

The Selection of a Detailed Teenage and Young Adult (TYA) Professional Assessment of Psychological Distress



In recent years we have learnt that the psychosocial needs of teenagers and young adults diagnosed with cancer are distinct from those in children and adults (National Institute for Health and Care Excellence, 2004, National Institute for Health and Care Excellence, 2005, Smith and Case, 2012, Ferrari et al., 2010, Zebrack et al., 2013). We know that different treatment centres have responded to this in different ways. In the US and the UK for example few centres adopt a standardised approach to the assessment and treatment of psychological distress in teenage and young people with cancer; instead their approach is varied and may not be optimal. The aim of this project was therefore to build a package of assessment and treatment of psychological distress in TYA with recently diagnosed cancer. In order to identify an appropriate process, and tools to assist such an assessment, we completed a scoping exercise and held a workshop, attended by ten TYA centres from across the UK. An initial professional consensus on a process from clinical assessment to screening, then to a more detailed assessment of screen-positive patients was reached.

Amanda Edmondson, Dan Stark
University of Leeds,
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Project title

The selection of a detailed TYA professional assessment of psychological distress

Background

Since the 1970s there has been a growing focus on psychological distress of adults diagnosed with cancer, with some referring to it as the 6th vital sign (Bultz and Johansen, 2011). The prevalence (20% to 47%, depending on the criteria used to define it, (Holland et al., 2013)) indicates that psychological distress within the cancer trajectory is common. Nonetheless, research has shown that psychological distress is sometimes unrecognised (and untreated) by cancer care professionals (Ma et al., 2013, Jacobsen, 2007, Fallowfield et al., 2001).

More recently specific literature has focused on teenagers and young adults (TYA) diagnosed with cancer (Kwak et al., 2013, Taylor et al., 2013, Zebrack et al., 2013). Cancer is the leading cause of disease-related death in both males and females in this age group (Office for National Statistics, 2011) and in recent years we have learnt that the psychosocial needs of this group are distinct from those in children and adults (Ferrari et al., 2010, Zebrack et al., 2013, Thomas DM et al., 2010). Prevalence rates of psychological distress would appear similar to that of adults, however, underestimation is suspected (Zebrack. et al., 2014). And, like adult services, there is an added concern that psychological distress may go unrecognised and untreated; evidence of unmet psychosocial needs for this group of patients is emerging (Zebrack et al., 2013).

From our knowledge of the adult cancer population we might deduce that the implications of unrecognised distress in TYA are numerous and potentially life threatening; for example, poor adherence to treatment recommendations (Kondryn et al., 2011), poor satisfaction with medical care (von Essen et al., 2002) and possibly reduced survival (Kennard et al., 2004). Moreover, a period of distress and increased social disruption at a formative period in life may have very long-term developmental, educational, social and vocational consequences in a group likely to survive their cancer (Gatta et al., 2014).

One of the current challenges prominent in TYA health literature therefore, is the development of a uniformed model of care for identifying and comprehensively assessing psychological distress in patients diagnosed with cancer (Bultz and Johansen, 2011). In a survey of US oncologists Pirl and colleagues (2007) identified very few centres which used standardised methods to screen for distress. We suspect the picture will be similar in the UK. We believe from clinical experience within our network of Principal Treatment Centres (PTC) for TYA cancer that the range of methods used clinically to assess psychological distress in TYA are varied and may not be optimal. We therefore welcome a nationally agreed way to assess those TYA with distress. Models of psychosocial care might employ self-report screening tools followed by a longer (detailed) professional assessment for those who screen positive. Information gathered can help support the clinical team to develop a care plan with the best chance of ameliorating the distress. For example, Depression care for people with cancer programme, an intervention employed in the SMaRT oncology trials (Sharpe et al., 2014) employed depression screening, followed by a manualised treatment programme specifically designed to be integrated with the patient cancer treatment.

