



# RESEARCH & CLINICAL SERVICE INTERFACE

OZPOS and PoCoG  
Psycho-oncology Professional Day

Final Report



This Professional Day was jointly funded by:  
**COSA and Cancer Australia**

# **OZPOS and PoCoG Psycho-oncology Professional Day 16 November 2009: Final Report**

## **Research and Clinical Service Interface**

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and the PoCoG Executive Office

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# Table of Contents

<b>1. Introduction.....</b>	<b>3</b>
<b>2. Participants .....</b>	<b>3</b>
<b>3. Professional Day Summary .....</b>	<b>3</b>
3.1. Plenary: Branding Distress – “Sixth Vital Sign” in Cancer Care: From Practice to Policy .	3
3.2. Research presentations .....	3
3.3. Clinical Workshops.....	4
3.3.1. <i>Sexuality and Intimacy in Cancer Care: Enhancing Clinical Practice</i> .....	4
3.3.2. <i>Mindfulness in Therapy</i> .....	4
3.4. Panel Discussion: Implementation and Outreach .....	5
3.5. PoCoG’s 2009 Annual General Meeting .....	5
3.6. Psycho-oncology Outcomes Database (PoD) Launch.....	5
<b>4. Professional Day Evaluation .....</b>	<b>5</b>
4.1. Plenary: Branding Distress – “Sixth Vital Sign” in Cancer Care: From Practice to Policy .	7
4.2. Research presentations .....	8
4.3. Clinical Workshops.....	8
4.3.1. <i>Sexuality and Intimacy in Cancer Care: Enhancing Clinical Practice</i> .....	8
4.3.2. <i>Mindfulness in Therapy</i> .....	9
4.4. Panel Discussion: Implementation and Outreach .....	10
<b>5. General Feedback on the Professional Day .....</b>	<b>11</b>
<b>6. Conclusions .....</b>	<b>12</b>
<b>7. Acknowledgements .....</b>	<b>13</b>
<b>8. Further inquiries .....</b>	<b>13</b>
<b>9. Appendices .....</b>	<b>14</b>

## 1. Introduction

The OZPOS and PoCoG Psycho-oncology Professional day was held on Monday 16 November 2009 at the Gold Coast Convention Centre, as a satellite event to the Clinical Oncological Society of Australia's (COSA) 36<sup>th</sup> Annual Scientific Meeting (ASM). The Professional Day aimed to strengthen existing collaborations and lead to the establishment of new psycho-oncology networks between researchers and clinicians in psycho-oncology.

## 2. Participants

Approximately 130 individuals registered to attend the Psycho-oncology Professional Day through ASN conferences in conjunction with their registration for the COSA ASM. The attendees were predominantly Australian psychosocial researchers and clinicians, nurses, social workers, oncologists, health professionals and others with an interest in psycho-oncology. There was no registration fee to attend the Professional Day courtesy of funding from both COSA and Cancer Australia.

## 3. Professional Day Summary

The Professional Day was structured into five main intervals comprising nine sessions as described below.

### 3.1. Plenary: Branding Distress – “Sixth Vital Sign” in Cancer Care: From Practice to Policy

The Professional Day opened with a plenary session entitled “Branding distress- 6th vital sign in cancer care: From practice to policy” from Dr Barry Bultz, Director of the Department of Psychosocial Resources, *Tom Baker Cancer Centre*, Calgary, Canada. Dr Bultz's presentation addressed the importance of routine screening for distress, which significantly affects 35 – 45% of the cancer patient population, to allow timely referral of patients to appropriate treatment services. He also discussed the *Canadian Partnership Against Cancer's* implementation plan for routine screening.

### 3.2. Research presentations

Research in psycho-oncology was presented in three themed sessions: “What About Me? CALD and Other Vulnerable Groups”; “At the Coalface – Clinical Issues Across the Cancer Journey”; and “What's Hot – Emerging Research in Psycho-oncology”.

### **3.2.1. What About Me? CALD and Other Vulnerable Groups**

The “What About Me? CALD and Other Vulnerable Groups” session was chaired by Dr Ilona Juraskova. The five speakers in this session presented their research on the issues faced by cancer patients from vulnerable or often neglected cancer patient populations. The presentations covered research about cancer patients from culturally and linguistically diverse (CALD) groups and rural and remote groups. The role of interpreters in oncology consultations with CALD patients was also addressed, as were the issues faced in supportive care screening. Details of the presentations in this session are included in Appendix A of this report.

### **3.2.2. At the Coalface – Clinical Issues Across the Cancer Journey**

The “At the Coalface – Clinical Issues Across the Cancer Journey” session was chaired by Dr Jaklin Elliott. This session saw five presenters speak of their research about the real problems and issues faced by patients from their cancer diagnosis to the end of treatment. Details of the presentations in this session are included in Appendix A.

### **3.2.3. What’s Hot – Emerging Research in Psycho-oncology**

The “What’s Hot – Emerging Research in Psycho-oncology” session was chaired by Dr Laura Kirsten. The six presenters in this session introduced the audience to new areas in psycho-oncology research, which included the latest intervention studies in development, psychosocial support in rural populations and gender differences in the psychological experiences of carers. Details of the presentations in this session are included in Appendix A.

## **3.3. Clinical Workshops**

The Psycho-oncology Professional Day hosted two workshops which were designed and conducted by PoCoG members with extensive experience in clinical psychology

### **3.3.1. Sexuality and Intimacy in Cancer Care: Enhancing Clinical Practice**

The “Sexuality and Intimacy in Cancer Care: Enhancing Clinical Practice” workshop, presented by Dr Katharine Hodgkinson and Dr Jemma Gilchrist, addressed intimacy and sexual functioning throughout the cancer care trajectory. Twenty five participants registered for and attended this session.

### **3.3.2. Mindfulness in Therapy**

The “Mindfulness in Therapy” workshop by Dr Elizabeth Foley aimed to facilitate an understanding of mindfulness and how this approach might assist clinicians in working with cancer patients and carers. Registrations for this session closed at 25 participants, with a short waiting list.

### 3.4. Panel Discussion: Implementation and Outreach

A panel discussion entitled “Implementation and Outreach” explored practical issues of service delivery with a multidisciplinary group of psycho-oncology professionals: Dr Barry Bultz (Clinical Psychologist), Prof. David Clarke (Consultation-Liaison Psychiatrist), Ms Kim Hobbs (Social Worker) and Prof. Brian Kelly (Psychiatrist), chaired by Dr Catherine Adams (Clinical Psychologist). The discussion was based on four case-studies or vignettes which illustrated several known service delivery problems in the Australian health care setting. Although four vignettes were planned for examination, only three were discussed at the Professional Day due to time constraints.

### 3.5. PoCoG’s 2009 Annual General Meeting

The PoCoG Annual General Meeting took place in the afternoon in the format of a presentation of PoCoG’s achievements in 2009. Professor Phyllis Butow, the Chair of PoCoG, presented on the resources offered by PoCoG, the Group’s research success and PoCoG’s plans for the coming years.

### 3.6. Psycho-oncology Outcomes Database (PoD) Launch

The day closed with the launch of the searchable online database of validated psychosocial and quality of life measures: the Psycho-oncology Outcomes Database (PoD) by Prof. David Currow, CEO Cancer Australia and Prof. Phyllis Butow, PoCoG Chair. The PoD contains information about more than 350 patient-reported questionnaires measuring outcomes such as quality of life, supportive care needs, psychological states and social support.

## 4. Professional Day Evaluation

The registrants of the Psycho-oncology Professional Day were invited to participate in an online follow-up survey to determine the satisfaction of the attendees and the direction of future psycho-oncology professional meetings. Of the 130 registrants, 62 individuals (47 female) participated in the feedback survey. Seven of these participants did not complete the questionnaire. The survey participants indicated they were psychosocial researchers, clinicians, nurses, social workers, students, oncologists and other professions not specified and the majority of the participants were members of either PoCoG ( $n = 45$ ) or OZPOS ( $n = 23$ ) and 16 participants were members of COSA. The participants had varying levels of professional experience, ranging from less than two years ( $n = 14$ ) to more than 10 years ( $n = 15$ ). Table 1 shows a summary of the participants’ demographic information.

**Table 1: Demographic Information**

Gender								
Female		Male						
47		8						
Place of Residence								
NSW	QLD	VIC	SA	WA	International			
27	6	11	7	2	1			
Profession								
Psychosocial Researcher	Nurse	Psychosocial Clinician	Social Worker	Students	Oncologist	Clinician/ Researcher	Other	
26	7	7	2	2	1	3	6	
Time since completing professional training								
<2yrs/ Student	2-5 Years	5-10 Years	>10 Years					
14	10	16	15					
Membership of other groups <sup>1</sup>								
PoCoG	OZPOS	COSA	CNSA	COGNO	ALTG	OSWA	AGITG	ANZGOG
45	23	16	8	5	4	3	3	3
ANZBCTG	ANZUP	PC4TG	ANZMTG	ASSG	ALLG	ANZCHOG	TROG	Other
3	3	2	2	1	1	0	0	10

<sup>1</sup> Members can belong to more than one group



Participants evaluated the sessions they attended and the results are presented below. Missing data were omitted from percentage calculations. The Professional Day Evaluation Survey questions can be found in Appendix B.

#### **4.1. Plenary: Branding Distress – “Sixth Vital Sign” in Cancer Care: From Practice to Policy**

Of the 62 survey participants, 50 indicated that they had attended the plenary session by Dr Barry Bultz and only 47 of these participants completed the survey. The survey participants rated the length, relevance, educational and informative value and format of the session. They also rated how important they felt it was to have an international speaker at such meetings. Participants were pleased overall with the length of the session, with 27 (57%) survey participants rating the length of the workshop to be “excellent” or “very good” and a further 17 (36%) rating the length as “satisfactory”. Similarly, 24 (51%) participants rated the format of the plenary session by Dr Bultz to be “excellent” or “very good”, a further 20 (43%) said the format of the plenary session was “satisfactory”.

There was a range of opinions on the relevance of the content and the informative or educational value of the session. When asked to rate the relevance of the session content to a psycho-oncology audience, 30 participants (64%) indicated the content was “very highly” or “highly relevant”, 8 (47%) indicated the content was “moderately” relevant to a psycho-oncology audience and 8 (17%) rated the content as “low” or “very low” relevance to the psycho-oncology audience.

Next, 22 participants (47%) rated the plenary session by Dr Bultz to be of “excellent” or “very good” informational/ educational value, 11 (23%) said the educational value was “satisfactory” and 13 (28%) rated the educational value to be “not very good” or “poor”. An inspection of the participants’ comments for this session accounts for the wide distribution of scores:

“Great topic but it was not pitched at the right level - not a lot of new information”;

“I thought that Dr Bultz did not target his talk to the audience appropriately and probably underestimated the experience and expertise of his audience”;

“Would have liked less focus on Canada (more on Australia or international), more focus on the importance of evidence (i.e. as a back-up for cultural/political change).”

“Great to hear what is happening overseas from such a highly funded centre.”

Opinions were mixed as to the value of international speakers, with the slight majority ( $N = 26$ , 55%) of the survey participants indicating that it was “very important” or “important” to have international speakers at future Professional Days. Eleven (23%) disagreed, expressing that they felt it was “not very” or “not at all important” to have presentations from international speakers at future psycho-oncology meetings.



