Coping with Aging and Cancer: A Conference on Reducing Barriers to Mental Health Care

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Cancer is prevalent in older adulthood

Older adults: 65 years of age or older

Older adults represent:
- 14.5% of the US population
- 53% of new cancer diagnoses
Prevalence of cancer is increasing

Estimated increase (1975-2040)

- 50-64 years: 4-fold
- 65-74 years: 6-fold
- 75-84 years: 10-fold
- ≥ 85 years: 17-fold
Prevalence of cancer is increasing

Increased cancer prevalence
- 2016: 15.5 million
- 2040: 26.1 million

Estimated proportion of cancer cases by age (2040)
- ≥ 65 years: 73%
  - 65-74 years: 24%
  - 75-84 years: 31%
  - > 84 years: 18%
- 50-64 years: 18%
- < 50 years: 8%

*Bluethmann, 2016, Cancer Epidemiol Biomarkers Prev*
Older adults are managing aging and cancer

<table>
<thead>
<tr>
<th>Changes in:</th>
<th>Aging</th>
<th>Cancer</th>
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</thead>
<tbody>
<tr>
<td><strong>Physical ability</strong></td>
<td>• Sight/Hearing problems</td>
<td>• Low energy</td>
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<td></td>
<td>• Forgetfulness</td>
<td>• Weakness</td>
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<td></td>
<td>• Difficulty walking</td>
<td>• Nausea</td>
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<td></td>
<td>• New illnesses</td>
<td>• Weight loss/gain</td>
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<tr>
<td></td>
<td>• Medications</td>
<td>• More medications</td>
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<tr>
<td><strong>Self-identity</strong></td>
<td>• Retirement</td>
<td>• Viewed as a patient</td>
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<tr>
<td></td>
<td>• Unable to do previous activities</td>
<td>• Unable to do more activities</td>
</tr>
<tr>
<td></td>
<td>• Viewed as “old” (ageism)</td>
<td>• Knowledge developed over a lifetime unseen</td>
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<td></td>
<td>• Strengths and expertise overlooked by others</td>
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<td><strong>Relationships</strong></td>
<td>• Loss of spouse/partner and loved ones</td>
<td>• Others do not know what to say or do</td>
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<td></td>
<td>• Greater difficulty visiting with friends/family</td>
<td>• Too tired/sick to meet friends/family</td>
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<td></td>
<td>• Loneliness</td>
<td>• Isolated</td>
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<tr>
<td><strong>Independence</strong></td>
<td>• Need help with daily activities</td>
<td>• Need help getting to appointments</td>
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<td></td>
<td>• Unable to drive</td>
<td>• Need help with meals and the home</td>
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<td></td>
<td>• Others worry whether you can care for yourself</td>
<td>• Worry about becoming dependent</td>
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<td></td>
<td>• Financial concerns</td>
<td>• Worry about paying for treatment</td>
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</table>
## Older adults with cancer experience distress

<table>
<thead>
<tr>
<th>Distress type</th>
<th>Symptoms</th>
<th>Rates in older adults with cancer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anxiety</td>
<td>• Nervousness&lt;br&gt;• Worry&lt;br&gt;• Restlessness&lt;br&gt;• Irritability&lt;br&gt;• Muscle tension</td>
<td>25-44%</td>
</tr>
<tr>
<td>Depression</td>
<td>• Sadness&lt;br&gt;• Decreased interest in activities&lt;br&gt;• Weight loss/gain&lt;br&gt;• Worthlessness&lt;br&gt;• Guilt</td>
<td>15-37%</td>
</tr>
</tbody>
</table>

Delgado-Guay, 2009, Support Care Cancer; Nelson, 2010, Psychooncology; Canoui-Poitrine, 2016, Psychooncology
Distress in cancer patients is problematic