Objectives

Primary aim – reach a consensus on a comprehensive assessment of screen-detected distress

Objectives

- i. To define one part of the process from clinical assessment to screening, then to more detailed assessment of screen-positive patients, then to a management plan, which meets the needs of TYA with cancer, is feasible within NHS services and supported by NHS professionals.
- ii. To define a tool which can support the comprehensive assessment, building upon or complementing the national approaches to Holistic Needs Assessment

Method

Design: The project employed a Delphi technique which is a consensus method designed to help enhance decision making through transforming opinion into group consensus (Hasson et al., 2000). The Delphi is an iterative multistage process which seeks to obtain consensus on the opinions of 'experts'. Expert (referred to as participants) opinion was gathered via email (Round 1) and face to face contact at a conference consensus' (Round 2).

Sample: Participants had expertise in caring for this group of patients, including completing assessments of distress.

Recruitment: 20 NHS Trusts featuring a TYA service (Principal Treatment Centres and Designated Hospitals) were invited to participate. The lead nurse based at each centre was sent an invitation email detailing the aims of the project and what it involved etc. Invitees were asked to accept / decline by way of an email to the project team.

16 Trusts expressed an interest in participating in the project and Trust approval was sought from all 16 Trusts: Leeds Teaching Hospital, Glasgow Beatson West of Scotland Cancer Centre, University College London Hospital, Birmingham Queen Elizabeth & Birmingham Royal Orthopaedic Hospital, Royal Marsden, The Christie, Manchester, Newcastle Freeman Hospital, Bristol Oncology Centre, Cardiff University Hospital of Wales, Lancashire Teaching Hospital Trust, Preston, Hull Castle Hill Hospital, The Clatterbridge Cancer Centre (the Wirral), Sheffield Weston Park, Southampton General and Gloucestershire NHS Trust.



13 TYA services participated in round 1: Leeds, Clatterbridge, Bristol, Glasgow, Royal Marsden, Southampton, Christie, Newcastle, Hull, Birmingham QE, Birmingham ROH, Sheffield, UCLH

10 TYA services participated in round 2 (15 TYA staff members)

Lead Nurses / CNS = 8, Nurse Consultants = 3, Psychologists = 3 and Youth Support Coordinator = 1

Consent: Consent was implied by way of acceptance to the invitation to participate in the project. For those attending the face to face conference (round 2) signed consent was sought.

Procedure:

Round 1- Email:

Each participating Trust was sent the following email:

“What do you do as a team when your TYA service sees a patient who you know / suspect is experiencing psychological distress? Discuss this as a team and prepare a short five minute presentation which will be used as a hand-out only (3 slides max). Please consider any process / pathway or tools that are used, and consider what you do particularly well and not so well. Within your discussion please aim to include a multi-disciplinary perspective. “

Round 2 – Face to face consensus conference

Lead nurses employed within each of approved Trusts were invited to nominate a colleague to represent their TYA cancer services at the event.

Following a brief introduction to the aim of the project, including how it fits into a wider programme of TYA research, the following exercises were completed with a group of 15 TYA experts.

- 1) *What might a ‘gold standard’ pathway for the assessment of psychological distress look like and what tool(s) might it feature?* The aim of this exercise was to generate content of the most effective way of working with distressed TYA patients.
 - a. *Rate the content from least to most important*
- 2) *Build a pathway (using tool(s) at diagnosis, during treatment, end of treatment and ‘other’.* For example - EOL, site specific, relapse. The aim was to produce a number of agreed pathways which could be used as a framework for the assessment and treatment of TYA patients diagnosed with cancer.

Results

Round 1 asked two questions:

- 1) What does the TYA service do with distressed patients, and
- 2) Tell us what the TYA service does well or where there may be room for improvement.

