive?

1 ☐ *yes*
0 ☐ *no*

Do antidepressants change one´s personality?

1 ☐ *yes*
0 ☐ *no*

If you take antidepressants, do you stay the same?

1 ☐ *yes*
0 ☐ *no*

Surveys: Other instruments *(Continuation of NAAD – General population survey)*

Is there anybody in your family or circle of friends who has already been treated for depression??

1 ☐ *yes*
0 ☐ *no*

Have you recently seen or heard something about depression?

1 ☐ *yes* ➔ NEXT QUESTION
0 ☐ *no*

What did you see or hear?

(PLAINTEXT)

Where did you notice about depression?

CODING BY INTERVIEWER. MULTIPLE ANSWERS POSSIBLE.

☐ *newspaper*
☐ *posters in the city*
☐ *posters in GP waiting room*
☐ *posteres in the tramway*
☐ *infoscreen in subway*
☐ *cinema*
☐ *at the bus-stop, advertising panels*
☐ *public information events*
☐ *art exhibition*
☐ *congregation*
☐ *employment centre*
☐ *school*
☐ *GP*
☐ *friends*
☐ *radio*
☐ *TV*
☐ *internet*
☐ *municipality*
☐ *other,*
e.g. (PLAINTEXT)

Surveys: Other instruments *(Continuation of NAAD – General population survey)*

Some questions asking for how depression is dealt with in the public.

Did you ever hear about the "Alliance Against Depression?"

1 ☐ *Yes*
0 ☐ *No* ➔ NEXT QUESTION

Where did you notice about the "Alliance Against Depression"?
CODING BY INTERVIEWER. MULTIPLE ANSWERS POSSIBLE.

☐ *newspaper*
☐ *posters in the city*
☐ *posters in GP waiting room*
☐ *posteres in the tramway*
☐ *infoscreen in subway*
☐ *cinema*
☐ *at the bus-stop, advertising panels*
☐ *public information events*
☐ *art exhibition*
☐ *congregation*
☐ *employment centre*
☐ *school*
☐ *GP*
☐ *friends*
☐ *radio*
☐ *TV*
☐ *internet*
☐ *municipality*
☐ *other,*
e.g. ________________________________ (PLAINTEXT)

Socio-demographic information

Gender

0 ☐ *female*
1 ☐ *male*

How old are you?

____________________ *Years*

Family status

CODING BY INTERVIEWER.

1 ☐ *married, lives with partner*
2 ☐ *lives with partner, not married*
3 ☐ *divorced, lives apart and without partner*
4 ☐ *widowed and without partner*
5 ☐ *lives alone (has never been married)*

Surveys: Other instruments *(Continuation of NAAD – General population survey)*

Do you have children?

_____________________ *Children*

How many persons live in your household?

_____________________ *Persons*

What is your highest school leaving certificate?

CODING BY INTERVIEWER.

1 ☐ *still in school*
2 ☐ *CSE*
3 ☐ *secondary school level*
4 ☐ *general qualification for university entrance*
5 ☐ *university diploma*
6 ☐ *no graduation*

What is your current occupation?

1 ☐ *still in training*
2 ☐ *employed*
3 ☐ *on release*
4 ☐ *housewife/ -man*
5 ☐ *unemployed*
6 ☐ *pensioner*
7 ☐ *early retirement/disabled*
8 ☐ *other*

Do you work within the health system?

1 ☐ *Yes*
0 ☐ *No*

What is your native language?

1 ☐ *German*
0 ☐ *other*

If other: (PLAINTEXT)

EUROPEAN ALLIANCE AGAINST DEPRESSION

Surveys: Other instruments – Nuremberg Alliance Against Depression: "Depression among the elderly"

Questionnaire

Assessment of changes in knowledge and attitudes about the topic "depression among the elderly"

ID

____

We would like to ask you to complete this questionnaire that assesses your perceptions regarding the topic "depression". To maintain your confidentiality, we will use a unique code to identify your interview which cannot easily be retraced.

Code (date of birth of mother)
If your mother would have been born at 1912, May 16th, the code would be:

16		05		1912
Day		Month		Year

Please now fill in **your code**, that is **the date of birth of your mother**, into the empty boxes:

Day		Month		Year

1. There are different opinions regarding "depression". We are interested in your view. To what extent do you agree to the following statements?

Three-scaled: *agree completely/ agree in parts/ don´t agree at all*

agree completely	agree in parts	don´t agree at all	
☐	☐	☐	***„In fact depression is not a real disease."***
☐	☐	☐	***„If somebody is suffering from depression, it is his/her own fault. "***
☐	☐	☐	***„If you are suffering from depression, you have to pull yourself together for getting over it."***
☐	☐	☐	***„Without external support you are at the mercy of depression."***
☐	☐	☐	***„Depression is a disease, such as e.g. asthma and diabetes, which should be treated by a doctor or psychotherapist."***

Surveys: Other instruments *(Continuation of NAAD: "Depression among the elderly")*

2. *If you suffer from depression, this can be due to different causes. To what extent do you estimate the importance of the following causes in regard to the development of depression?*

Five-scaled: *very important, quite important, moderately, less important or not important at all*

very important	quite important	moderately	less important	not important at all	
☐	☐	☐	☐	☐	**wrong lifestyle**
☐	☐	☐	☐	☐	**interpersonal**
☐	☐	☐	☐	☐	**disorder of brain metabolism**
☐	☐	☐	☐	☐	**stroke of fate (e.g. death of relative)**
☐	☐	☐	☐	☐	**heredity**
☐	☐	☐	☐	☐	**poor diet**
☐	☐	☐	☐	☐	**environmental poisons**
☐	☐	☐	☐	☐	**stimulus satiation by media**
☐	☐	☐	☐	☐	**our today´s achievement-orientated society**
☐	☐	☐	☐	☐	**loss of self-discipline**
☐	☐	☐	☐	☐	**weakness of character**

3. *A depression can affect experience and behaviour in different ways. What do you think, which symptoms are typical for a depression?*

compulsive grooming?
- ☐ *Yes*
- ☐ *No*

physical complaints (e.g. sleep disturbances, loss of appetite)?
- ☐ *Yes*
- ☐ *No*

hallucinations?
- ☐ *Yes*
- ☐ *No*

feelings of guilt?
- ☐ *Yes*
- ☐ *No*

loss of pleasure?
- ☐ *Yes*
- ☐ *No*

Surveys: Other instruments *(Continuation of NAAD: "Depression among the elderly")*

4. How often did you point out possible depressive affections of residents to the treating doctor within the last two months?
Please indicate the concrete number:

5. There are different attitudes towards suicidality in older adults. What do you think:
Four-scaled: *completely agree/ agree in parts/ agree just a little bit/ don´t agree at all*

completely agree	agree in parts	agree just a little bit	don´t agree at all	
☐	☐	☐	☐	**Suicidality in older adults is more acceptable than in younger people**
☐	☐	☐	☐	**Mostly suicidality is a result of a psychiatric disease**
☐	☐	☐	☐	**When you are advanced in years, life can be as worth living as in earlier life.**
☐	☐	☐	☐	**Suicidality should be addressed openly and directly vis-à-vis the affected person.**

6. How often did you point out suicidality of residents to the treating doctor within the last two months?
Please indicate the concrete number:

Finally, for statistical purposes we would like to obtain some information on your vocational background. Please answer the following questions by marking with a cross the appropriate statement:

<insert sociodemographic question>

Thank you very much for your cooperation!

