

# Caring for Patients With Serious Mental Illness: Guide for the Oncology Clinician

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## Challenges for Patients With Cancer and Serious Mental Illness

Advances in cancer care have resulted in improved cancer survival in the general population,<sup>1</sup> but decades of evidence reveal that individuals with serious mental illness (SMI) experience poorer quality of cancer care and disproportionate cancer mortality.<sup>2-5</sup> SMI, encompassing mental disorders such as schizophrenia, bipolar disorder, or major depressive disorder that significantly impede functioning,<sup>6,7</sup> affects more than 13 million adults in the United States.<sup>8</sup> Barriers to care for patients with SMI include late-stage cancer diagnoses at initial contact due to lower rates of cancer screening<sup>9,10</sup>; fragmented or inadequate psychosocial care, which may result in uncontrolled psychiatric symptoms<sup>11</sup>; and increased risk of medication interactions with cancer therapies.<sup>12</sup> This population has higher incidence of comorbidities,<sup>13</sup> smoking,<sup>14</sup> obesity,<sup>15</sup> and substance abuse<sup>14</sup>; fewer support systems for navigating cancer care<sup>16</sup>; and higher incidence of cognitive deficits that interfere with illness understanding and decision-making.<sup>17</sup> Patients' reluctance to share mental health history, deriving from traumatic experiences with discrimination, is also a common barrier and can lead to delays in psychiatric referral.<sup>18</sup>

## PERSPECTIVE

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Historically, people with SMI have experienced mental health discrimination. Common misperceptions include that they are dangerous, unpredictable, uncooperative, incapable of working, and/or unable to participate in research studies.<sup>19,20</sup> Self-stigma, the process of internalizing negative stereotypes and applying them to oneself, can also contribute to lower rates of disclosing psychiatric history and may deter help-seeking completely.<sup>21</sup> In a meta-analysis, a majority of nonpsychiatric medical physicians believed that people with SMI were more dangerous than cohorts with less serious psychiatric diagnoses. Although these physicians were amenable to seeing patients with SMI, they worried about the amount of time required as well as potential nonadherence to treatment.<sup>7</sup> Clinician inexperience can also contribute to delays and misdiagnoses. For example, implicit bias may occur if the clinician ascribes a patient's physical symptoms to mental illness, which can lead to delays in specialty referrals and initiation of treatment.<sup>22</sup> Structural discrimination, referring to discriminatory

institutional policies or laws that inhibit opportunities for marginalized populations, can also curb oncology specialists' investment in mental health training or accessing mental health services for their patients.<sup>23</sup> Moreover, since patients with SMI have higher incidence of substance use or abuse, oncology clinicians may miss opportunities to improve cancer treatment outcomes and survivorship if they do not assess for this and refer patients to addiction experts.<sup>24</sup>

## Overcoming Barriers With Patients With SMI

Collaborative care approaches that integrate psychological and physical care have demonstrated clinical effectiveness<sup>25,26</sup> and cost-effective access to care for a variety of health conditions among different populations and across practice settings.<sup>27</sup> Why, then, haven't these approaches been more widely adopted in oncology settings? The integration process may be perceived as too complex, requiring more time than oncology clinicians can devote to it without sacrificing care quality. Practical

strategies exist, however, for overcoming some of the barriers with patients with SMI, beginning with patient-provider communication.<sup>28</sup>

### Establishing Rapport for Effective Communication

Patients and clinicians have recommended establishing fast rapport by using person-first language, a type of linguistic approach that focuses on the person as a unique individual and not on the person's condition or diagnosis.<sup>29</sup> In this approach, an individual's medical diagnosis follows them as a human being, not the other way around: a patient with cancer rather than a cancer patient. Person-first language has been taught in most health professions programs for decades and is mandated by most scholarly journals as an important aspect of cultural competence in health care. It demonstrates the power of language to raise consciousness about and respect for all patients, and it affirms patients' autonomy and the right to identify themselves however they choose. Despite its obvious significance, it is nonetheless infrequently used in clinical practice.<sup>30</sup> To initiate person-first language with patients with SMI, clinicians and their staffs can show sensitivity and respect by first asking how they would like to be addressed (eg, Ms Smith, Pamela, Pam, Ms Pam). This can be followed with open-ended questions to find out about their current circumstances, hopes, fears, and possible adherence barriers, and how they feel the oncology team can be helpful. Clinicians can tailor their language, slowing their speech and using concrete terms and visual aids to explain procedures. As staff members become aware of how their perceptions of patients may impact their language and professionalism, practicing person-first thinking and language may boost their confidence in knowing how to communicate with all patients and each other as well.<sup>31</sup> **Table 1** contrasts examples of

**TABLE 1. Reframing Communication for Patients With Cancer and Mental Illness**

Language that comes across as blaming	Correction
<b>Biggest complaint</b>	<i>Biggest concern</i>
<b>Frequent fliers</b>	<i>Patient recently admitted/seen at X for Y concern</i>
<b>Patient failed cancer treatment</b>	<i>Treatment failed patient with cancer</i>
<b>Patient is difficult</b>	<i>Complex situation/inadequate options</i>
<b>No-show</b>	<i>Patient who missed an appointment</i>
<b>What is his/her problem?</b>	<i>How can I help?</i>
Language that inadvertently perpetuates stigma	Correction
<b>Drug addict</b>	<i>Person with substance use disorder</i>
<b>In drug rehab</b>	<i>In recovery</i>
<b>So OCD</b>	<i>Extremely neat and well organized</i>
<b>Moody or touchy</b>	<i>Sensitive</i>
<b>Off the deep end</b>	<i>Experiencing difficulty</i>
<b>Street person/vagrant/hobo</b>	<i>Without shelter/housing</i>

OCD, obsessive-compulsive disorder.

blaming and stigma-perpetuating language with corrections in person-first language.

