

Editorial

Psychosocial care in cancer: an overview of psychosocial programmes and national cancer plans of countries within the International Federation of Psycho-Oncology Societies

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Abstract

We report data from representatives of national professional psycho-oncology societies on the integration of psychosocial care into national cancer programmes or cancer plans. To date information on how, or whether, psychosocial care has been recognized and integrated into comprehensive cancer care internationally has been extremely limited. The value of the current survey, whilst not comprehensive, lies with the fact that it is the first to report on the current status of psychosocial care for cancer patients and their families from a global perspective.

Representatives of 29 countries that are members of the Federation of National Psycho-Oncology Societies, coordinated under the aegis of the International Psycho-Oncology Society (IPOS), participated in a survey aimed at clarifying access to psychosocial care. Results indicate that while psychosocial oncology has grown over the last decade, it is either not established or not completely established, or not an integral part of care in some countries, especially developing countries, where basic care is sometimes not provided to cancer patients.

Future targets need to focus on the integration of psychosocial oncology programmes into comprehensive cancer care and their coordination within multidisciplinary teams.

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Keywords: psychosocial; national cancer plans; societies; oncology; IPOS; Federation

Received: 4 July 2012
Revised: 14 July 2012
Accepted: 20 July 2012

Introduction

A number of important documents have been released in the last 5 years regarding the right of cancer patients to have their psychosocial needs recognized and addressed [1]. The US National Institutes of Health commissioned a study by the Institute of Medicine of the National Academies of Sciences on the delivery of psychosocial services to patients with cancer. The evidence was clear and unambiguous that 'attending to psychosocial needs should be an integral part of quality cancer care. . . It is not possible to deliver good quality cancer care without addressing patient's psychosocial health needs' [2].

In 2008, a document published by the Council of the European Union (EU) [3] acknowledged the significance of psychosocial aspects of cancer care and stated that 'to attain optimal results, a patient-centred comprehensive interdisciplinary approach and optimal psychosocial care should be implemented in routine cancer care, rehabilitation and post-treatment follow-up for all cancers' (par. 5), with an open invitation to all EU member states 'to take into account the psychosocial needs of patients and improve the quality of life for cancer patients through support, rehabilitation and palliative care' (par.19).

These position statements express what psychosocial oncology professionals have worked on for the last 25 years and what the International Psycho-Oncology Society (IPOS) has proposed as an International Standard of Quality Cancer Care [4]. The survey, conducted by IPOS in 2006 to assess development of psychosocial oncology at an international level, indicated that at least 5000 professionals and about 25 recognized psychosocial oncology professional societies were active. These results, presented at the 2006 IPOS World Congress in Venice, were an impetus for the creation of the IPOS Federation of national and regional psychosocial oncology societies with preparatory meetings in London in 2007 and the official Federation launch in 2008.

The main objective of the Federation is to represent psychosocial oncology worldwide, communicating a compelling, unified message that all cancer patients and their families, throughout the world, should receive optimal psychosocial care at all stages of the disease and survival.

Recent activity of the IPOS Federation has focused on clarifying what progress has been made in the development and integration of psychosocial oncology into comprehensive cancer care globally [5]. The aim is to understand how much, and in what way, psychosocial

oncology is recognized by national governments and included in national cancer plans. This report summarizes the situation in the countries belonging to the IPOS Federation. Information was collected through an email survey and open discussions with representatives of various national psychosocial oncology societies. Representatives of 30 countries were asked to report on the situation in their country with respect to a national cancer plan and 29 replied.

North America

In *Canada*, the Canadian Association of Psychosocial Oncology (CAPO) published the *National Standards for Psychosocial Oncology* in 1999, which was recently revised to include recommendations for standards of care, organizational standards, educational standards and integration of all phases of the cancer control trajectory, including prevention and survivorship [6]. The CAPO recommendations on standards for practice, professional issues, and organization and structure of psychosocial oncology programmes have been endorsed by the Canadian Association of Provincial Cancer Agencies, the Canadian Cancer Society, the Canadian Strategy for Cancer Control, and the Canadian Council on Health Services Accreditation. In 2005, the Canadian Strategy for Cancer Control added emotional distress as the sixth vital sign, implying that monitoring of emotional distress is a vital indicator of a patient's state of being, needs and progress through the disease [7]. Recently published documents on the assessment of psychosocial needs, anxiety, depression and fatigue, and on the organization and structure of psychosocial care in cancer survivors, represent a point of reference for other psychosocial associations throughout the world and the platform for the development of psychosocial oncology services in Canada [8–11]. Recently, a renewal of funding for five more years to the Canadian Partnership Against Cancer (2012–2017) was approved, and psychosocial oncology has been addressed within the Partnership under the Cancer Journey Action Portfolio. Within this portfolio, two central strategic initiatives will be extended, namely integrated person-centred care (including navigation, palliative and end-of-life care and screening for distress) and survivorship.