## 4.2. Research presentations

### 4.2.1. What About Me? CALD and Other Vulnerable Groups

Of the 62 survey participants, 26 participants attended this session. Two of the 26 participants did not complete the survey. Participants indicated high satisfaction with the session, as 23 (99%) of the participants indicated that the session content was “highly” or “very highly” relevant to a psycho-oncology audience and 22 (91%) stated that the session was of “excellent” or “very good” informative/educational value. One participant commented that this was a “fantastic session, (with) very interesting talks (on an) important and neglected issue”. This comment demonstrates that psycho-oncology professionals are aware of the importance of catering to the needs of groups who are notoriously forgotten or neglected in psycho-oncology research. The majority of the survey participants also agreed that the quality of the presentations were “excellent” or “very good” ( $n=21$ , 91%).

### 4.2.2. At the Coalface – Clinical Issues Across the Cancer Journey

Twenty-eight of the 62 survey participants attended this session, 24 of whom completed this section of the survey. Seventeen participants (71%) agreed that the content of this session was “very highly” or “highly” relevant and 18 participants (75%) rated the educational value of this session to be “excellent” or “very good”. Participants were generally pleased with the “...range of research topics” and the “Good variety of interesting presentations” in this session, as noted in their comments.

### 4.2.3. What’s Hot – Emerging Research in Psycho-oncology

Thirty-nine survey participants attended this session, 34 of whom completed this section of the survey. Thirty participants (88%) agreed that the content of this session was “very highly” or “highly” relevant and 29 participants (85%) rated the educational value of this session to be “excellent” or “very good”. Comments for this session were all positive. One comment confirmed the benefits of hosting an additional opportunity for researchers to present their findings:

“I thoroughly enjoyed this session and found it extremely informative and relevant. It was a good opportunity to hear more about some of these projects than otherwise would have been obtained by just seeing them in poster format at the COSA conference and also great to be able to network with people with a similar interest and to make good contacts for future collaborations etc. “

## 4.3. Clinical Workshops

### 4.3.1. Sexuality and Intimacy in Cancer Care: Enhancing Clinical Practice

Fourteen of the 15 survey participants who attended this session completed this section of the survey. Although the majority of the participants were happy with the format of the workshop

(“excellent” or “very good”:  $n=11$ , 79%), half of the participants felt that the length of the workshop was “satisfactory” ( $n=7$ , 50%). The comments for this session reveal that participants felt the workshop “could have been longer”. Participants felt that “There wasn’t enough time to cover all that we & (the workshop facilitators) wanted”. Twelve participants (86%) rated the workshop facilitators as “excellent” or “very good” and 13 of the 14 participants (93%) rated the level of audience engagement in the same high manner. The majority of the participants felt that the session was relevant to a psycho-oncology audience, with 86% rating the workshop as “relevant” or “highly relevant”. Nine participants (64%) rated the informative/educational value of the workshop to be “excellent” or “very good” and four (29%) as “satisfactory”.

The spread of opinions of the informative/educational value of the workshop may be attributed to the differing levels of experience and knowledge the participants had in addressing the issue of sexuality and intimacy in cancer care. Four of the 14 participants (29%) noted that the workshop was not pitched at an appropriate level for their skill base. One of these participants commented:

“I work predominantly in this area and hence felt that this did not extend my knowledge or skills - but I think it would have been perfect for those clinicians who have not had much experience in working with sexuality. It would be very hard to cater for all levels in one workshop.”

Other participants suggested that “perhaps the facilitators could be given some background information on the participants beforehand” and “In future, it would be helpful if it were clearly stated that a workshop is introductory and assumes no prior knowledge.”

#### **4.3.2. Mindfulness in Therapy**

Sixteen participants attended the Mindfulness in Therapy workshop. Judgments on the length of the workshop were mixed, with over a third of the participants noting that the length of the workshop was “satisfactory” ( $n=6$ , 38%). One of the participants noted that: “To be most useful, this workshop needed to be longer.” The majority of the participants indicated that the level of audience engagement in this session was “excellent” or “very good” ( $n=12$ , 75%). The majority of the audience also noted the relevance and educational/ informative value of the workshop was “very good” ( $n=8$ , 50%). Four participants stated that the workshop was not pitched at an appropriate level for their skill base, and one of these participants noted that “...one can only teach the bare basics of mindfulness in a two hour period.”

The general comments about the session reflected the participants’ dissatisfaction with the length of the session, as the two-hour timeslot limited the time spent on practical learning:

“During the session, we had to do the role play pretending that we were talking to the patient. I found that the presenter could have spent more time explaining how it is done rather than making us try without much technical knowledge (I think there was not enough time for her to spend more time). Perhaps the workshop could have been made into two sessions of: 1) theory and 2) practical and

could have made the each session longer because I really liked the workshop itself. Just needed more time.”

#### 4.4. Panel Discussion: Implementation and Outreach

Forty participants attended this session, and two of these participants did not complete the survey. Thirty-two (84%) of the participants “agreed” or “strongly agreed” that the panel experts represented the relevant disciplines in psycho-oncology. Additionally, 31 (82%) “agreed” or “strongly agreed” that the case vignettes represented typical and appropriate issues faced by psycho-oncology professionals. The majority of the participants “agreed” or “strongly agreed” that the discussion encouraged clinician – researcher communication ( $n=22$ , 58%); that the panel gave useful answers to questions ( $n=25$ , 66%) that the discussion was useful ( $n=23$ , 61%) and that they would attend future panel discussions like this ( $n=27$ , 71%).

Opinions on the format and length of this session were mixed, with the majority of responses for both items clustering around “very good” and “satisfactory” (format:  $n=30$ , 79%; length:  $n=29$ , 76%). Some of the comments about this session offered by the participants were:

“I thought that the panel needed to be more structured, they kind of waffled a bit and tended to give more personal opinions than perhaps evidence based practical answers. There was not enough time and the vignette that I was really interested in was missed altogether. I think it is a really good idea and a way to get discussion going however the panel needs to be clear on how much time they have to talk and be considerate of this. I also think that the chair needs to cut people off if they are taking up too much time and they need to bring the discussion back to the topic if/when it gets diverted.”

“Was disappointed that the panel was not more tightly facilitated and time monitored more to allow the input of all panel members - as well as time to cover all vignettes as proposed.”

“I really liked the format of case scenarios - it was a pity that not all of them could have been discussed - maybe longer session was required. Some case vignettes seemed to represent more extreme and controversial but nevertheless important cases in psycho-oncology - but I think that made them interesting to discuss.”

More than half of the participants agreed that the educational/ informative value of the panel discussion was “excellent” or “very good” ( $n=21$ , 55%), 11 participants (29%) rated the panel discussion as of “satisfactory” and six (16%) as “poor” or “very poor” educational/informative value. One participant noted:

“I didn't find much of the discussion personally relevant to my situation but I can imagine other people found it more valuable. I also felt that some of the panel members didn't really answer the questions posed, and instead just presented their own thoughts on the situation generally. I didn't actually think that many solutions to the problems were suggested.”

It appears that the participants believed the session lacked structure, or believed that panel members did not give concise, objective and to-the-point responses to the vignette questions, which restricted the opportunity for discussion between the audience and the panel.

## 5. General Feedback on the Professional Day

General feedback from the 55 participants who completed the questionnaire was positive, with 52 participants noting that the overall idea and purpose of the Professional Day was “excellent” or “very good”. Forty-four participants noted that the program content (i.e. the quality and relevance of the sessions, educational value of the day as a whole, etc) was “excellent” or “very good”, with a further eight participants (15%) giving a “satisfactory” rating. The participants rated the Professional Day positively overall, with 16 (29%) rating it as “excellent”, 32 (58%) as “very good” votes and 4 (7%) as “satisfactory”.

Forty-six participants (84%) noted that it was “very important” or “important” for members to be given the opportunity to present their abstracts outside the COSA ASM. Participants were also in agreement that holding the Professional Day in conjunction with the COSA ASM was an “excellent” or “very good” strategy ( $n=50$ , 91%), their comments also reflected this preference:

“Having this the day before COSA facilitated me attending both events (i.e. wouldn't get separate travel funding if the day was held alone)”

“Yes, it seems to be an easier way for many people logistically (take time off work, travel expenses)- and so it allows more people to attend.”

“I wouldn't fly to a different city for one day, holding it in conjunction with another event makes the trip and gaining the funding worth it.”

One hundred per cent of the participants stated that they would attend a future Professional Day. Seven participants (13%) noted that they would not attend a future Professional Day if they were required to pay a fee, 37 (67%) were prepared to pay up to \$100 and 10 (18%) would pay up to \$200 to attend future such meetings. When asked how often future Professional Days should be held, 49 (89%) participants suggested annually and 6 (11%) suggested biannually. Participants also noted that future workshops could be held in conjunction with other COSA groups, such as Oncology Social Work Australia (OSWA) or Cancer Nurses Society of Australia (CNSA), but highlighted the importance of maintaining the psycho-oncology focus of the day:

“I think a day of clinical training could absolutely include the social workers - sharing is important. I also think that there needs to be more connection between those who are mainly doing research and those who are clinicians for discussion about the realities of implementing research outcomes.”

“... It would also be a shame for the professional day to get too “big”, as by being a relatively smaller group, it was much easier to chat with people after the sessions in the tea breaks and to make good contacts for future collaborations etc. It was also great to spend the day with people with very similar interests, whereas a bigger conference like COSA has such a diverse audience that it is sometimes hard to make good links with people with similar professional interests and roles.”

Forty-three (78%) of the participants rated the program booklet as “excellent” or “very good” and 45 (82%) rated the catering in the top two categories. Forty-seven participants (86%) rated the length of the day as “excellent” or “very good”, a high rating considering that the two workshop sessions and the panel discussion received mostly “satisfactory” votes. This highlights the need for better planning and execution of individual sessions, particularly those involving audience participation.

The session chairs, presenters, panel members and workshop facilitators all agreed that they received adequate information prior to the workshop to prepare for their sessions.

The participants seemed to have gained a lot from the Professional Day, as evidenced by a number of comments:

“I have very much enjoyed this PoCoG/OZPOS initiative and hope that this is just a first of many similar psycho-oncology professional days. I would like to thank and congratulate the organising committee for a very interesting, useful and well organised event.”

“Worth doing, worth repeating. There are few opportunities, especially for clinicians, to meet at a national level”

“A lot of networking opportunities were available via the format of the Prof Day. During COSA, it becomes very busy and less easy to meet those working specifically in psycho-oncology. “

“Perhaps some opportunity to identify researchers in similar area (both content and geographical location) to strengthen, establish networks.”

Evidently, networking opportunities are valued just as highly as learning about the updates and advances in psycho-oncology by both clinicians and researchers.

## 6. Conclusions

The Professional Day was successful in providing a dedicated forum for the excellent psycho-oncology research being conducted in Australia; creating opportunity for clinicians to gain access to innovative research ideas; and providing an opportunity for researchers, especially those junior in their career, to present and receive feedback about their work and establish more formal links with clinicians and researchers.

The survey of the Professional Day participants has provided very positive energy and enthusiasm for this to be a regular collaboration between OZPOS and PoCoG, with a strong interest to include other professional groups of COSA, such as OSWA and CNSA. The survey also provided useful feedback which will inform future planning of these meetings.

