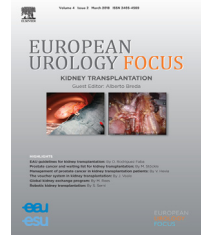




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Mini Review – Prostate Cancer

Mental Health and Cancer: Why It Is Time to Innovate and Integrate—A Call to Action

Asanga Fernando*

Cancer Services, St. George's University Hospitals NHS Foundation Trust, London, UK

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Abstract

Surgical, radio-oncological, and medical anti-cancer therapies have developed at pace and scale in recent years, yet there remains a huge unmet need for mental health in cancer care. Recent experience in the COVID-19 pandemic has added to recognition of this unmet need. There needs to be more effective clinical integration of relevant services, which must be informed by patient choice and clinical need, and accessible throughout the patient's whole cancer journey. This needs to be accompanied by training and research integration as well as more effective and creative use of technology such as virtual reality and simulation, quality assuring apps, and mobile technologies. Finally, as a clinical community we need to drive a shift in culture towards measurement of patient quality of life as a marker of treatment effectiveness. We also need to support our own clinical workforce with their own mental health needs so that we prevent the alarming rates of burnout prevalent among clinicians treating cancer. The call to action for innovation and staff support has been amplified by experience in the COVID-19 pandemic.

Patient summary: This report highlights the unmet need for mental health in cancer care. Patients need effective access to psychological support and mental health services throughout their cancer journey, including better use of technology. There is also a need to support the psychological wellbeing of cancer clinicians.

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* Cancer Services, St. George's University Hospitals NHS Foundation Trust, London, UK.
 E-mail address: asanga.fernando@stgeorges.nhs.uk

1. Introduction

The past few years have seen surgical, radio-oncological, and medical anticancer therapies develop at pace and scale. There has been growing clamour from national and international bodies to commit to effective and personalised cancer care. Yet despite this, the unmet need for mental health in cancer, and its impact on quality of life (QoL) remains as huge as ever.

Some 10% of patients will require formal psychological and mental health support within 1 yr of being diagnosed

with cancer [1]. Alarming, 73% of cancer patients with depression do not receive potentially effective care for their depression [2]. Depression is under-recognised and undertreated in cancer patients at all stages of treatment. Interestingly, despite more people living with and beyond cancer than dying from it for the first time in history, 78% of patients who have finished treatment highlight unmet emotional needs [3].

The case for urological malignancies is compelling to say the least. A recent literature review [4] addresses the

complex relationship between prostate cancer, depression, androgen deprivation therapy (ADT), erectile dysfunction, and suicidal ideation. The psychological and cognitive burdens of urological radiotherapy [5] and ADT [6] have been well documented.

It appears that despite recent developments in cancer treatment, many of which have improved patient survival, the clinical community has been rather myopic in failing to adequately consider how investing in the mental health of cancer patients can improve patient experience, QoL, functioning, and even engagement. This involves doing things differently, namely thinking innovatively and more effectively integrating mental health and psychological wellbeing into routine cancer services. It is worth pointing out that in a post-COVID-19 world, in which access to some cancer specialist treatments has been impacted, the paradigms of innovation and meaningful integration are even more important. We are likely to see more late effects of untreated cancers, including neuropsychiatric manifestations, and are already seeing a clear increase in rates of anxiety disorders in major patient groups, including cancer patients.

2. Effective integration

Effective clinical integration is contingent on first getting the right clinical services involved, and then embedding these services effectively.

We know that there is a clinical need for counselling, specialist psychology, and specialist psychiatry care for cancer patients [1], so it is important that a comprehensive psycho-oncology service includes access to these professionals, ideally with a single point of access. This model recognises both clinical need and patient choice. Some patients may prefer counselling, while others may value (more structured) psychological therapy, while others would benefit from specialist psychiatry, particularly if there are issues with capacity, treatment engagement, and prescribing of psychotropic medication, noting the underestimated nature of interactions between medical anticancer treatments and psychotropic medication. Training nurses effectively can provide a cost-effective resource in cancer care, as they can work together with psychiatrists [7]. Improving access to mental health resources for cancer patients is contingent on choice and patient engagement, and clinicians and commissioners should actively engage their patient groups in service development. Integration should also consider co-location not just physically but also in terms of information and data. Oncology and surgical clinics, ward rounds and MDTs providing embedded psychiatry and psychology should become the norm, taking into account patient choice, with clinicians having access to the same data-coding, documentation and prescribing systems.

Cancer also impacts carers and families, often with regard to finances, employment, sexual functioning, and relationships. If we are serious about improving the QoL of cancer patients, then access to these services needs to be widespread.

Patients often highlight the disparity in mental health resources between cancer centres and elsewhere in the pathway. A model for accessing psycho-oncology care across London has recently been published [8]. Better collaborative working between primary and secondary care is paramount in contributing to more accessible care. This need also exists for patients facing death at home or in palliative settings. Dying is a dynamic process, and having a good death is contingent on access to resources focusing on psychological support and mental health when necessary, especially in hospices and nursing homes. Co-location of services also offers the opportunity of better QoL data collection. The tragic burden of death in nursing and care home settings in the UK as a result of COVID-19 has sharply brought this into focus recently, both in terms of provision for patients and family and with regard to the staff providing care.

3. Innovation

It is vital that cancer services innovate beyond the clinical in terms of research and training. The author and colleagues have developed innovative simulation-based training programmes across cancer, including for clinicians concerned with communication around cancer, mental health comorbidity and end of life care.

The literature highlights a call for more mental health-related simulation [9], and this is something that we can benefit from in cancer care. Studies have demonstrated the utility of interprofessional simulation as a tool for improving staff confidence and knowledge in managing comorbid mental and physical illness [10]. Innovation is of course not limited to simulation training. An appraisal of the literature on the characteristics of technology-based interventions in prostate cancer and mental health has highlighted the need for further research in this area [11].

Increasingly, virtual reality is being utilised to enhance patient experience at the end of life and to improve QoL for patients with anxiety who have difficulty undertaking radio-oncological, medical, and surgical treatment. It is important to systematically evaluate and iteratively improve these interventions. In addition, improvements in telemedicine and more effective use of mobile technology in, for example, providing electronic cognitive behavioural therapy for cancer patients [12] need further exploration. We know that until recently, across healthcare there has been some reluctance for clinicians to engage and advocate for the use of app technology for a number of reasons; however, this does not mean that with better quality assurance processes, as well as better co-working with app developers, patients, carers, and clinicians, we cannot utilise these technologies more safely and effectively in monitoring, for example, the impact a treatment has on a patient's mood or functioning. Indeed, the COVID-19 pandemic has thrust upon us the need to embrace telemedicine where possible [13], and it is likely for the betterment of all concerned that we continue to move forward with this agenda in the aftermath of the pandemic.

Finally, perhaps the clearest call to action accentuated by the COVID-19 pandemic is that there is little point in advocating for better psychological support for cancer patients if we are unable to look after the wellbeing of our clinical workforce. It is well known that the demands on cancer clinicians lead to higher rates of burnout [14]. It is imperative that we are prepared to change our own culture by having safe, reflective spaces where clinicians can discuss their concerns in an empowering and not stigmatising manner, similar to the Balint groups used in psychiatry training schemes. It should not have to be considered innovative to highlight that staff also have very real psychological and social needs that require attention, especially if they are to continue to provide optimal patient-centred care.

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