In the *USA*, the first clinical practice guidelines and standard of care were published in 1997 by the National Comprehensive Cancer Network. A multidisciplinary panel was charged with examining barriers to psychosocial care. The Panel found the word 'distress' far more acceptable for use in routine care, by both oncologists and patients, thus leading to the guidelines being called Distress Management Guidelines [12]. The Institute of Medicine's establishment of a new standard for quality cancer care in 2008 was a milestone noting that quality cancer care must integrate the psychosocial into routine cancer care. Through the American Society for Clinical Oncology's Quality Oncology Practice Initiative

(QOPI), the quality of psychosocial care is now audited as well in all practices that request self-audit, on the basis of criteria developed by a working group in the American Psychosocial Oncology Society (APOS). The American College of Surgeon's Commission on Cancer accredits all cancer centres, and they have mandated that by 2015, all centres must have a plan for integration of psychosocial services into routine care. APOS is presently developing guidelines and consultation services to assist cancer centres in developing their programmes.

Europe

In Europe, there is diversity of care across nations and EU Member States from those with mandated cancer plans to those with no cancer plans. Although the EU's 2009 Partnership for Action against Cancer pledges that, by 2013, all Member States will have adopted integrated cancer plans, several are still in the process of developing their first plans and some have not yet started [13]. Not surprisingly, several differences have emerged between EU countries in terms of incorporating psychosocial guidelines into their cancer plans, and having psychosocial care routinely available in oncology settings. These are summarized as follows.

In *Austria*, the Austrian Platform of Psycho-Oncology (OEPPPO) was invited by their Ministry of Health to work within a task force focused on the establishment of the National Cancer Act. The first step involved evaluation of the status of psychosocial oncology services in Austria. Furthermore, the task force collected international recommendations in psycho-oncological services and education. The establishment of guidelines for psycho-oncology services in the national cancer plan is the next main commitment of the Austrian society.

In *France*, the French Psycho-Oncology Society (SFPO) has worked on a nationwide census of all the psychologists and psychiatrists in oncology hospitals. The SFPO is collaborating with the French Branch (Association Francophone pour les Soins Oncologiques de Support – AFSOS) of the Multi-national Association of Supportive Care in Cancer (MASCC) in developing national guidelines for management of depression and delirium. Guidelines for psycho-oncologists working with elderly cancer patients have been developed and published in the French journal *Psycho-Oncologie* [14].

In *Germany*, psychosocial oncology is in the national cancer plan and supported by the Federal Ministry of Health, with working groups defining the main goals for comprehensive cancer care (e.g. Working Group 4 'Patient Orientation', subgroup on 'patient communication, patient competence and shared decision making'; Working Group 2 with patient care subgoal 'psychosocial care of cancer patients') [15,16]. It was recommended that all cancer patients be informed about psychosocial oncology services and patients with a need, or a wish for, professional psychosocial support should have access. Guidelines for psychosocial oncology are in progress and expected to be completed by the

end of 2012 [17]. The German Cancer Society has established standards of care for Acute Care Hospitals according to which professional and psychosocial help is to be offered for all cancer patients in need. If a hospital does not fulfil this requirement, the certificate of the German Cancer Society is not given.

In *Hungary*, the 2006 National Cancer Act declared that every Cancer Centre should have a psychologist or a psychiatrist. However, political and economical constraints have prevented the National Cancer Act from being fully implemented. The Hungarian Psychosocial Society (MPOT) is currently working on National Guidelines.

In *Ireland*, the National Cancer Control Programme was established in 2007, and the restructuring of cancer services has taken place according to the National Cancer Strategy [18]. Cancer care is delivered through four Managed Cancer Control Networks, which provide integrated primary, hospital, palliative, psychosocial oncology and supportive care within eight cancer centres. The Irish Cancer Society has funded several psychosocial oncology research and education projects and has been a key driver in psychosocial oncology services. The Society founded the Irish Psycho-Oncology Group (IPOG) in 2005 and facilitated professional development, sharing and exchange of information. This group was subsumed into the National Cancer Control Programme in 2010.