## 7. Acknowledgements

The Professional Day was kindly funded by COSA and Cancer Australia. PoCoG and OZPOS would like to thank all of the Professional Day speakers and session chairs for their support in preparing the presentations and workshops, the COSA conference organisers for their assistance with general preparation and registrations for the day, and finally, all of the psycho-oncology professionals who attended and all of those participants who completed the evaluation survey.

## 8. Further inquiries

Further inquiries about the workshop report should be directed to:

PoCoG Executive Office

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## 9. Appendices

### Appendix A:

<b><i>OZPOS and PoCoG Psycho-oncology Professional Day Detailed Program.....</i></b>	<b>15</b>
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### Appendix B:

<b><i>OZPOS and PoCoG Psycho-oncology Professional Day Evaluation Survey Questions .....</i></b>	<b>35</b>
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## Appendix A: Psycho-oncology Professional Day Program

# RESEARCH & CLINICAL SERVICE INTERFACE

OZPOS and PoCoG  
Psycho-oncology Professional Day

16 November 2009

Gold Coast Convention Centre



This Professional Day is jointly funded by:  
COSA and Cancer Australia



# WELCOME

Welcome to the inaugural OZPOS/PoCoG Professional Day – we anticipate that this will be the first of many such successful meetings! The Program aims to be responsive to the needs of our members, with presentations of emerging research, the opportunity to participate in clinically-focused workshops, and contribute to discussion about the very real problems we face in delivery of quality psychosocial care. We hope that this meeting will assist in strengthening existing collaborations and lead to the establishment of new networks. We very much appreciate your feedback to ensure that our Professional Day in 2010 is bigger and even better!



Dr Jane Turner  
Chair, Psychosocial Oncology Group of COSA  
(OZPOS)

Meeting convenors



Prof. Phyllis Butow  
Chair, Psycho-oncology Research Group  
(PoCoG).



## PROGRAM OUTLINE

8.30 to 9.30am

### BRANDING DISTRESS-

#### “6TH VITAL SIGN” IN CANCER CARE: FROM PRACTICE TO POLICY

Dr Barry D. Bultz, PhD, R.Psych, Director, Department of Psychosocial Resources and Program Leader: Psychosocial Oncology, Supportive, Pain and Palliative Care, Tom Baker Cancer Centre, Calgary, Canada.

**Meeting room 9**

9.30-10.00am

Morning tea

10.00am -12.00pm

**What about me? CALD and other vulnerable groups**

Meeting room 9

**At the coalface - clinical issues across the cancer journey**

Meeting room 3

**Sexuality and Intimacy in Cancer Care: Enhancing Clinical Practice**

(workshop)

Meeting room 5

12.00 -12.30pm

Lunch

12.30 - 1.30pm

### Implementation and Outreach Workshop and panel discussion

The aim of this session is to explore practical issues of service delivery with a multidisciplinary group of professionals working in the area of psycho-oncology.

**Meeting room 9**

1.30 - 2.00pm

Afternoon tea

2.00 - 4.00pm

**Mindfulness in Therapy**  
(workshop)

Meeting room 3

**What's hot - emerging research in psycho-oncology**

Meeting room 9

4.00 - 4.30pm

PoCoG Annual General Meeting  
Meeting room 9

4:30 – 5:30pm

### Launch of the Psycho-oncology Outcome Database

(refreshments will be served in the in the foyer outside room 9 afterwards)

**Meeting room 9**

## PROGRAM IN DETAIL

8.30-9.30am

### BRANDING DISTRESS- “6TH VITAL SIGN” IN CANCER CARE: FROM PRACTICE TO POLICY

Room 9

Dr Barry D. Bultz, PhD, R.Psych, Director, Department of Psychosocial Resources and Program Leader: Psychosocial Oncology, Supportive, Pain and Palliative Care, Tom Baker Cancer Centre, Calgary, Canada.

9.30-10.00am

### MORNING TEA\*

10.00am -12.00pm

Room 9

### WHAT ABOUT ME? - CALD AND OTHER VULNERABLE GROUPS

*Chair: Dr Ilona Juraskova*

#### 10:00am Vikki Knott

Exploring community beliefs concerning health and ill health (cancer) among Chinese-Australian immigrants. *abs#01*

#### 10:20am Lynley Aldridge

Unmet needs in Chinese, Greek, and Arabic-speaking cancer patients in New South Wales. *abs#02*

#### 10:40am Phyllis Butow

Oncology consultations with patients from Culturally and Linguistically Diverse Backgrounds - The interpreters' perceptions of roles, challenges, and support needs. *abs#03*

#### 11:00am Eli Ristevski

'Giving patients a voice' or 'opening a can of worms'? Barriers and enablers to supportive care screening. *abs#04*

#### 11:20am Alison Zucca

Travel all over the countryside: Travelling for cancer treatment in NSW and Victoria. *abs#05*

Room 3

### AT THE COALFACE - CLINICAL ISSUES ACROSS THE CANCER JOURNEY

*Chair: Dr Jaklin Elliott*

#### 10:00am Philippa Youl

Psychosocial outcomes of long-term melanoma survivors. *abs#06*

#### 10:20am Monika Janda

The prognostic significance of quality of life following breast cancer. *abs#07*

#### 10:40am Paul Katris

"Factors predicting Treatment-induced nausea and vomiting in Australian Cancer Patients: A prospective longitudinal observational study". *abs#08*

#### 11:00am Belinda Thewes

Fear of Cancer Recurrence; An overview of a research program. *abs#09*

#### 11:20am Vikki Knott

Health professional awareness, attitudes and referral intentions to address patients' supportneeds: Application of the theory of planned behaviour. *abs#10*

Room 5

### WORKSHOP: SEXUALITY AND INTIMACY IN CANCER CARE: ENHANCING CLINICAL PRACTICE \*\*

**Presenters: Dr Katharine Hodgkinson and Dr Jemma Gilchrist**

12.00 - 12.30pm	<b>LUNCH*</b>
12.30 - 1.30pm	<b>IMPLEMENTATION AND OUTREACH</b> <b>Workshop and panel discussion</b>
1.30 - 2.00pm	<b>AFTERNOON TEA*</b>
2.00 - 4.00pm	
<b>Room 9</b>	<b>WHAT'S HOT - EMERGING RESEARCH IN PSYCHO-ONCOLOGY</b> <i>Chair: Dr Laura Kirsten</i>
<b>2:00pm</b>	<b>Anna Hawkes</b> Developing and pilot testing a telephone-delivered lifestyle intervention for colorectal cancer survivors - 'Canchange'. abs#11
<b>2:15pm</b>	<b>Haryana Dhillon</b> Look good feel better: a program evaluation. abs#12
<b>2:30pm</b>	<b>Emilee Gilbert</b> Gender Differences in self-silencing and psychological distress in informal cancer carers. abs#13
<b>2:45pm</b>	<b>Byeongsang Oh</b> Impact of Medical Qigong on quality of life, fatigue, symptoms, mood and inflammation in cancer patient: A randomized controlled trial. abs#14
<b>3:00pm</b>	<b>Jon Emery</b> Improving rural cancer outcomes in WA: The IRCO Project. abs#15
<b>3:15pm</b>	<b>Catherine Adams</b> A novel approach to expanding psycho-oncology support in rural areas of NSW. abs#16
<b>Room 3</b>	<b>WORKSHOP: Mindfulness in Therapy**</b> <b>Presenter: Dr Elizabeth Foley</b>
4.00 - 4.30pm Room 9	<b>POCOG ANNUAL GENERAL MEETING</b>
4:30 - 5:30pm Room 9	<b>LAUNCH OF THE PSYCHO-ONCOLOGY OUTCOME DATABASE</b>

\*All meals will be served in the foyer outside room 9

Delegates who indicated special dietary requirements when registering for the COSA ASM should ask convention centre staff members for assistance

\*\*Limited spaces available - separate worksho registration required



## CASE VIGNETTES FOR PANEL DISCUSSION

### Vignette 1

- Sophie is a 28 year-old psychologist who has recently been appointed to the Division of Oncology at Royal St Elsewhere's Hospital
- Despite her best efforts, she is unable to promptly see all new referrals
- Sophie makes a time to talk with the Director of Oncology about referrals and is distressed when he fails to attend. The next day he indicates that the clinic was over-booked, but does not apologise. When she raises the issue of referrals he clearly states that her job is to see patients who are distressed and it is not his job to be her assistant
- A new Medical Director, Dr Ferguson, has been appointed. This appointment follows a series of medical incidents at Royal St Elsewhere's, which lead to an official enquiry and the resignation of the previous Director
- Dr Ferguson is keen to redress public perception that the hospital is not offering quality care and embarks on an ambitious programme of fund-raising to promote research and purchase of new equipment
- Sophie decides to visit Dr Ferguson to discuss her concerns about referrals. She hopes he may include psychology in his ambitious new plans.
- Dr Ferguson announces during this meeting that he has decided that funding previously used for a part-time psychologist position would be better directed towards having more nurses to deliver chemotherapy, and monitor protocols

#### QUESTIONS

Barry, how might Sophie build an argument for funding for psychology services?

Kim, how might Sophie build a relationship with social work to better meet referral needs and triage psychosocial referrals?

Brian, are there other options available to Sophie in managing her referrals and imminent lack of funding?

David, how might Sophie enlist the aid of external agencies such as Beyond Blue to assist with her situation?

### Vignette 2

- The breast unit at Upsandowns Hospital has offered a comprehensive service for patients with cancer for many years
- The newly-appointed Cancer Care Coordinator, Ken Thurston, is enthusiastic about developing a strategy for screening patients for psychological distress
- Ken discusses the possibility of having patients complete the Distress Thermometer when they attend the outpatient clinic, so that this might be used as a prompt for discussion in the Breast Multidisciplinary Team meeting
- One of the senior surgeons, Dr North, indicates that he does not feel that this is appropriate. Dr North is particularly concerned about issues of privacy and confidentiality and says that hospital staff have no right to discuss personal issues of patients. He also states that he would be very unhappy for patients to receive the results of their screening as "the day we give patients their pathology results prior to their appointment, we can give them these screening results too!"
- The Breast Care Nurse adds that there would be little point in offering screening as they don't have a psychologist to whom they can refer anyway

#### QUESTIONS

Barry, any suggestions for Ken on approaches to introducing screening?

Brian, how might Ken address Dr North's concerns?

Kim, how might social work help meet the needs identified by screening?

David, how might the team be able to utilise resources from Beyond Blue to meet the needs of distressed patients?

### Vignette 3

- Lisa Willis is a 28 year-old woman who had her first baby 8 weeks ago
- She had experienced PR bleeding in late pregnancy and has just been diagnosed with metastatic colo-rectal cancer
- In view of her age and the poor prognosis the medical team request review by the psychologist
- After the interview with the psychologist Lisa is very distressed
- Her husband is furious when he finds out about the referral, insisting that his wife is “sick, not mad”. He says that Lisa was coping well and he does not want anyone upsetting her
- Lisa’s mother, Mrs Downs, is enraged that Lisa has been upset and demands to speak with the Nurse Unit Manager, as she feels that her daughter’s condition has gone downhill since the interview with the psychologist
- Mrs Downs indicates that she is considering approaching the media to highlight a system in which resources are squandered on talking instead of treatment

#### QUESTIONS

Kim, what role might a social worker play in supporting staff and/or patient in this situation?  
David, are there resources available to Lisa, her husband and mother that they may be able to access at home?

Brian, how might this situation been handled differently?

Barry, how might screening have been employed in this case to identify Lisa and her families needs before they met the psychologist?

