

BABEȘ-BOLYAI UNIVERSITY

College of Political, Administrative and Communication Sciences
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DOCTORAL THESIS

PSYCHO-ONCOLOGY IN SOUTH-EASTERN EUROPE
IMPLICATIONS FOR POLICY AND PRACTICE

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ABSTRACT

During the last two decades, cancer incidence almost doubled and cancer became the first cause of death for people aged below 70, determining the highest economic and societal cost. Cancer also determines an immense psychological burden in cancer survivors. One in two cancer patients reports significant psychological distress which has been associated with delayed care seeking, premature treatment termination, maladaptive coping, rapid cancer progression, suppressed immune response, poor health outcomes and low survival rates. Psycho-oncological care was observed to ameliorate patients' distress and to reduce healthcare utilization and costs. However, worldwide, integration of psycho-oncology in the standard cancer care remains deficient and psycho-oncological support is available only to a small percent of cancer patients. To investigate the status of psycho-oncology care in South-Eastern Europe, a mixed method research study engaged 615 cancer patients and 34 health practitioners from four state-owned oncology clinics from Albania, Republic of Moldova, Romania and Serbia. Although over 80% of the cancer participants needed urgent psychological support, less than 19% received it. All four settings confronted with insufficient mental health specialists, absence of standardized mental health care procedures, poor mental health literacy in patients and in the oncological personnel, inadequate policies and unsupportive health care systems. Combined with international guidelines, the original research proposes eleven actions for policy makers from South-Eastern Europe interested to transform psycho-oncology care from a luxury into a fundamental human right.

The larger domain of this doctoral thesis is represented by psycho-oncology services in countries with low and middle income from South-Eastern Europe. The specific subject of the current thesis consists in policy changes having the potential to alleviate the psychological burden of cancer survivors from Albania, Republic of Moldova, Romania and Serbia. The first two chapters of this thesis underline the problematic nature of cancer and of mental issues showing how each contribute to the global burden of disease in terms of economic, social and individual cost. These chapters also highlight how the two problems combined contribute to the global burden of disease, bringing evidence of the problematic nature of mental problems in cancer sufferers. Moreover, for each of the four countries of interest, a picture of the cancer burden and of the mental health situation in cancer survivors are presented in the last part of the first two chapters. Chapter three presents an original quantitative research study that collected evidence of the problematic nature of under addressed psychological distress in 615 cancer patients receiving care in four state-owned oncology hospitals from Albania, Republic of Moldova, Romania and Serbia. Similarly, chapter four presents an original qualitative study identifying barriers in ensuring proper mental health services in the four state-owned oncology hospitals. The last chapter of the thesis proposes new actions that can be incorporated in the current mental health policies for cancer survivors from Albania, Republic of Moldova, Romania and Serbia, taking into account original research findings and international guidelines for psycho-oncology care.

To address this subject, the five chapters follow the first five steps essential in proposing policy changes: identifying the problem, bringing empirical support of the importance to address the problem, identifying the causes of the problem, identifying how current policies contribute in maintaining the problem and providing appropriate solutions that can be incorporated into policy changes.

Key words: psycho-oncology, psychological distress, cancer survivors, policy changes, South-Eastern Europe

