**Prevalence and determinants of depression up to 5 years after colorectal cancer surgery: Results from the ColoREctal Wellbeing (CREW) study**

**AUTHORS**

Lynn Calman1 PhD, RN; Joshua Turner1 PhD; Deborah Fenlon2 PhD, RGN; Natalia V. Permyakova3 PhD; Sally Wheelwright1 PhD; Mubarak Patel4 MSc; Amy Din1 MSc; Jane Winter1,5 PhD, RGN; Alison Richardson1,5 PhD, RNT; Peter W. Smith6 PhD; Members of the CREW Study Advisory Committee†; Claire Foster1 PhD, CPsychol\*

**AUTHOR AFFILIATIONS**

1. School of Health Sciences, University of Southampton, Southampton, UK
2. College of Human and Health Sciences, Swansea University, Swansea, UK
3. Faculty of Medicine, University of Southampton, Southampton, UK
4. Division of Health Sciences, University of Warwick, Warwick, UK
5. University Hospitals Southampton NHS Trust, Southampton, UK
6. Social Statistics & Demography, Social Sciences, University of Southampton, Southampton, UK

†. Members listed in Acknowledgements

**\*CORRESPONDING AUTHOR**

Professor Claire Foster, Macmillan Survivorship Research Group (MSRG), School of Health Sciences, University of Southampton, Building 67, Southampton, SO17 1BJ, UK  
Email: [C.L.Foster@soton.ac.uk](mailto:C.L.Foster@soton.ac.uk), Tel: +44 (0)23 8059 6885

**CONFLICT OF INTEREST DISCLOSURE**

Dr Lynn Calman has received an honorarium for teaching from Boehringer Ingelheim.

Professor Deborah Fenlon has received an honorarium for teaching from Roche.

**WORD COUNT**

3,185 words (with amendments)

**FUNDING STATEMENT**

The work was supported by Macmillan Cancer Support as part of the Macmillan Survivorship Research Group programme (grant number 3546834).

**DATA ACCESSIBILITY**

The data underlying this article will be shared on reasonable request to the corresponding author. Information regarding data access is available at <http://horizons-hub.org.uk/access_data.html>

**PRIOR PRESENTATION**

Presented as an Oral Presentation, International Psycho-Oncology Society (IPOS) Annual Conference, Hong Kong, October 31 – November 2, 2018 and British Psycho-Oncology Society (BPOS) Annual Conference, Chester, UK, February 28 – March 1, 2019. Presented as a Poster Presentation at the National Cancer Research Institute (NCRI) Cancer Conference, Glasgow, UK, November 4 – 6 2018.

**ABSTRACT**

Aim:

Depression experienced by people with colorectal cancer (CRC) is an important clinical problem affecting quality of life. Recognition at key points in the pathway enables timely referral to support. This study aimed to examine depression pre- and 5 years post-surgery to examine its prevalence and identify determinants.

Methods:

The ColoREctal Wellbeing (CREW) study is a prospective UK cohort involving 872 adults with non-metastatic CRC recruited before curative-intent surgery. Questionnaires completed pre-surgery, and 3, 9, 15, 24, 36, 48 and 60 months post-surgery, captured socio-demographics, assessed depression (Centre for Epidemiologic Studies Depression Scale, CES-D) and other psychosocial factors. Clinical details were also gathered. We present prevalence of clinically significant depression (CES-D≥20) over time and its predictors assessed pre-surgery and 2 years post-surgery.

Results:

Pre-surgery, 21.0% of the cohort reported CES-D≥20 reducing to 14.7% 5 years post-surgery. Pre-surgery risk factors predicting subsequent depression: clinically significant depression and anxiety, previous mental health service use, low self-efficacy, poor health, having neoadjuvant treatment and low social support. Post-surgery risk factors at 2 years predicting subsequent depression: clinically significant depression, negative affect, cognitive dysfunction, accommodation type and poor health.

Conclusions:

Depression is highly pervasive in people with CRC, exceeding general population prevalence across follow-up. Our findings emphasise the need to screen and treat depression across the pathway. Our novel data highlights key risk factors of later depression at important and opportune timepoints: pre-surgery and the end of routine surveillance. Early recognition and timely referral to appropriate support is vital to improve long-term psychological outcomes.

**WHAT DOES THIS PAPER ADD TO THE LITERATURE?**

Depression in people living with colorectal cancer is an important clinical problem. Our study shows that the prevalence of depression exceeds general population prevalence over time. It also highlights risk factors of later depression at important timepoints (before surgery and end of routine follow-up) which informs strategies for recognition and referral to appropriate psychosocial support.

**INTRODUCTION**

Depressive disorders are one of the highest contributors to global disease burden affecting 4% of people(1). Its prevalence is greater in people living with cancer (rates range between 8 and 27%(2)) and thus a clinical and policy priority(3). In people living with colorectal cancer (CRC), the prevalence of depression is also greater when compared to the general population with rates reaching 37%(4-7). Depression in people living with cancer is associated with poor quality of life (QoL)(8), reduced adherence to treatment(9), reduced survival(10) and associated with an increased risk of suicide(11). More specifically, people with CRC and depression have poorer QoL, health status and wellbeing after diagnosis and surgery(5, 7).

Despite this, depression is often not identified in people with cancer and few are treated(6); possibly due to a range of factors associated with underreporting mental health issues (e.g. stigma)(12). Timely recognition and referral to support and intervention is recommended in clinical guidelines for depression internationally(13) with UK guidelines recommending targeting screening in people at most risk(14). However, determinants of depression in people living with cancer are poorly characterised(15) with calls for more evidence in people with CRC(16). Identification of people most at risk also informs intervention development, reduces disease burden and improves planning of psychosocial care resources(17).

Several determinants of depression in people with CRC have been described including: female gender(4, 18, 19), low socio-economic status(20), higher stage disease(21), receiving neoadjuvant and adjuvant treatments(22), and low social support(23, 24). Findings related to age are inconsistent(19, 21, 25) but may be owed to sample characteristics (e.g. recruitment of an older sample(25)). Depressive symptoms in people with CRC are also reported to reduce over time(4, 5) but much research is cross-sectional(16). We conducted a scoping review and found that no published longitudinal studies in people with non-metastatic CRC have examined pre-surgery risk factors associated with reporting depression up to 5 years post-treatment (Appendix 1).

UK clinical guidance recommends pre- and post-treatment as key timepoints to appraise psychological outcomes in people living with cancer(26). Assessment close to diagnosis allows for a better understanding of the impact of cancer and its treatment on depression outcomes(15, 26). Early screening is also encouraged due to its benefits: improving treatment adherence, reducing burden on health services and patients, enhancing communication between clinical teams and patients, and more timely referral to support(17, 27). Addressing psychological outcomes post-treatment gives patients the opportunity to reflect on the impact and psychosocial concerns following the intense scheduling of cancer treatment(15, 26). Post-treatment CRC surveillance is valuable to provide reassurance as patients feel greater concern when its frequency decreases(28), possibly due to reduced contact with clinical teams(29), therefore we highlight this timepoint important to consider. In the UK it is recommended that routine surveillance appointments cease after 2 years(30) with some variation in international guidelines(31).

This paper presents analysis from the ColoREctal Wellbeing study (CREW)(32), a UK prospective cohort investigating factors associated with recovery of health and wellbeing following CRC. Data were collected before and at regular intervals up to 5 years post-surgery. Data comprised of socio-demographic, clinical information, and patient-reported outcomes examining a selection of psychosocial variables (including depression) informed by a conceptual framework of recovery following cancer diagnosis and treatment(33). The analysis assesses ‘clinically significant levels’ of depression via self-report and whilst this is not a ‘clinical diagnosis’of depression, which requires a comprehensive assessment accounting contextual factors(14), the cut-off used has high concordance with psychiatric interviews(34) suggesting the experience of high levels of depressive symptomology(35). This paper:

1. Describes the prevalence of clinically significant levels of depression from pre-surgery and up to 5 years post-surgery and;
2. Given the levels of depression pre-surgery and at 2 years post-surgery, identifies which characteristics are associated with subsequent clinically significant levels of depression up to 5 years post-surgery.

**METHODS**

***Study sample***

CREW is a prospective cohort study of adults (≥18 years) with non-metastatic colorectal cancer (Dukes’ stage A-C) treated with curative-intent surgery. Inclusion and exclusion criteria are published elsewhere(32).

