Integrated Psychosocial Care for Survivors: What The Primary Care Behavioral Health Model Can Offer

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No COI to disclose

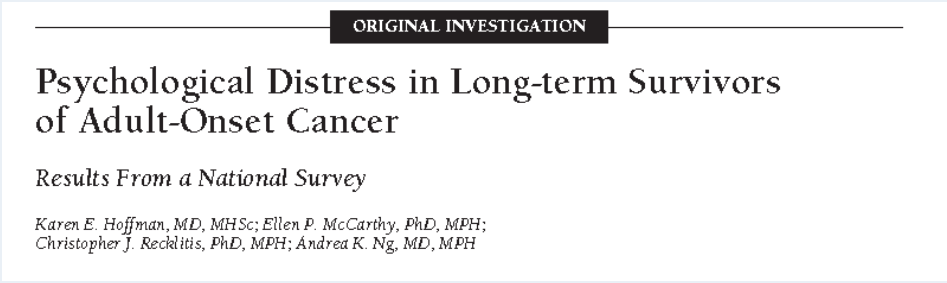
Overview

- Psychosocial care for survivors
  - Psychosocial needs
  - Need for integrated care
- Primary Care Behavioral Health Mod
  - Adaptation for survivorship care
    - Provider roles & services
    - Implementation examples
    - Advantages & challenges

- *Survivors months & years post-treatment*
- *Generalizing across groups*
  - *ages, gender, diagnoses*
- *Implications will differ according to your practice setting and population*

Psychological Outcomes in Survivors

- Most cohort & populations based studies indicate survivors at increased risk for poor psychosocial outcomes

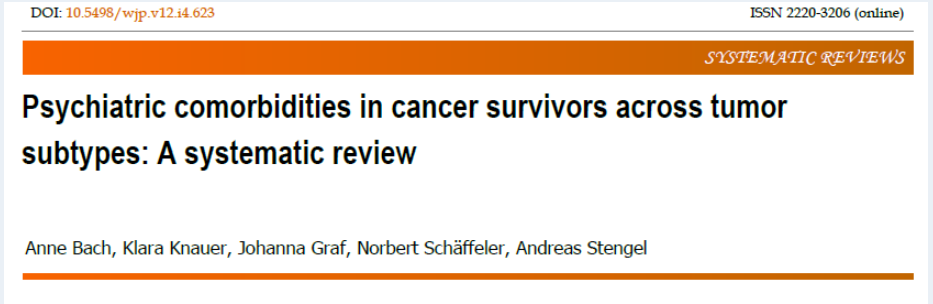


ORIGINAL INVESTIGATION

Psychological Distress in Long-term Survivors of Adult-Onset Cancer

Results From a National Survey

Karen E. Hoffman, MD, MHSc; Ellen P. McCarthy, PhD, MPH; Christopher J. Recklitis, PhD, MPH; Andrea K. Ng, MD, MPH

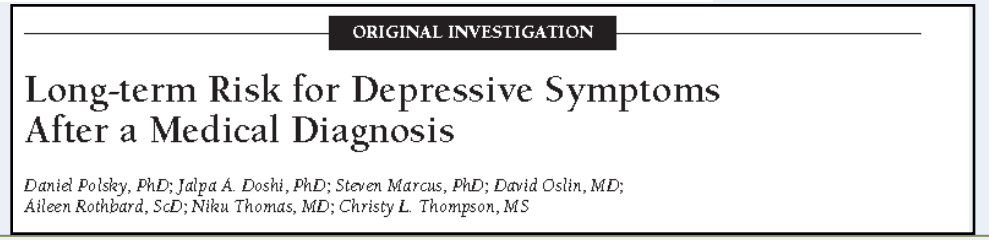


DOI: 10.5498/wjp.v12.i4.623 ISSN 2220-3206 (online)

SYSTEMATIC REVIEWS

Psychiatric comorbidities in cancer survivors across tumor subtypes: A systematic review

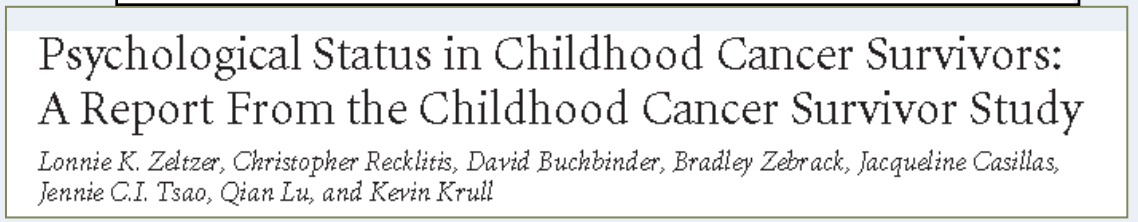
Anne Bach, Klara Knauer, Johanna Graf, Norbert Schäffeler, Andreas Stengel



ORIGINAL INVESTIGATION

Long-term Risk for Depressive Symptoms After a Medical Diagnosis

Daniel Polsky, PhD; Jalpa A. Doshi, PhD; Steven Marcus, PhD; David Oslin, MD; Aileen Rothbard, ScD; Niku Thomas, MD; Christy L. Thompson, MS



Psychological Status in Childhood Cancer Survivors: A Report From the Childhood Cancer Survivor Study

Lonnie K. Zeltzer, Christopher Recklitis, David Buchbinder, Bradley Zebrack, Jacqueline Casillas, Jennie C.I. Tsao, Qian Lu, and Kevin Krull

Psychological Problems: Depression & Anxiety

Depression and anxiety in long-term cancer survivors compared with spouses and healthy controls: a systematic review and meta-analysis

Alex J Mitchell, David W Ferguson, John Gill, Jim Paul, Paul Symonds

- Common in general population but more prevalent in survivors
  - Particularly anxiety
  - Particularly earlier in survivorship
  - Particularly younger survivors

▷ Increased symptoms reported more consistently than increase in diagnoses

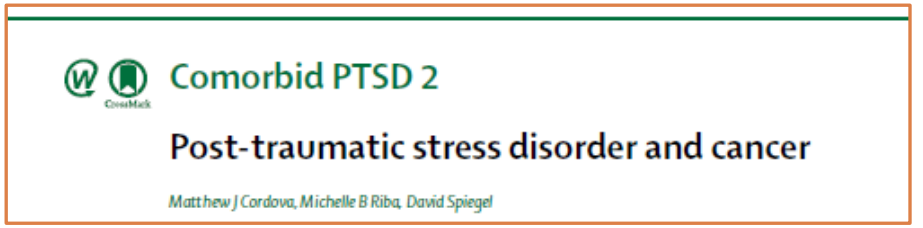
Post-Traumatic Stress: Symptoms v. Disorder

PTS Disorder:

- Not common in survivors (<10%)
- Survivors not typically > controls

PTS Symptoms or Sub-threshold PTSD

- More common in survivors' (10-20%)
  - Survivors more commonly report symptoms not PTSD diagnosis


Comorbid PTSD 2

Post-traumatic stress disorder and cancer

Matthew J Cordova, Michelle B Riba, David Spiegel


20 PSYCHIATRIC TIMES www.psychiatrictimes.com

Psychosomatics

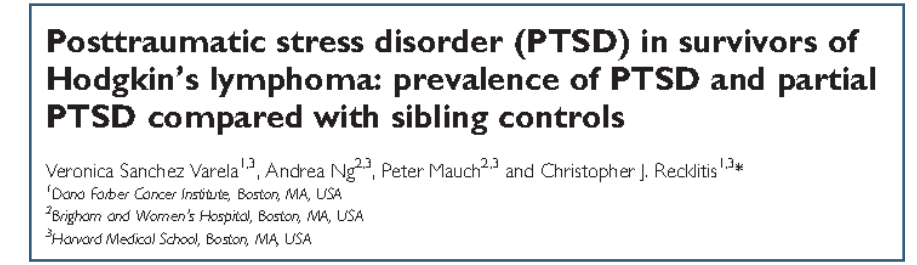
JULY 2020

Cancer-Related Posttraumatic Stress Disorder
Assessment and Treatment Considerations

» Matthew J. Cordova, PhD

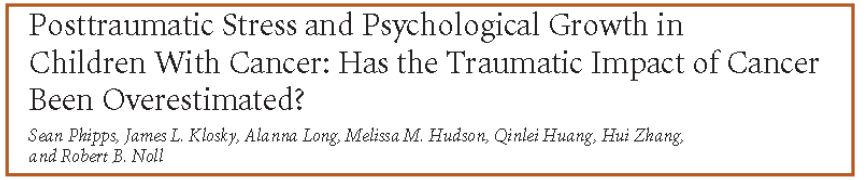
small minority of patients with cancer

Table. Key concepts in cancer-related PTSD


Posttraumatic stress disorder (PTSD) in survivors of Hodgkin's lymphoma: prevalence of PTSD and partial PTSD compared with sibling controls

Veronica Sanchez Varela[1,3], Andrea Ng[2,3], Peter Mauch[2,3] and Christopher J. Recklitis[1,3]*

[1]Dana Farber Cancer Institute, Boston, MA, USA
[2]Brigham and Women's Hospital, Boston, MA, USA
[3]Harvard Medical School, Boston, MA, USA


Posttraumatic Stress and Psychological Growth in Children With Cancer: Has the Traumatic Impact of Cancer Been Overestimated?

