

Development of an adaptable evidence-based clinical pathway for the screening, assessment and management of anxiety and depression in adult cancer patients: a practical Australian innovation

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- **Prevalence of distress in cancer patients is HIGH**
- Recent definitive study in Germany of in- and out-patients
- Stratified proportional sampling → appropriate representation of all tumour types
- 4020 patients (68% response rate)
- Patients scoring above 9 on PHQ interviewed with CIDI-O

4-week prevalence of clinical cases

Disorder	Prevalence (%)	95% CI (%)
Clinical diagnosis	32%	29 - 34
Anxiety	12%	10 - 13
Depression	7%	6 - 8
Adjustment disorder	11%	10 -12

We know interventions are effective

- › Recent meta-analysis: 198 studies - 22,238 patients
- › Significant **small-to-medium** effects for individual and group psychotherapy and psycho-education
 - Larger effects if **high distress** patients recruited
- › Effects **sustained**, in part, in the medium (< 6 months) and long term (> 6 months)

Faller H et al. *JCO* 2013; 31(6):782-93

Screening and management

- Screening patients with cancer for distress is widely recommended internationally
- Early detection and treatment:
 - ✓ Reduces patient suffering and the likelihood of developing a major mood disorder
 - ✓ Improves quality of life
 - ✓ Reduces health service utilisation
- Howell et al (2010), Canadian Association of Psychosocial Oncology: Toronto,
- NCCN, Clinical Practice Guidelines in Oncology. Distress Management Version 2.
- Andersen (2014) Screening, Assessment, and Care of Anxiety and Depressive Symptoms in Adults With Cancer: ASCO Guideline Adaptation.
- Howell et al (2011) *Current Oncology*,

Screening not the complete answer

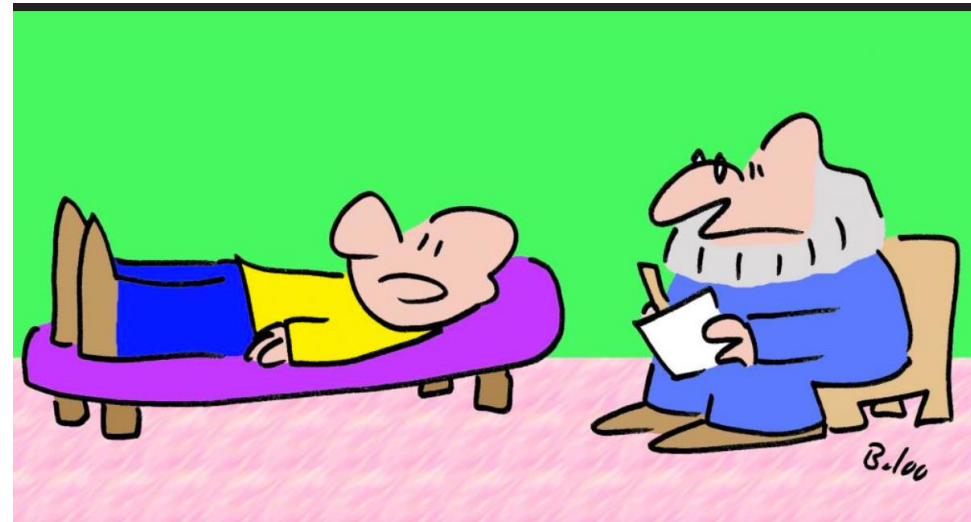
- › Synthesis of data from 40 years of screening in the *primary care setting* shows that:
 - › **Screening alone does not improve patient outcomes**

- › Mitchell A et al, 2011

Screening not the complete answer

- › US and UK data show many oncology health professionals
 - Do not value screening data
 - Do not respond to it