### Vignette 4

- Melody is a clinical psychologist with 5 years experience, none of which have been in psycho-oncology. She has just been employed to establish a psycho-oncology service in her health service
- The geographical area covered by this health service is about the same size as the UK, services about 200,000 people, has a high indigenous population and people are located in a mix of metropolitan, rural and remote locations
- There is one major cancer centre, where Melody will be located, and a number of smaller rural oncology settings providing outpatient chemotherapy. All radiotherapy is provided in the major cancer centre. Surgical Oncology services are provided in all hospitals in the Health Service
- Melody is charged with identifying psychosocial need in oncology patients across the area and developing ways to meet this need
- The funding for the project has been supplied by Cancer Australia. She has been allocated no funding other than that for her own wage. This funding is guaranteed for the next 12 months but any future funding will be based on the perceived success of the project. This will not be extra funding but will need to be “found” within the Health Services budget

#### QUESTIONS

Barry, having faced this type of situation in Canada, do you have any advice for Melody?

Kim, who does Melody need to establish relationships for her project to work?

Brian, from your experience in Australia how might Melody set about making sure she can prove whether her project has been successful?

David, how can Melody tap into external?

# ABSTRACTS

## Plenary Session

### *BRANDING DISTRESS-AS THE 6TH VITAL SIGN IN CANCER CARE: FROM PRACTICE TO POLICY*

Barry D. Bultz

In the development of specialized cancer services, the field of psychosocial oncology is one of the newest cancer programs to be implemented in the care of the patient.

It is well established that a diagnosis, the lengthy and often aversive treatment typical of cancer care, as well as the chronic feeling of uncertainty associated with cancer leads to significant distress in 35-45% of the cancer patient population.

**Methods:** In this presentation, the challenges associated with cancer, along with the importance of routine screening and treatment of distress will be discussed. Additionally, a program of Screening for Distress (supported by the Canadian Partnership Against Cancer), and the implementation plan for routine screening will be shared.

**Results:** Screening can be defined as the pro-active rapid identification of key indicators that allow for further assessment and appropriate referral and seeks to connect patients with the right resource at the right time. Screening is about more than emotional distress and should involve screening for psychosocial, practical, and physical concerns. Patients should be screened routinely, including at point of entry and at critical time points.

**Conclusions:** Given the prevalence of distress, cancer patients should be screened routinely for distress, the 6th Vital Sign. Screening provides patients with the opportunity to identify their concerns and opens the

door to a conversation between the patient and their health care team. Collaboration with national and international groups will further our knowledge about best practices for Screening for Distress.

## 01

### *EXPLORING COMMUNITY BELIEFS CONCERNING HEALTH AND ILL HEALTH (CANCER) AMONG CHINESE-AUSTRALIAN IMMIGRANTS*

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D. Turnbull<sup>1</sup>

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Studies with ethnic minority communities have shown that cultural beliefs can impact on health behaviours across the cancer pathway, including the uptake of screening<sup>1,2</sup>, and compliance with medical treatment<sup>3,4</sup>. This study aimed to explore beliefs about health and illness among Chinese-Australian immigrants using a framework adapted from Medical Anthropology<sup>5</sup>. Participants were recruited purposively to achieve maximum variation with respect to specific parameters including: age, length of stay since migration, acculturation level, education level and occupation. Eighteen Chinese-Australians, aged 21 to 83 years were interviewed in their preferred language (e.g., Mandarin, Cantonese) using items derived from the Explanatory Model Interview Catalogue<sup>6</sup>. Data were transcribed and analysed using thematic analysis<sup>7</sup>. Themes identified included i) perceived causes of cancer ii) cancer prevention iii) nature of symptoms iv) treatment preferences. Different causes of cancer were described, including genetics, environmental pollutants,

stress, and folk causes, such as fate, excess hot energy and general imbalance in the body. Some participants referred to cancer as an incurable disease. Cultural concepts stemming from knowledge about Traditional Chinese Medicine and Taoist philosophies were influential in participants' understanding of cancer. They reported using an array of methods to prevent cancer, including practicing Tai Chi and having a balanced diet. Some participants admitted not attending cancer screening because they did not feel abnormal, or were skeptical towards the reliability of screening. A contradiction in philosophy underpinning western and eastern treatments appeared to result in a skepticism towards western approaches to treatment: Western treatments were perceived as being too invasive or simply "did not get to the origin of cancer". Cultural beliefs concerning cancer are pervasive and are likely to have a significant impact on an individual's receptiveness towards cancer prevention and treatment. Thus, a one-size-fits-all approach to cancer control may not be adequate when attempting to improve health outcomes across all cultural groups in Australia.

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## 02

### UNMET NEEDS IN CHINESE, GREEK, AND ARABIC-SPEAKING CANCER PATIENTS IN NEW SOUTH WALES

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**Background:** Very little is known about the experiences of culturally and linguistically diverse (CALD) cancer patients in Australia. Our group is conducting a population-based study of Chinese, Greek, Arabic and English-speaking cancer patients to: 1) develop and validate culturally appropriate measures; and 2) explore psychological distress, unmet needs, quality of life, and patterns of care in these groups.

**Method:** This paper presents preliminary data for 70+ patients

recruited through the New South Wales Central Cancer Registry. Participants were born in a country where Chinese, Greek, or Arabic is spoken, and diagnosed with cancer between 2004-2007. Questionnaires (completed in their preferred language) included the HADS and FACT, a patterns of care section, and unmet needs items from the SCNS and CaSUN, along with culturally specific items of unmet need identified in an earlier qualitative phase of our research.

**Results:** Despite relatively high self-reported English proficiency and familiarity with the Australian health system, many participants experienced elevated levels of distress, and compromised quality of life. Over 30% experienced elevated levels of anxiety, and over 20% experienced elevated levels of depression, compared to 21% and 11% of a population-based sample of Australian cancer survivors[1]. Many experienced areas of unmet need, particularly in the cultural and sexual domains. Overall, approximately half of participants reported at least one moderate- or high- level unmet need. Highest ranked needs were for help managing concerns about cancer returning (23%), information about cancer and its treatment (21%), and guidance navigating the health system (20%).

**Conclusions:** This is the first study to explore some of the specific difficulties experienced by CALD cancer patients in a large, population-based sample. Results highlight areas of unmet need which might be better addressed by the health system, and strategies for intervening to better meet these needs will be discussed.

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## 03

### ONCOLOGY CONSULTATIONS WITH PATIENTS FROM CULTURALLY AND LINGUISTICALLY DIVERSE BACKGROUNDS - THE INTERPRETERS' PERCEPTIONS OF ROLES, CHALLENGES, AND SUPPORT NEEDS

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**Introduction:** An increasing proportion of people affected by cancer in Australia are from culturally and linguistically diverse (CALD) backgrounds. In our research into unmet needs in CALD cancer patients, interpreter accuracy, professionalism, and continuity emerged as key concerns. Our audiotape research into health communication shows that interpreters play an essential role in cross-cultural communication about cancer. Studies thus far have focused on interpreter accuracy, little is known about the interpreter's own perspective on such consultations.

**Methods:** 30 professional



interpreters (Greek n=7, Chinese n=11, and Arabic n=12) were recruited through 3 organisations providing health care interpreting in NSW and VIC. Participants took part in focus groups which were audio-taped, transcribed, and analysed for themes using N-Vivo software.

**Results:** Participants identified issues which fell within three themes. First, interpreter perceptions of their role and responsibilities: some saw themselves as merely a conduit of information, while others saw their role in broader terms, encompassing cultural brokerage, patient advocacy and provision of emotional support. Second, challenges experienced by interpreters: these included the constraints of time, telephone interpreting, the emotional content of the “bad news” consultation, family members undertaking interpreting for the patients, interpreting for large groups at family meetings and cultural sensitivities around the language used by clinicians. Third, need for training and support in areas such as medical terminology, field placements, communication skills, and debriefing.

**Discussion:** Cross-cultural communication about cancer is challenging. This study documented potential conflicts in the role of the interpreter between information provision and advocacy. It also highlighted training and support needs of interpreters, which would assist interpreters to better manage the professional, cultural and psychological demands of their role. Most importantly, findings inform clinicians about how to best collaborate with interpreters to enable culturally competent communication. Recommendations for consultations with interpreters will be presented.

## 04

‘Giving patients a voice’ or ‘opening a can of worms’? Barriers and enablers to supportive care screening

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Current research indicates that routine screening for supportive care needs combined with evidence-based referrals results in improvements in patient distress, quality of life, communication with the health care team and compliance with cancer treatments. While the need for routine supportive care screening is acknowledged, implementation into clinical practice remains challenging.

This study examined patient and clinician perspectives of incorporating supportive care screening into routine clinical care. A convenience sample of 154 cancer patients and 36 cancer clinicians from 10 treatment areas across two rural/regional areas of Victoria participated. Clinicians were trained in the principles of supportive care, and use of the screening tool (Distress Thermometer and Problem List) and evidence-based action and referral protocols. Patients undertook screening during treatment, followed by a screening discussion with the clinician. Data was collected using structured questionnaires and interviews.

Patients and clinicians found the screening process to be highly acceptable and identified a number of benefits. Both groups reported the identification of relevant (90%) and important issues (100%). Clinicians reported the prompt identification of patient problems (91%) and new issues (83%). Thematic analysis of clinician interviews found the screening discussion

initiated, enhanced and focussed communication, encouraged discussion about sensitive issues, and built rapport. While 90% of patients indicated they would repeat screening in future care, 36% of clinicians said it did not fit in with routine care and 30% were hesitant about continued use. Key barriers identified by clinicians included the practical issues of time and workload. Clinicians were confident in dealing with physical problems; however emotional needs were a challenge to their scope of practice.

This study confirms the importance of providing health professionals with the necessary knowledge, tools and practical skills as a foundation for evidence-based practice. Recognising the benefits and overcoming challenges is essential to implementation.

## 05

TRAVEL ALL OVER THE COUNTRYSIDE: TRAVELLING FOR CANCER TREATMENT IN NSW AND VICTORIA

A. C. Zucca<sup>1,2,3</sup>, A. W. Boyes<sup>1,2,3</sup>, A. Girgis<sup>1,2,3</sup>, A. E. Hall<sup>1,2,3</sup>

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**Background:** Travelling for cancer treatment is an additional burden on patients during an already difficult time. This presentation will describe the travel burden experienced by Australian cancer survivors over the first year after diagnosis.

**Methods:** A population-based longitudinal cohort of 1,453 recent cancer survivors of the eight most incident cancer sites were recruited from the NSW Central Cancer Registry and the Victorian Cancer Registry.

Participants completed a self-report survey that assessed travel time, living away from home for cancer treatment, travel-related treatment decisions and patient, disease and treatment-type characteristics. Results from the first two waves of data collection at six months and twelve months post-diagnosis are presented.

**Results:** During the first 12 months after diagnosis, 10% of participants had to temporarily live away from home in another town or city to receive cancer treatment. The vast majority of those who lived away from home did so to receive radiotherapy, followed by surgery and chemotherapy. Overall, 15% of participants who received radiotherapy had to travel more than two hours (one way) from their usual home address, and 9% of participants who received surgery had to travel more than two hours one way. Alarming, 5% of participants chose to not have a particular cancer treatment because of the time it would take to get to treatment. Data will be presented on the characteristics of survivors who 1) lived away from home for treatment, and 2) chose not to have a particular treatment. Unmet needs for access to monetary allowance for travel will also be presented.