Surveys: Suggestions for additional/ other items

The following questions are about depression, such as causes of depression, symptoms of depression and treatment of depression.

1. Has anyone in your family or friend ever suffered from any form of depression?
   1_No 2_Yes 3_Don't know

2. Has anyone in your family or friend ever been treated for depression?
   1_No 2_Yes 3_Don't know

3. If a person suffers from depression, this can be due to different causes. To what extent do you estimate the importance of the following causes in regard to the development of depression?

	Not important at all	*Less important*	*Moderately*	*Quite important*	*Very important*	*Don't know*
• Wrong lifestyle						
• Problems with other people						
• Metabolic disorders						
• Biological changes in the brain						
• Stroke of fate (e.g. death of relative), bereavement						
• Heredity						
• Environmental pollution (poisons)						
• Influence by the mass media (TV, papers)						
• Today's achievement-oriented society						
• Weakness of character and loss of self-discipline						
• Virus infections						
• Harmful stress						
• Illness						
• Unemployment						
• Financial problems						
• Post-natal depression						
• Premenstrual tension						
• Menopause						
• Loneliness/isolation						
• Divorce/end of relationship						
• Other, specify:						

Surveys: Suggestions for additional/ other items (Continued)

4. Depression can affect experience and behaviour in different ways. Which symptoms do you think are typical for depression?

	Totally disagree	*Partially disagree*	*Partially agree*	*Totally agree*	*Don't know*
• Compulsive thoughts and behaviour, recurrent thoughts and behaviour which are difficult to control					
• Physical complaints (e.g. sleep disturbances, loss of appetite)					
• Hallucinations, hearing voices and seeing images that are not there					
• Decrease of attention and concentration					
• Feelings of guilt and worthlessness					
• Loss of pleasure					
• Suicidal thoughts and behaviour					

5. There are different ways of treating depression. To what extent do you estimate the appropriateness of the following possibilities?

	Very appropriate	*Moderately appropriate*	*Not appropriate*	*Don't know*
• Talk to friends				
• Go on holiday				
• Take sedatives				
• Contact a psychotherapist or psychologist				
• Contact a GP				
• Contact a psychiatrist				
• Contact other medical doctor				
• Pull yourself together				
• Eat chocolate or sweet things				
• Light therapy				
• Take antidepressants				
• Autogenic training				
• A lot of sports				
• Contact a non-medical practitioner (e.g. healer, priest…)				

Surveys: Suggestions for additional/ other items (Continued)

6. Who, if anyone, would you approach for help and support if you suffered from depression?

	Very appropriate	*Moderately appropriate*	*Not appropriate*	*Don't know*
• Spouse/partner				
• Parents				
• Other relatives				
• Friends				
• Psychotherapist/psychologist				
• GP				
• Psychiatrist				
• Other medical doctor				
• Social worker				
• Colleagues at work				
• Other, specify				

7. Antidepressants have following effects:

	Totally disagree	*Partially disagree*	*Partially agree*	*Totally agree*	*Don't know*
• They have side-effects					
• They are addictive					
• They change one's personality					

8. The following are short statements about depression which you may answer if you…

	Strongly disagree	*Partially disagree*	*Partially agree*	*Strongly agree*
• Depression is not a real disorder				
• Depression can not be treated				
• If somebody is suffering from depression, it is his/her own fault				
• If someone is suffering from depression, he/ she has to pull himself/ herself together for getting over it				
• Anybody can suffer from depression				
• Depression mainly affects women				
• Children and young people do not suffer from severe depression				
• Depression is a medical condition like any other illnesses (e.g. bronchitis, asthma, diabetes)				
• Most depressive disorders improve themselves without treatment				
• Depression originates from biochemical abnormalities				
• Depression originates from psychological causes				
• Depression originates from social causes				
• Becoming depressed is a natural part of being old				

Evaluation level:

Attitudes towards suicidality

Introductory remarks

The core items in their current formulation have been selected from the “Attitudes towards suicide - ATTS” questionnaire, developed by Ellinor Salander Renberg and Lars Jacobsson, Department of Psychiatry, Umeå University in 1996.

The items chosen for the core items are the result of a thorough analysis of all proposed items and questions to assess attitudes towards suicide as made in the pooled instrument prepared by Prof. Värnik, the ATTS and all comments and remarks made by the work group on evaluation. During the work goup process, we came to the conclusion that these selected items cover all applicable areas and interests. However, please note that the psychometric parameters of the ATTS are no longer applicable for this core-item scale, as it only consists of some of the ATTS items.

The advantage of choosing items from the ATTS is that each partner who wants to use the entire ATTS-instrument can feel free to do so without losing any core item.

All questions asking for knowledge and regional characteristics in terms of epidemiology or offers have been moved to the optional section because it will be difficult to make cross-national comparisons on these topics. However, these items are of considerable interest on a regional level and should therefore be considered as “optional items”.

The psychometric characteristics of the suggested “*Attitudes towards suicide – ATTS*” (Renberg & Jacobsson 2003[13]) have already been investigated and the response rates in various samples (general population, coroners, GPs, nurses, politicians etc. in different European countries) are high. It is possible to conduct the ATTS through telephone interviews, as this was the method of administration in an Irish pilot study (Arensman & Moor-Corry).