Sean Phipps, James L. Klosky, Alanna Long, Melissa M. Hudson, Qinlei Huang, Hui Zhang, and Robert B. Noll

Cancer Specific Concerns: Fear of Cancer Recurrence (FCR)

- Can occur:
  - Across diagnoses
  - Many years after treatment
- Low intensity in most cases (80%) but not all!

Fear of recurrence in long-term breast cancer survivors—still an issue. Results on prevalence, determinants, and the association with quality of life and depression from the Cancer Survivorship—a multi-regional population-based study

Lena Koch[1]*, Heike Bertram[2], Andrea Eberle[3], Bernd Holleczek[4], Sieglinde Schmid-Höpfner[5], Annika Waldmann[6], Sylke R. Zeissig[7], Hermann Brenner[1] and Volker Arndt[1]

Fear of cancer recurrence in adult cancer survivors: a systematic review of quantitative studies

Sébastien Simard · Belinda Thewes · Gerry Humphris · Mélanie Dixon · Ceara Hayden · Shab Mireskandari · Gozde Ozakinci

Factors reported to influence fear of recurrence in cancer patients: a systematic review

Jade V. Crist[1] and Elizabeth A. Grunfeld[2]*

Received: 6 November 2017 | Revised: 21 March 2018 | Accepted: 19 April 2018
DOI: 10.1002/pon.4757

REVIEW

WILEY

Mind-body interventions for fear of cancer recurrence: A systematic review and meta-analysis

Daniel L. Hall[1,2] | Christina M. Luberto[1] | Lisa L. Philpotts[3] | Rhayun Song[4] | Elyse R. Park[1,5,6] | Gloria Y. Yeh[2]

Health Related: Mind/Body Syndromes

- Syndromes strongly affected by interplay of biological, social & psychological factors
  - Fatigue
  - Insomnia
  - Pain
  - Sexual health
  - Cognitive changes
  - FCR

Special Article

Psychotherapy and Psychosomatics

Psychother Psychosom 2017;86:13–30
DOI: 10.1159/000448856

Current Psychosomatic Practice

Giovanni A. Fava[a, d] Fiammetta Cosci[b] Nicoletta Sonino[c, d]

CLINICAL REVIEW

Systematic review and meta-analysis of cognitive-behavioural therapy for insomnia on subjective and actigraphy-measured sleep and comorbid symptoms in cancer survivors

Lauren R. Squires [a, b], Joshua A. Rash [b], Jonathan Fawcett [b], Sheila N. Garland [b, c, *]

Interpretation Bias in Breast Cancer Survivors Experiencing Fear of Cancer Recurrence

Malwina Tuman[1], Kailey E. Roberts[2], Geoffrey Corner[3], Courtney Beard[4,5], Carol Fadalla[1], Taylor Coats[1], Elizabeth Slivjak[6], Elizabeth Schofield[1] and Wendy G. Lichtenthal[1]*

Original Article

Improvement in Sexual Function After Ovarian Cancer: Effects of Sexual Therapy and Rehabilitation After Treatment for Ovarian Cancer

Sharon L. Bober, PhD [1,2]; Christopher J. Recklitis, PhD, MPH[1,2]; Alexis L. Michaud, BA[1]; and Alexi A. Wright, MD, MPH[1,2]

Psychosocial Morbidity: Medical Risk Factors

- Intensity and site of treatment
  - CNS, Head & Neck, BMT, disfiguring
- Physical health & functioning
  - pain, limitations, insomnia, chronic conditions, “poor” health
- Current medications
  - Chemoprevention, chronic disease related

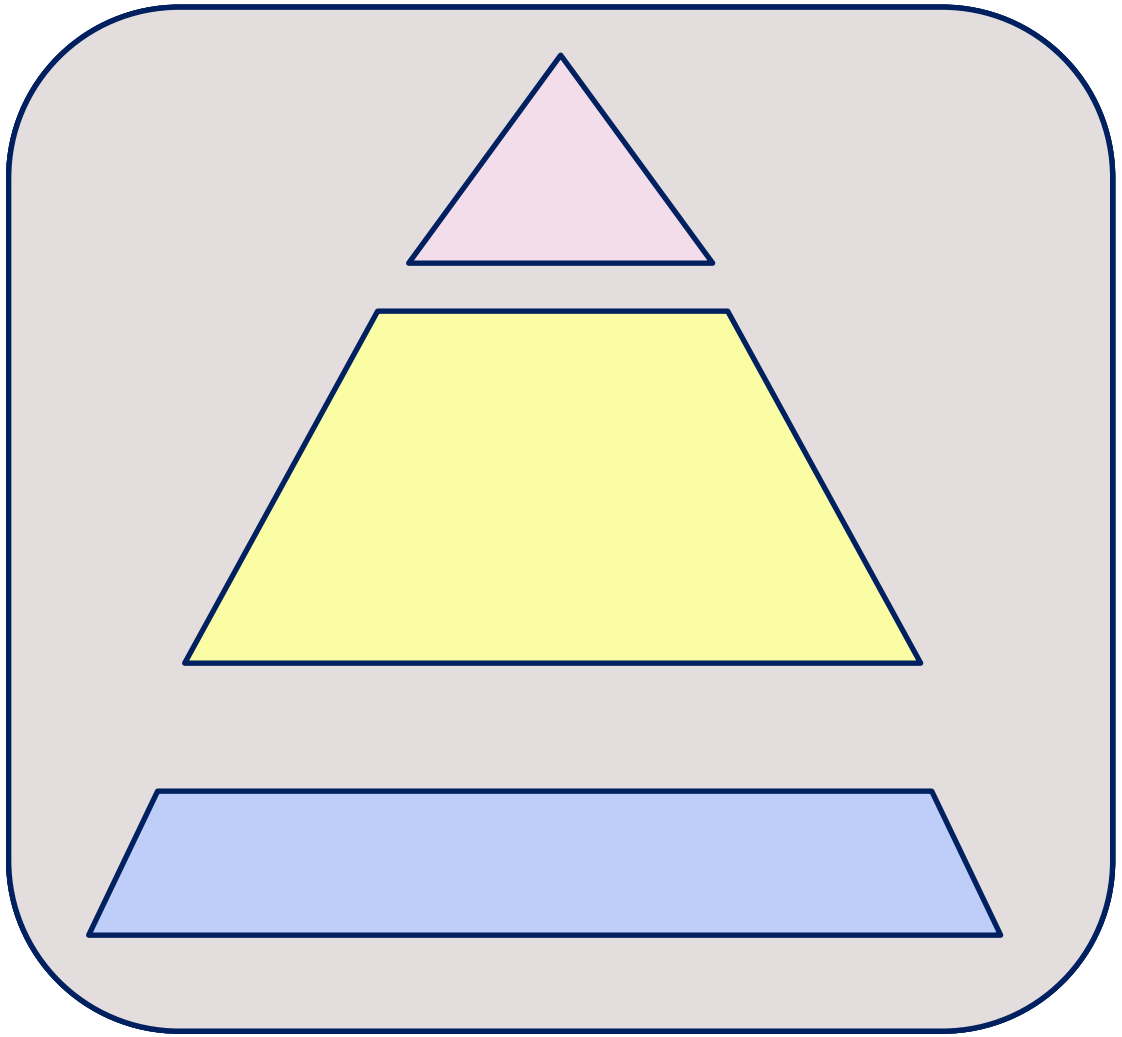
- What are the implications for psychosocial care?

Symptom Severity

- Majority of survivors (75-80%) are well-adjusted
  - –Higher prevalence of symptoms but not psychiatric diagnoses
  - –What are the implications for psychosocial care?

