## 1.A Algorithms for Cancer-Related Distress, Depression, & Global Anxiety

### SCREENING AND ASSESSMENT-DISTRESS & DEPRESSION IN ADULTS WITH CANCER

#### SCREEN FOR DISTRESS AND DEPRESSIVE SYMPTOMS

- **When:** entry to system, critical times in disease and/or treatment process, points of transition (post-treatment survivorship, palliative or end-of-life), or other stressful life course events (life crisis, personal transitions)

#### ASSESSMENT OF RISK OF HARM TO SELF AND/OR OTHERS

**IF YES** > URGENT referral to appropriate services for emergency evaluation; facilitate safe environment; standard psychiatric crisis care; one-to-one observation and/or other appropriate harm reduction strategies to reduce risk (presence of other symptoms such as psychosis, severe agitation, confusion or delirium, may also warrant referral for emergency evaluation).  **IF NO** > Continue with Algorithm

### SCREEN FOR DISTRESS AND DEPRESSIVE SYMPTOMS

ESASr*/DT* score 1-3  
ESASr*/DT* score 4-6  
ESASr*/DT* score 7-10

#### COMPREHENSIVE ASSESSMENT--CLARIFY NATURE/EXTENT OF DISTRESS

- Review ESASr scores and Problem/Concerns Checklist* and/or other measures used (e.g. SDI*) in dialogue with patient/family
- Identify/treat most distressing symptom(s) or problem(s) contributing to distress (e.g. life stressors, insomnia, pain, co-morbid illness, fatigue)
- Assess extent of interference of distress in daily life and functioning
- Identify pertinent history/risk factors for distress/depression,
- Identify if recurrent, advanced/progressive disease (i.e. vulnerable points), past/current history of depression/other psychiatric illness
- Identify if perceived lack of instrumental or emotional support
- Identify other risk factors (e.g. young age, female, living alone, dependent children, unemployed or lower socioeconomic status, inadequate coping skills)

#### FOCUSED ASSESSMENT FOR DEPRESSIVE SYMPTOMATOLOGY

- Use of specific validated measure for symptoms of depression; consider use of PRO such as the PHQ-9 to ascertain mild, moderate, severe levels
- Assess for DSM-V depressive symptoms: depressed mood, loss of pleasure, feelings of worthlessness or guilt, inability to concentrate, recurrent thoughts of death, fatigue, change in appetite or sleep patterns
- Impaired functioning in daily living
- Assess persistence of symptoms >2 weeks (all day, every day)

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ESASr=Edmonton Symptom Assessment Scale Revised; PHQ-9=Patient Health Questionnaire-9 items; PHQ-2=2 item screener for depression; use of algorithm does not substitute for appropriate clinical judgment; Reference: Howell et al. Screening, Assessment and Management of Psychosocial Distress. Anxiety and Depression. Canadian Association of Psychosocial Oncology (CAPO) 2015.
CARE MAP - DISTRESS AND DEPRESSION IN ADULTS WITH CANCER

**Care Pathway 1**
Prevention and supportive care

- NO/Mild Distress (<4 on ESASr or Distress Thermometer
- If using PHQ-9, score of 1-7 PHQ-9=Mild Depression (minimal depressive symptoms)
- “Normal” worries with situation
- Effective coping skills and access to social support
- Gradual resolution over weeks/months

- Offer referral to psychosocial support and/or peer support groups

**Care Pathway 2**
Psychosocial care

- Sub-threshold depressive symptoms
- If using PHQ-9, score of 8-14= Moderate Distress/Depression
- Two or more depressive symptoms for 2 weeks or more; or impairment in daily living or functioning
- Persistent maladaptive response which is difficult to control
- Risk factors (e.g. gaps in social support or coping skills)

- Referral to psychosocial services as required; any risk factors or suicidal concerns—refer

**Care Pathway 3**
Specialist referral for diagnosis

- Risk of harm to self and/or others and/or Suicidal Concerns on PHQ-9—any level= URGENT referral to appropriate services: facilitate safe environment one-to-one observation, initiate harm reduction interventions to reduce risk of harm to self and/or others

- If using PHQ-9, Score 15-19 for Moderate to Severe; Severe Symptoms= Score of 20-27
- Symptoms of Major Depression: depressed mood >2 weeks, change from baseline, impaired function plus >5 symptoms of depressed mood, insomnia or hyperinsomnia, psychomotor agitation or retardation, fatigue, weight change/loss of appetite, guilt/worthlessness, impaired concentration (DSM V criteria)

