SOCIAL WORK INTERVENTIONS IN CANCER CARE

FINAL REPORT

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Acknowledgements

This study has been undertaken as an academic and practitioner collaboration between social work members of OSWANZ (Oncology Social Work Australia New Zealand) and the principal investigator Dr Rosalie Pockett, Sydney School of Education and Social Work, at the University of Sydney. High level practice input and research consultation has been provided by clinical specialist social workers in oncology, Kim Hobbs (Westmead Hospital, Sydney) and Ray Araullo (Royal North Shore Hospital, Sydney). Data analysis has been undertaken by Kashmira Dave, doctoral researcher and educationalist.

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Finally, and most importantly, the researchers wish to acknowledge those patients and families whose experiences provided the context for this study and hope that the findings will contribute to improving social work services for those who find themselves in similar situations.

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Acknowledgement of Country

We acknowledge the tradition of custodianship and law of the Country on which the University of Sydney campuses stand. We pay our respects to those who have cared and continue to care for Country

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Introduction

This Report presents the findings of an interventions study investigating the reasons for referral to oncology social workers and the types of interventions undertaken by them in cancer services in hospital and health settings. The study is the third part of a larger project describing oncology social work practice in Australia. The first part involved a national survey of oncology social work that resulted in findings about the social work oncology workforce (Pockett, Peate, Hobbs, Dzidowska, Bell et al, 2016). The second part of the project involved a systematic literature review of social work intervention research with adult cancer patients (Pockett, Dzidowska, Hobbs, 2015).

The intervention study was an academic and practitioner collaboration between the University of Sydney and practitioners from six health care settings providing cancer care in metropolitan, regional and rural centres in New South Wales, Victoria and Queensland.

Background

Social work practice in the health field is intrinsically contextualised by the social determinants of health and health inequalities. Those with complex social circumstances made more complicated by a diagnosis of cancer are the main client population of social workers working in cancer settings. Those with poorer cancer outcomes are often from communities experiencing impoverished and inequitable access to appropriate services particularly in rural and regional centres and in Indigenous communities. (AIHW 2017; Shahid, Finn, Bessarab & Thompson, 2008; Treloar, Gray, Brener, Jackson et al, 2013; Underhill, Bartel, Goldstein, Snodgrass et al, 2009). A fuller discussion of these issues is included in the Study Protocol (Appendix 1) and the discussion of the findings.

Aims

The overarching aim of the project was to improve understanding of the scope of oncology social work practice in hospital and health settings. The specific aim of this study was to investigate the reasons for referral to social workers, and the types of interventions undertaken by social workers. A secondary objective was to use the findings to inform future psychosocial intervention with cancer patients and carers and also to be a catalyst for more specific research investigating social work interventions, patient and carer needs and outcomes.

Methodology

The study involved a retrospective file review of 250 Medical Records at six health sites that provide social work services to cancer patients. The study was methodologically informed by the clinical data-mining approach used widely in practice-based research in social work and social science research (Dodd & Epstein 2012; Epstein, 2001; Fawcett & Pockett, 2015).

The research was considered an LNR (Low and Negligible Risk) study of the quality assurance type, and did not require individual patient consent. However lengthy ethics processes were involved as it was a multi-state and multi-site project with application procedures varying slightly between states. Ethics approvals were received from lead Human Research Ethics Committees (HRECs) in each state and Site Specific Approvals (SSAs) were received from each site. An additional application was required by the Health and Medical Research office, Queensland Department of Health to proceed with the study in that state. In total, ten applications were prepared by the Principal Investigator. Research contracts were completed between the University of Sydney and St Vincent's Hospital Melbourne; Central Queensland Hospital and Health Service and Cairns and Hinterland Hospital and Health Service. The study had staggered start and finish dates across the participating sites as a result of the different requirements and the time taken to obtain approvals. The first approvals were received for the lead site, Royal North Shore Hospital NSW, in October 2015 and approval from the final site in Queensland was received in February 2017. (Appendices 2-11). Data collection was fully completed at all sites by 31st December 2017.

Study sites and number of Medical Records reviewed

NSW

Royal North Shore Hospital Sydney (Lead site) (66 Medical Records reviewed)

Mid North Coast Cancer Institute, Coffs Harbour (36 Medical Records)

Queensland

Cairns and Hinterland Hospital and Health Service (30 Medical Records)

Central Queensland Regional Integrated Cancer Care Service, Rockhampton Hospital and Health Service (30 Medical Records)

Victoria

Yarra Ranges Health (33 Medical Records)

St Vincent's Hospital Melbourne (55 Medical Records)

Opportunistic sampling was used by participating social workers at each site selecting cases from their cancer caseload in the previous twelve month period from the date of commencement of the study at their site. The selected cases were representative of their work with cancer patients and carers (Appendix 12).

The eligibility criteria for inclusion in the study were patients over 18 years of age with a diagnosis of cancer, who had been seen by social workers in the previous 12 month period and who had received social work interventions that were documented in the Medical Record. A Coding Guide was developed for social workers reviewing the medical records (Appendix 13) and data was collected on a Data Collection Sheet designed for the study (Appendix 14).

The Australian classification system for social work interventions was used to code the interventions (NSW Directors of Allied Health, 2015). Data was deidentified using a master code system and entered onto an SPSS data base developed for the study.

Statistical Analysis

Analysis of the data was undertaken using Excel software and included descriptive and variable analyses of aggregated data across the six sites including demographic data; general cancer information, social work contact types, referral data and interventions undertaken. Qualitative analysis was used to review additional notes made by coders when reviewing records and this informed the analysis of the quantitative data.

Descriptive statistics were used to obtain the frequencies and percentages of all data elements collected. These included case data, demographic data and cancer information. Social work data included the source of referrals to social work, reasons for referral, occasions of contact, the contact types, the reasons for intervention as an IFI (Indicator of intervention) and the social work interventions undertaken.

Cross analysis of data was undertaken of the following elements: cancer primary site and age ranges, cancer primary site and residential location, cancer primary site, stage and social work contact, cancer primary site and reasons for intervention (IFIs) by the five most frequent choices listed by social workers, and cancer primary site and the five most frequent interventions. Cross analysis was also undertaken of social work occasions of service, gender, relationship status and parental status.

The reasons for intervention listed by the social workers were mapped to the Code set of Indicators for Intervention in the Allied Health Minimum Data Set v2.0 (NSW Directors of Allied Health, 2015).

The interventions undertaken by social workers were mapped to the ICD-10 Codes listed in the Code set list for Social Work Interventions in the Allied Health Minimum Data Set v2.0 (NSW Directors of Allied Health, 2015).

Findings

The findings are presented as a series of tables, figures and commentary in six sections.