Question 1)

Process: Overall a formalised pathway / process for assessing and treating psychological distress in TYA cancer was not common. Instead, elements of a pathway existed, and informally. For example, patients would be allocated a keyworker, a holistic needs assessment would be carried out and the patient would be discussed at the psychosocial MDT meeting/Diagnostic/Therapeutic MDT meeting. In some centres the Diagnostic/Therapeutic MDT meeting and the psychosocial MDT meeting were separate. In some MDT discussions patients risk and /or need was scored using the traffic light system.

Two services reported how nurses felt confident in recognising and addressing psychological issues and would manage short term issues, although it wasn't always clear how this would be documented. Most services referred to a list of different professionals / services who provide psychological support, for example one service referred to all staff being trained to deliver level 2 psychological assessments and support (Level 2 refers to all health and social care professionals with additional expertise. They are expected to screen patients for psychological distress throughout the patient pathway and comprehensively assess the impact of cancer on their patients' lives. The assessment process should lead to a resolution of concerns or an offer of appropriate psychological support) (National Institute for Health and Care Excellence, 2004). Some staff were also trained to offer level 3 assessment and support (level 3 refers to trained and accredited professionals who are competent in assessment and diagnosis, and can deliver specific psychological interventions) (National Institute for Health and Care Excellence, 2004). The process around referral, for example, to who / when was less clear. It was also unclear how psychosocial care featured within the patients care plan; a small number (4) of TYA service referred to care plan development and / or review in the process of assessing and treating patients with distress.

Tools: In all but one of the services measurement tools for screening and / or assessment were used, however the use of tools was described by one service as 'ad hoc' in terms of when, how and who would use them. Variation in psychosocial care was evident within & across services. Moreover, when assessments were conducted, how they were documented and shared was less clear. Screening tools were definitely less common than HNA tools; in some services staff felt professional judgement and experience was as reliable and valid, and this allowed for a more informal and flexible approach to assessment which felt more appropriate and facilitative to them in eliciting psychosocial concerns.

Across the TYA services a number of different tools for screening needs / distress or completing a holistic needs assessment were being used:

- Integrated Assessment Map (IAM) – (Bristol TYA Service)
- National Cancer Survivor Initiative/ Macmillan – Identifying Your Concerns + Care plan (NCSI, 2012)
- Adapted versions of the distress thermometer used as part of HNA
- How Am I? (UCLH)
- *Sheffield Profile for Assessment and Referral to Care* -(Ahmedzai and Noble, 2007)
- Teen & Young Adult Worry & Memory Thermometers 16-24 (Royal Marsden)
- Lifestyle Questionnaire (The Christie)
- TYA Assessment of Need (CLIC Sargent)
- Hospital Anxiety and Depression Scale (Snaith and Zigmond, 1994)
- Macmillan Holistic Needs Assessment
- Patient Health Questionnaire (PHQ9) (Kroenke K et al., 2001)
- Generalised Anxiety Disorder (GAD-7)(Spitzer RL et al., 2006)
- Somerset Holistic Needs Assessment

Only one service did not routinely monitor psychological distress. In that service any psychosocial assessment was described as 'limited and open to individual approach'. The TYA team and the ward based nurses were reported to feel confident to recognise signs of psychological distress and felt

comfortable to address short term issues at a basic level. Tools were not used and referral of appropriate cases was based on professional judgement. The TYA team reported how they felt benefit from discussing it as a team and knowing they had the support of the TYA psychologist.

Question 2)

What TYA services do well / room for improvement?

The following list describes elements of the TYA service from each of the different services which work very well:

- The TYA service is comprised of a large well skilled MDT
- Recognition of mental health & wellbeing in TYA team
- Clear psychological support pathways & protocols across all levels
- Weekly psychosocial MDT with scores
- Full team involvement and ability for anyone to list a patient for discussion at the MDT meeting
- Monthly meeting - focus on HNA / assessments / formulations (planning stages)
- Refer patients with significant psychological distress to a level 4 practitioner (i.e. TYA psychologist) who will undertake a thorough psychological assessment and provide intervention
- Option to TYA – work with psychologist or other MDT member, with support from psychologist
- Psychologist presence on unit
- Those under 18 years have good access to clinical psychologists
- End of treatment support continues
- Informal assessment and generalised supportive interventions
- Wide range of support groups to support young people and their parents
- Trust & staff engagement with an integrated approach to care