**Discussion:** In addition to practical hardship, travelling for treatment is a barrier to receiving recommended lifesaving treatments, particularly radiotherapy. The impact of travel on compliance with treatment regimes may be a contributing factor to the poorer survival rates of those living in rural and regional areas.

## 06

### PSYCHOSOCIAL OUTCOMES OF LONG-TERM MELANOMA SURVIVORS

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**Background:** While melanoma is one of the most common invasive cancers in Australia, surprisingly little is known about the psychosocial outcomes of melanoma survivors.

**Aim:** The broad aim of this study is to identify psychosocial and clinical supportive care needs of long-term melanoma survivors up to nine years post diagnosis.

**Methods:** Participants consisted of a cohort of melanoma patients ascertained from a recently completed population-based study. Quality of life (SF-36®, Skin Cancer Index), anxiety and depression (BSI® 18), and post traumatic stress (Impact of Events Scale) measures were used to identify long term psychosocial effects of melanoma.

**Results:** A total of 2,516 (response rate=74.9%) self-administered questionnaires were received. Overall, approximately one-fifth (20.9%) indicated they were worried their melanoma would progress. Just over half (55.3%) of female participants were very concerned about disease progression compared to 44.7% of men ( $p < 0.001$ ). Moderate or higher levels of concern about disease progression was significantly associated with increasing thickness of original melanoma ( $p < 0.001$ ), but did not vary significantly with increasing years since diagnosis. Compared to men, women were significantly more likely to indicate they were worried that family members may develop melanoma (40.7% and 59.3% respectively) ( $p < 0.001$ ). Participants with earlier stage melanoma tended to indicate they thought the melanoma diagnosis wasn't real or they tried not to think about it compared to those with later stage disease ( $p=0.03$  and  $p=0.05$  respectively), again independent of number of years since diagnosis. Over half the participants (59.2%) were

moderately or highly concerned they would develop an additional melanoma. Multivariate analysis of predictors of psychosocial outcomes will be presented.

**Conclusions:** An understanding of psychosocial outcomes will assist in informing the development of supportive care programs to address the needs of long-term melanoma survivors and their families.

## 07

### THE PROGNOSTIC SIGNIFICANCE OF QUALITY OF LIFE FOLLOWING BREAST CANCER

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**Introduction:** Evidence suggests a positive association between quality of life (QOL) and overall survival (OS) among metastatic breast cancer (BC) patients, although the relationship in early-stage BC is unclear. This work examines the association between QOL and OS following a diagnosis of early-stage BC.

**Methods:** A population-based sample of Queensland women ( $n=287$ ) with early-stage, invasive, unilateral BC, were prospectively observed for a median of 6.6 years. QOL was assessed at six and 18 months post-diagnosis using the Functional Assessment of Cancer Therapy, Breast (FACT-B+4) questionnaire. Raw scores for the FACT-B+4 scales were computed and individuals were categorised according to whether QOL declined, remained stable or improved over time. OS was measured from the date of diagnosis to the date of death or was censored at the date of last follow-up. Risk ratios (RR) and 95% confidence intervals (CI) for the association between QOL and OS were obtained using Cox proportional hazards survival

models adjusted for confounding characteristics.

**Results:** A total of 27 (9.4%) women died during the follow-up period. Three baseline QOL scales (emotional, general and overall QOL) were significantly associated with OS, with RRs ranging between 0.89 (95% CI: 0.81, 0.98;  $P=0.01$ ) and 0.98 (95% CI: 0.96, 0.99;  $P=0.03$ ), indicating a 2%-11% reduced risk of death for every one unit increase in QOL. When QOL was categorised according to changes between six and 18 months post-diagnosis, analyses showed that for those who experienced declines in functional and physical QOL, risk of death increased by two- (95% CI: 1.43, 12.52;  $P<0.01$ ) and four-fold (95% CI: 1.15, 7.19;  $P=0.02$ ), respectively.

**Conclusions:** This work indicates that specific QOL scales at six months post-diagnosis, and changes in certain QOL scales over the subsequent 12-month period (as measured by the FACT-B+4), are associated with overall survival in women with early-stage breast cancer.

## 08

### "FACTORS PREDICTING TREATMENT-INDUCED NAUSEA AND VOMITING IN AUSTRALIAN CANCER PATIENTS: A PROSPECTIVE LONGITUDINAL OBSERVATIONAL STUDY".

C. Pirri<sup>1</sup>, P. Katris<sup>2</sup>, J. Trotter<sup>3</sup>, E. Bayliss<sup>3</sup>, R. Bennett<sup>1</sup>, P. Drummond<sup>1</sup>

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**Purpose:** Despite significant advances in antiemetic management, almost 50% of cancer patients still experience nausea and vomiting during treatment. The goal of antiemetic therapy is complete prevention of treatment-induced nausea and/

or vomiting (TINV). However, realisation of this goal remains elusive, thus supplementary strategies identifying patients at high risk must be employed in the interim. Consequently, we examined TINV incidence and its risk factors, including patient, clinical and pre-treatment quality of life (QOL) / psychological factors.

**Methods:** 200 newly-diagnosed cancer patients beginning combined treatment participated in this prospective, longitudinal, observational study. QOL (including TINV), psychological adjustment, and patient/clinical characteristics were examined at pre-treatment, on-treatment (8 weeks) and post-treatment.

**Results:** Overall, 62% of patients experienced TINV, with TIN incidence (60%) doubling that of TIV (27%). Patients with TINV experienced significantly greater impairment in QOL (physical, emotional and social functioning; fatigue; global physical health) and psychosocial adjustment (anxiety, depression) throughout treatment or part thereof ( $.001 < p \leq .034$ ), while those unaffected experienced significantly better QOL (social functioning, global QOL) in the early stages of treatment ( $.031 \leq p \leq .05$ ). Eight independent risk factors predicted 73% of TIN incidence: high premorbid/anticipatory NV, moderately/highly emetogenic chemotherapy (M/HEC), longer treatment ( $> 3$  months), female gender, surgery prior to chemoradiation, private health insurance and low emotional functioning (pretreatment). Six independent risk factors predicted 77% of TIV incidence: premorbid/anticipatory vomiting, M/HEC, female gender, cancer resection and low role functioning (pretreatment).

**Conclusions:** TINV still represents a very major concern for patients. Several pretreatment risk factors for the development of TIN and TIV, respectively, were identified.

Patients about to undergo cancer treatment, particularly combined treatment involving emetogenic chemotherapy and surgery, should be screened for these factors with a view to modifying standard pretreatment/maintenance antiemetic therapy. Furthermore, and consistent with recent research, it is recommended that additional interventions combining antiemetics with other effective pharmacological (e.g. anxiolytics) and non-pharmacological approaches (e.g. progressive muscle relaxation, acupuncture) should be considered by clinicians in attempts to improve control of both TIN and TIV for their patients.

## 09

### FEAR OF RECURRENCE IN YOUNG WOMEN

Belinda Thewes<sup>1</sup>, Phyllis Butow<sup>1</sup>, Eugenie Batterby<sup>1</sup>, Jane Beith<sup>2</sup>, Susan Pendlebury<sup>3</sup>, Michael Cavanagh<sup>4</sup>, Maree Abbott<sup>4</sup>, Felicity Brazel<sup>5</sup>

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**Background:** Fear of cancer recurrence (FCR) is one of the greatest areas of unmet need for help amongst cancer survivors, and about 40% of cancer survivors report clinical levels of FCR. Younger patients are particularly vulnerable to experiencing FCR. An overview of our current research into FCR will be presented including the preliminary findings of a descriptive studies exploring FCR in young women with a history of early breast cancer. This study reports the prevalence of FCR in early-stage breast cancer survivors, aged 45 years or less



at diagnosis, and describes the clinical, demographic and behavioural factors associated with high levels of FCR in this group.

**Methods:** Data on FCR in young breast cancer survivors was collected in a cross-sectional web-based self-report survey of 81 early stage breast cancer survivors, aged 45 years or less at diagnosis at least one year prior.

**Results:** 69% of younger breast cancer survivors reported clinical levels of FCR. FCR in young women was associated with younger age at diagnosis ( $r=-0.48$ ,  $p<0.001$ ), having locally advanced disease ( $t=-2.5$ ,  $p=0.01$ ), over estimation of risk of recurrence ( $F=6.65$ ,  $p<0.01$ ), frequency of breast self examination ( $F=7.81$ ;  $p=0.001$ ), unplanned medical appointments ( $t=-2.07$ ,  $p<0.05$ ;  $t=-2.8$ ,  $p<0.01$ ), and symptoms of depression and anxiety ( $r=0.56$ ,  $p<0.001$ ).

**Conclusions:** FCR is an important survivorship issue which has significant implications for well-being following cancer treatment. The results of these studies will be used to guide the development of psychological and educational interventions for cancer patients who experience high levels of FCR.

## 10

### HEALTH PROFESSIONAL AWARENESS, ATTITUDES AND REFERRAL INTENTIONS TO ADDRESS PATIENTS' SUPPORT NEEDS: APPLICATION OF THE THEORY OF PLANNED BEHAVIOUR

K. Kam<sup>1</sup>, V. Knott<sup>2</sup>, A. Hine<sup>3</sup>, S. Chambers<sup>4</sup>

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<sup>2</sup>Cancer Support, Cancer Council, SA, Adelaide, Australia, <sup>3</sup>General Practice Network South, Inc, Adelaide, SA, Australia, <sup>4</sup>Research, Cancer Council, Qld, Brisbane, QLD, Australia

**Aim:** The provision of "supportive care" to address the informational, physical, practical, psychosocial and spiritual needs is identified as best practice when providing quality cancer care<sup>1</sup>. However, despite the existence of supportive services, these services are underutilised<sup>2</sup>. Previous research has focussed on identifying patient level factors in predicting patient use of support services, using the Theory of Planned Behaviour<sup>3</sup>. Incorporating the TPB<sup>4</sup>, the study aimed to assess oncology professionals' awareness and attitudes towards supportive care needs along with attitudes towards referral of cancer patients to existing community support services. **Methods:** An exploratory cross-sectional survey of 52 oncology professionals including nurses (71.1%), medical practitioners (21.4%) and allied health professionals (9.6%) from various South Australian health institutions assessed for past referral patterns, perceived attitudes of peers, barriers, and attitudes toward referral. **Results:** Referral to support services such as helpline, allied health or complementary services is uncommon. A hierarchical regression entering the TPB variables (past referral, attitude towards referral, perceived norm, and control) explained 44% of the variance on the outcome "intention to refer", with attitude ( $\beta = 0.44$ ;  $p = .001$ ) and perceived attitudes of peers ( $\beta = 0.32$ ;  $p = .012$ ) being the most important predictors. Barriers to referral for support include: lack of local services for remote patients, and financial considerations. **Conclusion:** Interventions with health professionals should focus on the development of a culture which recognises the importance of addressing a breadth of patient needs across the cancer journey. In addition, innovative approaches to meet the needs of rural and remote patients should be a priority for future research and action.

