

**Psycho-oncology Co-operative
Research Group**

CLINICAL PATHWAY

**for the Screening,
Assessment and Management
of Anxiety and Depression in
Adult Cancer Patients**



PoCoG

Psycho-oncology Co-operative Research Group

The Australian Clinical Pathway for the Screening, Assessment and Management of Anxiety and Depression in Adult Cancer Patients was developed by Phyllis N. Butow, Melanie A. Price, Joanne M. Shaw, Jane Turner, Josephine M. Clayton, Peter Grimison and Nicole Rankin on behalf of the Psycho-oncology Co-operative Research Group (PoCoG).

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OVERVIEW

This Clinical Pathway provides evidence-based recommendations to guide best practice and consistent care in the management of anxiety and depression in people diagnosed with cancer.

Target patient population:

Adult cancer patients (18 years or over) at any phase of the cancer continuum and regardless of cancer type, stage or treatment modality. This Clinical Pathway focuses only on cancer-related anxiety and depression.

Target audience:

All health professionals providing care to patients with cancer including: treating clinicians (surgeons, medical oncologists, radiation oncologists, haematologists, palliative care physicians, other medical specialists), nurses (cancer care coordinators, nurse specialists, clinical nurse specialists and educators, general cancer nurses, palliative care nurses), psychologists, social workers, psychiatrists and general practitioners.

Overall recommendations:

Formalised routine screening for anxiety and depression in patients with cancer should be carried out using validated measures at key points in the patient's journey. The Edmonton Symptom Assessment System (ESAS-r) or Distress Thermometer (DT) with problem checklist are recommended as brief screening tools. If possible anxiety or depression is identified, completion of a more detailed screening tool, such as the Hospital Anxiety and Depression Scale (HADS), is recommended.

When anxiety or depression is identified it is recommended one person in a treating team takes responsibility for ensuring that appropriate assessment, referral and follow-up are undertaken (they do not necessarily carry these out themselves).

INTRODUCTION

Cancer is known to generate existential turmoil and to impact on patients' psychological and social as well as physical functioning.

High levels of psychosocial morbidity have been found in patients across demographic backgrounds and cancer types and stages.^[1-2] For example, a large (n=10,153) Canadian study found that just under a quarter of all cancer patients had clinical or subclinical levels of anxiety while clinical or subclinical levels of depression were present in up to 16.5% of the sample.^[2] However, rates can be much higher in particular subgroups, demonstrated in the Canadian study which found that more than half of patients who were female and/or aged below 50 presented with clinical or subclinical anxiety.^[2]

Of greater concern than the relatively high prevalence of distress in cancer patients is that anxiety and depression often go undetected in this population. Newell et al.^[3] compared cancer patients' (n=204) reports of psychosocial problems (including anxiety and depression measured using the Hospital Anxiety and Depression Scale [HADS]) with their oncologist's perception of same. They found that only 17% of patients with HADS-defined anxiety and 6% of those with HADS-defined depression were perceived as anxious or depressed by their oncologist. Suboptimal recognition of clinically-relevant distress in cancer patients has been observed in a range of settings.^[4-5]

Unlike other common symptoms (e.g. fatigue), anxiety and depression are readily treatable, and a strong evidence-base for interventions exists.^[6-7] Early identification and treatment of anxiety and depression typically leads to better outcomes in terms of treatment adherence, doctor-patient communication and frequency of clinic calls and visits.^[8] Despite this, few cancer services routinely screen patients for anxiety and/or depression and patterns of referral, treatment, and follow-up are highly variable across services.^[9]

Clinical pathways provide evidence-based recommendations to guide best practice and consistent care for specific patient concerns in homogeneous patient groups.^[10] Research has shown that the implementation of clinical pathways for depression in patients with heart disease significantly increased detection of psychological morbidity and rates of referral for treatment.^[11] The provision of a clear clinical pathway in the cancer setting, in combination with staff training and effective intervention, will improve patient outcomes.^[11-12]

Until now, there have been no standardised Australian clinical referral pathways for anxiety and depression in cancer.^[13] This document presents a clinical pathway for the identification and management of anxiety and depression and incorporates referral and management recommendations according to the nature and severity of symptoms, tailored to the Australian context.^[13-15]

The recommendations made in this Clinical Pathway are intended as a guide only, and individual centres will need to adapt them to suit their own context and resources.

This Clinical Pathway was developed based on a thorough review of the evidence, and refined through comprehensive stakeholder review, as part of a consensus process using Delphi methods.^[16]

GUIDELINES

A number of existing national and international guidelines for the assessment and management of anxiety and depression were used in the development of the Clinical Pathway for the Screening, Assessment and Management of Anxiety and Depression in Adult Cancer Patients, including:

- **Consensus Statement on Depression, Anxiety and Oncology (2001).** The International Consensus Group on Depression and Anxiety^[16]
- **A Pan-Canadian Practice Guideline: Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety) in Adults with Cancer (2010).** Canadian Partnership Against Cancer (Cancer Journey Action Group) and the Canadian Association of Psychosocial Oncology^[17]
- **NCCN Clinical Practice Guidelines In Oncology (NCCN Guidelines®) for Distress Management V.2.2013:** National Comprehensive Cancer Network® (NCCN®)^[18]
- **Treatment of Depression in Cancer Patients (2007).** Supportive Care Guidelines Group of Cancer Care Ontario Program in Evidence-based Care^[19]
- **National Collaborating Centre for Mental Health. Depression in adults with a chronic physical health problem. Treatment and management (2009).** National Institute for Health and Clinical Excellence (NICE)^[20]
- **Australian and New Zealand Clinical Practice Guidelines for the Treatment of Depression (2004):** Royal Australian and New Zealand College of Psychiatrists Clinical Practice Guidelines Team for Depression^[21]

- *beyondblue Guide to the Management of Depression in Primary Care: A guide for health professionals (2013)*: beyondblue: The National Depression Initiative^[22]
- *Putting Evidence into Practice: Evidence-based Interventions for Anxiety (2008)*: The Oncology Nursing Society^[23]
- *Putting Evidence into Practice: Interventions for Depression (2008)*: The Oncology Nursing Society^[24]
- *American College of Physicians (ACP) Clinical Practice Guidelines; Evidence-Based Interventions to Improve the Palliative Care of Pain, Dyspnea and Depression at the End of Life (2008)*: American College of Physicians^[25]

Key recommendations from existing guidelines were used in the development of the Clinical Pathway for Anxiety and Depression in Adult Cancer Patients.

SCREENING

Overall, there is a consensus among existing guidelines that all patients should be routinely screened for emotional difficulties. This is based on evidence of **a)** a high prevalence of emotional difficulties among patients, **b)** low levels of reporting of these concerns by patients to their healthcare providers, and **c)** a low detection rate from health professionals.^[26]

All guidelines suggest that screening should be a continual process (some suggest particular critical time points) and should be continued in palliative care.^[18] Guidelines suggest the use of standardised screening tools. Specifically, screening tools should identify the level and nature of concerns using a valid and reliable measure for which there are established, clinically-meaningful cut-offs.^[17]

ASSESSMENT

All guidelines agree that if possible anxiety and/or depression is identified through screening, a more comprehensive assessment should be carried out to determine the severity of symptoms, contributing stressors, risk factors and vulnerabilities.^[16] A formal psychological assessment conducted by a specialist mental health professional can be preceded by a conversation between the patient and a cancer care team member (e.g. nurse) after screening has been completed to clarify patient feelings, identify symptoms suggestive of anxiety and/or depression and to make a referral recommendation for formal assessment. Consideration of cultural differences in symptom presentation is important when discussing the need for referral.^[21] If these initial discussions reveal the presence of anxiety and/or depression, or the outcome is unclear, guidelines recommend referral to an appropriate health professional for formal psychological assessment to confirm diagnosis.^[18-19, 21] Timely identification of risk of harm to self or others and appropriate referral is crucial.

TREATMENT

Treatment decisions will take into account the patient's psychosocial and cultural background, as well as their specific diagnosis.^[16, 18-19] There was agreement amongst the guidelines that psychosocial/ psychological intervention combined with supportive care is an effective management approach for anxiety and depression, with antidepressants suggested for moderate to severe depression and, potentially, in cases of significant anxiety. Recommendations for specific psychological and pharmacological therapies varied, although most agreed that the evidence supported the use of therapist-delivered cognitive behavioural therapy (CBT), psychoeducation and selective serotonin reuptake inhibitors (SSRIs).^[16, 19, 21-25] A combination of psychological and pharmacological therapies was suggested to confer the greatest benefit.^[17, 19, 21-23, 25]

SUMMARY

The development of an effective clinical pathway based on these guidelines requires that they be expanded to include specific timelines and roles for health professionals, as well as evidence-based targeted and tailored implementation strategies to embed into routine care. The recommendations made in this Clinical Pathway are intended as a guide only, and individual services will need to adapt them to suit their own context and resources.^[26]

1

PROFESSIONAL ROLES



PROFESSIONAL ROLES

Oncology services will vary widely in the number and profile of staff and other resources available for addressing psychological distress in cancer patients.

The Clinical Pathway presented in this document gives recommendations for the different health professionals responsible for delivering interventions, for review, and follow up. A number of different health professionals are recommended to accommodate the availability of staff at different services, however these are not exhaustive. For example, mental health professionals such as psychiatrists and psychologists are recommended to deliver treatment for severe anxiety and depression;^[16-17, 23] however a service that does not have access to these professionals may employ a specialist social worker or general practitioner to provide care at this level.^[17-18] Suggestions of roles which could be undertaken by each professional group are listed in Table 1.

The appropriateness of referral and treatment will depend on what is elicited in the initial assessment, so doing this well is crucial. The suitability of staff responsible at each point will also depend on individual expertise. Health professionals carrying out screening and/or making a referral for formal psychological assessment need to have the skills and confidence to comfortably discuss anxiety and depression with patients, and to facilitate referral. They also need to be able to respond with empathy to immediate feelings and concerns. For many patients it could be the first time they have spoken about anxiety and/or depression, and so screening and referral needs to be done in a thoughtful and sensitive way.

Individual skills and training within each team will determine who is best placed to undertake specific roles. No professional should take on any role for which they have not received training or which they do not feel competent to undertake.

The Clinical Pathway recommends a high level of involvement for GPs. While such a high level of involvement is typically the case for GPs based in rural and remote areas, this is out of necessity, and urban GPs often have limited involvement in care while patients are undergoing active cancer treatment.^[27]

TABLE 1: PROFESSIONAL ROLES

	General practitioner	Treating clinician*	Nurse**	Social worker	Clinical psychologist	Psychiatrist
Screening and assessment		•	•	•		
Comprehensive and focused assessments (including formal diagnosis)					•	•
Supportive care for physical symptoms (e.g. pain, fatigue)	•	•	•			
Psycho-education	•	•	•	•	•	
Supportive counselling	•	•	•	•	•	•
Referral to psycho-oncology service	•	•	•	•		
Relaxation strategies			•	•		
Support group facilitation			•	•	•	
Skills training e.g. problem-solving, relaxation skills, stress management, communication skills				•	•	•
Psychological therapy e.g. cognitive behavioural therapy, interpersonal therapy, supportive-expressive therapy				•	•	•

	General practitioner	Treating clinician*	Nurse**	Social worker	Clinical psychologist	Psychiatrist
Training for other health professionals in the recognition and management of anxiety/depression					•	•
Referral to psychiatrist	•	•			•	
Pharmacotherapy	•	•				•
Follow up and monitoring of progress (care coordination) Step 1	•	•	•	•		
Follow up and monitoring of progress (care coordination) Step 2	•	•	•	•		
Follow up and monitoring of progress (care coordination) Step 3	•	•		•	•	
Follow up and monitoring of progress (care coordination) Step 4					•	•
Follow up and monitoring of progress (care coordination) Step 5					•	•

* surgeon, medical oncologist, radiation oncologist, haematologist, palliative care physician

** cancer care coordinator, nurse specialist, clinical nurse specialist, clinical nurse consultant, general cancer nurses, palliative care nurse

2

SCREENING AND ASSESSMENT



SCREENING AND ASSESSMENT

4.1 Screening

Screening is a rapid method of identifying patients with anxiety and/or depression and typically achieved by brief self-report questionnaires with the goal of determining which patients need referral for formal psychological assessment.

The National Cancer Institute^[28] has identified the times when screening is most appropriate as:

- Soon after diagnosis
- At start of treatment
- At end of lengthy treatment
- Regularly after active treatment has ceased and during remission
- At time of recurrence
- With transition to palliative care.

Responsibility for screening will vary depending on the resources available to the institution and the expertise of available staff. Deciding on the best placed health professional to take responsibility for routine screening will depend on the resources available and patient characteristics. For example, for newly diagnosed patients entering an oncology service, the best placed health professionals may be the cancer care coordinator or other nursing staff, whereas in follow-up care during survivorship, the best placed health professional may be the patient's GP.^[29]

Importantly, staff working with cancer patients should be given training and support on identifying and discussing anxiety and depression with patients, as well as being familiar with the different psychosocial services available at their institution.^[18] By doing so, every meeting with a patient would be an opportunity to **informally** screen for anxiety and/or depression outside of the periods listed above.

Questions about how a patient is coping or feeling would ideally be a comfortable part of every clinician's conversation with a patient.

Health professionals carrying out screening and/or having a conversation about the screening result and possible referral recommendation for formal psychological assessment need to have the skills and confidence to comfortably discuss psychological distress (anxiety and depression) with patients, understand potential pathways and services available for additional care, and to address any particular concerns or preferences an individual might have about accessing psychosocial support and/or seeing a mental health professional. For many patients it could be the first time they have spoken about anxiety and/or depression, and so these discussions need to be done in a thoughtful and sensitive way. The appropriateness of treatment and/or referral will depend very much on what is solicited in the initial referral conversation, so doing this well is crucial.^[18]

Several organisations have recommended formalised routine screening for anxiety and depression in patients with cancer, although a gold standard tool for use with this population has not yet been established.^[30] A number of screening instruments are available. Table 2 lists some commonly used self-report screening instruments. This pathway recommends that formalised routine screening for anxiety and depression in patients with cancer be carried out using validated measures at key points in the patient's journey. No screening tool is foolproof; all should be supplemented by a conversation with a clinical staff member to clarify patient feelings suggestive of anxiety and/or depression and where appropriate referral to a specialist psychosocial health professional for formal psychological assessment.

TABLE 2: SELF-REPORT SCREENING INSTRUMENTS COMMONLY USED FOR IDENTIFICATION OF ANXIETY AND DEPRESSION IN CANCER PATIENTS

Title	Items (no.)	Time (min)	Constructs measured
Edmonton Symptom Assessment System (ESAS)-r ^[31]	10	2-3	Nine symptoms common in cancer patients: anxiety, depression, pain, tiredness, nausea, drowsiness, appetite, wellbeing and shortness of breath and a general 'other symptom' category
Distress Thermometer (DT) and Problem List ^[32]	Varies	2-5	Distress and problems related to distress
Hospital Anxiety and Depression Scale (HADS) ^[33]	14	3-5	Symptoms of clinical anxiety and depression
Depression, Anxiety and Stress Scale (DASS) ^[34]	21	5-10	Anxiety, depression and general stress
Brief Symptom Inventory (BSI-18) ^[35]	18	5-10	Somatisation, depression, anxiety, general distress
Profile of Mood States (POMS) ^[36]	65	10-15	6 mood states: anxiety, fatigue, confusion, depression, anger, vigour

We recommend either the Edmonton Symptom Assessment System (ESAS-r) or Distress Thermometer (DT), with a Problem List, as a brief screening tool.

Copies of the ESAS-r and DT are provided in Appendix 1.

If a brief screening tool is used, it must be scored and discussed with each patient.

If potential anxiety and/or depression is identified, we recommend patients complete a more detailed screening tool, such as the Hospital Anxiety and Depression Scale (HADS).

We recommend one person takes responsibility for ensuring appropriate assessment, referral and follow-up are undertaken (but does not necessarily carry these out themselves).

The Edmonton Symptom Assessment System (ESAS)^[37] is increasingly being used in the oncology setting as a tool for rapid assessment of multiple mood and physical symptoms. The ESAS-r^[31] consists of consists of ten visual analogue items (0-10), including one for anxiety (ESAS-A) and one for depression (ESAS-D).

The ESAS was originally developed to assess symptom distress in palliative care patients^[37] and has also been validated for use as a distress screening tool in non-palliative cancer patients.^[31] Recommended cut-offs for the ESAS-A of ≥ 3 and ESAS-D of ≥ 2 ensure no possible case of anxiety or depression is missed.^[38] One advantage of the ESAS-r is that it also assesses common symptoms (such as pain and fatigue) that may need to be addressed before or alongside anxiety and depression. The Canadian Problem Checklist is often used with the ESAS-r to identify specific areas of concern for patients.^[39]

Scores on the ESAS-A and ESAS-D items are moderately correlated with scores on the DT.^[40]

In addition, a number of studies have investigated the screening performance of the ESAS in cancer survivors against established measures such as the HADS and the anxiety and depression subscales of the Patient Health Questionnaire.^[38, 41] In line with the recommendations of Bagha et al.^[38] the Clinical Pathway for the Screening, Assessment and Management of Anxiety and Depression in Adult Cancer Patients recommends cut-offs of ≥ 3 for the ESAS-A and ≥ 2 for the ESAS-D to identify potential cases with few false negatives.