***Data collection***

Details of study procedures are previously reported(32). Eligible participants were recruited from 29 UK National Health Service (NHS) centres between November 2010 and March 2012. Participants consented and completed questionnaires before surgery (baseline). Follow-up questionnaires were mailed at regular intervals: 3, 9, 15, 24 months and annually up to 5 years post-surgery. Clinical and treatment information was gathered from NHS medical databases at participating centres. Ethical approval was granted by the UK NHS NRES Committee South Central - Oxford B (REC ref: 10/H0605/31). Information collected in the study did not inform the care of the participants involved due to the study design and anonymisation of the data.

***Measures***

Patient-reported depression was captured using the 20-item Centre for Epidemiologic Studies Depression Scale (CES-D)(36). Higher scores indicate greater levels of depression (range 0-60). A recent meta-review demonstrated that CES-D was responsive to change and suitable for screening for depression in people with cancer(37).

A score of ≥20 has previously been used in studies involving people with cancer to define a ‘clinically significant level’ of depression(38) and has been shown to be highly concordant with psychiatric interviews(34). A recent meta-analysis examining the screening accuracy of CES-D noted the ≥20 cut-off to be more appropriate when compared to the standard ≥16 cut-off(35). Thus the ≥20 cut-off was selected as an indicator of a clinically significant levels of depression for this study but this does not constitute a formal diagnosis of clinical depression.

*Determinants/Covariates*

Table 1 lists the validated patient reported outcome measures, socio-demographic questions and clinical information captured pre-surgery and 2 years post-surgery which were used as covariates in the analyses. Covariates are presented according to the conceptual framework domains(33) and the rationale for each measure is provided elsewhere(32). Validated measures were repeated at every timepoint unless otherwise indicated. Selection of covariates, including EORTC subscales, were informed by our scoping review (Appendix 1). Alongside depression, accommodation type, health status (EQ-5D), age and ethnicity was found to be significantly associated with participant attrition in the CREW study(39) and were included in the model to account for this.

***Statistical analysis***

Total CES-D score was summarised at each timepoint using its median and interquartile range to examine changes over time. The number and proportion of participants reporting clinically significant levels of depression (CES-D≥20) were also assessed over time.

Two multivariable logistic regression models were fitted to predict clinically significant levels of depression up to 5 years after surgery (Appendix 2): Model 1 included depression together with other covariates collected pre-surgery (baseline); Model 2 included depression together with other covariates collected at 2 years post-surgery. Multicollinearity was assessed in each model using the Variance inflation factor (VIF). The VIF ranged from 1.05 to 2.18 for Model 1 and from 1.08 to 2.51 for Model 2. VIF below 10.00 indicates that there was no multicollinearity in our models.

Missing data were imputed according to published guidelines for the measures selected. If unavailable, these were omitted from the final model. Number of comorbidities were first assessed at 3 months but were included in Model 1 due to its stability over time(40).

A population-average approach was applied to account for the time-varying nature of the binary outcome, where each model was adjusted for the clustering of observations within the participants(41). Regression analyses were based on a backwards elimination of statistically non-significant predictors. Significance level was fixed at 5% and all analyses were completed in Stata 14.

**RESULTS**

***Sample characteristics***

One thousand and eighteen participants were recruited into CREW and 872 consented to questionnaire follow-up. Figure 1 presents the participant flow over follow-up; full details of study recruitment and descriptive statistics are published elsewhere(39, 42). The sample was representative of the eligible patients treated during the recruitment period(39, 42). Table 2 shows demographic and clinical characteristics of the 741 participants who returned a baseline questionnaire and had completed the CES-D with a mean age of 67.54 (SD=10.26). Over 54% of the sample underwent laparoscopic surgery and 40% underwent open surgery for CRC.

***Depression over time***

At baseline (pre-surgery), people who were women, single, lived in rented accommodation and had previously used mental health services were more likely to report clinically significant CES-D scores (Table 2).

Median scores peaked before surgery at 12.0 (IQR=11.7) and decreased to 9.5 (IQR=12.0) at 5 years (Table 3). Similarly, the proportion of participants reporting clinically significant levels of depression also peaked pre-surgery at 21.0% and reduced to 14.7% at 5 years (Table 3). Overall, 303 participants (34.8%) reported clinically significant depression at least once during the 5 years of follow-up.

***Pre-surgery determinants of clinically significant levels of depression***

Table 4 presents only significant pre-surgery factors associated with the likelihood of reporting a clinically significant level of depression.

Participants who reported clinically significant levels of depression pre-surgery had a higher risk of being depressed over follow-up (OR=3.44, 95% CI=2.18–5.45); this was similar for highly anxious people (OR=1.82, 95% CI=1.15–2.87). People with a low level of self-efficacy (confidence) to manage consequences of a chronic condition were also at a greater risk of reporting clinically significant levels of depression (Table 4). Conversely, people who reported ‘full’ social support (OR=0.41, 95% CI=0.23–0.74) had lower odds of reporting clinically significant depression and this was also the case for ‘perfect’ health status (OR=0.42, 95% CI=0.24–0.75).

Greater risk of reporting clinically significant levels of depression up to 5 years post-surgery were found in people who underwent neoadjuvant treatment (OR=2.99, 95% CI=1.75–5.09) and in those who reported previous use of mental health services (OR=3.33, 95% CI=1.48–5.24) compared to those who did not. People with rectal cancer also had lower odds of having clinically significant depression compared to those with colon cancer (OR=0.55, 95% CI=0.35–0.87).

Age and domestic status were also found to be statistically significant predictors of subsequent clinically significant depression. Younger participants (<51 years old) were at greater risk of experiencing clinically significant levels of depression when compared to people aged 61-70 (OR=0.50, 95% CI=0.26–0.97), although this was not evident when compared to other age groups (Table 4). The odds of reporting clinically significant levels of depression were two times higher for people who did not have a partner (OR=2.02, 95% CI=1.32–3.09) compared to those who did.

***Determinants 2-years post-surgery***

Table 5 presents only significant factors captured at 2 years post-surgery.

Predictors of clinically significant levels of depression reported at 2 years are presented in Table 5. Similar to pre-surgery, participants reporting clinically significant levels of depression at 2 years were at greater risk of subsequent depression up to 5 years (OR=3.14, 95% CI=1.41–7.04). Those who had higher scores for negative affect were also at greater risk (OR=1.21, 95% CI=1.08–1.36).

People reporting problems with cognitive function (OR=2.21, 95% CI=1.03–4.77) and poorer wellbeing (OR=2.40, 95% CI=1.25–4.61) at 2 years also had higher odds of experiencing clinically significant depression later. Participants who did not own their accommodation were also at greater risk of reporting clinically significant depression (OR=2.38, 95% CI=1.23–4.62).

In contrast, the risk of reporting clinically significant levels of depression were lower amongst those who had ‘perfect’ health status at 2 years (OR=0.28, 95% CI=0.12–0.68).

**DISCUSSION**

This is the first prospective cohort to examine the prevalence and risk factors associated with clinically significant levels of depression in people with non-metastatic CRC assessed pre- and up to 5 years post-surgery. Our results reveal that clinically significant levels of depression remain a long-term problem for a considerable proportion of people, despite median CES-D scores reducing over time from diagnosis in the cohort. These results are consistent with previous findings(4, 5). For example, our prevalence rates across each timepoint occur within the range observed by cross-sectional studies of people living with CRC (7−37%(4-7)) and are considerably higher compared to the median prevalence found in the general population (CES-D≥20; 11.8%)(35).

The novelty of this study is the investigation of risk factors of clinically significant levels of depression at two key timepoints in the cancer care pathway as recommended by UK clinical guidance(26): close to diagnosis (pre-surgery) and when post-treatment routine surveillance ends (2 years post-surgery). Identifying risk factors improves planning of psychosocial care and informs intervention development(17). We identified several pre- and post-surgery risk factors of depression consistent with previous work(4, 5, 7, 19, 20, 22-25).