Patient Demographic Data

Cancer Information

Referrals to Social Work

Social Work Contact

Reasons for Intervention Following Social Workers’ Assessment

Social Work Interventions

Demographic Data

Types of Cases

Type of Case N=250			
		Frequency	Percent
	NCO -New Case Outpatient	92	36.8
	NCI- New Case Inpatient	67	26.8
	OCB- Ongoing Case both inpatient and outpatient	32	12.8
	OCI- Ongoing Case Inpatient	27	10.8
	OCO- Ongoing Case Outpatient	32	12.8
	Total	250	100

Table 1.1

Table 1.1 and Figure 1.1. Two thirds of cases selected were new and one third were ongoing cases known to the social worker. Almost half (49.6%) of the cases were outpatients, and slightly more than a third (37.6%) were inpatients. The remaining 12.8% were both inpatients and outpatients. Only one site was a day patient site and this accounted for (15%) of the total cases. The higher level of outpatients is unexpected and may be due to the opportunistic selection of sites in the study. Although a limitation it demonstrates the range of case types selected by social workers.

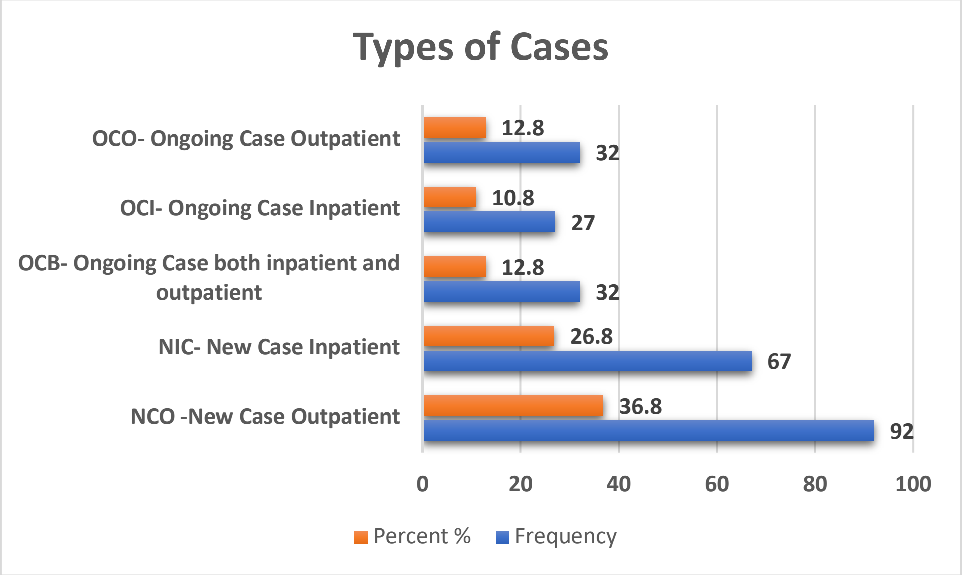


Figure 1.1

Case Type by Site Type

Case Type (N=250)	Regional Cancer Centre	Metropolitan	Regional Day Hospital	Metropolitan	Regional Health Service	Regional Health Service	Total
NCO new case outpatient	25	7	33	6	17	4	92
NCI new case inpatient	5	36	0	23	3	0	67
OCB ongoing case both inpatient & outpatient	0	11	0	10	4	7	32
OCI ongoing case inpatient	0	12	0	14	1	0	27
OCO ongoing case outpatient	6	0	0	2	5	19	32
Total	36	66	33	55	30	30	250

Table 1.2 Shows the distribution of case types by sites. The Metropolitan centres had higher numbers of inpatient cases and fewer outpatient cases in comparison to the regional centres which had a mixture of both. One regional centre was for day patients only.

Patient Age distribution

Age range (N=250)	Frequency Males	% Total cases	Frequency Females	% Total cases
15-20	4	1.6	2	0.8
21-30	8	3.2	2	0.8
31-40	4	1.6	11	4.4
41-50	18	7.2	31	12.4
51-60	32	12.8	24	9.6
61-70	30	12	24	9.6
71-80	24	9.6	20	20
81-90	5	0.8	8	3.2
90+	2	0.8	1	0.4
Total	127	50.8	123	49.2

Table 1.3

Table 1.3 and Figure 1.3 show an even spread of males and females across the distribution of ages. These clustered around the middle years, tailing off to the very young and very old. Approximately 75% were aged 40-80 years and the cluster around the middle to older years reflects cancer incidence and the likelihood of patient issues consistent with life stage, for example, employment, aged care, and carer responsibilities. There was double the number of female cases between 31-50 years (16.8%) compared to males (8.8%) which may be accounted for by the diagnosis of breast cancer in this age range.

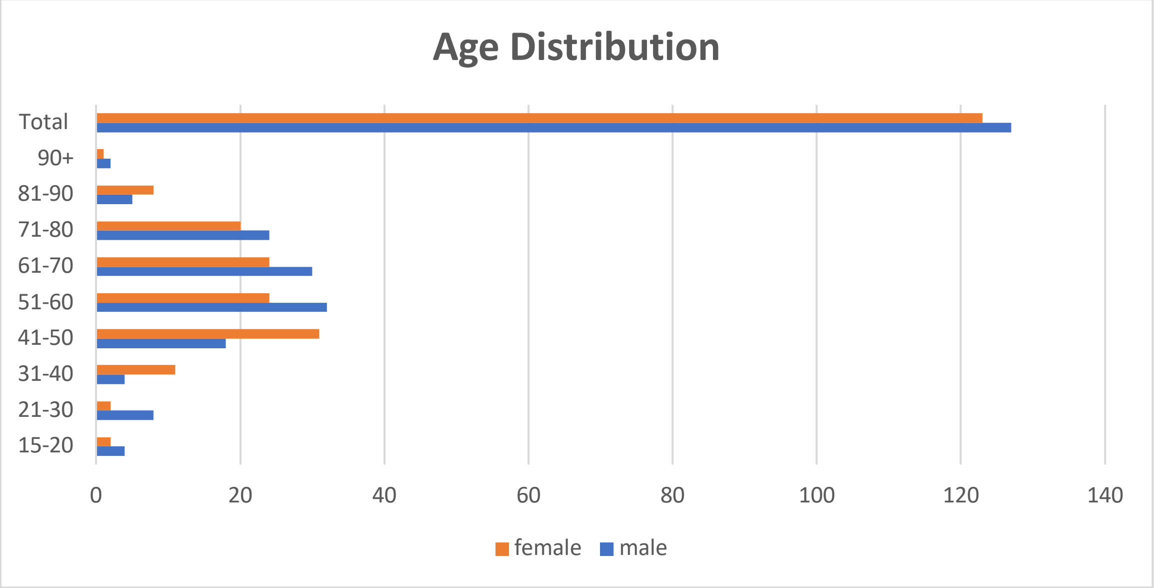


Figure 1.3

Gender

Gender (N=250)	Frequency	Percent
Male	126	50.4
Female	122	48.8
Total	250	100

Table 1.4

Table 1.4 and Figure 1.4 show a fairly even distribution of cases according to gender. This reflect the scope of social work practice across gender-cancer types.