### Trauma-Informed Care

It is important for staff to realize that many patients with SMI have had a lifetime of exposure to trauma. These experiences have left them deeply distressed or disturbed, beginning with abuse and/or neglect in their early years and continuing into adulthood.<sup>32,33</sup> In a study of individuals with SMI spanning 30 years, participants reported a mean lifetime prevalence rate of 47% for physical abuse, 37% for sexual abuse, and 30% for posttraumatic stress disorder, compared with prevalence rates in the general population of 21%, 23%, and 7%, respectively.<sup>34</sup> According to the US Substance Abuse and Mental Health Services Administration, traumatic experiences often adversely impact

people in every functional sphere: physically, mentally, emotionally, socially, and spiritually.<sup>35</sup> Common forms of trauma include familial physical and sexual violence; childhood abuse and/or neglect; neighborhood/community violence, including bullying, gang wars/shootings, robberies, and rape; and natural disasters. Types of trauma that are less understood include racism as well as other stigma-related or prejudice-related incidences; these include being ridiculed or treated differently because of one's mental illness or disability, historical trauma (eg, genocide), and other types of long-term hardship, such as extreme poverty.<sup>36</sup>

Trauma-informed care is an approach that emphasizes sensitivity to the impact of trauma in patients' lives. Health care professionals' heightened sensitivity is essential for helping patients feel safe and for not inadvertently triggering

patients' previous trauma responses while they cope with all the challenges of a cancer diagnosis and treatment.<sup>36</sup> To help patients feel safe and more in control, 2 of the aims of trauma-informed care, clinicians can check for illness understanding, offer options, and

empower patients as ultimate authorities who will decide what happens to their own bodies regarding treatment preferences and goals. Patients with SMI, however, may require more explanation about their cancer and treatment options, including such explanations in

visual formats, as well as more time to process what has been presented to them. It may be helpful to ask patients their preferences about staff member gender and to promote continuity of care when possible. In this regard, for example, a staff member whom patients have



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## Bridging the Gaps: Taking Care of the Whole Person

Over the last 15 years, data have continued to emerge that highlight the large disparities in both the screening and treatment of cancer in individuals with (vs without) serious mental illness. The authors of this review effectively present practical guidance for oncology clinicians to enhance the person-centered approach to treating patients with the “double stigma,” cancer and serious mental illness.<sup>1,2</sup> Specifically, the authors focus on the importance of a communication style that is engaging and intended to be respectful and curious. They also acknowledge the effects on clinicians of individual and systemic factors, such as cognitive biases, suboptimal distress screening and management, provider burnout, and limited access to clinical trials.

The multidisciplinary field of psycho-oncology is uniquely positioned to address and manage the challenges associated with caring for this vulnerable patient population.<sup>3</sup> As psycho-oncologists, we tailor our approaches to the patient interview and exam with our knowledge of the impacts of cancer and its treatments on mental health. We can apply our armamentarium of psychotherapeutic modalities as well as our expertise in psychopharmacology to cancer care. Educational efforts and training led by us across a cancer setting can empower nonpsychiatric providers and trainees in medicine to care for patients with psychiatric symptoms and disorders, and support them as they do so.

While psycho-oncologists are not accessible in every cancer care setting, this review emphasizes that improving access to psychiatric services through other

approaches, such as collaborative care and community outreach, can also improve cancer outcomes. Yet while many organizations and agencies have mandated distress screening in the cancer setting, patients with psychiatric symptoms, and specifically those with serious mental illness, may not be identified through these traditional methods. These individuals may also not disclose their psychiatric history to their oncology providers. The effects of self-stigma, as stated in this review article, can be profound, influencing health behaviors and how and when patients access medical care. Patients with cancer and serious mental illness consequently can have poorer prognoses and shorter survival times.<sup>4</sup>

It is imperative to bridge these gaps in cancer care. Earlier diagnosis and treatment of cancer in patients with serious mental illness is needed. We can develop more population-based methods to assure that these patients are being identified and offered medical care in a timely and effective matter.<sup>5</sup> We must thereby confront the biases in medicine about patients who suffer from psychiatric disease. While there may be higher comorbidity indices, more potential for significant drug-drug interactions, changes in decision-making capacity, and/or difficulties with adherence and coping, generalizing these associations to an individual patient can be a deterrent to providing comprehensive cancer care. We need to leverage the involvement of psycho-oncology clinicians, social workers, patient navigators, caregivers, primary care providers, chaplains, and others who can collaboratively participate in a patient's cancer care and advocate for the

already met, trained in person-first language and trauma-informed care, can accompany them to consults for additional support, to answer questions or concerns afterward, and to provide materials to study at home when they are not under pressure. This type of additional support

may be particularly helpful when cancer care requires invasive procedures, such as colonoscopies; imaging and procedures related to gastrointestinal, genitourinary, gynecologic, and breast cancers; and mask fitting prior to radiation. Oncology clinicians can invest in person-first and

trauma-informed literature and workshops for themselves and staff (much of it free)<sup>37,38</sup> that will help overcome patients' previous experiences with discrimination and improve communication.<sup>39</sup> Tailored approaches can be discussed with staff members.

patient with mental illness; that strategy can help harvest good clinical outcomes along the care continuum.