Importantly, our findings underscore the need for depression screening close to diagnosis with clinically significant levels pre-surgery identified as a risk for later depression. Early screening has been shown to positively impact care by improving more timely referrals for psychological intervention(17, 27). Our analysis at 2 years post-surgery also suggests the need for assessment of depression and depressive symptomology (negative affect) when post-treatment surveillance ends. Regular appraisal of psychological needs throughout the pathway aligns with recent emphasis of risk stratification in the UK NHS Long Term Plan to inform personalised care for people with cancer and facilitate referral to appropriate levels of care(43). Psychosocial interventions for people with colorectal cancer have been reported to be beneficial in improving depression and anxiety symptomology, as well as QoL (44, 45). Novel strategies for follow-up have been tested in Australia(46) , Canada(47) and are being considered in the USA(48). Such strategies can help target specialist resources as these become increasingly scarce(48). Innovative models of psychological screening and care (e.g. stepped-care and nurse-led collaborative interventions) for people with cancer are effective in reducing psychological symptoms, improve QoL for people with a depressive or anxiety disorders and are cost-effective(49, 50). Internationally, variability in models and approaches to survivorship care and complexity in reimbursement for psychosocial and integrated care make implementation a challenge(51).

Our pre-surgery analysis also highlights at-risk groups at whom we should direct depression screening. People undergoing neoadjuvant treatment commonly face more complex surgery, stoma formation, additional side effects, and increased treatment time length(22) which can explain our findings and so attention should focus on this group. People with rectal cancer had a lower risk of clinically significant depression over time but no previous CRC studies have reported tumour site as a significant predictor of depression(16). This relationship was also unexpected as people with rectal cancer often have complex treatment regimens (including neoadjuvant treatment)(52) which may impact psychological outcomes, particularly those who later have a permanent stoma(53). One possible explanation could be that a more complex treatment pathway may result in greater contact with clinical teams and this may improve perceptions of support(29, 54) that could help to reduce depression symptomology. Nevertheless, this finding requires further investigation.

Our analysis further recommends that depression screening should target people with a history of mental health problems or with psychological comorbidities (e.g. anxiety). This is unsurprising as levels of anxiety tend to peak close to diagnosis(55) and commonly co-occurs with depression(8).

The value of assessing self-efficacy and social support early in the pathway was highlighted by our pre-surgery analysis. This is important given the increasing role of self-management for people with cancer(56); thus confidence to manage consequences of cancer and its treatment need to be assessed early on. Assessing the level of social support at the point of diagnosis is imperative given its importance for depression outcomes and later QoL(23).

Our analysis at 2 years post-surgery highlighted other at-risk groups whom assessment and support for depression may be helpful. People with cognitive difficulties post-surgery were at greater risk of later depression which is important as cognitive dysfunction is a commonly reported consequence of CRC treatment(57). However, caution should be applied as it can be difficult to delineate cognitive dysfunction as a result of cancer treatment or as a symptom of depression and/or anxiety(58). Type of accommodation (rented or other) was also highlighted as a risk factor but this specifically has not been previously reported. It could be used as a descriptor of socio-economic status (SES) which has been noted to be a risk factor for anxiety, depression and distress in people with cancer(20, 59). This highlights the need for additional support for this group as low SES may indicate a low availability of resources important for coping which may result in poorer psychological outcomes(59).

Study strengths include the scale and representative nature of the CREW sample with over 91% of all eligible patients approached to participate(39, 42). Loss to follow‐up is expected in cohort studies but our response rates remained high up to 5 years (Figure 1; 71%). Participants who withdrew by 5 years were more likely to report clinically significant depression, were ≥80 years, did not own accommodation (renting or other) and were of non-white ethnicity at baseline(39). Therefore, our findings may underestimate the true prevalence of depression among the CRC cancer survivors in the UK. Additionally, our sample represents patients from one type of healthcare system (the UK NHS) whereby access and provision of specialist services are universal and free at the point of delivery.

Patient-reported depression may not account for contextual factors considered in diagnostic interviews(14). Nevertheless, the cut-off used suggested clinically significant levels of depressive symptomology(35) and is highly concordant with psychiatric interviews(34). High prevalence of depression over time may be attributed to its undertreatment(6), however due to a high level of missing data, as a result of poor self-report of health service use in CREW, we were unable to examine use of psychological treatment which may explain our findings. We examined our mental health service use data in a bivariate analysis with CES-D scores for interest (Appendix 3).

Scoping of the literature (Appendix 2) identifies this is as one of the first studies to include a pre‐surgery assessment on a range of socio-demographic, psychosocial and clinical factors and the only to collect data up to 5 years later to examine risk factors of clinically significant levels of depression. The importance of this work is highlighted by the dearth of evidence examining the long-term psychological impacts in people living with and beyond cancer(3), including people with CRC(16). The need for research into the short- and long-term psychological impacts of cancer and its treatment has been identified as a Top 10 research priority in the UK(60) and our analysis contributes knowledge to this for two crucial timepoints in the CRC care pathway.

In summary, our results indicate that depression is an enduring problem in people with non-metastatic CRC even at 5 years after surgery. Before surgery it affects 1 in 5 people and 1 in 7 people at five years after surgery, both of which are higher than reported in the general population. Our findings clearly highlight the need for screening for depression across the pathway to improve depression outcomes in the long-term. Early screening should be focussed on those with mental health histories, high levels of anxiety, low self-efficacy, poor health status, and low levels of support, whilst clinicians should also monitor people who undergo neoadjuvant treatment. The end of routine oncology surveillance is also an opportune time to assess depression symptoms, especially as frequency of contact with clinical teams decreases. At this timepoint, assessment should focus on people with poor health, a lower SES and problems from treatment (e.g. cognitive dysfunction). Depression in people living with cancer is associated with poor health and wellbeing and has an impact on survival and adherence to treatment, early recognition and treatment may lead to overall improved outcomes for patients.

**ACKNOWLEDGEMENTS**

We thank all CREW study participants and recruiting NHS Trusts; Carol Hill, Kerry Coleman, Bjoern Schukowsky, Christine May (study support); Matthew Breckons, Cassandra Powers, Alex Recio‐Saucedo, Bina Nausheen, Ikumi Okamoto, Kim‐Chivers Seymour, Joanne Haviland (researchers); Jo Clough, Alison Farmer (research partners). Members of the Study Advisory Committee: Jo Armes, Janis Baird, Andrew Bateman, Nick Beck, Graham Moon, Claire Hulme, Peter Hall, Karen Poole, Susan Restorick‐Banks, Paul Roderick, Claire Taylor, Jocelyn Walters, Fran Williams, Lynn Batehup, Jessica Corner, and Deborah Fenlon. We would also like to thank Michael Sharpe for his valuable feedback on our manuscript and Angus McNair for his valuable advice.

**REFERENCES**

1. World Health Organization. Depression and other common mental disorders: global health estimates. 2017.

2. Krebber AMH, Buffart LM, Kleijn G, Riepma IC, de Bree R, Leemans CR, et al. Prevalence of depression in cancer patients: a meta-analysis of diagnostic interviews and self-report instruments. Psycho-Oncology. 2014;23(2):121-30.

3. Niedzwiedz CL, Knifton L, Robb KA, Katikireddi SV, Smith DJ. Depression and anxiety among people living with and beyond cancer: a growing clinical and research priority. BMC cancer. 2019;19(1):1-8.

4. Clark C, Fino N, Liang J, Hiller D, Bohl J, Clark CJ, et al. Depressive symptoms in older long-term colorectal cancer survivors: a population-based analysis using the SEER-Medicare healthcare outcomes survey. Supportive Care in Cancer. 2016;24(9):3907-14.

5. Mols F, Schoormans D, de Hingh I, Oerlemans S, Husson O. Symptoms of anxiety and depression among colorectal cancer survivors from the population-based, longitudinal PROFILES Registry: Prevalence, predictors, and impact on quality of life. Cancer. 2018;124(12):2621-8.

6. Walker J, Hansen CH, Martin P, Symeonides S, Ramessur R, Murray G, et al. Prevalence, associations, and adequacy of treatment of major depression in patients with cancer: a cross-sectional analysis of routinely collected clinical data. The Lancet Psychiatry. 2014;1(5):343-50.

7. Tsunoda A, Nakao K, Hiratsuka K, Yasuda N, Shibusawa M, Kusano M. Anxiety, depression and quality of life in colorectal cancer patients. Int J Clin Oncol. 2005;10(6):411-7.

8. Spiegel D, Giese-Davis J. Depression and cancer: mechanisms and disease progression. Biological Psychiatry. 2003;54(3):269-82.