STEP 1: THE PROBLEM

In 2020, worldwide, 19 million people received a diagnosis of cancer, 44 million lived with cancer and 10 million died of cancer (Sung et al., 2021). During the last two decades, cancer incidence almost doubled (Ma & Yu, 2006) and cancer became the first cause of deaths for people aged below 70 (Sung et al., 2021). Of all the major reasons of death, worldwide, cancer causes the highest economic burden with alarmingly increasing indirect costs and escalating direct costs (Choi et al., 2019). Moreover, due to an increase of cancer incidence in younger populations, cancer causes one of the highest costs for society with over 226 million years of life lost worldwide due to early death and with over 233 million worldwide disability adjusted life years (Fitzmauric et al., 2019). Besides the economic and societal costs, cancer significantly impacts the QOL of patients and of their caregivers (Wu & Harden, 2015). Both the global quality of life (QOL) and the individual components of the physical, psychological and financial domains of the QOL were observed to significantly predict cancer survival (Sitlinger & Zafar, 2018). Of the three domains of the QOL, the psychological one received increased attention in the field of scientific research and is the focus of this PhD thesis. The psychological burden of cancer is immense and the attention this field has been receiving in the last two decades is determined by the immense influence of patients' psychological distress on cancer progression, outcomes and survival. Beginning with diagnosis, cancer patients report moderate to severe levels of psychological distress (Landsbergen et al., 2012; Chirico, Lucidi, Mallia, D'Aiuto, & Merluzzi, 2015). Distress is defined as "a multi-determined unpleasant emotional experience of a psychological (cognitive, behavioral, emotional), social, and/or spiritual nature that may interfere with the ability to cope effectively with cancer, its physical symptoms and its treatment" (Ownby, 2019). Research shows that between 50% to 75% of cancer patients experience moderate-to-severe distress (Ernst, Friedrich, Vehling, Koch, & Mehnert-Theuerkauf, 2021; Esser et al., 2018; Sitlinger & Zafar, 2018). Studies reported that cancer patients' significant distress is associated with delayed care seeking, premature termination of treatment and maladaptive coping strategies (Tromp et al., 2005). Significant psychological distress was also observed to influence cancer development and progression, acting on health behaviors, gene function, and immune response (McGregor & Antoni, 2009) and thus influencing patients' health outcomes and survival (Kim et al., 2017). At the same time, psychosocial oncological aftercare was observed to reduce psychological symptoms and distress, enhance psychological adjustment and improve functional adjustment, rehabilitation and QOL in cancer patients (Jansen, Zwieteren, Coupé, Leemans, & Verdonck-de Leeuw, 2016). Moreover, psychosocial oncology care has the potential to reduce healthcare utilization and costs, lowering the economic burden of cancer (Jansen et al., 2016). However, patients are not screened for distress and mental health care is not implemented appropriately. Although the National Comprehensive Cancer Network, the American Society of Clinical Oncology and the Canadian Association of Psychosocial Oncology recommend that distress should be assessed in all cancer patients during their first visit and at proper moments throughout the disease trajectory (Deshields & Nanna, 2010), only 60% of oncological services reported screening outpatient for distress and 30% reported screening all patients (Jacobsen & Ransom, 2007). Moreover, between 5% to 10% of oncology patients were sent to psycho-oncology services (McCarter et al., 2018). Studies show that approximately 30% of cancer patients benefited from MH care (Mitchell, 2013). Worldwide, the integration of mental health (MH) within oncological care remains deficient and psycho-oncological support is available only to a small percent of cancer patients (Grassi et al., 2016). One geographical area of concern in terms of psychosocial oncological care is South-Eastern Europe. If we consider the link between human development and cancer burden, South-Eastern Europe is a mottled area, dealing not with one major cancer-related issue but with a plethora of cancer related problems: high incidence but also high mortality, high rates of disability-adjusted life years but also of years of life lost, industrialization-related cancers but also infection-related cancers and obesity and infections as a risk factors in onset of cancer (Bray et al., 2018; Fidler & Bray, 2018). Although the variability of oncological problems faced by the psychosocial oncological care from South-Eastern Europe is huge, this region is considered to fail to integrate in the oncologic treatment the psychosocial care (Grassi et al., 2016).

STEP 2: EMPIRICAL RESEARCH SUPPORTING THE IMPORTANCE OF ADDRESSING THE PROBLEM

This thesis aimed to investigate if, indeed, psychosocial oncological care is deficient in LMICs from SEE, to identify the causes of the problem and to propose solutions. The research initiative presented in the thesis took the form of the IMeRS project (“Improve Mental Health Referral in Oncology Settings”). **The IMeRS project** (“Improve Mental Health Referral in Oncology Settings”) was part of a larger capacity building project (the REMASTER project – “Research Training: Socio-Economics of Mental Health Service Delivery in SE Europe”) funded by the “National Institute of Health Fogarty” (award number 1D43TW009122-01).