- **Pirl et al. 2009. JCO**
- **Sanchez-Varela, et al., 2013. Psych-Onc**
- **DeLaage et al., 2016. PHemOnc**
- **Ross et al., 2003. NEJM**
- **Rasic et al., 2008, Psych-Onc**

Symptom Severity



High Distress
- Clinical range
- Signifiant Impairment

Mild Distress
- Moderate impairment

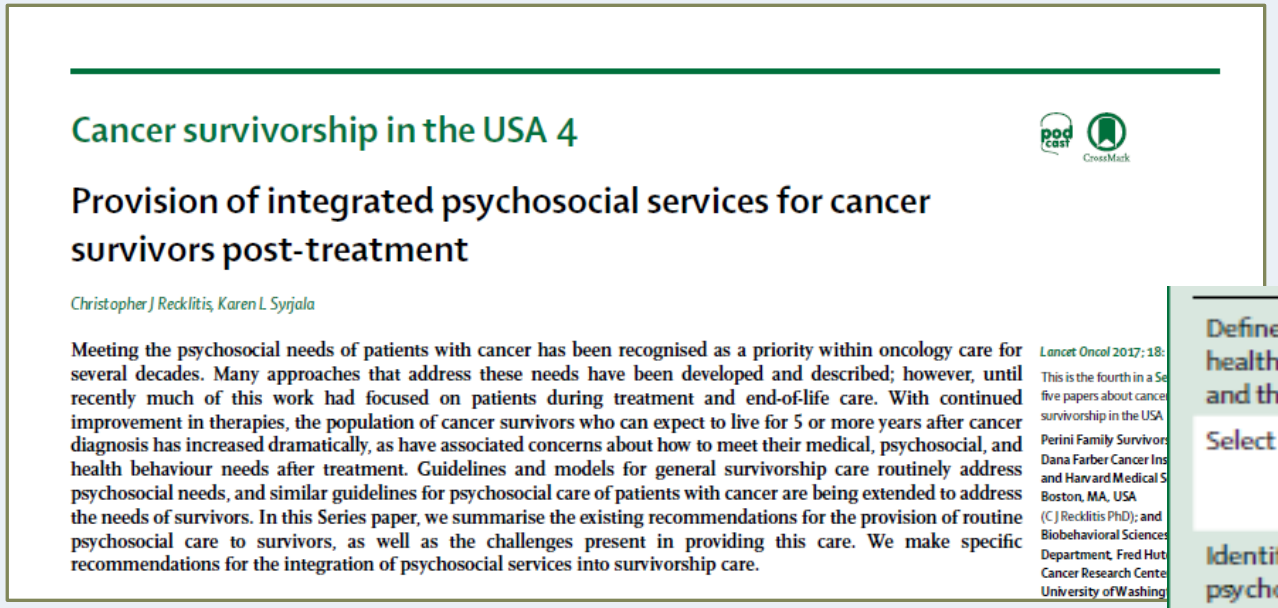
Low Distress
- No impairment

Model & figure adapted from Anne Kazak

Summary: Implications for Integration

- Psychosocial morbidity ↑, but moderate severity & prevalence
  - Methods for identifying those (~20-30%) in need
  - Be prepared for range of severity; rarely major mental illness
- Common mental health concerns & biopsychosocial problems
  - Range resources & interventions (e.g., anxiety, depression, fatigue, fertility, sexual health, insomnia)
- Psychosocial adaptation tied to physical health
  - Knowledge and access to survivorship team
- Long-term medical follow-up after cancer therapy
  - Patients and providers need help: we can serve both

Integrated Care



Cancer survivorship in the USA 4

Provision of integrated psychosocial services for cancer survivors post-treatment

Christopher J Recklitis, Karen L Syrjala

Meeting the psychosocial needs of patients with cancer has been recognised as a priority within oncology care for several decades. Many approaches that address these needs have been developed and described; however, until recently much of this work had focused on patients during treatment and end-of-life care. With continued improvement in therapies, the population of cancer survivors who can expect to live for 5 or more years after cancer diagnosis has increased dramatically, as have associated concerns about how to meet their medical, psychosocial, and health behaviour needs after treatment. Guidelines and models for general survivorship care routinely address psychosocial needs, and similar guidelines for psychosocial care of patients with cancer are being extended to address the needs of survivors. In this Series paper, we summarise the existing recommendations for the provision of routine psychosocial care to survivors, as well as the challenges present in providing this care. We make specific recommendations for the integration of psychosocial services into survivorship care.

Lancet Oncol 2017; 18:

This is the fourth in a Se
five papers about cancer
survivorship in the USA

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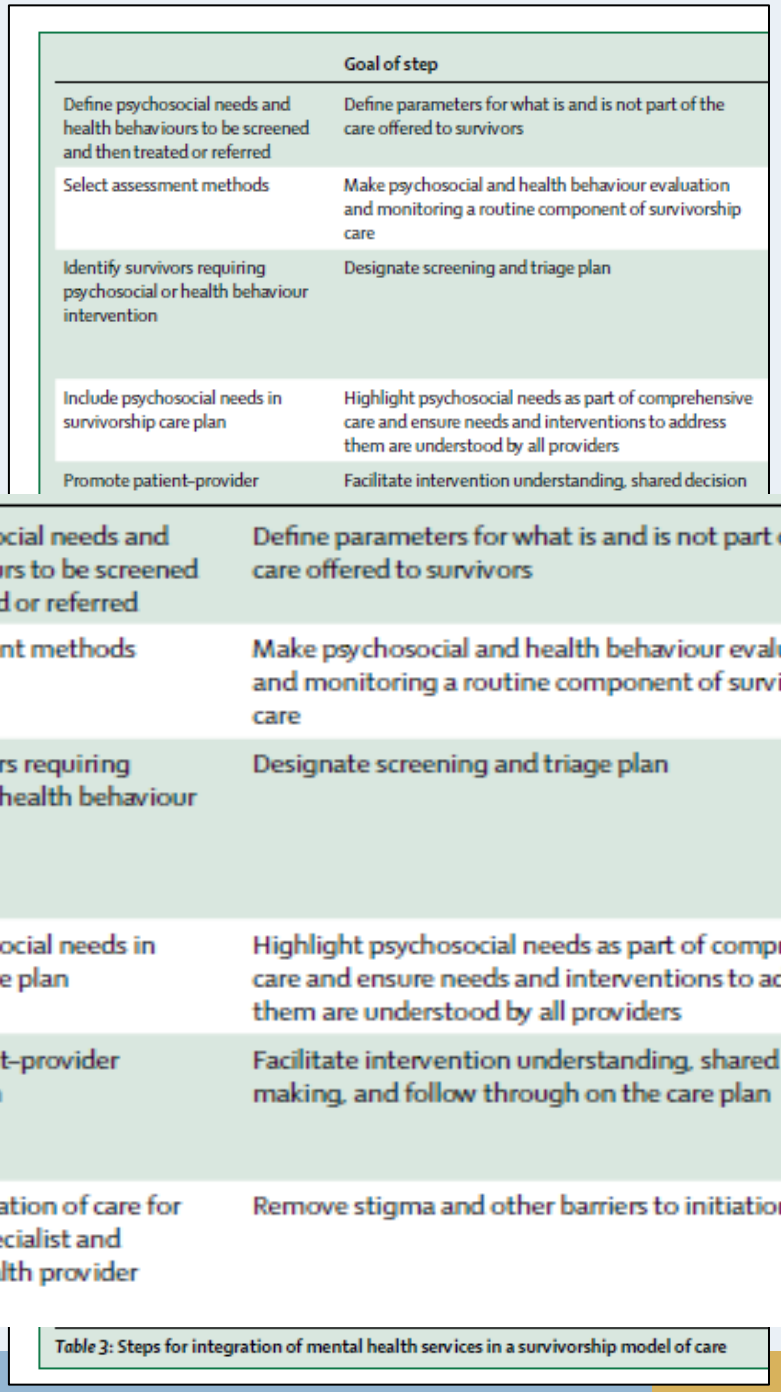
University of Washing



	Goal of step
Define psychosocial needs and health behaviours to be screened and then treated or referred	Define parameters for what is and is not part of the care offered to survivors
Select assessment methods	Make psychosocial and health behaviour evaluation and monitoring a routine component of survivorship care
Identify survivors requiring psychosocial or health behaviour intervention	Designate screening and triage plan
Include psychosocial needs in survivorship care plan	Highlight psychosocial needs as part of comprehensive care and ensure needs and interventions to address them are understood by all providers
Promote patient–provider communication	Facilitate intervention understanding, shared decision making, and follow through on the care plan
Establish co-location of care for survivorship specialist and behavioural health provider	Remove stigma and other barriers to initiation of care

Table 3: Steps for integration of mental health services in a survivorship model of care

