Improving outcomes for patients by attending to their distress

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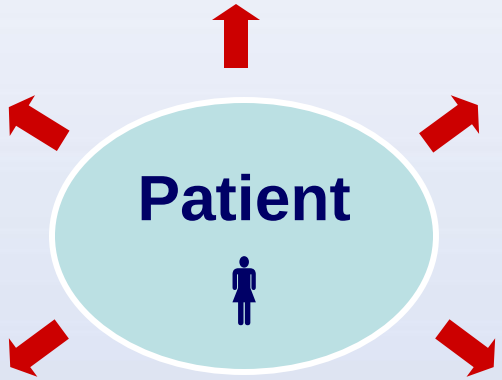
Disclosure Statement: No Conflicts of Interest to declare

"The emotional trauma of having cancer diagnosis and treatment can be as potentially harmful for the patient as the disease itself".

Meyerowitz B, *Psychological Bulletin*, 1980

Impact of Cancer and its consequences



Family and interpersonal

uncertainty regarding social roles and tasks, separation from partners, children

Emotional and Psychological problems

fear, sadness, worries, despair, loss of autonomy and control, change of self-image

Existential and spiritual problems

Confrontation with the mortality of one's own life, search for meaning, consolation; spiritual, religious, philosophical explanations

Physical symptoms and functional problems

pain, fatigue, dysfunction, psychosomatic symptoms, disabilities

Problems with the health care system

impersonal treatment, lack of time, lack of intimacy, terminology hard to understand

Social, financial, and occupational strain

Responsibility of important social and occupational functions, new dependencies

Adapted from
Koch & Mehnert, 2005,
IPOS online curriculum
www.ipos-society.org

We know that…(scientific evidence)

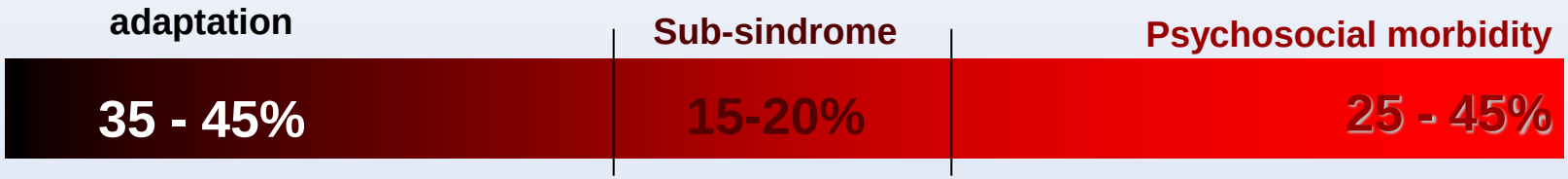
1. **50%** of cancer patients suffer from ***distress***