Psycho-oncologists can and do treat patients' psychiatric distress and illness. We can and do evaluate patients for suicide, which is prevalent in patients with cancer. We can and do diagnose and treat cognitive problems, such as delirium. We can and do promote health behaviors, such as intentional physical activity and sleep management. However, this can all be done more expansively and sustainably with the right prioritization of institutional efforts and allocation of funding. We need to address the insurance barriers, delays in scheduling, limited availability of mental health specialists, and provider burnout, which are but a few of the remarkably widespread problems in our medical system. Inherently, formal and informal caregivers can also suffer distress due to demands of multiple roles and unmet psychosocial needs, all of which have been amplified during the COVID-19 pandemic.<sup>6,7</sup>

Access to mental health services in general is a pervasive problem. When an individual with serious mental illness is diagnosed with cancer, processes must be in place that facilitate the medical and psychiatric care of that individual—specifically, so that treatment is not withheld or minimally offered and that potential medical and psychiatric emergencies are not overlooked. This would not only help individual patients, but it would improve population health and the distribution of clinical services and efforts. It would also enhance our understanding of the interplay between oncologic and psychiatric disease. By having these processes in place, we can develop more effective treatments, decrease health care costs, and customize our models of care to the needs of patients who suffer from the “double stigma.” If we, as a nation, are truly aiming to provide comprehensive cancer care, we must collectively improve the care of our most vulnerable and marginalized patients.

We can lead and implement more of these endeavors and practices while we also take care of the health care

providers and caregivers. In these unprecedented times, greater attention is rightfully being given to the health disparities in our medical system. In parallel, there is more recognition that health care providers and caregivers are suffering from burnout, increased workload, and fatigue.<sup>8</sup> Furthermore, among the general population, physicians and nurses populate the groups at highest risk of suicide.<sup>9</sup> Research has shown that long-lasting changes in health care provider wellness take place by intervening at the organizational level, which requires support from leadership.<sup>10</sup>

To serve more of our most vulnerable patient populations, we must also consider the health of those who are treating them and doing the caregiving. Interventions must take place to assure that we are creating environments that are psychologically safe and that foster more self-care. By prioritizing clinician well-being, we can work toward lessening the stigma associated with seeking mental health care. We can demonstrate the importance of preventive care. We can increase the opportunity for good health behaviors, such as exercise, mindfulness, and sleep routines. By doing so, we can henceforth provide better and safer patient care.<sup>11</sup>

When it comes to caring for our patients with cancer and serious mental illness, we can all work together to advocate for earlier and more effective screening, diagnosis, and treatment. We can advocate for safe practices while also encouraging the enrollment of these patients in clinical trials. We can work together to promote and enforce organizational changes to support clinicians and caregivers who are at the helm of caring for these individuals with medical and psychiatric illness. We can do better for them and for ourselves.

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### Screening and Identification of Mental Illness

The American Society of Clinical Oncology and the Commission on Cancer mandated psychosocial distress screening as a quality care standard in 2015,<sup>40</sup> but only 50% to 65% of patients with cancer are currently screened for distress.<sup>41</sup> Reasons given for the slow implementation rate are lack of staff training<sup>42</sup> and fragmentation between mental health and oncology care.<sup>43</sup> Mental health clinics are often geographically isolated from main health care structures,<sup>44</sup> with separate electronic health records (EHRs).<sup>12</sup> If communication between oncology and mental health care teams exists at all, it is likely infrequent.<sup>16</sup> Moreover, even if measures are used to assess patients' distress in oncology clinics, they are not typically meant to assess SMI, so serious psychiatric disorders may be missed.<sup>12,16,43,44</sup>

The most practical method for identifying SMI may be assessment of patients' medications. A staff member can compile a list of commonly prescribed psychotropic medications for SMI that can be checked against patients' reported medications or EHR medication history. In a recent international study of 13,200 primary care clinicians, only 40% in the United States reported frequently coordinating with social services,<sup>45</sup> but disruptions in patients' psychiatric care and/or failure to manage symptoms result in decreased adherence to cancer treatment and decreased quality of life and survivorship,<sup>46</sup> accentuating inequities in care.<sup>47</sup> If patients are taking a medication commonly prescribed to treat mental illness, clinicians can ask about patients' prescribers, so they can be contacted right away. If patients do not list any psychotropic medications in the medical record, clinicians need to remember they may be reluctant to share their mental health history because of stigma-related experiences. Gentle questioning to find out the cause of

reticence can open the door to building trust. Psychological safety enables effective communication,<sup>48</sup> and person-first and trauma-informed communication strategies have been demonstrated as facilitators of psychological safety with patients, caregivers, and staffs.<sup>49</sup> Additionally, not all patients have a formal diagnosis of mental illness or insight into that diagnosis. It is helpful to ask patients if they have a history of seeing a social worker or psychiatrist or if they have ever received a mental health diagnosis. If they are accompanied by a caregiver, it is also important to partner with them to obtain additional history.

