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Psycho-oncology best practice guidelines and a service perspective: conceptualising the fit and towards bridging the gap

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The purpose of this paper is two-fold. Firstly, it provides a summary of psycho-oncology best practice guidelines from the UK, US, Australia and Canada. The second aim of this paper is the examination of how a service in Ireland has progressed in adopting these best practice guidelines. A *Working Model of Psychology in Action* is presented to illustrate the interplay of components currently influencing psycho-oncology in context. The benchmarking process delineates efforts aimed at realising the best practice principles and is helpful in understanding the strengths and also the limitations of the service. The exploration of the challenges in applying non-national guidelines also highlights systemic dimensions such as contextual, organisational, professional and cultural dynamics. With a view to the future, gaps in the guidelines as well as current and potential aims in service development in psycho-oncology in the broader field are discussed.

Keywords: psycho-oncology; best practice guidelines; service development; model of psychology in action

Introduction to the field of psycho-oncology

The historical context of psycho-oncology

Historically, the management and treatment of cancer has focused on survival but today, psychological and quality of life issues are recognised as important. Professor Jimmie Holland founder of the sub-specialty of psycho-oncology has been tireless in her efforts to identify and respond to the psychological domain of cancer (e.g., Holland, 2003). In the 1950s the psychosomatic movement was placing theoretical import on the psychological aetiology of disease such as cancer. However, such investigations hindered multi-disciplinary studies between psychiatry and physicians, as each field represented competing rather than collaborative viewpoints. Meanwhile, case studies of psychotherapy that incidentally captured the emotional and psychological response of hospital patients to cancer facilitated insight and interest into coping with life threatening illness and provided the first papers that informed the field. It would take another two decades before the sub-speciality of psycho-oncology was formally created when communicating diagnosis to the patient became more commonplace, marrying a recognition and interest in the psychobiology of cancer and the psychological responses of patients and their families to the illness. As validated instruments, theoretical models and various psychological interventions emerged through research and interdisciplinary collaboration, clinical care has undoubtedly

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strengthened. The formation of the International Society of Psychosocial Oncology (IPOS) in 1984 established an increasingly cohesive body of knowledge in the field and facilitated the development of best practice guidelines in various countries, which will be described below.

The psychological impact of cancer

The emotional and psychological sequelae of cancer across the lifespan have been well documented (Holland et al., 2010). The experience of a cancer diagnosis, illness and treatment may lead to moderate-severe emotional difficulties (e.g., anxiety, depression and stress), relationship issues, cognitive limitations and a range of physical problems that impact emotionally (e.g., incontinence, disfigurement, problems with sexuality, fertility issues, pain, sleep difficulties, nausea, lack of appetite, diarrhoea, toxicity and hormonal drug effects). Distress, as defined by Holland, is 'a multifactorial unpleasant emotional experience. . .which extends along a continuum, ranging from common normal feelings of vulnerability, sadness and fear to problems that can become disabling, such as depression, anxiety, panic, social isolation and existential and spiritual crisis' (Holland, Anderson, & Breitbart, 2007, p. 66). Zabora, Brintzenhofesoc, Curbow, Hooker, and Piantadosi (2001) reported on the prevalence of psychological distress among a large sample of cancer patients ($n = 4496$) and compared the prevalence across cancer diagnoses. To summarise, the percentage of cases where distress levels were rated as significant ranged from 30% to 43%, depending on cancer type. The study found that lung and brain cancers are risk factors in the development of psychological difficulties. Similarly, the younger age groups (< 30 years old) and single individuals were found to possess higher rates of distress. Those with recurrent disease have consistently been found to experience elevated levels of emotional distress.

Psychological interventions for cancer patients and their effectiveness

The psychological care of a person with cancer begins at the time of initial diagnosis, through treatment, recovery, remission and survivorship and for some through death and bereavement. The wide-ranging outcomes of psychological therapies include reducing the side effects of cancer treatments and improving patients' immune functioning and longevity. The Institute of Medicine's (US) 2007 report stated that there is a strong evidence base that supports the value of psychosocial interventions in cancer care. The body concluded that a quality cancer service is one that integrates psychological interventions into routine cancer care (Adler & Page, 2008).