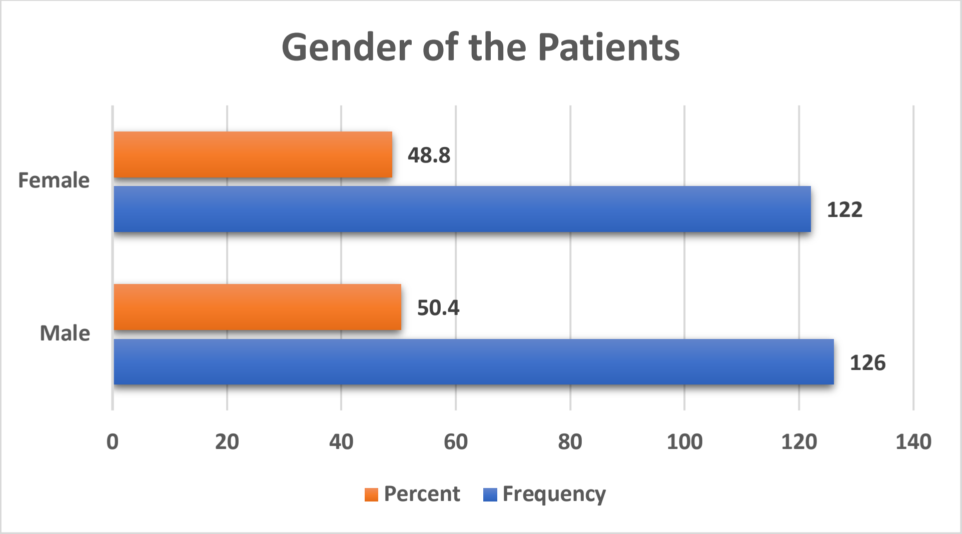


Figure 1.4

Relationship Status

Marital Status (N=250)	Frequency	Percent
Married/De Facto	126	50.4
Separated	14	5.6
Divorced	39	15.6
Widowed	25	10
Single	42	16.8
Not stated	4	1.6
Total	250	100

Table 1.5

Table 1.5 and Figure 1.5. 50% of patients were partnered with the other half being non-partnered. The importance of family support in treatment and care planning is well documented. Gender, relationship status, parental status and occasions of service are presented in Tables 4.6 – 4.14.

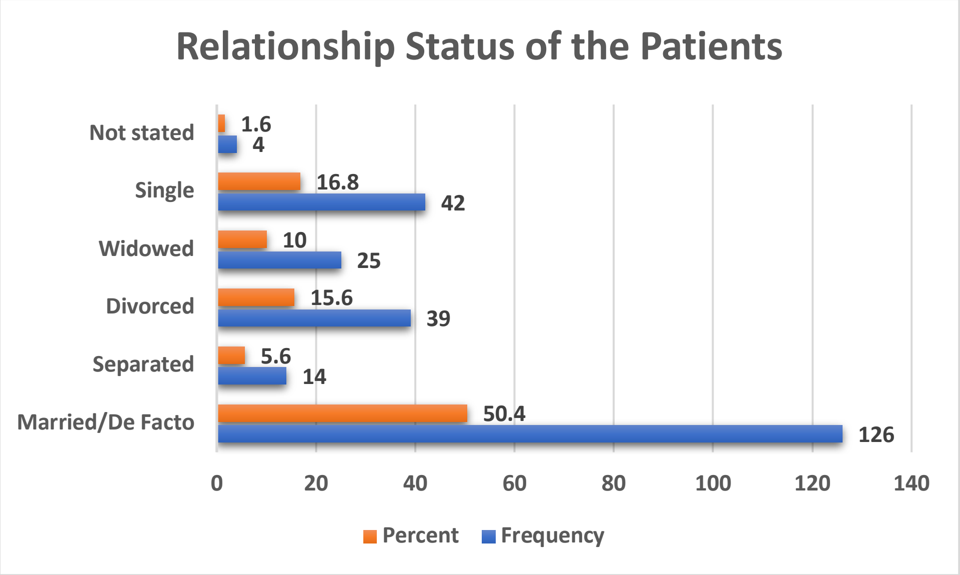


Figure 1.5

Parental Status at Diagnosis

Parental status at diagnosis (N=250)			
		Frequency	Percent
	Dependent children	63	25.2
	Adult children	128	51.2
	No children	50	20
	Not stated	9	3.6
	Total	250	100

Table 1.6

Table 1.6 and Figure 1.6 At the time of diagnosis, 25% of patients had dependent children and over half had adult children. Dependent children were across patient age ranges.

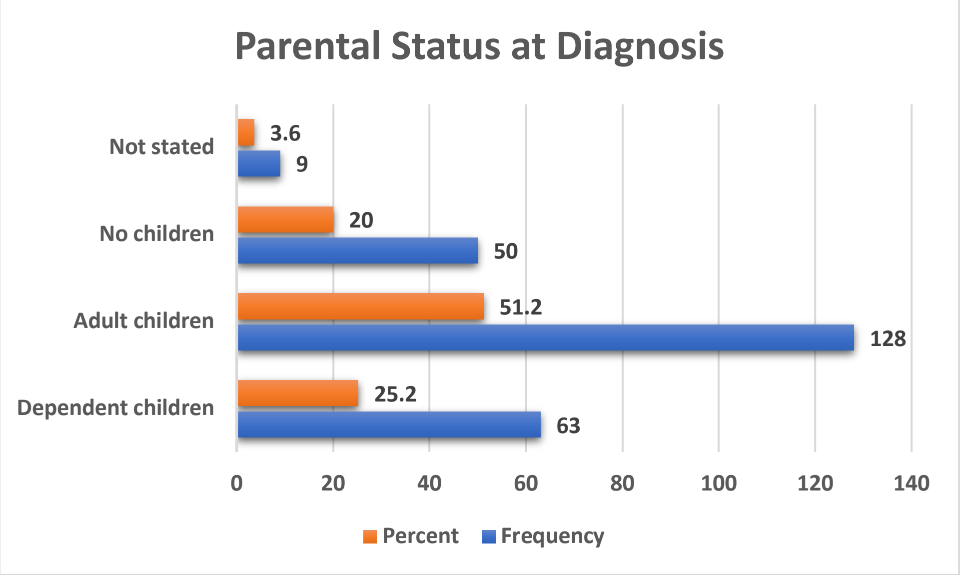


Figure 1.6

Country of Birth

Country of Birth (N=250)	Frequency	Percentage
Australia	177	70.8
Other than Australia	73	29.2

Table 1.7

Table 1.7 and Figure 1.7 The majority of patients (70.8%) were born in Australia. This is consistent with ABS figures for the Australian population with 28.5% born overseas (ABS, 2019a). The study did not capture cultural background, ethnicity or whether the patients were first generation Australian born.