[13] Renberg ES, Jacobsson L (2003). Development of a questionnaire on attitudes towards suicide (ATTS) and its application in a Swedish population. Suicide Life Threat Behav; 33(1): 52-64

Attitudes towards suicidality - Core Items

1. Has anybody in your family or friend ever suffered from suicidality (*concept has to be specified*)?
   1_No 2_Yes 3_Don't know

2. Has anybody in your family or friend ever been treated for suicidality (*concept has to be specified*)?
   1_No 2_Yes 3_Don't know

	Strongly agree	***Agree***	***Un-decided***	***Disagree***	***Strongly disagree***
• People who talk about suicide do not die by suicide.					
• It is always possible to help a person with suicidal thoughts.					
• People who take their own lives are usually mentally ill.					
• There is a risk of evoking suicidal thoughts in a person´s mind if you ask about it.					
• A person once they have suicidal thoughts will never let them go.					
• Suicide happens without warning.					
• Once a person has made up his/her mind about taking his/her own life no one can stop him/her.					
• Many suicide attempts are made because of revenge or to punish someone else.					
• I would consider the possibility of taking my life if I were to suffer from a severe, incurable disease.					
• If someone wants to commit suicide it is his or her business and we should not interfere.					
• I am prepared to help a person in a suicidal crisis by making contact.					

End of core items

Attitudes towards suicidality - Optional Items

	Strongly agree	***Agree***	***Un-decided***	***Disagree***	***Strongly disagree***
• The tendency toward suicide is not genetically (i. e. biologically) inherited and passed from one generation to another.					
• If assessed by a psychiatrist, everyone who commits suicide would be disgnosed as depressed.					
• A time of high suicide risk in depression is at the time when the person begins to improve.					
• A person who has made a past suicide attempt is more likely to attempt suicide again than someone who has never attempted.					
• Most people who attempt suicide fail to kill themselves.					
• There is a strong correlation between alcoholism and suicide.					
• Suicide is among the top 10 causes of death in (resp. country).					

1. The mean suicide rate (per 100,000 inhabitants) in <your country> is …
   1_< 10
   2_10-19
   3_20-29
   4_30-39
   5_> 40
   6_Don't know

2. Suicide rate for the young compared to mean suicide rate in <your country> is …
   1_Lower
   2_Higher
   3_The same
   4_Don't know

3. Number of men suicides compared to number of women suicides in <your country> is …
   1_The same
   2_Higher
   3_Lower
   4_Don't know

4. The suicide rate for the young in <your country> has during recent years …
   1_Increased
   2_Decreased
   3_Remained the same
   4_Don't know

5. The most common method employed to kill oneself in <your country> is …
   1_Hanging
   2_Firearms
   3_Poisoning
   4_Don't know

6. Suicide rates for <your country> compared to <others> are …
   1_Lower
   2_Higher
   3_The same
   4_Don't know

7. People from which marital status category commit suicides the most rarely?
   1_Married
   2_Widowed
   3_Single
   4_Don't know

8. Compared to other countries suicide rate in <your country> is …
   1_Among highest
   2_Among middle
   3_Among lowest
   4_Don't know

9. The risk of death by suicide for a person who has attempted suicide in the past is … than for someone who has never attempted suicide.
   1_Lower than
   2_Similar to
   3_Higher than
   4_Don't know

10. Who commits more frequently suicide <u>attempts</u> – men or women?
    1_equal rates
    2_Women more frequently
    3_Men more frequently
    4_Don't know

11. The most common method for attempted suicide in <your country> is …
    1_Hanging
    2_Poisoning
    3_Cutting one's wrists
    4_Don't know

Attitudes towards suicidality – Other instruments: ATTS

Attitudes towards suicide (ATTS)

Ellinor Salander Renberg, Lars Jacobsson (1996)
Department of Psychiatry, Umeå university

		Strongly Agree	***Agree***	***Undecided***	***Disagree***	***Strongly Disagree***
1	It is always possible to help a person with suicidal thoughts.					
2	Suicide can be justified.					
3	Taking one's own life is among one of the worst things to do to one's relatives.					
4	Most suicide attempts are impulsive actions (by nature).					
5	Suicide is an acceptable means to terminate an incurable disease					
6	Once a person has made up his/her mind about taking his/her own life no one can stop him/her					
7	Many suicide attempts are made because of revenge or to punish someone else.					
8	People who take their own lives are usually mentally ill.					
9	It is everyone's responsibility to try to stop someone from dying by suicide.					
10	When a person dies by suicide it is something that he/she has considered for a long time.					
11	There is a risk of evoking suicidal thoughts in a person's mind if you ask about it.					
12	People who make suicidal threats seldom complete suicide.					
13	Suicide is a subject that one should not talk about.					
14	Loneliness could for me be a reason to take my life.					
15	Almost everyone has at one time or another thought about suicide.					
16	There may be situations where the only reasonable resolution is suicide.					
17	I could say that I would take my life without actually meaning to.					
18	Suicide can sometimes be a relief for those left behind (friends & family).					
19	Suicides among young people are particularly puzzling since they have everything to live for.are particularly puzzling since they have everything to live for.					

Attitudes towards suicidality – Other instruments: ATTS (Continued)

20	I would consider the possibility of taking my life if I were to suffer from a severe, incurable, disease.					
21	A person once they have suicidal thoughts will never let them go					
22	Suicide happens without warning.					
23	Most people avoid talking about suicide					
24	If someone wants to commit suicide it is his or her business and we should not interfere.					
25	It is mainly loneliness that drives people to suicide.					
26	A suicide attempt is essentially a cry for help.					
27	On the whole, I do not understand how people can take their lives.					
28	Usually relatives have no idea about what is going on when a person is thinking of suicide.					
29	A person suffering from a severe, incurable, disease expressing wishes to die should get that help to do so.					
30	I am prepared to help a person in a suicidal crisis by making contact.					
31	I can understand that people suffering from a severe, incurable disease dies by suicide.					
32	People who talk about suicide do not die by suicide.					
33	People have the right to take their own lives.					
34	Most suicide attempts are caused by conflicts with a close person.					
35	I would like to get help to take my own life if I were to suffer from a severe, incurable, disease.					
36	Suicide can be prevented.					

Closing statements:
Ask if they **would like to add anything else in relation to the survey**, which they think the interview has failed to mention, or which they may have strong opinions on themselves?

____
____
____
____
____

Ask the respondent if they **have any questions** and if they **would like to request any further information on the topics covered in the survey through the post.** ___________

EUROPEAN ALLIANCE AGAINST DEPRESSION

Evaluation level:

Assessment of suicide attempts/ deliberate self-harm (DSH)

Introductory remarks[14]

When talking about the non-fatal suicidal acts, different terms are used interchangeably, e.g. *parasuicide, suicide attempts, deliberate self harm, self harm*. Overall, more disparity seems to occur with regard to terminology than with regard to definitions. During the 2nd general meeting of the EAAD project team in 2005 the group agreed to use the following definition within the EAAD project:

"An act with non-fatal outcome, in which an individual deliberately initiates a non-habitual behaviour that, without intervention from others, will cause self harm, or deliberately ingests a substance in excess of the prescribed or generally recognized therapeutic dosage, and which is aimed at realising changes which the subject desired via the actual or expected physical consequences" (WHO/EURO 1996)

However, different terminologies might be used on regional level to account for cultural differences or practicability. Some case examples will be prepared illustrate how this definition should be applied to concrete situations and to ensure comparability of data assessment to a certain extent. Additonally, it has been suggested to gather information to compare the different recording systems in the participating regions. This would also include definitions and prevalence of undetermined deaths, prevalence of other causes of mortality (e.g. accidental drowning, accidental poisoning, single road traffic accidents).