The Distress Thermometer (DT)^[42] is a one-item visual analogue scale that asks patients to rate their distress on a scale of zero to ten (0-10). This scale is recommended due to its brevity, ease of administration and, importantly, because it does not cause additional distress to, and is accepted by, patients who are asked to complete it.^[43] The National Comprehensive Cancer Network® (NCCN®) recommends accompanying the DT with a Problem List to identify specific areas of concern for patients.^[18]

An advantage of using the DT in conjunction with a Problem List is that it identifies the level of distress as well as the areas of concern to target. This information can then be used to ensure that appropriate referrals are made. For example, the NCCN suggests that "patients with practical and psychosocial problems should be referred to social workers; those with emotional or psychological problems should

be referred to mental health professionals including social workers; spiritual concerns should be referred to certified chaplains".^[18]

A large, recent meta-analytic review looked at 42 studies conducted within a 10-year period, across 20 different countries and a range of tumour types, compared scores on the DT to clinical cut-offs on longer, validated measures of anxiety and depression to determine the most appropriate DT cut-off for identifying distressed patients.^[44] From the pooled results of the 42 studies, a cut-off score of 4 on the DT was found to provide the best balance between sensitivity (0.81, 95 % CI 0.79–0.82) and specificity (0.72, 95 % CI 0.71–0.72).^[44]

The Hospital Anxiety and Depression Scale (HADS):^[33] is a 14-item measure with two subscales – 7 items (individual item scores 0-3, subscale score range 0-21) measure anxiety and 7 items (individual item scores 0-3, subscale score range 0-21) measure depression. A cut-off of 8 or more on either of the subscales is recommended to ensure no possible case of anxiety or depression is missed.^[45] A score of 11 or more suggests moderate to severe anxiety or depression.^[45] A formal psychological assessment by a specialist psychosocial health professional is recommended to confirm caseness of anxiety or depression.

The HADS is regarded as ideal for use within cancer settings "because it excludes questions about physical symptoms, which may be confused with symptoms caused by depression or anxiety disorders".^[16] The HADS has been used to measure distress, anxiety and depression in patients with a variety of cancer types and at various stages of the cancer trajectory.^[46-47] A systematic review of 33 screening instruments considered the HADS one of the two best short (5-20 items) screening measures for this population in terms of its psychometric properties.^[47] Findings from a large meta-analysis also supported use of the HADS as an appropriate distress screening measure for oncology, particularly non-palliative, settings, although the authors cautioned against reliance on the HADS as a case-finding tool.^[46] In line with this, the Clinical Pathway for the Screening, Assessment and Management of Anxiety and Depression in Adult Cancer Patients recommends using formal psychological assessment to more accurately determine the nature and severity of anxiety and/or depressive symptoms identified by these brief screening tools.

If self-report screening measures are used, they must be scored, evaluated, and discussed with each patient.

These screening questions can be completed by paper and pencil, or using multimedia technologies, (e.g. a tablet or touchpad, computer, smartphone linked to online software or in-house database), if using multimedia technologies, automatic scoring systems can be used to trigger HADS completion and provide red flags to staff with allocated responsibility.

Every health service with which a patient comes into contact (including general practice and surgery) will need to identify who are the most appropriately trained and supported staff members to: a) coordinate screening, referral and formal psychological assessment, and b) carry out these processes. In some centres a different staff member may be identified within each tumour stream or treatment modality to coordinate this process.

The method of screening and screening measures used by a particular service will depend on its suitability and acceptability to staff and patients.

SCREENING VS. ASSESSMENT

Several studies, including a recent meta-analysis by Mitchell et al.^[30] suggest that a two-step approach to screening is the best method for assisting clinicians in the identification of patients to be referred for formal psychological assessment and, potentially, management of depressive symptoms. This involves completion of two stem questions (delivered by the clinician or in a self-report format) followed-up by formal psychological assessment where necessary. The two-step algorithm would incorporate both screening (ruling out non-cases) and case-finding (ruling in probable cases). If patients score above clinical cut-offs on the brief screening instrument it is recommended that a more detailed screening instrument such as the Hospital Anxiety and Depression Scale (HADS) is also completed, prior to completion of a formal diagnostic assessment via clinical interview.

2.2 Assessment

Determining severity of anxiety and depression:

At any clinical encounter, staff should be alert to signs of anxiety and depression. If screening identifies possible anxiety and/or depression a conversation should be conducted by a member of the cancer care team, (e.g. nurse) with the patient to clarify whether the symptoms are suggestive of anxiety and/or depression and require referral for formal psychological assessment. Formal psychological assessment conducted by specialist psychosocial health professionals is typically a semi-structured interview that can be based on standardised diagnostic criteria (Diagnostic and Statistical Manual of Mental Disorders-Fifth edition (DSM-5)^[48] or International Classification of Diseases-version 10 (ICD-10)^[49]) and should aim to identify:

- 1) the nature of the primary problem and its possible causes
- 2) the severity of relevant symptoms

Causes/nature of anxiety and depression:

Determinants of anxiety and depression are multi-factorial and therefore must be considered in the context of the patient's situation. Formal psychological assessment should include consideration of the following:

- Physical symptoms: such as unrelieved pain, fatigue, lymphoedema
- Medical-induced factors: such as treatment-related side effects
- Substance-induced factors: such as drug and alcohol abuse
- History of mental health issues: such as prior depression or anxiety
- Suicide risk factors
- Resources and strengths: support networks, positive/protective factors

Symptoms and severity

Signs and symptoms of anxiety and/or depression are listed in Table 3.^[49] Level of anxiety or depression will ultimately be decided based on clinical judgment.

TABLE 3: SIGNS AND SYMPTOMS OF ANXIETY AND DEPRESSION^[49]

Anxiety ^[49]	Depression ^[49]
<ul style="list-style-type: none">● Autonomic arousal (e.g. accelerated heart rate, sweating, trembling and dry mouth)● Symptoms of chest and abdomen (difficulty breathing, feeling of choking, chest pain and nausea)● Symptoms of brain and mind (feeling dizzy, unsteady, faint or light headed, feeling objects are unreal, depersonalization, fear of losing control or dying, difficulty concentrating, mind going blank and irritability)● General symptoms (hot flushes or cold chills and numbness or tingling)● Symptoms of tension (muscle tension or aches and pains, restlessness, inability to relax, difficulty swallowing and lump in throat)● Reduced self-esteem and self-confidence● Difficulty getting to sleep because of worrying	<ul style="list-style-type: none">● Lowered mood● Decreased energy and activity● Marked tiredness after activity● Diminished pleasure, interest and concentration● Loss of libido● Significant change in appetite and sleep patterns (loss of appetite and early wakening)● Feelings of worthlessness or excessive, inappropriate guilt● Recurrent thoughts of death or suicide

Suicide / self-harm risk assessment: For patients with moderate, severe or very severe anxiety and/or depression, a formal risk assessment for suicide and self-harm should be conducted to assess previous history, strength of intent, means and capacity.

Table 4 provides a guide to categorising different levels of anxiety and depression based on ICD-10.^[49] Level of anxiety and/or depression will ultimately be decided based on clinical judgment.

Responsibility for identifying anxiety and/or depression

It is recommended that the entire clinical team share the responsibility for the identification of symptoms suggestive of anxiety and/or depression, and that individuals who conduct screening and referral as a routine part of their role be designated as such.^[17] For example, in an oncology clinic where formal routine screening is done by self-report, the person who is responsible for having a conversation to discuss the results of the screening with the patient in the first instance to review and recommend referral for formal psychological assessment may be the cancer care coordinator.

TABLE 4: CATEGORISATION OF MINIMAL, MILD, MODERATE, SEVERE AND VERY SEVERE ANXIETY AND DEPRESSION

	Anxiety ^[49]	Depression ^[49]
Minimal	<ul style="list-style-type: none"> ● Minimal symptoms of anxiety, typical response to cancer illness, response in proportion to stressors, e.g. worry, uncertainty about the future, concerns about illness ● Effective coping skills, minimal effect on daily functioning ● Minimal/no risk factors ● Gradual resolution over weeks/months on its own or with simple intervention 	<ul style="list-style-type: none"> ● Minimal symptoms of depression, typical response to cancer illness, response in proportion to stressors, e.g. sadness about loss of good health ● Effective coping skills, minimal effect on daily functioning, access to social support ● Minimal/no risk factors ● Gradual resolution over weeks/months on its own or with simple intervention
Mild	<ul style="list-style-type: none"> ● Mild anxiety symptoms ● Coping skills, but noticeable effect on daily functioning, access to social support ● Minimal risk factors ● Gradual resolution over weeks/months with simple intervention 	<ul style="list-style-type: none"> ● Mild symptoms of depression ● Change in life events and/or support system ● Coping skills, but noticeable effect on daily functioning, access to social support ● Minimal risk factors ● Gradual resolution over weeks/months with simple intervention
Moderate	<ul style="list-style-type: none"> ● Moderate symptoms of anxiety (does not meet criteria for high risk but two or more symptoms present for two weeks) ● Maladaptive response (out of proportion to the stressors) ● Disruption of daily functioning ● Less able to control anxiety without intervention ● Risk factors present ● Nature of anxiety disorder established (e.g. generalised anxiety disorder (GAD), panic, post-traumatic stress disorder (PTSD), obsessive compulsive disorder (OCD), phobia) 	<ul style="list-style-type: none"> ● Moderate symptoms of depression (does not meet criteria for high risk but two or more symptoms present for two weeks) ● Disruption of daily functioning ● Risk factors present (e.g. gaps in social support or effective coping mechanisms)
Severe	<ul style="list-style-type: none"> ● Moderate to severe symptoms of anxiety (meets criteria for high risk) ● Maladaptive response (out of proportion to the stressors) ● Disruption of daily functioning ● Unable to control anxiety without intervention ● Risk factors present ● Nature of anxiety disorder established (e.g. GAD, panic, PTSD, OCD, phobia(s)) 	<ul style="list-style-type: none"> ● Moderate to severe symptoms of depression (meets criteria for high risk) ● Disruption of daily functioning ● Risk factors present (e.g. gaps in social support or effective coping mechanisms)
Very severe and complex cases	<ul style="list-style-type: none"> ● Severe symptoms of anxiety (high or elevated level of worry or difficult to control anxiety about several things most days) ● Re-experiencing events in a distressing way (e.g. dreams, intense recollections, flashbacks, physical reactions) ● One or more occasion of spells or attacks of sudden fear, discomfort, anxiousness or uneasiness ● Risk factors present 	<ul style="list-style-type: none"> ● Severe symptoms of depression (depressed mood and/or loss of pleasure for more than two weeks) ● Four additional symptoms (feelings of worthlessness and/or guilt, insomnia, hypersomnia, weight gain/loss) ● Psychomotor agitation or retardation, fatigue ● Risk factors present

3

REFERRAL



REFERRAL

Staff will be reluctant to screen patients for psychological distress if they are not sure what to do with the information they get.

Indeed, screening without availability of appropriate referral pathways and treatment resources is considered unethical.^[28] Implementation of this Clinical Pathway will require evaluation of the services and resources available within the particular service to address the range of issues that may arise as a result of screening and referral conversations. As routine screening commonly includes identification of broad supportive care needs, this involves identifying services available to address the following:

- Physical symptoms: such as pain and fatigue may require discussion with a cancer care nurse, a note to the patient's oncologist, or trigger referral to a physiotherapist, dietitian, or speech pathologist.
- Practical problems: such as financial or work related issues may trigger referral to social work.
- Spiritual issues: such as those related to death and meaning or purpose of life may trigger referral to pastoral care service.
- Psychological/emotional issues: such as those related to anxiety or depression may trigger referral according to the Clinical Pathway presented in this document.

All staff need to be provided with education and given access to information about available supportive care services. All staff also need to be educated about the nature of anxiety, depression and psychological distress more generally so that they are better able to tolerate and confidently address a degree of patient distress on their own.

The Clinical Pathway recommends different referral options and interventions. The specific details of each step, the healthcare professionals involved, and the types of treatment provided will vary according to the existing resources and structure of each service, as well as patient preference. Each service should identify its own referral network. The clinical networks that are currently in place in a service (whether formally or informally) are also important to consider. Building on the strengths of clinical networks currently in place will likely provide more effective care for that particular service and be more acceptable to staff.

PATIENT EDUCATION AND SHARED DECISION MAKING

There should be a culture of acceptance that the diagnosis of cancer and the treatment or care that follows has the potential to be distressing and patients should therefore be encouraged to view psychosocial care as an integral part of comprehensive cancer care. It is important to assure patients that while some feelings of psychological distress are natural reactions to a cancer diagnosis and treatment, some will benefit from referral for additional psychosocial care.

There is still a significant stigma associated with anxiety and depression which may contribute to patients' willingness to accept a referral or to start or continue treatment.^[50-51] There is a need for sensitive and thoughtful discussion with the patient about diagnosis and treatment options, with a view to developing an acceptable treatment plan. This will involve:

- 1) providing feedback on the outcome of screening,
- 2) providing information about anxiety and depression, different treatments, useful management strategies (such as lifestyle changes) and local services, and
- 3) discussing the recommendation for referral and deciding on a treatment plan.

Patient preference is important in determining the most appropriate treatment^[17] and therefore a number of treatment recommendations have been made within each step of the Clinical Pathway described below. Patients may also have preferences for the health professionals involved in providing care (e.g. they may prefer to receive treatment for depression from their general practitioner with whom they already have a comfortable long-term relationship).

The main treatments used in the steps are detailed in the following section.

Each of the five steps of the Clinical Pathway are summarised in Figures 1 to 6, which detail:

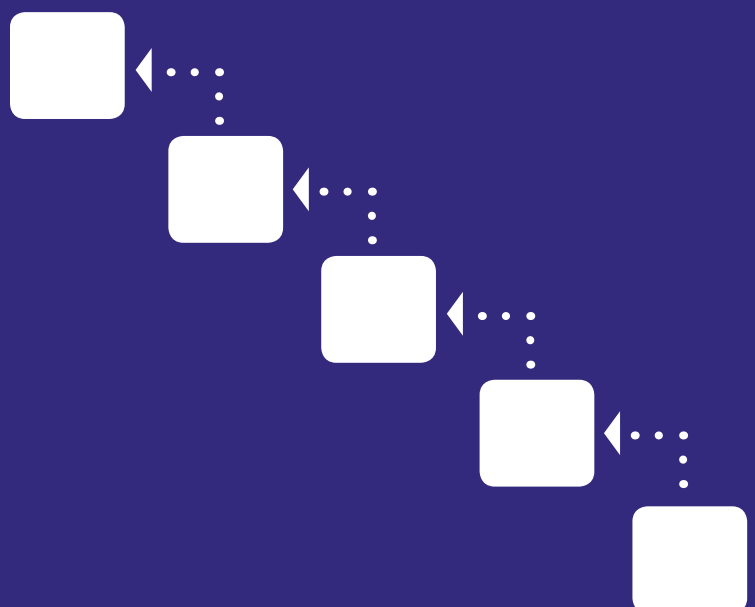
- 1) Initial treatment recommendations
- 2) Evidence-based recommendations for the treatment duration and training required to deliver this treatment
- 3) Recommendations for progress review and training required to conduct the review
- 4) Decision making following review and health professionals involved
- 5) Recommendations for timing of review in the maintenance and continuations phases (where appropriate)
- 6) Recommendations for timing of long-term review and training required to conduct the review.

The specific details of each step, the healthcare professionals involved, and the types of treatment provided will vary according to the existing resources and structure of each service, as well as patient preference. Each service should identify its own referral network. Recommendations for treatment length are a guide only and will ultimately be determined by clinical need, patient situation, and patient preference.

4

CLINICAL PATHWAY

FOR THE SCREENING, ASSESSMENT
AND MANAGEMENT OF ANXIETY AND
DEPRESSION IN ADULT CANCER PATIENTS
USING A STEPPED CARE MODEL



CLINICAL PATHWAY

FOR THE SCREENING, ASSESSMENT AND MANAGEMENT OF ANXIETY AND DEPRESSION IN ADULT CANCER PATIENTS USING A STEPPED CARE MODEL

4.1 Stepped Care

Stepped care has proven to be an effective model of healthcare delivery, particularly for chronic disorders.

In stepped care, the first intervention should be the least intensive of those currently available, which is still likely to be effective.^[52-53] More intensive interventions are reserved for patients who do not benefit from simpler first line treatments.^[52]

Stepped care is self-correcting in that the outcomes of interventions are monitored systematically and care is stepped up if current interventions are not achieving significant health gain.^[52-53] For example, psycho-education can be delivered via self-help materials with GP support accessed according to need. If this fails, a referral to a psychologist could be considered.

Patient preferences are critical in determining the most appropriate intervention, the intervention setting and the intervention provider.

Given the prevalence of anxiety and depression in the general community is quite high, patients may have an existing relationship with a mental health professional. Cancer diagnosis and treatment can often exacerbate pre-existing psychological issues. When referring for intervention, it is important to establish patient preferences for treatment through existing mental health care professionals or psycho-oncology services.