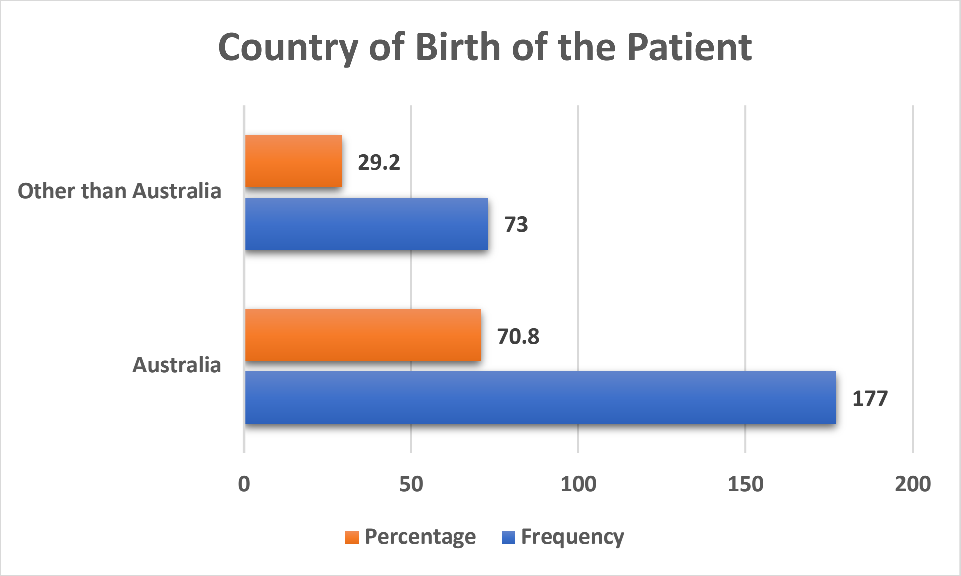


Figure 1.7

Complete list of Countries of Birth

Country (N=250)	Frequency	Percent
Australia	177	70.8
United Kingdom *[1]	13	5.2
Unknown/Not stated	14	5.6
Netherlands	7	2.8
China *[2]	4	1.6
Germany	4	1.6
India *[3]	3	1.2
Lebanon	3	1.2
Malaysia	3	1.2
Philippines *5	3	1.2
Vietnam *5	3	1.2
Croatia	2	0.8
Egypt	2	0.8
Italy	2	0.8
New Zealand *4	2	0.8
Sri Lanka	2	0.8
USA	2	0.8
France	1	0.4
Hong Kong	1	0.4
Hungary	1	0.4
Korea	1	0.4
Peru	1	0.4
South Africa	1	0.4

Table 1.8

Table 1.8 shows the range of countries of birth which are consistent with ABS population figures. In the most recent Census, those born in the United Kingdom were the largest group of overseas-born residents, accounting for 4.0% of Australia's total population. This was followed by those born in China (2.6%) [*2], India (2.4%) [*3], New Zealand (2.3%) [*4] and the Philippines and Vietnam (both 1.0%) [*5]. (ABS, 2019a)

Aboriginal and Torres Strait Islander Status

Aboriginal or Torres Strait Islander (N=250)			
		Frequency	Percent
	Yes	9	3.6
	No	240	96
	Missing	1	0.4
	Total	250	100

Table 1.9

Table 1.9 and Figure 1.9. A very small percentage of patients in the study (3.6%) identified as Aboriginal or Torres Strait Islander. This compares with Australian population figures of 3.3% at the time of the 2016 Census (ABS, 2016).

Although consistent with the ABS figures, this is an unexpectedly low figure given that cancer incidence and mortality are higher in Aboriginal and Torres Strait Islander people. (ABS, 2019b).

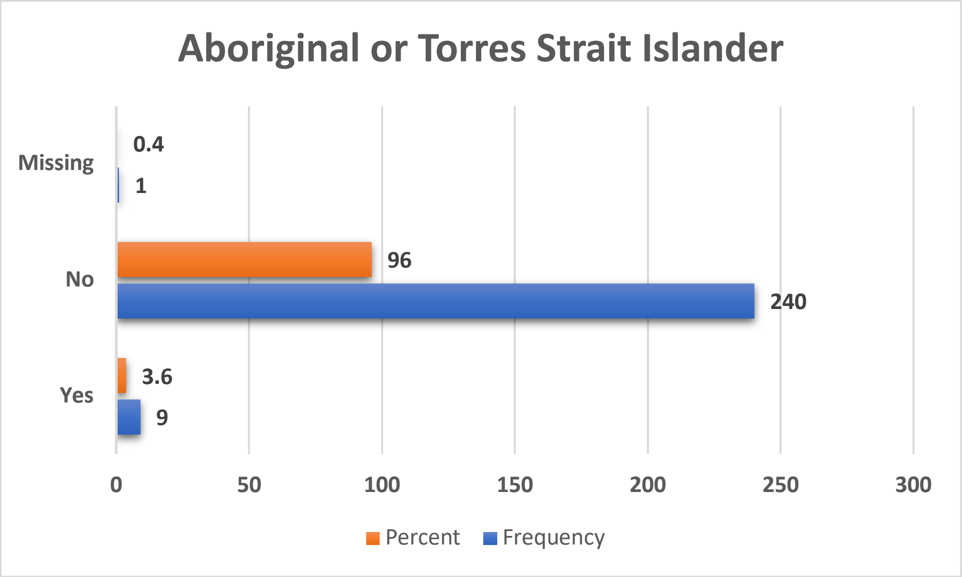


Figure 1.9

Residential Location

Residential location (N=250)			
	Residential location	Frequency	Percent
	Metropolitan	97	38.8
	Rural/Regional	144	57.6
	Remote	7	2.8
	Other	2	0.8
	Total	250	100

Table 1.10

Table 1.10 and Figure 1.10. Nearly 60% of patients lived in rural, regional or remote communities. This compares with 2016 Census data showing only 31.5% of the population lives in these areas (ABS, 2018).