### Referring Patients With SMI to Clinical Trials

Historically, inequities in care for patients with SMI who have cancer have been exacerbated by lack of research. Almost 25 years ago, a National Cancer Institute Clinical Trials Program Review Group asserted there were "too many exclusion criteria in the current clinical trials system" and "entry criteria for all studies need to be simplified and broadened."<sup>50,51</sup> Currently, however, half of the most circulated and cited US clinical trials, including oncology trials, exclude patients with psychiatric conditions.<sup>52</sup> Oncology clinicians reported that their main reasons for nonreferral of patients with SMI to trials were the patients' possible lack of motivation to participate, inability to provide informed consent, inability to complete protocols and return for follow-up appointments; the potential for increased patient burden and compromised safety; and perceived risk and additional burden for investigators.<sup>19</sup> However, when patients with SMI, including schizophrenia, are provided with more details about the study and given more time to process this information, their motivation and capacity to consent is improved.<sup>53,54</sup> In a trial bridging cancer care and psychiatric care, patients had high

rates of consent, symptoms remained stable or improved during the trial, and they were able to complete the trial.<sup>54</sup> People with SMI have also demonstrated the ability to successfully participate in remote interventions. Recently, 315 people with confirmed diagnoses of bipolar disorder, major depressive disorder, and/or schizophrenia or schizoaffective disorder were recruited from advertisements placed in large search engines, and they participated in a fully remote smartphone intervention for reducing severity of psychiatric symptoms and increasing self-esteem. Although retention was a challenge, some of the main reasons oncologists gave for not referring (eg, lack of motivation, inability to provide consent, and burden for investigators) were not encountered, and results indicated that people with SMI can be successfully recruited and treated remotely for reduced symptom severity.<sup>55</sup>

Oncology clinicians may believe that they are protecting their patients by not referring them for trials. Ironically, lack of research drives misperceptions about the ability of people with SMI to participate in research,<sup>16</sup> and participation in trials may be needed to dispel these limiting misperceptions that lead to care inequities.<sup>39,56</sup> **Table 2** describes types and examples of barriers that might occur with patients with SMI and practical recommendations for overcoming them.

### Pulling the Team Together to Enhance Care for Patients With Mental Illness

As patients with SMI begin the challenging process of managing the demands of cancer treatment, ongoing mental health care is needed to address their complex psychological needs and help them be successful. The clinical team can brainstorm the most efficient way to tailor the existing practice for an integrated approach<sup>57</sup> to increase access to the psychiatric