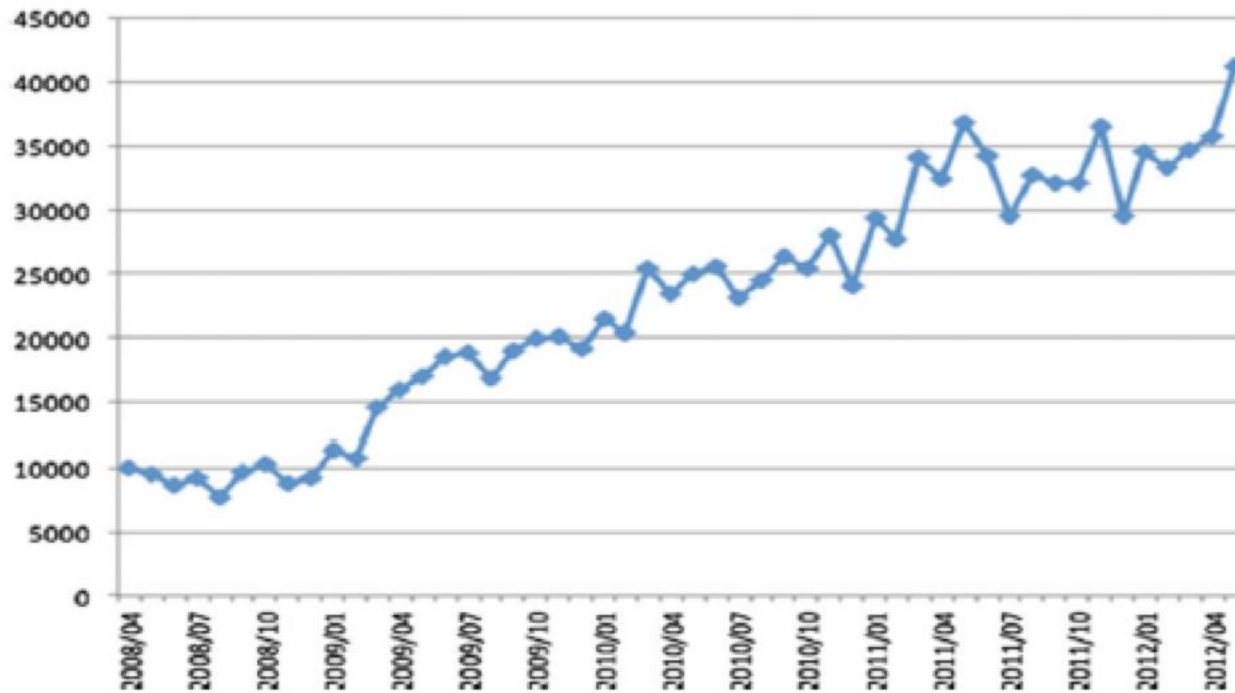
- › Patient referral remains adhoc



"The bartender referred me to a shoe shine boy, and the shoe shine boy referred me to you."

Screening not the complete answer

Distress screening rates in Canada, 2008-2012



Despite this, psychosocial outcomes not improved

Howell D et al, Pall and Supp Care 2014



What happens in practice?



MIND THE GAP

Actual practice...

- Screening not routinely and systematically conducted
- Emotional symptoms commonly undetected, severity under-estimated
- Reasons for not screening?
 - ✓ Lack of confidence, insufficient training
 - ✓ Time pressures
 - ✓ Lack of psychosocial staff and referral guidance - what to do if someone is identified through screening?

Mitchell et al., Psych-oncology , 2008; Absolom et al., Psycho-oncology 2011

So what next?