The high number of non-metropolitan patients in the study is only partly explained by the data collection sites in regional and rural locations. Social workers in large tertiary referral services in metropolitan areas saw high numbers of people from outside these areas. Non-metropolitan patients are likely to have higher need for social work assistance due to managing the logistics of receiving treatment far from home, financial disadvantage and experiences of social isolation.

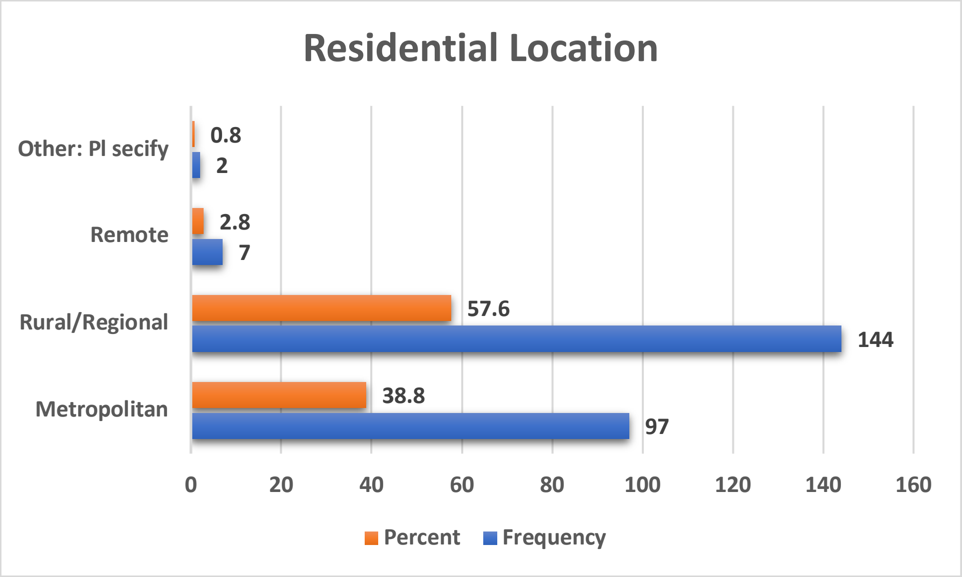


Figure 1.10

Employment Status at Diagnosis

Employment status at diagnosis (N=250)			
		Frequency	Percent
	Employed Full Time	47	18.8
	Employed Part Time	20	8
	Centrelink	120	48
	Self-funded	21	8.4
	Not stated	17	6.8
	Other (pl specify)	25	10
	Total	250	100

Table 1.11

Table 1.11 and Figure 1.11. Just over a third of patients (35.2%) were either in full time or part time employment or were self-funded. Almost half (48%) were receiving Centrelink benefits at the time of diagnosis. Given the working age range of the majority of patients, this may be an indicator of social risk and the likelihood of referral to social work.

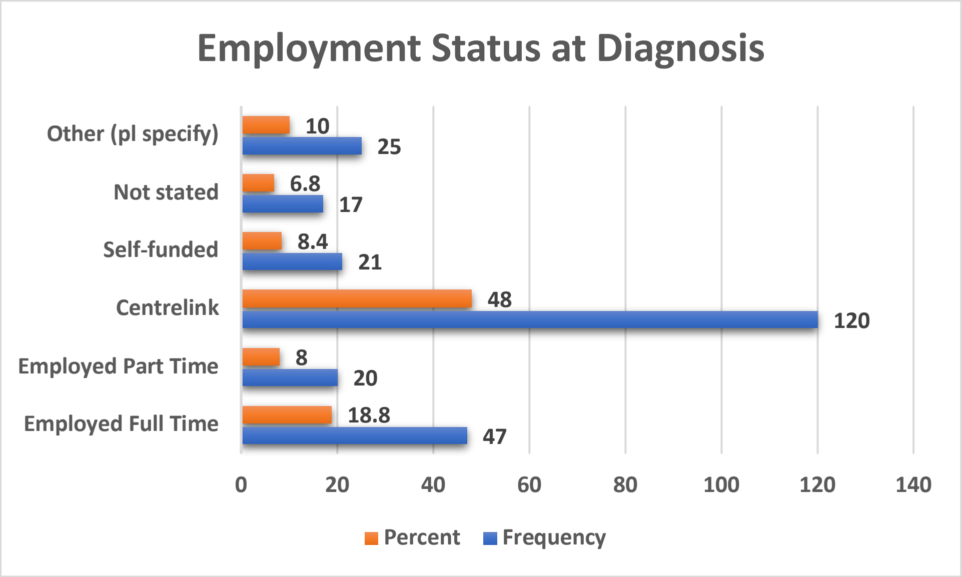


Figure 1.11

Employment status at time of audit

Employment status at time of audit (N=250)		
	Frequency	Percent
Employed Full Time	15	6
Employed Part Time	11	4.4
Centrelink	147	58.8
Self-funded	25	10
Not Stated	10	4
Other (Pl specify) *Deceased	41 14	16.4 5.6
Total	250	100

Table 1.12

Table 1.12 and Figure 1.12. At the time of the medical record review almost 60% of patients were receiving Centrelink payments with 20% being employed or self-funded. This has decreased from 35.2% at the time of diagnosis. * At the time of the audit, in 14 cases (5.6%) the patient had died since the first contact with social work.

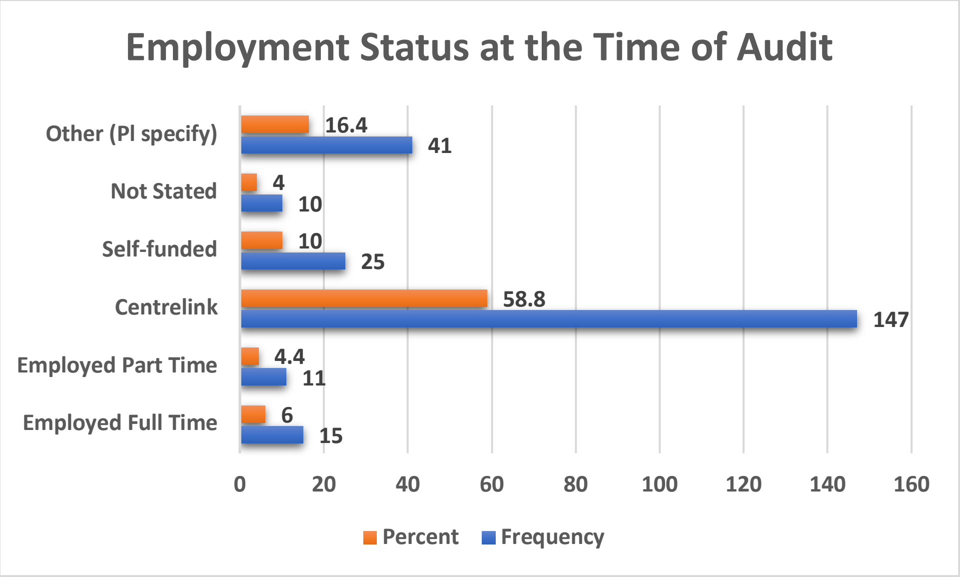


Figure 1.12

Cancer Information

Cancer Primary Site

Primary Site (N=250)	**Frequency**	**Percent**
Brain	9	3.6
Breast	42	16.8
Colorectal	30	12
Gynaecological	5	2
Haematological	48	19.2
Head & Neck	25	10
Liver	3	1.2
Lung	37	14.8
Melanoma	5	2
Pancreatic	12	4.8
Prostate	7	2.8
Skin	3	1.2
Upper GI	10	4
Urological	14	5.6
Total	250	100