It is difficult to say with any certainty how many patients are likely to be initially categorised at each step since this can vary according to gender, cancer type, stage of disease, time since treatment, demographic variables and the measurement instrument used.^[1-2, 54-55] However, based on past research it could be expected that:

- 25-30% of patients will experience minimal depression and 40-45% minimal anxiety (Step 1)
- 42-45% of patients will experience mild depression and 35-37% mild anxiety (Step 2)
- 22-36% will experience moderate to severe depression (Steps 3-5), with up to 10% classed as severe depression (Steps 4-5); and around 20-30% will report moderate to severe anxiety (Steps 3-5), with 7-8% classed as severe (Steps 4-5)
- Suicidal thoughts have been identified in 6-11% of cancer patients^[56-58] although only around 10% of these individuals (i.e. 1% of all cancer patients) express actual suicidal intent (Step 5)^[57]

4.2 The Clinical Pathway Stepped Care model

Figure 1 provides an overview of the Clinical Pathway for the screening, assessment and management of anxiety and depression in adults with cancer, utilising the stepped care approach. The five steps of the Clinical Pathway are summarised in Figures 2-6. Each figure details:

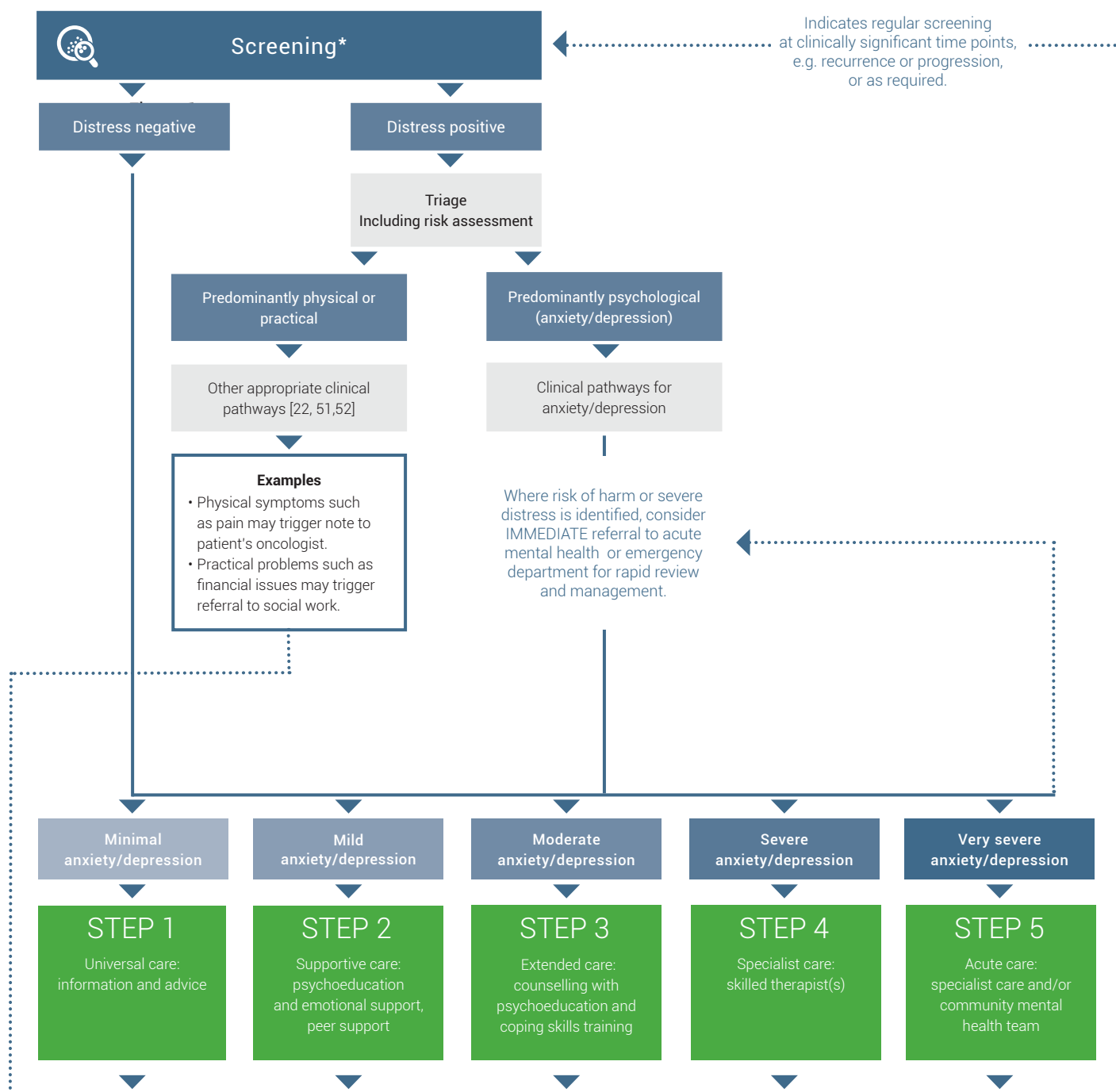
- 1) Recommended interventions and health professionals to deliver intervention
- 2) Recommended intervention duration, review period and health professionals involved
- 3) Decision-making following review and health professionals involved
- 4) Recommended timing of review in the maintenance and continuation phases (where appropriate)
- 5) Recommended timing of long-term review and health professionals involved

The exact nature of each step, the professionals involved and the interventions provided will depend on local resources and current service structure, as well as patient preference.

Each service should identify its own referral network.

Recommendations for treatment length are a guide only and will ultimately be determined by clinical need, patient situation, and patient preference.

Figure 1 – Overview of Stepped Care



* ESAS clinical cutoffs that trigger HADs assessment are ≥ 3 on the anxiety item and > 2 on the depression item.
Distress thermometer clinical cutoff that triggers HADs assessment is ≥ 4

Figure 2 – STEP 1: Universal Care – Minimal Anxiety and/or Depression



^ Treating clinician; surgeon, medical oncologist, radiation oncologist, haematologist, palliative care physician

RECOMMENDED INTERVENTIONS

STEP 1: Universal Care – Minimal Anxiety and/or Depression

Patient education: is the formal or informal provision of information with the aim of increasing a patient's knowledge and reducing their uncertainty. This includes information about cancer diagnosis and treatment, cancer service, staff and contacts, self-care and symptom management.^[59]

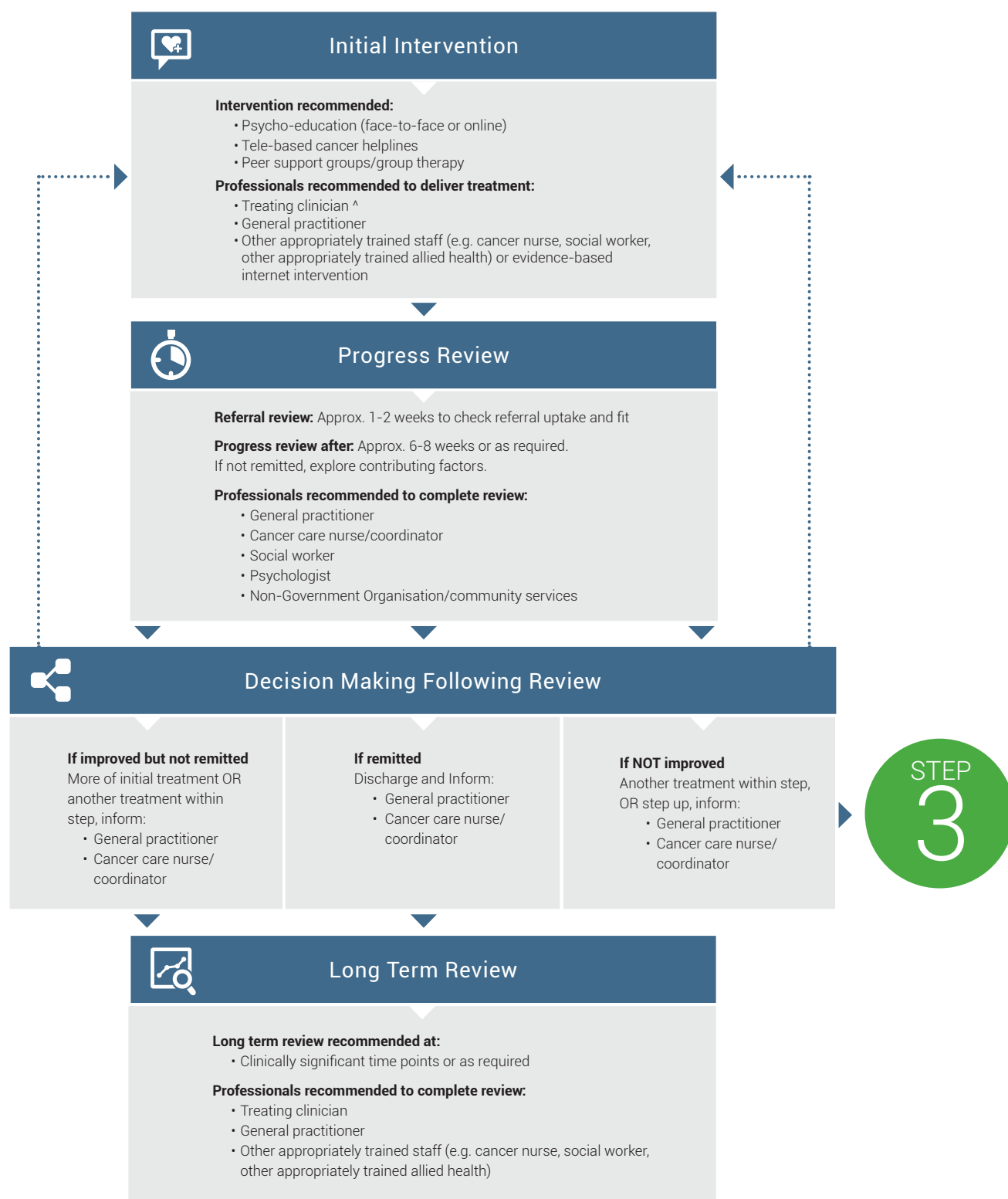
Psycho-education may be delivered through informal discussion, pamphlets and brochures, formal educational sessions, and video, audio and online resources.

Brief emotional support: involves health care professionals being confident and comfortable in discussing anxiety and depression with patients. Simply taking time to ask patients how they are feeling, listening and responding empathetically can help to prevent the emergence of anxiety and depression and/or identify it early.^[59] It may also help to normalise anxiety and depression and encourage acceptance of a referral, if needed at a later date.

Resources:

Materials on how patients can manage anxiety and/or depression can be found on the Cancer Australia website and Cancer Council websites for each state. These are rigorously developed and kept up to date. We recommend them for use for all patients.

Figure 3 – STEP 2: Supportive Care – Mild Anxiety and/or Depression



[^] Treating clinician; surgeon, medical oncologist, radiation oncologist, haematologist, palliative care physician

RECOMMENDED INTERVENTIONS

STEP 2: Supportive Care – Mild Anxiety and/or Depression

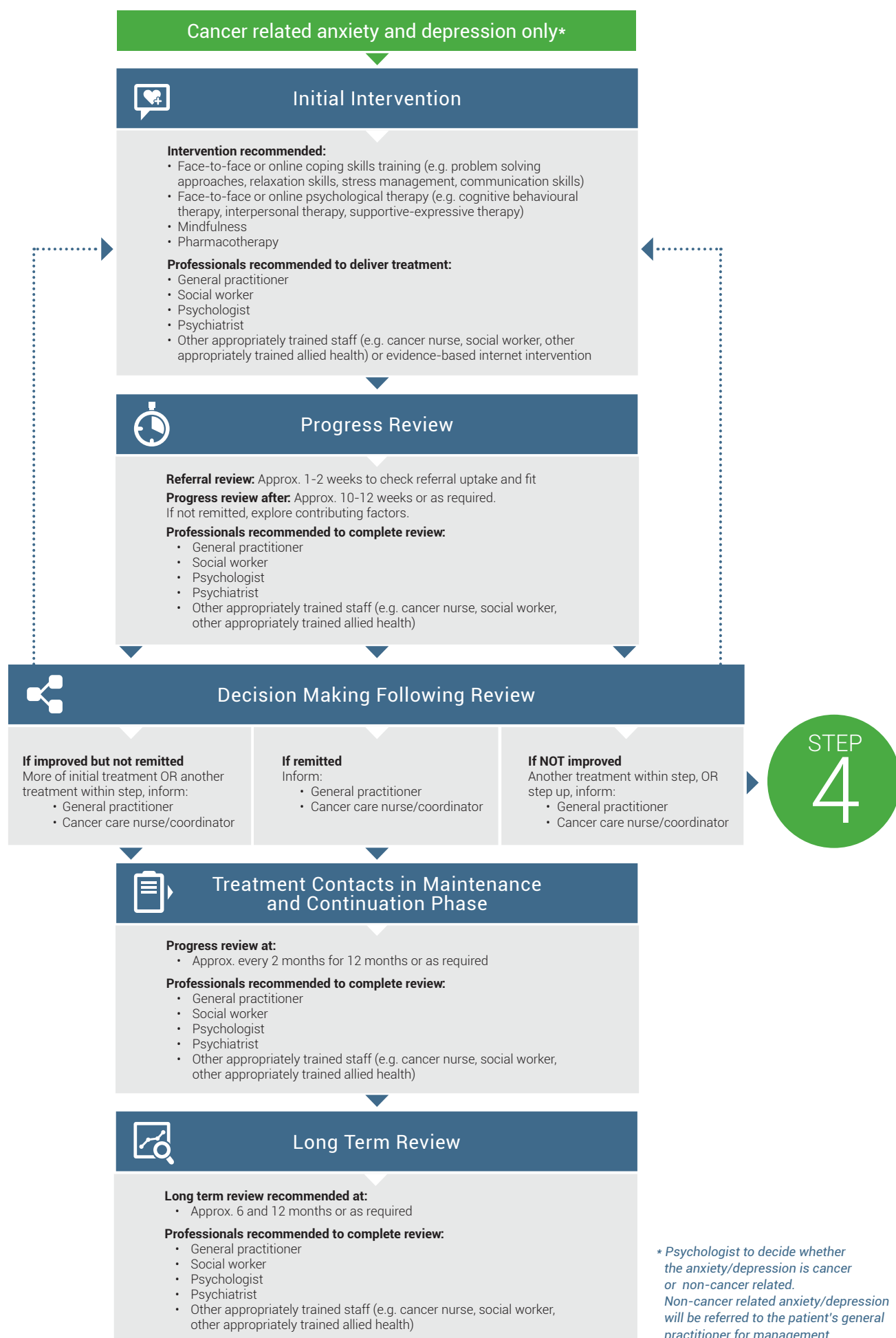
The majority of cancer patients might be expected to enter the stepped care model at Step 2, and the treatments recommended here may be most beneficial for recently diagnosed patients.

Psycho-education: as for Step 1 but may be more targeted to issues that are identified through discussion with patients.^[59] Psycho-education is pivotal in reducing uncertainty and is known to improve knowledge about disease and treatment, have a positive impact on anxiety, depression and overall mood, and can also help to reduce physical symptoms associated with a cancer diagnosis and recovery such as nausea, vomiting and pain.^[59] There are a number of psycho-education websites to address general psychological distress and unmet need.

Tele-based cancer helplines: offer emotional support for people with cancer in addition to providing psycho-educational materials and referral to further psychosocial services, if needed.^[60-61] In particular, telephone help-lines provide opportunities for effective delivery of psychological interventions to geographically-isolated patients (see Step 3 for descriptions). There is evidence that this type of intervention can effectively improve psychosocial outcomes such as sexual dysfunction and personal growth and reduce levels of anxiety and depression.^[62-63]

Peer support groups/group therapy: support groups serve a number of purposes – they facilitate mutual support and friendship between people affected by cancer, provide a forum for sharing thoughts and ideas, allow participants to seek advice from health professionals and each other, and provide opportunities to learn coping skills in a non-judgmental and caring environment.^[64] Participation in cancer support groups has been shown to reduce anxiety and depression in patients and survivors with a variety of tumour types.^[65-67] Evidence also supports the effectiveness of group psychotherapy in improving anxiety and depression across a range of cancer types.^[68-69]

Figure 4 – STEP 3: Extended Care – Moderate Anxiety and/or Depression



RECOMMENDED INTERVENTIONS

STEP 3: Extended Care – Moderate Anxiety and/or Depression

Patients recently diagnosed with cancer who are identified with moderate levels of depressive symptoms may benefit most from problem-solving approaches and cognitive behavioural therapy.^[6, 70-72] Patients with advanced disease may be more likely to benefit most from approaches that facilitate the processing of existential concerns and fear of mortality, such as supportive-expressive psychotherapy.^[73]

PSYCHOLOGICAL THERAPY

Face-to-face or online coping skills training

Psychological therapy delivered by specialist psychosocial health professionals has typically been as face-to-face treatment. However, there are now a number of evidence-based psychological therapy programs being delivered on-line.