- › After screening, there needs to be a clear clinical pathway
- › Services need adequate resources and staff to provide the care required
- › We need to understand and address the barriers and facilitators to implementing the pathway

Clinical Pathway for Anxiety and Depression

- PoCoG* developed an **evidence-based clinical pathway** for identifying and managing anxiety and depression in cancer patients
 - ✓ Development guided by:
 - ✓ existing empirical evidence
 - ✓ wide stakeholder consultation
 - ✓ in-depth clinician interviews
 - ✓ a delphi process with 87 multidisciplinary stakeholders

* Psycho-oncology Co-operative Research Group, one of 13 cancer clinical trials groups in Australia

Stakeholder Consultation

- › Process of stakeholder involvement designed to ensure **engagement**
- › Gaining multi-disciplinary perspectives designed to ensure the pathway is **acceptable** to all groups
- › Pathway designed to provide clear and detailed guidance

- Aim: Multidisciplinary consensus on key components of the clinical pathway
- Method: Conducted **a two round** on-line Delphi study
- Participants: 87 Clinician from a range of disciplines
 - medical & radiation oncologists, nurses, psychologists, social workers, palliative care physicians, psychiatrists, GPs and cancer surgeons
- ✓ National sample representing a range of settings including:
 - Rural / regional / metropolitan
 - Public / private
 - Tertiary referral centres, regional hospitals
 - Outpatient/community services

Results confirmed

- ✓ Overall support for the clinical pathway
- ✓ Support for routine formal screening
- ✓ Support for the stepped-care model of treatment