The following list describes elements of the TYA service from each of the different services where it was felt there was room for improvement:

Practice Issues:

- Lack formal L2 interventions & developing formulations of patients' difficulties if not referred to a psychologist
- No care plan developed following completion of HNA by CNS team
- Completed HNA's not uploaded onto Electronic Patient Record (EPR)
- Standardised screening and assessment tools NOT used by all team members
- HNA repeated by several different health professionals & information not shared
- Duplication of referral to Psychology
- Focus on active treatment, not follow up.

- Insufficient assessment tools (absence / effectiveness)
- Lack of supported self-management
- Need to improve ward staff awareness of MH issues

Service Issues:

- Lacking a TYA psychologist or family therapy
- No late effects clinics
- Lacking a formalised pathway for psychological distress identification and following support, “still feels ad hoc”
- Equity of services across the age range
- Need for a greater diversity of psychological services available to patients
- Lack of availability of community mental health services

Round 2

Featured two parts.

- 1) *What might a ‘gold standard’ pathway for the assessment of psychological distress look like, and rate the content from least to most important,*
- 2) *Build a pathway for the different treatment groups.*

Part 1)

In this exercise 2 main findings were noted.

1. Overall the group found it difficult to physically map what they did with this group of patients, i.e. they found it difficult to construct a care pathway related to the assessment of psychological distress. Provision of psychosocial care was not thought of as a ‘pathway’. Provision was informal and narratives were offered. For example, staff discussed how it was important to consider where the patient is in their journey with cancer as this would determine what support / resource might be offered. There was limited reference to timelines / tools / decision making flow charts etc. There was ambivalence toward the use of tools to screen and / or assess levels of distress; clinical judgement and experience were considered more reliable and feasible.

It was evident in the discussions that there was some confusion regarding the purpose of a screening tool and when it might be used. Those services that did use a screening tool appeared to use it as part of a holistic needs assessment rather than prior to, or to inform the need to do a further assessment.

2. There was not agreement on a ‘gold standard’ pathway. It was questioned whether a pathway was needed. For some TYA services there wasn’t an apparent gap in psychosocial provision therefore thinking of ways to provide a ‘gold standard’ service was not felt necessary. Throughout the exercise there was a sense of a distinct approach to psychosocial care, which was perceived as secondary when compared with medical care. Psychological

issues were dealt as and when a need is identified informally, whether it be a patient / family request or significant signs of distress are observed incidentally, then a referral to psychology is placed without any further assessment. It is worth noting however that a more structured approach to the assessment and treatment of psychological issues during cancer treatment has been shown to improve cancer related symptoms of depression, anxiety, pain and functional ability overall (Sharpe et al., 2014).

Next we broke down exercise 1 further to map out the psychosocial pathway for different patient groups.

Part 2)

Small groups worked on different patient groups and produced a pathway from clinical assessment through to care plan development / review. Common features were apparent - appointment schedules, allocation of keyworker, schedules for psychosocial screen and assessment, and a traffic light system for identifying distress and an action plan (see appendices 1. Initial consensus on psychosocial care pathways for TYA patients - newly diagnosed, going through treatment, during long term follow up or relapsed.

Discussion

At the end of the scoping exercise and the workshop we defined a process from general assessment psychological screening to more detailed assessment of screen-positive patients, and then to a management plan, which may better meet the needs of TYA at different points in their care. More needs to be done to develop support from all NHS professionals for this approach. Tools which complement the national approaches to Holistic Needs Assessment were identified, but very varied and not selected on explicit grounds.

Although in the main we have met the aims of this piece of work it is important to note a number of areas for further work.