Problem solving approaches: “focuses on generating, applying, and evaluating solutions to identified problems”.^[74] Problem-solving therapy has been shown to reduce anxiety and depression in distressed cancer patients (N = 132), with effects maintained for at least 12 months post-intervention.^[70]

Relaxation skills: these are techniques designed to induce physical and mental relaxation, and include progressive muscle relaxation, guided imagery and hypnosis. Relaxation training has been shown to improve anxiety and depression in patients who have undergone a range of treatment types and at different stages of the cancer trajectory.^[71, 75-77]

Stress management: interventions which provide training in anxiety-reduction skills, increased awareness of sources of stress and indicators of stress, noticing and replacing negative thoughts to improve the ways patients manage stressors. Stress management has been shown to improve emotional well-being and positive affect.^[78-80]

Communication skills: teaches patients skills in seeking, providing, and clarifying information with the goal of modifying patients' discourse and enhancing participation in their health care. Research shows that training patients in communication skills has a positive impact on a range of outcomes,^[81] and so may be of particular use with minority patient populations.^[82] This type of training can be quite labour-intensive, although basic tools aimed at improving communication such as question prompt-lists can significantly reduce patient anxiety^[82] and increase question-asking in consultations^[83] including questions on sensitive topics such as prognosis.^[84]

Face-to-face or online psychological therapy

Cognitive behavioural therapy (CBT): “focuses on identifying, challenging, and changing maladaptive thoughts and behaviours to reduce negative emotions and promote psychologic adjustment”.^[74] CBT is one of the most common and effective psychotherapies for anxiety and depression and its effectiveness in treating anxiety and depression in cancer patients and survivors is well-established.^[6, 71-72]

Interpersonal therapy: including family and couples therapy focusing on “problems within interpersonal interactions and relationships, emphasising areas such as grief, role transitions, disputes, or interpersonal deficits to reduce distress and promote psychologic adjustment”.^[74] The involvement of family members in discussions of and processing of interpersonal experiences such as grief is considered central to promoting an adaptive family response to a crisis such as a cancer diagnosis and is also an important factor in the prevention and treatment of anxiety and depression.^[85-87] Interpersonal therapy also benefits the emotional and social well-being of partners and children of cancer patients and survivors.^[88]

Supportive-expressive therapy/supportive psychotherapy: “focuses on the communication and processing of subjective experience and on the joint creation of meaning within a therapeutic relationship to reduce distress”.^[74] Targeted and manualised psychotherapies, particularly for those with advanced illness, have recently been developed, including Meaning-Centred Group Therapy,^[69] Dignity Therapy,^[89] Mindfulness-Based Meditation Therapy,^[90] and a brief supportive-expressive intervention referred to as CALM (Managing Cancer and Living Meaningfully).^[91] Supportive-expressive therapy is effective against depression,^[73] and has been found to improve overall mood and reduce cancer-related distress in metastatic breast cancer patients.^[92]

Mindfulness: interventions that incorporate the principles of mindfulness such as mindfulness-based stress reduction (MBSR), mindfulness-based cognitive therapy (MBCT), and Acceptance Commitment Therapy (ACT) teach patients to increase their awareness of thoughts and the impact they can have on symptoms of anxiety and depression, with the aim of interrupting these automatic processes and facilitating non-judgmental awareness of thoughts.^[90, 93] Some evidence exists for the effectiveness of mindfulness-based interventions in reducing symptoms of anxiety and depression in cancer patients.^[93-94]

Internet-based interventions: psychological treatments for anxiety and depression are increasingly being delivered as structured online programs and there are now a number of cancer-specific online therapies. This mode of delivery, typically using cognitive behavioural therapy models, provides information, as well as interactive exercises, to help change unhelpful thoughts and behaviour patterns, and has been demonstrated to be as effective as face to face treatment.^[95-96] Evidence-based online therapy overcomes many of the barriers relating to access and inequity, particularly for rural/remote areas. They have the advantage of being convenient, cost-effective and anonymous.

PHARMACOLOGIC INTERVENTIONS FOR MOOD AND ADJUSTMENT DISORDERS

Depending on the severity of symptoms, pharmacotherapy may be indicated. The aim of this section of the document is to outline the key principles underpinning pharmacological management of anxiety and depression. For detailed information about specific drugs, readers are referred to the Therapeutic Guidelines which are available on-line in most public hospitals. These Guidelines are developed by an expert group and are regularly updated. The general information below is based on information in Therapeutic Guidelines referenced below unless stated otherwise.

The Therapeutic Guidelines Version 7, 2013 provides comprehensive evidence-based information about specific drugs to treat anxiety and depression, their side-effect profiles and drug interactions.^[97]

DEPRESSION

There is strong evidence that antidepressants effectively treat clinical depression.^[74]

No particular class of antidepressants has been shown to be more effective than another in the treatment of depression,^[74] with direct comparison between classical tricyclic antidepressants and SSRIs in a number of head-to-head trials showing no differences.^[98]

Compared with the general adult population, prescription of antidepressant medication for patients with cancer is more complex, and a number of factors must be taken into account in both selection of a particular drug and the dose, including:

- Side-effect profile – for example, there is potential for initial exacerbation of nausea and sleep disturbance, and some drugs can lower seizure threshold;
- Potential for drug interactions – for example, SSRIs may interact with anticonvulsants, anticoagulant therapy, and tamoxifen. Some SSRIs have a long half-life with active metabolites meaning that the potential for ongoing interactions increases. Some drugs when prescribed with SSRIs will increase the risk of serious adverse serotonin-related toxicity;
- Patient response to previous treatments;
- Family history of response to treatments;
- Patient comorbidities – for example elderly patients are vulnerable to exacerbation of pre-existing cognitive deficits and the development of confusion, and in patients with pre-existing heart disease, renal impairment or liver disease the choice of drug is affected, and dose reduction will commonly be required;
- The potential for beneficial impact on other symptoms – for example improvement in sleep, treatment of hot flushes, or as an adjunct to treatments for pain.

In the general adult population, the first-line pharmacological treatment of depression will most commonly be an SSRI or SNRI, mainly because of their more favourable side-effect profile compared with the older drugs such as tricyclic antidepressants (TCAs).

In patients with cancer, TCAs may have a valuable role even in low dose to relieve sleep disturbance and assist with pain management. However, their side-effect profile (especially anticholinergic effects) may limit treatment and their use can be associated with troubling side-effects including constipation, urinary retention and postural hypotension. Note that TCAs are lethal in overdose and should not be prescribed for patients for whom suicide is considered a risk.

Stimulants such as methylphenidate and dexamethasone have been used in a palliative setting because of their rapid onset of action and their effect on other symptoms such as attention and concentration. However, there is a lack of evidence and recent European Guidelines on the management of depression in a palliative setting do not recommend the use of psychostimulants.^[99]

RESISTANT DEPRESSION

It may take two to four weeks before an improvement in mood is evident after initiation of antidepressant treatment. It is important to remember that when using antidepressant medication, the patient continues to require frequent and regular contact with and psychological support from their treating clinician to promote full recovery. Failure to respond to treatment should lead to a systematic approach comprising:

- Review of the diagnosis – for example is this really depression rather than grief? Delirium should always be considered as a possible underlying condition in a medically ill person with sudden onset of mood disturbance;
- Exclusion of any other contributory condition (for example identification of unaddressed alcohol abuse or other causes of a depressive syndrome such as hypothyroidism, metabolic disturbance such as hypercalcaemia or central nervous system disease);
- Review of any problems with adherence to medication;
- Review of psychosocial and personality factors, and adequacy of concurrent psychological support/intervention;
- Review of drug interactions (including depressive syndromes secondary to other medications such as corticosteroids, antihypertensive agents);
- Finally review and titration of the dose. The Therapeutic Guidelines lists dose ranges for antidepressants.

If the person's mood fails to improve with the above steps specialist review is recommended. Augmentation with other medication may be appropriate, and in some instances ECT may be considered as the safest and most effective treatment option.

ANXIETY

Psychological interventions which might include a combination of CBT, relaxation training and guided imagery are the first-line therapy for generalised anxiety. Pharmacotherapy will be indicated if psychological interventions do not provide sufficient improvement in symptoms, or when relief of anxiety is required urgently, for example in order for a patient to complete a course of radiotherapy.

Selective serotonin reuptake inhibitors (SSRIs) are the first line choice of medication for treatment of anxiety requiring pharmacotherapy.^[77, 100] Patients who are anxious may be highly sensitive to the side-effects of medication, which can include an initial exacerbation of anxiety and sleep disturbance.

For this reason, some clinicians may choose to commence drug treatment with a lower dose than usual and increase the dose as the person adjusts to side-effects.

Benzodiazepines have a limited role in the treatment of anxiety disorders and are not first-line treatment except in a short-term crisis situation (for example, a patient who requires fitting of a face-mask for radiotherapy or in palliative care settings). Use of benzodiazepines is associated with significant morbidities including confusion, ataxia and falls in the elderly. Development of dependence and tolerance can occur within one month of regular consumption. Use of benzodiazepines with a short half-life can lead to rebound anxiety and a cycle of dosage escalation as the person interprets their symptoms as requiring more medication.

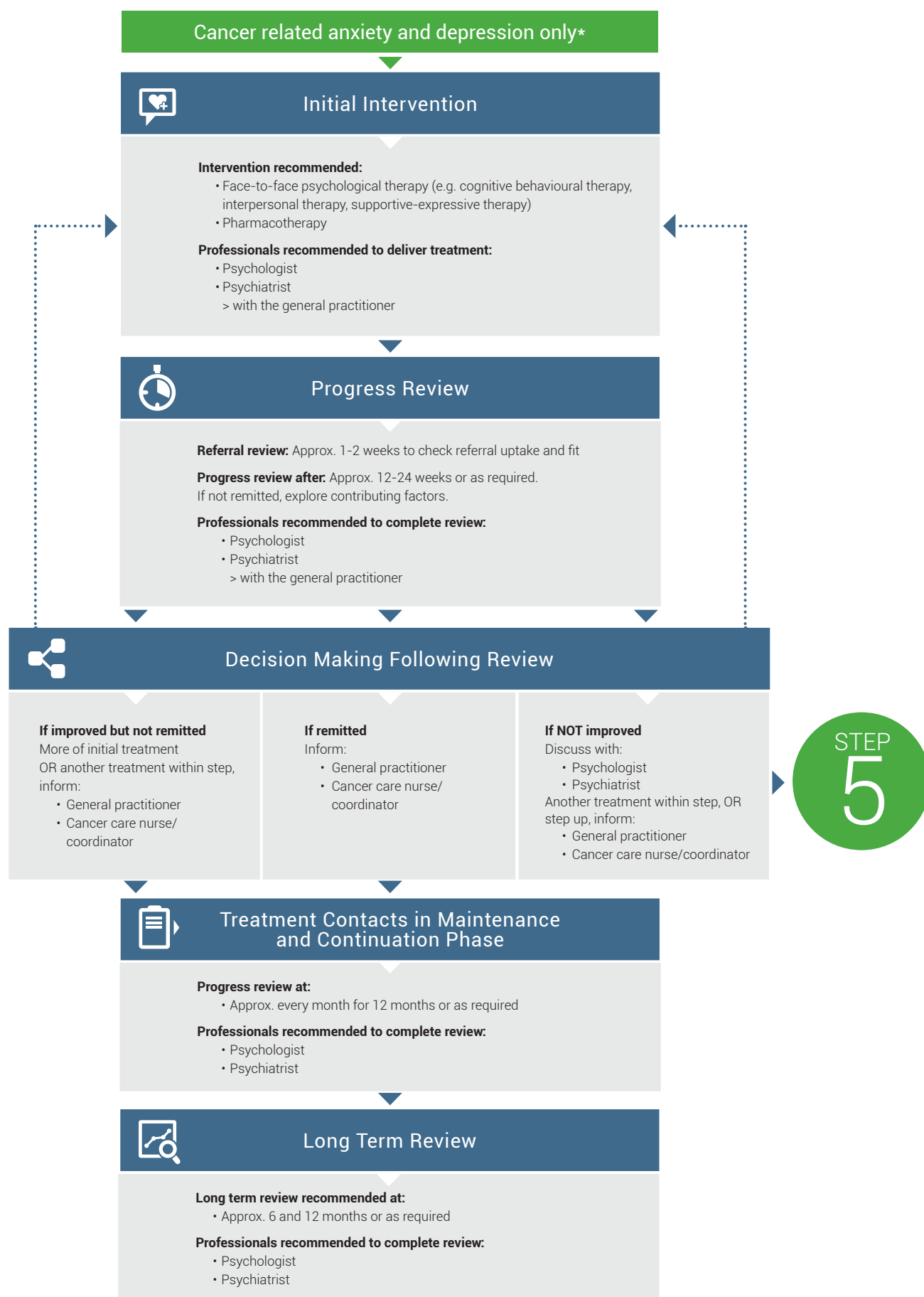
Antipsychotic medication for the treatment of anxiety is not recommended. Older persons are especially vulnerable to the side-effects of antipsychotic medication and there are reports of increased risk of cardiac events and stroke associated with their use in this population.

Psychotropic Expert Groups. Therapeutic guidelines: psychotropic. Version 7.
Melbourne: Therapeutic Guidelines Limited; 2013.^[97]

Palliative Care Expert Group. Therapeutic guidelines: palliative care. Version 3.
Melbourne: Therapeutic Guidelines Limited; 2010.^[101]

For patients with moderate or severe anxiety and/or depression a formal risk assessment for suicide and self-harm should also be conducted to assess previous history, strength of intent, means and capacity. If a patient is found to be at risk of suicide or self-harm contact or escort the patient to the emergency department or acute mental health team for rapid review and management, and psychiatric intervention as appropriate. Discuss with the patient's treating team.

Figure 5 – STEP 4: Specialist Care –Severe Anxiety and/or Depression



* Psychologist to decide whether the anxiety/depression is cancer or non-cancer related. Non-cancer related anxiety/depression will be referred to the patient's general practitioner for management.

RECOMMENDED INTERVENTIONS

STEP 4: Specialist Care –Severe Anxiety and/or Depression

PSYCHOLOGICAL THERAPY

Recommended interventions include the following as described for Step 3:

Cognitive behavioural therapy (CBT): “focuses on identifying, challenging, and changing maladaptive thoughts and behaviours to reduce negative emotions and promote psychologic adjustment”.^[74] CBT is one of the most common and effective psychotherapies for anxiety and depression and its effectiveness in treating anxiety and depression in cancer patients and survivors is well-established.^[6, 71-72]

Interpersonal therapy: including family and couples therapy focusing on “problems within interpersonal interactions and relationships, emphasising areas such as grief, role transitions, disputes, or interpersonal deficits to reduce distress and promote psychologic adjustment”.^[74] The involvement of family members in discussions of and processing of interpersonal experiences such as grief is considered central to promoting an adaptive family response to a crisis such as a cancer diagnosis and is also an important factor in the prevention and treatment of anxiety and depression.^[85-87] Interpersonal therapy also benefits the emotional and social well-being of partners and children of cancer patients and survivors.^[88]

Supportive-expressive therapy/supportive psychotherapy: “focuses on the communication and processing of subjective experience and on the joint creation of meaning within a therapeutic relationship to reduce distress”.^[74] Targeted and manualised psychotherapies, particularly for those with advanced illness, have recently been developed, including Meaning-Centred Group Therapy,^[69] Dignity Therapy,^[89] Mindfulness-Based Meditation Therapy,^[90] and a brief supportive-expressive intervention referred to as CALM (Managing Cancer and Living Meaningfully).^[91] Supportive-expressive therapy is effective against depression,^[73] and has been found to improve overall mood and reduce cancer-related distress in metastatic breast cancer patients.^[92]

PHARMACOLOGIC INTERVENTIONS FOR MOOD AND ADJUSTMENT DISORDERS

Depending on the severity of symptoms, pharmacotherapy may be indicated. The aim of this section of the document is to outline the key principles underpinning pharmacological management of anxiety and depression. For detailed information about specific drugs, readers are referred to the Therapeutic Guidelines which are available on-line in most public hospitals. These Guidelines are developed by an expert group and are regularly updated. The general information below is based on information in Therapeutic Guidelines referenced below unless stated otherwise.

The Therapeutic Guidelines Version 7, 2013 provides comprehensive evidence-based information about specific drugs to treat anxiety and depression, their side-effect profiles and drug interactions.^[97]

DEPRESSION

There is strong evidence that antidepressants effectively treat clinical depression.^[74]

No particular class of antidepressants has been shown to be more effective than another in the treatment of depression,^[74] with direct comparison between classical tricyclic antidepressants and SSRIs in a number of head-to-head trials showing no differences.^[98]

Compared with the general adult population, prescription of antidepressant medication for patients with cancer is more complex, and a number of factors must be taken into account in both selection of a particular drug and the dose, including:

- Side-effect profile – for example, there is potential for initial exacerbation of nausea and sleep disturbance, and some drugs can lower seizure threshold;
- Potential for drug interactions – for example, SSRIs may interact with anticonvulsants, anticoagulant therapy, and tamoxifen. Some SSRIs have a long half-life with active metabolites meaning that the potential for ongoing interactions increases. Some drugs when prescribed with SSRIs will increase the risk of serious adverse serotonin-related toxicity;
- Patient response to previous treatments;
- Family history of response to treatments;
- Patient comorbidities – for example elderly patients are vulnerable to exacerbation of pre-existing cognitive deficits and the development of confusion, and in patients with pre-existing heart disease, renal impairment or liver disease the choice of drug is affected, and dose reduction will commonly be required;
- The potential for beneficial impact on other symptoms – for example improvement in sleep, treatment of hot flushes, or as an adjunct to treatments for pain.