9. DiMatteo M, Lepper HS, Croghan TW. Depression is a risk factor for noncompliance with medical treatment: Meta-analysis of the effects of anxiety and depression on patient adherence. Archives of Internal Medicine. 2000;160(14):2101-7.

10. Pinquart M, Duberstein PR. Depression and cancer mortality: a meta-analysis. Psychological Medicine. 2010;40(11):1797-810.

11. Henson KE, Brock R, Charnock J, Wickramasinghe B, Will O, Pitman A. Risk of Suicide After Cancer Diagnosis in England. JAMA Psychiatry. 2019;76(1):51-60.

12. Kissane DW. Unrecognised and untreated depression in cancer care. The Lancet Psychiatry. 2014;1(5):320-1.

13. Ferenchick EK, Ramanuj P, Pincus HA. Depression in primary care: part 1—screening and diagnosis. BMJ. 2019;365:l794.

14. National Institute for Health and Clinical Excellence (NICE). Depression in adults: recognition and management (CG90). In: National Institute for Health and Clinical Excellence (NICE), editor. London: National Institute for Health and Clinical Excellence (NICE),; 2009.

15. Pitman A, Suleman S, Hyde N, Hodgkiss A. Depression and anxiety in patients with cancer. BMJ. 2018;361:k1415.

16. Mosher CE, Winger JG, Given BA, Helft PR, O'Neil BH. Mental health outcomes during colorectal cancer survivorship: a review of the literature. Psychooncology. 2016;25(11):1261-70.

17. Mitchell AJ. Screening for cancer-related distress: When is implementation successful and when is it unsuccessful? Acta Oncologica. 2013;52(2):216-24.

18. Braamse AMJ, van Turenhout ST, sive Droste JST, de Groot GH, van der Hulst RWM, Klemt-Kropp M, et al. Factors associated with anxiety and depressive symptoms in colorectal cancer survivors. European Journal of Gastroenterology & Hepatology. 2016;28(7):831-5.

19. Powell-Chandler A, Boyce K, James O, Scourfield L, Torkington J, Bisson J, et al. Psychological sequelae of colonic resections. Colorectal Disease. 2020;22(8):945-51.

20. Dunn J, Ng SK, Holland J, Aitken J, Youl P, Baade PD, et al. Trajectories of psychological distress after colorectal cancer. Psycho-Oncology. 2013;22(8):1759-65.

21. Xia S, Sun M, Liu X. Major depression but not minor to intermediate depression correlates with unfavorable prognosis in surgical colorectal cancer patients underwent adjuvant chemotherapy. Psychology, Health & Medicine. 2020;25(3):309-18.

22. Gray NM, Hall SJ, Browne S, Johnston M, Lee AJ, Macleod U, et al. Predictors of anxiety and depression in people with colorectal cancer. Support Care Cancer. 2014;22(2):307-14.

23. Haviland J, Sodergren S, Calman L, Corner J, Din A, Fenlon D, et al. Social support following diagnosis and treatment for colorectal cancer and associations with health-related quality of life: Results from the UK ColoREctal Wellbeing (CREW) cohort study. Psycho-Oncology. 2017:n/a-n/a.

24. Gonzalez-Saenz de Tejada M, Bilbao A, Baré M, Briones E, Sarasqueta C, Quintana JM, et al. Association between social support, functional status, and change in health-related quality of life and changes in anxiety and depression in colorectal cancer patients. Psycho-Oncology. 2017;26(9):1263-9.

25. Deckx L, van Abbema DL, van den Akker M, van den Broeke C, van Driel M, Bulens P, et al. A cohort study on the evolution of psychosocial problems in older patients with breast or colorectal cancer: comparison with younger cancer patients and older primary care patients without cancer. BMC Geriatr. 2015;15:79.

26. National Institute for Health and Clinical Excellence (NICE). Improving supportive and palliative care for adults with cancer (CSG4). In: National Institute for Health and Clinical Excellence (NICE), editor. London: National Institute for Health and Clinical Excellence (NICE),; 2004.

27. Carlson LE, Waller A, Mitchell AJ. Screening for Distress and Unmet Needs in Patients With Cancer: Review and Recommendations. Journal of Clinical Oncology. 2012;30(11):1160-77.

28. Berian JR, Cuddy A, Francescatti AB, O’Dwyer L, Nancy You Y, Volk RJ, et al. A systematic review of patient perspectives on surveillance after colorectal cancer treatment. Journal of Cancer Survivorship. 2017;11(5):542-52.

29. Arora NK, Finney Rutten LJ, Gustafson DH, Moser R, Hawkins RP. Perceived helpfulness and impact of social support provided by family, friends, and health care providers to women newly diagnosed with breast cancer. Psycho-Oncology. 2007;16(5):474-86.

30. Cairns SR, Scholefield JH, Steele RJ, Dunlop MG, Thomas HJ, Evans GD, et al. Guidelines for colorectal cancer screening and surveillance in moderate and high risk groups (update from 2002). Gut. 2010;59(5):666-89.

31. Jorgensen ML, Young JM, Solomon MJ. Optimal delivery of colorectal cancer follow-up care: improving patient outcomes. Patient Relat Outcome Meas. 2015;6:127-38.

32. Fenlon D, Richardson A, Addington-Hall J, Smith P, Corner J, Winter J, et al. A cohort study of the recovery of health and wellbeing following colorectal cancer (CREW study): protocol paper. BMC Health Services Research. 2012;12(1):90.

33. Foster C, Fenlon D. Recovery and self-management support following primary cancer treatment. British Journal Of Cancer. 2011;105:S21.

34. Agrell B, Dehlin O. Comparison of six depression rating scales in geriatric stroke patients. Stroke. 1989;20(9):1190-4.

35. Vilagut G, Forero CG, Barbaglia G, Alonso J. Screening for Depression in the General Population with the Center for Epidemiologic Studies Depression (CES-D): A Systematic Review with Meta-Analysis. PloS one. 2016;11(5):e0155431-e.

36. Radloff LS. The CES-D Scale:A Self-Report Depression Scale for Research in the General Population. Applied Psychological Measurement. 1977;1(3):385-401.

37. Wakefield CE, Butow PN, Aaronson NA, Hack TF, Hulbert-Williams NJ, Jacobsen PB. Patient-reported depression measures in cancer: a meta-review. The Lancet Psychiatry. 2015;2(7):635-47.

38. Katz MR, Kopek N, Waldron J, Devins GM, Tomlinson G. Screening for depression in head and neck cancer. Psycho-Oncology. 2004;13(4):269-80.

39. Wheelwright S, Permyakova NV, Calman L, Din A, Fenlon D, Richardson A, et al. Does quality of life return to pre-treatment levels five years after curative intent surgery for colorectal cancer? Evidence from the ColoREctal Wellbeing (CREW) study. PLOS ONE. 2020;15(4):e0231332.

40. Cummings A, Grimmett C, Calman L, Patel M, Permyakova NV, Winter J, et al. Comorbidities are associated with poorer quality of life and functioning and worse symptoms in the 5 years following colorectal cancer surgery: Results from the ColoREctal Well-being (CREW) cohort study. Psycho-Oncology. 2018;27(10):2427-35.

41. Hu FB, Goldberg J, Hedeker D, Flay BR, Pentz MA. Comparison of population-averaged and subject-specific approaches for analyzing repeated binary outcomes. American journal of epidemiology. 1998;147(7):694-703.

42. Foster C, Haviland J, Winter J, Grimmett C, Chivers Seymour K, Batehup L, et al. Pre-Surgery Depression and Confidence to Manage Problems Predict Recovery Trajectories of Health and Wellbeing in the First Two Years following Colorectal Cancer: Results from the CREW Cohort Study. PLOS ONE. 2016;11(5):e0155434.

43. NHS England. Universal personalised care: implementing the comprehensive model. In: NHS England, editor. 2019.

44. Zhang X, Liu J, Zhu H, Zhang X, Jiang Y, Zhang J. Effect of Psychological Intervention on Quality of Life and Psychological Outcomes of Colorectal Cancer Patients. Psychiatry. 2020;83(1):58-69.

45. Meng X, Wang X, Dong Z. Impact of non-pharmacological interventions on quality of life, anxiety, and depression scores in patients with colorectal cancer: a systematic review and meta-analysis of randomized controlled trials. Supportive Care in Cancer. 2021.