The following list of ICD 10 codes may help you to identifiy suicides in your national/ regional registers which are not necessarily labelled as suicidal but nevertheless might be fall under the definition mentioned above.

- ICD 10: Y10-Y34 Undetermined intent, comment: This group is often added to suicides in calculating rates

The following groups need clarification in every single case:
- ICD 10: R54: Senility (could hide elderly suicides)
- ICD 10: R98-R99: Ill-defined and unknown causes,
- ICD 10: R98: Unattended death
- ICD 10: R99: Other ill-defined and unspecified causes of mortality

Additionally, the following ICD 10 codes are often used in an incorrect manner by the coding physicians and may lead to overdiagnosis of suicide attempts:
- ICD 10: X42, X45 and X62, X65

[14] Most of the statements and text elements have been taken from the presentation given by Dr. Ella Arensman, NSRF Cork (Ireland) during the 2nd General Meeting of EAAD in 2005. ICD codes for the identification of hidden suicides have been provided by Prof. Airi Värnik, Estonia.

EAAD Questionnaire for suicide attempts

1. GENERAL INFORMATION

1.1 Country: _ _ _ _ _ _ _ _ _ _ _ _ _

1.2 Service/Hospital: _ _ _ _ _ _ _ _ _ _ _ _ _

1.3 Date of admission: D D/M M/Y Y Y Y

1.4 Attended by:
- 1 _ Emergency Department
- 2 _ Intensive Care Unit
- 3 _ Other ward, specify: _ _ _ _ _ _ _ _ _ _ _ _ _
- 9 _ Not known

1.5 Date of discharge from hospital: M M/Y Y Y Y[15]

1.6 Date of suicide attempt: M M/Y Y Y Y[1]

1.7 Time span between suicide attempt and first medical / psychiatric contact:
- _ _ _ _ _ _ _ _ _
- 9_ Not known

1.8 Did the suicide attempt give reason to today's medical / psychiatric contact?
- 1_ Rather yes
- 2_ Rather no
- 9_ Not known

1.9 Would the suicide attempt also have been revealed without active exploration by the doctor?
- 1_ Rather yes
- 2_ Rather no
- 9_ Not known

[15] Due to data protection laws in some countries no detailed information including the respective day is collected. Where possible, this information should be collected as well.

EAAD Questionnaire for suicide attempts (continued)

2. IDENTIFICATION OF THE PATIENT

2.1 Patient's identification number: _ _ _ _ _ _ _ _ _ _ _ _ _

2.2 Sex:
1 _ Male
2 _ Female
9 _ Not known

2.3 Date of birth: M M/Y Y Y Y

2.4 Place of residence: _ _ _ _ _ _ (post code or similar)

2.5 Present marital status:
1 _ Single
2 _ Married/ living with partner
3 _ Widowed
4 _ Divorced / separated
9 _ Not known

2.6 Education (1):
1 _ None
2 _ Primary education
3 _ Secondary education
4 _ Non-university higher education
9 _ Not known

2.7 Education (2): Does the patient currently go to school?
1 _ Yes
2 _ No
9 _ Not known

2.8 Employment status?
1 _ Full-time employed
2 _ Part-time employed
3 _ Employed, but on sick leave
4 _Temporary work
5 _Unemployed
6 _Armed services
7 _Full-time student
8 _Disabled, permanently sick
9 _Retired
10 _Housewife/homemaker
11 _Other, specify _ _ _ _ _ _ _ _ _ _ _ _ _ _
99 _Not known

2.9 Has the patient been in psychiatric/ psychotherapeutic treatment within the last 4 weeks?
1_Yes
2_No
9_Not known

2.10 Has there been any contact to an institution of the health care system in relation to the crisis leading to the current suicidal act within the last 4 weeks?
1_Yes
2_No
9_Not known

EAAD Questionnaire for suicide attempts (continued)

3. METHOD

Method: _
(in words and according to ICD-10 codes, see below)

In case of self-poisoning:

Name of substance/ drug: _
Dose: _ _ _ _ _ _ _ _

X60 _ Intentional self-poisoning by and exposure to nonopioid analgesics, antipyretics and antirheumatics

X61 _ Intentional self-poisoning by and exposure to antiepileptic, sedative-hypnotic, antiparkinsonism and psychotropic drugs, not elsewhere classified
X62 _ Intentional self-poisoning by and exposure to narcotics and psychodysleptics (hallucinogens), not elsewhere classified
X63 _ Intentional self-poisoning by and exposure to other drugs acting on the autonomic nervous system
X64 _ Intentional self-poisoning by and exposure to other and unspecified drugs, medicaments and biological substances
X65 _ Intentional self-poisoning by and exposure to alcohol
X66 _ Intentional self-poisoning by and exposure to organic solvents and halogenated hydrocarbons and their vapours
X67 _ Intentional self-poisoning by and exposure to other gases and vapours
X68 _ Intentional self-poisoning by and exposure to pesticides
X69 _ Intentional self-poisoning by and exposure to other and unspecified chemicals and noxious substances
X70 _ Intentional self-harm by hanging, strangulation and suffocation
X71 _ Intentional self-harm by drowning and submersion
X72 _ Intentional self-harm by handgun discharge
X73 _ Intentional self-harm by rifle, shotgun and larger firearm discharge
X74 _ Intentional self-harm by other and unspecified firearm discharge
X75 _ Intentional self-harm by explosive material
X76 _ Intentional self-harm by smoke, fire and flames
X77 _ Intentional self-harm steam, hot vapours and hot objects
X78 _ Intentional self-harm by sharp object
X79 _ Intentional self-harm by blunt object
X80 _ Intentional self-harm by jumping from a high place
X81 _ Intentional self-harm by jumping or lying before moving object
X82 _ Intentional self-harm by crashing of motor vehicle
X83 _ Intentional self-harm by other specified means
X84 _ ntentional self-harm by unspecified means

Evaluation level:

Assessment of training effects

Assessment of training effects

Subject of the training ....

Place of the training ....

Date of the training ....

