Psychological distress among cancer patients: Screening for triage and referral

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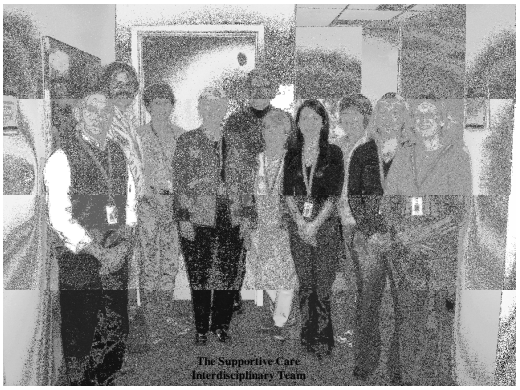
Northern Health Research Conference
Algoma University College
Sault Ste. Marie, Ontario
Friday, June 1, 2007



The Supportive Care Interdisciplinary Team

We have fifteen minutes!

1. Why screen for psychological distress?
2. What process are we using?
3. What do we think we know from our first 5,198 records?

Why screen for psychological distress?

1. The diagnosis, or the fear of a diagnosis, of a life-threatening illness creates immediate distress.
2. Everyone experiences a shift in his or her level of comfort.
3. Approximately one-third of all cancer patients experience prolonged high-distress.

Why screen for psychological distress?

4. Because we cannot see everyone.
5. Not everyone needs to be seen.
6. We cannot rely on the old adage of "build it and they will come".
7. To know that people are in distress, and not at least attempt to identify those who are most in need, would be professionally irresponsible.

And if I may, while on this topic . . .

- Screening for psychological distress needs to be viewed in the same way as we would view screening for . . . diabetes, say.
- By that, I mean, that while it would not be appropriate, generally, for me to screen for diabetes, although I am sure I could, I ought not to for it is outside the scope of my practice.

And furthermore, if you will allow me . . .

- Given what we know about the existence of psychological distress in this population:
  1. we must assess for those most in need of having their unmet needs met;
  2. we need to think of this as being as routine a "best practice" as is sending someone up to the lab; and,
  3. we need to think seriously about how that information (the result) is shared – by whom and to whom.

And what do I mean?

- Any screening tool is simply that . . . a tool.
- Ideally, certain tools are only used by certain people.
- Although the guidelines for using a screening tool are generally just that (guidelines), screening implies that you are going to do something appropriate in the event that you identify "a case".

Ideally . . .

- the screening tool is but one bit of evidence used by a program team; and
- the team decides – perhaps in consultation with the patient – "to whom that bit of information goes" and who it is that will sit with the patient and pursue the matter.

What tool might you use?

- It think it is fair to say that it is not so important what tool you use, but that you do use one; and,
- similarly, it may not be so important when you use that tool, but, again, that you at least do something!

What tool might you use?

- And it is probably important that it be recognized as a screening tool and not a diagnostic tool.
- Why? Two reasons:
  1. Diagnostic tools come with labels and biases and assumptions, and stigma . . . and are lengthy and subtle and occasionally deceptive.
  2. Diagnostic tools reduce the importance of the person-to-person contact that is essential in initiating the kind of outreach and connection I would argue as being a cornerstone to what we need to be doing.

What tool might you use?

- Remember, a screening tool is merely a "thermometer".
- The gentleman has an elevated core temperature, or so it would appear . . .
  1. Could be he has a raging infection.
  2. Could be he fell asleep in the sauna!

Requirements of a screening tool

1. It must be easily administered.
2. It must be easily scored.
3. It must be easily interpreted.
4. It must be valid and reliable.

The Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983)

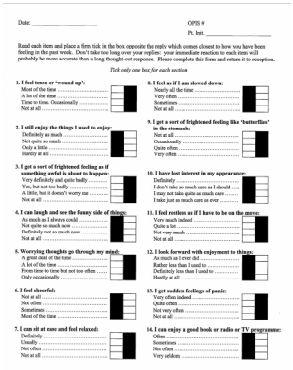
1. is an easily administered self-report measure designed specifically for persons with a physical illness;
2. is made up of 14 items, each consisting of a four-point Likert scale ranging from zero to three, with varying response categories, that applies to the previous week;

The Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983)

3. usually takes about three to five minutes to complete and is very easy to score;
4. is divided into two subscales, with:
   a. seven items pertaining to symptoms associated with anxiety, and
   b. seven items pertaining to symptoms associated with depression;

The Hospital Anxiety and Depression Scale (HADS; Zigmond & Snaith, 1983)

5. appears to be a suitable instrument for oncology settings (Razavi, Delvaux, Farvacques, & Robaye, 1990);
6. contains no somatic items that may confound results by elevating the scores of cancer patients; and
7. has good reliability and validity in physically ill patients.



Date: _____ OPD #

Pt. Init. _____

Read each item and place a firm tick in the box opposite the reply which comes closest to how you have been feeling in the past week. Don't take too long over your replies: your immediate reaction to each item will probably be more accurate than a long thought-out response. Please complete this form and return it to reception.

Tick only one box for each section

1. I feel tense or "wound up":
Most of the time
A lot of the time
Time to time. Occasionally
Not at all

2. I still enjoy the things I used to enjoy:
Definitely as much
Not quite so much
Only a little
Hardly at all

3. I get a sort of frightened feeling as if something awful is about to happen:
Very definitely and quite badly
Yes, but not too badly
A little, but it doesn't worry me
Not at all

4. I can laugh and see the funny side of things:
As much as I always could
Not quite so much now
Definitely not so much now
Not at all

5. Worrying thoughts go through my mind:
A great deal of the time
A lot of the time
From time to time but not too often
Only occasionally

6. I feel cheerful:
Not at all
Not often
Sometimes
Most of the time

7. I can sit at ease and feel relaxed:
Definitely
Usually
Not often
Not at all

8. I feel as if I am slowed down:
Nearly all the time
Very often
Sometimes
Not at all

9. I get a sort of frightened feeling like 'butterflies' in the stomach:
Not at all
Occasionally
Quite often
Very often

10. I have lost interest in my appearance:
Definitely
I don't take as much care as I should
I may not take quite as much care
I take just as much care as ever

11. I feel restless as if I have to be on the move:
Very much indeed
Quite a lot
Not very much
Not at all

12. I look forward with enjoyment to things:
As much as I ever did
Rather less than I used to
Definitely less than I used to
Hardly at all

13. I get sudden feelings of panic:
Very often indeed
Quite often
Not very often
Not at all

14. I can enjoy a good book or radio or TV programme:
Often
Sometimes
Not often
Very seldom

Scoring the HADS

- For each subscale, a score ranging from 0 – 21 (7 x 0 = 0; 7 x 3 = 21) is calculated:
  1. scores less than eight on either of the two subscales are deemed to be "non-cases";
  2. scores of eight, nine, or ten are rated as "borderline"; and
  3. scores of eleven or more on either of the two subscales is indicative of the "probable" presence of psychological distress.

Scoring the HADS

4. However, if a "borderline" score (i.e., eight, nine, or ten) is found on both subscales at the same time, the individual is considered "at risk" for psychological distress.

What process are we using?

1. All new Cancer Centre patients are asked to complete the HADS as part of the New Patient Package.
2. Patients complete the HADS while sitting in the waiting room, prior to seeing anyone.
3. The receptionists place the completed HADS in the Supportive Care mail slot.

What process are we using?

4. Twice per day, Alan picks up the completed HADS, scores them, and, if required (i.e., if "high"):
   a. makes photocopies of the "high-HADS";
   b. prints and attaches "OPIS face sheets" to the "high-HADS"; and
   c. brings the "high-HADS packages" to our weekly clinical meeting.

What process are we using?

