Promoting positive outcomes for people in transport accidents

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Workshop preparation

Workshop pre-reading:

Preferred outcome measures
What are your preferred self report measures for routine use in measuring changes in clients. These may be measures you already routinely use or have considered using.

Typical recovery trajectories after a transport accident
Using the diagram draw the typical patterns of recovery for people who have been in a transport accident. What label would you give each pattern of recovery?
Routine outcome measures
What are your attitudes?

1. How \textit{regularly} do you use outcome measures in your day to day practice?

2. How often have you participated in \textit{education activities} in the last five years that have discussed outcome measures?

3. Outcome measures \textit{are useful} for working with people with mental health problems.

4. Using outcome measures in my practice involves \textit{more effort than it is worth}.

5. The following are the reasons I think that outcome measures should be used.

- Supervision
- Reflect on own strengths
- Peer reviews
- Review of treatment
- Decision- making about closure
- Decision- making about progress
- Reviews with clients
- Reflection on cases
- Your other reasons?

6. Overall \textit{how useful} do you think that outcome measures are?
Why promote positive outcomes?
Strategy, standards and service

Ensuring that people benefit from effective psychology treatments is an integral part of Australia’s mental health strategy, the professional standards for psychologists and increasingly a service requirement of informed consumers.
Why promote positive outcomes?
National Mental Health Strategy

• To undertake regular reviews of outcomes of services provided to people with serious mental health problems and mental health disorders, as a central component of the delivery of mental health services and

• To encourage the development of national outcomes standards for mental health services, and systems for assessing whether services are meeting these standards

In order to achieve these objectives, routine outcome measures are being introduced throughout Australian public and private mental health services.
Why promote positive outcomes?
Better Mental Health Outcomes (BOMH)

Most people with a mental disorder who seek help from a health professional, ask for help from their general practitioner rather than from a specialist mental health professional.

In recognition of this, the Commonwealth is supporting general practitioners to build a strong system of primary mental health care through the Better Outcomes in Mental Health Care Initiative (BOMHC).

It encourages evidence-based practice in primary mental health care and recognises that good practice in mental health includes both pharmacological and non-pharmacological interventions. The use of outcome measures by GP’s and psychologists is a requirement of funding under this scheme. 
Why promote positive outcomes?
Treatment without benefit is not ethical

An ethical requirement of members of the APS is that:

19. Members must terminate a consulting relationship when it is reasonably clear that the client is not benefiting from it. They must offer to help the client locate alternative sources of assistance. When a client indicates to a member that he or she would like a second opinion the member must offer every practical assistance to obtain a competent second opinion.

20. When there is evidence of a problem or a condition with which the member is not competent to deal, the member must make this clear to the client and must refer the client to an appropriate source of expertise.

Why promote positive outcomes?
Consumers

‘….consumers support the introduction of routine outcome assessments and see the process as having potential to contribute to the treatment they receive.’

‘Key process issues from the consumers’ perspective include how the consumer is approached for information, how outcome measurement is used to strengthen therapeutic dialogue and the use of consumer ratings in treatment planning.’

‘….consumers ….. want to see strong consumer involvement at all stages’

Why promote positive outcomes?
But practitioners are ambivalent
Why promote positive outcomes?
Practitioner ambivalence
Why promote positive outcomes?
Comparisons across professions

- Nursing (196): 2.17
- Psychology (17): 2.13
- Social Work (19): 2.11
- Occ Therapy (17): 2.09
- Medical (67): 1.83
Why promote positive outcomes? Benefits must exist for practitioners

- to be of benefit to anyone, then the outcomes measures must be seen by service providers to be “good measures with face validity, that they will own.”

- Routine measurement of outcomes would provide a standardized language for assessing clients and communicating results.