   and some will develop psychological morbidity

DISTRESS CONTINUUM

Normal Distress

Severe Distress



Worries
Fears
Sadness

Maladjustment
Anxiety
Depression

Adapted from J.Holland, IPOS, 2005
IPOS online curriculum
www.ipos-society.org

Epidemiology of Psychological Morbidity in cancer patients

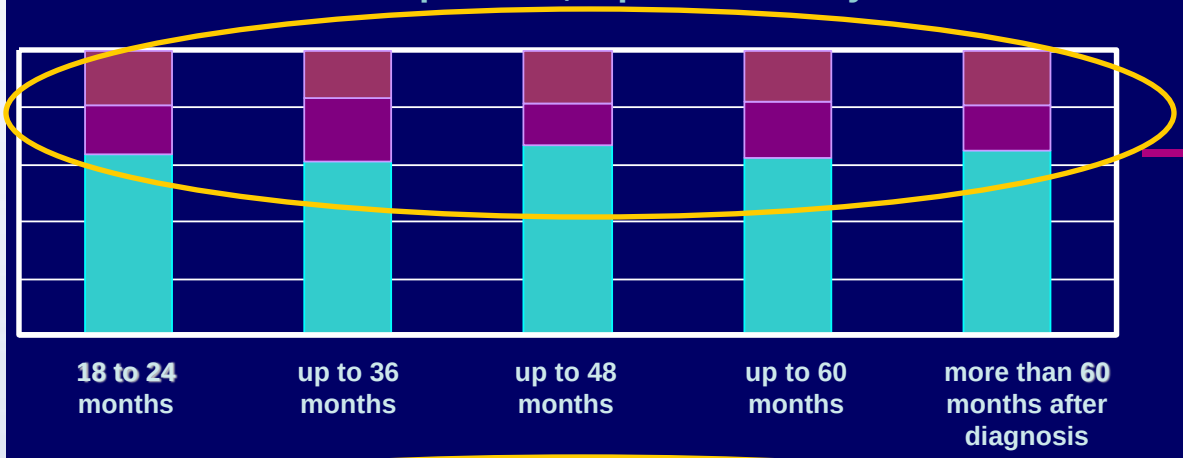
	Prevalence rates in empiric studies on mental distress
Anxiety disorders	**Screening up to approx. 50%, clinical interview up to approx. 30%, in terminally ill patients up to 80%**
Depression	**Screening up to approx. 50%, clinical interview up to approx. 15% , in terminally ill patients up to 77%**
Adjustment disorders	**Screening or clinical interview up to approx. 50%** (frequently mixed anxiety and depressed mood)
Post-traumatic stress disorder	**Screening or clinical interview up to approx. 30%**
Cognitive disorders (delirium)	**Screening or clinical interview up to approx. 85% in terminally ill patients**

Derogatis 1983, Massie & Holland 1990, Razavi 1990, Bruera et al. 1992, Chochinov et al. 1995, Pereira et al. 1997, van't Spijker et al. 1997, Breitbart & Krivo 1998, Noyes et al. 1998, Sellick & Crooks 1999, Zabora et al. 2001, Kangas et al. 2002, Prieto et al. 2002, Stark et al. 2002, Katz et al. 2003, Osborne et al. 2003, Uchitomi et al. 2003, Akechi et al. 2004, Carlson et al. 2004, Kissane et al. 2004, Grassi et al. 2005

adapted from Koch & Mehnert, IPOS 2005

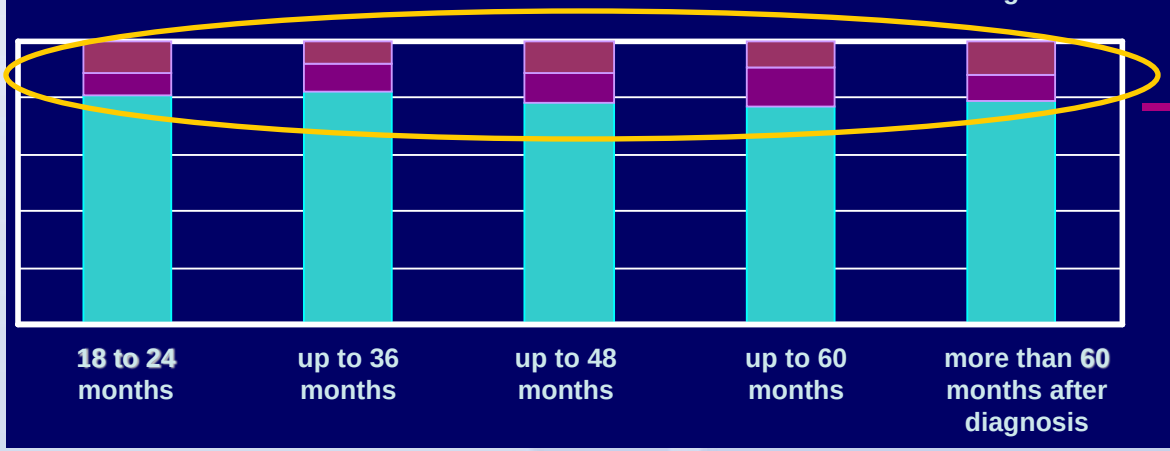
Prevalence of Anxiety and Depression
in differing periods of time since diagnosis

N=1083 breast cancer patients, representatively selected from the Hamburg Cancer Register