46. Jefford M, Kinnane N, Howell P, Nolte L, Galetakis S, Bruce Mann G, et al. Implementing novel models of posttreatment care for cancer survivors: Enablers, challenges and recommendations. Asia Pac J Clin Oncol. 2015;11(4):319-27.

47. Mittmann N, Beglaryan H, Liu N, Seung SJ, Rahman F, Gilbert J, et al. Examination of Health System Resources and Costs Associated With Transitioning Cancer Survivors to Primary Care: A Propensity-Score-Matched Cohort Study. Journal of Oncology Practice. 2018;14(11):682-+.

48. Alfano CM, Mayer DK, Bhatia S, Maher J, Scott JM, Nekhlyudov L, et al. Implementing personalized pathways for cancer follow-up care in the United States: Proceedings from an American Cancer Society-American Society of Clinical Oncology summit. CA Cancer J Clin. 2019;69(3):234-47.

49. Krebber AMH, Jansen F, Witte BI, Cuijpers P, de Bree R, Becker-Commissaris A, et al. Stepped care targeting psychological distress in head and neck cancer and lung cancer patients: a randomized, controlled trial. Annals of Oncology. 2016;27(9):1754-60.

50. Sharpe M, Walker J, Hansen CH, Martin P, Symeonides S, Gourley C, et al. Integrated collaborative care for comorbid major depression in patients with cancer (SMaRT Oncology-2): a multicentre randomised controlled effectiveness trial. The Lancet. 2014;384(9948):1099-108.

51. Recklitis CJ, Syrjala KL. Provision of integrated psychosocial services for cancer survivors post-treatment. Lancet Oncol. 2017;18(1):e39-e50.

52. National Institute for Health and Clinical Excellence (NICE). Colorectal cancer: diagnosis and management (CG131). In: National Institute for Health and Clinical Excellence (NICE), editor. London: National Institute for Health and Clinical Excellence (NICE),; 2011.

53. Chongpison Y, Hornbrook MC, Harris RB, Herrinton LJ, Gerald JK, Grant M, et al. Self-reported depression and perceived financial burden among long-term rectal cancer survivors. Psychooncology. 2016;25(11):1350-6.

54. Clark L, Holcombe C, Hill J, Downey H, Fisher J, Krespi MR, et al. The Perception of Support Received from Breast Care Nurses by Depressed Patients Following a Diagnosis of Breast Cancer. The Annals of The Royal College of Surgeons of England. 2009;91(1):43-5.

55. Stark DPH, House A. Anxiety in cancer patients. British journal of cancer. 2000;83(10):1261.

56. NHS England. The NHS Long Term Plan. London: NHS England. 2019.

57. Vardy JL, Dhillon HM, Pond GR, Rourke SB, Bekele T, Renton C, et al. Cognitive Function in Patients With Colorectal Cancer Who Do and Do Not Receive Chemotherapy: A Prospective, Longitudinal, Controlled Study. Journal of Clinical Oncology. 2015;33(34):4085-92.

58. Yi JC, Syrjala KL. Anxiety and Depression in Cancer Survivors. Medical Clinics. 2017;101(6):1099-113.

59. Andrykowski MA, Aarts MJ, van de Poll-Franse LV, Mols F, Slooter GD, Thong MS. Low socioeconomic status and mental health outcomes in colorectal cancer survivors: disadvantage? advantage?... or both? Psychooncology. 2013;22(11):2462-9.

60. Li F, Morgan A, McCullagh A, Johnson A, Giles C, Greenfield D, et al. Abstract 3348: Top 10 living with and beyond cancer research priorities. Cancer Research. 2019;79(13 Supplement):3348-.

61. Department for Communities and Local Government. The English index of multiple deprivation (IMD) 2015—guidance. In: Department for Communities and Local Government, editor. 2015.

62. Brugha TS, Cragg D. The list of threatening experiences: the reliability and validity of a brief life events questionnaire. Acta Psychiatrica Scandinavica. 1990;82(1):77-81.

63. Sherbourne CD, Stewart AL. The MOS social support survey. Social Science & Medicine. 1991;32(6):705-14.

64. Lorig KR, Ritter P, Stewart AL, Sobel DS, Brown BW, Bandura A, et al. Chronic Disease Self-Management Program: 2-Year Health Status and Health Care Utilization Outcomes. Medical Care. 2001;39(11):1217-23.

65. Foster C, Breckons M, Hankins M, Fenlon D, Cotterell P. Developing a scale to measure self-efficacy to self-manage problems following cancer treatment. Psycho-Oncology. 2013;22:1-29.

66. Watson D, Clark LA, Tellegen A. Development and validation of brief measures of positive and negative affect: the PANAS scales. Journal of personality and social psychology. 1988;54(6):1063.

67. Spielberger C, Gorsuch R, Lushene R, Vagg P, Jacobs G. Manual for the state-trait anxiety inventory. Palo Alto. CA: Consulting psychologists press; 1970.

68. International Wellbeing Group. Personal wellbeing index. Australian Centre on Quality of Life, Deakin University Melbourne; 2006.

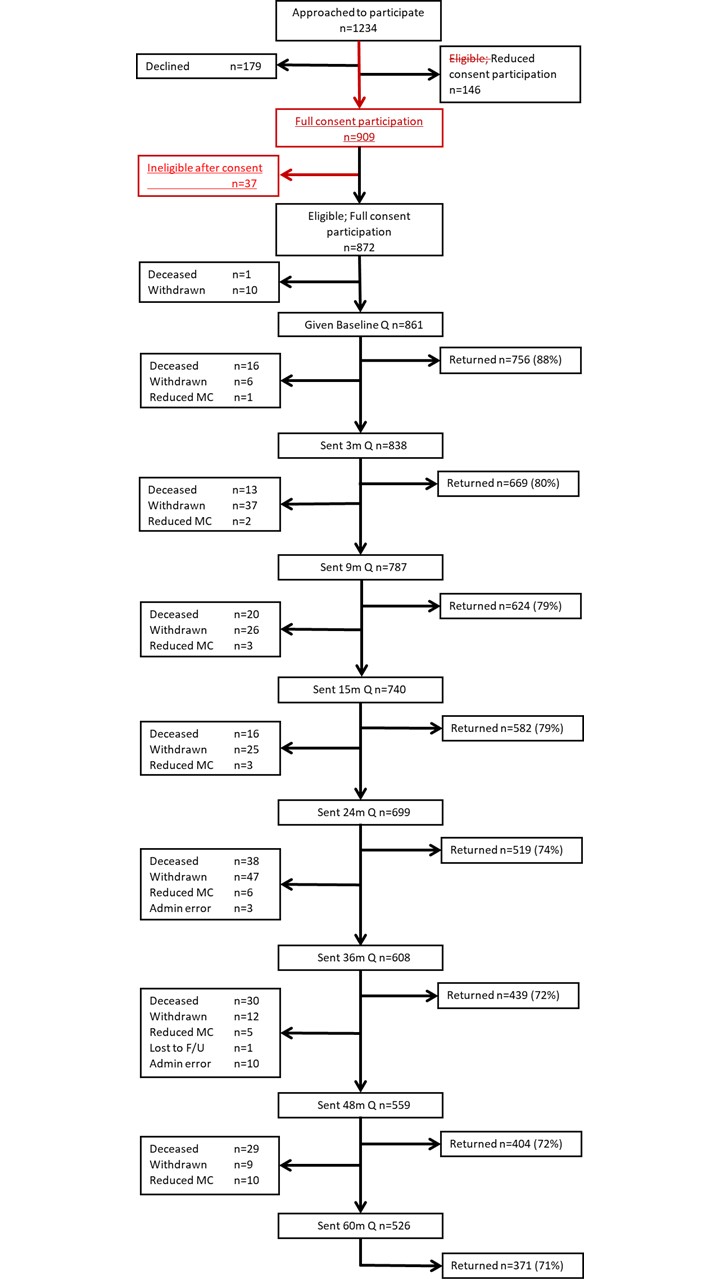
69. EuroQol Group. EuroQol--a new facility for the measurement of health-related quality of life. Health policy (Amsterdam, Netherlands). 1990;16(3):199.