In the general adult population, the first-line pharmacological treatment of depression will most commonly be an SSRI or SNRI, mainly because of their more favourable side-effect profile compared with the older drugs such as tricyclic antidepressants (TCAs).

In patients with cancer, TCAs may have a valuable role even in low dose to relieve sleep disturbance and assist with pain management. However, their side-effect profile (especially anticholinergic effects) may limit treatment and their use can be associated with troubling side-effects including constipation, urinary retention and postural hypotension. Note that TCAs are lethal in overdose and should not be prescribed for patients for whom suicide is considered a risk.

Stimulants such as methylphenidate and dexamethasone have been used in a palliative setting because of their rapid onset of action and their effect on other symptoms such as attention and concentration. However, there is a lack of evidence and recent European Guidelines on the management of depression in a palliative setting do not recommend the use of psychostimulants.^[99]

RESISTANT DEPRESSION

It may take two to four weeks before an improvement in mood is evident after initiation of antidepressant treatment. It is important to remember that when using antidepressant medication, the patient continues to require frequent and regular contact with and psychological support from their treating clinician to promote full recovery. Failure to respond to treatment should lead to a systematic approach comprising:

- Review of the diagnosis – for example is this really depression rather than grief? Delirium should always be considered as a possible underlying condition in a medically ill person with sudden onset of mood disturbance;
- Exclusion of any other contributory condition (for example identification of unaddressed alcohol abuse or other causes of a depressive syndrome such as hypothyroidism, metabolic disturbance such as hypercalcaemia or central nervous system disease);
- Review of any problems with adherence to medication;
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If the person's mood fails to improve with the above steps specialist review is recommended. Augmentation with other medication may be appropriate, and in some instances ECT may be considered as the safest and most effective treatment option.

ANXIETY

Psychological interventions which might include a combination of CBT, relaxation training and guided imagery are the first-line therapy for generalised anxiety. Pharmacotherapy will be indicated if psychological interventions do not provide sufficient improvement in symptoms, or when relief of anxiety is required urgently, for example in order for a patient to complete a course of radiotherapy.

Selective serotonin reuptake inhibitors (SSRIs) are the first line choice of medication for treatment of anxiety requiring pharmacotherapy.^[77, 100] Patients who are anxious may be highly sensitive to the side-effects of medication, which can include an initial exacerbation of anxiety and sleep disturbance.

For this reason, some clinicians may choose to commence drug treatment with a lower dose than usual and increase the dose as the person adjusts to side-effects.

Benzodiazepines have a limited role in the treatment of anxiety disorders and are not first-line treatment except in a short-term crisis situation (for example, a patient who requires fitting of a face-mask for radiotherapy or in palliative care settings). Use of benzodiazepines is associated with significant morbidities including confusion, ataxia and falls in the elderly. Development of dependence and tolerance can occur within one month of regular consumption. Use of benzodiazepines with a short half-life can lead to rebound anxiety and a cycle of dosage escalation as the person interprets their symptoms as requiring more medication.

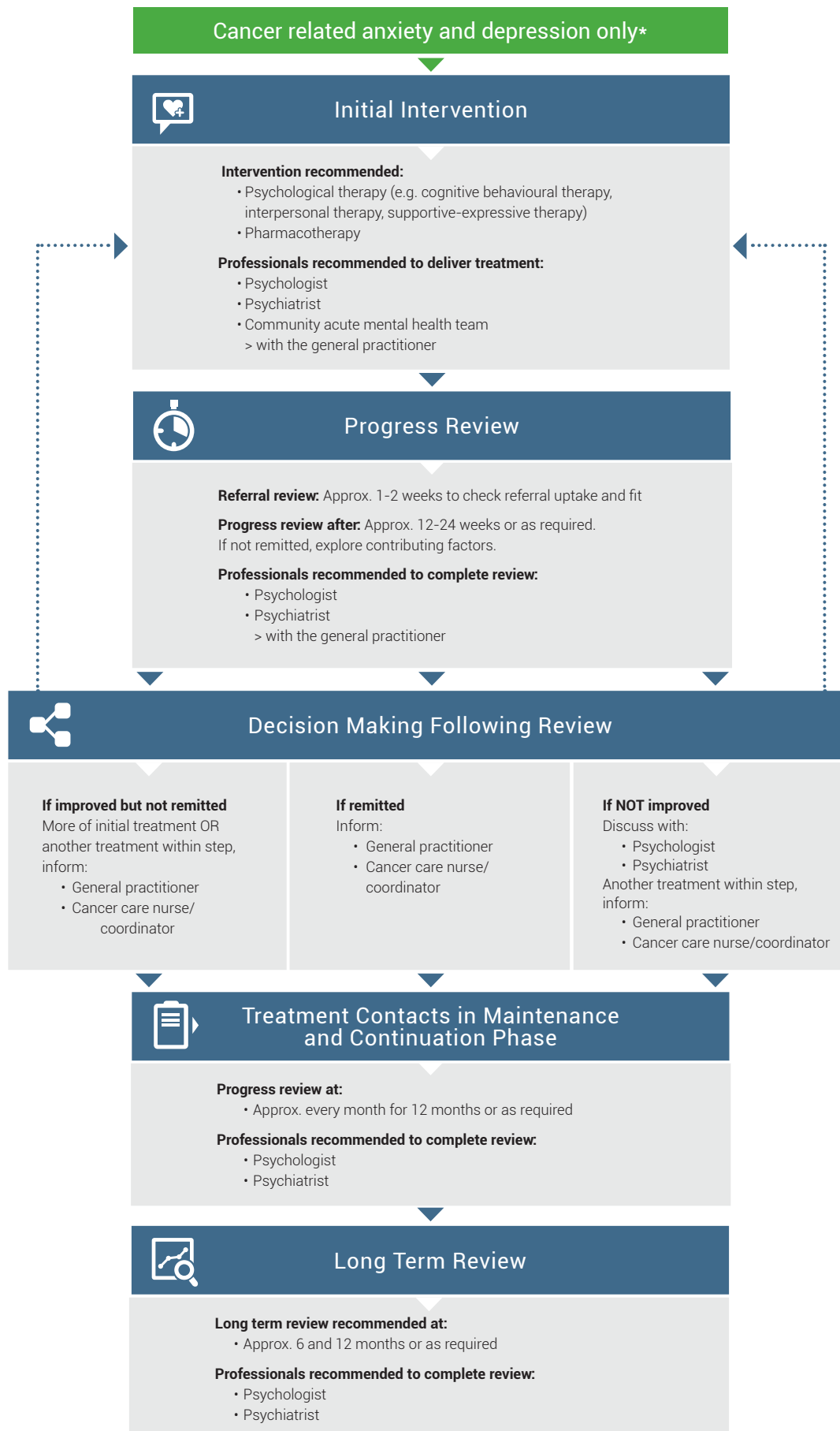
Antipsychotic medication for the treatment of anxiety is not recommended. Older persons are especially vulnerable to the side-effects of antipsychotic medication and there are reports of increased risk of cardiac events and stroke associated with their use in this population.

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For patients with moderate or severe anxiety and/or depression a formal risk assessment for suicide and self-harm should also be conducted to assess previous history, strength of intent, means and capacity. If a patient is found to be at risk of suicide or self-harm contact or escort the patient to the emergency department or acute mental health team for rapid review and management, and psychiatric intervention as appropriate. Discuss with the patient's treating team.

Figure 6 – STEP 5: Acute Care – Very Severe Anxiety and/or Depression and Complex Cases



* Psychologist to decide whether the anxiety/depression is cancer or non-cancer related. Non-cancer related anxiety/depression will be referred to the patient's general practitioner for management.

RECOMMENDED INTERVENTIONS

STEP 5: Acute Care – Very Severe Anxiety and/or Depression and Complex Cases

Recommended interventions include the following as described for Step 4:

Cognitive behavioural therapy (CBT): “focuses on identifying, challenging, and changing maladaptive thoughts and behaviours to reduce negative emotions and promote psychologic adjustment”.^[74] CBT is one of the most common and effective psychotherapies for anxiety and depression and its effectiveness in treating anxiety and depression in cancer patients and survivors is well-established.^[6, 71-72]

Interpersonal therapy: including family and couples therapy focusing on “problems within interpersonal interactions and relationships, emphasising areas such as grief, role transitions, disputes, or interpersonal deficits to reduce distress and promote psychologic adjustment”.^[74] The involvement of family members in discussions of and processing of interpersonal experiences such as grief is considered central to promoting an adaptive family response to a crisis such as a cancer diagnosis and is also an important factor in the prevention and treatment of anxiety and depression.^[85-87] Interpersonal therapy also benefits the emotional and social well-being of partners and children of cancer patients and survivors.^[88]

Supportive-expressive therapy/supportive psychotherapy: “focuses on the communication and processing of subjective experience and on the joint creation of meaning within a therapeutic relationship to reduce distress”.^[74] Targeted and manualised psychotherapies, particularly for those with advanced illness, have recently been developed, including Meaning-Centred Group Therapy,^[69] Dignity Therapy,^[89] Mindfulness-Based Meditation Therapy,^[90] and a brief supportive-expressive intervention referred to as CALM (Managing Cancer and Living Meaningfully).^[91] Supportive-expressive therapy is effective against depression,^[73] and has been found to improve overall mood and reduce cancer-related distress in metastatic breast cancer patients.^[92]

PHARMACOLOGIC INTERVENTIONS FOR MOOD AND ADJUSTMENT DISORDERS

Depending on the severity of symptoms, pharmacotherapy may be indicated. The aim of this section of the document is to outline the key principles underpinning pharmacological management of anxiety and depression. For detailed information about specific drugs, readers are referred to the Therapeutic Guidelines which are available on-line in most public hospitals. These Guidelines are developed by an expert group and are regularly updated. The general information below is based on information in Therapeutic Guidelines referenced below unless stated otherwise.

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DEPRESSION

There is strong evidence that antidepressants effectively treat clinical depression.^[74]

No particular class of antidepressants has been shown to be more effective than another in the treatment of depression,^[74] with direct comparison between classical tricyclic antidepressants and SSRIs in a number of head-to-head trials showing no differences.^[98]

Compared with the general adult population, prescription of antidepressant medication for patients with cancer is more complex, and a number of factors must be taken into account in both selection of a particular drug and the dose, including:

- Side-effect profile – for example, there is potential for initial exacerbation of nausea and sleep disturbance, and some drugs can lower seizure threshold;
- Potential for drug interactions – for example, SSRIs may interact with anticonvulsants, anticoagulant therapy, and tamoxifen. Some SSRIs have a long half-life with active metabolites meaning that the potential for ongoing interactions increases. Some drugs when prescribed with SSRIs will increase the risk of serious adverse serotonin-related toxicity;
- Patient response to previous treatments;
- Family history of response to treatments;
- Patient comorbidities – for example elderly patients are vulnerable to exacerbation of pre-existing cognitive deficits and the development of confusion, and in patients with pre-existing heart disease, renal impairment or liver disease the choice of drug is affected, and dose reduction will commonly be required;
- The potential for beneficial impact on other symptoms – for example improvement in sleep, treatment of hot flushes, or as an adjunct to treatments for pain.

In the general adult population, the first-line pharmacological treatment of depression will most commonly be an SSRI or SNRI, mainly because of their more favourable side-effect profile compared with the older drugs such as tricyclic antidepressants (TCAs).

In patients with cancer, TCAs may have a valuable role even in low dose to relieve sleep disturbance and assist with pain management. However, their side-effect profile (especially anticholinergic effects) may limit treatment and their use can be associated with troubling side-effects including constipation, urinary retention and postural hypotension. Note that TCAs are lethal in overdose and should not be prescribed for patients for whom suicide is considered a risk.

Stimulants such as methylphenidate and dexamethasone have been used in a palliative setting because of their rapid onset of action and their effect on other symptoms such as attention and concentration. However, there is a lack of evidence and recent European Guidelines on the management of depression in a palliative setting do not recommend the use of psychostimulants.^[99]

RESISTANT DEPRESSION

It may take two to four weeks before an improvement in mood is evident after initiation of antidepressant treatment. It is important to remember that when using antidepressant medication, the patient continues to require frequent and regular contact with and psychological support from their treating clinician to promote full recovery. Failure to respond to treatment should lead to a systematic approach comprising:

- Review of the diagnosis – for example is this really depression rather than grief? Delirium should always be considered as a possible underlying condition in a medically ill person with sudden onset of mood disturbance;
- Exclusion of any other contributory condition (for example identification of unaddressed alcohol abuse or other causes of a depressive syndrome such as hypothyroidism, metabolic disturbance such as hypercalcaemia or central nervous system disease);
- Review of any problems with adherence to medication;
- Review of psychosocial and personality factors, and adequacy of concurrent psychological support/intervention;
- Review of drug interactions (including depressive syndromes secondary to other medications such as corticosteroids, antihypertensive agents);
- Finally review and titration of the dose. The Therapeutic Guidelines lists dose ranges for antidepressants.

If the person's mood fails to improve with the above steps specialist review is recommended. Augmentation with other medication may be appropriate, and in some instances ECT may be considered as the safest and most effective treatment option.

ANXIETY

Psychological interventions which might include a combination of CBT, relaxation training and guided imagery are the first-line therapy for generalised anxiety. Pharmacotherapy will be indicated if psychological interventions do not provide sufficient improvement in symptoms, or when relief of anxiety is required urgently, for example in order for a patient to complete a course of radiotherapy.

Selective serotonin reuptake inhibitors (SSRIs) are the first line choice of medication for treatment of anxiety requiring pharmacotherapy.^[77, 100] Patients who are anxious may be highly sensitive to the side-effects of medication, which can include an initial exacerbation of anxiety and sleep disturbance.

For this reason, some clinicians may choose to commence drug treatment with a lower dose than usual and increase the dose as the person adjusts to side-effects.

Benzodiazepines have a limited role in the treatment of anxiety disorders and are not first-line treatment except in a short-term crisis situation (for example, a patient who requires fitting of a face-mask for radiotherapy or in palliative care settings). Use of benzodiazepines is associated with significant morbidities including confusion, ataxia and falls in the elderly. Development of dependence and tolerance can occur within one month of regular consumption. Use of benzodiazepines with a short half-life can lead to rebound anxiety and a cycle of dosage escalation as the person interprets their symptoms as requiring more medication.

Antipsychotic medication for the treatment of anxiety is not recommended. Older persons are especially vulnerable to the side-effects of antipsychotic medication and there are reports of increased risk of cardiac events and stroke associated with their use in this population.

Psychotropic Expert Groups. Therapeutic guidelines: psychotropic. Version 7. Melbourne: Therapeutic Guidelines Limited; 2013.^[97]

Palliative Care Expert Group. Therapeutic guidelines: palliative care. Version 3. Melbourne: Therapeutic Guidelines Limited; 2010.^[101]

For patients with moderate or severe anxiety and/or depression a formal risk assessment for suicide and self-harm should also be conducted to assess previous history, strength of intent, means and capacity. If a patient is found to be at risk of suicide or self-harm contact or escort the patient to the emergency department or acute mental health team for rapid review and management, and psychiatric intervention as appropriate. Discuss with the patient's treating team.

5

TAILORING THE CLINICAL PATHWAY TO CANCER SERVICES



TAILORING THE CLINICAL PATHWAY TO CANCER SERVICES

Factors that need to be considered when tailoring the pathway include:

RESOURCES

Oncology services will vary widely in the number and profile of staff and other resources available for addressing psychological distress in cancer patients. The Clinical Pathway gives recommendations for the different health professionals responsible for delivering interventions, for review, and follow up. A number of different health professionals are recommended to accommodate the availability of staff at different services, however, these are not exhaustive. For example, mental health professionals such as psychiatrists and psychologists are recommended to deliver treatment for severe anxiety and depression;^[16-17] however, a service that does not have access to these professionals may employ a suitably qualified specialist social worker or general practitioner to provide care at this level.^[17-18]

The clinical networks that are currently in place in a service (whether formally or informally) are also important to consider.^[29] Building on the strengths of clinical networks currently in place will likely provide more effective care and be more acceptable to staff.

The Clinical Pathway provides an evidence-based guide to managing patients with anxiety and depression. Your local stepped care model will need to be tailored to your service structure and referral networks available. Individual skills and training within each team will determine who is best placed to undertake specific roles.

Staff responsibility for routine screening of patients is a local decision and will vary depending on local resources and the expertise of staff. All staff carrying out screening and referral need to have the skills and confidence to comfortably discuss anxiety and depression with patients, respond empathically and to facilitate referral.

No professional should undertake any role for which they have not received training or which they do not feel competent to undertake.

Ongoing GP involvement may be important if your centre is in a rural or remote area, where specialist services are limited.

PATIENT CHARACTERISTICS

Demographics: this includes consideration of cultural backgrounds (patients from culturally and linguistically diverse populations and indigenous patients), socio-economic status, health literacy, age, and so on. Such factors are likely to affect the appropriateness of any screening and/or assessment tools used as well as treatments that patients will find acceptable and effective.