5. At the weekly clinical meeting:
   a. we go through each of the "cases";
   b. the team decides how to proceed; and
   c. phone calls are placed within 72 hours.
6. Or, if the "high-HADS" are so high they need to be acted on sooner, Alan takes them directly to Lori, in which case she will stop me and we will jointly triage, and not wait for the Thursday morning meeting.

And what then?

7. A file is opened if the person is going to be seen by one of the counsellors in Supportive Care.
8. A file is not opened if "services are declined" (i.e., "thanks, but no-thanks").
9. Regardless, the data are captured and all HADS forms are kept in a common file.

Some HADS data

- We began collecting HADS data on October 10, 2000; as of May 18, 2007 we have collected HADS data on 5,198 cancer patients.
- Over the past six-plus years we have collected "completely completed" HADS from 4,505 patients (RR = 87%).
- If we include the "incomplete" HADS during that same time frame, our N = 4,800 (RR = 92%).

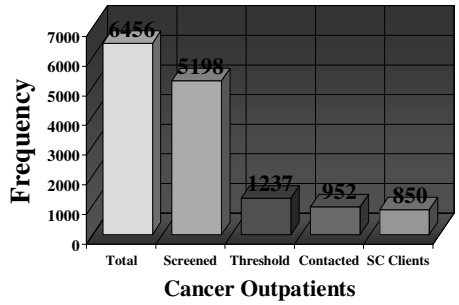
Some more HADS data

- Looking at that larger number of patients (i.e., N = 4,800), the average (mean) scores are as follows:
  - **Anxiety Subscale = 6.73 / 21 (SD = 4.52)**
  - **Depression Subscale = 4.39 / 21 (SD = 3.94)**
  - **Overall Distress Score = 11.08 / 42 (SD = 7.29)**
- And 1,237 of these patients (26%) have scored above "threshold".

We had been worried

- What if, after all this trouble, nobody bothered to take us up on our invitation?
- Well, of these (the 26%):
  1. we were successful in contacting 952 patients (78%) by phone; and, of these . . .
  2. 850 patients (89%) made an appointment when called and asked whether they would like an appointment with one of the Counsellors in Supportive Care.

HADS screening data (N = 5,198)



Supportive Care clients by HADS threshold score

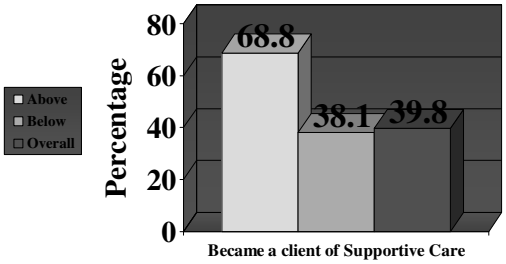


Table 1 – HADS scores by site

Primary Site	Frequency (N)	Percent (%)	Anxiety Subscale	Depression Subscale	Overall Distress
Breast	1,125	23.3	7.41	3.69	11.09
Prostate	855	17.8	5.62	3.61	9.22
Colorectal	603	12.5	6.35	4.53	10.64
Lung	552	11.4	7.76	6.27	14.03
Skin	173	3.6	5.38	3.50	8.88
NHL	170	3.6	6.85	4.63	11.48
Bladder	106	2.2	6.19	4.76	10.95
Kidney	100	2.1	6.06	3.59	9.65
TOTAL	3,684	76.6	6.68	4.26	10.89

Table 2 – Percentage above threshold

Males

Primary Site	Frequency (N)	% Above Threshold
Breast	5	40.0
Prostate	855	15.9
Colorectal	357	19.0
Lung	310	38.1
Skin	101	15.8
NHL	85	24.7
Bladder	70	25.7
Kidney	62	16.1
TOTAL	1,845	21.1

Females

Primary Site	Frequency (N)	% Above Threshold
Breast	1,120	26.3
Prostate	-	-
Colorectal	246	27.6
Lung	242	43.0
Skin	72	22.2
NHL	85	34.1
Bladder	36	19.4
Kidney	38	28.9
TOTAL	1,839	28.8

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Regional Cancer Care

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