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## 11

### DEVELOPING AND PILOT TESTING A TELEPHONE-DELIVERED LIFESTYLE INTERVENTION FOR COLORECTAL CANCER SURVIVORS - 'CANCHANGE'

A. L. Hawkes<sup>1</sup>, S. Gollschewski<sup>1</sup>, B. M. Lynch<sup>2</sup>, S. K. Chambers<sup>1</sup>

<sup>1</sup>Viertel Centre for Research in Cancer Control, Cancer Council Queensland, Spring Hill, QLD, Australia, <sup>2</sup>Cancer Prevention Research Centre, The University of Queensland, Brisbane, QLD, Australia

**Introduction:** An ageing population, growing incidence of some cancers and improvements in early detection/treatment has seen an increase in cancer survivors. Approximately 60% of people with colorectal cancer (CRC) are surviving. However, up to 40% of CRC survivors experience ongoing distress and a significant proportion have poor lifestyle behaviours (physical activity, nutrition, weight-management, smoking), which impacts on quality of life (QoL), disease recurrence, other chronic diseases such as cardiovascular disease, and potentially survival. For the first time, we developed and pilot-tested a theory-based intervention focusing on lifestyle

factors, psychosocial support and symptom management to improve lifestyle behaviours and QoL for CRC survivors.

**Methods:** We investigated the acceptability and short-term effectiveness of the intervention with  $n=20$  recently diagnosed CRC survivors recruited from Brisbane practices. Participants received 6 x weekly telephone sessions with a qualified health professional ('Health Coach'). Program acceptability, CRC-specific symptoms, QoL (FACT-C), and lifestyle factors [physical activity (Active Australia Survey), diet (fruit and vegetables, red and processed meat intake), alcohol intake, smoking, and body mass index] were recorded at baseline and post-intervention (6 weeks follow-up).

**Results:** The majority said the intervention was 'excellent' (76%), helped them address their current issues (80%), and would recommend it to others (100%). From baseline to post-intervention we observed: non-significant improvements in CRC-specific symptoms and QoL; a significant decrease in processed meat intake [median (IQR) 1.0(3.0) vs 0.0(1.0),  $p=0.01$ ]; and non-significant improvements in sedentary behaviour, and the proportion of participants meeting the guidelines for fruit/vegetable intake. There was no change in smoking status, while the results for alcohol intake, physical activity and body mass index were variable.

**Conclusions:** The intervention was highly acceptable to CRC survivors and had some benefit on health outcomes. A large-scale randomised controlled trial ( $n=350$ ) has commenced and will be detailed in the presentation.

M. A. Price<sup>1,3</sup>

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**Aim:** To evaluate the impact of the Look Good Feel Better Program (LGFB) on the self-consciousness of appearance of people with cancer who attend a LGFB workshop. **Methods:** This was a prospective cohort study, with consenting participants completing a questionnaire before, and 1-, and 3-months after attending a workshop. The primary outcome is change in self-consciousness of appearance measured by the Derriford Appearance Scale (DAS24). This abstract reports preliminary results of the first 70 respondents. **Results:** Of 619 participants invited to take part in the study, 267 (43%) consented. Of the first 70 participants all were English-speaking females, 80% were partnered, 40% worked outside the home, 37% were retired, with a mean age of 57 years (range 33 — 81). 63% of participants had breast cancer and 87% were within a year of initial cancer diagnosis. 53 participants were receiving chemotherapy at the time of study entry, at first follow-up 81% reported not knowing of any change in their cancer status, and 61% no change in their anticancer treatment. 73% reported concerns regarding their appearance, most commonly changes in hair, breast, or weight. There were no significant changes in self-consciousness of appearance, quality of life, anxiety, depression, stress, or adjustment to illness between the pre- and 1-month post-workshop responses. 95% of participants agreed they found the workshop enjoyable and helpful, 94% found it practical. 83% strongly disagreed that the workshop was irrelevant and 21%

reported finding it confronting. **Conclusions:** The LGFB program is enjoyable, helpful and practical to participating women diagnosed with cancer. Significant changes in self-confidence of appearance and other psychosocial outcomes are not apparent in this preliminary sample.

## 13

### GENDER DIFFERENCES IN SELF-SILENCING AND PSYCHOLOGICAL DISTRESS IN INFORMAL CANCER CARERS

E. Gilbert<sup>1</sup>, J. M. Ussher<sup>1</sup>, J. Perz<sup>1</sup>, P. Butow<sup>2</sup>, G. Wain<sup>3</sup>, C. L. Joyce<sup>1</sup>

<sup>1</sup>School of Psychology, University of Western Sydney, Penrith South DC, NSW, Australia, <sup>2</sup>School of Psychology, The University of Sydney, Sydney, NSW, Australia, <sup>3</sup>Department of Gynaecological Oncology, Westmead Hospital, Wentworthville, NSW, Australia

It is now widely recognised that cancer is a relational experience, with the pattern of communication adopted by couples directly influencing coping and psychological well-being. Couples who are mutually responsive, attend to each others needs, and talk openly about their stress, have been reported to be able to engage in effective emotion and problem focused coping. Conversely, many partners are over-protective towards the person with cancer, engaging in "protective buffering" in an attempt to prevent distress, or "disengaged avoidance", involving complete denial of cancer or its effects. This is analogous to the pattern of self-silencing initially identified by Dana Jack (1991) as an explanation for women's greater susceptibility to depression. Self-silencing is characterized as the propensity to engage in compulsive caretaking, pleasing the other, and inhibition of self-expression in relationships, in an attempt to achieve intimacy and meet relational needs. This study examined gender differences in self-silencing,

## 12

### LOOK GOOD FEEL BETTER: A PROGRAM EVALUATION

H. M. Dhillon<sup>1</sup>, H. L. Shepherd<sup>1,2</sup>,

the relationship between self-silencing and psychological distress, and reasons for self-silencing, in 484 informal cancer carers (329 women & 155 men), using a mixed method design. Men reported greater self-silencing than women, however, women reported higher depression and anxiety, even though depression and anxiety were significantly correlated with self-silencing. This reflects gender differences in patterns of self-silencing, explored in interviews with 53 cancer carers. Both men and women reported self-silencing of their concerns in relation to the person with cancer, because of a desire to prioritise patient needs, or to protect them from conflict. Women positioned self-silencing as a requisite for coping, demonstrating awareness of external judgement, whilst men positioned self-silencing as a normal aspect of masculine behaviour. These findings demonstrate the utility of self-silencing theory for understanding gender differences in cancer carer distress, and provide insight into reasons why self-silencing occurs in women and men.

## 14

### IMPACT OF MEDICAL QIGONG ON QUALITY OF LIFE, FATIGUE, SYMPTOMS, MOOD AND INFLAMMATION IN CANCER PATIENT: A RANDOMIZED CONTROLLED TRIAL

B. Oh<sup>1</sup>, P. N. Butow<sup>2</sup>, S. J. Clarke<sup>3</sup>, P. J. Beale<sup>4</sup>, N. Pavlakis<sup>5</sup>

<sup>1</sup>Sydney Cancer Centre, Royal Prince Alfred Hospital, Camperdown, NSW, Australia, <sup>2</sup>Center for Medical Psychology & Evidence-based Decision Making, University of Sydney, Sydney, NSW, Australia, <sup>3</sup>Medicine, University of Sydney, Sydney, NSW, Australia, <sup>4</sup>Sydney Cancer Centre, Concord Hospital, Sydney, NSW, Australia, <sup>5</sup>Dept. of Oncology, Royal North Shore Hospital, Sydney, NSW, Australia

**Background:** Substantial numbers of cancer patients use complementary therapies (CM), even without a supportive

evidence base. This study aimed to evaluate in a randomised controlled trial, the use of Medical Qigong (MQ) compared to usual care, to improve the quality of life (QOL) of cancer patients.

**Methods:** One hundred sixty two patients with a range of cancers were recruited. QOL and fatigue were measured by FACT-G, and FACT-F, respectively, and mood status by POMS. The inflammatory marker serum C-reactive protein (CRP) was monitored serially.

**Results:** Regression analysis indicated that the MQ group significantly improved overall QOL ( $t_{144} = -5.761$ ,  $p < 0.001$ ), fatigue ( $t_{153} = -5.621$ ,  $p < 0.001$ ), mood disturbance ( $t_{122} = 2.346$ ,  $p = 0.021$ ) and inflammation (CRP) ( $t_{99} = 2.042$ ,  $p < 0.044$ ) compared to usual care after controlling for baseline variables. Analysis of the FACT-G subscales revealed that the MQ group significantly improved satisfaction with sex life ( $t_{92} = -3.783$ ,  $p < 0.001$ ), side effects of nausea ( $t_{152} = -2.071$ ,  $p = 0.040$ ) and sleep disturbance ( $t_{150} = -2.603$ ,  $p = 0.010$ ) compared to the usual care group.

**Conclusion:** This study suggests that MQ can improve cancer patients' overall QOL and mood status and reduce specific side effects of treatment. It may also produce physical benefits in the long term through reduced inflammation.

## 15

### IMPROVING RURAL CANCER OUTCOMES IN WA: THE IRCO PROJECT

J. Emery<sup>1</sup>, D. Holman<sup>1</sup>, C. Saunders<sup>1</sup>, F. Walter<sup>2</sup>, L. Fritschi<sup>1</sup>, K. Aret<sup>1</sup>, A. Nowak<sup>1</sup>, L. Monterosso<sup>3</sup>, D. Preen<sup>1</sup>, R. Moorin<sup>1</sup>, L. Vaz<sup>1</sup>, P. Booth<sup>4</sup>, M. Mears<sup>1</sup>, C. Jefferies-Stokes<sup>1</sup>, A. Kirke<sup>1</sup>, C. Willix<sup>1</sup>

<sup>1</sup>University of Western Australia, Crawley, WA, Australia, <sup>2</sup>Cambridge University, Cambridge, United Kingdom, <sup>3</sup>Curtin University, Bentley, WA, Australia,

<sup>4</sup>Cancer Voices WA, Perth, WA, Australia

**Background:** Several studies have demonstrated that rural cancer patients in Australia have poorer outcomes. However, many of these studies have relied on administrative datasets which do not provide sufficient detail to identify critical factors underlying poorer outcomes.

**Methods:** We are applying two theoretical models to inform the development of a multi-level intervention to improve rural cancer outcomes in Western Australia:

a. A model of total patient delay. This builds on previous models that break down the patient journey from development of initial symptoms, through symptom appraisal and presentation to a healthcare professional, to diagnosis in primary and secondary care and final treatment. We are using calendar landmarking techniques and in-depth interviews to measure and explore patient symptom appraisal and their decisions regarding treatment type and location. Medical notes audits in primary and secondary care will further assess time to diagnosis and treatments received, comparing them against national and international standards.

b. The development and evaluation of complex interventions in healthcare. This framework will inform the development of the multi-level intervention and future design of a cluster randomised controlled in rural WA.

**Results:** We will present data from the first 30 participants. Early qualitative analyses suggest the following themes that contribute to delayed presentation to healthcare in rural patients: optimistic symptom attribution; incorrect beliefs about symptom severity with cancer; misinterpretation of symptoms due to co-morbidities; rural stoicism; requirement for



greater symptom severity before presenting due to GP workforce shortages. Additional quantitative data on total patient delay will be presented.