Recklitis & Syrjala, Lancet Oncology, 2017

Integrated Care Models

	Model	Brief description
Robinson and Reiter (2007);[76] Funderburk et al (2013);[79] Tsan et al (2012)[80]	Primary Care Behavioral Health Model and Primary Care-Mental Health Integration initiative	In these care models, behavioural health providers are placed into primary care settings to work collaboratively with the primary care team to provide integrated mental health care. The role of the behavioural health provider includes providing assessment, consultation, and brief focused mental health care in the primary care setting, as well as referral to mental health specialty care when needed
Alfano et al (2012);[7] Wade and de Jong (2000)[81]	Rehabilitation model	The rehabilitation approach emphasises an integrated approach to care aimed at helping patients to maximise their functioning across physical, social, psychological, and vocational or educational domains. The rehabilitation model emphasises the need to assess the overall burden of symptoms and to provide coordinated care, an emphasis on optimising function, and the importance of patient education and self-management
Coleman et al (2009);[82] Adams et al (2007)[83]	Chronic care model	The chronic care model is designed to improve care for patients with chronic disease by providing planned and proactive outpatient care to minimise the need for acute and reactive interventions. The model advocates changes in care delivery, health-care organisation structure, increased use of patient self-management and community resources, and information technology to make it easier for providers to deliver evidence-based patient-centred care
Katon et al (1995);[84] Dwight-Johnson et al (2005)[85]	Collaborative care model	The collaborative care model addresses both physical and psychological symptoms of patients with chronic conditions, typically by providing upfront mental health services to medical patients in a way that is convenient and efficient. Applications of the model often include care managers and care planning initiatives to increase communication, as well as patient education and individual or group-based behavioural health interventions
Chodosh et al (2005);[86] Bodenheimer et al (2002);[87] McCorkle et al (2011)[88]	Illness self-management model	The illness self-management model emphasises the value of educating and empowering patients with chronic disease to take an active role in monitoring and directing their care. Interventions based on this model can include a variety of specific activities including goal setting, self-monitoring, decision making, planning, and engaging health promoting behaviours, as well as self-evaluation
Sia et al (2004);[89] Ferrante et al (2010);[90] Sprandio (2012)[91]	Patient Centered Medical Home model	Routine care is delivered by a personal physician who coordinates with other providers to ensure that care is patient-centred, accessible, and comprehensive. The Patient Centered Medical Home model emphasises systemic initiatives to support patient access to personal physicians, standardisation, and coordination of care, as well as changes to payment models and performance indicators to support the activities needed to maintain these services and ensure their function as the patient's medical home
Haaga (2000);[92] Reid et al (2003)[93]	Stepped-care models	Stepped-care models minimise cost and patient burden by providing interventions in sequence with easily deliverable, low-cost interventions offered first, with more resources and time-intensive interventions reserved for patients who do not respond to the initial intervention

Table 4: Medical care models relevant to psychosocial care for cancer survivors

Primary Care Behavioral Health Model

- Behavioral health providers (BHPs) in primary care collaborate with PCPs to provide integrated BH care.
- Detect & address broad spectrum of behavioral health needs
  - Prevention, early identification & quick resolution of problems
  - Not a replacement for specialty MH care; alternative or bridge

Integration of Mental Health/Substance Abuse & Primary Care; AHRQ, Evidence Report/Technology Assessment #173
Integrated Primary Care Behavioral Health Services, Operations Manual, VA Health Care Network

"Survivorship" Behavioral Health Strategies

- Support the oncology provider in identifying & treating behavioral problems
- Resolve some problems in survivorship context, but refer most to the community
  - Refer to specialized behavioral care or PC as needed
- Temporarily co-manage survivors requiring focal BH services, as part of survivorship care
- Oncology provider as overall care manager
  - Provider & survivor are consumers of BH care

Integrated Primary Care Behavioral Health Services, Operations Manual, VA Health Care Network

Survivorship Behavioral Health Roles

Oncology MD/NP Team Leader

- Oversees medical and behavioral health care
- Front-line BH provider
- Refers to BH and other specialists

BHP as consultant

- *Easily accessible in PC setting*
- *Scheduled & unscheduled visits*
- *Assessment, education, treatment for broad array of concerns*
- *Problem-focused*
- *Brief interventions*
- *Resources & Referral*

Survivorship Behavioral Health Model

Support oncology provider in identifying behavioral problems

- BH Services
  - Case Identification
  - Referral & Resources
  - Consultation & Education
  - Evaluation & Brief treatment
  - Case-management

Case Identification

- Oncology providers as front-line BH assessors
  - Identified survivors sent on for BH assessment
- BH provider assist with scope and methods
  - Selecting targets (depression, substance use, insomnia?)
  - Selecting methods
    - Health history forms
    - Self-report checklists

Instructions: Please **check off** any symptoms that you have had since your last visit.

D. HEALTH SCREENING

MOUTH AND THROAT
- ☐ Gum problem
- ☐ Oral pain
- ☐ Dry mouth
- ☐ Mouth sores
- ☐ Difficultly swallowing

NEUROLOGICAL
- ☐ Seizures
- ☐ Numbness/tingling
- ☐ Weakness
- ☐ Speech problems
- ☐ Balance problems
- ☐ Tremors/involuntary movements
- ☐ Headache/migraines

NOSE AND SINUSES
- ☐ Frequent colds
- ☐ Nosebleeds
- ☐ Sinus trouble

MUSCULOSKELETAL
- ☐ Joint or muscle stiffness/weakness
- ☐ Joint swelling/redness
- ☐ Decreased range of motion
- ☐ Bone fractures

BEHAVIORAL
- ☐ Anxiety or panic
- ☐ Depression
- ☐ Confusion
- ☐ Irritability
- ☐ Hopelessness/suicidal thoughts
- ☐ Memory/attention issues

URINARY
- ☐ Increased frequency or urgency
- ☐ Pain or burning
- ☐ Blood in urine
- ☐ Incontinence (loss of bladder control)

LUNGS
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Cough

EARS
- ☐ Hearing changes
- ☐ Ringing in ears

GASTROINTESTINAL
- ☐ Heartburn/indigestion
- ☐ Decreased appetite
- ☐ Nausea and/or vomiting
- ☐ Abdominal pain
- ☐ Change in bowel habits
- ☐ Blood in stool
- ☐ Pain with bowel movements

EYES
- ☐ Sensitive to light
- ☐ Visual field changes
- ☐ Cataracts
- ☐ Excessive tearing or dry eye
- ☐ Momentary loss of sight

HEAR
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- ☐ Chi
- ☐ Night sweats
- ☐ Sleep problems
- ☐ Fatigue
- ☐ Weight loss/gain

OTHER SYMPTOMS (Please list):

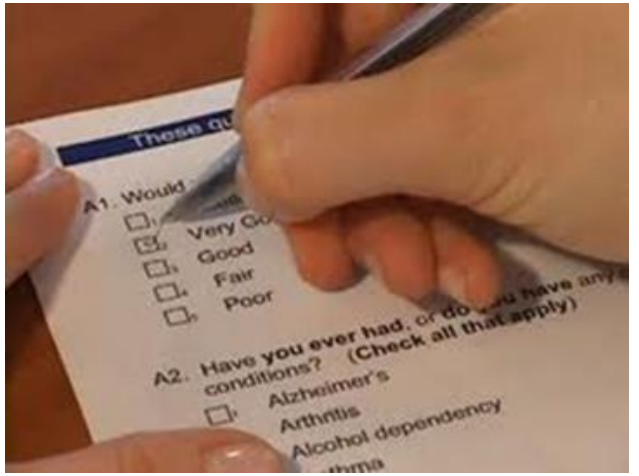
_____

_____

- Brief to complete & evaluate
- Fits medical setting
- Prioritizes patient perspective
- Minimizes stigma