- Routine measurement of outcomes should be undertaken in a way that is useful in planning of treatment

Overview

- Introduction
- Trajectories
- Measures
- Challenges
- Treatment planning
Mental health trajectories

1. Stable adaptive functioning
2. Temporary deviation
3. Positive turnaround
4. Deteriorating course
5. Stable maladaptive functioning

Intervention intensity

Low
Medium
High
Pretrauma vulnerability and resilience

Pretrauma  Trauma  Posttrauma

Resilient

Vulnerable
The trauma features

Pretrauma  Trauma  Posttrauma
Health practitioners are naive

We are prone to everyday errors and biases in clinical judgment

Biases and errors result from our judgment heuristics (shortcuts) that work well in everyday life, but lead to errors in clinical judgment e.g., longer term and attractive clients form the basis for our internal schemas

Such errors are most likely under conditions of INFORMATION OVERLOAD. Precisely the situation in the fifty minute hour

Only by being aware of this susceptibility and taking steps to address it can a clinician be as effective a decision maker as possible.

Decision aids: be they actuarial benchmarks, treatment manuals, outcome measures are an effective means of limiting such bias and error.
RCT’s can be misleading

Message: Most change <25 hours; < 3 months up to 50% of gains made are lost at 2 yrs
Effect sizes in RCT’s and real life

Number of people

No improvement  Outstanding improvement

Average untreated person  Average treated person

75% of untreated persons
Routine treatment

Comorbidity; >50% drop out; therapist factors are potent; treatment stays the same; > 25+ hours for effects; fluctuating outcomes
Alternative recovery trajectories

A: Kick start, B: self managed, C: incremental, D: palliative

Time (Year)

Outcome
What are outcome measures?

Need to be distinguished from other kinds of measures of enduring characteristics such as personality traits, transient processes such as thoughts or expectations and satisfaction with treatment.

Measure change in meaningful areas of a person’s life in a way that informs collaborative decisions about treatment.

Enormous number of reasonably well constructed measures that are possible candidates for routine use by practitioners
# Health outcome measures

## Is popular good?

Most widely evaluated outcome measures within 3921 reports (Garratt et al 2002)

<table>
<thead>
<tr>
<th>Measure</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>SF36</td>
<td>408</td>
</tr>
<tr>
<td>Sickness impact profile</td>
<td>111</td>
</tr>
<tr>
<td>Nottingham health profile</td>
<td>93</td>
</tr>
<tr>
<td>EORTC QLQC30</td>
<td>82</td>
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<tr>
<td>QALY</td>
<td>79</td>
</tr>
<tr>
<td>EuroQol</td>
<td>77</td>
</tr>
<tr>
<td>Health assessment questionnaire</td>
<td>62</td>
</tr>
<tr>
<td>Arthritis impact measurement scales</td>
<td>59</td>
</tr>
<tr>
<td>Quality of wellbeing scale</td>
<td>53</td>
</tr>
<tr>
<td>General health questionnaire</td>
<td>43</td>
</tr>
<tr>
<td>Health utilities index</td>
<td>41</td>
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<tr>
<td>COOP charts</td>
<td>33</td>
</tr>
<tr>
<td>Functional assessment of cancer</td>
<td>32</td>
</tr>
<tr>
<td>WHOQOL</td>
<td>24</td>
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<tr>
<td>Healthy years equivalent</td>
<td>24</td>
</tr>
<tr>
<td>*Beck depression inventory</td>
<td>23</td>
</tr>
<tr>
<td>Asthma quality of life questionnaire</td>
<td>21</td>
</tr>
<tr>
<td>*McGill pain questionnaire</td>
<td>19</td>
</tr>
<tr>
<td>WOMAC</td>
<td>18</td>
</tr>
<tr>
<td>*Hospital anxiety and depression scale</td>
<td>18</td>
</tr>
<tr>
<td>Duke health profile</td>
<td>17</td>
</tr>
<tr>
<td>SF12</td>
<td>15</td>
</tr>
<tr>
<td>*Psychological general wellbeing index</td>
<td>15</td>
</tr>
<tr>
<td>St George's respiratory disease questionnaire</td>
<td>15</td>
</tr>
<tr>
<td>MOSHIV</td>
<td>14</td>
</tr>
<tr>
<td>Rotterdam symptom check list</td>
<td>14</td>
</tr>
</tbody>
</table>
Selecting quality outcome measures