<table>
<thead>
<tr>
<th>Distress negatively impacts:</th>
<th>Distress associated with:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>• Fatigue&lt;br&gt;• Nausea&lt;br&gt;• Pain&lt;br&gt;• Dyspnea&lt;br&gt;• Poor quality of life&lt;br&gt;• Poor emotional, social, cognitive function</td>
</tr>
<tr>
<td>Treatment process</td>
<td>• Poor treatment adherence&lt;br&gt;• Difficulty making decisions&lt;br&gt;• Poor communication with healthcare team</td>
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<tr>
<td>Treatment course</td>
<td>• Chemotherapy dose delays/reductions&lt;br&gt;• Longer hospitalizations</td>
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Psychological treatments have been developed

**Median number of sessions:** 6 (Range: 1-55 sessions)
**Median duration:** 6 weeks

**Clinician:** Nurse, psychologist, or social worker
- Social workers provide most psychosocial services in cancer centers

**Session type:** Individual (60%) and group sessions (33%) offered

**Goals:**
- Improve ability to cope
- Reduce distress (anxiety, depression)
- Improve quality of life
- Provide information on distress and coping with cancer

Types of psychological treatments

Cognitive-behavioral therapy
- Targets maladaptive thoughts and behaviors
- Thoughts: Monitor thoughts/beliefs, challenge inaccurate thoughts, identify new ways of thinking
- Behaviors: Reduce avoidance of anxiety-provoking situations, relaxation training

Problem-solving therapy
- Assists with solving a target problem(s)
- Teaches problem-solving skills that can be applied to future problems

Acceptance and commitment therapy
- Teaches patients to accept the present
- Focuses on engaging in behaviors consistent with personal values

Types of psychological treatments

**Relaxation Training:** Deep breathing, muscle relaxation, guided imagery

**Psychoeducation:** Provides information on illness-related topics, coping strategies, stress management, and support

**Information only:** Provides information on health topics

**Supportive psychotherapy**
- Developing trust between patient and therapist
- Creates safe context for patient to express thoughts, emotions, concerns

Faller, 2013, J Clin Oncol; Fawzy, 1994, General Hospital Psychiatry; Ayers, 2007, Psychology and Aging
Types of psychological treatments

Combination strategies
- Includes a combination of described treatments
- May add:
  - Peer counseling
  - Relationship stress management
  - Sexual health information
  - Group support
  - Lifestyle change (e.g., diet, exercise)

Psychological treatments are helpful

**Cognitive-Behavioral Therapy:** Improvements in depression, anxiety, and quality of life

**Problem-Solving Therapy:** Improvements in depression, anxiety, quality of life, social functioning

**Acceptance and Commitment Therapy:** Improvements in quality of life, anxiety, depression, growth

**Relaxation Training:** Lasting impact on anxiety

Bell, 2009, Psychology Review; Rost, 2012, Cognitive and Behavioral Practice; Feros, 2013, Psychooncology
Psychological treatments are helpful

**Supportive Psychotherapy:** Improvements in anxiety, depression, quality of life but less than other interventions

**Combination Interventions with Lifestyle Improvements (diet, exercise):** Improvements in distress, quality of life, physical health

**Psychoeducation:** Limited impact

**Information-Only:** Limited impact

Evidence-based psychological interventions are not reaching older adults with cancer

50% of cancer patients with a psychiatric disorder do not receive mental health services

In older adults with cancer:
- 32% reported unmet needs for emotional support
- Over 50% reported needing help coping with their illness

Evidence-based psychological interventions are not reaching older adults with cancer

36.5 - 49.9% of cancer patients with elevated distress receive psychosocial care

Of 57 U.S. cancer centers, only 21.5% reported high capacity to provide quality psychosocial care

Zebrack, 2016 Cancer; Zebrack, 2015, Jrl Clin Oncol
Dissemination and implementation are necessary

**Dissemination:** Active spreading of evidence-based interventions to the target audience (e.g., clinicians, leadership, institutions)