- a) There was unfamiliarity with tools used widely in healthcare for screening for psychological distress and their clinical value. Clinical judgment and experience was considered more reliable and valid - perhaps as a result of the dearth of validated tools for this population. This strengthens the need for our companion study, which aims to validate a screening tool for distress for teenage and young adults diagnosed with cancer.
- b) A potential learning need for TYA staff was identified. There was a lack of knowledge regarding the difference between tools used for screening, those for a holistic needs assessment, and those to assess psychological issues in detail. Education around the use of measurement tools and their clinical utility may be welcomed.
- c) For those staff who are not trained to recognize mental health issues, this type of work can be very daunting and people may become concerned about issues relating to competency and accountability.

- d) Care pathways and measurement tools help us provide standardised care and equitable services to our patients, but they also have a professional risk-management aspect and therefore we need to consider how much psychological morbidity and 'risk' TYA cancer services are aware of in services. How / whether psychological risk is noticed and identified may impact on the perceived need for a formalised pathway, and any implementation efforts.

In the future, commissioned TYA services must demonstrate clinical effectiveness and will need to consider how we demonstrate our effectiveness in relation to psychological wellbeing for patients whether they are remaining well, having lower levels of distress managed by their wider TYA MDT members, or specifically referred to a psychologist.

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Appendices

Psychosocial Care Pathway for TYAs at First Diagnosis			
Diagnosis	SKILLS / SERVICE SET UP	All core staff complete level 2 psychological skills training (to include YSC)	MDT weekly meeting to discuss medical and psychosocial information
	PRE DIAGNOSIS	TYA MDT team gets names awaiting histology (designated and PTC) a- all patients regardless of diagnosis (disease type)	TYA team to contact local team and offer support to young person and NHS team Discussion around choices - place of care, introduce TYA service
	DIAGNOSIS APPT	Assigned key worker / social worker Key worker to be present at consultation about diagnosis	Informal expert discussion - Key worker to introduce TYA service (if not discussed previously) what's next, meet the team, date of next contact, and contact details
	EARLY APPT post diagnosis	Key worker to spend time 1:1 with TYA patient - patient led as to timing / location	Relationship building / gathering information - Informal general assessment of demeanour, body language, interaction with parents / professionals
	FIRST SCREEN	Within 1 to 2 weeks of diagnosis key worker TO COMPLETE FIRST SCREEN using recommended tools and upload / copy into EPR. Entry to include score & action	<ul style="list-style-type: none"> • CanTeen Distress Thermometer and concerns checklist • Royal Marsden – Worry and Memory Thermometer • Macmillan – 'Identifying Your Concerns Tool' • SPARC
Share screening score at MDT meeting – is score normal given context?			
MDT ACTION		Discussion at MDT – provide overall score / indication of need in relation to all domains e.g. Medical / Treatment, Social and Psychological status. Use HNA from social work to inform score	This would be a recognised system which clearly indicates level need / input required for each patient as they move through the care pathway
		Green (score of 0-3) – mild concern	Amber (4-6) – moderate concern
		Red (7-10) – significant concern	
	Watch and wait Assess in 4-6 weeks time Offer routine practical advice • Regular exercise • Sleep advice • Diet Information provision • Information booklet - TYA specific? • Support groups • Complementary therapy (relaxation, massage) • Hair loss support • Spiritual care	Rescreen in X days Offer routine practical Advice • Regular exercise • Sleep advice • Diet Information provision • Information booklet - TYA specific? • Support groups • Complementary therapy (relaxation, massage) • Hair loss support • Spiritual care - Ask if patients wants extra support at this time Refer to GP -if good relationship with GP -if past medical history of depression/anxiety or on medication	Step up to comprehensive assessment and / or referral to level 3 or 4 practitioner Use CanTeen Psychosocial Assessment Patient displaying suicidal ideation? Acute immediate help required? Immediate referral to Clinical Psycho-Oncology / Liaison Psychiatry Severe disruption of function? Refer to Clinical Psycho-Oncology Refer to social worker if distress relates to financial, family, practical or legal concerns.
CARE PLAN	Develop care plan with patient to include psychosocial assessment and agreed action		