Table 2.1

Table 2.1 and Figure 2.1. A good range of cancer sites were included in the study. This contrasts with much of the psycho-oncology literature where the predominant cohorts tend to be breast and prostate cancer patients, indicative of the overall incidence of these cancers. Psychosocial distress levels are reportedly highest in less common cancers and those which have a poor prognosis for example head and neck, lung, melanoma and pancreatic cancers (Zabora, Brintzenhofeszoc, Curbow, Hooker, & Piantadosi, 2001).

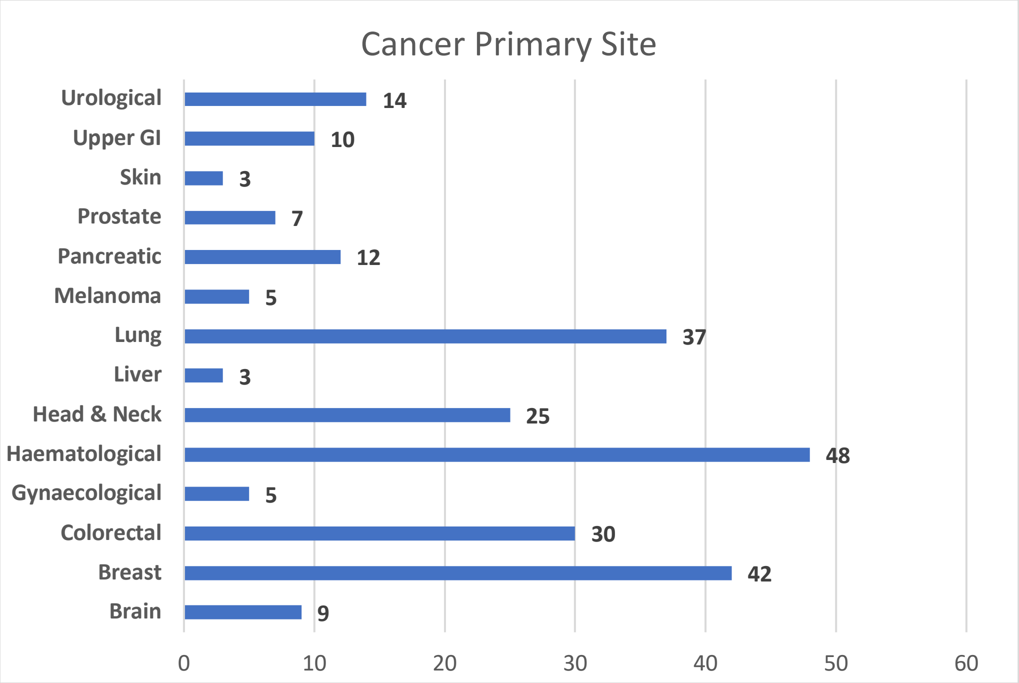


Figure 2.1

Four Most Common Cancer Primary Sites in the Study

Cancer Primary Site (*n=157)*	**Frequency**	**Percentage**
Haematological	48	19.2
Breast	42	16.8
Lung	37	14.8
Colorectal	30	12
Total	157	62.8

Table 2.2 Lists the four most common cancer primary sites reviewed in the study which account for nearly two thirds of cases (62.8%). Three of these sites; breast, colorectal and lung are reported in *Cancer in Australia 2017*, as three of the top four cancer incidence sites, the fourth being prostate (AIHW, 2017). Gynaecological cancer (10% nationally) is under-reported in this study.

This table reflects the clinical areas in which the social work reviewers practiced and from which they selected cases to review and isn't representative of the *Cancer Australia* data. One possible explanation is that although haematological cancers are classified as rare and less common cancers they typically require social work contact due to intensive and long-term treatment regimens often with a poor prognosis for example, acute myeloid leukaemia in adults. In this study, haematological cases had the highest figure of social work contact at recurrence of the disease.

Cancer Primary Site and Age

	Cancer Primary Site (N=250)										
Age		15-20	21-30	31-40	41-50	51-60	61-70	71-80	81-90	90+	
	Brain	1	0	1	2	1	1	3	0	0	9
	*Breast	0	0	6	11	10	10	5	0	0	42
	*Colorectal	0	1	1	5	6	11	4	2	0	30
	Gynaecological	0	0	0	2	2	0	1	0	0	5
	*Haematological	5	5	3	9	9	4	8	4	1	48
	Head & Neck	0	1	2	5	5	8	2	2	0	25
	Liver	0	1	0	0	2	0	0	0	0	3
	*Lung	0	0	1	6	10	8	10	2	0	37
	Melanoma	0	0	1	3	0	0	1	0	0	5
	Pancreatic	0	0	0	1	4	4	1	2	0	12
	Prostate	0	0	0	0	2	2	3	0	0	7
	Skin	0	0	0	0	0	1	0	0	2	3
	Upper GI	0	0	0	0	2	5	3	0	0	10
	Urological	0	2	0	4	4	0	3	1	0	14
Total		6	10	15	47	57	54	44	13	3	250

Table 2.3 * Indicates the four most common primary sites in the study.

Table 2.3 and Figure 2.3. Cross tabulation of cancer primary sites and age groups shows social workers saw patients across all life stages, requiring in-depth understandings of life course approaches, the social contexts of each age group and the impacts of a cancer diagnosis and treatment. Higher numbers of patients with cancer in the four most frequent primary sites were also from regional and rural areas adding further social complexities and needs.