Project objectives. The project aimed to develop a set of recommendations targeting the quality improvement of the MH care services for cancer patients from each participating country. As, at the beginning of the project, in each country the situation of patients with cancer was poorly described and thus scarcely understood, the project team agreed to engage in a comprehensive situation analysis with three large objectives:

Aim 1: Identify the need for mental health care among patients with cancer from four SE European state owned oncology clinics

Aim 2: Determine the availability of mental health care within cancer care services in selected countries

Aim 3: Identify determinants of mental health care usability in patients with cancer accessing services of the four cancer settings enrolled in the study

Project design. The IMeRS project used a mixed methodology combining quantitative study having a cross-sectional design with a qualitative study and with a desk research to identify best strategies in improving MH care services in cancer treatment centers. The project was conducted across two phases implemented in parallel in each of the four participating countries. Phase I (Quantitative study) consisted in surveying 615 patients receiving care in the four state-owned oncology clinics. The main constructs assessed within this phase were (1) distress levels in patients with cancer, (2) problematic life domains, (3) knowledge and intention to access MH services, (4) prevalence of accessing MH services, (5) prevalence of being referred to MH care, (6) satisfaction towards received MH care and attributed importance to MH care, (7) coping mechanism and (8) preferred characteristics of MH care services. Constructs were integrated in a paper and pencil survey. Phase II (Qualitative study) consisted in face-to-face interviews with health practitioners and MH practitioners that worked in each of the four state-owned oncology facilities. The main constructs assessed in this phase were (1) knowledge, beliefs and attitudes of MH practitioners and of oncologists regarding MH care delivered for oncology patients, (2) their perceived responsibility in the process of MH care for oncology patients and (3) perceived barriers and facilitators in ensuring MH care for oncology patients. Constructs were integrated in two semi-structured interview guides one addressing oncology clinicians and one addressing MH practitioners. Data collection methodology included data collection instruments, the process of recruiting study participants and a standardized procedure for participants approach and for data collection, storage, analysis and report in accordance to ethical standards of human research. The study materials received the Institutional Review Board approval (CPHS PROTOCOL NUMBER 2014-07-6541).

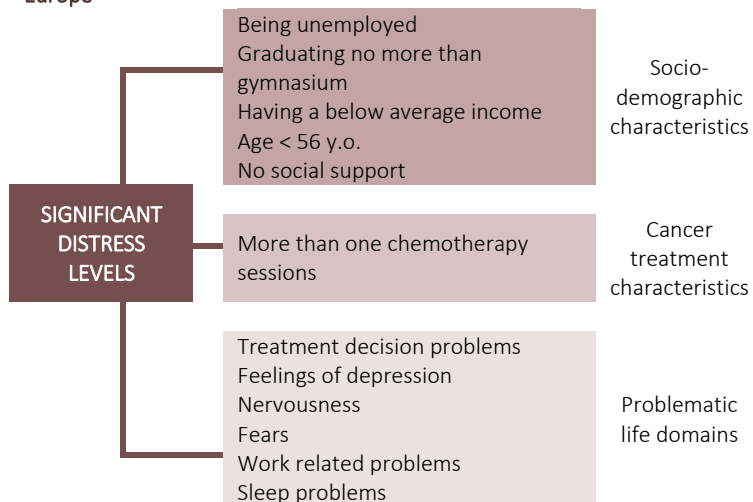
STEP 3: PROBLEM CAUSES

The **quantitative study results** shows that out of the 615 patients with cancer from four public oncology clinics from SEE that participated in the research, 84% were in need for MH care as these patients presented moderate to severe psychological distress, scoring 4 and above on the 10 point DT scale scale.