In *Italy*, the Italian Society of Psycho-Oncology (SIPO), established in 1985, carried out a survey together with the Italian Association of Cancer Patients and the National Institute of Health in 2005. Results indicated the existence of at least 100 psychosocial oncology services within the National Health System and a follow-up to be completed by 2012 will update these figures. The most recent national cancer plan 2010–2012 and the Document on reducing the burden of cancer – years 2011–2013 [19], published by the Ministry of Health recognizes and acknowledges comprehensive psychosocial care of cancer patients in several paragraphs of the Act. Psychosocial oncology is one of seven areas of basic and essential level training for oncology professionals (diagnosis, prevention, screening, rehabilitation, palliative care, pain treatment, psychosocial oncology). SIPO published the second edition of its standard-of-care document [20] and, in cooperation with the Italian Association of Medical Oncology (AIOM), is working on national guidelines for psychosocial care.

In *Lithuania*, no National Cancer Act is available, while psychosocial oncology activity is provided by consulting psychiatrists/psychologists working mostly in large hospitals.

In *Poland*, although psychosocial oncology is not taken into consideration by the National Cancer Act, the Polish Ministry of Health received a proposal from the Polish Society of Psycho-Oncology to consider the role of psychosocial care.

In *Portugal*, the Portuguese Cancer Programme has acknowledged the importance of psychosocial issues, plus the need to implement psychosocial oncology units in the main cancer centres or to integrate psychosocial professionals in other oncology services. Multidisciplinary

psychosocial oncology units are available in the main cancer centres as well as in the new palliative care units. International guidelines (IPOS) have been adopted for patients' and families' treatment and for team education. Many needs are not yet addressed, especially in smaller hospitals, for example, distress screening, basic psychosocial care or recruitment of trained professionals to implement and develop quality psycho-oncology programmes. The two Portuguese societies of psycho-oncology (Academy of Portuguese Psycho-Oncology (APPO) and Portuguese Psycho-Oncology Society belonging to the IPOS Federation of the National Societies) have focussed on educational programmes for professionals and are working, together with the Ministry of Health, to implement consistent and extended national psychosocial oncology programmes.

In *Romania*, psychosocial oncology is not developed in terms of the National Cancer Act, and no statute of psychosocial oncology care is available. This care is provided by psychosocial care professionals supported by charities and NGOs.

In *Slovenia*, the important role of psychosocial help in oncology and in palliative care was recognized in a few documents at the national level: Guidelines for Lung Cancer Treatment (2006), National Programme of Palliative Care (2008) and National Programme of Cancer Control (2008, 2010–2015). However, specific professional guidelines for psychosocial oncology and palliative care based on data about psychosocial needs of Slovenian cancer patients and formally supported by the health care system are not yet developed. Although, in the last decade, psychosocial oncology care was developed in the majority of hospitals, specialized for treatment of cancers, the need for further development of psychosocial oncology is still underestimated. The Slovenian Association of (Psychologists in) Psychosocial Oncology and Palliative Care, established in 2011 under the umbrella of the Slovenian Society of Clinical Psychologists, is a first attempt to fill this gap.

In *Spain*, a major development in psychosocial oncology has been the inclusion of the Spanish Society of Psycho-Oncology (SEPO), as a partner in the National Strategy in Cancer, where providing psychological care to cancer patients and their families is the main and only objective of the chapter on Quality of life of the National Strategy in Cancer. The action described in the Strategy is to 'promote the access to psycho-oncological care, to patients and families who may benefit from it'. Psychosocial oncology has also been included in the chapters of the strategy document on care of children and adolescents, and palliative care.

Sweden does not have a national cancer plan, although in 2009, a national cancer strategy was published by the government, as a guideline rather than a mandatory document. The strategy did not include a chapter on rehabilitation or psychosocial support but was the starting point of a process of development of the national organization for cancer care. Six regional cancer centres are to be formed with each required to develop competencies in psychosocial support and

cancer rehabilitation, and integrate these into routine cancer care. A government working group for cancer rehabilitation was formed in 2010, and the Swedish Psycho-Oncology Society (SWEDPOS) was invited to participate. The need for guidelines for psychosocial support and cancer rehabilitation has been acknowledged. In 2012, the first regional guidelines for southern Sweden were published, with the government supporting the development of national guidelines to be published in 2013. SWEDPOS is engaged in this work with their president as head of the working groups for both the regional and the national guidelines.