Symptom Checklists: Practicality

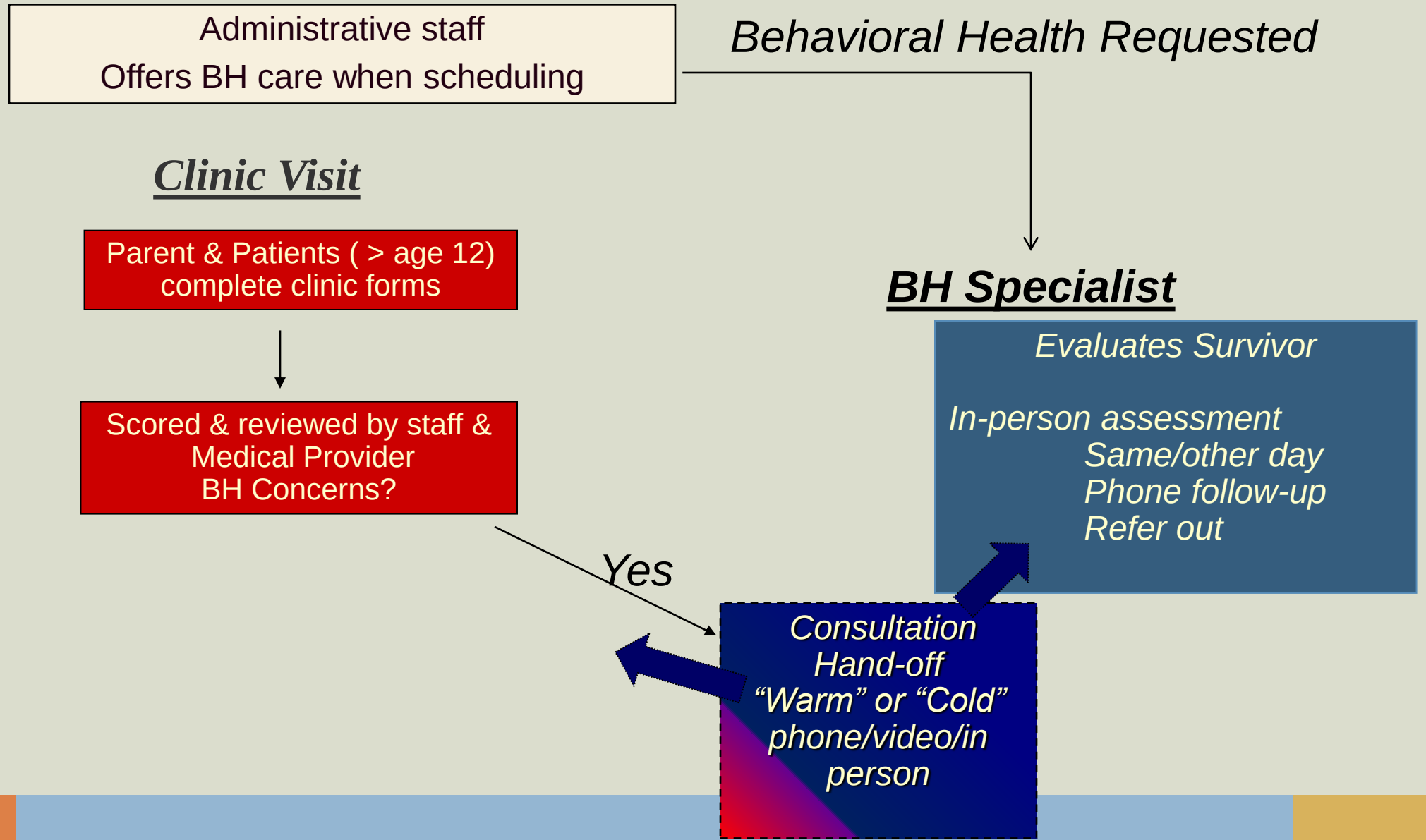
- Self-report is efficient & standardized
- Well accepted by survivors
- Screening forms may inform evaluation but not stand alone as the evaluation



Recklitis et al. 2016. Cancer
Recklitis et al. 2017. Psych Assess
Salmon et al. 2015. PsychOnc

Recklitis, JCO 21, 2003
Liptak et al. APOS 2009

Perini Clinic Schema



Responding to Identified Needs

- Referral to external resources
- Consultation to provider and/or patient
- Assessment of survivors

– Interview

– Triage focus– where to from here?

➢ One stop shopping—

- Oncology providers need to feel you are “on it”
- Survivors need a responsive point of contact

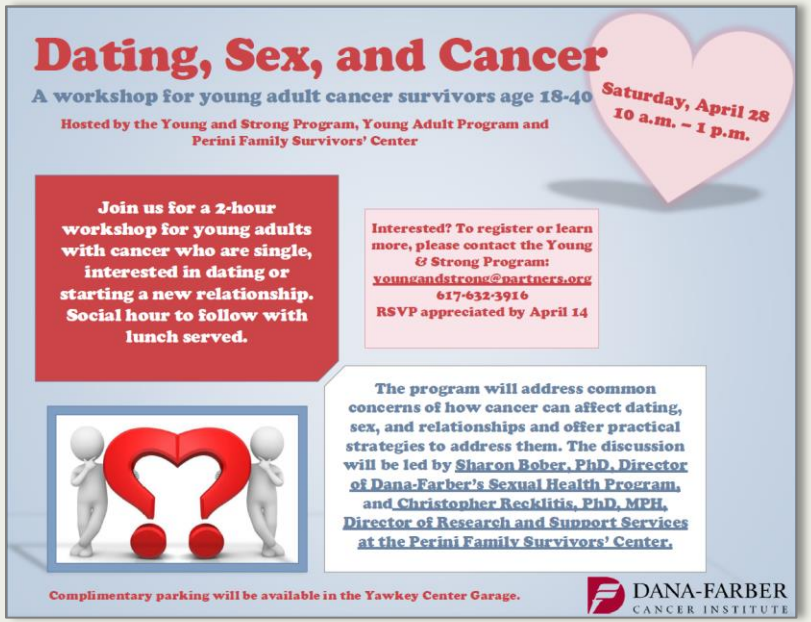
Resources

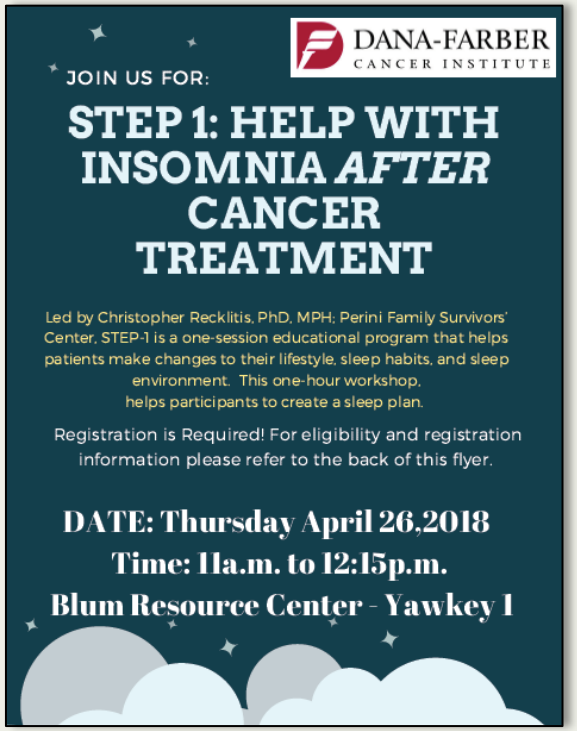
- Available to providers & survivors
  - Information on symptoms & treatments (e.g., teaching sheets, NIMH),
  - Support groups, advocacy groups
  - Books, workshops
  - Mental health referrals
- Broad range of topics—anxiety, sex & dating, education & employment, sleep, fatigue—like a PCP!

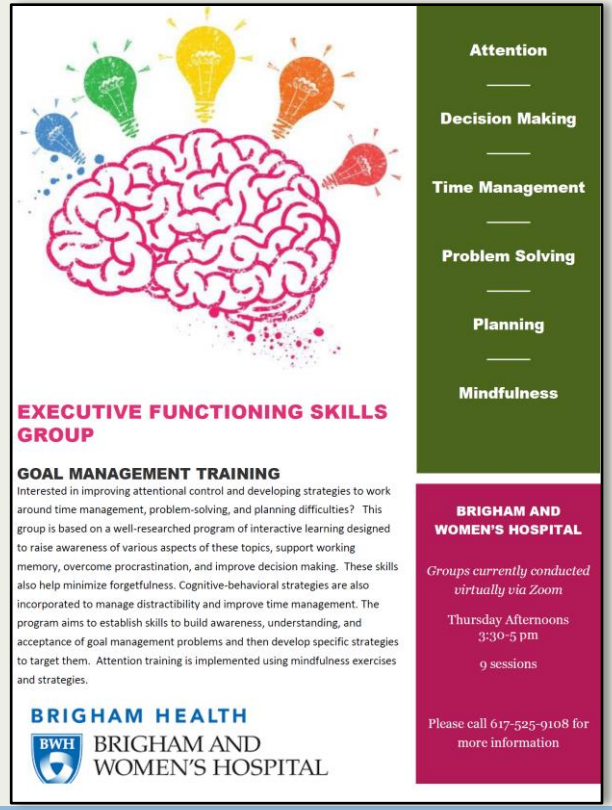
Education & Support Programs

- Collaborative disease specific programs
  - Educate survivors about medical late-effects
  - Psychosocial challenges
- Psychosocial support for survivors with health challenges
  - Education/support group:, fertility, dating, education
  - Low-intensity behavioral intervention: fatigue, insomnia, sexual