**TABLE 2. Strategies to Improve Cancer Care for Patients With Serious Mental Illness**

Barriers	Examples	Recommendations
<b>Patient-clinician communication is impacted by patient's history of discrimination and other kinds of trauma/abuse</b>	<p>Patient appears reluctant to answer questions or share information about mental health history.</p> <p>Patient is hesitant to engage in discussion about plan for cancer treatment.</p>	<ul style="list-style-type: none"> <li>Develop proficiency in person-first language and trauma-informed care: warm greeting, ask patients how they want to be addressed, sit with/have no desk between clinician and patients, slow pace of speech, short sentences, concrete language, eye contact with both patients and caregivers, allow extra time for patients to consider options, ask open-ended questions about patient's strengths, hopes, fears, and how team can be helpful.</li> <li>Ask patients who trusted allies are. Who helps with medications, transportation, insurance, activities of daily living, or other needs? Engage trusted allies to facilitate communication and make recommendations for care.</li> <li>Have designated staff member trained in trauma-informed care available. Creating a "safe" space may be necessary for effective communication to occur.<sup>33</sup></li> </ul>
<b>Untreated psychiatric symptoms</b>	<p>Patient presents with atypical affect and/or behavior such as unhygienic appearance, smiling inappropriately, or lack of eye contact.</p> <p>Clinician does not ask patient about history of mental illness due to lack of experience or concern about patient's reaction to such a question.</p> <p>Patient omits history of mental illness and distress assessment scores are in normal range,<sup>30</sup> but patient presents with atypical affect.</p> <p>Patient has started cancer treatment but has missed multiple appointments with psychiatric provider, and psychiatric medications have not been reviewed.<sup>39</sup> Patient is having uncontrolled psychiatric symptoms (eg, paranoia, major depression) or is experiencing drug interactions between psychiatric and cancer treatments.</p>	<ul style="list-style-type: none"> <li>Increase mental health expertise:                         <ol style="list-style-type: none"> <li>Support mental health training and cross-training in mental health and oncology for oncologists, fellows, and nurses.</li> <li>Increase mental health literacy, including common symptoms and facial affect or behaviors commonly associated with certain SMI, and awareness of own stigma-related perceptions regarding SMI.<sup>7,39</sup></li> </ol> </li> <li>Develop tools to aid in early recognition of SMI:                         <ol style="list-style-type: none"> <li>MA or oncology nurse can compile list of psychotropic medications commonly used to treat SMI; consequently, check patients' reported medications against list, and alert oncology clinician about possible SMI.</li> <li>If no medication for SMI is reported but patient exhibits symptoms of SMI, clinician can ask if patient has ever seen a psychiatrist or therapist, and if so, for what.</li> </ol> </li> <li>Contact patient's psychotropic medication prescriber and other mental health care providers in patient's life (eg, psychiatric nurse/social worker, counselor, therapist, patient advocate in group home) to build team to support patient and improve communication of health information.</li> <li>Oncology nurses can help patients with tobacco cessation prior to surgery, monitor for adverse effects of chemotherapy, tailor treatment regimens to address associated nausea or anxiety (eg, olanzapine), and monitor for other symptoms.</li> <li>Partner with pharmacist to assess medication interactions.</li> <li>Patients with stable SMI can tolerate varenicline and are 5 times more likely to quit with vs without tobacco cessation medications.<sup>24</sup></li> <li>Fund portion of psychiatrist's or psychiatric NP's time.</li> </ul>
<b>Patient does not demonstrate illness understanding or seems to lack capacity to make informed decisions</b>	<p>Patient declines treatment recommendations without reasonable explanation or accepts all recommendations without asking about risks and benefits.</p>	<ul style="list-style-type: none"> <li>MA, oncology nurse, or navigator helps patients navigate the initial cancer diagnosis and may accompany them to consults to provide additional explanation/clarification afterward.<sup>63</sup></li> <li>Slow down speech, use short sentences and concrete language, and check for understanding.<sup>84</sup> Employ teach-back method to aid patient/caregiver in comprehending the illness itself and treatment options/plans.<sup>72,85</sup></li> <li>If appropriate, engage caregiver/trusted ally to help explain the cancer and proposed treatment.</li> <li>Use videos and take-home materials with video links, pictures of procedures, diagrams, and definitions of terminology. It may help the patient to review the information at home when less pressured or when additional support is present.</li> <li>Encourage patients and caregiver to write down 3 questions before oncology visits.</li> <li>When necessary, refer patient for formal capacity assessment to facilitate decisions about cancer treatment; capacity assessments are focused on a specific issue and can change over time.</li> </ul>

CWH, community health worker; ED, emergency department; MA, medical assistant; NP, nurse practitioner; OSW, oncology social worker; PCP, primary care physician; SMI, serious mental illness; TB, tumor board.

expertise patients need. Most patients will have someone from mental health or primary care managing their medications. Who on the team can take responsibility for initial and ongoing engagement with the patient's mental health team?

Psychiatrists or psychologists with additional training in pharmacology can provide initial and ongoing assessment of psychiatric symptoms, illness

understanding, and decisional capacity of patients with SMI. Updates regarding medication efficacy, adherence, and adverse effects should be shared not only between oncology and psychiatric clinicians but with people dispensing medication to patients, whether they are caregivers, home health nurses, or staff members at a group home.<sup>58</sup> Psychiatric clinicians are also more likely to provide

treatment that can address exacerbated symptoms expected in cancer care, thus potentially reducing emergency department visits and hospitalizations.<sup>59</sup>

Although many patients with SMI have a psychiatric clinician prescribing their medications, many others work with their primary care physicians (PCPs) for medication management. Currently, PCPs provide about a third

TABLE 2 CONTINUED. Strategies to Improve Cancer Care for Patients With Serious Mental Illness