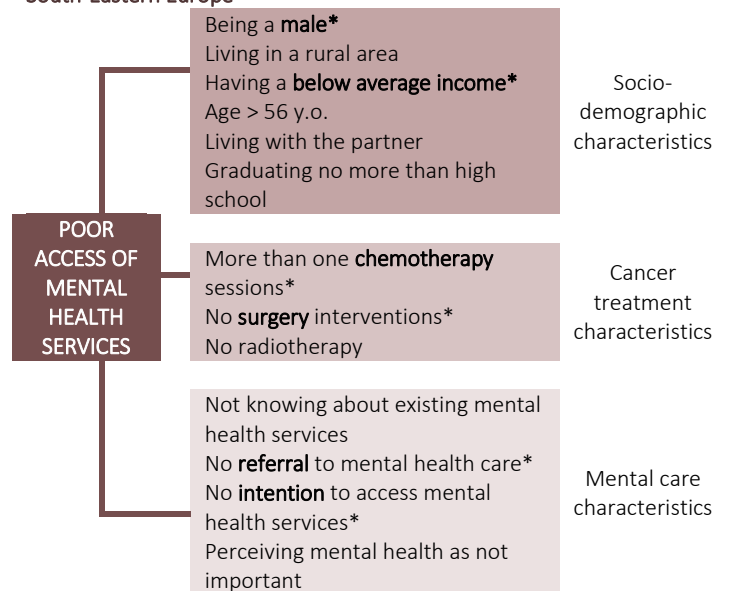
The “Distress Thermometer” (DT) has been utilised in psycho-oncology research worldwide as it is recommended as a clinical, validated and specifically designed tool for screening psychological distress (Snowden et al., 2013). The DT represents a visual ten-point scale of distress ranging from a score of zero that represents the absence of distress to a score of ten representing extreme distress. The DT is considered to be the shortest screening instrument for psychological distress in oncology patients (Akizuki, Yamawaki, Akechi, Nakano, & Uchitomi, 2005). It is a self-report scale created by the Distress Management Panel of the NCCN, being firstly introduced in 1998 and validated using prostate oncology patients. It is a paper-and-pencil screening tool which can be easily understood by the respondent and be completed in less than 5 minutes. It gives the opportunity for the oncology patients to be referred to clinical psychologists, dietitian, social workers and other healthcare professionals based on the mentioned factors that caused distress to the respondent. NCCN recommends that regular distress screening ought to be included in the oncology patients’ routine care. The DT was proved to have a 77% sensitivity and a 66% specificity in terms of detecting distress associated with cancer and an 81% sensitivity and a 60% specificity in identifying depression (Mitchell, 2007). Along with the DT there is also a checklist of psychosocial issues for the oncology patients to indicate if any of those issues represented a difficulty for them during the past week, in order to identify possible sources of distress. The DT has been used to investigate psychological distress across a variety of cancers such as brain, prostate, breast cancer and many others and it has been considered the “sixth vital sign among respiratory rate, pulse, body temperature, pain and blood pressure” (Bultz et al., 2015). In the last decade, integrating psychological distress screening in the standard care of oncology patients was strongly advocated. The most recent guidelines recommended by NCCN state that a DT score of 4 or above is an indicator for moderate to severe psychological distress and it is a cutoff point for oncology specialists to refer identified patients to MH care in order to assess their need for treatment (Cutillo, 2017).

The results of the quantitative study also highlighted (1) the profile of patients at risk for moderate-to-severe distress and thus, the patients most in need for MH care and (2) the underlined the patient related characteristics, the cancer related characteristics and the mental care related characteristics that significantly impacted accessing mental health care services by cancer patients.