70. Avis NE, Smith KW, McGraw S, Smith RG, Petronis VM, Carver CS. Assessing Quality of Life in Adult Cancer Survivors (QLACS). Quality of Life Research. 2005;14(4):1007-23.

71. Aaronson NK, Ahmedzai S, Bergman B, Bullinger M, Cull A, Duez NJ, et al. The European Organization for Research and Treatment of Cancer QLQ-C30: a quality-of-life instrument for use in international clinical trials in oncology. JNCI: Journal of the National Cancer Institute. 1993;85(5):365-76.

72. Knight RG, Waal-Manning HJ, Spears GF. Some norms and reliability data for the State-Trait Anxiety Inventory and the Zung Self-Rating Depression scale. British Journal of Clinical Psychology. 1983;22(4):245-9.

**Figure 1:** CREW study participant flowchart



NOTE

Participants who were not sent a questionnaire because of mental capacity issues or through administrative error remained eligible for the questionnaire at the next timepoint.

Definitions: *Full consent*: participants consented to questionnaire follow-up and the collection of medical details; *Reduced consent*: participants consented to the collection medical details only.

Abbreviations: F/U: Follow-up; MC: Mental capacity; Q: Questionnaire.

**Table 1:** CREW study measures presented by conceptual framework domains(33) for regression analysis

| Domain | Characteristic of interest | Measure |
| --- | --- | --- |
| Pre-existing factors (Socio-demographics) | Age |  |
| Gender |  |
| Ethnicity |  |
| Employment Status† |  |
| Accommodation type† |  |
| Deprivation Index | Index of Multiple Deprivation (IMD)(61) |
| Clinical factors | Tumour site |  |
| Dukes’ stage† |  |
| Neoadjuvant treatment† |  |
| Surgery type |  |
| Adjuvant treatment† |  |
| Stoma status |  |
| Number of comorbidities‡ | Self-reported measure(40) |
| Previous use of mental health services§ |  |
| Environmental factors | Domestic status |  |
| Life Events | List of Threatening Experience Questionnaire (LTE-Q)(62) |
| Social support | Medical Outcomes Study - Social Support Survey (MOS-SSS)(63) |
| Personal factors | Self-efficacy | Self-efficacy for Managing Chronic Disease (SEMCD) scale(64) |
| Cancer Survivors’ Self-Efficacy Scale (CS-SES)(65) |
| Affect | Positive and Negative Affect Schedule Short Form (PANAS-SF)(66) |
| Psychosocial outcomes | State anxiety¶ | State-Trait Anxiety Inventory, State scale (STAI-S)(67) |
| Wellbeing | Personal Wellbeing Index–Adult (PWI-A)(68) |
| Health Status | EuroQoL 5 Dimensions 3 Levels (EQ-5D-3L)(69) |
| Quality of Life (QoL)‡ | Quality of Life in Adult Cancer Survivors (QLACS) scale(70):  *Cancer-Specific Summary Score (QLACS-CSS), Benefit of Cancer (QLACS-BC)* |
| Symptoms & Functioning‡ | European Organization for Research and Treatment of Cancer quality of life measure (EORTC QLQ-C30)(71):  *Function scales: Physical, Emotional, Cognitive, Social*  *Symptom scales: Fatigue, Pain, Insomnia, Financial Worry* |

NOTE

† To avoid imprecise estimates from the low counts in the regression analyses two or more groups were merged together: Unemployed and retired (Employment status); renting and other (Accommodation type); Stages C1 and C2 (Dukes’ stage); radiotherapy, chemotherapy and both (Neoadjuvant treatment; Adjuvant treatment)

‡ Collected from 3 months onwards. Selection of EORTC subscales was informed by previous work involving people with CRC(7, 22, 24, 25).

§ Self-reported at baseline only.

¶We used a cut-off of ≥40 to indicate a clinically significant level of anxiety(72).

# Items comprising the QLACS-CSS and QLACS-BC were collected from 9 months onwards.

**Table 2:** Sociodemographic and clinical information comparisons of CES-D<20 and ≥20 reported at baseline (N=741)

| **Covariates reported at Baseline** | **n (%)** | **CES-D<20**  **n (%)** | **CES-D≥20**  **n (%)** | ***P* value**\* |
| --- | --- | --- | --- | --- |
| **Age groups, years** |  |  |  |  |
| 50 or younger | 47 (6.4%) | 32 (68.1%) | 15 (31.9%) | .073 |
| 51-60 | 113 (15.3%) | 83 (73.5%) | 30 (26.5%) |  |
| 61-70 | 285 (38.6%) | 236 (82.8%) | 49 (17.2%) |  |
| 71-80 | 217 (29.4%) | 173 (79.7%) | 44 (20.3%) |  |
| 81 or older | 77 (10.4%) | 58 (75.3%) | 19 (24.7%) |  |
| **Gender** |  |  |  |  |
| Male | 440 (59.4%) | 373 (84.8%) | 67 (15.2%) | **<.001** |
| Female | 301 (40.6%) | 210 (69.8%) | 91 (30.2%) |  |
| **Ethnicity** |  |  |  |  |
| White British | 623 (92.7%) | 491 (78.8%) | 132 (21.2%) | .898 |
| Other ethnic group | 49 (7.3%) | 39 (79.6%) | 10 (20.4%) |  |
| **Deprivation (IMD) quintile** |  |  |  |  |
| 1st quintile (least deprived) | 146 (20.1%) | 123 (84.2%) | 23 (15.8%) | .086 |
| 2nd quintile | 150 (20.6%) | 123 (82%) | 27 (18%) |  |
| 3rd quintile | 142 (19.5%) | 113 (79.6%) | 29 (20.4%) |  |
| 4th quintile | 136 (18.7%) | 99 (72.8%) | 37 (27.2%) |  |
| 5th quintile (most deprived) | 153 (21%) | 114 (74.5%) | 39 (25.5%) |  |
| **Domestic status** |  |  |  |  |
| Married / Living with partner | 524 (71.1%) | 430 (82.1%) | 94 (17.9%) | **<.001** |
| Single / Widowed / Divorced / Separated | 213 (28.9%) | 150 (70.4%) | 63 (29.6%) |  |
| **Employment status** |  |  |  |  |
| Employed | 201 (27.3%) | 158 (78.6%) | 43 (21.4%) | .980 |
| Unemployed / Retired | 535 (72.7%) | 421 (78.7%) | 114 (21.3%) |  |
| **Accommodation type** |  |  |  |  |
| Owner occupied | 589 (79.9%) | 473 (80.3%) | 116 (19.7%) | **.021** |
| Renting / other† | 148 (20.1%) | 106 (71.6%) | 42 (28.4%) |  |
| **Previous use of mental health services** |  |  |  |  |
| No | 670 (94.5%) | 536 (80%) | 134 (20%) | **<.001** |
| Yes | 39 (5.5%) | 22 (56.4%) | 17 (43.6%) |  |
| **Tumour site** |  |  |  |  |
| Colon | 475 (64.4%) | 374 (78.7%) | 101 (21.3%) | .911 |
| Rectal | 263 (35.6%) | 208 (79.1%) | 55 (20.9%) |  |
| **Dukes’ stage** |  |  |  |  |
| A | 109 (14.7%) | 93 (85.3%) | 16 (14.7%) | .335 |
| B | 391 (52.8%) | 303 (77.5%) | 88 (22.5%) |  |
| C (C1 & C2) | 229 (30.9%) | 178 (77.7%) | 51 (22.3%) |  |
| Could not be determined‡ | 11 (1.5%) | 9 (81.8%) | 2 (18.2%) |  |
| **Neo-adjuvant treatment (any type)** |  |  |  |  |
| No | 592 (80.7%) | 465 (78.5%) | 127 (21.5%) | .649 |
| Yes | 142 (19.3%) | 114 (80.3%) | 28 (19.7%) |  |
| **Surgery type**§ |  |  |  |  |
| Laparoscopic | 401 (54.3%) | - | - | - |
| Open | 299 (40.5%) | - | - |  |
| Not available | 38 (5.2%) | - | - |  |
| **Adjuvant treatment (any type)**§ |  |  |  |  |
| No | 477 (64.6%) | - | - | - |
| Yes | 261 (35.4%) | - | - |  |
| **Stoma**§ |  |  |  |  |
| No | 262 (35.9%) | - | - | - |
| Yes | 468 (64.1%) | - | - |  |
| **Number of comorbidities¶** |  |  |  |  |
| 0 | 168 (27.6%) | 143 (85.1%) | 25 (14.9%) | .055 |
| 1 | 194 (31.9%) | 160 (82.5%) | 34 (17.5%) |  |
| 2 | 144 (23.6%) | 107 (74.3%) | 37 (25.7%) |  |
| 3+ | 103 (16.9%) | 78 (75.7%) | 25 (24.3%) |  |