**STEPPED CARE MODEL**
Intensity of intervention graded to severity and responsiveness of distress to initial treatment

- Provide universal education and information (verbal or written) and support self-management in following areas:
  - Normalcy of distress in cancer; signs and symptoms of worsening distress and need for additional support
  - Benefits of peer support groups and services (e.g., patient library, reliable internet sites)
  - Availability of practical supports (e.g. transportation, financial assistance, drug benefit, etc.)
  - Specific stress reduction strategies (e.g. relaxation approaches, coping skills training)
  - Self-management support to facilitate management of other symptoms i.e. exercise, mindfulness, optimal nutrition

- Low intensity psychological interventions (behavioural activation, guided self-help-based on CBT*, problem-solving, psychoeducation)
- As appropriate, combine with pharmacotherapy-attention to interactions and side-effects
- Refer to specialist psychosocial services, as required

- High intensity interventions (CBT*, Interpersonal therapy, Individual psychotherapy)
- Combine with pharmacotherapy, as appropriate—check adherence
- Psychiatric standard of care for crisis interventions and suicidal concerns on PHQ-9
- Reassess effect at 8-weeks

**Follow-up and ongoing re-assessment**

* CBT—cognitive-behavioral therapy; major depression based on clinical interview or threshold depression on valid tool
ASSESSMENT OF RISK OF HARM TO SELF AND/OR TO OTHERS

If YES > URGENT referral to appropriate services for emergency evaluation; facilitate safe environment; standard psychiatric crisis care; one-to-one observation and/or other appropriate harm reduction strategies to reduce risk (presence of other symptoms such as psychosis, severe agitation, confusion or delirium, may also warrant referral for emergency evaluation). If NO > Continue with Algorithm

SCREEN FOR ANXIETY
When: entry to system, critical times in disease and/or treatment process, points of transition (post-treatment survivorship, palliative or end-of-life), prior to procedures or other stressful life course events (life crisis, personal transitions)

ANXIETY Identified on Screening using Valid Brief Measure (ESASr* anxiety item)

- ESASr Anxiety score 1-3
- ESASr Anxiety score 4-6
- ESASr Anxiety score 7-10

COMPREHENSIVE ASSESSMENT--CLARIFY NATURE/EXTENT OF ANXIETY
- Review ESASr scores and sources of anxiety in dialogue with patient/family; other sources of distress
- Assess interference of anxiety in daily life and functioning
- Identify pertinent history/risk factors for anxiety, e.g. handling of situational stressors in past
- Effects of transition/recurrence fears post-treatment
- Past/current history of anxiety disorder, panic disorder, social phobias or other anxiety disorder, comorbid depression
- Inability to undergo stress-inducing procedures/fear of closed spaces or claustrophobia (problem for radiation treatment)
- Other factors (e.g. young age, female, live alone, dependent children, unemployed or lower SES*, inadequate coping skills)

FOCUSED ASSESSMENT FOR ANXIETY SYMPTOMATOLOGY
- Use of specific validated measure for generalized anxiety disorder i.e. GAD-7 to ascertain mild, moderate, severe levels
- Assess for anxiety, fears or worries, out of proportion to level of threat; excessive feelings of anxiety or worry; difficulty concentrating or focusing on work or other activities
- Ruminating or catastrophizing about cancer and other issues
- Feelings of dread, panic that recurs, agitated, trembling, etc.

ESASr=Edmonton Symptom Assessment Scale Revised; GAD-7=Generalized Anxiety Disorder 7 items; *Socioeconomic status SES; Team decides referral standard; Reference: Howell et al. Screening, Assessment and Management of Psychosocial Distress, Anxiety and Depression, Canadian Association of Psychosocial Oncology (CAPO) 2015. Use of algorithm does not substitute for appropriate clinical judgment.
Howell et al. Canadian Association of Psychosocial Oncology, 2015
REFERENCE-Howell et al. 2015 Distress Guideline, Canadian Association of Psychosocial Oncology
Reference: Howell et al. Screening, Assessment and Management of Psychosocial Distress, CAPO
Figure 1.A.1: Algorithm for Cancer-Related Distress, Depression & Global Anxiety