Factors significantly impacting the psychological distress level 615 patients diagnosed with cancer from four public oncology clinics from South-Eastern Europe



Factors significantly impacting access of mental health services in 615 patients diagnosed with cancer from four public oncology clinics from South-Eastern Europe



*variables also having significant power in predicting mental health care access

The qualitative study results showed that neither of the four public cancer treatment facilities had the appropriate human resources to cover the real MH care demands of oncology patients and the appropriate mechanisms in place. In each of the four cancer treatment clinics, one psychotherapist and one psychiatrist had to address the MH needs of all cancer patients that received care in that public facility. Although psychological services delivered by the public cancer treatment facilities were covered by patients' health insurance, the limited number of MH practitioners made it impossible to address all patients in need for MH care or to conduct appropriate follow-up. At the same time, all four settings confronted with the absence of standardized procedures for MH screening, referral, treatment and follow-up. Based on their clinical judgment and according to their level of MH knowledge, oncologists referred patients further to MH care. In each of the four public oncology clinics, oncologists were the first to see the patient, to identifying patients' needs for MH care and conducting referral for psychological care. Moreover, as oncologist spent a lot of time with their patients they were the ones who noticed changes in patients' MH status beginning with diagnosis and during cancer treatment. However, due to limited time resources, referral was not based on the results of using a standardized MH screening procedure and did not follow a specific communication protocol. Although some of the health practitioners were aware of this screening instrument – such as the case of the oncology clinic from Romania where the DT scale was validated and practitioners received training in using it – the burden these oncologists faced made screening for MH problems impossible to be integrated as a part of their work. The results of the qualitative study also underlined both the organizational strengths and weaknesses and the outside opportunities and threats that impacted the adequate provision of MH care for patients with cancer receiving treatment at four public cancer facilities from South-Eastern Europe.

<ul style="list-style-type: none"> • Free of charge psychological and psychiatric care for referred cancer patients • Psychological care delivered inside the oncology hospital • Oncologists aware of patients' MH needs and conduct referral • Positive experiences for referred patients • MH practitioners highly available for addressing patients' needs • Social workers starting to be engaged in some of the settings 	<ul style="list-style-type: none"> • MH community centers available • Palliative care community centers available • Psychiatric hospitals available in the community • Regional community centers available • Increase in younger patients' MH awareness • Improvements in artificial intelligence • Existing models of good practice
<p style="text-align: center;">STRENGTHS</p>	<p style="text-align: center;">OPPORTUNITIES</p>
<p style="text-align: center;">WEAKNESSES</p> <ul style="list-style-type: none"> • Insufficient MH personnel • Absence of standardized MH screening and referral • Oncologists' burden • Absence of multidisciplinary care • Insufficient MH knowledge in oncologists 	<p style="text-align: center;">THREATS</p> <ul style="list-style-type: none"> • Low cancer literacy in patients • Low MH literacy in patients and in the general population • MH for cancer patients is not prioritized in the health care system: poor resource allocation for MH care in cancer patients • Health care systems fail to properly address MH care • Poor legislation addressing MH care in cancer patients