- Brevity and ease of administration favours self-report measures
- Can be scored by hand without an algorithm
- Reliability has been demonstrated both internally and across administrations
- Validity has been demonstrated by associations with established measures or clinical judgments
- Responsive to change means that the measure changes as the person problems change in nature and magnitude
- Australian norms so scores can be interpreted against average Australians who are well and have mental health problems
- In common languages, such as Greek, Italian, Chinese and Vietnamese
- Freely available at no cost

Reduces the number of measures recommended for routine use
1. General mental health measures

Widely used general measures covering the common mental health problems of anxiety and depression (Hickie, 2002). Reflect general mental distress.

4.1 Mental health screening: Kessler K10 (10 items)
Australian norms across a national survey of 10,000+ people. The most widely used mental health measure by Australian general medical practitioners.

4.2 Anxiety/depression: Lovibond’s DASS(42 items)
Australian norms. The second most widely used measure by GP’s. Together with the K10 is recommended as part of the Commonwealth’s Better Mental Health Outcomes (BOMH) scheme. Available in all common languages.

4.3 Anxiety/depression/health concerns: Hickie’s SPHERE (34 items)
Australian norms across 49,000 GP attendances.

Will be freely available on the TAC website.
2. Condition specific measures

2.1 Alcohol: *Alcohol Use Disorders Identification Test (AUDIT)*
(Mandated best practice, Australian norms, large groups)

2.2 Cognitive: *Wechsler Memory Scale* (Australian norms, large groups)

2.3 Health concerns: *SPHERE SOMA scale* (Australian norms, large groups)

2.4 Trauma: *Posttraumatic Checklist (PCL)*
(Australian norms for specific military and sexual assault populations only)

2.5 Pain: *Orebro Musculoskeletal Pain Screening Questionnaire*
Wide range of other measures that each refer to particular sites of pain such as the neck, arms and legs. Unique in being generic. No Australian norms but overseas norms. In New Zealand used to predict outcomes using Yellow Flag approach (NZ Guidelines link).
3. Functional status

These are measures of a person's day to day behaviour in undertaking activities of living in the areas of work, home and recreation. Surprisingly there are no Australian norms or widely accepted and used measures for activities of daily living or for those with mental health populations (Smith, 2001; Eager, 2000).

3.1 Health status: SF-12 and SF-36 (Australian norms)
Require purchase and use of a computer based scoring algorithm

3.2 Orebro Musculoskeletal Pain Screening Questionnaire
Until good measures are available adapting the wording of the Orebro items 15, 16, 20-24 is recommended irrespective of whether pain and physical disability is a feature. New Zealand guidelines for assessing risk and prognosis for recovery from lower back pain.

3.3 Multiaxial Pain Inventory
Similar justification to Orebro. Use items 1-18 below.
Listed below are 19 daily activities. Please indicate how often you do each of these by circling a number on the scale listed below each activity. Please complete all 19 questions.

1. Wash dishes.
   0 Never
   1 2 3 4 5 Very often

2. Mow the lawn. (___ Check here if you do not have a lawn to mow.)
   0 Never
   1 2 3 4 5 Very often

3. Go out to eat.
   0 Never
   1 2 3 4 5 Very often

4. Play cards or other games.
   0 Never
   1 2 3 4 5 Very often

5. Go grocery shopping.
   0 Never
   1 2 3 4 5 Very often

6. Work in the garden. (___ Check here if you do not have a garden.)
   0 Never
   1 2 3 4 5 Very often

7. Go to a movie.
   0 Never
   1 2 3 4 5 Very often

8. Visit friends.
   0 Never
   1 2 3 4 5 Very often
10. Work on the car. (___ Check here if you do not have a car.)
   0  1  2  3  4  5  6
   Never  1  2  3  4  5  6
   Very often

11. Take a ride in a car or bus.
   0  1  2  3  4  5  6
   Never  1  2  3  4  5  6
   Very often

12. Visit relatives. (___ Check here if you do not have relatives within 100 miles.)
   0  1  2  3  4  5  6
   Never  1  2  3  4  5  6
   Very often