During Treatment

Psychosocial Care Pathway for TYAs During Treatment					
During Treatment	REVIEW CARE PLAN	Maintain contact with patient and REVIEW working care plan See TYA psychologist as an introduction to the service (on the ward) – not active support			
	RESCREEN & RESCORE AS TREATMENT COMMENCES	CanTeen Distress Thermometer and concerns checklist; Royal Marsden – Worry and Memory Thermometer; Macmillan – ‘Identifying Your Concerns Tool’; SPARC HAS SIGNIFICANT CHANGE OCCURRED SINCE TREATMENT COMMENCED?			
		YES		NO	
	ASSESSMENT	Complete HNA: CanTeen Psychosocial Assessment. – ensure it is recorded and shared – ability to update & identify issues		Continue with working care plan AND rescreen at 6-8 weeks or EOT, whichever comes sooner	
		HNA identified issues of psychological / social concern?			
		NO	YES		
		Green (score of 0-3)	Amber (4-6)		Red (7-10)
	ACTION	<p>Watch and wait – rescreen at 6-8 weeks or EOT, whichever comes sooner</p> <p>Offer routine practical advice</p> <ul style="list-style-type: none"> • Regular exercise • Sleep advice • Eating well during treatment <p>Information provision</p> <ul style="list-style-type: none"> • Information booklet - TYA specific? • Drop in sessions – Chomp & Chat • Support groups • Complementary therapy (relaxation, massage) • Hair loss support • Spiritual care 	<p>Reassess in X days:</p> <p>Offer Practical Advice</p> <ul style="list-style-type: none"> • Regular exercise • Sleep advice • Eating well during treatment <p>Information provision</p> <ul style="list-style-type: none"> • Information booklet - TYA specific? • Drop in sessions – Chomp & Chat • Support groups • Complementary therapy (relaxation, massage) • Hair loss support • Spiritual care <p>Ask if patient wants extra support at this time.</p> <p>Refer to GP</p> <ul style="list-style-type: none"> -if good relationship with GP -if past medical history of depression/anxiety or on medication 		<p>Referral to level 3 or 4 practitioner</p> <p>Patient displaying suicidal ideation? Acute immediate help required? Immediate referral to Clinical Psycho-Oncology / Liaison Psychiatry</p> <p>Severe disruption of function? Refer Clinical Psycho-Oncology</p> <p>Refer to social worker if distress relates to financial, family, practical or legal concerns.</p>
		DISCUSS AT PSYCHOSOCIAL MDT			
	CARE PLAN REVIEW	Update care plan - revise action points based on revised score / needs assessment			