STEP 4: POLICIES CONTRIBUTING TO THE PROBLEM

Although MH care is considered a human right, psycho-oncology is deficiently integrated in the health care system of many countries worldwide, as resulted from a survey conducted among psycho-oncologists from 38 countries (Grassi et al., 2016). Worldwide, the integration of psycho-oncology ranges across six levels from total absence of psycho-oncological care (level 1), to the presence of capacity building activities (level 2), limited psycho-oncological care dependent on donor funding (level 3a), available psycho-oncological care locally supported through multiple financing sources and independent of the health care system plus limited availability of psycho-oncology education (level 3b), psycho-oncology care spread nationally and widely supported by a variety of health profession but with limited policy impact plus high availability of psycho-oncology education (level 4a), to comprehensive and unrestricted availability of psycho-oncology care with increased policy impact plus the integration of psycho-oncology education in the academic environment within universities. In Europe, major differences between countries in providing psychosocial care have been observed with half of the countries having a level 3 and half a level 4 integration of psycho-oncology. South-Eastern European countries are negatively spotted with a concerning eye on the action of policy makers to restrict investments in psycho-oncology and to transform psycho-oncological care from a human right into a luxury. Through austerity policies, governments from but not limited to South-Eastern Europe reduced health care expenditures and this limits the integration of psychosocial services in the mainstream of health care (Grassi et al., 2016). For example, in North and Western European countries that cover psychosocial care in their national health insurance plan and strongly integrate psychosocial services in cancer care and psycho-oncologists in cancer care teams, the percentage of Gross Domestic Product (GDP) allocated for health goes above 10% (i.e., Germany 11.70% of the GDP, France 11.06 of the GDP, UK 10.15% of the GDP). In countries from South and Eastern Europe where the health care system fails to allocate enough coverage for this type of services, the percentage of GDP allocated for health can reach 5% (i.e., Serbia 8.67% of the GDP, Moldova 6.38% of the GDP, Romania 5.74% of the GDP, Albania 5.23% of the GDP), as reported by the WHO in the “Global Health Expenditure Database” (apps.who.int/nha/database).

If we take a closer look at the legislation describing MH in oncology care in the four South-Eastern European countries targeted in this PhD thesis, we can first conclude that specific laws on psycho-oncology are absent. Second, we can observe that the current available regulations that usually fall under the framework contracts of national health insurance houses transform MH care for cancer patients into a complicated, time consuming and overburdening process for both patients and oncologists. In each of the four countries, the legislation concerning to cancer patients does not correspond to cancer patients’ characteristics and needs but are either general laws that concern the fundamental rights of all patients or laws that specify the rights and obligations of patients with health insurance. Specific legislation on psycho-oncology is missing in South-Eastern European countries and this impacts the adequate integration of psycho-oncological services into the mainstream health care services addressing patients with cancer. Policies addressing MH in cancer patients should address the individual, organization and health-system barriers through resource allocation and funding, national specific guidelines in psycho-oncology, availability of psycho-oncological assistance for primary and secondary cancer survivors in both urban and rural areas, sufficient number of MH practitioners trained in psycho-oncology, development of contracts between MH practitioners trained in psycho-oncology and health insurance companies, national dissemination of psycho-oncological support (Grassi et al., 2016). This level of specificity in cancer care policies can help South-Eastern European counties migrate from limited psycho-oncological care to full integration of psycho-oncology in the mainstream of health care services and academic environment. In the end, it all comes down to recognizing psycho-oncology as a specialty at a ministerial level, integrating the already existing international psycho-oncology guidelines in the national cancer control plans and joining efforts with international psycho-oncology associations in order to develop capacities for providing adequate psycho-oncology services in the foreseeable future (Bultz et al., 2015).

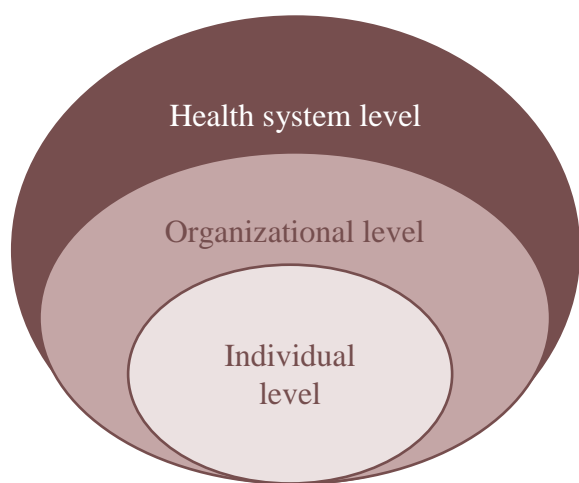
STEP 5: POLICY SOLUTIONS TO ADDRESS THE PROBLEM

The identified determinants of the poorly addressed psychosocial needs of cancer patients from four oncology clinics from South-Eastern Europe and the proposed solutions are mapped below in an adapted model of the socio-ecological framework. The socio-ecological framework has been used to categorize determinants of health behaviors at multiple levels, including the individual, interpersonal, institutional, socio-cultural and environmental levels and has been found useful in explaining the layers of interventions that could influence behavioral change even for cancer prevention and control (Palafox et al., 2018). Problems and solutions are detailed on the next page in the form of a Needs-Gaps-Opportunities approach.