Education & Support

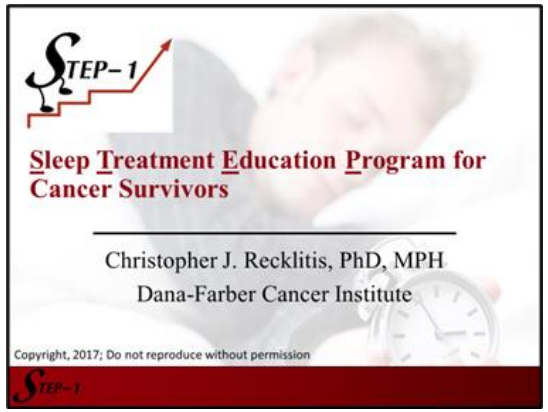






Low-intensity Survivor Interventions

- Sharon Bober: *1-session sexual health intervention for women (NCI: R03CA153815)*
- Clara Hungr: *Brief group fatigue intervention*
- Christopher Recklitis: *Educational video promoting sun protection (NCI: R03CA230818)*
- *Eric Zhou & Christopher Recklitis: 1-session synchronous online intervention for insomnia* (*NCI:* R21CA261863 & R21CA267857)

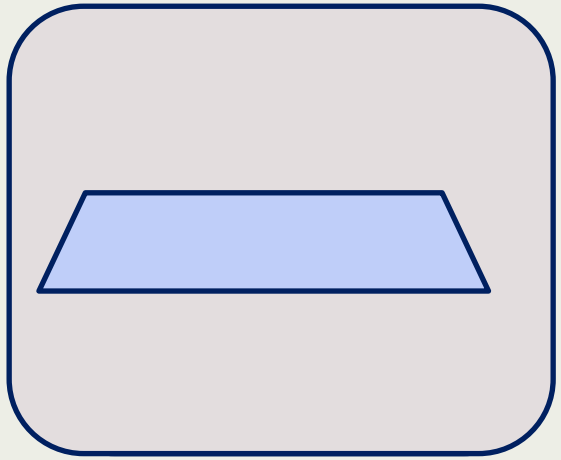


Chevalier L, et al., J PsychoOnc 2022; Zhou ES, et al, Cancer 2020

Assessment & Triage

- Evaluate symptoms
  - Duration, severity, **impairment**
  - Context & supports
  - Survivor preferences

- Evaluate in context of physical health
  - Hormonal, cardiac, neurological, anemia, nutrition
  - Medication effects

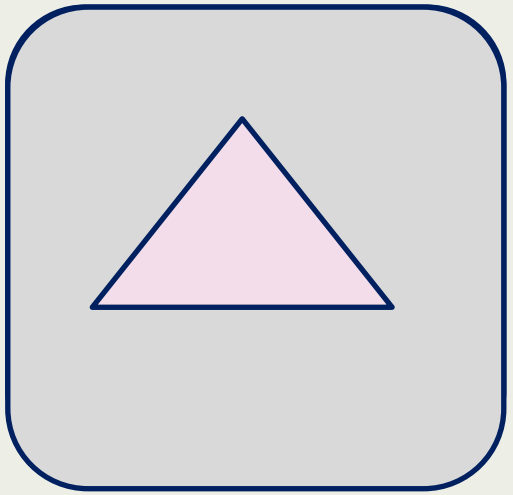


Intervention

Low Distress
- Low/no impairment

- Routine Supportive & Preventive Care
  - Reassurance & anticipatory guidance
  - Education & information
  - Self-help & support resources
- Coaching within self-management frame
- Monitoring—ongoing access to BH
- Assessment may be the intervention

Husson et al., 2011. Ann Onc
Stanton, 2010. JCO
Jacobsen, 2009. JCO
Recklitis & Syrjala, 2017. Lancet Onc



Intervention

High Distress
- Clinical range
- Significant Impairment

- Assessment Focus
  - Urgent/emergent needs
  - Likely diagnoses
  - Treatment experiences
    - Past/present care team

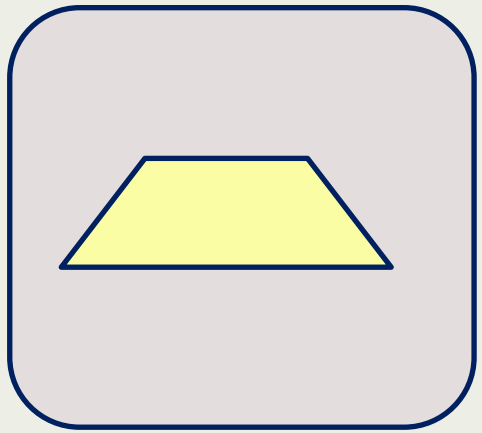
- Referral to specialty mental health
- Follow-up

Kearney J, et al., 2016

Refer to Specialized MH Care

- MH expertise supports a “bridge” to specialty MH care

- Routine Supportive & Preventive Care
- Guide to mental health treatment
  - Reassurance & anticipatory guidance
  - Education & information
    - Diagnostic/prognostic information
    - Information on types of treatment and providers
  - Self-help & support resources
    - Guidance on insurance
    - Help identify likely providers
    - Follow-up & monitoring
    - Service intensity in-line with survivor needs & resources



Intervention

Mild Distress
- Moderate impairment

Potentially most complex

Targeted Care

- Further evaluation
  - Symptom focus
  - Interference & distress?
  - Priorities & preferences
- Offer a range of options
  - Self-help/supportive
  - Mental health care
- Not time-limited offers
- Follow-up/monitoring/access

- Routine Care
- Education, information, monitoring
- Reassurance & anticipatory guidance
- Self-help & support resources

Brief Treatment in Survivor Setting

- Short-term focal problem treatment
  - Limited number of (brief) treatment encounters
  - Focal problem is acute & agreed upon
  - Address barriers to care
  - Often address cancer-related issues (late-effects, identity, intimacy)
  - Co-management of current medical challenge

➢ Resist the call to provide all care to all survivors

Brief Treatment: Example

- 55-year-old survivor with progressing cardiomyopathy had angry outburst at cardiology.
- On-the fly intake session (45 mins).
  - Articulate, “high functioning,” no significant MH history.
  - Frustrated & “ineffective” at cardiology.

➢ Managing expectations & problem solving

➢ Non-judgmental observation—observe and reflect

Brief Treatment: Example

- 2 follow-up visits; 30 mins pre-/post cardiology

➢ Adjusting expectations & preparing for visits helped

➢ Insight! “I reverted to child role,” “not acting like myself,” and “expecting to be taken care of by MD.”

- Significant progress and treatment terminated
- Referral to community therapy if needed

➢ Progress toward goals is the indication for termination

Psychosocial Care in Cancer Settings:

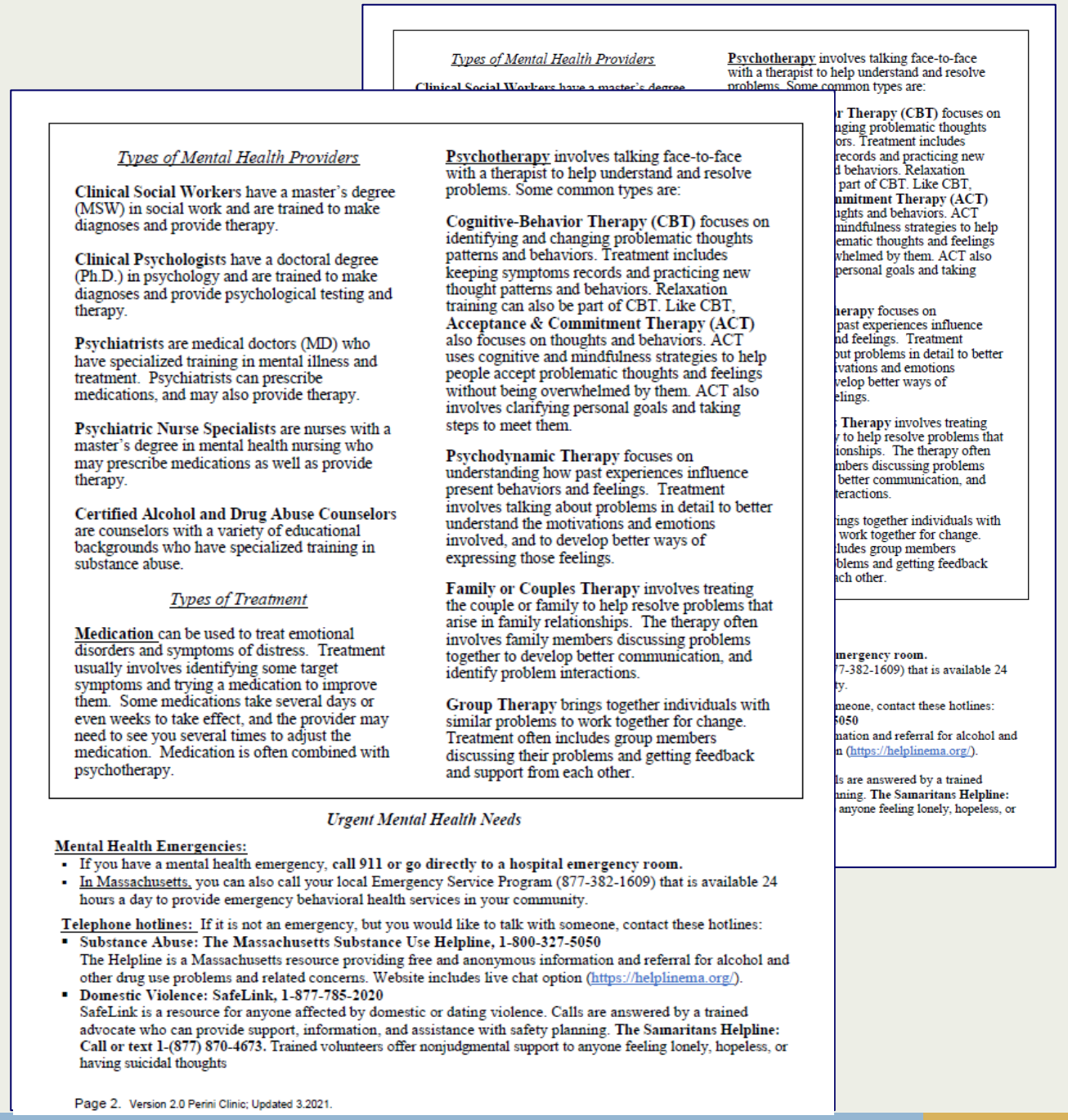
- Cancer center **can** provide optimal care
- Cancer center **may (not always)** provide optimal care
  - Access issues (e.g., transportation, insurance)
  - Understanding of treatment & late-effects
  - Integration with medical care
    - Patients may have complex medical needs
    - May not be looking for behavioral health care
  - Lack of BH expertise & resources
  - Distance & availability are barriers
    - Plays into denial or resistance to treatment
  - Maintains dependence on cancer center