Psychosocial Care Pathway for TYAs During Long Term Follow Up & Discharge (up to 5 years)					
Long Term Follow Up & Discharge	EOT MEETING – REVIEW CARE PLAN	<p>Outreach home visit to review care plan for end of treatment – Key worker, social worker</p> <p>Review overall score (Green , Amber or Red)</p> <p>PSYCHOLOGICAL : Rescreen using recommended tools CanTeen Distress Thermometer and concerns checklist; Royal Marsden – Worry and Memory Thermometer; Macmillan – ‘Identifying Your Concerns Tool’; Emotional Thermometers + help (Alex Mitchell); SPARC</p> <p>Review resilience questions - Resilience Scale for Adolescents (READ) 13-15 years. The Brief Resilience Scale (USA/English) – aged 19-62</p>			
	Distress score above 4?				
	YES		NO		
	REASSESS & RESCORE	Complete HNA: Use HEADSS or CanTeen Psychosocial Assessment.		Continue working to EOT care plan	
	HNA identified issues of psychological / social concern?				
	NO		YES		
	ACTION	Green	Amber		Red
		<p>Watch and wait – rescreen only at follow up outpatient appointments. Offer Practical Advice</p> <ul style="list-style-type: none"> Regular exercise Sleep advice Eating well during treatment <p>Information provision</p> <ul style="list-style-type: none"> Information booklet - TYA specific? Drop in sessions – Chomp & Chat Support groups Complementary therapy (relaxation, massage) Hair loss support Spiritual care 	<p>Practical Advice</p> <ul style="list-style-type: none"> Regular exercise Sleep advice Eating well during treatment <p>Information provision</p> <ul style="list-style-type: none"> Information booklet - TYA specific? Drop in sessions – Chomp & Chat Support groups Complementary therapy (relaxation, massage) Hair loss support Spiritual care <p>Reassess in X days</p> <p>Refer to GP</p> <ul style="list-style-type: none"> -If good relationship with GP -If past medical history of depression/anxiety or on medication 	<p>Referral to level 3 or 4 practitioner</p> <p>Patient displaying suicidal ideation? Acute immediate help required? Immediate referral to Clinical Psycho-Oncology / Liaison Psychiatry</p> <p>Severe disruption of function? Refer Clinical Psycho-Oncology</p> <p>Refer to social worker if distress relates to financial, family, practical or legal concerns.</p>	
REFER TO APPROPRIATE ORGANISATION		DISCUSS AT PSYCHOSOCIAL MDT			
CAREPLAN REVIEW	Care plan review - revise action points based on revised score and allocate person responsible				
OTHER	<p>Inform patient of next End of treatment Day</p> <p>Invitation for 6/52 course – Macmillan HOPE</p> <p>Invite them to download online App – directory of local services</p> <p>Offer contact details for TYA team for ongoing support</p>				

Psychosocial Care Pathway for Relapse Patients			
Relapse	CONFIRMED	Consultant confirms to TYA team that relapse has occurred	
	CONTACT & CARE PLANNING	TYA professional to attend clinic appointment TYA professional to conduct home visit or to see patient at next admission – develop working care plan, to include screening	
	SCREEN	CanTeen Distress Thermometer and concerns checklist; Royal Marsden – Worry and Memory Thermometer; Macmillan – ‘Identifying Your Concerns Tool’; Emotional Thermometers + help (Alex Mitchell); SPARC Include resilience questions - Resilience Scale for Adolescents (READ) 13-15 years. The Brief Resilience Scale (USA/English) – aged 19-62 DISTRESS SCORE ABOVE 4?	
		YES	NO
	ASSESSMENT	Complete HNA: Use HEADSS or CanTeen Psychosocial Assessment.	Continue with working care plan AND rescreen at 6-8 weeks or EOT, whichever comes sooner
	ACTION	Share assessment scores at MDT meeting - Discussion at MDT – provide overall score / indication of need in relation to all domains e.g. Medical / treatment, social and psychological status. Green (score of 0-3) Watch and wait – rescreen at in/outpatient appointments. Approximately every 4-6 weeks Offer Practical Advice • Regular exercise • Sleep advice • Eating well during treatment Information provision • Information booklet - TYA specific? • Drop in sessions – Chomp & Chat • Support groups • Complementary therapy (relaxation, massage) • Hair loss support • Spiritual care Amber (4-6) Practical Advice • Regular exercise • Sleep advice • Eating well during treatment Information provision • Information booklet - TYA specific? • Drop in sessions – Chomp & Chat • Support groups • Complementary therapy (relaxation, massage) • Hair loss support • Spiritual care Reassess in X days Refer to GP -If good relationship with GP -If past medical history of depression/anxiety or on medication Red (7-10) Referral to level 3 or 4 practitioner Patient displaying suicidal ideation? Acute immediate help required? Immediate referral to Clinical Psycho-Oncology / Liaison Psychiatry Severe disruption of function? Refer Clinical Psycho-Oncology Refer to social worker if distress relates to financial, family, practical or legal concerns.	
	CARE PLAN REVIEW	Update care plan - revise action points based on revised score and allocate person responsible	