	Strongly agree	*Tend to agree*	*Undecided*	*Tend to disagree*	*Strongly disagree*	*Don't know*
The instructor gave an appropriate introduction into the workshop						
The instructor is familiar with the topic						
The instructor communicates the topic clearly and understandable						
The training was well structured and target-oriented						
All shown figures were clearly arranged and readable						
Chosen training approaches (e.g casematerial, roleplays) were helpful						
The training improved my knowledge						
The overall impression of the training corresponds with my expectations						
Presented material was interesting and up-to-date						
There was enough time left for discussion and/or questions						

What should be done differently next time?

What did you not like about the training course?

What did you like about the training course?

Evaluation level:

Evaluation among GPs and special target groups

Introductory remarks

Different evaluation questionnaires should be prepared for specific training groups. This is especially true for the evaluation of intervention activities among GPs. Many of the general questions asked to the general population are not adequate to reflect meaningful changes in GPs' knowledge. However, attitudes concerning mental disorders, depression or suicide could be interesting to research among this target group.

The evaluation work group has not agreed on a core item set to assess attitudes and knowledge about mental health among GPs. However, two examples of what might be asked among this target group are presented here. The first questionnaire was developed by our Irish EAAD partners and focuses on epidemiological information. The other examples are CME questions that are used to assess the actual training among GPs within the German Aliiance Against Depression and which mainly refer to concrete topics of the trainings. Another example of how attitudes among depressive disorders might be assessed among GPs is presented in the "Annex" with the "Depression Attitude Questionnaire", developed by N. Botega et al. However, without express permission to use this instrument within EAAD, we will not include it within the "official" section of available instruments.

Evaluation among GPs: NSRF Baseline Questionnaire

Baseline Questionnaire for General Practitioners
Information on cases of deliberate self harm, mood disorder and suicide
Attitudes towards suicide survey

Information on cases of
1. deliberate self harm
2. mood disorders
3. suicide

The questions included in this questionnaire are inclusive of all cases where patients (1) presented with deliberate self harm, (2) presented with mood disorders, or (3) died by suicide

General Practitioner
1) Health Board: _______________2) Area of Practice:_______________

DSH

'An act with non-fatal outcome in which an individual deliberately initiates a non-habitual behaviour, that without intervention from others will cause self harm, or deliberately ingests a substance in excess of the prescribed or generally recognised therapeutic dosage, and which is aimed at realising changes that the person desires via the actual or expected physical consequences' WHO/Euro Multicentre Study Working Group

The following are examples: deliberately ingesting prescribed and non-prescribed medication more than the prescribed dosage, deliberately slashing wrist(s) or cutting other parts of the body.

In 2004, how many cases of the following methods of DSH presented at your practice?

Drug-overdose (medication)	X	_______
Drug-overdose (illicit drugs)	X	_______
Self-cutting	X	_______
Poisoning (e.g. domestic chemicals)	X	_______
Hanging	X	_______
Drowning	X	_______
Firearms	X	_______
Jumping from a high place	X	_______
Jumping or lying before moving object	X	_______
Crashing of motor vehicle	X	_______
Other specified means	X	_______

How many of the cases would have a history of one or more episodes of DSH? _______

Of the total number of cases, how many were female _______ or male______

Evaluation among GPs: NSRF Baseline Questionnaire (Continued)

Of the total number of cases, how many in the following age groups:

< 10	________	50– 54	_______
10 – 14	________	55– 59	_______
15– 19	________	60– 64	_______
20– 24	________	65 – 69	_______
25– 29	________	70 – 74	_______
30– 34	________	75 – 79	_______
35– 39	________	80 – 84	_______
40– 44	________	85yrs +	_______
45– 49	_______		

Of the total number of patients presenting with DSH how many were referred to:

An A&E department ________
Psychiatrist private ________
Counsellor ________
Psychologist ________
Psychotherapist ________

Admitted to a psychiatric in-patient
unit/ward/hospital after treatment ________
If other, please specify ________

2) Mood Disorders

In 2004, how many cases of the following mood disorders presented at your practice?

Depressive symptoms (Specific Diagnosis Uncertain)	X	________
Major Depressive Disorder	X	________
Bipolar I Disorder	X	________
Bipolar II Disorder	X	________
Dysthymic Disorder	X	________
Cyclothymic Disorder	X	________

Of the total number of cases, how many were female _______ or male______

Of the total number of cases, how many were between the ages of:

< 10	________	50– 54	_______
10 – 14	________	55– 59	_______
15– 19	________	60– 64	_______
20– 24	________	65 – 69	_______
25– 29	________	70 – 74	_______
30– 34	________	75 – 79	_______
35– 39	________	80 – 84	_______
40– 44	________	85yrs +	_______
45– 49	________		

Of the total number of patients presenting with mood disorders, how many were referred to:

An A&E department ________
Psychiatrist private ________
Counsellor ________
Psychologist ________
Psychotherapist ________
Admitted to a psychiatric in-patient
unit/ward/hospital after treatment ________
If other, please specify………………………… ________

Evaluation among GPs: NSRF Baseline Questionnaire (Continued)

3) Suicide

In 2004, how many cases of the following methods of suicides presented at your practice?

Drug-overdose (medication)	X	________
Drug-overdose (illicit drugs)	X	________
Self-cutting	X	________
Poisoning (e.g. domestic chemicals)	X	________
Hanging	X	________
Drowning	X	________
Firearms	X	________
Jumping from a high place	X	________
Jumping or lying before moving object	X	________
Crashing of motor vehicle	X	________
Other specified means	X	________

How many of these cases would have a history of one or more episodes of DSH? ________

How many of these cases would have a history of mood disorder? _________

Of the total number of these cases, how many were female ________ or male_______

Of the total number of these cases, how many were between the ages of:

< 10	_________	50– 54	________
10 – 14	_________	55– 59	________
15– 19	_________	60– 64	________
20– 24	_________	65 – 69	________
25– 29	_________	70 – 74	________
30– 34	_________	75 – 79	________
35– 39	_________	80 – 84	________
40– 44	_________	85yrs +	________
45– 49	________		

Thank you for completing this survey

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Evaluation among GPs: German Alliance Against Depression – CME-Questionnaire

„Recognising Depression and Improving Treatment“

CME-Questionnaire

1. How high do you estimate the significance of depressive disorders in the GP practice?

a) low, because only a small part of the patients at the GP practice is suffering from depression.

b) high, because a depression is hidden behind nearly every physical depression.

c) low, because normally depressive disorders need a special treatment.

d) high, because every 10th patient at the GP practice is affected. However, only few of them are treated adequately.