13. Prepare a meal.
   0  1  2  3  4  5  6
   Never  1  2  3  4  5  6
   Very often

14. Wash the car. (___ Check here if you do not have a car.)
   0  1  2  3  4  5  6
   Never  1  2  3  4  5  6
   Very often

15. Take a trip.
   0  1  2  3  4  5  6
   Never  1  2  3  4  5  6
   Very often

16. Go to a park or beach.
   0  1  2  3  4  5  6
   Never  1  2  3  4  5  6
   Very often

17. Do the laundry.
   0  1  2  3  4  5  6
   Never  1  2  3  4  5  6
   Very often

18. Work on a needed household repair.
   0  1  2  3  4  5  6
   Never  1  2  3  4  5  6
   Very often
**Self-report measures**

**Minimising response bias**

<table>
<thead>
<tr>
<th><strong>DO</strong></th>
<th><strong>DON'T</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Do be warm, friendly and helpful</td>
<td>Do not force or command patients to fill out the questionnaire</td>
</tr>
<tr>
<td>Do request and encourage patients to fill out the questionnaire</td>
<td>Do not tell the patient that treatment is dependent on their filling out the questionnaire.</td>
</tr>
<tr>
<td>Do have patients fill out the questionnaire before any others that are in the battery</td>
<td>Do not minimise the importance of filling out the questionnaire.</td>
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<tr>
<td>Do let patients know that you will be there to assist them if needed.</td>
<td>Do not accept an incomplete questionnaire without first encouraging the patient to fill out unanswered questions</td>
</tr>
<tr>
<td>Do tell patients to answer a question based on what THEY think the question means</td>
<td>Do not paraphrase, rephrase, interpret or explain a question</td>
</tr>
<tr>
<td>Do encourage patients to answer ALL the questions</td>
<td>Do not answer the question for the patient</td>
</tr>
<tr>
<td>Do read and repeat a question verbatim for the patient</td>
<td>Do not tell the patient how you feel they should answer</td>
</tr>
<tr>
<td>Do stress there is no right or wrong answer</td>
<td>Do not allow other people to help the patient fill out the questionnaire</td>
</tr>
<tr>
<td>Do inform patients that they will be required to fill out the questionnaire again at a later date</td>
<td>Do not assume the patient can do it and just doesn’t want to (i.e. if a person tells you they cannot do it - accept that he is telling the truth.</td>
</tr>
<tr>
<td>Do thank patients for filling out the questionnaire</td>
<td>Do not tell the patient to go home and get their family to help them.</td>
</tr>
<tr>
<td>Do provide definition of a single word a person is unfamiliar with</td>
<td></td>
</tr>
</tbody>
</table>
# Mental health treatment plan

## Linking goals and measures

7. **Agreed treatment plan and measures**
   What practical goals have been agreed with the person? How will these goals be achieved, by what date, and using what progress measures?

<table>
<thead>
<tr>
<th>Practical goals</th>
<th>Interventions/strategies</th>
<th>Progress measures standardised/customised</th>
<th>Estimated date of achievement or review</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
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<td>2.</td>
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</table>
Why a few measures used regularly is best

- Become familiar with a few of the best available measures and use them regularly

- Provides practise in their administration, scoring and interpretation and their utility for signalling the need for adjustments in the nature, intensity and duration of interventions.

- By using core measures over time the practitioner could build a database of recovery curves that can be used for the purposes of benchmarking.

- With advances in the use of information technology it seems likely that data like this could be combined across practitioners to develop norms for recovery from common mental health problems.
Small group exercises

1. Preferred outcome measures

• Break into small groups of 6-7 people
• Appoint a chairperson (the person whose last name comes first in the alphabet)
• Make a complete list of each person’s top three preferred outcome measures
• Then, by giving each person three votes, take a vote to determine the top three measures for the group
• Why were these measures selected by your group?

2. What are the challenges in using routine outcome measures?

• Make a complete list of each person’s top three challenges
• Then, by giving each person three votes, take a vote to determine the top three challenges
Questions and discussion
Evaluation forms