

Emotional Vital Signs

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Disclosure

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Learning Objectives

- Learn about the role emotional vital signs can play in primary care
- Be introduced to the OQ-10 a tool to measure a patient's emotional vital signs
- Understand the impact of the use of emotional vital signs on patient progress in mental health counselling.

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How many of you collect mental health or emotional vital signs in your practice?

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Mental Health in Primary Care

- Primary care patients with significant psychological problems, such as anxiety or depression can be difficult to identify as they often do not report these conditions as the reason for their visit to their clinician (Prestidge & Lake, 1987)
- Patients tend to present vague physical or distress symptoms (Rosenthal et al, 1991; Gage & Leidy, 1991; Molde & Baker, 1985; Wright, 1988)

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- Studies indicate that the prevalence of patient distress may be as high as 70% in some primary care outpatient populations (Cummings & Vadenboss, 1981; VonKorff, Shapiro & Burke, 1987; Coyne, Fechner-Bates, & Schwenk, 1994; Tessler, Mechanic & Dimond, 1976)
- Published literature for suggests that a large number of these distressed patients do not meet the formal diagnostic criteria for psychotic diagnosis of depression and anxiety

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- Nagel, 1998 found that of 457 patients surveyed, 71% of those screened as positive for depression would not have been classified as having major depression based on the DSM-IV criteria.
- Schwenk, Coyne, & Fechner-Bates (1996) & Coyne, Schwenk, & Fechner-Bates (1995) suggest that the presentation of psychological problems is usually more subtle in primary care than in psychiatric settings and psychological distress screening tools should reflect these differences.

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- Several studies have examined whether self-report tools can detect psychiatric conditions and/or changes in functional status in primary care practice (Parkerson & Broadhead, 1997; Wells, Stewart & Hays, 1988; Stewart, Hays & Ware, 1988; Spitzer, et al, 1994; and Berwick et al, 1991).
- Psychological distress that fails to meet criteria for psychiatric diagnosis may still be integral to a patient's well-being and subsequent treatment

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- Tools need to be considered that can detect psychological distress affecting the patient's quality of life, even though identification of distress may not lead to a diagnosis (Rothballer Seelert, Hill, Rigdon & Schwenzfeier, 1999)

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The OQ-10

- Developed by Lambert, Finch, Okishi, Burlingame, McKelvey, Reisinger (1997)
- Identify and gauge a patient's general psychological functioning including both positive and negative affect, without the expectation of that the score will provide a diagnosable condition

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- The OQ is designed to provide a total score that is indicative of a patient's current level of psychological distress.
- The items are both positively and negatively worded and each item is scored on a 5-point Likert scale (range 0-4) for a maximum score of 40.
- Higher scores indicate more distress.

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10 questions

Looking at the last week, including today, help us understand how you have been feeling:

1. I am a happy person
2. I am satisfied with my life
3. I am satisfied with my relationships with others
4. I felt loved and wanted
5. I feel my love relationships are full and complete

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- 6. I feel fearful
- 7. I feel something is wrong with my mind
- 8. I feel blue
- 9. I feel lonely
- 10. I feel stressed at work/school.

- A 1999 study of the OQ in primary care done by (Rothballe Seelert, Hill, Rigdon & Schwenzfeier, 1999) found that two factors emerged:
 1. Psychological well-being
 2. Psychological distress

- Using an OQ cut-off of 17, the study found that 24% of the sample could be labelled as highly distressed – diagnosable with clinically significant depression or anxiety.
- Using a more liberal cut-off of 12, nearly 50% of the sample was could be identified as distressed.

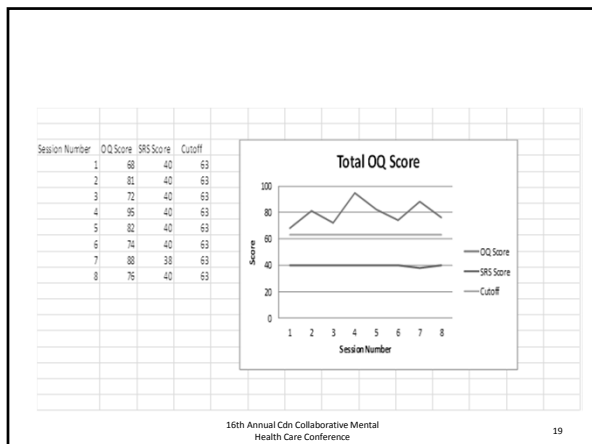
Suggestions for Primary Care:

- The ability to identify and gauge psychological distress
- Generally psychological complaints are often milder and the functional status of patients are greater in primary care than in psychiatric settings (Schwenk, Coyne, & Fechner-Bates, 1996; Coyne, Schwenk, & Fechner-Bates, 1995).