Stage of illness: this includes consideration of inpatient versus outpatient care, as well as whether patients are undergoing initial treatment, have advanced disease or are in palliative care. Such factors will influence type and duration of treatment as well as the health professionals involved.

Cancer type: the recommended time frames and interventions presented as part of the pathways may be better suited to patients with solid tumours than haematology patients. There may also be factors unique to different tumour streams which may influence appropriate treatments and timeframes for monitoring and review.

CLOSING STATEMENT

This pathway was developed in the Australian context. The intention is that this pathway will facilitate fully integrated and effective screening, detection and management of anxiety and depression in cancer services and aid in reducing the enormous burden of suffering that patients with these psychological morbidities experience, as well as reducing the economic costs to services that are incurred when anxiety and depression are not adequately treated. While clearly delineated pathways such as these facilitate implementation, careful attention to patient, health professional and system barriers will optimise chances of success.

APPENDICES

APPENDIX 1: Screening Instruments

ESAS-R and the Canadian Problem Checklist

FIGURE 5.1

Edmonton Symptom Assessment System Screening Tool and the Canadian Problem Checklist

Edmonton Symptom Assessment System Screening Tool

Patient's Name: _____

Date of Completion: _____

Time: _____

Completed by:

- ☐ Patient
☐ Family
☐ Health professional
☐ Assisted by family or health professional

Please circle the number that best describes:

No pain	0 1 2 3 4 5 6 7 8 9 10	Worst possible pain
No tiredness (tiredness = lack of energy)	0 1 2 3 4 5 6 7 8 9 10	Worst possible tiredness
No drowsiness (drowsiness = feeling sleepy)	0 1 2 3 4 5 6 7 8 9 10	Worst possible drowsiness
No nausea	0 1 2 3 4 5 6 7 8 9 10	Worst possible nausea
No lack of appetite	0 1 2 3 4 5 6 7 8 9 10	Worst possible lack of appetite
No shortness of breath	0 1 2 3 4 5 6 7 8 9 10	Worst possible shortness of breath
No depression (depression = feeling sad)	0 1 2 3 4 5 6 7 8 9 10	Worst possible depression
No anxiety (anxiety = feeling nervous)	0 1 2 3 4 5 6 7 8 9 10	Worst possible anxiety
Best well-being (well-being = how you feel overall)	0 1 2 3 4 5 6 7 8 9 10	Worst possible well-being
No _____ (other problem) (for example, constipation)	0 1 2 3 4 5 6 7 8 9 10	Worst possible _____

Source: Regional Palliative Care Program in Edmonton, Alberta.

Canadian Problem Checklist

Please check all of the following items that have been a concern or problem for you in the past week, including today:

Practical

- ☐ Work/School
☐ Finances
☐ Getting to and from appointments
☐ Accommodation

Emotional

- ☐ Fears/Worries
☐ Sadness
☐ Frustration/Anger
☐ Changes in appearance
☐ Intimacy/Sexuality

Social/Family

- ☐ Feeling a burden to others
☐ Worry about family/Friends
☐ Feeling alone

Informational

- ☐ Understanding my illness and/or treatment
☐ Talking with the health-care team
☐ Making treatment decisions
☐ Knowing about available resources

Spiritual


- ☐ Meaning/Purpose of life
☐ Faith

Physical

- ☐ Concentration/Memory
☐ Sleep
☐ Weight

Source: Canadian Partnership Against Cancer, Cancer Journey Action Group Guide to Implementing Screening for Distress, the 6th Vital Sign: Moving Towards Person-Centered Care. Part A. Background, recommendations and implementation. Toronto, ON: The Partnership; 2009.

Distress Thermometer and Problem List



National
Comprehensive
Cancer
Network®

NCCN Distress Thermometer for Patients

Help for distress

Distress is an unpleasant emotional state that may affect how you feel, think, and act. It can include feelings of unease, sadness, worry, anger, helplessness, guilt, and so forth. Everyone with cancer has some distress at some point of time. It is normal to feel sad, fearful, and helpless.

Feeling distressed may be a minor problem or it may be more serious. You may be so distressed that you can't do the things you used to do. Serious or not, it is important that your treatment team knows how you feel.

The Distress Thermometer is a tool that you can use to talk to your doctors about your distress. It has a scale on which you circle your level of distress. It also asks about the parts of life in which you are having problems. The Distress Thermometer has been tested in many studies and found to work well. Please complete the Distress Thermometer and share it with your treatment team at your next visit.

The Distress Thermometer helps your treatment team know if you need supportive services. You may be referred to supportive services at your cancer center or in your community. Supportive services can include help from support groups, chaplains, social workers, counselors, and many other experts. Supportive services can also be found through the support services.

Support Services

National Cancer Institute's Cancer Information Service

Telephone
1-800-4-CANCER

Website
www.cancer.gov/aboutnci/cis/page1

Cancer Support Community

Telephone
1- 888-793-9355

Website
www.cancersupportcommunity.org/MainMenu/Cancer-Support

U.S. Health Resources and Services Administration

Website
www.findahealthcenter.hrsa.gov/Search_HCC.aspx



National
Comprehensive
Cancer
Network®

NCCN Distress Thermometer and Problem List for Patients

NCCN DISTRESS THERMOMETER

Instructions: Please circle the number (0–10) that best describes how much distress you have been experiencing in the past week including today.

Extreme distress

10

9

8

7

6

5

4

3

2

1

No distress

0



PROBLEM LIST

Please indicate if any of the following has been a problem for you in the past week including today.

Be sure to check YES or NO for each.

YES NO <u>Practical Problems</u>	YES NO <u>Physical Problems</u>
<input type="checkbox"/> Child care	<input type="checkbox"/> Appearance
<input type="checkbox"/> Housing	<input type="checkbox"/> Bathing/dressing
<input type="checkbox"/> Insurance/financial	<input type="checkbox"/> Breathing
<input type="checkbox"/> Transportation	<input type="checkbox"/> Changes in urination
<input type="checkbox"/> Work/school	<input type="checkbox"/> Constipation
<input type="checkbox"/> Treatment decisions	<input type="checkbox"/> Diarrhea
	<input type="checkbox"/> Eating
	<input type="checkbox"/> Fatigue
<u>Family Problems</u>	<input type="checkbox"/> Feeling swollen
<input type="checkbox"/> Dealing with children	<input type="checkbox"/> Fevers
<input type="checkbox"/> Dealing with partner	<input type="checkbox"/> Getting around
<input type="checkbox"/> Ability to have children	<input type="checkbox"/> Indigestion
<input type="checkbox"/> Family health issues	<input type="checkbox"/> Memory/concentration
	<input type="checkbox"/> Mouth sores
<u>Emotional Problems</u>	<input type="checkbox"/> Nausea
<input type="checkbox"/> Depression	<input type="checkbox"/> Nose dry/congested
<input type="checkbox"/> Fears	<input type="checkbox"/> Pain
<input type="checkbox"/> Nervousness	<input type="checkbox"/> Sexual
<input type="checkbox"/> Sadness	<input type="checkbox"/> Skin dry/itchy
<input type="checkbox"/> Worry	<input type="checkbox"/> Sleep
<input type="checkbox"/> Loss of interest in usual activities	<input type="checkbox"/> Substance abuse
	<input type="checkbox"/> Tingling in hands/feet
<input type="checkbox"/> <u>Spiritual/religious concerns</u>	
Other Problems: _____	

Hospital and Anxiety Depression Scale

The journal reference for the development of the original questionnaire is:

Zigmond AS, Snaith RP. *The Hospital Anxiety And Depression Scale*.

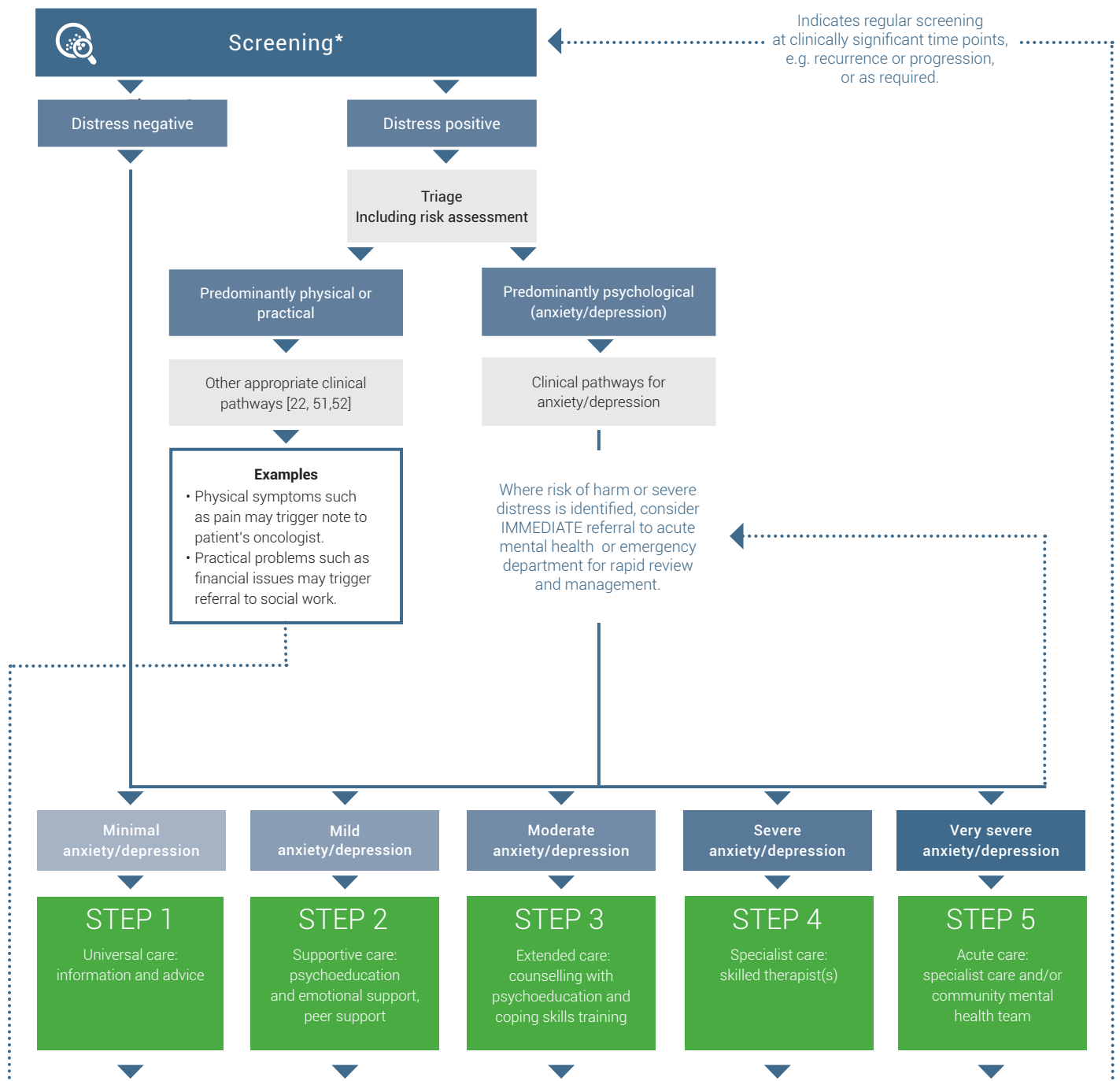
Acta Psychiatr Scand 1983, 67: 361–70.

Information about permission and current licensing requirements can be found here:

https://eprovide.mapi-trust.org/instruments/hospital-anxiety-and-depression-scale#basic_description

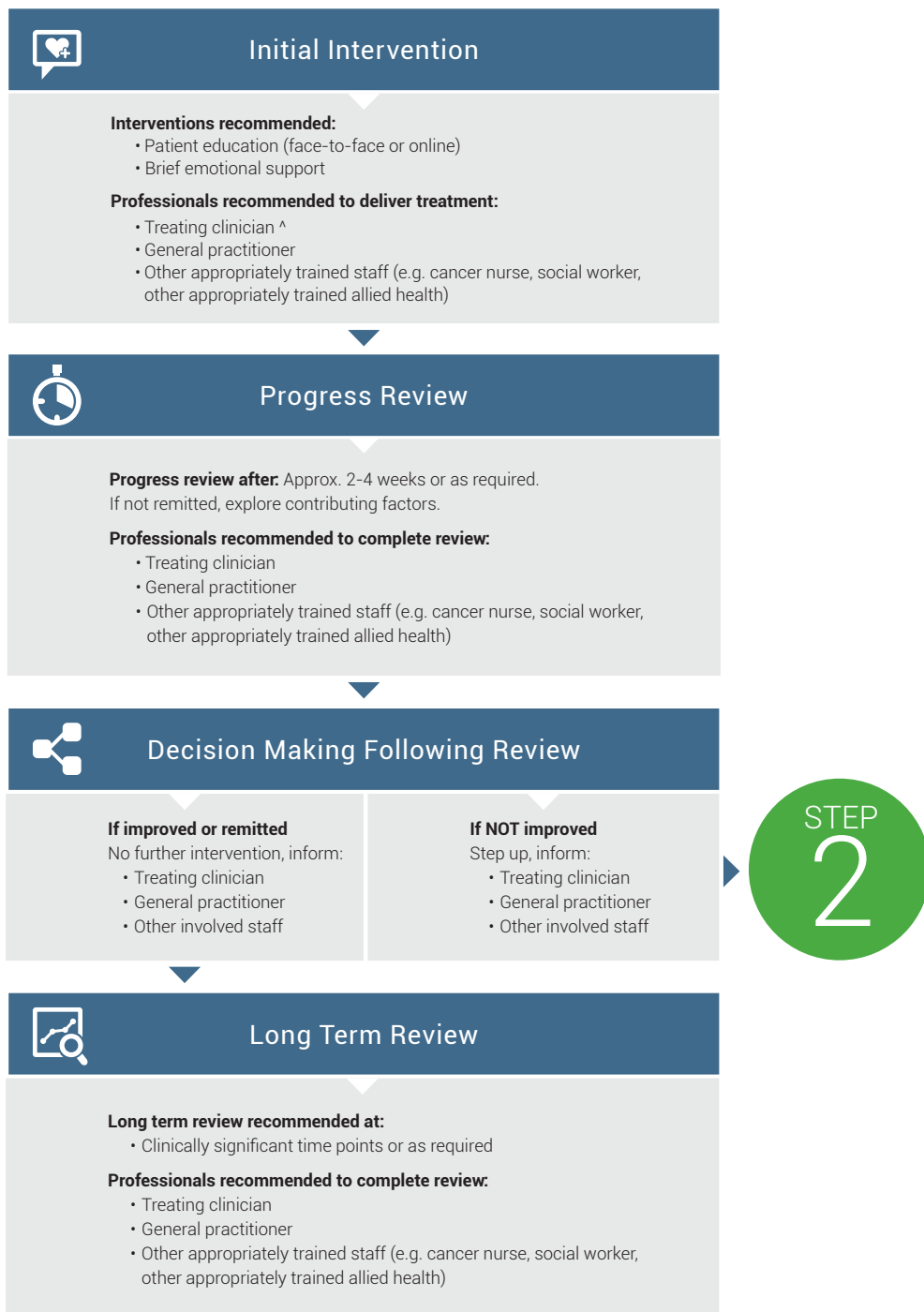
APPENDIX 2: Clinical Pathway Steps

Overview of Stepped Care



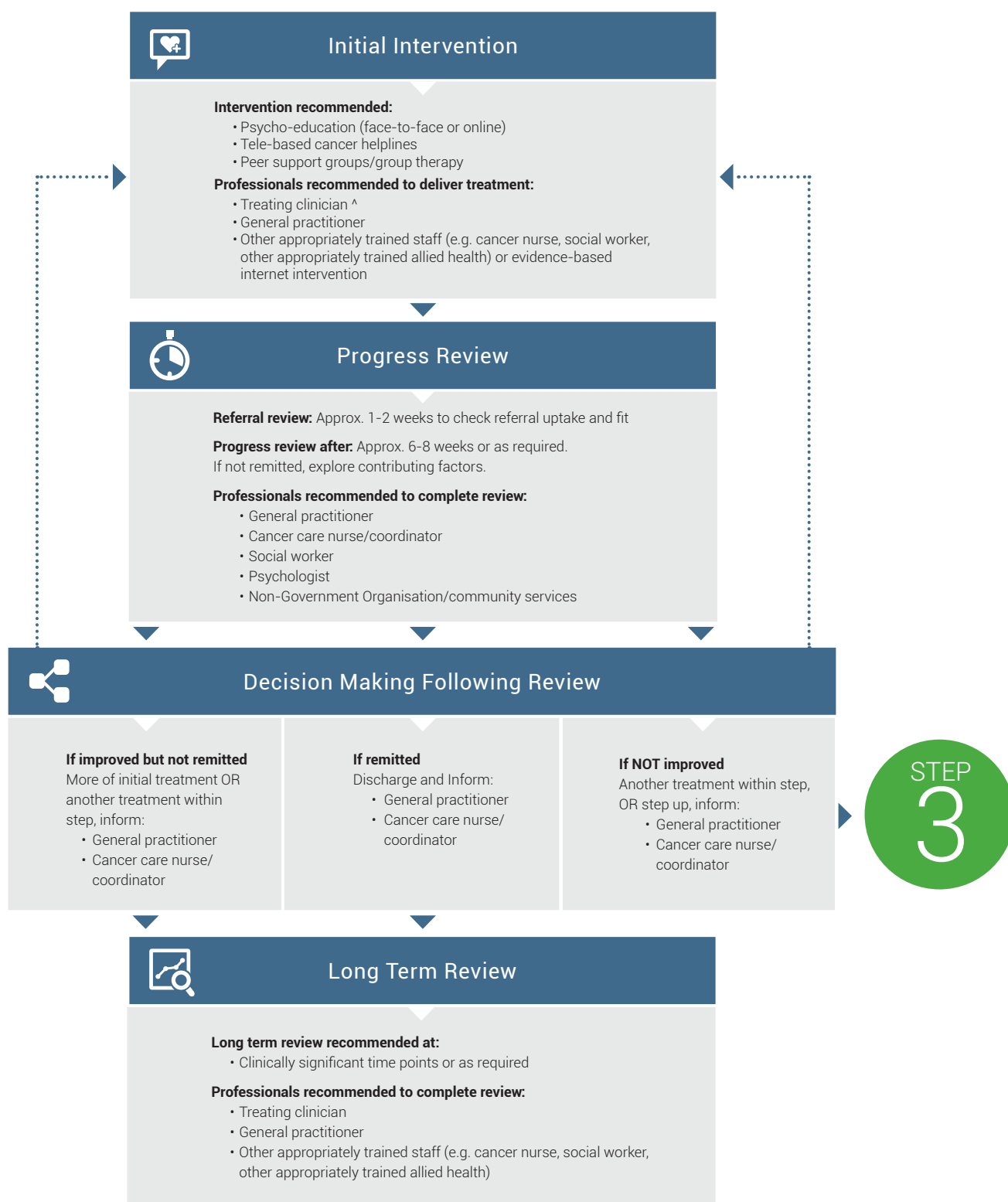
* ESAS clinical cutoffs that trigger HADs assessment are >3 on the anxiety item and >2 on the depression item.
Distress thermometer clinical cutoff that triggers HADs assessment is >4

