Addressing Mental Health Impacts in Cancer Patients and Survivors at Federally Qualified Health Centers

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ABSTRACT

I was diagnosed with Hodgkin's Lymphoma on October 9th, 2020, as a senior in college during the height of the COVID-19 pandemic. My brush with cancer held the mirror of my mortality to my face which induced a level of clarity that transformed the course of my life. I now live a life that is committed to integrating health justice at individual, local, and systemic levels.

Over the course of my time in chemotherapy, radiation, and remission I was privileged to have ample resources to address my immediate physical health. However, I lacked sufficient tools to address the acute and long-term effects cancer had on my mental health. I noticed there were gaps in care to detect and integrate mental health services into the cancer patient experience and long-term recovery. Therefore, after college, when I started my first full-time job, I was determined to incorporate my embodied knowledge into my advocacy goals as a Health Policy Research Fellow at the Weitzman Institute. My experience with cancer coupled with my positionality as an Indian Muslim American woman motivates me to examine the impact cancer has on the mental well-being of people who hold marginalized identities—especially racial and ethnic minorities. Thus, this blog post was born seeking to contextualize cancer and mental health screenings in Federally Qualified Health Center (FQHC) populations.

Keywords: Hodgkin's lymphoma, cancer, mental health

The Link Between Cancer and Mental Health

The experience of having cancer is a type of trauma that has a long-lasting impact on the psychological health and well-being of cancer patients and cancer survivors.[1] Numerous studies have established a connection between cancer populations and the increased likelihood to experience mental health disorders and symptoms. Psychiatric disorders impact at least 30%–35% of cancer patients at all stages of the disease trajectory.[2] Depression and anxiety are the most common form of comorbidity in patients with oncological diseases with an estimated rate of 10% and 22%, respectively. [3],[4]

Patients experiencing mental health distress often fall under the radar leading to a lack of a diagnosis and/or quality treatment. Research indicates that early detection and intervention lead to improved remission and reduce the emotional and financial toll of the illness.[5] The anxiety of cancer coming back (recurrence) is a common fear that has both psychological and physiological implications for people who survive cancer. While the patient may be physically recovered, often their mental health needs are not sufficiently addressed and examined by clinicians and researchers alike.[6]

Primary healthcare settings, including FQHCs, should implement and screen cancer and cancer remission patients to identify those who are experiencing negative mental health impacts from their cancer experience. FQHCs play an important role in addressing this topic as they mainly serve low-income and communities of color, who are often underserved and are at risk of developing mental health issues such as depression after a cancer diagnosis. [7]

Disparities in Cancer and Mental Health

Both cancer and mental health are issues that affect communities of color and low-income communities and where disparities in screening and follow-up exist. Although overall cancer incidence is decreasing due to better screening and improved treatment, certain racial and ethnic groups face different types of cancer prevalence. In comparison to other populations, black individuals have one of the highest rates of new breast cancers as well as higher rates of prostate, colon, and rectum cancer. The rate of newly diagnosed colon and rectum cancer was highest among Black people (40 per 100,000), then White and Hispanic persons (36 and 33 per 100,000, respectively). Additionally, despite having the lowest overall cancer incidence and mortality rates, Asian and Pacific Islander men and women have among the highest rates of liver and stomach cancer, which is about twice as common as in White individuals. Among all demographic categories, black men have the highest age-adjusted lung cancer incidence rates.[8]

Those belonging to racial and ethnic minorities also report consistently higher psychological stress and mental trauma compared to White people.[9] Yet, lack of diagnosis and accessible culturally appropriate care contributes to minority mental health being inadequately addressed or swept under the rug. For example, Major Depressive Disorder (MDD) often goes underdiagnosed and untreated, especially among racial minority populations. Major depression diagnosis rates are 31% and 39% lower, respectively, in majority Black and Hispanic areas than in majority White communities. Low-income African American populations are less likely to report psychological symptoms and follow through with the initial course of treatment. Lack

of provider education that recognizes different presentations of the disease is cited as the underlying problem for this disparity of diagnosis.[10] More than 2,700 persons, ages 18 to 75, were polled by the Blue Cross Blue Shield Association about their views on mental health. They discovered that those who identify as Black or Hispanic are more likely to avoid scheduling an appointment with a mental health professional and “wait and see if they can handle [their symptoms] on their own.”[11] This calls for culturally relevant tools integrating into the mental health education process within health centers.