An ecological perspective on the problems and solutions to improve psycho-oncology care	
<i>Problems</i>	<i>Solutions</i>
POLITICAL LEVEL	
<ul style="list-style-type: none"> • Poor resources allocated to address MH in cancer patients. • Absence of national standard clinical guidelines to address MH in cancer patients. • No integration of psycho-oncology in the education of medical personnel and of psychologists. • Absence of specific health policies concerning MH in cancer patients. 	<ul style="list-style-type: none"> ○ Psycho-oncology acknowledged as a specialty at a ministerial level ○ Psycho-oncology care integrated in the routine cancer care ○ Psycho-oncology care standards integrated in the national cancer plans ○ Specific policies guiding and monitor the implementation of psycho-oncology ○ Strong collaborations with international cancer societies
ORGANIZATIONAL LEVEL	
<ul style="list-style-type: none"> • Number of MH practitioners limited to 1 or 2 per public oncology hospital. • Insufficient oncological staff, improper workload distribution and increased number of responsibilities for oncology clinicians. • No formal and continuous education on psycho-oncology for oncology clinicians. • Absence of standardized procedures for MH screening and management in cancer patients. 	<ul style="list-style-type: none"> ○ Guidelines for health professionals' education in psycho-oncology ○ Partnership with universities and associations for continuing education in psycho-oncology ○ Psycho-oncology integrated in the academic and professional environment ○ Internal policies in oncology hos monitoring ○ Higher number of psychologists and social workers employed in oncology hospitals ○ Multi-disciplinary teams managing patients in oncology hospitals
INDIVIDUAL LEVEL	
<ul style="list-style-type: none"> • Cancer patients: poor cancer literacy, increased MH service use stigma, limited awareness of the availability of mental care services, low importance attributed to MH, low intention to access MH services. • Individual characteristics associated with poor mental care access/intention to access mental care/knowledge of mental care availability/importance attribute to MH: male gender, aged >56, rural residency, high school and lower education degrees, below average income, unemployment. • Individual characteristics associated with significant psychological distress: unemployment, low education levels, below average income, absence of social support. 	<ul style="list-style-type: none"> ○ Public awareness campaigns addressing cancer literacy and MH literacy ○ National strategic framework targeting cancer literacy ○ National health policies promoting the increase of cancer literacy <ul style="list-style-type: none"> ○ Psycho-education delivered for cancer survivors ○ Resources allocated for national and local cancer based organizations ○ Partnership with EU-cancer based organizations