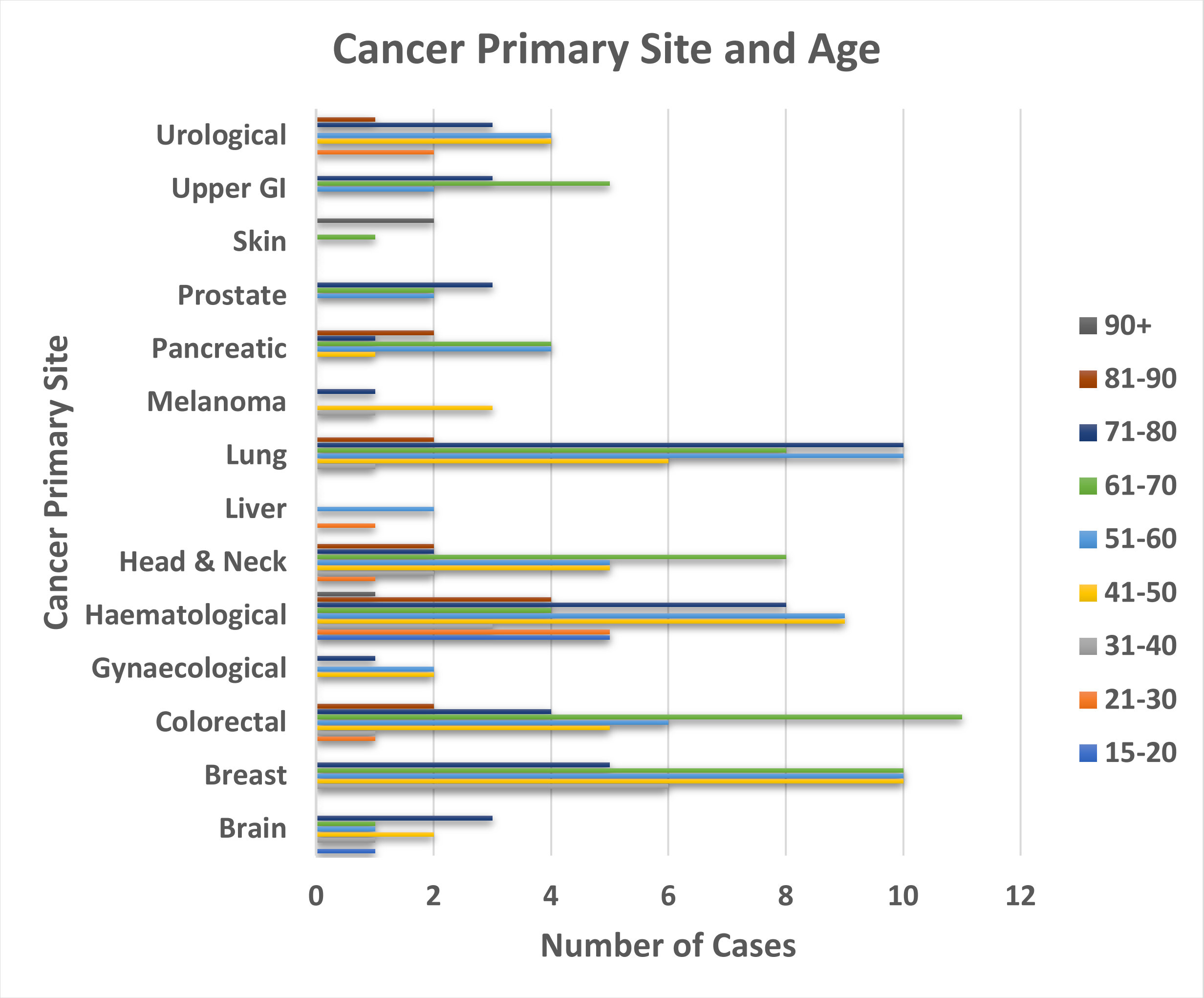

Cancer Primary Site and Age
Cancer Primary Site
Urological
Upper GI
Skin
Prostate
Pancreatic
Melanoma
Lung
Liver
Head & Neck
Haematological
Gynaecological
Colorectal
Breast
Brain
0
2
4
6
8
10
12
Number of Cases
90+
81-90
71-80
61-70
51-60
41-50
31-40
21-30
15-20

Figure 2.3

Cancer Primary Site and Residential Location

	Cancer Primary Site					
Residential location (N=250)		Metropolitan	Rural /Regional	Remote	Other:	Total
	Brain	5	4	0	0	9
	*Breast	17	25	0	0	42
	*Colorectal	8	21	1	0	30
	Gynaecological	0	5	0	0	5
	*Haematological	21	24	2	1	48
	Head & Neck	10	15	0	0	25
	Liver	1	1	0	1	3
	*Lung	15	21	1	0	37
	Melanoma	2	3	0	0	5
	Pancreatic	6	5	1	0	12
	Prostate	1	6	0	0	7
	Skin	0	3	0	0	3
	Upper GI	4	6	0	0	10
	Urological	7	5	2	0	14
Total		97	144	7	2	250
Percent		38.8	57.6	2.8	0.8	100

Table 2.4 * Indicates the four most common primary sites in the study

Table 2.4 and Figure 2.4. Cross tabulation of the cancer primary sites in the study with patients' residential location shows that 60.4% of patients in the study were from rural, regional or remote locations. This may be accounted for in part but not exclusively by the four regional centres that were included in the study. It also illustrates the high need of those in regional and remote locations for social work services.