FQHCs Role in Addressing Mental Health of Cancer Populations from Underserved Backgrounds

FQHCs should be aware of the negative impact cancer has on their patient’s mental health given that some of their patients who had or currently have cancer have their medical home with them. Especially given the under diagnosis of mental health diagnosis cited above, FQHCs should place heightened attention and focus on addressing the mental health needs of this population. Racial and ethnic minority patients comprise 62.24% of the FQHC patient population in 2020.[12] In fact, a majority of their patients fall within these demographics as FQHCs serve one in seven racial minorities, one in five Medicaid beneficiaries, and one in five uninsured persons.[13] This indicates that FQHCs have a wide reach in minority communities.

FQHCs can prioritize addressing the mental health concerns of cancer populations by incorporating depression and anxiety screenings into existing primary care visits and additional ambulatory care practices. Currently, FQHCs already use mental health screenings during visits with data reported from HRSA regarding depression

screenings. In 2020, depression screenings and follow up plans comprised of 64.21 % of FQHC preventive health screening and services.[14]

Although there is no universal standardized tool for depression screening in patients with cancer, a meta-analysis of screening and case-finding tools for depression in cancer settings identified 63 studies that used 19 different screening tools for depression.[15] National guidelines have authorized GAD7, HADS, PHQ2, and PHQ9 to measure the degree of anxiety and depression in cancer patients. Further, in oncology clinics, the Distress Thermometer, a visual analog scale, is routinely used as a screening for psychosocial distress.[16] This type of screening tool can be applied to primary care visits when discussing stress and mental wellness, particularly when going over patient health history. Moreover, advocacy organizations such as Mental Health America advocate for increased mental health screenings as a part of regular cancer care.[17] This is especially true for racial and ethnic minority communities who regularly use FQHCs. Screening efforts also require a proper follow-up mechanism to be fruitful in addressing mental health challenges. If patients believe there are not enough effective treatment alternatives available, they may be less willing to disclose their mental health problems.[18]

One study by Dr. Erin Hahn published in The Journal of the American Medical Association found that depression screening for people with newly diagnosed breast cancer was very successful in identifying people who needed mental health care. Teams of medical oncologists at various locations were divided into two groups. Physicians and nurses in the first group received training on depression screening, performance reviews, and assistance in deciding how to best incorporate the PHQ-9

depression screening into their present workflow. Only education was given to physicians and nurses in the second group, which was the control group. Ultimately, this study found that implementing a depression screening for people with newly diagnosed breast cancer was very successful in identifying people who needed mental health care and the patient care and regular operations of the medical oncology teams successfully incorporated the new screening program.[19]

There are several examples of other conditions and traumas where mental health screenings and interventions have been deployed. One prominent example is new mothers who are at risk for Post-Partum Depression (PPD). The American Academy of Pediatrics advocates for post-partum depression screenings during follow-up medical appointments including follow-up maternal appointments and some instances of newborn primary care visits.[20] Research on PPD notes that postpartum depression screening increases awareness of the condition, but improving clinical outcomes necessitates improved care that provides effective treatment and ongoing monitoring. Additionally, one study cited the use of Post-Traumatic Stress Disorder (PTSD) and Depression screenings administered in children and their parents after a single-incident trauma occurs.[21] The screening functions to provide early intervention for those who are most at risk and ensure the well-being and proper development of both the child and the parents. The screening tool titled “Screening Tool for Early Predictors of PTSD” (STEPP) was administered in trauma centers in trauma rooms of the emergency department. This kind of early screening is critical to avoiding chronic trauma disorders.

CONCLUSION

The observed disparities in both cancer screening and mental health care among racial and ethnic populations have resulted in an alarming public health challenge. There is growing evidence that cancer patients and survivors experience untreated mental health problems. Clinicians, researchers, and healthcare leaders must advocate for the use of depression and anxiety screenings in both cancer patients and cancer survivors during primary care visits in FQHC settings. This will improve rates of under-diagnosis and provide earlier access to care. Additionally, early intervention may minimize long-term disability and avert years of suffering. Depression has a significant impact on a patient's quality of life, daily activities, and functioning, as well as on healthcare professionals, payers, and employers. The benefits of catching depression and anxiety earlier lead to fewer outcomes of suicide, the severity of symptoms, and an increased likelihood of seeking treatment.[22] Those at risk could increase the likelihood of suicide and developing other health issues if left untreated.[23]

Screenings have been implemented in a variety of settings and contexts proving effective in addressing trauma's impact on mental health.[24] This is ideal as cancer is often manifests as a traumatic experience for the patient. Screenings for mental health can close the service gap by enabling early detection, intervention, and effective treatment can help patients achieve remission, avoid relapses, and lessen the psychological and financial toll of their illness.[25] Mental health screenings at FQHCs for cancer populations ought to be adopted nationwide in an effort to reach

health equity and quality trauma informed care for all. Ultimately, this will result in enhanced outcomes and quality of life, especially for those most underserved.

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