Answer d) is correct

2. Depressed patients

a) hold others responsible for their destiny.
b) are often tired.
c) always suffer from severe sadness.
d) only have in seldom exceptional cases suicidal thoughts.
e) frequently cry.

Answer b) is correct

3. Which of the following symptoms is untypical for a depressive disorder?

a) loss of concentration and attention
b) pessimistic thoughts
c) confusion
d) reduced appetite
e) sexual dysfunctions

Answer c) is correct

4. Depressive disorders are mainly the consequence of

a) current relationship problems
b) the modern society
c) both biological and psychosocial factors
d) changes of the dopaminergic system

Answer c) is correct

Evaluation among GPs: GAAD – CME-Questionnaire (Continued)

5. Which answer is wrong? One of the treatment methods whose efficacy has been proven is

a) the prescription of antidepressant drugs
b) the treatment with tranquilizers
c) the cognitive behavioural therapy
d) the interpersonal therapy
e) the electroconvulsive shock treatment

Answer b) is wrong

6. Why do many pharmacological therapies with antidepressants fail?

a) The antidepressant drug is administered for too long.
b) Patients are getting physically addictive.
c) The antidepressants´ latency to work properly affects the patients´ compliance.
d) The simultaneous taking of other medications neutralises the antidepressant effect.

Answer c) is correct

7. How high is the risk of relapse after the first episode of a depressive disorder?

a) approx. 10%
b) approx. 20%
c) approx. 30%
d) approx. 40%
e) over 50%

Answer e) is correct

8. Which of the following topics does normally not occur within a psychotic depression?

a) becoming impoverished
b) being persecuted
c) sin
d) hypochondria
e) being guilty

Answer b) is correct

Evaluation among GPs: GAAD – CME-Questionnaire (Continued)

9. How long should the pharmacological therapy with antidepressants be maintained at least after the depressive symptoms have faded away within the scope of the long-term therapy?

a) 4 weeks
b) 3 months
c) 6 months
d) 12 months
e) 2 years

Answer c) is correct

10. When dealing with depressed people suffering from acute suicidality, it is important …

a) not to address the topic “suicidality” too much
b) to talk faithfully to the patient about his suicidal thoughts and plans
c) to be reticent in order to give the patient the possibility to make own decisions
d) not to take any responsibility off the patient.
e) to talk the patient out off his suicidal thoughts and plans.

Answer b) is correct

Evaluation level:

Evaluation of prescription profiles

Evaluation of prescription profiles

Introductory Remarks:
One of the basic assumptions concerning the actual (pharmacological) treatment of depressed patients is that the majority of patients treated for depression in the primary care area does not receive an adequate pharmacological treatment. This assumption has been supported by various studies (e.g. Montano 1994, Sartorius & Ustun 1995, Lepine et al. 1997; Katon et al. 1996, Hotopf et al. 1997, Lingam & Scott 2002).

According to results of these studies, treatment is not comprehensive in terms of the following areas:

- type of medication (e.g. prescription of benzodiazepines or neuroleptics)
- dose rates (e.g. too low to avoid side-effects)
- duration of treatment (e.g. several patients withdraw from pharmacological treatment after acute symptoms of a depressive episode have disappeared or are not able to cope with side-effects)

Based on these facts, the training for GPs carried out in the Nuremberg Alliance Against Depression and the German Alliance Against Depression address the need for adequate, sufficient, individualised and structured pharmacological treatment of depressive disorders. Respective elements of the trainings include information about different types of antidepressants, their mechanisms of action, the need for patient education, systematic algorithms how and to which extent pharmacological treatment of depression should be provided by a GP etc.

In addition to specialised trainings for GPs, we addressed the need for adequate pharmacological treatment knowledge among the broad public and community facilitators (key messages).

Methodological approach

Possible indicators
We intended to analyse and compare prescription rates of antidepressants (AD), anxiolytics, neuroleptics and sedatives/hypnotics in the intervention as well as the control region during the baseline year, the intervention period (two years) and a fourth follow-up year. The analyses of anxiolytics, neuroleptics and sedatives/hypnotics are necessary to draw conclusions in terms of treatment with inadequate substances.

Three main indicators are possible to analyse changes in prescription behaviour. First, **volume of sales** can be analysed for different pharmaceuticals. Second, **sales of packages** and third **amounts of active ingredients** can be analysed. Due to the amount of different compounds, package sizes and regional preferences, the selection of appropriate indicators for comparisons between regions is a crucial point. Limitations of the above mentioned indicators volumes of sales and sales of packages are obvious. However, due to the fact that only these indicators allow a (even limited) combination with additional information (e.g. differentiation by different groups of MDs, number of treated patients) in Germany we decided to include also

these indicators in the German project. Ratios between volumes of sales, sales of packages and/or number of treated patients may also provide interesting evidence.

For international drug utilization studies the analysis of **Defined Daily Doses (DDD)** based on the **Anatomical Therapeutic Chemical (ATC)** classification is recommended by the WHO Regional Office for Europe[16].
The classification of a substance in the ATC/DDD system is not a recommendation for use, nor does it imply any judgements about efficacy or relative efficacy of drugs and groups of drugs but it allows to make international comparisons.

To be in line with the WHO recommendation and to allow international comparison we recommend to utilise the ATC/DDD system for respective analyses in the EAAD framework. The complete list of ATC groups analysed in the “Nuremberg Alliance Against Depression” can be found in the after these introductory remarks.

Differentiation by type of medical doctors
Differentiation by different types of medical doctors is another crucial point for the analyses. It is obvious that prescription rates of psycho-pharmaceuticals differ between GPs and psychiatrists or neurologists. Thus separate analyses for at least these two groups are necessary. Additionally overall figures for the intervention region should be analysed.

Timeframe
All data should at least be available for the intervention period and – if possible – for a baseline and a follow-up period. In Germany deductions of MDs are carried out based on quarters. Therefore we decided not to analyse monthly variations but three-month periods. From our point of view monthly analyses or quarters should be the minimum break-down chosen for EAAD purposes

[16] More information about the methodology of the ATC/DDD system can be found on the website of the WHO Collaborating Centre for Drug Statistics Methodology in Oslo (http://www.whocc.no/).