Resolve Problems in the Community

Effective Referrals

- Connect survivors with community resources
  - Including Primary Care
  - Address barriers to care
- Promote development & integration with community--work/school/peers/survivors/chronic disease groups

Referral Support



Types of Mental Health Providers

Clinical Social Workers have a master's degree (MSW) in social work and are trained to make diagnoses and provide therapy.

Clinical Psychologists have a doctoral degree (Ph.D.) in psychology and are trained to make diagnoses and provide psychological testing and therapy.

Psychiatrists are medical doctors (MD) who have specialized training in mental illness and treatment. Psychiatrists can prescribe medications, and may also provide therapy.

Psychiatric Nurse Specialists are nurses with a master's degree in mental health nursing who may prescribe medications as well as provide therapy.

Certified Alcohol and Drug Abuse Counselors are counselors with a variety of educational backgrounds who have specialized training in substance abuse.

Types of Treatment

Medication can be used to treat emotional disorders and symptoms of distress. Treatment usually involves identifying some target symptoms and trying a medication to improve them. Some medications take several days or even weeks to take effect, and the provider may need to see you several times to adjust the medication. Medication is often combined with psychotherapy.

Psychotherapy involves talking face-to-face with a therapist to help understand and resolve problems. Some common types are:

Cognitive-Behavior Therapy (CBT) focuses on identifying and changing problematic thoughts patterns and behaviors. Treatment includes keeping symptoms records and practicing new thought patterns and behaviors. Relaxation training can also be part of CBT. Like CBT, **Acceptance & Commitment Therapy (ACT)** also focuses on thoughts and behaviors. ACT uses cognitive and mindfulness strategies to help people accept problematic thoughts and feelings without being overwhelmed by them. ACT also involves clarifying personal goals and taking steps to meet them.

Psychodynamic Therapy focuses on understanding how past experiences influence present behaviors and feelings. Treatment involves talking about problems in detail to better understand the motivations and emotions involved, and to develop better ways of expressing those feelings.

Family or Couples Therapy involves treating the couple or family to help resolve problems that arise in family relationships. The therapy often involves family members discussing problems together to develop better communication, and identify problem interactions.

Group Therapy brings together individuals with similar problems to work together for change. Treatment often includes group members discussing their problems and getting feedback and support from each other.

Urgent Mental Health Needs

Mental Health Emergencies:

- If you have a mental health emergency, **call 911 or go directly to a hospital emergency room.**
- In Massachusetts, you can also call your local Emergency Service Program (877-382-1609) that is available 24 hours a day to provide emergency behavioral health services in your community.

Telephone hotlines: If it is not an emergency, but you would like to talk with someone, contact these hotlines:

- **Substance Abuse: The Massachusetts Substance Use Helpline, 1-800-327-5050**
  The Helpline is a Massachusetts resource providing free and anonymous information and referral for alcohol and other drug use problems and related concerns. Website includes live chat option (https://helplinema.org/).
- **Domestic Violence: SafeLink, 1-877-785-2020**
  SafeLink is a resource for anyone affected by domestic or dating violence. Calls are answered by a trained advocate who can provide support, information, and assistance with safety planning. **The Samaritans Helpline: Call or text 1-(877) 870-4673.** Trained volunteers offer nonjudgmental support to anyone feeling lonely, hopeless, or having suicidal thoughts

Page 2. Version 2.0 Perini Clinic; Updated 3.2021.

Recklitis et al. Oncology . 2008 Oct;22(11 Suppl Nurse Ed).

Persistence pays off

Jill--

I spent some time this morning looking into resources for your patient and his family. Below you will see the information I think it would be helpful to pass along to them. I am also attaching a copy of this information, and a booklet on helping children with grief.

My # 1 suggestion is that they look into a consultation with staff from the Children's Room who can help them learn more about what is available-- they also have information about summer camp programs that you mentioned they might be interested in.

You mentioned patient has a counselor at school which is a great resource. I did not include any information about other counseling programs in their area, but suggest if he needs additional individual counseling they can get referral information from the school, or pediatrician. They can also contact the Elliot Center (https://www.eliotchs.org/behavioral-health-clinics/) for information about their programs in the Lynn area.

Resources

Bereavement resources for families after death of an infant

1. The Children's Room provides grief support to children, teens, and families
https://childrensroom.org/about/

2. The Massachusetts Center for Unexpected Infant and Child Death
http://www.magriefcenter.org/home

3. First Candle
https://firstcandle.org/bereavement-support/
If you or someone you know has experienced a loss, call our grief line at 800-221-7437

4. Maternal Child Health Library
Listing of resources for families https://www.mchlibrary.org/collections/suid-sids/Bereavement/index.php

5. The Good Grief Program. A written resource for parents to help children grieving a loss is attached .

Persistence Pays Off

I wanted to follow-up with you after our meeting a few weeks ago. At that time, I suggested that you could look into some stress-reduction programs to help you manage the stress you have been experiencing related to your health concerns. Below you will see a list or resources you may want to look into. I look forward to our follow-up meeting in September to hear how you are you doing and to think together about any other resources you might be interested in.

Please feel free to contact me before our scheduled meeting if needed

Best regards,

Christopher Recklitis

Stress Reduction Resources

Books available from Amazon and other sources

- **Get Out of Your Mind and Into Your Life: The New Acceptance and Commitment Therapy (A New Harbinger Self-Help Workbook)** by Steven C. Hayes and Spencer Smith | Nov 1, 2005
- **The Happiness Trap: How to Stop Struggling and Start Living: A Guide to ACT** by Russ Harris and Steven C. Hayes PhD | Jun 3, 2008
- **The Mindfulness and Acceptance Workbook for Anxiety: A Guide to Breaking Free from Anxiety, Phobias, and Worry Using Acceptance and Commitment Therapy** by John P. Forsyth and Georg H. Eifert | Jan 2, 2008

Instructor led stress reduction programs

- The Massachusetts General Hospital Cancer Center has several stress reduction programs including one for cancer survivors specifically.

https://bensonhenryinstitute.org/services-treatments-services/

- The Center for Mindfulness at UMass Memorial Health Center offers mindfulness and stress reduction programs

https://www.ummhealth.org/umass-memorial-medical-center/services-treatments/center-for-mindfulness/mindfulness-classes

-

Online courses that can be done independently

- https://thehappinesstrap.com/8-week-program/ The Happiness Trap Online Program. 8 weeks. Self-Paced. 1-2 hrs per week
- https://www.learntolive.com/ Learn to Live has developed several different online program stop help individuals overcome anxiety, insomnia, depression and other issues.

Motivation for Care

- Survivors may have limited interest in care
  - Stigma, costs, inconvenience
  - ➢ Low intensity symptoms & need to return to pre-illness role
- Respect autonomy, open honest communication
  - Focus on their own goals
  - Educate to inform their decisions
  - Build in follow-up—be creative!