In *Switzerland*, psychosocial oncology is among the main topics (epidemiology and monitoring, prevention, early detection, research, therapy, care giving, psychosocial oncology, rehabilitation, palliative care) of the National Cancer Act 2011–2015, published by Oncosuisse, the Swiss anticancer association. For psychosocial oncology, several goals are being pursued (e.g. national standards and guidelines for the support of patients and relatives with standardized distress screening being evaluated and implemented into primary cancer treatment; guidelines for the financing of psycho-oncological options within primary care are established).

In *the Netherlands*, the Dutch Society for Psychosocial Oncology (NVPO) has been important in having psychosocial oncology represented in the Ministry of Health's 2005–2010 Progress Report on the Dutch National Cancer Control Programme [21]. Since 2005, psychosocial oncology is covered by a working group on integration of psychosocial care and is one of seven prioritized themes that the Dutch National Cancer Control Plan (Dutch NCCP) Steering Committee supports. Psychosocial health care professionals in oncology are part of the organization and structure of cancer control, and have helped increase attention on cancer care, including follow-up screening with an assessment of the patient's psychosocial situation and the late effects of treatments, relapses and metastases. Furthermore, the working group Integration of Psychosocial Care within the Dutch NCCP recommended that patients' and relatives' psychosocial problems should be appropriately treated and, where possible, prevented. National guidelines on rehabilitation (www.oncoline.nl/oncologische-revalidatie), on return to work, and on detection of the need for psychosocial support using the Distress Thermometer (DT) are available [22].

In the *UK*, the National Institute of Health and Clinical Excellence (NICE) developed guidelines in palliative and supportive care, which included psychosocial care [23]. These recommend a four-tier psychosocial care model where most support is provided by front line staff (e.g. levels 1 and 2 including doctors, nurses and allied health care professionals), whereas level 3 care is provided by specialist counsellors and highly specialist mental health care (level 4) is provided by psychiatrists and clinical psychologists. For this model to be implemented effectively, cancer staff must regularly and proactively ask patients about their concerns (physical,

emotional, spiritual, financial, family and psychosexual). National programmes of Advanced Communication Skills Training have been implemented. At least one core member of each oncology multidisciplinary team must be trained to deliver basic psychological assessments and interventions, ideally under supervision by accredited mental health specialists. Documents have been published on psychosocial issues in cancer care by the National Cancer Action Team, as a part of the National Cancer Programme (National Health Service, UK) [24,25]. Patients that require more complex interventions must have access to trained and accredited mental health professionals within routine cancer services. As a result of cuts to services across the UK National Health Service following the financial crisis, in 2011, Macmillan Cancer Research (www.macmillan.org.uk) published an evidence-based review on effectiveness and cost savings of providing psychological support emphasizing its importance for cancer patients.

Australia and New Zealand

In *Australia*, national guidelines on implementation of psychosocial oncology were set up in 2000, when comprehensive clinical guidelines were published by the National Breast Cancer Centre [26]. A multidisciplinary steering group prepared further guidelines, published by the National Breast Cancer Centre and the National Cancer Control Initiative and approved by the National Health and Medical Research Council in 2003 [27,28]. Currently, the 2003 guidelines are undergoing updating, highlighting the need for regular review of guidelines. In West Australia (WA), the WA Health Cancer Services Framework of the Cancer Services Taskforce [29] made the following recommendations: (i) the number of, and access to, clinical psychologists and counselling psychologists for patients should increase as well as the public, specialist and GP awareness of these systems (Initiative 12); (ii) each tumour collaborative should have links to a specialist clinical psychology service (Initiative 13); (iii) supportive care should be an integral component of cancer care (Initiative 6); (iv) referral to psychosocial support services should be actively managed (Initiative 11, 43); and (v) consumer awareness of options for accessing psychosocial support should increase (Initiative 16).

In *New Zealand*, the New Zealand Cancer Control Strategy published a document providing objectives based on best evidence and suggesting best-practice service approaches to ensure that adults with cancer, and their families, have access to the supportive care needed throughout the stages of cancer, from diagnosis onwards [30]. After a nationwide stock-take of supportive care in New Zealand, a prioritized implementation plan was published in 2011. The Psycho-Social Oncology New Zealand Society supports the guidelines, with many members being involved in their development and implementation.