NEEDS	GAPS	OPPORTUNITIES
Empower cancer patients in the cancer treatment decisions and in the self-management process.	POOR CANCER RELATED KNOWLEDGE IN CANCER PATIENTS AND IN THEIR CAREGIVERS	<ul style="list-style-type: none"> ➤ Join the EU efforts in creating a strategic framework on cancer literacy ➤ Increase collaboration with EU-cancer based organizations ➤ Integrate recommendations to increase cancer literacy in European and national health policies ➤ Include specific cancer literacy guidelines in the NCPs ➤ Integrate psychoeducation in the cancer treatment ➤ Implement capacity buildings to educate health practitioner
Reduce stigma associated with accessing psychosocial care	POOR MENTAL HEALTH KNOWLEDGE IN CANCER PATIENTS	<ul style="list-style-type: none"> ➤ Increase mental health awareness in patients, in the general population and in public health practitioners ➤ Increase access to mental health care ➤ Deliver the best evidence based treatments ➤ Involve mental health professionals in multidisciplinary cancer care teams ➤ Screen all patients for distress ➤ Incorporate patients' psychoeducation in the cancer treatment ➤ Support continuous research in psycho-oncology
Improve identification of mental health needs in cancer patients	POOR MENTAL HEALTH KNOWLEDGE IN ONCOLOGISTS	<ul style="list-style-type: none"> ➤ Join efforts with EU-cancer organizations to develop guidelines for health professionals' education in psycho-oncology ➤ Establish collaborations with universities to integrate psycho-oncology in the education curriculum of health professionals at various stages of their education continuum ➤ Develop internal policies for oncology treatment centers to guide and monitor implementation of continuous psycho-oncology education in health professionals
Improve referral of cancer patients to mental health care	WORKING IN ISOLATION	<ul style="list-style-type: none"> ➤ Increase the number of professionals (i.e., psychologists, social workers) employed by oncology treatment centers ➤ Develop multi-disciplinary teams working with cancer patients throughout the disease trajectory ➤ Integrate guidelines for multidisciplinary care in the NCPs
Include psychological support in the routine standard care of cancer patients	PSYCHO-ONCOLOGY IS NOT PRIORITISED BY THE CURRENT HEALTH CARE SYSTEMS	<ul style="list-style-type: none"> ➤ Increase resources allocation for psycho-oncology services ➤ Increase resources allocation for psycho-oncology clinical and implementation research ➤ Develop strong collaborations with cancer societies (i.e., IPOS, UICC) to create training opportunities and receive support in drafting psycho-oncology standards ➤ Advocate for integrating psycho-oncology standards in NCPs ➤ Advocate for the recognition of psycho-oncology by the national ministries as a specialty with specific educational and professional requirements

Based on the guidelines of international cancer societies, on previous research findings and on the results of a mixed-methods research project conducted in four public oncology settings from Albania, Republic of Moldova, Romania and Serbia, I propose eleven actions that should be considered by policy maker and public administrator from South-Eastern Europe interested to reduce the psychological burden of cancer survivors. Hopefully, these actions might have the potential transform psychological care for cancer survivors from a luxury into a fundamental human right (Travado et al., 2017).



1. Recognize psycho-oncology as a separate specialty with stand-alone specific educational requirements and standards of occupational practice
2. Increase the level of specificity of health policies focused on psycho-oncology
3. Allocate resources to implement programmes for screening, prevention and management of psychological distress in cancer patients
4. Include in the national control plans specific guidelines for screening, referral and management of psychological distress in the national cancer plans
5. Integrated psycho-oncology care in the basic health care services package covered by health insurance
6. Employ inter-disciplinary teams in approaching the cancer patient
7. Deliver continuous education on psycho-oncology for medical personnel (i.e., oncologists)
8. Establish internal policies in oncology hospitals for quality assurance of psycho-oncology care
9. Implement raising awareness campaigns addressing cancer literacy and mental health literacy
10. Increase availability of psycho-education resources online and offline
11. Support national and local development of cancer-based societies

First, patients should be empowered to engage in the cancer treatment decisions and in the self-management process through actions aimed at increasing their levels of cancer related and mental health related knowledge. Second, identification and addressability of patients' psychological needs should be increased through actions aimed at improving psycho-oncology education in health practitioners and increasing inter-disciplinary collaboration in oncology hospitals. Third, psychological support should be included in the standard cancer care by prioritizing psycho-oncology by the current health care systems. In the end, it all comes down to recognizing psycho-oncology as a specialty at a ministerial level, integrating the already existing international psycho-oncology guidelines in the national cancer control plans and joining efforts with international psycho-oncology associations in order to develop capacities for providing adequate psycho-oncology services in the foreseeable future. Hopefully, these actions might have the potential transform psychological care for cancer survivors from a luxury into a fundamental human right.

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