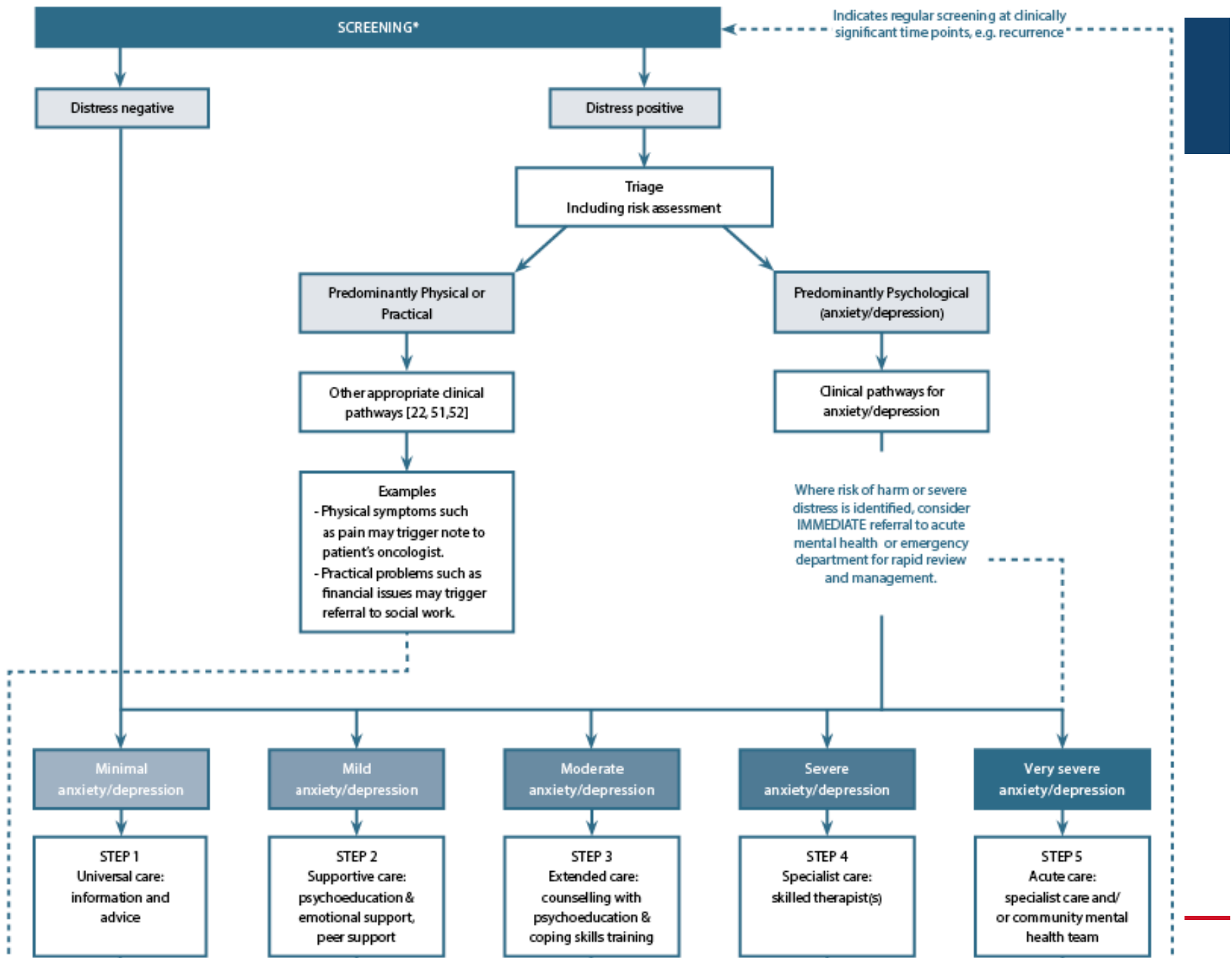
Results highlighted

- ✓ Need for flexibility in pathway implementation
- ✓ Lack of consensus on specific screening methods and roles for management and co-ordination of care

Pathway to fill the gap

- › Development of a clinical pathway to standardise psychosocial care:
 - ✓ outlines the best practice steps for the identification and management of anxiety and depression
 - ✓ Incorporates screening, assessment, referral and management recommendations
 - ✓ Provides recommendations of timing for follow up

- ✓ Recommends utilising a stepped care model
 - Least intensive intervention likely to be effective
 - More intensive interventions reserved for patients who require specialist mental health treatment



CANCER RELATED ANXIETY AND DEPRESSION ONLY*

INITIAL INTERVENTION

Intervention recommended:

- Face-to-face or online coping skills training (e.g. Problem solving approaches, Relaxation skills, Stress management, Communication skills)
- Face-to-face or online psychological therapy (e.g., Cognitive behavioural therapy, Interpersonal therapy, Supportive-expressive therapy)
- Mindfulness
- Pharmacotherapy

Professionals recommended to deliver treatment:

- General practitioner
- Social worker
- Psychologist
- Psychiatrist
- Other appropriately trained staff (e.g. cancer nurse, social worker, other appropriately trained allied health) or evidence-based internet intervention

PROGRESS REVIEW

Referral review: Approx 1-2 weeks to check referral uptake and fit

Progress review after: Approx. 10-12 weeks or as required

If not remitted, explore contributing factors.

Professionals recommended to complete review:

- General practitioner
- Social worker
- Psychologist
- Psychiatrist
- Other appropriately trained staff (e.g. cancer nurse, social worker, other appropriately trained allied health)

DECISION MAKING FOLLOWING REVIEW

If improved but not remitted
More of initial treatment OR another treatment within step, Inform:
- General practitioner

If remitted
Inform:
- General practitioner
- Cancer care nurse/coordinator

If NOT Improved
Another treatment within step, OR step up, Inform:
- General practitioner