Middle East

In *Israel*, the standards for psychosocial oncology were developed by the Israel Psycho-Oncology Society and approved in 2003 by the Israel National Council and Ministry of Health. These included structural standards, professional qualifications/competency, standards for psychosocial services to patients and their families, integration of psychosocial care into the multidisciplinary team, and standards pertaining to the multifaceted activities and responsibilities of the Society itself.¹ The Israel Psycho-Oncology Society continues to develop training programmes for a diverse population of Israel's health professionals. The Society's imperative is to be constantly sensitive to the heterogeneous nature of Israel – comprised of different religious and social cultures – by integrating these differences into the development process. Education, teaching, psychosocial interventions and research are the cornerstones of the society for pursuing and transmitting knowledge.

In *Turkey*, changes are ongoing, including a new law on the mandatory presence of clinical psychologists in cancer centres, which is about to be approved, indicating a trend towards more structured, multidisciplinary cancer care in health care institutions.

Asia

In *China*, the National Strategy for Cancer Control has begun shifting attention to psychosocial aspects of cancer care, with the emphasis on enhancing quality of life through the management of pain, fatigue and psychological distress among patients and their families. Overall, the current Program of Cancer Prevention and Control in China (2004–2010) is a much more comprehensive strategy than previous plans [31]. However, no official document specially focuses on psychosocial oncology so far.

In *Japan*, The Cancer Control Act was implemented in 2007. The Ministry of Health, Labour and Welfare and every prefecture are responsible for provision of quality palliative care to cancer patients from an early stage and to expanding the use of morphine and other drugs to help ease their pain and suffering. All comprehensive cancer centres and their affiliated hospitals are expected to have a palliative care team including a psycho-oncologist as an essential member. The Ministry of Health, Labour and Welfare funds training for psycho-oncologists and communication skills training for oncologists. The outcome of the above activities in the past 5 years is that over 30,000 oncologists received training in managing distress and delirium, and communication skills; 623 have completed an advanced communication skills training programme using the Japanese SHARE model [32]. The Japanese Psycho-Oncology Society (JPOS) offers training programmes in aspects of psychosocial oncology, such as depression and delirium to psycho-oncologists, nurses and psychologists separately every year, and is

establishing a qualification for psycho-oncologists. All these activities are coordinated or hosted by JPOS.

In *Korea*, the 2003 Cancer Control Act did not include any guidelines on psychosocial care of cancer patients, describing instead palliative care for terminal cancer. The Korean Psycho-Oncology Society (KPOS), established in 2006, has been striving for the promotion of psychosocial oncology in Korea and in 2009 published guidelines for distress management for Korean cancer patients using the DT as a screening tool [33]. This activity was supported by funding from the National Research and Development Programme for Cancer Control, administered by the Korean Ministry for Health and Welfare.

In *Taiwan*, the 2003 Cancer Control Act did not specifically include psychosocial care for cancer patients. It only listed providing palliative care services and implementing a quality assurance plan alongside the main tasks of cancer prevention and treatment. Since the establishment of the Taiwan Psycho-oncology Society (TPOS) in 2009, provision of communication skills training for oncologists has been its prime task. In 2010, the SHARE model developed in Japan was introduced and implemented in Taiwan. The Bureau of Health Promotion, which has administered a Certification Programme of Cancer-Care Quality since 2007, funded the training. Since 2011, it also specified those personnel who should receive communication training as part of its accreditation criteria. The DT was validated in a Taiwanese population for screening of psychosocial stress among cancer patients in 2004 [34] and has since been implemented in at least one hospital. The requirement for routine psychosocial screening for cancer patients in all cancer centres is advocated and may be included in the Certification Programme of Cancer-Care Quality in the near future.

The increasing activities in China, Japan, Korea and Taiwan has led to the development of the East Asian Psycho-Oncology Network (EAPON) as a way to foster communication and collaboration on psychosocial oncology among East Asian countries and to reinforce commitment to psychosocial oncology care.

South America

Brazil

The data available for South America are restricted to the IPOS Federated Brazilian Society of Psycho-Oncology (BSPO), established in 1994. BSPO is linked to many NGOs, thus enabling the population to be informed and updated on information related to patients' rights and advocacy. They are also collaborating with Brazilian governmental agencies. The Ministry of Health established the National Policy for Oncology Care with the task of implementing promotion, prevention, diagnosis, treatment, rehabilitation and palliative care in all oncology units. In 1998, it became a mandatory requirement that there be psychologists available in oncology centres. The National Cancer Institute (INCA), as a technical branch of the Federal Government, under the direct

administration of the Ministry of Health, delivers cancer care within the Integrated Public Health System (SUS), by formulating and coordinating public policies, developing research activities and disseminating practices and knowledge on medical oncology.