***P*-values in bold indicate a statistically significant difference at the 5% level.**

\* Chi-square, χ2

† Other accommodation includes: Temporary accommodation, living in residential or nursing home, living with others (e.g. friends or family)

‡ Dukes’ stage could not be determined for 11 Full Consent patients with small tumours following neo-adjuvant therapy

§ Captured from the medical records after Baseline

¶ Self-reported at 3-month

Abbreviations: IMD: Index of Multiple Deprivation

**Table 3:** Descriptive statistics for the CES-D score and clinically significant level of depression (CES-D≥20) at each timepoint from pre-surgery to 5 years post-surgery

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Timepoint** | ***Pre-surgery*** | ***Post-surgery*** | | | | | | |
| **Baseline** | **3mo** | **9mo** | **15mo** | **24mo** | **36mo** | **48mo** | **60mo** |
| ***N*** | *741* | *642* | *605* | *534* | *483* | *382* | *369* | *319* |
| **CES-D total,**  **Median (IQR)** | 12.0  (11.7) | 11.1  (12.0) | 10.0  (13.0) | 9.0  (12.0) | 9.0  (10.9) | 8.0  (11.7) | 9.0  (11.0) | 9.5  (12.0) |
| **CES-D≥20,**  **n (%)** | 158  (21.3) | 124  (19.3) | 106  (17.5) | 70  (13.1) | 73  (15.1) | 49  (12.8) | 48  (13.0) | 47  (14.7) |

NOTE

Abbreviations: CES-D: Centre for Epidemiologic Studies Depression Scale; IQR: Interquartile Range

**Table 4:** Multivariable logistic regression model of clinically significant depression (CES-D≥20) up to 5 years post-surgery, significant covariates collected pre-surgery (baseline)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Theme Block** | **Covariates** | **Odds ratio** | **95% Confidence Interval** | ***P value*** |
| **Socio-demographic factors** | **Age groups, years** | | | |
| 50 or younger | REF | - | - |
| 51-60 | 0.50 | 0.22 – 1.10 | .086 |
| 61-70 | 0.50 | 0.26 – 0.97 | **.040** |
| 71-80 | 0.55 | 0.27 – 1.13 | .103 |
| 81 or older | 0.77 | 0.33 – 1.80 | .550 |
| **Clinical and treatment factors** | **Tumour site** | | | |
| Colon | REF | - | - |
| Rectum | 0.55 | 0.35 – 0.87 | **.011** |
| **Neoadjuvant treatment** | | | |
| None | REF | - | - |
| Yes, any therapy | 2.99 | 1.75 – 5.09 | **< .001** |
| **Previous use of mental health services** | | | |
| No | REF | - | - |
| Yes | 3.33 | 1.81 – 6.12 | **< .001** |
| Unknown | 0.65 | 0.23 – 1.81 | .411 |
| **Environmental factors** | **Domestic status** | | | |
| Married / living with a partner | REF | - | - |
| Single / widowed / divorced / separated | 2.02 | 1.32 – 3.09 | **.001** |
| **Personal factors** | **Self-Efficacy (SEMCD)** | | | |
| Low confidence | REF | - | - |
| Moderate confidence | 0.42 | 0.24 – 0.73 | **.002** |
| Confident | 0.35 | 0.20 – 0.61 | **< .001** |
| Very confident | 0.18 | 0.08 – 0.37 | **< .001** |
| **Psychosocial factors** | **Depression (CES-D)** | | | |
| <20 | REF | - | - |
| ≥20 (Clinical Level) | 3.44 | 2.18 – 5.45 | **< .000** |
| **Anxiety (STAI-S)** | | | |
| <40 | REF | - | - |
| ≥40 (High Level) | 1.82 | 1.15 – 2.87 | **.010** |
| **Social Support (MOS-SSS)** | | | |
| <100 (Not full) | REF | - | - |
| =100 (Full) | 0.41 | 0.23 – 0.74 | **.003** |
| **Health Status (EQ-5D-3L)** | | | |
| Not perfect health | REF | - | - |
| Perfect health | 0.42 | 0.24 – 0.75 | **.003** |

NOTE

***P*-values in bold indicate a statistically significant difference at the 5% level. The model controls for the time-point of the outcome report (post-surgery 3m to 60m), which was statistically significant.**

Abbreviations: CES-D: Centre for Epidemiologic Studies Depression Scale; EQ-5D-3L: EuroQoL 5 Dimensions 3 Levels; MOS-SSS: Medical Outcome Study Social Support Scale; SEMCD: Self-Efficacy for Managing Chronic Disorders Scale; STAI-S: State-Trait Anxiety Inventory - State Scale

**Table 5:** Multivariable logistic regression model of clinically significant depression (CES-D≥20) up to 5 years post-surgery, significant covariates collected at 2 years

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Theme Block** | **Covariates** | **Odds Ratio** | **95% CI** | ***P*** |
| **Socio-demographic factors** | **Accommodation type** | | | |
| Owner occupied | REF | - | - |
| Rented / Other | 2.38 | 1.23 – 4.62 | **.010** |
| **Personal factors** | **Affect (PANAS-SF)** | | | |
| Negative Affect | 1.21 | 1.08 – 1.36 | **.001** |
| **Psychosocial factors** | **Depression (CES-D)** | | | |
| <20 | REF | - | - |
| ≥20 (Clinical Level) | 3.14 | 1.41 – 7.04 | **.005** |
| **Health status (EQ-5D-3L)** | | | |
| Not perfect health | REF | - | - |
| Perfect health | 0.28 | 0.12 – 0.68 | **.005** |
| **Wellbeing (PWI-A)** | | | |
| ≥70 (Good) | REF | - | - |
| <70 (Poorer) | 2.40 | 1.25 – 4.61 | **.008** |
| **Cognitive functioning (EORTC QLQ-C30)** | | | |
| No problem | REF | - | - |
| Some problem | 2.21 | 1.03 – 4.77 | **.043** |

NOTE

***P*-values in bold indicate a statistically significant difference at the 5% level.**

Abbreviations: CES-D: Centre for Epidemiologic Studies Depression Scale; EORTC-QLQ-C30: European Organisation for Research and Treatment of Cancer Quality of Life Core-30 Questionnaire; EQ-5D-3L: EuroQoL 5 Dimensions 3 Levels; PANAS-SF: Positive and Negative Affect Schedule Short Form; PWI-A: Personal Wellbeing Index – Adult

**Appendix 1:** Scoping review search strategy & key studies identified which involve people with CRC including at least one follow-up timepoint

*Dates literature searches conducted:*

* October 2016
* August 2017
* September 2018
* May 2019
* July 2019
* October 2020
* March 2021

*Databases searched:*

* CINHAL
* APA PsycINFO
* APA PsycARTICLES
* MEDLINE (EBSCO)
* ISI Web of Science

*Limiters:*

* Date published: 01/01/2010 to 01/10/2020
* English language
* Human studies
* Peer-reviewed