- While there are tools that can be used in primary care geared towards DSM diagnoses, the OQ-10 focuses on positive and negative aspects of a patient's mental health, so that OQ-10 scores may reveal milder degrees of distress.
- The cut-offs of 12 or 17 can be used to guide whether a provider should intervene to further assess and/or reduce a patient's self reported distress.

What the Research tells us about mental health outcomes?

- Change will happen earlier than later
- Mental Health programs typically underserve the needs of our clients
- The median number of sessions provided is typically 3 and often less
- We need to titrate services according to the needs of the client
- Treatment needs to be tailored to the many aspects of the client, including problem, complaint or disorder and also include attitudes, values, history, culture, resources and context (Wampold, 2001, 2007)
- Data needs to be from the client perspective and not from the clinician's perspective



CCC Depression Clients (January 2006 – June 2013)

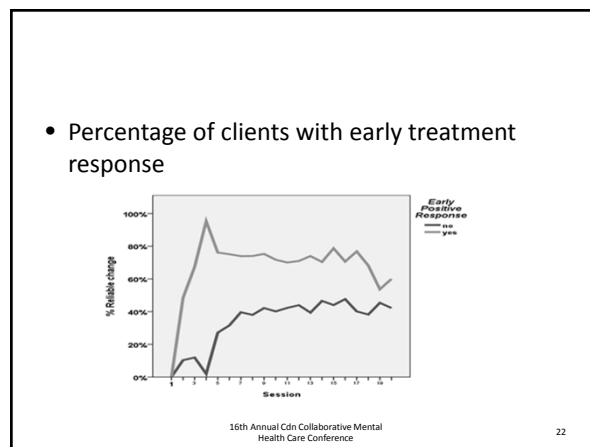
- 5,252 counselling clients with depression
- Both first/last session OQ results available for 3408 clients
- Of these clients, 91 also participated in a specialized depression group
- Mean number of individual counselling sessions for overall sample = 5.5
 - For those 91 clients who participated in both counselling and group, the mean number of counseling sessions was 12.5 with a range of 1-73.

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Demographics of Depression Clients

- male 35%; female 64%
- 42% were age 20-29 yrs.
- mean age= 34 yrs., range of 17 – 66 yrs.
- unemployed to corporate executives
- single to married
- children to grandparents

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Category	Overall depression sample: Status at last session	Group therapy clients:		CCC Cases	US Baseline Study
		First counselling session to first group session	First to last session overall		
Deteriorated	211 (6.2%)	9 (11.5%)	5 (6.8%)	648 (7.6%)	8.2%
Stable	1,444 (42.4%)	38 (48.7%)	30 (40.5%)	4055 (47.4%)	56%
Improved	919 (27.0%)	24 (30.8%)	26 (35.1%)	1933 (22.6%)	20.9%
Recovered	834 (24.5%)	7 (9.0%)	13 (17.6%)	1915 (22.4%)	14.1%
Total	3,408	78	74	8,551	6,072

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Depression Counselling OQ Results 2008 - 2012	Average First Session OQ	Average Last Session OQ	Change Score	Results
n=2427	87.3	70.6	-16.8	p < .001*

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Combined Programming 2007-2011	N=46	Change Score	Results
First Counselling Session	92.3		
First Session of Group	84.09	-8.2	$t(45) = 2.55, p < .05^*$
Last Session of Group	71.74	-12.4	$t(45) = 5.43, p < .001^*$
From first session of counselling to last session of group		-20.6	$t(45) = 6.17, p < .001^*$

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Conclusions

- The use of emotional vital signs can be used to assess distress
- These measures can guide whether a provider should intervene to further assess and/or reduce a patient's self reported distress.
- Longer measures can be used to assesses distress and patient progress in mental health treatment.

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