Cognitive-behavioural therapy with cancer patients is the psychological intervention that has demonstrated the strongest evidence in meta-analyses (e.g., Tatrow & Montgomery, 2006), having repeatedly been shown to effectively reduce anxiety, depression and perception of pain in randomised clinical trials (e.g., Manne & Andrykowski, 2006). However, in some studies, statistical and clinical change was not found when distress was low on commencement of intervention (e.g., McKiernan, Steggle, Guerin, & Carr, 2010). Psycho-educational methods including relaxation training have been evaluated (e.g., Devine, 2003). The differences between individual and group interventions (Sheard & Maguire, 1999) and the impact of length of intervention (Rehse & Pukrop, 2003) have also been explored. Other Psychotherapeutic approaches have demonstrated efficacy such as

Cognitive-Existential Group Psychotherapy (Kissane et al., 2003), Meaning Centred Psychotherapy for terminal patients (Breitbart et al., 2010) and Social Cognitive Theory (Graves, 2003). Psychological interventions aimed at improving impaired thinking, concentration or memory problems related to chemotherapy, steroid treatment or cancer type are developing (Ferguson et al., 2007). A central challenge for the future is the continuation of research specifically evaluating the effectiveness or change processes involved in psychological therapy with patients with cancer across the care spectrum of the disease.

International best practice guidelines

The growing availability of empirically based knowledge on the psychological impact of cancer and the effectiveness of psychological interventions together with the highly political position that cancer takes in health care, has led to the development of international best practice guidelines in psycho-oncology. As defined by Turner et al. (2005), clinical practice guidelines are 'a summary of the best available scientific evidence, presented in a format which is useful to guide clinical decision-making' (p. 159). The following four guidelines are offered as exemplary in the field and have been selected for the purpose of summarising the best practice standards in psycho-oncology. The selection of these particular guidelines was largely based on their accessibility to the authors in that they are available in English. Given the considerable overlap across guidelines, for the purposes of this article and in the interest of avoiding repetition, the distinguishing and dominant features of the guidelines are weighted more heavily.

America

National Comprehensive Cancer Network (NCCN). Clinical Practice Guidelines in Oncology: Distress Management, 2010. These guidelines recommend distress be adopted as the sixth vital sign in medicine (following from the other vital signs such as temperature and blood pressure; e.g. Holland & Bultz, 2007; Bultz & Carlson, 2006). As Bultz et al. (2011) puts it 'branding distress as the 6th Vital Sign provided a framework for care providers to conceptualise distress in the medical model' (p. 463). The guidelines advocate the use of the Distress Thermometer (DT) as the screening tool to be used to monitor distress in the patient at key points in the cancer experience beginning at the point of entry to the system. A method of administration of the DT is outlined in detail. Distress management guidelines are focused on the patient from diagnosis through treatment. Competencies and professional roles are outlined and the guidelines assert that education and training in the assessment and management of distress should be provided for the multi-disciplinary team (MDT). Interventions are described by flow chart for a variety of presenting problems. The establishment of interdisciplinary institutional committees to implement standards for distress management is recommended.

United Kingdom

National Institute for Health and Clinical Excellence (NICE). Improving Supportive and Palliative Care for Adults with Cancer, 2004. The NICE guidelines recommend a four-tiered model of psychosocial assessment and support. A model that is actively

responsive to patient needs is proposed by means of systematic screening for psychological distress. This model allows for and recommends that psychological support is offered by all professionals involved in caring for patients with cancer, whereby the oncology MDT offers psychological support in the form of compassionate communication, effective information and problem-solving at Levels 1 and 2. The majority of patients with transient emotional difficulties will be helped by the interventions offered by MDT members. The model asserts that patients with more severe psychological distress should be managed by a variety of psychological specialists including mental health nurses, clinical, counselling and health psychologists, psychotherapists and liaison psychiatrists. Accredited professionals at Level 3 provide counselling and specific psychological interventions delivered according to an explicit theoretical framework. Clinical Psychologists and Psychiatrists operate at Level 4 and assess complex psychological problems including severe depression and anxiety, organic brain syndromes, personality disorders, substance misuse and psychotic illness. Counselling Psychologists are not included at this level but may have the skills to assess difficulties at this level depending on their specific training and experience. The guidelines also offer advice in relation to the integration and co-ordination of psychological care between primary care services and oncology services.