Barriers	Examples	Recommendations
<b>Communication deficits among patient's health care teams in different systems</b>	Patient's history of mental illness, including associated hospitalizations/ED visits and medication information, is not available to oncology team.	<ul style="list-style-type: none"> <li>Have navigator or other designated staff member function as liaison/coordinator to contact patient's psychotropic medication provider to facilitate exchange of health information, arrange a meeting, and be the patient's champion/caregiver in building a care team.<sup>44</sup> This duty would typically fall to a navigator or OSW, but an oncology nurse or CWH could also manage it. If your oncology clinic does not have access to an OSW or navigator, consider training a staff member to perform duties of a health navigator (Figure 1).</li> <li>Have patient sign release of health information as standard part of first visit.</li> </ul>
<b>Communication deficits in tumor board</b>	<p>Patient's psychosocial history, current circumstances/barriers to treatment, and preferences are omitted or minimally considered at TB.</p> <p>Oncology recommendations may not account for patient's values, goals, or ability to adhere to treatment.</p>	<ul style="list-style-type: none"> <li>Invite patient's mental health provider, PCP, and other mental health team members (eg, provider from group home) to attend tumor board to provide current, accurate, multidimensional view of patient's treatment preferences/goals, facilitators (eg, has reliable caregiver, quit smoking), and barriers to cancer care (eg, lack of illness understanding, history of nonadherence to psychotropic medications). Alternately, have oncology team member contact mental health team member prior to TB for guidance.</li> </ul>
<b>Potential for diagnostic overshadowing</b>	Patient has multiple comorbid medical conditions. Clinician mistakenly assumes one cluster of symptoms is related to SMI and not to another medical comorbid condition.	<ul style="list-style-type: none"> <li>Recognize that diagnostic overshadowing is a quality and safety issue for patients with mental illness.<sup>11</sup></li> <li>Gain expertise in distinguishing symptoms from mental illness and cancer; maintain a broad differential diagnosis and rule out medical symptoms first.</li> <li>Clinicians can ask themselves what tests they would suggest if patient did not have diagnosis of major depression, bipolar disorder, schizophrenia, etc.</li> <li>Patients with SMI may have experienced previous care in which providers attributed their symptoms to mental illness rather than fully considering medical contributors.<sup>86</sup></li> <li>Attend to nonverbal cues indicating pain or discomfort not typically associated with cancer.</li> </ul>
<b>Lack of research</b>	<p>Clinician may assume patients with SMI would not be able to consent to a clinical trial or that a trial would cause too much burden or stress; therefore, no referrals to clinical trials are made.</p> <p>Information about trials may be presented quickly and not allow time for patients and caregivers to fully consider risks and benefits.</p>	<ul style="list-style-type: none"> <li>Clinicians can consider whether to refer patients with SMI to clinical trials by asking themselves this question: If I would consider referring another patient with the same type of cancer, stage, tumor type, and support structure to this clinical trial, why am I not referring this patient?</li> <li>Once potential participation is broached with a patient, elicit feedback from family champion/caregiver and/or group home social worker/patient advocate/CWH, as they may play key role in patient's transportation and/or online access. Invite patients with SMI to partner with you in research, given the need for high-quality data to guide cancer treatment.</li> <li>If the caregiver is amenable but the patient refuses right away, ask open-ended questions to discern reasons. Patients with SMI may need more explanation and additional time to consider, and may decide to participate if asked again (see "Referring patients with SMI to clinical trials" in main text).<sup>50,51</sup></li> <li>Being mindful that many clinical trials exclude participation of patients with SMI, ask designated staff member to reach out to appropriate study contact regarding eligibility restrictions for patients with SMI; frequently, restrictions are poorly defined. If there are exclusionary criteria, ask to broaden eligibility criteria or clarify the rationale for the exclusion criteria.<sup>19</sup></li> </ul>

CWH, community health worker; ED, emergency department; MA, medical assistant; NP, nurse practitioner; OSW, oncology social worker; PCP, primary care physician; SMI, serious mental illness; TB, tumor board.

of care for patients with SMI<sup>60</sup>; thus, they may value rapid access to psychiatric expertise or to a consultant when needed. They may also bring their own multidisciplinary alliances to the table.<sup>61</sup> With greater projected gaps in the psychiatric clinician workforce and greater demand for services,<sup>62</sup> PCPs will likely play an even larger role for many patients during the survivorship period. Regardless of situation or prescribing practices, PCPs are allies who may have considerable influence with patients and caregivers, and they may offer excellent

advice for building trust with and engaging patients in cancer care.

Oncology nurses and advanced practice clinicians fill key roles in a team prepared for all types of patients with comorbidities, taking the lead in identifying SMI and making referrals to psychiatric clinicians for care and assessment of patients' decisional capacity. As experts in symptom management and tracking, oncology nurses are often the first to note changes in patients' symptoms and/or treatment adherence barriers. They may help conduct

chemotherapy teaching and tailor medication guidance for patients with SMI in collaboration with pharmacists, who should be able to help with assessment of medication interactions. Common challenges include tailoring antiemetics and decreasing the risk of mood instability when steroids are used. Nurses may also fulfill 2 important aspects of caring for patients that can build trust and adherence to cancer care: establishing tailored communication (eg, phone calls, texts) to remind patients/caregivers about appointments, and

supporting the emotional needs of caregivers, who typically keep patients on track.<sup>63,64</sup> Caregivers routinely drive and accompany patients to appointments, and they typically pick up, administer, and monitor medications and schedules. Support is particularly important for caregivers of patients with schizophrenia or severe bipolar disorder, as these patients may have difficulty communicating about symptoms, organizing thoughts and scheduling, or lack insight regarding the urgency for treatment. When faced with the additional complexities of cancer care, caregivers are at particular risk for distress and burnout. They frequently feel helpless, inadequate, overwhelmed, and uncertain, especially when they cannot identify or access health care resources for help.<sup>65</sup> Their emotional and physical health must thus be considered throughout the cancer care continuum.<sup>63-65</sup> Oncology nurses and/or social workers may be able to help them cope with emotional stressors and exhaustion by offering educational resources and individual and/or family support groups. Of note, caregivers for patients with SMI are less likely to be spouses and include other family members and community mental health staff from group living environments.<sup>54</sup>

Many cancer centers have oncology social workers (OSWs) and navigators. OSWs can also conduct psychosocial assessments to identify sources of distress, psychiatric comorbidity, and patients' unique needs. They can make early referrals to psychiatric services and may serve as liaisons between the oncology team and mental health team to prevent disruptions in cancer care.<sup>11</sup> As licensed professionals, they can, like oncology nurses, provide evidence-based treatments/brief therapies, follow-up, and education. Almost half (48.4%) of caregivers, however, reported unmet service needs as their biggest stressor,<sup>66</sup> and connecting them to support services is one of the expert skills of a navigator.