Core set of ATC codes recommended for analyses

N05AA	Phenothiazines with aliphatic side-chain
N05AB	Phenothiazines with piperazine structure
N05AC	Phenothiazines with piperidine structure
N05AD	Butyrophenone derivatives
N05AE	Indole derivatives
N05AF	Thioxanthene derivatives
N05AG	Diphenylbutylpiperidine derivatives
N05AH	Diazepines, oxazepines and thiazepines
N05AK	Neuroleptics, in tardive dyskinesia
N05AL	Benzamides
N05AN	Lithium
N05AX	Other antipsychotics
N05BA	Benzodiazepine derivatives
N05BB	Diphenylmethane derivatives
N05BC	Carbamates
N05BD	Dibenzo-bicyclo-octadiene derivatives
N05BE	Azaspirodecanedione derivatives
N05BP	*Herbal anxiolytics*
N05BX	Other anxiolytics
N05CA	Barbiturates, plain
N05CB	Barbiturates, combinations
N05CC	Aldehydes and derivatives
N05CD	Benzodiazepine derivatives
N05CE	Piperidinedione derivatives
N05CF	Benzodiazepine related drugs
N05CH	*Homeopathic and anthroposophic hypnotics and sedatives*
N05CM	Other hypnotics and sedatives
N05CP	*Herbal hypnotics and sedatives*
N05CX	Hypnotics and sedatives in combination, excl. barbiturates
N06AA	Non-selective monoamine reuptake inhibitors
N06AB	Selective serotonin reuptake inhibitors
N06AF	Monoamine oxidase inhibitors, non-selective
N06AG	Monoamine oxidase A inhibitors
N06AP	*Herbal antidepressants*
N06AX	Other antidepressants

Annex: Additional material

Introductory Remarks

This section contains the “Depression Attitude Questionnaire” by Botega et al. This is an example of how respective attitudes might be assessed among GPs.

Another instrument presented here is the revised Suicide Intervention Response Inventory (SIRI-2), provided by our Belgian EAAD partners and developed by Neimeyer & Bonnelle. The SIRI-2 is a reliable and validated instrument that was specifically designed to assess the ability of professional caregivers in responding to suicidal patients (compare Neimeyer RA, Bonnelle K. 1997. The Suicide Intervention Response Inventory: a revision and validation. Death Studies, 21: 59 – 81.). Regarding the terms of use of this questionnaire, the instrument can be used and distributed within EAAD for free, as long as it is referenced properly.

Additional material: Surveys – The Depression Attitude Questionnaire (DAQ)

DEPRESSION ATTITUDE QUESTIONNAIRE

N. Botega et al.

The purpose of this study is to explore the range of medical views on depression. We are interested in your observations derived from day-to-day medical practice.

In completing the items, please consider as depressed those patients in whom you recognize depression to be a significant part of the clinical picture, not just those who happen to be seeing a psychiatrist.

All information will be treated in strict confidence.

Thank you for co-operation and for adding any comments you think appropriate.

Your age: Sex: male female

Year of gaining M. B. or equivalent: 19 __ __

Time working as a general practitioner:
Under 1 year 1 – 2 years 3 – 5 years 6 – 7 years 8 – 9 years 10 years or over

At present are you working in general practice: full time part time

The questionnaire contains statements that reflect different viewpoints on depression. Under each statement there is a line with *"strongly disagree"* at one end and *"strongly agree"* at the other.

Please indicate a point on each line which best reflects your **daily clinical experience**.

For example:

Work in primary health care involves dealing with depressed patients.

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don´t know
	X				

This response would indicate more agreement than disagreement but some uncertainty.

Additional material (Continuation of DAQ)

During the last 5 years, I have seen an increase in the number of patients presenting with depressive symptoms.

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don´t know

The majority of depression seen in general practice originates from patients´recent misfortunes.

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don´t know

Most depressive disorders seen in general practice improve without medication.

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don´t know

An underlying biochemical abnormality is at the basis of severe cases of depression.

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don´t know

It is difficult to differentiate whether patients are presenting with unhappiness or a clinical depressive disorder that needs treatment.

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don´t know

It is possible to distinguish two main groups of depression: one psychological in origin and the other caused by biochemical mechanisms.

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don´t know

Becoming depressed is a way that people with poor stamina deal with life difficulties.

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don´t know

Additional material (Continuation of DAQ)

Depressed patients are more likely to have experienced deprivation in early life than other people.

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don´t know

I feel comfortable in dealing with depressed patients´needs.

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don´t know

Depression reflects a characteristic response in patients which is not amenable to change.

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don´t know

Becoming depressed is a natural part of being old.

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don´t know

The practice nurse could be a useful person to support depressed patients.

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don´t know

Working with depressed patients is heavy going.

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don´t know

There is little to be offered to those depressed patients who do not respond to what GPs do.

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don´t know

It is rewarding to spend time looking after depressed patients.

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don´t know

Additional material (Continuation of DAQ)

Psychotherapy tends to be unsuccessful with depressed patients.

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don´t know

If depressed patients need antidepressants, they are better off with a psychiatrist than with a general practitioner.

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don´t know

Antidepressants usually produce a satisfactory result in the treatment of depressed patients in general practice.

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don´t know

Psychotherapy for derpessed patients should be left to a specialist.

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don´t know

If psychotherapy were freely available, this would be more beneficial than antidepressants for most depressed patients.

Strongly agree	Tend to agree	Neither agree nor disagree	Tend to disagree	Strongly disagree	Don´t know

What percentage of patients you have seen over the past 3 months would you estimate depression to be significant part of the clinical picture?

under 5%	5-10%	11-20%	21-30%	31-40%	41-50%	51-60%	61-70%	over 70%

What percentage of these *depressed patients* have you decided an antidepressant was required?

under 5%	5-10%	11-20%	21-30%	31-40%	41-50%	51-60%	61-70%	over 70%

Thank you!

Additional material: Surveys – SUICIDE INTERVENTION RESPONSE INVENTORY (SIRI-2)

Developed by Robert A. Neimeyer, Department of Psychology, University of Memphis, Memphis, Tennessee, USA (1981).

The following items represent a series of excerpts from counselling sessions. Each excerpt begins with an expression by the client concerning some aspect of the situation he / she faces, followed by two possible helper responses to the client´s remark.

You are to rate each response in term of how appropriate or inappropriate you fell the reply is to the client´s comment. In the blank you should record a rating from –3 to +3, corresponding to the chart below. Be sure to respond to each item, and try not to leave any blanks.

+ 3 Highly appropriate response
+ 2 Appropriate response
+ 1 Marginally appropriate response
0 Neither appropriate nor inappropriate
- 1 Marginally inappropriate response
- 2 Inappropriate response
- 3 Highly inappropriate response

1. Client: I decided to call in tonight because I really feel like I might do something to myself…… I´ve been thinking about suicide.
Helper A: You say you ´re suicidal, but what is it that ´s *really* bothering you?
Helper B: Can you tell me more about your suicidal feelings?