Australia

National Breast Cancer Centre and the National Cancer Control Initiative: Clinical Guidelines for the Psychosocial Care of Adults with Cancer, 2003. These guidelines were developed partly in response to the successful implementation of the sister guidelines (National Breast Cancer Centre, 2000) relating specifically to breast cancer psychosocial care. The newer set of guidelines focus on the wider cancer patient population. The guidelines are comprehensive in their scope including systematic literature reviews and comprehensive recommendations for clinicians dealing with challenging situations (e.g., breaking bad news, discussing prognosis). The guidelines set out detailed assessment information on the individual and cancer-related factors that determine the nature and level of psychological distress experienced by the patient. These guidelines also offer information on the effectiveness of different interventions for the treatment of psychological problems and highlight the importance of establishing an optimal referral network. Turner et al. (2005) provide a summary review of these guidelines and call for implementation strategies to translate the guidelines into improved clinical care.

Canada

Canadian Association of Psychosocial Oncology (2010); Howell et al. (2009). These guidelines offer similar recommendations in that routine, systematic and standardised assessment and evidence-based interventions to address the range of psychosocial health needs including physical, informational, emotional, psychological, social and spiritual. Emphasis is placed on assessment of psychosocial health needs through transitional periods of care including palliative and survivorship stages. Family centred care is to be available across the healthcare system and includes matching service provision with multi-cultural needs. Competencies and education in specific psychosocial and supportive care skills are matched with

standards that determine the role of each professional. Of note, standards of care include the arena of prevention, providing access to psychosocial support for those at high risk for cancer.

When taken together, the best practice guidelines while complementing each other are (naturally) repetitive and yet they also vary in the emphasis they place on different components of psycho-oncology care. Furthermore, the guidelines have been described as not always clear (Westwood & Wood, 2007). As yet, there has not been a move to adopt a particular set as the global standard. Additionally, there is an invariable gap between clinical guidelines and actual clinical practice and the need to make practitioners aware of guidelines has been repeatedly voiced (e.g., Jacobsen, 2010; Jacobsen, & Ransom, 2007). The sheer volume of these four guidelines may appear onerous and daunting to already stretched services. Therefore, a summary of broad-based principles derived from all four guidelines is being offered in this paper as a potentially helpful addition to the field of psycho-oncology service development.

Methodology

Summary of the principles from the international best practice guidelines

The methodology for summarising the guidelines was as follows. It was proposed that the particular focus of the summary principles selected for this paper would target those standards relevant to a psychology/psycho-oncology service rather than including guidelines relevant to the wider dimensions of psychosocial care of cancer patients (e.g., pastoral care) while at the same time including principles relating to the MDT's functioning broadly. A particular rationale for focusing on psycho-oncology specifically relates to concerns about the possible compromise in the delivery of the NICE guidelines at tier four (where psycho-oncology operates) due to resource limitations (e.g., Price, Hotopt, Higginson, Monroe, & Henderson, 2006) and therefore, psycho-oncology service delivery requires further exploration.

Broad-based values were firstly extrapolated which incorporated many related components along the same theme (in a manner not dissimilar to qualitative analysis). The summary principles were generated with a dual focus; firstly, on their function or rationale (e.g., quality focused principles) and secondly, on their measurable goals (e.g., use of standardised measures to achieve a quality service). The first author proposed a set of summary principles and these were further developed and refined through a process of reliability checks by two psychologists, resulting in 13 summary principles. In addition, a five-tiered categorisation system for the principles was developed to offer different groupings for the principles defined by function, namely (1) strategy/awareness, (2) psycho-oncology service components, (3) resources/operational, (4) quality assurance and (5) networks/partnerships. The following figure depicts the 13 summary recommendations or principles from the four international guidelines in psycho-oncology (Figure 1). The components of the summary guidelines by definition point to a framework for the effective delivery of psycho-oncology services.

Following the summary framework, an exploration is made of how one Irish setting has evolved in implementing these guidelines. The service selected is the Department of Psycho-oncology (DoP) at St. Luke's Hospital (SLH) in Dublin. The rationale for choosing this service is not as an exemplar of good practice per se, but rather as an illustration of a service that is developing and striving to meet

Figure 1. Summary of broad-based principles from psycho-oncology best practice guidelines.

international best practice guidelines and the challenges this entails. The potential contribution of an analysis of a particular service in a case study methodology has been outlined in parallel studies (e.g., Hallahan & Garland, 2004; Levin, Weiner, Saravay, & Deakins, 2004).