*Search terms:*

Subject/MeSH Headings used where appropriate

|  |
| --- |
| Colorectal neoplasms OR Colorectal cancer |
| (Colon OR Rectum) AND (neoplasms OR cancer) |
|  |
| Depression OR MM Depression |
| Anxiety OR MH Anxiety Disorder |
| “Mental Health” |
| “Psychological disorder” |
| “Psychological distress” |
| “Worry” |
| MH Stress, Psychological |
| MH Mental Disorders |
| MH Fear |

| **Lead author, Year** | **Country of study** | **Sample** | **Assessment timepoints** | **Depression measure** | **Key findings** | **Comparison to the ColoREctal Wellbeing (CREW) study** |
| --- | --- | --- | --- | --- | --- | --- |
| Dunn et al., 2013 (1) | Australia | 1,884 CRC survivors; stages I-IV | T1: 5 months after diagnosis  Follow-up: 12 (T2), 24 (T3), 36 (T4), 48 (T5) and 60 (T6) months post-diagnosis | Brief Symptom Inventory-18 (BSI-18) | * Four trajectories of depressive symptoms: constant low levels, constant high levels, and people who increase from low and those who reduce from high levels. * Males, younger participants, later stage, poor social support and lower education were more likely to experience high levels of depression. * 16.1% of participants were in the ‘constant high’ level trajectory for depressive symptoms (BSI-18 Depression subscale). | * No pre-surgery assessment of psychological distress. * Recruitment of patients with metastatic CRC. |
| Hart & Charles, 2013 (2) | USA | 139 CRC patients  (stages I-IV) | T1: Pre-surgery  Follow-up: T2: 6 months, T3: 12 months; T4: 18 months post-surgery | Centre for Epidemiologic Studies Depression Scale (CES-D) | * Mean (SD): T1: 10.45 (8.11), T2: 9.33 (7.80), T3: 9.41 (8.74), T4: 9.49 (9.28) * Older adults reported lower levels of depressive symptoms. Men had fewer depressive symptoms than women. | * The prevalence of clinical levels of depression was not assessed. * No follow-up assessment beyond 18 months post-surgery. * Recruitment of patients with metastatic CRC. |
| Gonzalez-Saenz de Tejada et al., 2017 (3); Quintana et al., 2018 (4) | Spain | 972 CRC patients (including patients in relapse) | T1: Pre-surgery  Follow-up: T2: 12 months; T3: 24 months post-surgery; | Hospital Anxiety and Depression Scale (HADS) | * 19.6% of participants reported depression at T1 * Patients with depression improved less than participants not reporting depression or anxiety in all health-related quality of life (QOL) domains (EORTC QLQ-C30) domains. * Overall, few differences in depression symptoms in people undergoing either open or laparoscopic surgery. * Mean (SD) [Laparoscopy vs Open]: T1: 4.28 (4.12) vs 5.33 (4.84); T2: 3.52 (3.85) vs 4.08 (4.31); T3: 3.50 (3.97) vs 4.28 (4.38) | * Recruitment of patients with metastatic CRC. * Recruitment of patients in relapse (CREW excluded patients with previous cancer diagnosis). * No follow-up assessment beyond 24 months post-surgery. |
| Mols et al., 2018 (5) | Netherlands | 315 CRC survivors (stages I-IV) | Annual follow-up (1 to 4 years): T1: 2010, T2: 2011, T3: 2012, T4: 2013 | Hospital Anxiety and Depression Scale (HADS) | * Significantly higher prevalence of depression (19.0%, N=2,625) compared to a matched population (12.8%, N=315) during their first assessment. * Reduction in depression symptoms over time with the largest difference identified when examining the first and fourth assessments (mean change -0.89). * Fewer depressive symptoms were reported in people who were older, low QOL and lower physical, role, cognitive, emotional and social functioning. | * Participants recruited 1 to 4 years post-diagnosis. * Recruitment of participants with metastatic CRC. |

**Paper References**

1. Dunn J, Ng SK, Holland J, Aitken J, Youl P, Baade PD, et al. Trajectories of psychological distress after colorectal cancer. Psycho-Oncology. 2013;22:1759-65.

2. Hart SL, Charles ST. Age-related patterns in negative affect and appraisals about colorectal cancer over time. Health Psychology. 2013;32:302.

3. Gonzalez-Saenz de Tejada M, Bilbao A, Baré M, Briones E, Sarasqueta C, Quintana JM, et al. Association between social support, functional status, and change in health-related quality of life and changes in anxiety and depression in colorectal cancer patients. Psycho-Oncology. 2017;26:1263-9.

4. Quintana JM, Antón-Ladisla A, González N, Lázaro S, Baré M, de Larrea NF, et al. Outcomes of open versus laparoscopic surgery in patients with colon cancer. European Journal of Surgical Oncology. 2018;44:1344-53.

5. Mols F, Schoormans D, de Hingh I, Oerlemans S, Husson O. Symptoms of anxiety and depression among colorectal cancer survivors from the population-based, longitudinal PROFILES Registry: Prevalence, predictors, and impact on quality of life. Cancer. 2018;124:2621-8.

**Appendix 2:** Availability of the covariates in two time-points of the regression analyses

| Thematic Block | Topic / Measure | Taken time-points in separate regression models | |
| --- | --- | --- | --- |
| Baseline (pre-surgery) | 2 years post-surgery |
| Pre-existing factors (Socio-demographics) | Age | + | + |
| Gender | +1 | +1 |
| Ethnicity | +1 | +1 |
| Employment Status | + | + |
| Accommodation type | + | + |
| Index of Multiple Deprivation (IMD) | +1 | +1 |
| Clinical factors | Tumour site | + | + |
| Duke's stage | + | + |
| Neoadjuvant treatment | + | + |
| Adjuvant treatment | - | + |
| Surgery type | - | + |
| Stoma status | - | + |
| Number of Comorbidities | +2 | + |
| Previous use of mental health services | + | - |
| Environmental factors | Domestic status | + | + |
| Life Events | - | + |
| Medical Outcome Study Social Support Scale (MOS-SSS) | + | + |
| Personal factors | Self-Efficacy for Managing Chronic Disease 6-Item Scale (SEMCD) | + | - |
| Cancer Survivor Self-Efficacy Scale (CS-SES) | - | + |
| Positive and Negative Affect Schedule Short Form (PANAS-SF) | + | + |
| Psychosocial outcomes | Centre for Epidemiologic Studies Depression Scale (CES-D) | + | + |
| Quality of Life in Adult Cancer Survivors (QLACS) scale:  *QLACS Cancer-Specific Summary Score (QLACS-CSS)* | - | + |
| *QLACS Benefit of Cancer subscale (QLACS-BC)* | - | + |
| State-Trait Anxiety Inventory - State scale (STAI-S) | + | + |
| Personal Wellbeing Index - Adult (PWI-A) | + | + |
| EQ-5D-3L | + | + |
| EORTC-QLQ-C30: *Physical functioning* | - | + |
| EORTC-QLQ-C30: *Emotional functioning* | - | + |
| EORTC-QLQ-C30: *Cognitive functioning* | - | + |
| EORTC-QLQ-C30: *Social functioning* | - | + |
| EORTC-QLQ-C30: *Fatigue* | - | + |
| EORTC-QLQ-C30: *Pain* | - | + |
| EORTC-QLQ-C30: *Insomnia* | - | + |
| EORTC-QLQ-C30: *Financial Worry* | - | + |

KEY

‘+’ included in regression analysis for timepoint

‘-’ indicates excluded from regression analysis for timepoint due to measure not assessed at timepoint

NOTE

Data are taken from same timepoint unless otherwise annotated: 1 data taken from baseline timepoint, 2 data taken from 3-month follow-up timepoint

**Appendix 3:** Self-Reported Health Service Use (*Have you used any of the following health and social services in the last 12 months?*)

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **Timepoint (post-surgery)** | **24 months** | | **36 months** | | **48 months** | | **60 months** | |
| **CES-D score** | **≥20**  **n (%)** | **<20**  **n (%)** | **≥20**  **n (%)** | **<20**  **n (%)** | **≥20**  **n (%)** | **<20**  **n (%)** | **≥20**  **n (%)** | **<20**  **n (%)** |
| ***n*** | 73 | 410 | 49 | 333 | 48 | 321 | 47 | 272 |
| **Mental Health Services** | 2 (2.7) | 0 (0) | 2 (4.1) | 1 (0.3) | 3 (6.3) | 1 (0.3) | 1 (2.1) | 1 (0.4) |
| **Counselling services** | 4 (5.5) | 2 (0.5) | 6 (12.2) | 2 (0.6) | 2 (4.2) | 5 (1.6) | 1 (2.1) | 2 (0.7) |
| **Psychiatrist** | 4 (5.5) | 2 (0.5) | 4 (8.2) | 1 (0.3) | 3 (6.3) | 0 (0) | 2 (4.3) | 1 (0.4) |
| **Self-help group** | 5 (6.8) | 4 (1.0) | 2 (4.1) | 5 (1.5) | 3 (6.3) | 6 (1.9) | 3 (6.4) | 4 (1.5) |

NOTE

Abbreviations: CES-D – Centre for Epidemiologic Studies Depression Scale