Mental Health Screening Education

Kessler Psychological Distress Scale (K10)

- Developed in 1994 for screening populations on non-specific psychological distress
- Screening tool with 10 questions focusing on anxiety and depressive symptoms experienced in the last four weeks
- 5 response categories with values 1-5
- Totals = 10-15 low or no risk 16-29 medium risk 30-50 high risk
- High risk (30 over) – if urgent or you have concerns medical referral for psych consult or non-urgent a referral to GP on discharge
- Consider what interventions may be required to keep the patient safe in the meantime.

Scoring

Scoring the K-10 is simple. The total score is the sum of all 10 items 1 – 10. Scores range from 10 – 50. Missing items are excluded from the calculation of the total score.

Interpretation

- 10-19: This score indicates that the client or patient may currently not be experiencing significant feelings of distress.

- 20-24: The client or patient may be experiencing mild levels of distress consistent with a diagnosis of a mild depression and/or anxiety disorder.

- 25-29: The client or patient may be experiencing moderate levels of distress consistent with a diagnosis of a moderate depression and/or anxiety disorder.

- 30-50: The client or patient may be experiencing severe levels of distress consistent with a diagnosis of a severe depression and/or anxiety disorder.

The K-10 is a measure of psychological distress that first should be considered at face value. Higher scores indicate greater psychological distress, whatever the cause. However, they are available for consideration by the clinician and consumer to gauge the impact of the consumer's distress on his or her functioning (Coombs, 2005).

Depression

The key signs:

- feeling down, depressed or hopeless, or
- having little interest or pleasure in doing things on most days over the past month

When assessing the severity of depression in an adult and planning management, practitioners should consider symptom severity, symptom persistence, functional impairment, response to any previous intervention and also the wider psychosocial context, identifying factors that may impact positively or negatively on outcome.

Other possible signs of depression include daily:

- Irritability
- Fatigue or loss of energy
- sleep problems- (falling asleep, staying asleep or waking too early)
- changes in appetite/weight –(both loss or increase)
- low self esteem or feeling worthless
- problems with concentration
- reduced sex drive
- feelings of emptiness or loneliness

Suggested screening questions for depression.

- During the past month, have you often been bothered by feeling down, depressed or hopeless?
- During the past month, have you often been bothered by little interest or pleasure in doing things?
- Often people with depression also experience constant worry (anxiety) which can cause physical symptoms.

Suggested screening question for anxiety.

- During the past month have you been worrying a lot about everyday problems?

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<u>Suicide risk assessment</u>
Key questions to ask:

- intent
- planning
- availability of means
- barriers to committing suicide
- previous attempts

Associated risk factors include but not limited to: Alcohol and drug use, depression and/or anxiety, lack of support networks, rational thinking is impaired, an adverse life event etc.

Action:

- Ensure patient safety if agitated/distressed, try to calm, maintain observation and seek assistance from other staff
- Patient having suicidal thoughts, the assessment form suggests a referral to psych consult
- The assessment and management of people at risk of suicide guideline suggests:

Key Suicide Risk Factors
• The majority of people who die by suicide suffered an associated psychiatric disorder at the time of their death. People who meet the criteria for more than one disorder at a time are at even greater risk.

• Substance abuse and intoxication are strong risk factors. Up to half of those who die by suicide have consumed alcohol before taking their lives.

• Recent loss, loved ones dying or committing suicide, isolation, depression or bipolar disorder, previous attempts, serious physical illness and a past history of abuse are key risk factors. In youth, an identifiable stressful event (relationship break-up, bullying) precedes most suicide attempts.

• The highest rates for suicide are among males 20–34 years. Mäori youth have higher rates than non-Mäori youth. However, 75% of all suicides occur in people over the age of 24.

Some staff may have difficulty asking questions around mental health issues however service users appreciate the enquiry and the ability to explain their circumstances. Any questions should be delivered in a non judgemental way, using open questions (eg So tell me about….?) to facilitate optimum engagement showing empathy with the service user as with any other person you assess.

Questions that a clinician might consider include:
• How has your mood been lately?
• Has anything been troubling or worrying you?
• Have you had times when you have been feeling sad or ‘down’?
• Have you ever felt like life is just getting on top of you?
• Do you sometimes wish you could just make it all stop, or that you could just end it?
• Have you thought about how you might do this?
• Have you ever wished you were dead?
• Have you ever thought about taking your own life?

If a person endorses any of these questions careful probing is warranted (the what, where and how of the situation). The clinician needs to go on to determine the level of intent, the presence of a plan, access to means, any underlying mental health problems and the availability of supports and protective factors. The severity and pervasiveness of current suicidal ideation also gives important information about severity and immediacy of risk (eg, are the thoughts mild and fleeting or is the person preoccupied with thoughts of suicide?)