An Irish psycho-oncology service and best practice principles

An introduction to the Department of Psycho-oncology at St. Luke's Hospital

SLH provides in-patient and out-patient chemotherapy and radiotherapy for adults and children with cancer. It functions as one of the cancer services operating under the Irish National Cancer Control Programme (NCCP). The DoP at SLH, established in 2003 was developed to include (1) clinical services, (2) interdisciplinary staff training and psycho-education for patients and their families and (3) research in psycho-oncology. The department currently comprises three permanent psychologists and three psychologists in training on placement annually. The number of new referrals to the department for individual psychological intervention for 2010 was

329, representing approximately 10% of the hospital's total number of patients annually. The rate of referral has increased substantially (by 40%) in the last two years.

A working model of psychology in action

A process map in Figure 2 depicts the current *Working Model of Psychology in Action* as exists at SLH. There are six component sets or groupings in this working model described here as (1)–(6), all of which include sub-components.

- The first set is the individuals' (patients) psychological experiences of the cancer diagnosis and treatment. These experiences are subdivided into (a) the set of experiences prior to intervention with the psycho-oncology service and (b) the experiences arising in response to the contact with the service, as illustrated in a process map format moving into and out of the service.
- The DoP is the second set, naturally forming a central component of this proposed working model where the operational units are incorporated. Within this set, clinical services are a core element, including psychological assessment and therapeutic intervention. The multi-disciplinary clinical work is also positioned here as a central feature of the department. Supervision and continued professional development (CPD) as well as teaching/training/consultation also constitute the sub-components of the DoP. Research is another important activity of the DoP being examined. The final sub-component of the DoP set is 'Professional/Political representation'. The components under 'Professional' include the line management structures, the weekly department team meetings and monthly journal clubs all of which help maintain and develop the department's core functions. Subsumed under 'Political' is the psychologists' work on professional bodies and their organisational and political commitments.
- The context and stakeholders are the third grouping in the working model. The context of the working model is an oncology hospital. The stakeholders of this working model include the patients, the psychologists, the MDT and professional bodies, all of whom have an influence or share an interest in the functioning of this working model.
- The fourth area of the model is global Research, the world of psychological knowledge on the impact of cancer and the effectiveness of interventions.
- The fifth component of the working model is the arena of International Best Practice Guidelines.
- The final grouping is the Psychological Skills Workforce Training dimension which includes the building of psychological resources through training of psychologists, multi-disciplinary members and patient support groups.

The inter-relations and inter-dependence of all component factors are illustrated with arrows and key comments on the processes. The patients feed into the DoP with presenting problems and as a result experience a response, the aim being the alleviation of psychological difficulties. The patients' experiences also form the data for psychological research (global) that in turn, informs the international best practice guidelines. Global research and best practice guidelines direct the functions of the DoP and clinical data and research from the DoP is inputted back into global research. The best practice guidelines also guide the processes of workforce

Figure 2. A working model of psychology in action at SLH.

dimension in curricula recommendations and accreditation. The working model appropriately demonstrates the central role of the MDT in psychology in action whereby the department's MDT work is central to its operation and the MDTs are also stakeholders. The DoP's relationships with its stakeholders are bi-directional and are most important in that the perceived responsiveness and effectiveness of the psycho-oncology services will affect uptake by the stakeholders. There is also a two-way relationship between the DoP and its context, whereby the department has a role in changing the protocols of the hospital but this variable also may influence the nature of the department, for example, in its policies and in the availability of resources (psychology personnel). The DoP has an important role in inputting to the workforce dimension of teaching psychological skills and psychologists in training also feed into the DoP while on placement. Notably, a percentage of individuals post-cancer treatment opt to contribute to cancer support centres and may develop basic psychological skills to facilitate this voluntary contribution.

A key strategy within the DoP is the explicit endorsement of all of the sub-components. The working model helps capture the reality that while the department's functions complement each other (e.g., clinical, teaching and research), they also compete for resource and time allocation. There is a strong culture of teamwork within the department and the Head of Department provides leadership in relation to operational and strategy decisions. Fundamentally, the working model illustrates the complex inter-play between the individual patient's experience and the clinical, research, organisational and political dimensions. All these factors are relevant to how the DoP fares in the evaluation of the service with best practice guidelines.