➢ Wish to forget about cancer, other times want to—acknowledge, integrate, cope with it

PCBH Resources

UMASS MEDICAL SCHOOL

CIPC
UMASS MEDICAL SCHOOL

AHRQ Agency for Healthcare Research and Quality

https://www.umassmed.edu/cipc/pcbh/overview/

https://integrationacademy.ahrq.gov/

Primary Care Behavioral Health Integration and Care Utilization: Implications for Patient Outcome and Healthcare Resource Use

Daniel D. Maeng, PhD[1], Ellen Poleshuck, PhD[1], Tziporah Rosenberg, PhD[1], Amie Kulak, MHSA[2], Thomas Mahoney, MD[2], George Nasra, MD[1], Hochang B. Lee, MD[1], and Yue Li, PhD[3]

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Review article

Patient outcomes associated with primary care behavioral health services: A systematic review

Kyle Possemato[a,b,*], Emily M. Johnson[a], Gregory P. Beehler[a,c], Robyn L. Shepardson[a,b], Paul King[a,d], Christina L. Vair[e], Jennifer S. Funderburk[a,b,f], Stephen A. Maisto[a,b], Laura O. Wray[a,g]

[a] *VA Center for Integrated Healthcare, New York/New Jersey VA Healthcare System, United States*
[b] *Department of Psychology, Syracuse University, Syracuse, NY, United States*

Financing the Primary Care Behavioral Health Model

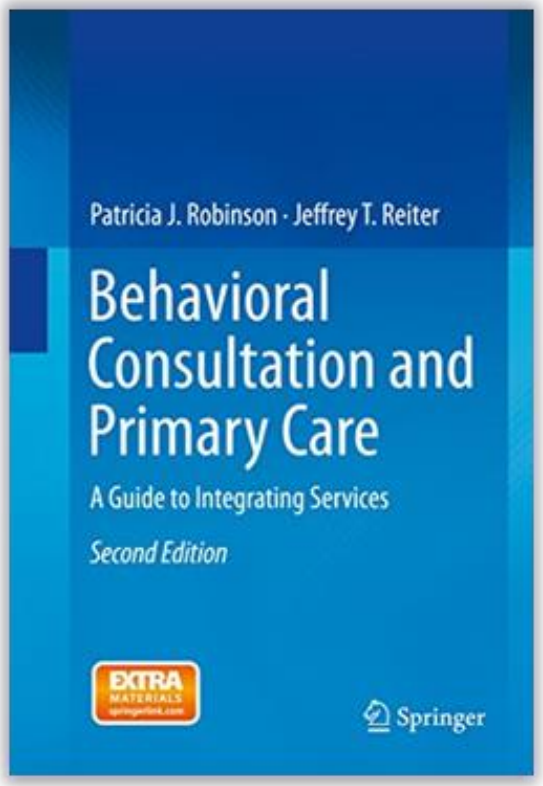
Dennis S. Freeman[1] · Lesley Manson[2] · Jeff Howard[1] · Joel Hornberger[1]

Published online: 16 February 2018

The Impact of Brief Interventions on Functioning Among those Demonstrating Anxiety, Depressive, and Adjustment Disorder Symptoms in Primary Care: The Effectiveness of the Primary Care Behavioral Health (PCBH) Model

Kevin M. Wilfong[1] · Jeffrey L. Goodie[1] · Justin C. Curry[2] · Christopher L. Hunter[2] · Phillip C. Kroke[1]

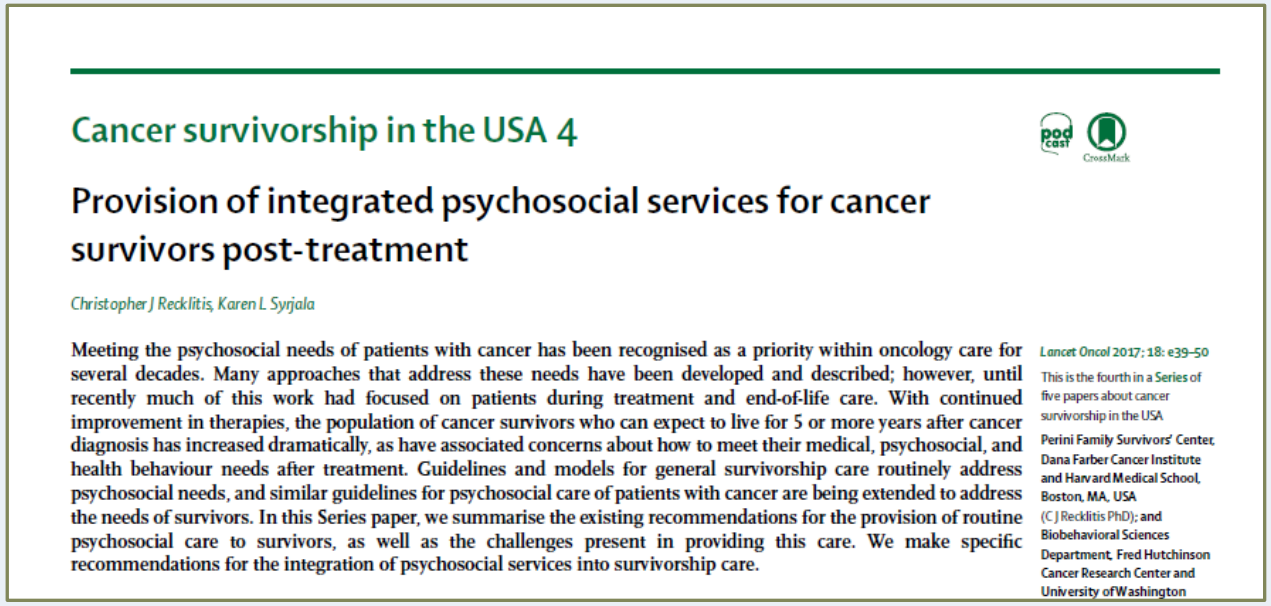
PCBH Resources



PCBH: Challenges

- Requires change in:
  - Oncology & BH roles—Flexibility!
  - Systems, training, management, resources
- Person power & reimbursement
- BH problems may be intractable:
  - Limits on services, insurance,
- Difficult to demonstrate value-added
- ➢ Valuable guide for BH integration in survivorship care

PCBH Model & Integrated Care



Cancer survivorship in the USA 4

Provision of integrated psychosocial services for cancer survivors post-treatment

Christopher J Recklitis, Karen L Syrjala

Meeting the psychosocial needs of patients with cancer has been recognised as a priority within oncology care for several decades. Many approaches that address these needs have been developed and described; however, until recently much of this work had focused on patients during treatment and end-of-life care. With continued improvement in therapies, the population of cancer survivors who can expect to live for 5 or more years after cancer diagnosis has increased dramatically, as have associated concerns about how to meet their medical, psychosocial, and health behaviour needs after treatment. Guidelines and models for general survivorship care routinely address psychosocial needs, and similar guidelines for psychosocial care of patients with cancer are being extended to address the needs of survivors. In this Series paper, we summarise the existing recommendations for the provision of routine psychosocial care to survivors, as well as the challenges present in providing this care. We make specific recommendations for the integration of psychosocial services into survivorship care.

Lancet Oncol 2017; 18: e39–50

This is the fourth in a Series of five papers about cancer survivorship in the USA

Perini Family Survivors' Center, Dana Farber Cancer Institute and Harvard Medical School, Boston, MA, USA (C J Recklitis PhD); and Biobehavioral Sciences Department, Fred Hutchinson Cancer Research Center and University of Washington

Define psychosocial needs and health behaviours to be screened and then treated or referred	Define parameters for what is and is not part of the care offered to survivors
Select assessment methods	Make psychosocial and health behaviour evaluation and monitoring a routine component of survivorship care
Identify survivors requiring psychosocial or health behaviour intervention	Designate screening and triage plan
Include psychosocial needs in survivorship care plan	Highlight psychosocial needs as part of comprehensive care and ensure needs and interventions to address them are understood by all providers
Promote patient–provider communication	Facilitate intervention understanding, shared decision making, and follow through on the care plan
Establish co-location of care for survivorship specialist and behavioural health provider	Remove stigma and other barriers to initiation of care

PCBH: Advantages of Flexibility

- Tailored to meet needs of:
  - Local population
  - Oncology providers
  - Care system
- Utilize local strengths & resources
  - Medical services and expertise, resources
  - Navigators, social work, nursing
  - Start with what you have
- Community programs
  - Medical, social, advocacy, faith-based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CLINICAL CORRESPONDENCE

WILEY

Utilization of integrated psychosocial care in a pediatric cancer survivorship clinic: A retrospective medical record review

Clara Hungr | Christopher J. Recklitis

Hungr & Recklitis Psycho-Oncology, 2019

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