Africa

Nigeria

In 2011, the first meeting of the Nigerian Psycho-Oncology Society (POSON) was held in Ibadan and attended by 30 professionals from several disciplines who agreed for the need to have a central organization for encouraging the improvement of psychosocial education, care and research in Nigeria. POSON, which is part of the Federation since 2011, is organizing a second workshop and conference in 2012 at Ibadan, where delegates from other parts of the country are expected to attend.

South Africa

For many years, South Africa has not had an active National Cancer Registry. This will change in the near future. The Health Department is working on a National Cancer Control Plan, although it is not possible to know when it will be implemented. Various stake-holders have been contacted regarding such a plan, in which aspects of Palliative Care will be included. The South African Oncology Social Workers' Forum (www.saoswf.org.za) is active in pursuing the development of psychosocial oncology in the country.

Conclusions

It is clear that psychosocial oncology has grown over the last decade. Publications of reports, guidelines, recommendations and standards of psychosocial oncology care have improved implementation of psychosocial activities, services and programmes. In line with the World Health Organization policy on the fundamental need to preserve mental health in all phases of life since 'there can be no health without mental health' [35], no cancer health is possible without taking into consideration mental health [36], and consequently, it is not possible to organize cancer care without a specific investment in psychosocial oncology.

However, few countries have national cancer plans, and in others, psychosocial oncology is not specifically offered except within the context of more, general psychological support. The problem of underfunding of mental health programmes is also present, in spite of data showing that psychosocial interventions are effective in terms of improving the patients' quality of life and in reducing health systems costs by properly treating psychosocial complications of cancer [37].

Finally, psychosocial oncology is either not established or not completely established, or not an integral part of cancer care in many countries, especially developing nations, where basic care is sometimes not provided to cancer patients.

The dissemination of existing documents described here, and compiled by members of the IPOS Federation, can be a mutually beneficial resource aimed at promoting psychosocial care in oncology. Individual societies are able to draw on these existing Federation resources to help them create alliances with politicians, administrators, leading practice-policymakers and health providers in order to support the recognition of, and need for, psychosocial oncology care to be integrated with national cancer plans. This can in turn favour the implementation of good evidence-based psychosocial oncology programmes and their coordination within multidisciplinary teams.

Recently, IPOS has promoted an International Standard of Quality Cancer Care, which states that all cancer patients should have access to psychosocial care and that distress should be assessed as the sixth Vital Sign [4]. This is a worthy goal for all psychosocial oncology societies to try to achieve. This seems of particular importance at a time when immigration and other social phenomena have made many countries multi-ethnic and multi-cultural, and where language, ethnicity, race and religion influence both the patients' and their families' psychosocial perceptions and responses to cancer, creating new needs and challenges in the organization of psychosocial oncology services [38]. As a federation of societies, we should be able to establish a critical mass of expertise, evidence and opinion to speak with one voice in order to help sway cancer health service providers to include psychosocial care as part of quality multidisciplinary care.

Note

1. All the documents are posted on the IPOS website.

Appendix A

Elisabeth Andritsch (Austria), Zeynep Armay (Turkey), Chioma Asuzu (Nigeria), Lea Baider (Israel), Wayne A. Bardwell (USA), Giedre Bulotiene (Lithuania), Chih-Tao Cheng (Taiwan), Sarah Dauchy (France), Pia Dellson (Sweden), Krystyna de Walden-Galuszko (Poland), Haryana Dhillon (Australia), Maria Die-Trill (Spain), Nick Hulbert-Williams (United Kingdom), Juliet Ireland (New Zealand), Jong-Heun Kim (Korea), Clare Manicom (South Africa), Deborah McLeod (Canada), Lucia M. Silva Monteiro (Portugal), Ying Pang (China), Maria Helena Pereira Franco (Brazil), Laura Monica Radu (Romania), Magdalena Rohánszky (Hungary), Andrea Schumacher (Germany), Anja Simonič (Slovenia), Susanne Singer (Germany), Lili Tang (China), Mecheline van der Linden (The Netherlands), Kazuhiro Yoshiuchi (Japan), Joachim Weis (Germany), Brigitta Wössmer (Switzerland), Shelagh Wright (Ireland).

Acknowledgements

The results reported are based on information provided by the country referents who are co-authors on this article. Although we have endeavoured to be accurate, possible inaccuracies may be inherent to the views expressed. Final editorial changes were the responsibility of the two lead authors.

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