Conceptualising the fit with the guidelines and towards bridging the gap at SLH

The following review considers how current practice at the DoP at SLH has developed with respect to the central components and summary principles from best practice international guidelines.

1. Fostering the organisation's awareness of the psychosocial needs of cancer patients and engaging support for the best practice principles

Since its establishment, the DoP has promoted the hospital's awareness of the psychological needs of patients through staff teaching, psycho-educational inputs, feedback on clinical case work, research in psycho-oncology and by means of psychology representation on hospital committees as depicted in the *Working Model of Psychology in Action*. The uptake of the distress management standards raises the need for the development of a strategy across services in the NCCP and the Principal Psychologist has contributed to the development of strategy documents in this regard, including the specific recommendation that the summary principles be adopted. In the last year, the psychologists have accepted invitations to speak on national radio and television about psychological issues in cancer. The public and the organisation's response to the department's promotion of awareness of psychological needs is evident in an increase in enquiries, referrals and feedback to the service.

2. Screen for distress at critical junctures in the cancer journey

Screening for emotional difficulties is carried out by the medical and nursing teams routinely as part of their broad-based intake assessment. All patients are informed about the psycho-oncology service and are given the department's information leaflet

at their first contact with the hospital. While the DT is not yet being utilised, research has been carried out to examine the validity and reliability of this measure with an Irish population (Creedon, Hession, & Hevey, 2009). A rating of the estimated level of patient distress (1–10) has been adopted as part of the psycho-oncology referral form to facilitate prioritisation of referrals. The high increase in referral rate in the last year indicates better screening. Although screening or assessment of emotional difficulties is being carried out routinely at intake, it is not yet consistently detected across the cancer care continuum. Given the high number of referrals to psycho-oncology presently and the small size of the department, considerations need to be made about how screening will be linked to further intervention, and what resources will be available for patients. Recognising the limits of service seems imperative to providing patient centred and ethical care, and points to the complexity of considering how, when and whether to apply guidelines across services. This point also echoes the need to consider the principles within the process framework of the *Working Model of Psychology in Action*, where negotiation and liaison with the multi-disciplinary stakeholders is imperative.

3. Adopt a tiered model of assessment and intervention

A tiered model has not been formally adopted in SLH but is generally the case on the ground. The Pastoral Care service focuses on responding to spiritual and emotional concerns of all patients, Medical Social Work engages in supportive counselling and responds to the psychosocial needs and the DoP accepts referrals for patients with complex psychological difficulties. The Psychiatry service operates from a connected hospital, providing a responsive service, as and when required, for patients needing psychiatric assessment and intervention. There is ongoing liaison between all these professionals to negotiate roles. It could be interpreted that the absence of a formal tiered model could be related to an absence of a screening programme, whereby the parameters and domains of psychosocial healthcare needs would be concretely divided and routinely captured for each patient. Service-based research describing the process and challenges of adopting the tiered model (e.g., Steginga, Hutchinson, Turner, & Dunn, 2006) will be helpful in guiding SLH in this regard.

4. Systematic, multi-layered and client-centred interventions

The department endorses the principle that patients are to be offered the intervention that best matches their needs which may be a combination of interventions with different professional inputs and which may change over time. This requires ongoing liaison with all departments providing emotionally supportive interventions and underlines the importance of the MDT work as central to psycho-oncology service delivery as described in the *Working Model of Psychology in Action*. The clinical services provided by the DoP include psycho-educational interventions, psychological assessment and therapeutic interventions for in-patients and out-patients. It is worth noting that considerations from the patient's point of view include their attitude to psychological therapy, and therefore, interventions need to be diverse enough to minimise stigma and maximise gains. Psycho-educational interventions range from an open, group-based weekly progressive muscular relaxation class for patients where patients are given a compact disc and instructions for ongoing practice and application of the skill, to monthly 'Cancer Insights', a public lecture series, which includes talks on a range of psychological coping strategies. The psycho-educational interventions have served as a means of providing access to psychological input across

a broad group of patients on specific issues such as coping, survivorship, pain, sleep, body image and sexuality. A DVD of these cancer insights series has been produced in order to provide greater accessibility to psycho-education for patients and their families. The department also contributes to MDT psychosocial groups (e.g., Breast, Gynaecological, Head and Neck and Brain tumour).