**Implementation:** Process of integrating these interventions into a care setting

Must consider the unique characteristics of care settings (e.g., large hospitals, community clinics) and target patients (older adults with cancer)
Models of Dissemination

Push-Pull-Infrastructure Model

**Push:** Active process of providing information to healthcare institutions and providers

**Pull:** Spreading of information through networks and peer influence

- Intervention must address preferences, concerns, and capacity of potential adopters
- Intervention must be provided through channels available to potential adopters
- Researchers must understand the networks of potential adopters
- Collecting feedback from adopters allows for relevant modifications to intervention

**Infrastructure**

- Relationships between researchers and individuals/organizations connected to healthcare system
- Engagement of stakeholders
- Development of structured plans for dissemination

Dearing, 2010, Patient Education and Counseling
Process Models of Implementation

**Process Models:** Describe the steps of implementation and provide practical guidance for implementation

**Quality Implementation Framework**

- Four phases
  1. Assess characteristics of the setting and determines whether the intervention needs to be adapted for the setting
  2. Create a plan for implementation and develop an implementation plan
  3. Initiate implementation
  4. Evaluate successes and failures of implementation
Determinant Models of Implementation

**Determinant Models:** Identify the barriers and resources that influence the success of implementation efforts

**Consolidated Framework for Implementation Research**
- Factors that influence implementation
  1. Fit between the intervention and setting
  2. Characteristics of the institution (inner setting)
  3. Economic, political, and social context of an institution (outer setting)
  4. Individuals involved with the intervention and implementation
  5. Implementation process
Evaluation Models of Implementation

**Evaluation Models:** Provide framework for assessing the success of implementation

**RE-AIM**
- **Reach:** Percentage of the target population of patients who receive the intervention
- **Efficacy:** Positive and negative impact of the intervention on patients
- **Adoption:** Number of institutions that implement an intervention
- **Implementation:** Match between the original intervention and the delivered intervention
- **Maintenance:** Extent to which an intervention continues to be offered over time

Barriers to dissemination/implementation

**Person factors**
- Disinterest in using new psychological treatments
- Limited experience with an intervention
- Low confidence in ability to use an intervention
- Lack of time
- Limited access to training opportunities

Williams, 2015, Psychooncology; Aarons, 2012, Implementation Science; Andersen, 2016, Psychooncology
Barriers to dissemination/implementation

Administrative Factors
- Concern about financial implications
- Lack of institution funds
- “Red tape”
- Indifference from institutional leadership
- Personnel changes

Williams, 2015, Psychooncology; Glasgow, 2007, Annual Review of Public Health
Barriers to dissemination/implementation

Environmental Factors

- Insufficient resources for therapist time, support staff, space
- Inconsistent funds that result in unpredictability
- “Mis-fit” between the intervention and setting
- Commitment to established practices that are inconsistent with new interventions
- Practical limitations (e.g., parking costs)

Andersen, 2016, Psychooncology; Glasgow, 2007, Annual Review of Public Health
Purpose of the conference

Bring together experts from various perspectives:
- Older adults with cancer and their caregivers
- Researchers
- Healthcare providers
- Advocacy organization members

Identify:
- **Barriers** to access to evidence-based psychological interventions for older adult cancer patients
- **Strategies** to improve older adult cancer patients’ access to evidence-based psychological interventions
Questions to Consider – Barriers/ Facilitators

- What makes it difficult for older adults with cancer to get psychological care?
- What factors associated with being an older adult with cancer make accessing psychological care difficult?
- What characteristics of the hospital or clinic make accessing psychological care difficult?
- What characteristics of the hospital or clinic make accessing psychological care easier?
Questions to Consider – Strategies

- Are there ways to increase awareness of psychological treatments in patients, families, providers, and institutions?

- Are there ways to make psychological interventions more comfortable for and helpful to older adults with cancer?

- Are there ways to improve the hospital or clinic to make receiving psychological interventions easier for older adults with cancer?