STEP 1: Universal Care – Minimal Anxiety and/or Depression



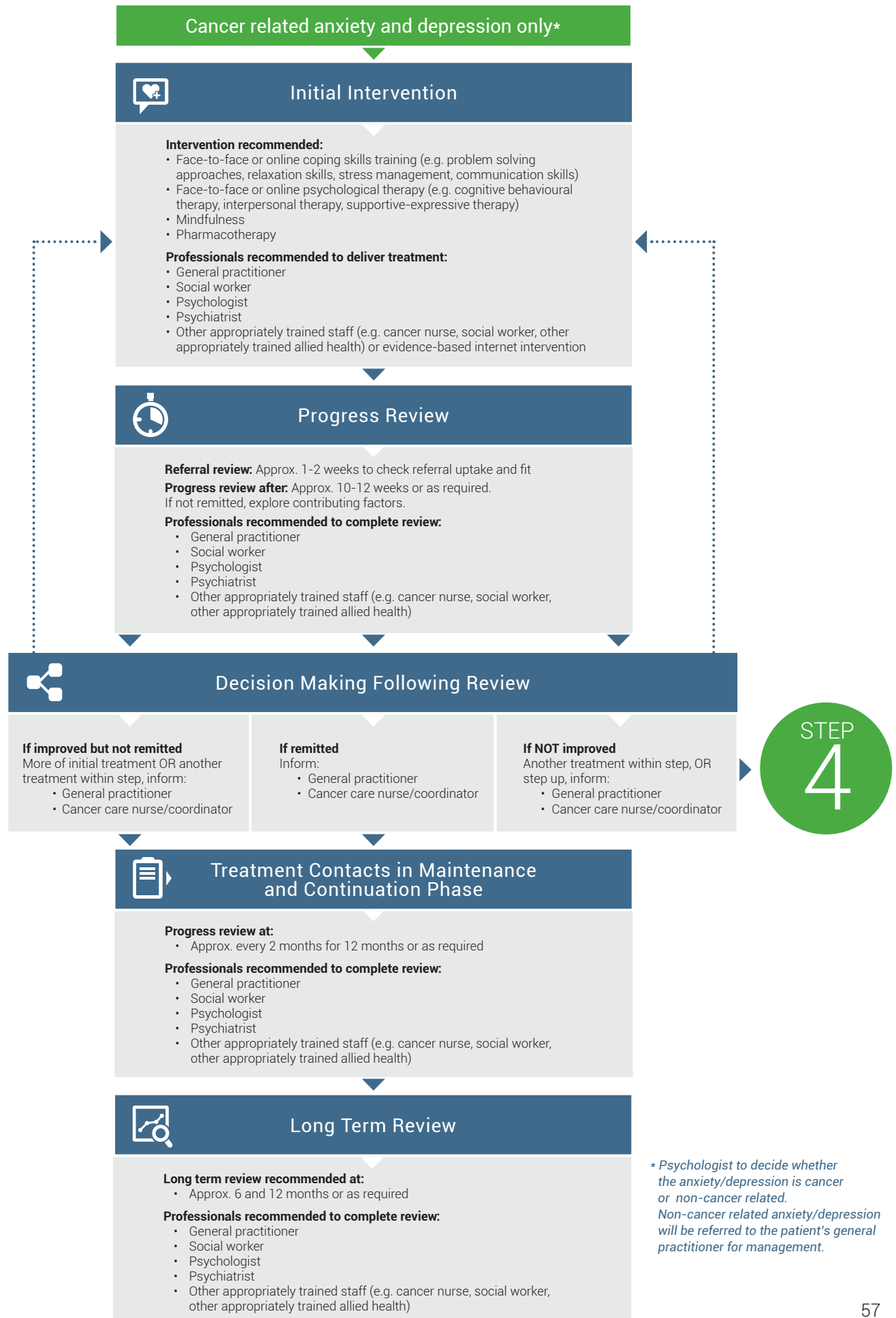
[^] Treating clinician; surgeon, medical oncologist, radiation oncologist, haematologist, palliative care physician

STEP 2: Supportive Care – Mild Anxiety and/or Depression

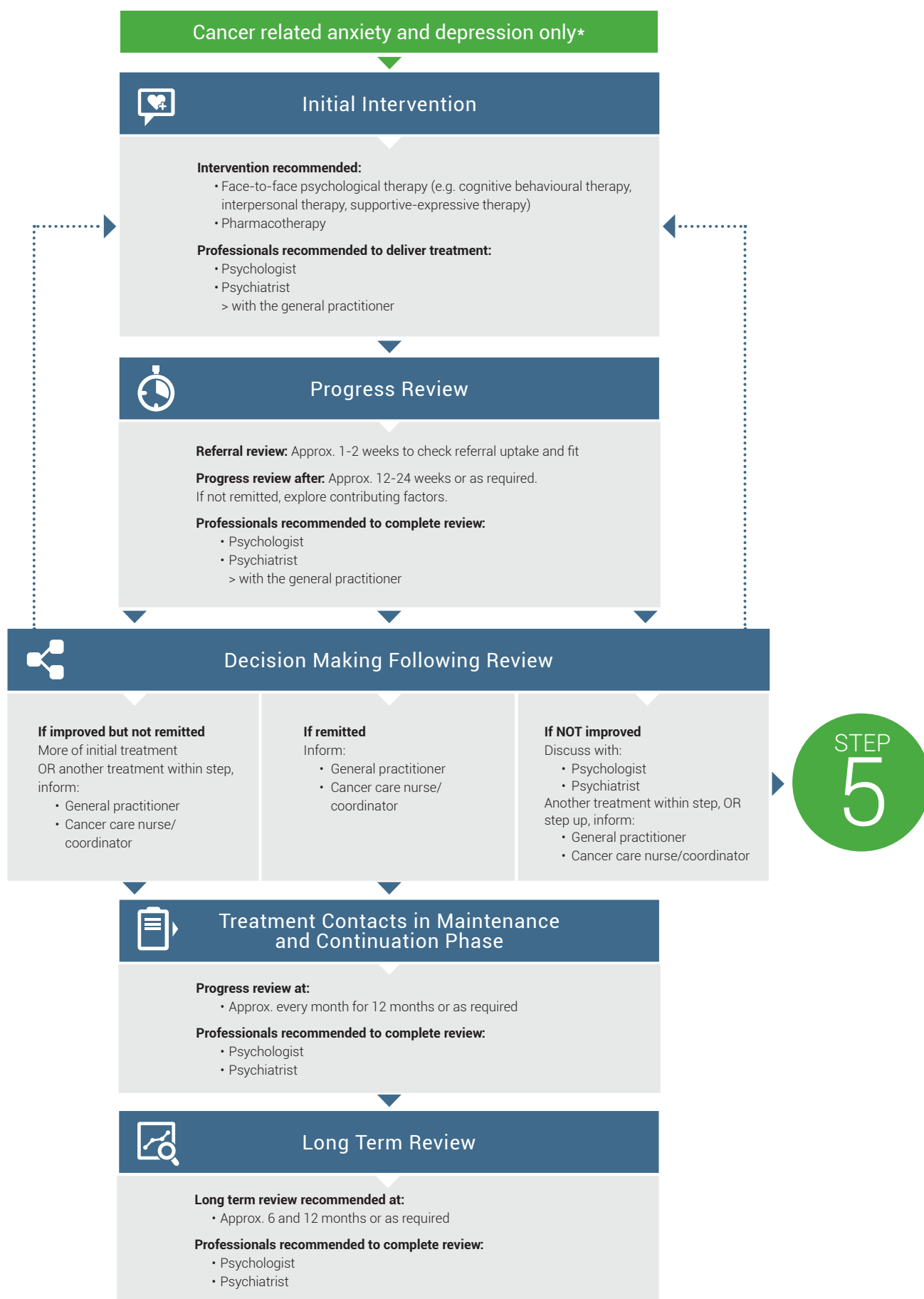


[^] Treating clinician; surgeon, medical oncologist, radiation oncologist, haematologist, palliative care physician

STEP 3: Extended Care – Moderate Anxiety and/or Depression

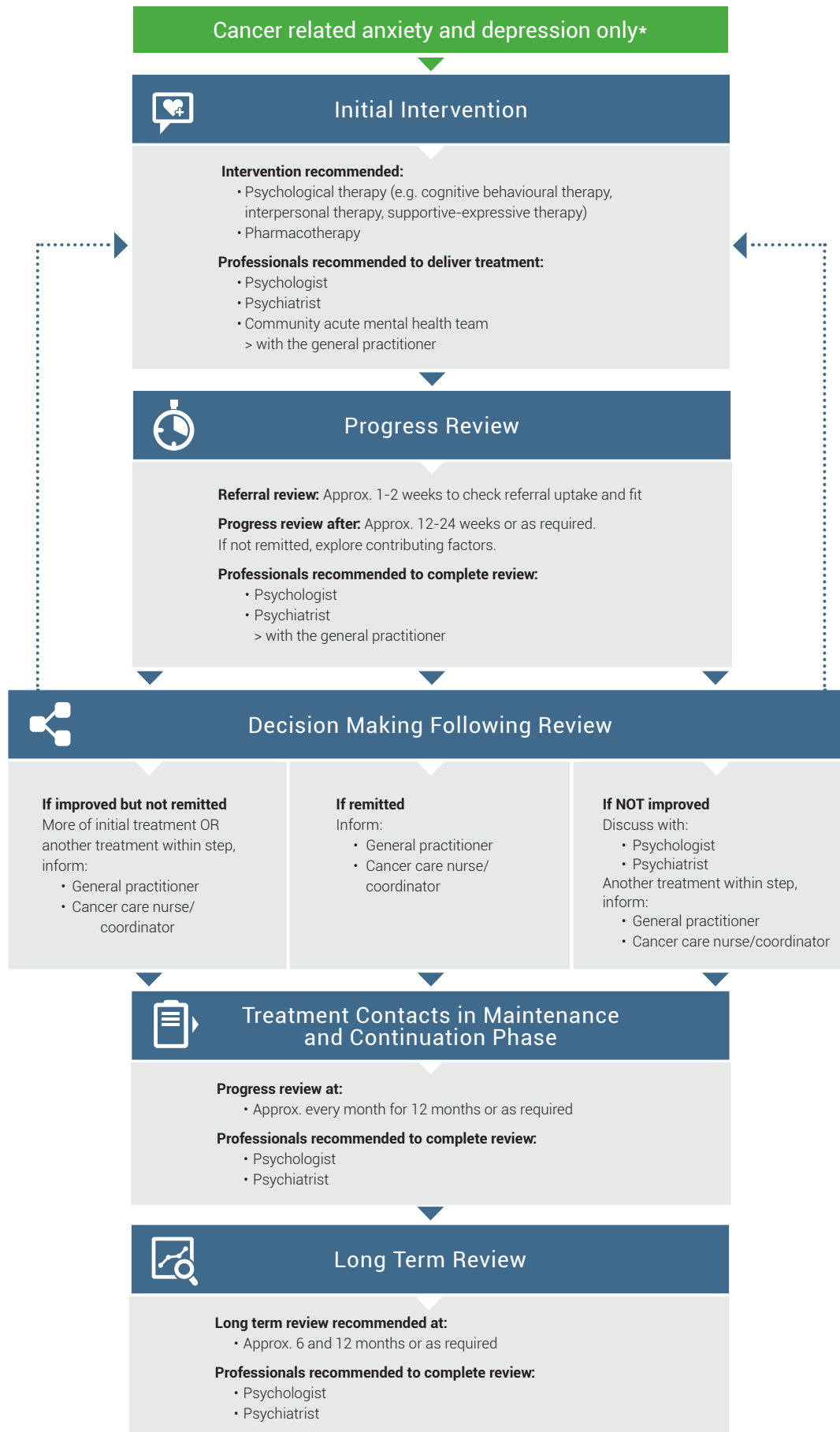


STEP 4: Specialist Care –Severe Anxiety and/or Depression



* Psychologist to decide whether the anxiety/depression is cancer or non-cancer related. Non-cancer related anxiety/depression will be referred to the patient's general practitioner for management.

STEP 5: Acute Care – Very Severe Anxiety and/or Depression and Complex Cases



* Psychologist to decide whether the anxiety/depression is cancer or non-cancer related. Non-cancer related anxiety/depression will be referred to the patient's general practitioner for management.

REFERENCES

1. Zabora J, Brintzenhofesoc K, Curbow B, et al. *The prevalence of psychological distress by cancer site.* Psychooncology, 2001. 10(1): 19-28.
2. Linden W, Vodermaier A, MacKenzie R, et al. *Anxiety and depression after cancer diagnosis: Prevalence rates by cancer type, gender, and age.* J Affect Dis, 2012. 141(2-3): 343-51.
3. Newell S, Sanson-Fisher RW, Girgis A, et al. *How well do medical oncologists' perceptions reflect their patients' reported physical and psychosocial problems? - Data from a survey of five oncologists.* Cancer, 1998. 83(8): 1640-51.
4. Fallowfield L, Ratcliffe D, Jenkins V, et al. *Psychiatric morbidity and its recognition by doctors in patients with cancer.* Br J Cancer, 2001. 84(8): 1011-5.
5. Keller M, Sommerfeldt S, Fischer C, et al. *Recognition of distress and psychiatric morbidity in cancer patients: a multi-method approach.* Ann Oncol, 2004. 15(8): 1243-9.
6. Osborn RL, Demoncada AC, Feuerstein M. *Psychosocial interventions for depression, anxiety, and quality of life in cancer survivors: Meta-analyses.* Int J Psychiat Med, 2006. 36(1): 13-34.
7. Chien CH, Liu KL, Chien HT, Liu HE. *The effects of psychosocial strategies on anxiety and depression of patients diagnosed with prostate cancer: A systematic review.* Int J Nurs Studies, 2014. 51(1): 28-38.
8. Howell D, Hack TF, Oliver TK, et al. *Survivorship services for adult cancer populations: a pan-Canadian guideline.* Current Oncology, 2011. 18(6): E265-81.
9. Mitchell AJ. *Screening for cancer-related distress: When is implementation successful and when is it unsuccessful?* Acta Oncologica, 2013. 52(2): 216-24.
10. Queensland Health Clinical Pathways Board. *Clinical Pathways. 2002.* <https://www.health.qld.gov.au/improvement/pathways>. [15/06/2017].
11. Ski CF, Page K, Thompson DR, et al. *Clinical outcomes associated with screening and referral for depression in an acute cardiac ward.* J Clin Nurs, 2012. 21(15-16): 2228-34.
12. Mooney S. *'I know they are distressed. What do I do now?'* Psychooncology, 2013. 22(9): 1946-52.
13. Butow P, Price MA, Shaw JM, et al. *Clinical pathway for the screening, assessment and management of anxiety and depression in adult cancer patients: Australian guidelines.* Psychooncology, 2015. 24(9): 987-1001.
14. Rankin NM, Butow PN, Thein T, et al. *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.* BMC Health Services Res, 2015. 15(1): 28.
15. Shaw JM, Price MA, Clayton JM, et al. *Developing a clinical pathway for the identification and management of anxiety and depression in adult cancer patients: an online Delphi consensus process.* Support Care Cancer, 2016. 24(1): 33-41.
16. Ballenger JC, Davidson JRT, Lecrubier Y, et al. *Consensus statement on depression, anxiety, and oncology.* J Clin Psychiat, 2001. 62: 64-7.
17. Howell D, Keller-Olaman S, Oliver T, et al. *A Pan-Canadian Practice Guideline: Screening, Assessment and Care of Psychosocial Distress (Depression, Anxiety) in Adults with Cancer,* Canadian Partnership Against Cancer (Cancer Journey Action Group) and the Canadian Association of Psychosocial Oncology, Editor. 2010: Toronto, ON.
18. National Comprehensive Cancer Network (NCCN). *NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for distress management V.2.2013.* National Comprehensive Cancer Network®, Inc.
19. Rodin G, Katz M, Lloyd N, Green E, Mackay JA Wong RKS, *Treatment of depression in cancer patients.* Current Oncology, 2007. 14(5): 180-8.