**Conclusions:** this study will inform strategies to improve outcomes for rural cancer patients.

## 16

### A NOVEL APPROACH TO EXPANDING PSYCHO-ONCOLOGY SUPPORT IN RURAL AREAS OF NSW

C. Adams<sup>1,2,4</sup>, L. Gianacas<sup>2</sup>, W. Levick<sup>3,4</sup>

<sup>1</sup>The Breast Centre, Gateshead, NSW, Australia, <sup>2</sup>Psycho-Oncology Service, Calvary Mater Newcastle, Newcastle, NSW, Australia, <sup>3</sup>Psychology, Hunter New England Area Health Service, Newcastle, NSW, Australia, <sup>4</sup>Psychology, University of Newcastle, Newcastle, NSW, Australia

**Background:** There is a recognised need to provide timely and appropriate psychosocial support to rural cancer patients and their families. However, the lack of resources in rural areas means the need for support by far outweighs the services available, particularly psychological support. In addition to this, anecdotal evidence suggests that even experienced psychologists are uncomfortable seeing cancer patients. Thus, the ability to access support services is reduced even further. This project provided basic psycho-oncology training to experienced psychologists working in rural areas of the Hunter New England Area Health Service in NSW.

**Method:** The project 1. Identified rural psychologists, both in public and private practice, and assessed levels of knowledge, education and need in relation to psycho-oncology, 2. Developed and implemented a training package based on this assessment, 3. Developed a referral pathway for rural cancer patients, eventually to be linked to QUICATOUCH psychosocial

screening.

**Results:** Of the 76 psychologists identified, 31 attended training. The training was evaluated at the end of each session and at 3 and 12 months post training. All participants reported an increased knowledge about working with cancer patients. The training reduced fears about working with cancer patients with 22 participants agreeing to participate in the referral pathway. The 9 psychologists who refused to be part of the pathway did so because it was not possible in their current role. Referral trends along the newly established pathway were monitored.

**Conclusions:** This project has demonstrated that timely and cost effective

training in psycho-oncology can be provided to experienced, rural based psychologists. Increased confidence in working with cancer patients and their families significantly increased the availability of psychological support for these people in rural NSW. This simple model has the potential to be modified to reflect local services and implemented in all rural areas of Australia.

## Workshop Abstracts

### SEXUALITY AND INTIMACY IN CANCER CARE: ENHANCING CLINICAL PRACTICE

K. Hodgkinson, J. Gilchrist

This workshop will review the impact of cancer on intimacy and sexuality, and identify the common barriers that both clients and clinicians demonstrate when addressing intimacy and sexuality. The workshop will aim to improve clinical practice by developing strategies to recognize and overcome those barriers to intervention. Participants will also refine their existing skills for assessing concerns, and generating comprehensive intervention strategies for dealing with common sexual concerns in cancer care. Case examples will be used to illustrate a breadth of intervention approaches and to provide opportunity for discussion and collaboration in clinical problem solving.

### MINDFULNESS IN THERAPY

E. Foley

This interactive workshop aims to facilitate an understanding of mindfulness and how this approach might assist clinicians in working with cancer patients and carers. Participants are encouraged to step out of habitual patterns of judgment and rumination as they fully engage with their experience as it unfolds. Mindfulness may support coping throughout the cancer journey by giving individuals tools for interacting with their experience in safe way. This workshop aims to clarify what mindfulness is and the range of forms it may take in therapy. Workshop participants may develop a sense of when to use mindfulness and in what form and develop skill in being a mindful therapist.

## PRESENTERS

**Vikki Knott** works as a Senior Project Officer, Cancer Support, Cancer Council SA. Her role is to identify and endeavour to close the gaps in supportive care systems by advocacy of those agencies and organisations in South Australia providing supportive care. She also participates in research to respond to identified gaps in supportive care needs and supervises several students studying Psychology at the University of Adelaide. Currently, Vikki's research interests focus on understanding the emotional and social impact of cancer and on identifying barriers to the seeking of psychosocial support.

**Lynley Aldridge** is a psychology graduate who has worked in the area of psycho-oncology for the last four years. Since January 2008 she has been co-ordinating a large national study examining unmet needs, distress, patterns of care and quality of life in cancer patients from culturally and linguistically diverse backgrounds.

As well as Chairing PoCoG, **Phyllis Butow** is Professor and NHMRC Principle Research Fellow in the School of Psychology, University of Sydney. She is Co-Director of the Centre for Medical Psychology and Evidence-based Decision-making (CeMPED) and Co-Director of the Surgical Outcomes Research Centre. Phyllis has worked for over 18 years in the area of Psycho-oncology. She is a world leader in research focussed on doctor-patient communication in oncology.

**Eli Ristevski** is a lecturer at Monash University Department of Rural and Indigenous Health. Eli's background is in public health and sociology. She has been working in collaboration with cancer service providers and consumers in Gippsland on a number of research projects over the last 7 years.

**Alison Zucca** Research Officer Centre for Health Research and Psycho-oncology (CHeRP) Alison works in the area of cancer survivorship and has been working with CHeRP for over 7 years.

**Philippa Youl** is the Executive Manager of Research at the Viertel Centre for Research in Cancer Control, Cancer Council Queensland. She has a background in clinical oncology and has worked in the field of cancer epidemiology for the past 18 years and has a particular interest in skin cancer and the impact it has on the individual and their family.

**Monika Janda** is a behavioural scientist with 15 years of experience in cancer research. She has over 50 publications in peer-reviewed journals and has presented her work at national and international conferences. She is currently involved in epidemiological and behavioural research to

address the public health impact of melanoma, endometrial cancer and ovarian cancer.

**Paul Katris** is a registered psychologist in Perth WA. He has worked in the cancer control sector for over 13 years in both research and executive cooperative oncology group roles. He heads up the WA Clinical Oncology Group - a multidisciplinary educational body on all clinical aspects of cancer control under a WA Department of Health contract administered by the Cancer Council WA. He also provides advice on issues regarding psycho-oncology research and service delivery to interested WA stakeholder organisations - and to anyone willing to listen!

**Belinda Thewes** is a clinical and research psychologist who is currently a National Breast Cancer Foundation Post-Doctoral Research Fellow in the Centre for Medical Psychology and Evidence-Based Decision Making at the University of Sydney.

Associate Professor **Anna Hawkes**, Senior Research Fellow, Viertel Centre for Research in Cancer Control, Cancer Council Queensland has been working in chronic disease management with a focus on heart disease and cancer research for over 10 years and has an interest in innovative approaches to the delivery of care.

**Haryana Dhillon's** background is in investigator-initiated cancer clinical trials which sparked her interest in consent in the medical setting. Her PhD project is investigating strategies to improve informed consent. She also coordinates a study assessing cognitive function in people with colorectal cancer. Her research interests are primarily in the area of cancer and include quality of life, psycho-social and supportive care interventions, communication, clinical trials. She has an ongoing interest in the workload and other professional issues arising for data managers, research nurses and clinical trial coordinators.

**Byeongsang Oh**, Medical Oncology Research Fellow, Sydney Cancer Centre, Royal Prince Alfred Hospital and University of Sydney. Dr Byeongsang Oh is a highly motivated and trained researcher in the area of integrative oncology, quality of life cancer patients and is most interested in the use of complementary and alternative medicine (CAM) in cancer care.

**Jon Emery** is Winthrop Professor of General Practice and the Head of the School of Primary Aboriginal and Rural Health Care at the University of Western Australia. He chairs the recently formed Cancer Australia Primary Care Collaborative Cancer Clinical Trials Group, known as PC4. His research focuses on complex interventions for cancer diagnosis and management in primary care.

## DISCUSSION PANEL MEMBERS

### Dr Barry Bultz

*Clinical Psychologist*

*Director Dept. of Psychosocial Resources, Tom Baker Cancer Centre; Adjunct Professor and Head, Division of Psychosocial Oncology, Department of Oncology, Faculty of Medicine, University of Calgary*

Barry Bultz was appointed Director, in 1981, of the Department of Psychosocial Resources at the Tom Baker Cancer Center in Calgary, Alberta, where he has subsequently developed and leads one of the first interdisciplinary psychosocial oncology programs in Canada. He is a co-founder and Past President of the Canadian Association of Psychosocial Oncology (CAPO). In 1985, he chaired the 1st Canadian conference in Psychosocial Oncology and in 2003, the 6th World Congress of Psycho-Oncology. He has served on the Board of Directors of the American Psychosocial Oncology and is currently a member of the Board of the International Psycho-Oncology Society. He is internationally regarded for the concept of Emotional Distress being designated as the 6th Vital Sign in oncology. He has been an active member of many collaborative psychosocial research initiatives. He is Adjunct Professor and Chair of the Division of Psychosocial Oncology, one of the first such Divisions in a Medical School, at the University of Calgary, where he also holds faculty appointments in Psychiatry, Surgery and Psychology. He is the author of over 100 scholarly publications and serves on several editorial boards for cancer-related journals.

### Prof. David Clarke

*Consultation-liaison psychiatrist*

*Research Advisor beyondblue and Professor in the Discipline of Psychological Medicine, School of Psychology, Psychiatry and Psychological Medicine, Monash University*

Professor David Clarke practised as a general practitioner before training in psychiatry. He works at the interface between psychiatry and physical health care as a consultation-liaison psychiatrist. He is currently Clinical Director of General Hospital and Primary Care Psychiatry at Monash Medical Centre and Southern Health.

He is heavily involved in both undergraduate and postgraduate medical education at Monash University. His research has been in psychosocial aspects of chronic illness, and depression.

David is also the Research Advisor for *beyondblue*. He produced recently for *beyondblue*'s an evidence-based guide to managing depression in primary care, designed to assist GPs to assess and diagnose depression and put into place management plans that include evidence-based treatments. He has developed a chronic disease

management support resource for people with heart – titled “Better living with heart failure: a manual for self-management”, and is currently editing with Prof Ian Olver a *beyondblue* MJA Supplement – Cancer and Depression (due March 2010).

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### Ms Kim Hobbs

*Social Worker*

*Westmead Centre for Gynaecological Cancer*

Kim Hobbs is a Clinical Specialist Social Worker at the Westmead Centre for Gynaecological Cancer. She has worked for many years in oncology social work (possibly longer than some of the audience has been alive).

In addition to her clinical caseload, Kim is actively involved in research, service planning and resource development.

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### Prof. Brian Kelly

*Psychiatry*

*Professor of Psychiatry, School of Medicine and Public Health, University of Newcastle*

Prof Kelly is a Psychiatrist and has been undertaking research and clinical practice in psycho-oncology, with a particular interest in palliative care, and has experience in developing services in rural and remote regions.

## WORKSHOP PRESENTERS

**Katharine Hodgkinson** is a Clinical Psychologist with both clinical and research experience in psycho-oncology. She is the director of HeadWAY Health, a private psychology practice in Sydney, which specialises treating cancer patients and their families.

**Dr Jemma Gilchrist** is a Senior Clinical Psychologist in the Dept of Psycho-oncology at Westmead Cancer Care Centre in Sydney, which is a comprehensive cancer treatment facility in a public hospital.

**Dr Elizabeth Foley** is a Clinical Psychologist who currently manages a private practice and holds academic positions at Sydney and Macquarie Universities. Elizabeth has previously held two Cancer Institute Fellowships and completed a clinical PhD in mindfulness based therapy for cancer patients and carers.