Reasons for clinical referral include the presentation of all the psychological difficulties cited earlier, from all cancer groupings in terms of cancer type, age, marital status and disease severity and stage. The range of therapeutic interventions available in the department includes Cognitive Behaviour Therapy, Psychodynamic psychotherapy, Mindfulness-Based Stress Reduction, Eye Movement Desensitisation and Reprocessing and Emotion Focused Therapy, and individual, couple and group intervention models are all utilised based on their respective demonstration of efficacy in working with chronic illness such as cancer. A recognised gap is the delivery of services for survivor groups and plans are underway to begin to address this need by following the care pathways described by Holland and Reznik (2005).

Under-detection of psychological difficulties is a problem at this time. Although the rate of referral of approximately 10% is in line with figures from other studies (e.g., Malafa et al., 2009) and is increasing steadily, it is still far below prevalence rates. The department is currently considering recommending the automatic referral of the high-risk patients, where the patient consents.

5. Assess for and respond to the psychosocial and psychological needs of partners and carers

Partners and carers may be referred to the DoP (and to Medical Social Work). The two departments are planning a psychosocial support group for this population. A re-evaluation of the current psychology referral process to include allied health professionals and nurse managers in addition to the medical team may further facilitate the identification of psychological needs in this population. A focus group including staff and service users is recommended for feedback on the best care pathway for this group.

6. Role delineation

The role of the psychologist and a description of the psycho-oncology service is documented on the department's information leaflet and referral form and the psychologists work within their scope of practice. Discussion and negotiation are required on occasions of overlap in roles, for example, with Medical Social Work and Psychiatry.

7. Inter-disciplinary collaboration and co-ordination

Psychologists work with the MDT in the provision of patient care, which is co-ordinated through formal structures (e.g., Palliative care psychosocial weekly meetings, Pain service MDT meetings) and on a case-by-case basis by linking with the key professionals working with the patient as noted in the *Working Model of Psychology in Action*. Effective communication and team building requires time, energy and commitment. Barriers to successful collaboration on occasions have included heavy and/or complex workloads which limit time to devote to team building and reinforcing links. An ongoing challenge is how team members share and concede territory, move and cross boundaries, to embrace diversity (e.g., Dawson, 2007) in order to develop and maintain trust. An ethos of the DoP is that diversity

and overlap in roles are strengths rather than threats, which is balanced with appropriate recognition of the boundaries in scope of practice.

8. Effective teamwork and a culture of recognition of all contributions

This principle requires that all members of the MDT be recognised and supported in their role in responding and intervening with patients in distress. The DoP currently supports other MDT roles in responding to distress, by teaching on the Masters in Oncology Nursing and by providing workshops to all staff. Additionally staff are supported in positive strategies to minimise compassion fatigue risk by attending staff relaxation classes. Some staff groups (e.g., Radiotherapy Nurses) engage in reflective practice supervision with the Principal Psychologist in relation to difficult psychological issues with patients, which is instructive in psychological skills but also serves to recognise the psychological work being carried out by MDT members other than psychologists.

9. Workforce planning

The psychologists are committee members of professional bodies and national working groups pursuant to developing and establishing the role of the psychologist in conjunction with national and inter-national policy and service development (e.g., Psycho-oncology Steering Group of the NCCP; Heads of Psychology Services Ireland; Division of Counselling Psychology (PSI); Steering Group for the professional training doctorate courses in Clinical and Counselling Psychology, Trinity College Dublin). This summary principle of workforce planning is integrated into the current *Working Model of Psychology in Action* under political representation. The Principal Psychologist at SLH has been involved in workforce planning and development in psycho-oncology following on from the changes in the delivery of radiation oncology (Hollywood, 2003). The issue of workforce planning is an area in psycho-oncology service development that requires further attention (Otfinowski, Christian, Mackenzie, Handman, & Bultz, 2003).