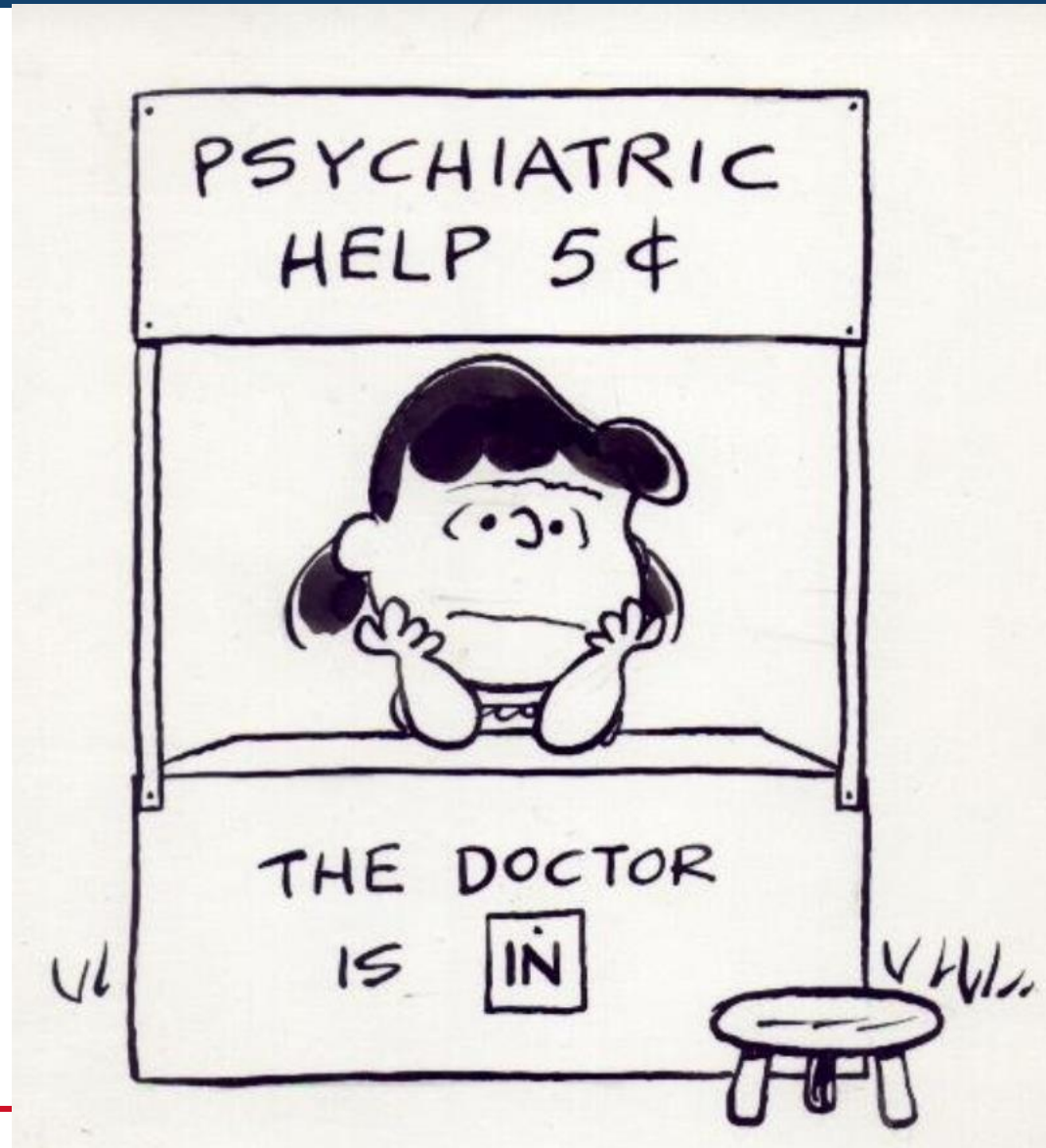
STEP 4

The Pathway

- › The pathway has really clear definitions of anxiety and depression
- › It explicitly articulates the definition of anxiety and depression and provides for managing suicide risk
- › It is designed to be implemented in all settings irrespective of who is present in the existing cancer care team → aim is to get services to identify the supports for the clients



Patient reluctance



Culture of health services

“there needs to be explicit support from the institution that spending time on these issues is time well spent. That it’s valued and supported, people are given time to do it, and that it is a priority...so that everybody’s engaged in this being an important service initiative...”

- Facilitate the integration of the clinical pathway for anxiety and depression in cancer patients into routine care
 - Develop and evaluate implementation strategies to promote uptake of pathways in the Australian health context.
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Rankin et al. *BMC Health Services Research*
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RESEARCH ARTICLE

Open Access

Everybody wants it done but nobody wants to do it: an exploration of the barrier and enablers of critical components towards creating a clinical pathway for anxiety and depression in cancer

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Clinical pathway for the screening, assessment and management of anxiety and depression in adult cancer patients: Australian guidelines

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