2. Client: And now my health is going downhill too, on top of all the rest. Without my husband around to care for me anymore, it just seems like the end of the world.
Helper A: Try not to worry so much about it. Everything will be all right.
Helper B: You must feel pretty lonely and afraid of what might happen.

3. Client: But my thoughts have been so terrible …. I could never tell them to anybody.
Helper A: You can tell me. I ´m a parofessional, and have been trained to be objective about these things.
Helper B: So some of your ideas seem so frightening to you, that you imagine other people would be shocked to know you are thinking such things.

4. Client: No one can understand the kind of pain I´ve been going through. Sometimes I just feel like I have to hurt myself, so I cut my wrists.
Helper A: It seems like you´ve been suffering so much that cutting your wrists is the only way you can make the pain go away.
Helper B: But you ´re so young, you have so much to live for. How can you think of killing yourself?

Additional material (Continuation of SIRI-2)

5. Client: What are you anyway? Are you a doctor? How do you know what I´ve been going through? You´ve probably always had it pretty soft.
Helper A: So you ´re wondering if I can understand how you feel.
Helper B: You ´re not even giving me a chance. I´ve had a pretty rough life too; you ´re not the only one who ´s seen some hard times.

6. Client: My life has been worthless ever since my wife, Emma, died four years ago. The kids are grown and married now, and I´ve been retired from job at the railroad for some time. It just seems that I ´d be better off dead.
Helper A: But try to think of what Emma would want for you. She ´d want you to continue leading a productive life, wouldn´t she?
Helper B: It sounds like everything just collapsed around you when Emma died. … But what has happened recently to make things even worse, to make you think that dying is the only way out?

7. Client: I really need help. … It ´s just ….{voice breaks: silence}
Helper A: It must be hard for you to talk about what ´s bothering you.
Helper B: Go on, I ´m here to listen to you talk.

8. Client: When you sum up my problem like that, it makes it seem less confusing and not so scary.
Helper A: See, it really isn´t so bad after all. It certainly isn´t anything you would think of killing yourself over, is it?
Helper B: Sometimes talking about problems does make them a bit clearer. I think you realize how dangerous your suicidal feelings were, and that ´s why you decided to contact me.

9. Client: You were supposed to help me, but you´ve only made things worse.
Helper A: I ´m sorry. I was only trying to help.
Helper B: You sound pretty angry.

10. Client: How could you ever help me? Have you ever wanted to kill yourself?
Helper A: It sounds like you ´re concerned about whether I can understand and help you.
Helper B: Sure, I´ve thought about suicide sometimes. But I always found more realistic solutions to my problems.

11. Client: I don´t know … this whole thing with my wife really gets to me {sobs}. I try so hard to keep from crying ….
Helper A: Do you think that the reason it´s hard for you to cry is because you´re a man?
Helper B: With all the hurt you´re feeling, it must be impossible to hold those tears in.

Additional material (Continuation of SIRI-2)

12. Client: How can I believe in God anymore? No God would ever let this happen to me; I´ve never done anything to deserve what´s happened.
Helper A: Things have gotten so bad, that it´s difficult to see any meaning in the things that have happened to you.
Helper B: Well, God works in mysterious ways. Maybe this is His way of testing your faith.

13. Client: I don´t know why I´m calling you. My family is financially well off, and my husband spends plenty of time with me, even though he has a successful law career. Even my kids have been doing well. They get good marks at school and have lots of free time activities with their friends. But nothing seems to interest me. Life is just a bore ….
Helper A: Considering all you have going for you, your problems can´t be all that serious. Try to focus more on the positive aspects of your situation.
Helper B: So even though things seem to be going well at one level, life still seems pretty depressing, even if it´s hard to say exactly why.

14. Client: I have to hang up now. My mother´s coming home soon and I don´t want her to know I´ve been talking to you.
Helper A: Okay, but if you keep feeling suicidal, remember you can always call back.
Helper B: All right, but first I want you to promise me you won´t do anything to hurt yourself, until you call and talk to me. Will you repeat that promise?

15. Client: Is it really true that many people feel this way? I thought I was the only one who had such dreadful, sinful ideas.
Helper A: No, there are many people who suffer from mental illness. But with appropriate treatment by a qualified physician, some of these patients can be cured.
Helper B: It is true. You´re not the only one who has suicidal thoughts. And you can be helped to get through this crisis, just as others have been.

16. Client: I´m so lonely, so tired {crying}. There just isn´t anywhere left to turn.
Helper A: You seem so alone, so miserable. Have you been feeling suicidal?
Helper B: Come on now. Things can´t be all that bad.

17. Client: {Over telephone} It´s hard to talk here, with all these people ….
Helper A: Would it help if I asked questions?
Helper B: Why don´t you call back some other time when you can talk more easily?

Additional material (Continuation of SIRI-2)

18. Client: I have a gun pointed at my head right now, and if you don´t help me, I´m going to pull the trigger!
Helper A: You seem to be somewhat upset.
Helper B: I want you to put down the gun so we can talk.

19. Client: Why should you care about me, anyway?
Helper A: I´ve been trained to care about people. That´s my job.
Helper B: Because I think your death would be a terrible waste, and it concerns me that things are so that you are considering suicide. You need help to get through this critical period.

20. Client: I really hate my father! He´s never shown any love for me, just complete disregard.
Helper A: You must really be angry at him for not being there when you need him most.
Helper B: You shouldn´t feel that way. After all, he is your father, and he deserves some respect.

21. Client: I don´t think there´s really anyone who cares whether I´m alive or dead.
Helper A: It sounds like you ´re feeling pretty isolated.
Helper B: Why do you think that no one cares about you anymore?

22. Client: I tried going to a therapist once before, but it didn´t help. … Nothing I do now will change anything.
Helper A: You´ve got to look on the bright side! There must be something you can do to make things better isn´t there?
Helper B: Okay, so you´re feeling hopeless, like even a therapist couldn´t help you. But has anyone else been helpful before – maybe a friend, relative, teacher, or clergyman?

23. Client: My psychiatrist tells me I have an anxiety neurosis. Do you think that´s what´s wrong with me?
Helper A: I´d like to know what this means to you, in this present situation. How do you feel about your problem?
Helper B: I´m not sure I agree with that diagnosis. Maybe you should seek out some psychological testing, just to be certain.

24. Client: I can´t talk to anybody about my situation. Everyone is against me.
Helper A: That isn´t true. There are probably lots of people who care about you if you´d only give them a chance.
Helper B: It must be difficult to find help when it´s so hard to trust people.

25. Client: {Voice slurred, unclear over telephone}
Helper A: You sound so tired. Why don´t you get some sleep and call back in the morning?
Helper B: Your voice sounds so sleepy. Have you taken anything?