10. Utilise standardised assessment tools and therapeutic interventions that have demonstrated efficacy in scientific research studies

The therapeutic interventions utilised in the DoP are those recommended in the best practice guidelines. Pre- and post-intervention standardised questionnaires are used but not yet standard with all patients, for all interventions. An increased use of the measures recommended specifically for this population will increase the compliance rating in relation to this principle. However, a particular issue that hinders the use of questionnaires with patients is their medical status at times, whereby the side effects of treatment (e.g., nausea, fatigue and weakness) make the completion of these measures quite demanding. The psychologists keep abreast of best practice guidelines and evolving empirical research (e.g., including APA Research Supported Psychological Treatments) through supervision, journal clubs, team meetings and CPD.

11. All professionals to be offered training to meet and update their skill requirements for their role

Staff training on psychological skills is delivered using different formats from occasional lectures to regular input into the Masters in Oncology Nursing programmes run by the hospital in conjunction with the universities as illustrated

in the *Working Model of Psychology in Action*. The psychologists also deliver training to the doctorate courses in clinical and counselling psychology. Reflective practice supervision on psychological issues for the MDT may be developed further. Staff working in oncology in other sites have also attended training events. Mitchell, Kaar, Coggan, and Herman (2008) point to insufficient training and low confidence as key barriers in health professionals adopting distress screening. Staff training is perhaps an area with the greatest scope for growth, yet is restricted by the demands of every healthcare service in terms of time, resources and professional engagement or 'buy in'. The psychologists also engage in continued professional development which is supported by the hospital.

12. *Research/evaluation/monitoring*

The department has an established record in clinical research producing 14 peer-reviewed publications in the last seven years plus dozens of presentations at national and international conferences. Other research outcomes include a manualised CBT group-based intervention programme for women with breast cancer (McKiernan, Steggle, Guerin, & Carr, 2010). A specific target in the research programme for the next three years is investigating the effectiveness of Emotion Focused Therapy with cancer patients. The effectiveness of psychological intervention is evaluated on a case-by-case basis through a variety of means including as mentioned above, utilising pre- and post-intervention questionnaires, ratings of increased functional capacity, adherence with medical treatment and qualitative self-report by patients. A service feedback questionnaire has also been used to elicit information from the department's stakeholders and used in the re-organisation of priorities for the service, in line with the values of the *Working Model of Psychology in Action*.

13. *Establish explicit partnerships between hospital and primary care services to ensure optimal, responsive patient care*

A partnership has been established with the NCCP Psycho-oncology Strategy Group and national strategy plans are being developed. The department developed the psycho-oncology care pathway for the Health Service Executive GP Cancer Referral Guidelines. A working relationship exists with the Irish Cancer Society and the psychologists run workshops for its national conferences. The DoP established a relationship with the Irish Hospice Foundation, which is chairing the development of a strategy for the National Primary Care Palliative Care Programme. The inclusion of a question about potential need for access to psychological input in the national survey was recommended to the IHF. An endorsement of this need in primary care/palliative care was subsequently rated by 71% of respondents, which has helped in building awareness and it is hoped will help in building psychological resources. GP practices and hospitals in the Dublin and Wicklow areas were sent information about the public lecture series run by the DoP and the DVDs of the Cancer Insights series will be available to all professionals and patients nationally. The psychologists have links with nationwide cancer support groups and present occasional lectures for these groupings. The DoP seeks to offer an indirect input (e.g., DVD) to cancer services in the community where direct intervention is not feasible and in turn, it has developed referral links for patients returning home. This strategy echoes the recommendations of Bultz et al. (2011).

Summary of strengths and deficits of the psycho-oncology service at SLH

The above review of the DoP at SLH captures its functioning across multiple strands of delivery as well as its interaction with other departments. The three core functions of the department – clinical, teaching and research, are operating well and need to be maintained. The analysis also highlights areas requiring further development including the formal application of a tiered model of psychosocial care. A specific issue arising in the context of increased multi-disciplinary working is the expansion in the limits of confidentiality to include the provision of information to the team as required, in team decision making, which may cause difficulty for some patients. Given that the summary principles relate to many departments involved in the provision of psychological and psychosocial care, it would be important for a future analysis to include these services. Another limitation of this benchmarking review is that it has been carried out by psychologists working in the service rather than objective raters.