Anxiety Screening:

in 36% of the patients an anxiety disorder is possible or probable



Depression Screening:

in 21% of the patients depression is possible or probable

HADS Screening

adapted from Koch & Mehnert, IPOS 2005

IPOS online curriculum, www.ipos-society.org

We know that… (scientific evidence)

2. Psychosocial morbidity has significant negative clinical consequences

> yet ~70% of this suffering goes unrecognized…

Consequences of Psychosocial Morbidity in Cancer Patients

- **Deterioration of Quality of Life**
- **Reduced compliance w/ treatment**
- **Less efficacy of chemotherapy**
- **Higher perception of pain and other symptoms**
- **Shorter survival expectancy**
- **Longer hospital stay and increased costs**
- **Burden for the family**
- **Higher risk of suicide**

Parker et al., Psychooncology, 2003; Colleoni et al., Lancet, 2000; Walker et al., EJC, 1998; Spiegel et al., Cancer, 1994; Faller et al., Arch Gen Psychiatry, 1999; Watson et al., Lancet, 1999; Pitceathly & Maguire, EJC, 2003; Prieto et al., J Clin Oncol., 2002; Henriksson et al., J Affect Dis, 1995; Grassi et al. 2005; McDaniel et al. 1995, Ehlert 1998, Saupe & Diefenbacher 1999, Linton 2000, Cavanaugh et al. 2001, Härter et al. 2001, Carlson & Bultz, 2004

adapted from Grassi & Yosuke, IPOS, 2005

We know that… (scientific evidence)

3. Psycho-oncology services provide **effective** (**evidence-based, RCT's**) interventions for:

(a) preventing or reducing the distress and **psychosocial morbidity** associated w/ cancer

(b) improving patients' skills to cope with the demands of treatment and the uncertainty of the disease and **improving their Quality of Life**

>> And are cost effective as well as general health costs reductive

RCTs in Psycho-Oncology Interventions

AUTHORS	SAMPLE	INTERVENTION	OUCOME
Linn et al. (Cancer, 1982)	120 patients in advanced phase	Counselling vs. control	Improvement in QoL
Weisman et al. (Cancer, 1984)	117 outpatients	Psychotherapy vs Relaxation vs control	Decrease in stress symptoms and increase in problem-solving skills
Greer et al. (BMJ, 1992)	174 patients w/ psychological disorders	Short-term psychotherapy (APT) vs traditional care	Decrease in anxiety & depression, improvement in coping and QoL
Spiegel et al. (JNCI, 1998)	125 metastatic breast cancer patients	Group Psychotherapy vs control	Decrease in anxiety, depression, pain, improvement in QoL
Goodwin et al. (N Eng J Med, 2001)	235 metastatic breast cancer patients	Group Psychotherapy vs control	Decrease psychological stress symptoms
Simpson et al. (Ca Pract, 2001)	Breast cancer patients	Group psychotherapy vs control	Psychosocial improvement + 23,5% reduction of health care billings !

Li, Fitzgerald & Rodin. Evidence-based Treatment of Depression in Cancer Patients. ***JCO* 2012**, 30: 1187-96.

Clinical practice guidelines for the psychosocial care of adults with cancer

NATIONAL BREAST CANCER CENTRE
Incorporating the Ovarian Cancer Program

NHMRC
National Health & Medical Research Council
INVESTING IN AUSTRALIA'S HEALTH

NATIONAL CANCER CONTROL INITIATIVE

NHS

National Institute for Clinical Excellence

Guidance on Cancer Services

Improving Supportive and Palliative Care for Adults with Cancer

NCCN National Comprehensive Cancer Network®

NCCN Clinical Practice Guidelines in Oncology™

Distress Management

CANCER CARE FOR THE WHOLE PATIENT

MEETING PSYCHOSOCIAL HEALTH NEEDS

INSTITUTE OF MEDICINE

Journal of the National Comprehensive Cancer Network

The NCCN Guideline for Distress Management: A Case for Making Distress the Sixth Vital Sign

Psychosocial care of patients has traditionally been seen as separate from routine medical care and has been criticized as being "soft" and lacking evidence. This traditional perspective continues in many settings, despite the fact that patients and families, when asked, state that emotional care is highly valued. The question of how to integrate psychosocial care into routine cancer care has also been an issue, partly because of the stigma associated with cancer.