Navigators can build trust with patients and facilitate their day-to-day care, helping them deal with the complexities of the system by connecting them to services as they progress through the care continuum.<sup>67,68</sup> Often, they serve as point persons for communication, so when patients have questions or concerns, they call the navigator. Lay navigators, who do not have formal health care training, can offer emotional support, help with coordination of appointments, and assist in addressing barriers related to social determinants of health, such as impaired health literacy or lack of transportation or childcare.<sup>69</sup> Community health workers (CHWs) are nonclinical public health workers who possess deep knowledge of the community a patient is from. Like navigators, CHWs may serve as liaisons between patients and health care teams, providing outreach, education, and informal counseling, and they may accompany patients to oncology consults and other appointments.<sup>70</sup>

### Tumor Boards

Information about patients with SMI from all the people involved in their care presents a multidimensional view of these patients' unique circumstances, barriers, facilitators, preferences, and goals, which are key considerations for developing workable treatment plans. Because tumor boards are composed largely of oncology specialists,<sup>71</sup> it may happen that patients' psychosocial histories, medical and psychiatric comorbidities, complex circumstances and barriers, and preferences/goals for treatment are minimally considered or omitted entirely.<sup>71</sup> These gaps in knowledge can limit consideration of barriers to cancer care, contribute to delays in care, and in some cases, prevent patients with SMI from receiving the care they need.<sup>72</sup> If community mental health clinicians and PCPs are invited to and attend tumor boards when their patients are being discussed, their input may help

to inform proactive plans for both cancer and mental health treatment and address care barriers.

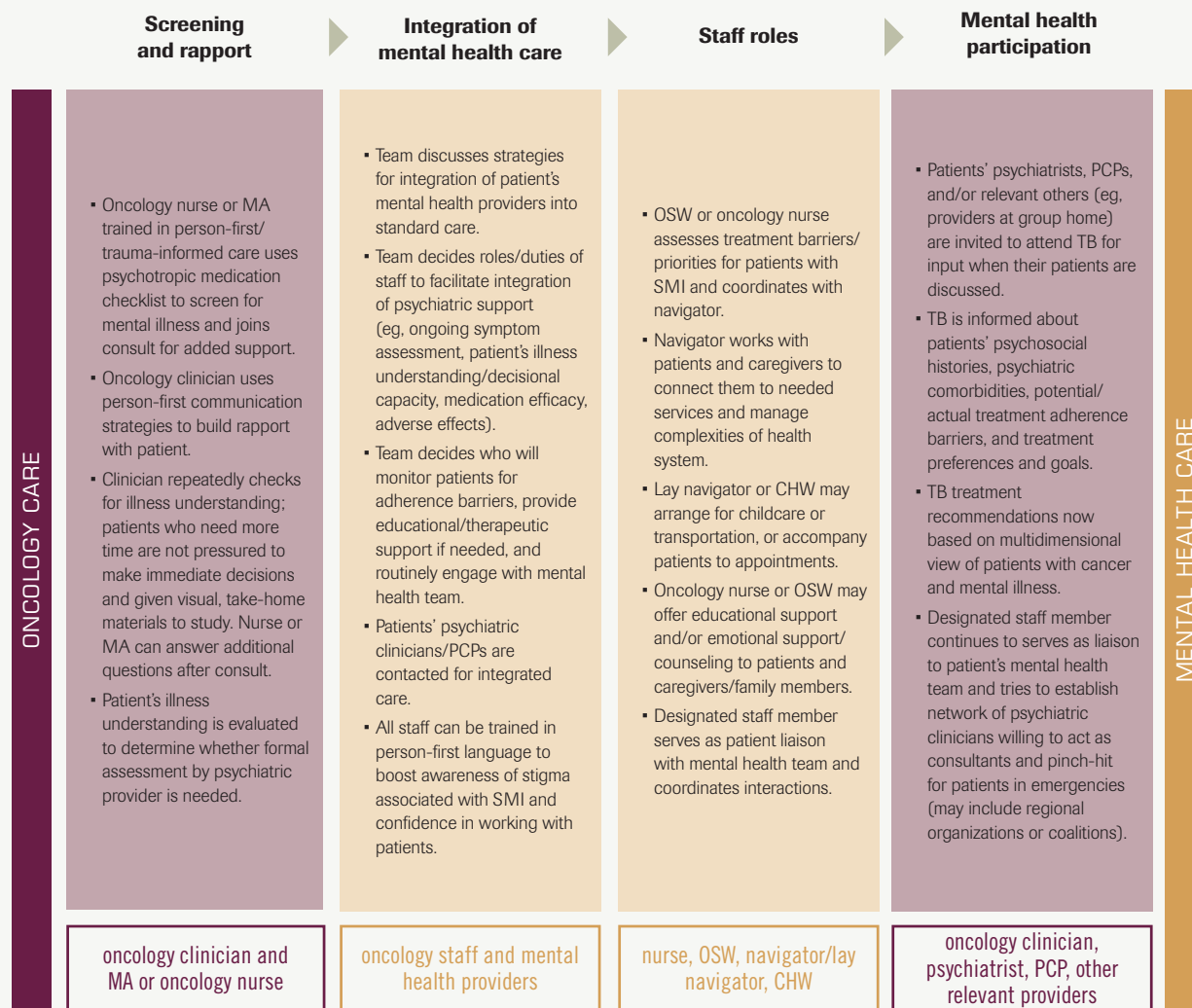
Collaborative care models use a team-based approach to integrate mental health services in primary or specialty care to increase access to integrated mental health services for patients with cancer.<sup>73,74</sup> We recognize that, given limited time and resources, it will not be feasible for all oncology practices to implement all aspects of a collaborative care model. Therefore, we aimed to provide pragmatic recommendations that can be adapted to different practice settings, regardless of size or affiliation with larger health care systems. The **Figure** illustrates the steps an independent oncology practice can take to connect with and integrate a patient's mental health team as part of routine cancer care. Next, we present recent developments in collaborative care approaches for patients with SMI.