Discussion: beyond the best practice principles

This paper argues for the importance of incorporating process dimensions as well as outcomes in best practice psycho-oncology. Additionally, consideration about barriers to implementation of the guidelines is crucial. An APA policy statement, adopted in 2005, captures these sentiments aptly, ‘evidence based practice in psychology is the integration of the best available research with clinical expertise in the context of patient characteristics, culture and preferences’ (APA, 2005, p. 1; also Sackett, Straus, Richardson, Rosenberg, & Haynes, 2000). It is hoped that the summary principles and benchmarking process proposed in this paper may be a useful yardstick for other services to utilise.

The international psycho-oncology guidelines offer broad-based principles but do not specifically address the difficulties of balancing demand and resource provision. In situations where there is an increasing referral rate in psycho-oncology, demand is likely to exceed resource capacity. While an increase in the number of referrals represents a positive development as a higher percentage of patients’ psychological needs are being identified, considerations need to be made as to how to best manage limited psychological resources. Ongoing prioritisation of referrals is essential and patients not categorised as priority patients may be invited to attend psycho-educational/group interventions and may avail of the psychosocial support offered by other departments. Liaison with all departments offering emotional and psychosocial support also helps in optimal triaging of patients. Patients may be referred to other services (e.g., local Psychologist, various Cancer support services) on completion of a particular intervention and agreements may need to be established about shared care arrangements. Targeted screening (e.g., of patient populations with known higher risk of developing psychological difficulties such as head and neck patients) is another possible strategy in balancing demand and resource provision (e.g., Thomas, NandaMohan, Nair, Robinson, & Pandey, 2009). Notably, recent studies are now questioning the appropriateness of full patient population screening citing the argument that this approach has yet to demonstrate conclusively that screening itself positively influences the psychological well-being of cancer patients (Bidstrup, Johansen, & Mitchell, 2011). Representation of the psychological perspective on national working groups is crucial since these policy

documents will influence recommendations about resource levels and delivery models.

Team collaboration and partnerships are sub-themes in this paper, both in relation to the functioning within the department, within the MDT and beyond. This is an area requiring more exploration to define the factors that facilitate optimal team functioning in psycho-oncology. The *Working Model of Psychology in Action* underlines the importance of the systemic, organisational and political dimensions of the psycho-oncology service and other organisations may test and potentially adopt this model. Walshe, Caress, Chew-Graham and Todd (2007) has explored the structural, procedural, financial, professional and legitimacy barriers to partnership working in the context of palliative care, noting that the NICE guidelines failed to acknowledge these challenges and cites the principle of adopting a defined and shared goal as essential, which echoes the need for all party 'buy in' to specific best practice principles. Dudgeon et al. (2011) advocate that change in practice requires clinical leadership, a commitment to patient-centred care and target-based performance management. These systematic and directive approaches need to be integrated with more subtle but important dimensions as described by McCorkle (2011) who notes that successful collaborative efforts are built on trust, humility and kinship. A particular challenge in working in psycho-oncology is compassion fatigue. The support structures of clinical supervision and CPD are preventative factors in this regard. It is also the case that appropriately balancing clinical, research and teaching responsibilities within a psycho-oncology post, helps sustain the psychologist in working in this most rewarding but very demanding area. Teaching and research are also cornerstones to maintaining a quality service. In summary, the authors argue for the need for an integrative model between the clinical care guidelines and the complex service development issues is the provision of psycho-oncology care.

Conclusion

This paper sought to extrapolate key recommendations and emerging trends in psycho-oncology through a process of exploring dominant themes across best practice guidelines. The central question remains about how to establish an infrastructure that ensures optimum service provision in line with best practice guidelines and in conjunction with complex dimensions of service delivery, while also sustaining and growing the psycho-oncology department across its developmental stages. This paper has taken a step towards embracing this challenge by offering an account of the process of psycho-oncology service delivery. The exploration of the service detailed information on both standard and creative methods to optimise psychological resources and revealed the various competing possibilities of focus. An integrative *Working Model of Psychology in Action* for psycho-oncology was proposed, illustrating the interaction between clinical, research and teaching aspects of a service while also demonstrating the important influence of contextual, organisational and political factors. Key challenges for psycho-oncology now and into the future include the generation of priorities and guidelines in relation to balancing demand and resource provision, the continued building of psychological skills for the MDT and representing the need for psycho-oncology resources on national strategy initiatives, all of which are targeted on further enhancing cancer care.

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