In 1997, the National Comprehensive Cancer Network (NCCN) established a multidisciplinary panel to examine this problem.[1] Because patient and physician attitudes toward pain can pose similar barriers to care as can distress, the panel used as a model the rating system for assessing pain that resulted in successful improvement of pain management in the United States. The rating system's success seemed partly based on routinely using a single question to assess a patient's pain: "How is your pain on a scale of 0 to 10?" The system uses a score of 5 or higher as the indication to reassess pain medications or refer the

Canadian Association of Psychosocial Oncology
Association Canadienne d'Oncologie Psychosociale

Standards of Psychosocial Health Services for Persons with Cancer and their Families

Approved May 28, 2010

COUNCIL OF
THE EUROPEAN UNION

EN

Council Conclusions on reducing the burden of cancer

2876th EMPLOYMENT, SOCIAL POLICY, HEALTH AND CONSUMER AFFAIRS Council meeting

- *To attain optimal results, a patient-centered comprehensive interdisciplinary approach and **optimal psycho-social care should be implemented in routine cancer care, rehabilitation, post-treatment and follow-up** for all cancer patients* (point 5);
- *Stresses the healthcare and psychosocial needs of children and their families* (point 8)
- *Emphasizes that cancer treatment and care is multidisciplinary, involving the cooperation of oncological surgery, (…) as well as psycho-social support and rehabilitation and when cancer is not treatable, palliative care.* (point 11)
- *Take into account **the psycho-social needs of patients and improve quality of life** for cancer patients should be taken into account through support, rehabilitation and palliative care* (point 19)

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Document signed up by the 27 EU Member States, June 10, 2008
www.eu2008.si/en/News_and_Documents/Council_Conclusions/June/0609_EPSCO-cancer.pdf

WP7

HEALTHCARE

Psychosocial Oncology Action

- To implement a training strategy to improve **psychosocial care** and **communication skills** among health care providers in Europe

Hosted by the **Institut Catalan of Oncology**
with the collaboration of **IPOS** as main partner

Key areas:

- Mapping the psychosocial needs and resources in EU countries
- Develop an educational training program to be replicated
- Pilot the training program in one underserved country

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IPOS New International Standard of Quality Cancer Care:

- **Quality cancer care** today **must integrate** the **psychosocial domain into routine cancer care**
- **Distress should be measured as the 6th vital sign** after temperature, blood pressure, pulse, respiratory rate and pain

Endorsed by UICC
IPOS, August 2010

- **Psycho-oncology is considered today an important part of quality cancer care**
- **Evidence-based interventions reduce distress and psychological symptoms or morbidity associated with cancer and its treatment, enhances compliance with treatment and quality of life, contributing to improve patients' clinical outcomes**
- **Psychosocial care is recommend to integrate routine cancer care**

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Collaborating and working together is critical to put EU recommendations and clinical guidelines into nat'l policies and practice, to improve patients' outcomes

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Add Quality to Life Project

- ***Communication and Interpersonal Skills in Cancer Care*** by Walter Baile, MD (USA)
- ***Anxiety and Adjustment Disorders in Cancer Patients*** *b*y Katalin Muszbek, MD (Hungary)
- ***Distress Management in Cancer Patients*** by Jimmie C. Holland, M.D, USA
- ***Depression and Depressive Disorders in Cancer Patients*** *b*y Luigi Grassi, MD (Italy) and Yosuke Uchitomi, MD, P.D (Japan)
- ***Psychosocial Assessment in Cancer Patients*** by Uwe Koch, MD, PhD & Anja Mehnert, PhD (Germany)
- ***Cancer: A Family Affair*** by Lea Baider PhD (Israel)
- ***Loss, Grief and Bereavement*** by David Kissane MD (Australia)
- ***Palliative Care for the Psycho-Oncologist*** by William Breitbart MD USA)
- ***Ethical Implications of Psycho-Oncology*** by Antonella Surbone MD, PhD, FAC (Italy)

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CS it Learning to care