### Recent Developments Adapting the Collaborative Care Model for SMI and Cancer

To date, few teams that care for people with serious medical illnesses, like cancer, are staffed with cross-trained experts in mental health care.<sup>75</sup> The collaborative care model is a promising approach that increases access to mental health expertise and has been found to improve patients' psychiatric symptoms in more than 70 randomized trials.<sup>54,58,76-78</sup> However, patients with SMI and cancer have traditionally been excluded from collaborative care trials. In 2019, Irwin and colleagues piloted a person-centered collaborative care model for patients with SMI.<sup>54,79</sup> Key components of the intervention, called Bridge, included (1) early screening, identification, and tracking of patients with SMI, (2) person-centered, team-based care, including psychiatry and social work, and (3) collaboration between the mental health intervention team and oncology to guide treatment recommendations and integrate input



FIGURE. Example of Team Approach to Care for Patients With SMI



CWH, community health worker; MA, medical assistant; OSW, oncology social worker; PCP, primary care physician; SMI, serious mental illness; TB, tumor board

from community-based mental health clinicians. The pilot trial demonstrated that the intervention was feasible and acceptable for patients with SMI, caregivers, and oncology clinicians. Results from the subsequent randomized clinical trial assessing the intervention's efficacy in improving cancer outcomes for this population are forthcoming.<sup>54</sup>

Cancer care has the potential to be

a healing opportunity for patients who have been marginalized in many areas of their lives. One of the core elements of person-centered collaborative care is the creation of patient-clinician partnerships. For example, oncology clinicians can support patients' decision-making processes and empower them to decide what happens to their bodies regarding treatment preferences and goals. Person-first

language and trauma-informed care can be used to initiate and safeguard the partnership to increase patient engagement in care, and there is evidence that engagement has the potential to improve both cancer and mental health outcomes.<sup>80</sup> More research is under way that explores how person-centered collaborative care can impact health outcomes, quality of life, and patient satisfaction.<sup>74</sup>

Another opportunity to gather information about marginalized populations is through cultivation of a population-based registry, a tool that can capture important data (eg, cancer type, stage of diagnosis at consult, physical and psychiatric comorbidities, history of screenings) and facilitate both early identification and systematic tracking. Population-based management using data available in commercial EHRs can be done by any trained team member and can be an efficient strategy to fill information gaps about a specific population and identify unmet needs. This information may be aggregated with mandated efforts for distress screening to identify a population at high risk for gaps in cancer care delivery using *International Classification of Diseases, Tenth Edition* codes, problem lists, or commonly prescribed medications. Our research team, for example, developed a population-based registry for screening EHRs to identify patients with both SMI and a new cancer diagnosis; such a registry can facilitate referrals for consultation and clinical trials as well as prioritize patients experiencing challenges accessing cancer care.<sup>81</sup>

### Adapting the Tumor Board Model for SMI and Cancer

Virtual multidisciplinary tumor boards or conferences are gaining ground as a strategy to increase access to multispecialty cancer care for patients in underserved settings. Virtual approaches enable providers located in distant settings to share information and may help ensure appropriate dispersal of resources and access to specialty expertise, as has been demonstrated during the COVID-19 pandemic.<sup>82</sup> These models also hold promise for integrating mental health and cancer care and may be considered for building collaborations between comprehensive cancer centers and community-based settings that serve individuals with SMI. More research is

needed, however, to confirm whether virtual multidisciplinary conferences have the capacity to increase access to quality cancer care for patients with SMI.

### Conclusions

In this review, we focused on supporting oncologists in their efforts to address the complex needs of patients with serious mental illness. We provided practical recommendations for overcoming barriers to cancer care and provided a simple method for identifying the population at the time of cancer diagnosis. We offered evidence-based strategies for improved patient-clinician communication and partnership, methods to build illness understanding, and strategies to prepare and support patients undergoing treatment procedures. We emphasized the importance of ongoing collaborations with patients' psychiatric providers as part of routine care, and in this vein, the relevance of inviting patients' mental health clinicians to tumor boards for their input. We also recommended referral of patients with SMI to clinical trials to dispel misperceptions about SMI and this population's ability to participate, and to provide critical evidence to guide cancer care delivery with potential to mitigate disparities in cancer outcomes. Finally, we discussed innovative approaches to care delivery, including adaptation of the collaborative care model and the tumor board model, for increasing access to evidence-based mental health and cancer care for a marginalized population. ■

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