VENUE PLAN





## Appendix B: OZPOS and PoCoG Psycho-oncology Professional Day Evaluation Survey Questions

OZPOS and PoCoG Psycho-oncology Professional Day Evaluation Survey					
1. Please select the sessions of the Professional Day that you attended	<p>Plenary session 8.30 - 9.30am Branding Distress - 6th Vital Sign in Cancer Care: From Practice to Policy" by Dr Barry Bultz</p> <p>Oral Presentations 10.00am - 12.00pm: What About Me? CALD and Other Vulnerable Groups" chaired by Dr Ilona Juraskova</p> <p>Oral Presentations 10.00am - 12.00pm: At the Coalface - Clinical Issues Across the Cancer Journey" chaired by Dr Jaklin Elliott</p> <p>Clinical Workshop 10.00am - 12.00pm: Sexuality and Intimacy in Cancer Care: Enhancing Clinical Practice" facilitated by Dr Katharine Hodgkinson and Dr Jemma Gilchrist</p> <p>Panel Discussion 12.30 - 1.30pm: "Implementation and Outreach" chaired by Dr Catherine Adams</p> <p>Oral Presentations 2.00 - 4.00pm: What's Hot - Emerging Research in Psycho-oncology" chaired by Dr Laura Kirsten</p> <p>Clinical Workshop 2.00 - 4.00pm: Mindfulness in Therapy" facilitated by Dr Elizabeth Foley</p>				
2. Did you present in, form part of the panel or chair any of the sessions listed in question 1?	Yes	No			
<b>Qs 3 – 5 for those who attended the plenary session: "Branding Distress- 6th Vital Sign in Cancer Care: From Practice to Policy"</b>					
3. Please rate the following aspects of the plenary session "Branding Distress- 6th Vital Sign in Cancer Care: From Practice to Policy" by Dr Barry Bultz					
Length of the session	Excellent	Very Good	Satisfactory	Not Very Good	Poor
Relevance of the session content to psycho-oncology audience	Very High	High	Moderate	Low	Very Low
Educational/ informative value	Excellent	Very Good	Satisfactory	Not Very Good	Poor
Format	Excellent	Very Good	Satisfactory	Not Very Good	Poor
4. How important do you consider it is to have an international speaker at future Professional days?					
5. Comments about the plenary session "Branding Distress- 6th Vital Sign in Cancer Care: From Practice to Policy" by Dr Barry Bultz					
<b>Qs 6 – 7 For those who attended the session: "What About Me? CALD and Other Vulnerable Groups"</b>					
6. Please rate the following aspects of the session: "What About Me? CALD and Other Vulnerable Groups" chaired by Dr Ilona Juraskova					
Length of the session	Excellent	Very Good	Satisfactory	Not Very Good	Poor
Relevance of the session content to psycho-oncology audience]	Very High	High	Moderate	Low	Very Low

## Appendix B: OZPOS and PoCoG Psycho-oncology Professional Day Evaluation Survey Questions

Educational/ informative value	Excellent	Very Good	Satisfactory	Not Very Good	Poor
Overall quality of the presentations	Excellent	Very Good	Satisfactory	Not Very Good	Poor
Format	Excellent	Very Good	Satisfactory	Not Very Good	Poor

7. Comments about the session “What About Me? CALD and Other Vulnerable Groups”

**Qs 8 – 9 For those who attended the session: “At the Coalface: Clinical Issues across the Cancer Journey”**

8. Please rate the following aspects of the session: “At the Coalface: Clinical Issues across the Cancer Journey” chaired by Dr Jaklin Elliott

Length of the session	Excellent	Very Good	Satisfactory	Not Very Good	Poor
Relevance of the session content to psycho-oncology audience	Very High	High	Moderate	Low	Very Low
Educational/ informative value	Excellent	Very Good	Satisfactory	Not Very Good	Poor
Overall quality of the presentations	Excellent	Very Good	Satisfactory	Not Very Good	Poor
Format	Excellent	Very Good	Satisfactory	Not Very Good	Poor

9. Comments on the session: “At the Coalface: Clinical Issues across the Cancer Journey”<sup>2</sup> chaired by Dr Jaklin Elliott

**Qs 10 – 13 for those who attended the session: “Sexuality and Intimacy in Cancer Care: Enhancing Clinical Practice”**

10. Please rate the following aspects of the session: “Sexuality and Intimacy in Cancer Care: Enhancing Clinical Practice” by Dr Katharine Hodgkinson and Dr Jemma Gilchrist

Length of the workshop	Excellent	Very Good	Satisfactory	Not Very Good	Poor
Relevance of the session content to psycho-oncology audience	Very High	High	Moderate	Low	Very Low
Usefulness of supplementary material (e.g. handouts, slides etc)	Excellent	Very Good	Satisfactory	Not Very Good	Poor
Audience engagement	Excellent	Very Good	Satisfactory	Not Very Good	Poor
Presenters/ facilitators	Excellent	Very Good	Satisfactory	Not Very Good	Poor
Educational/ informative value	Excellent	Very Good	Satisfactory	Not Very Good	Poor
Overall quality of the presentations	Excellent	Very Good	Satisfactory	Not Very Good	Poor
Format	Excellent	Very	Satisfactory	Not Very	Poor

## Appendix B: OZPOS and PoCoG Psycho-oncology Professional Day Evaluation Survey Questions

	Good	Good			
11. Was the “Sexuality and Intimacy in Cancer Care: Enhancing Clinical Practice” Clinical Workshop pitched at an appropriate level for your skill base?	Yes	No			
12. If you answered NO" above, please comment on problems and how they could be addressed in the future					
13. Comments about the “Sexuality and Intimacy in Cancer Care: Enhancing Clinical Practice” Clinical Workshop					
<b>Qs 14 – 16 for those who attended the session: “Implementation and Outreach”</b>					
14. Please rate the following aspects of the Panel Discussion: “Implementation and Outreach”					
Length of the session	Excellent	Very Good	Satisfactory	Not Very Good	Poor
Relevance of the session content to psycho-oncology audience]	Very High	High	Moderate	Low	Very Low
Educational/ informative value	Excellent	Very Good	Satisfactory	Not Very Good	Poor
Format	Excellent	Very Good	Satisfactory	Not Very Good	Poor
15. Please indicate the extent you agree with the following statements about the Panel Discussion: “Implementation and Outreach”					
The panel experts represented relevant disciplines within psycho-oncology	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
The case vignettes represented typical and appropriate issues faced by psycho-oncology professionals	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
The panel discussion encouraged psycho-oncology clinician and researcher communication	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
The panel experts gave useful answers to the questions	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
The discussion was useful for me	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
I would like another panel discussion like this in future meetings	Strongly Agree	Agree	Unsure	Disagree	Strongly Disagree
16. Comments about the panel discussion: “Implementation and Outreach”					

## Appendix B: OZPOS and PoCoG Psycho-oncology Professional Day Evaluation Survey Questions

### Qs 17 – 18 for those who attended the session: “What’s Hot: Emerging Research in Psycho-oncology”

17. Please rate the following aspects of the session: “What’s Hot: Emerging Research in Psycho-oncology” chaired by Dr Laura Kirstin

Length of the session	Excellent	Very Good	Satisfactory	Not Very Good	Poor
Relevance of the session content to psycho-oncology audience	Very High	High	Moderate	Low	Very Low
Educational/ informative value	Excellent	Very Good	Satisfactory	Not Very Good	Poor
Format	Excellent	Very Good	Satisfactory	Not Very Good	Poor

18. Comments about the session “What’s Hot - Emerging Research in Psycho-oncology”

### Qs 19 – 22 For those who attended the session: “Mindfulness in Therapy”

19. Please rate the following aspects of the “Mindfulness in Therapy” workshop facilitated by Dr Elizabeth Foley:

Length of the workshop	Excellent	Very Good	Satisfactory	Not Very Good	Poor
Relevance of the session content to psycho-oncology audience	Very High	High	Moderate	Low	Very Low
Usefulness of supplementary material (e.g. handouts, slides etc)	Excellent	Very Good	Satisfactory	Not Very Good	Poor
Audience engagement	Excellent	Very Good	Satisfactory	Not Very Good	Poor
Presenters/ facilitators	Excellent	Very Good	Satisfactory	Not Very Good	Poor
Educational/ informative value	Excellent	Very Good	Satisfactory	Not Very Good	Poor
Overall quality of the presentations	Excellent	Very Good	Satisfactory	Not Very Good	Poor
Format	Excellent	Very Good	Satisfactory	Not Very Good	Poor

20. Was the “Mindfulness in Therapy” Clinical Workshop pitched at an appropriate level for your skill base?

Yes	No
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21. If you answered “NO” above, please comment on problems and how this could be addressed in future workshops

22. Comments about the “Mindfulness in Therapy” Clinical Workshop

## Appendix B: OZPOS and PoCoG Psycho-oncology Professional Day Evaluation Survey Questions

Qs 23 – 25: Session Chairs, Presenters, Workshop Facilitators and Panel Members							
23. Did you receive adequate information prior to the Professional Day to assist in your preparation for your session?							
24. How can the preparation and coordination of future workshops be improved?							
25. General comments from presenters, panel members and session chairs							
Qs 26 – 38 for ALL survey participants							
26. How would you rate the following aspects of the Professional Day?							
Overall idea and purpose of the Professional Day	Excellent	Very Good	Satisfactory	Not Very Good	Poor		
Advertisements and notifications about the Professional Day	Excellent	Very Good	Satisfactory	Not Very Good	Poor		
Format of the sessions (concurrent workshops and oral presentations, plenary sessions)	Excellent	Very Good	Satisfactory	Not Very Good	Poor		
Program content (quality and relevance of sessions, educational value of the day as a whole, etc)	Excellent	Very Good	Satisfactory	Not Very Good	Poor		
Program booklet (layout, comprehensiveness etc)	Excellent	Very Good	Satisfactory	Not Very Good	Poor		
Length of the day	Excellent	Very Good	Satisfactory	Not Very Good	Poor		
Catering	Excellent	Very Good	Satisfactory	Not Very Good	Poor		
Timing of the Professional Day (day prior to COSA ASM)	Excellent	Very Good	Satisfactory	Not Very Good	Poor		
Delegate materials (program, PoCoG annual report, PoD flyer and PoD competition entry form)	Excellent	Very Good	Satisfactory	Not Very Good	Poor		
Overall rating	Excellent	Very Good	Satisfactory	Not Very Good	Poor		
27. How important is it for members to be given the opportunity to present their abstracts outside the COSA ASM?	Very Important	Important	Unsure	Not very Important	Unimportant		
28. Would you attend a Professional Day in the future?							
29. How often should future OZPOS/PoCoG Professional Days be held?							
30. Should future Professional Days be held in conjunction with other groups?			Yes	No			
30a. Comments on holding future Professional Days with other groups							
31. This year, the Professional Day was funded by Cancer Australia and COSA. Would you attend a Professional Day in the future if you were required to pay for your registration?							

## Appendix B: OZPOS and PoCoG Psycho-oncology Professional Day Evaluation Survey Questions

32. What would you consider to be a reasonable registration fee for future professional days?								
33. General comments about the Professional Day.								
34. Gender	Male				Female			
35. Select your place of residence	NSW	ACT	QLD	SA	WA	TAS	NT	International
36. What is your profession?	Psychosocial researcher Psychosocial Clinician Both researcher/ clinician Nurse Social Worker Student Oncologist Other							
37. How long has it been since you completed your professional training?	< 2 years/ student		2 - 5 years		5 – 10 years		>10 years	
38. Please select the groups for which you are a member.	COSA OZPOS PoCoG CNSA OSHA AGITG ANZGOG ANZBCTG PC4TG ANZUP ASSG ALLG ALTG TROG ANZCHOG ANZMTG COGNO OTHER, please specify:							