20. National Collaborating Centre for Mental Health. *Depression in adults with a chronic physical health problem. Treatment and management*. Clinical guideline [cg91]. 2009, National Institute for Health and Clinical Excellence (NICE): London, UK.
21. Ellis PM, Hickie I, Smith DAR, et al. *Australian and New Zealand clinical practice guidelines for the treatment of depression*. ANZ J Psychiat, 2004. 38(6): 389-407.
22. beyondblue: the national depression initiative, *beyondblue guide to the management of depression in primary care: a guide for health professionals*. 2013. beyond blue ltd: <http://resources.beyondblue.org.au/prism/file?token=bl/0484> Accessed 15/06/2017.
23. Sheldon LK, Swanson S, Dolce A, Marsh K, Summers J. *Putting Evidence Into Practice (R): Evidence-Based Interventions for Anxiety*. Clin J Oncol Nurs, 2008. 12(5): p. 789-97.
24. Fulcher CD, Badger T, Gunter AK, Marrs JA, Reese JM. *Putting Evidence Into Practice (R): Interventions for depression*. Clin J Oncol Nurs, 2008. 12(1): 131-40.
25. Qaseem A, Snow V, Shekelle P, et al. *Evidence-based interventions to improve the palliative care of pain, dyspnea, and depression at the end of life: a clinical practice guideline from the American College of Physicians*. Ann Intern Med, 2008. 148(2): 141-6.
26. Andersen BL, DeRubeis RJ, Berman BS, et al. *Screening, Assessment, and Care of Anxiety and Depressive Symptoms in Adults With Cancer: An American Society of Clinical Oncology Guideline Adaptation*. J Clin Oncol, 2014. 32(15): 1605-20.
27. Hanks H, Veitch PC, Harris MF. *A rural/urban comparison of the roles of the general practitioner in colorectal cancer management*. Aust J Rural Health, 2008. 16(6): 376-82.
28. National Cancer Institute Supportive and Palliative Care Editorial Board. *Adjustment to Cancer: Anxiety and Distress (PDQ®)*. Updated 13/01/2017 [cited <https://www.cancer.gov/about-cancer/coping/feelings/anxiety-distress-hp-pdq> Accessed 15/06/2017].
29. Couper JW, Pollard AC, Clifton DA. *Depression and cancer*. Med J Aust, 2012: 13-6.
30. Mitchell AJ, Meader N, Davies E, et al. *Meta-analysis of screening and case finding tools for depression in cancer: Evidence based recommendations for clinical practice on behalf of the Depression in Cancer Care consensus group*. J Affect Disord, 2012. 140(2): 149-60.
31. Watanabe SM, Nekolaichuk CL, and Beaumont C. *The Edmonton Symptom Assessment System, a proposed tool for distress screening in cancer patients: development and refinement*. Psychooncology, 2012. 21(9): 977-95.
32. National Comprehensive Cancer Network (NCCN). *NCCN Clinical Practice Guidelines in Oncology (NCCN Guidelines®) for distress management V.2.2016*. 2016.
33. Zigmond AS, Snaith RP. *The Hospital Anxiety and Depression Scale*. Acta Psychiatr Scand, 1983. 67(6): 361-70.
34. Lovibond PF, Lovibond SH. *The structure of negative emotional states: Comparison of the Depression Anxiety Stress Scales (DASS) with the Beck Depression and Anxiety Inventories*. Behav Res Ther, 1995. 33(3): 335-43.
35. Derogatis LR. *BSI-18: Administration, Scoring and Procedures Manual*. 200, National Computer Systems: Minneapolis.
36. McNair PM, Lorr M, Droppleman LF. *POMS manual (2nd ed.)*. 1981. Educational and Industrial Testing Service: San Diego.
37. Bruera E, Kuehn N, Miller MJ, et al. *The Edmonton Symptom Assessment System (ESAS): a simple method for the assessment of palliative care patients*. J Palliat Care, 1991. 7(2): 6-9.

38. Bagha SM, Macedo A, Jacks LM, et al. *The utility of the Edmonton Symptom Assessment System in screening for anxiety and depression*. Eur J Cancer Care, 2013. 22(1): 60-9.
39. Cancer Journey Action Group. *Guide to Implementing Screening for Distress, the 6th Vital Sign - Moving Towards Person-Centered Care: Part A: Background, Recommendations, and Implementation*. 2009, Canadian Partnership Against Cancer: Ontario.
40. Steinberg T, Roseman M, Kasymjanova G, et al. *Prevalence of emotional distress in newly diagnosed lung cancer patients*. Support Care Cancer, 2009. 17(12): 1493-7.
41. Ripamonti CI, Bandieri E, Pessi MA, et al. *The Edmonton Symptom Assessment System (ESAS) as a screening tool for depression and anxiety in non-advanced patients with solid or haematological malignancies on cure or follow-up*. Support Care Cancer, 2014. 22(3): 783-93.
42. Roth AJ, Kornblith AB, Batel-Copel L, et al. *Rapid screening for psychologic distress in men with prostate carcinoma - A pilot study*. Cancer, 1998. 82(10): 1904-8.
43. Gessler S, Low J, Daniells E, et al. *Screening for distress in cancer patients: is the distress thermometer a valid measure in the UK and does it measure change over time? A prospective validation study*. Psychooncology, 2008. 17(6): 538-47.
44. Ma XL, Zhang J, Zhong WN, et al. *The diagnostic role of a short screening tool-the distress thermometer: a meta-analysis*. Support Care Cancer, 2014. 22(7): 1741-55.
45. Bjelland I, Dahl AA, Haug TT, Neckelmann D. *The validity of the Hospital Anxiety and Depression Scale - An updated literature review*. J Psychosom Res, 2002. 52(2): 69-77.
46. Mitchell AJ, Meader N, Symonds P. *Diagnostic validity of the Hospital Anxiety and Depression Scale (HADS) in cancer and palliative settings: A meta-analysis*. J Affect Disord, 2010. 126(3): 335-48.
47. Vodermaier A, Linden W, Siu C. *Screening for Emotional Distress in Cancer Patients: A Systematic Review of Assessment Instruments*. J Natl Cancer Instit, 2009. 101(21): 1464-88.
48. American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.). 2013, Arlington, VA: American Psychiatric Publishing. ISBN:978-0-89042-555-8.
49. World Health Organization, *International Classification of Diseases (ICD)*, Version-10.
50. Holland JC. *History of psycho-oncology: Overcoming attitudinal and conceptual barriers*. Psychosom Med, 2002. 64(2): 206-21.
51. Prins MA, Verhaak PFM, Bensing JM, van der Meer K. *Health beliefs and perceived need for mental health care of anxiety and depression - The patients' perspective explored*. Clin Psychol Rev, 2008. 28(6): 1038-58.
52. Bower P, Gilbody S. *Stepped care in psychological therapies: access, effectiveness and efficiency - Narrative literature review*. Br J Psychiat, 2005. 186: 11-7.
53. Seekles W, van Straten A, Beekman A, et al. *Stepped care treatment for depression and anxiety in primary care. a randomized controlled trial*. Trials, 2011. 12: 171.
54. Gao W, Bennett MI, Stark D, et al. *Psychological distress in cancer from survivorship to end of life care: Prevalence, associated factors and clinical implications*. Eur J Cancer, 2010. 46(11): 2036-44.
55. Mehnert A, Brahler E, Faller H, et al. *Four-week prevalence of mental disorders in patients with cancer across major tumor entities*. J Clin Oncol, 2014. 32(31): 3540-6.
56. Spencer RJ, Ray A, Pirl WF, et al. *Clinical Correlates of Suicidal Thoughts in Patients With Advanced Cancer*. Am J Geriatr Psychiat, 2012. 20(4): 327-36.
57. Leung YW, Li M, Devins G, et al. *Routine screening for suicidal intention in patients with cancer*. Psychooncology, 2013. 22(11): 2537-45.
58. Urban D, Rao A, Bressel M, et al. *Suicide in lung cancer: who is at risk?* Chest, 2013. 144(4): 1245-52.
59. Devine EC, Westlake SK. *The effects of psychoeducational care provided to adults with cancer: meta-analysis of 116 studies*. Oncol Nurs Forum, 1995. 22(9): 1369-81.

60. Hawkes AL, Hughes KL, Hutchison SD, et al. *Feasibility of brief psychological distress screening by a community-based telephone helpline for cancer patients and carers.* BMC Cancer, 2010. 10.
61. Sandgren AK, McCaul KD, King B, et al. *Telephone therapy for patients with breast cancer.* Oncol Nur Forum. 2000, 27(4): 683-8.
62. Sandgren AK, McCaul KD. *Long-term telephone therapy outcomes for breast cancer patients.* Psychooncology, 2007. 16(1): 38-47.
63. White VM, Macvean ML, Grogan S, et al. *Can a tailored telephone intervention delivered by volunteers reduce the supportive care needs, anxiety and depression of people with colorectal cancer? A randomised controlled trial.* Psychooncology, 2012. 21(10): 1053-62.
64. Dunn J, Steginga SK, Rosoman N, et al. *A Review of Peer Support in the Context of Cancer.* J Psychosoc Oncol, 2003. 21(2): 55-67.
65. Lindemalm C, Strang P, Lekander M. *Support group for cancer patients. Does it improve their physical and psychological wellbeing? A pilot study.* Support Care Cancer, 2005. 13(8): 652-7.
66. Ashing K, Rosales M. *A telephonic-based trial to reduce depressive symptoms among Latina breast cancer survivors.* Psychooncology, 2014. 23(5): 507-15.
67. Montazeri A, Jarvandi S, Haghighat S, et al. *Anxiety and depression in breast cancer patients before and after participation in a cancer support group.* Pat Educat Counsel, 2001. 45(3): 195-8.
68. Kissane DW, Bloch S, Smith GC, et al. *Cognitive-existential group psychotherapy for women with primary breast cancer: A randomised controlled trial.* Psychooncology, 2003. 12(6): 532-46.
69. Breitbart W, Rosenfeld B, Pessin H, et al. *Meaning-centered group psychotherapy: an effective intervention for improving psychological well-being in patients with advanced cancer.* J Clin Oncol, 2015. 33(7): 749-54.
70. Nezu AM, Nezu CM, Felgoise SH, et al. *Project genesis: Assessing the efficacy of problem-solving therapy for distressed adult cancer patients.* J Consult Clin Psychol, 2003. 71(6): 1036-48.
71. Jacobsen PB, Jim HS. *Psychosocial interventions for anxiety and depression in adult cancer patients: Achievements and challenges.* Ca-a Cancer J Clinicians, 2008. 58(4): 214-30.
72. Hart SL, Hoyt MA, Diefenbach M, et al. *Meta-Analysis of efficacy of interventions for elevated depressive symptoms in adults diagnosed with cancer.* J Nat Cancer Instit, 2012. 104(13): 990-1004.
73. Kissane D, Li YL. *Effects of supportive-expressive group therapy on survival of patients with metastatic breast cancer: A randomized prospective trial.* Cancer, 2008. 112(2): 443-4.
74. Li M, Fitzgerald P, Rodin G. *Evidence-Based Treatment of Depression in Patients with cancer.* J Clin Oncol, 2012. 30(11): 1187-96.
75. Luebbert K, Dahme B, Hasenbring M. *The effectiveness of relaxation training in reducing treatment-related symptoms and improving emotional adjustment in acute non-surgical cancer treatment: A meta-analytical review.* Psychooncology, 2001. 10(6): 490-502.
76. Sloman R. *Relaxation and imagery for anxiety and depression control in community patients with advanced cancer.* Cancer Nurs, 2002. 25(6): 432-5.
77. Traeger L, Greer JA, Fernandez-Robles C, et al. *Evidence-based treatment of anxiety in patients with cancer.* J Clin Oncol, 2012. 30(11): 1197-1205.
78. Jacobsen PB, Meade CD, Stein KD, et al. *Efficacy and costs of two forms of stress management training for cancer patients undergoing chemotherapy.* J Clin Oncol, 2002. 20(12): 2851-62.
79. Antoni MH, Lechner SC, Kazi A, et al. *How stress management improves quality of life after treatment for breast cancer.* J Consult Clin Psychol, 2006. 74(6): 1143-52.
80. Antoni MH, Wimberly SR, Lechner SC, et al. *Reduction of cancer-specific thought intrusions and anxiety symptoms with a stress management intervention among women undergoing treatment for breast cancer.* Am J Psychiat, 2006. 163(10): 1791-7.

81. Cegala DJ. *Patient communication skills training: a review with implications for cancer patients*. Pat Educat Couns, 2003. 50(1): 91-4.
82. Clayton J, Butow P, Tattersall M, et al. *Asking questions can help: development and preliminary evaluation of a question prompt list for palliative care patients*. Br J Cancer, 2003. 89(11): 2069-77.
83. Brown R, Butow PN, Boyer MJ, et al. *Promoting patient participation in the cancer consultation: evaluation of a prompt sheet and coaching in question asking*. Br J Cancer, 1999. 80(1-2): 242-8.
84. Butow PN, Dunn SM, Tattersall MHN, et al. *Patient participation in the cancer consultation - Evaluation of a question prompt sheet*. Ann Oncol, 1994. 5(3): 199-204.
85. Kissane D. *Family-based grief counselling*. Aust Fam Physician, 1994. 23(4): 678.
86. Kissane D, Bloch S. *Family grief*. Br J Psychiat, 1994. 164(6): 728-40.
87. Whitman H, Gustafson J. *Group therapy for families facing a cancer crisis*. Oncol Nurs Forum. 1988. 16(4): 539-43.
88. Northouse LL. *Helping families of patients with cancer*. Oncol Nurs Forum, 2005. 32(4): 743.
89. Chochinov HM, Kristjanson LJ, Breitbart W, et al. *Effect of dignity therapy on distress and end-of-life experience in terminally ill patients: a randomised controlled trial*. Lancet Oncol, 2011. 12(8): 753-62.
90. Felder JN, Dimidjian S, Segal Z. *Collaboration in Mindfulness-Based Cognitive Therapy*. J Clin Psychol, 2012. 68(2): 179-86.
91. Nissim R, Freeman E, Lo C, et al. *Managing Cancer and Living Meaningfully (CALM): a qualitative study of a brief individual psychotherapy for individuals with advanced cancer*. Palliat Med, 2012. 26(5): 713-21.
92. Classen C, Butler LD, Koopman C, et al. *Supportive-expressive group therapy and distress in patients with metastatic breast cancer - A randomized clinical intervention trial*. Arch Gen Psychiat, 2001. 58(5): 494-501.
93. Piet J, Wurtzen H, Zachariae R. *The effect of Mindfulness-Based Therapy on symptoms of anxiety and depression in adult cancer patients and survivors: A systematic review and meta-analysis*. J Consult Clin Psychol, 2012. 80(6): 1007-20.
94. Shennan C, Payne S, Fenlon D. *What is the evidence for the use of mindfulness-based interventions in cancer care? A review*. Psychooncology, 2011. 20(7): 681-97.
95. Andersson G, Cuijpers P. *Internet-based and other computerized psychological treatments for adult depression: a meta-analysis*. Cog Behav Ther, 2009. 38(4): 196-205.
96. Cuijpers P, Donker T, van Straten A, et al. *Is guided self-help as effective as face-to-face psychotherapy for depression and anxiety disorders? A systematic review and meta-analysis of comparative outcome studies*. Psychol Med, 2010. 40(12): 1943-57.
97. Psychotropic Expert Groups. *Therapeutic Guidelines: psychotropic Version 7*. 2013, Therapeutic Guidelines Limited. ISBN 978-9808253-9-8: Melbourne <https://www.clinicalguidelines.gov.au/portal/2226/therapeutic-guidelines-psychotropic-version-71>.
98. Laoutidis ZG, Mathiak K. *Antidepressants in the treatment of depression/depressive symptoms in cancer patients: a systematic review and meta-analysis*. BMC Psychiat, 2013. 13.
99. Rayner L, Price A, Hotopf M, et al. *The development of evidence-based European guidelines on the management of depression in palliative cancer care*. Eur J Cancer, 2011. 47(5): 702-12.
100. American Psychiatric Association. *Practice Guidelines for the treatment of psychiatric disorders: compendium*. 2006: American Psychiatric Pub.
101. Farrington C, Palliative Care Expert Group. *Therapeutic guidelines: palliative care. Version 3*. Melbourne: Therapeutic Guidelines Limited; 2011. British Medical Journal Publishing Group.



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