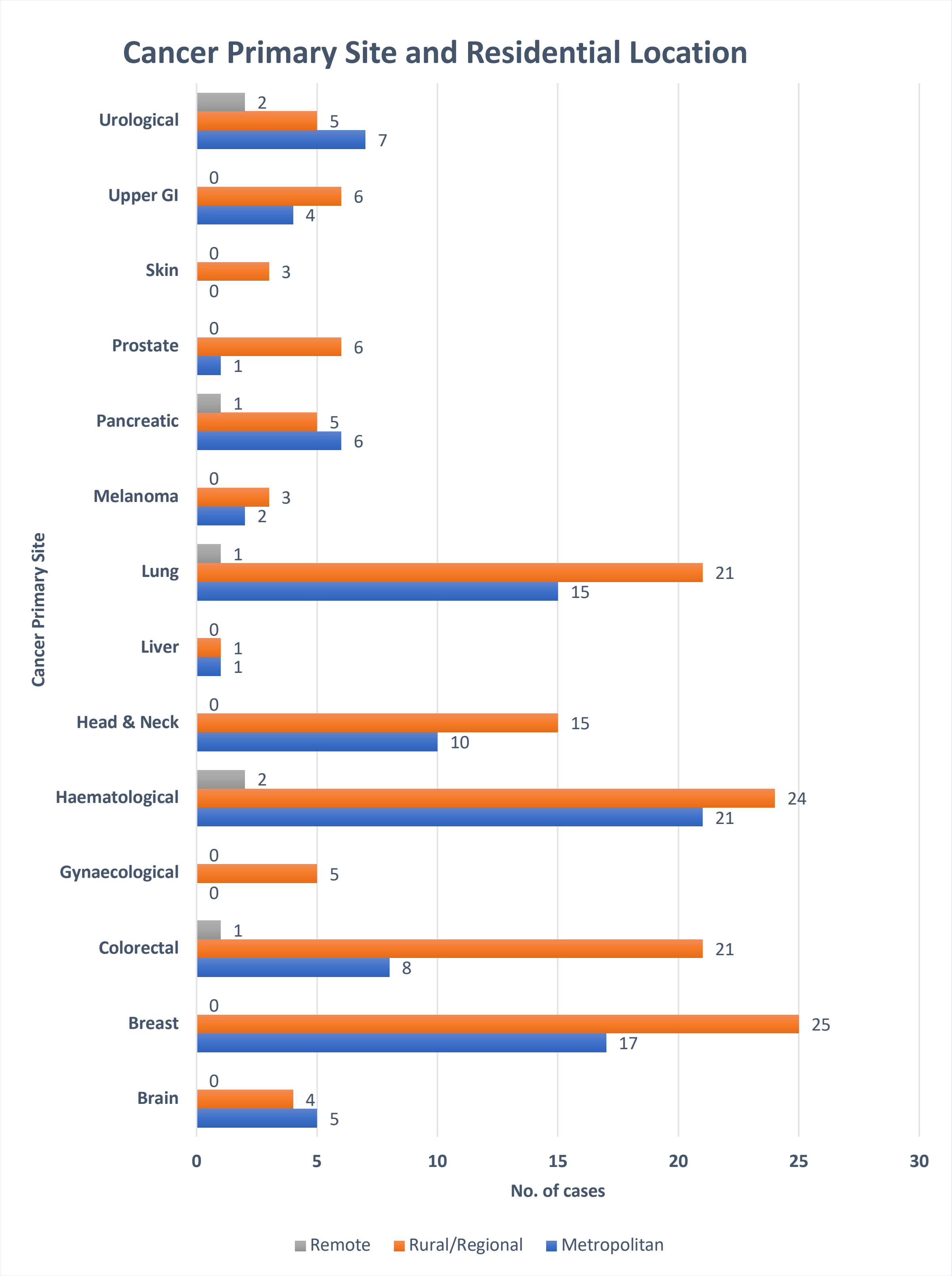

Cancer Primary Site and Residential Location
Cancer Primary Site
Urological 2 5 7
Upper GI 0 6 4
Skin 0 3 0
Prostate 0 6 1
Pancreatic 1 5 6
Melanoma 0 3 2
Lung 1 21 15
Liver 0 1 1
Head & Neck 0 15 10
Haematological 2 24 21
Gynaecological 0 5 0
Colorectal 1 21 8
Breast 0 25 17
Brain 0 4 5
0
5
10
15
20
25
30
No. of cases
Remote
Rural/Regional
Metropolitan

Figure 2.4

Four Most Common Cancer Primary Sites in the Study by Residential Location

Cancer Primary Site	Frequency	Metropolitan	Rural/Regional/Remote
Haematological	48	21	27
Breast	42	17	25
Lung	37	15	22
Colorectal	30	8	22
Total *(n=157)*	157	61 (38.8%)	96 (60.5%)

Table 2.5 In the four most common cancer primary sites in the study, higher numbers of patients from rural, regional and remote residential locations were seen by social workers.

Cancer Stage at Diagnosis (if known)

Cancer stage	Frequency	Percent
Early stage	96	38.4
Recurrence	36	14.4
End stage	49	19.6*
Other	64	25.6
*Advanced	37	14.8
Unknown	27	10.8
(N=250)	250	100

Table 2.6

Table 2.6 and Figure 2.6 Show that nearly 40% of cases reviewed were at an early stage of cancer at diagnosis. At this stage patients are dealing with such issues as treatment options, lifestyle changes, fears of recurrence post treatment, the impact of the diagnosis on families, talking to children about the diagnosis, and strategies to remain hopeful.

In the Other category, social workers specified 'Advanced' in 37 cases (14.8%) which is a similar number to those in the Recurrence (14.4%) and End stage (19.6%) categories. At these stages patients and families are experiencing more distress, less hope for a cure, knowledge of poorer survival rates, making plans and facing mortality.

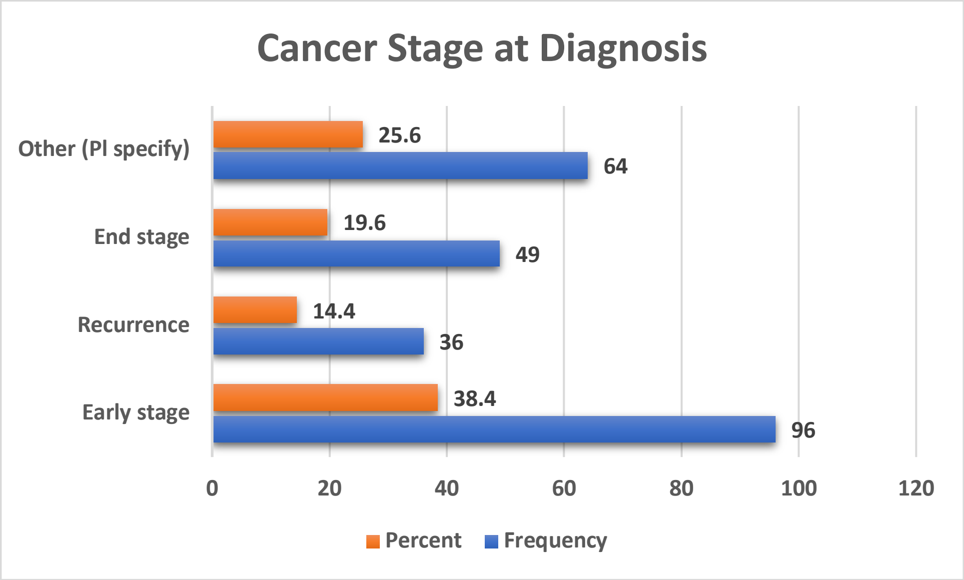


Figure 2.6

Cancer Stage at Social Work Contact

	Cancer Stage at Social Work Contact (N=250)	**Frequency**	**Percent**
	Following initial diagnosis	134	53.6
	Recurrence of cancer	46	18.4
	End stage/palliative care	51	20.4
	Other	16	6.4
	Not Stated	2	0.8
	Total	250	100

Table 2.7

Table 2.7 and Figure 2.7. In over 50% of cases, social work contact was following the initial diagnosis of cancer. This is the time of greatest lifestyle adjustment and upheaval, as patients come to terms with their diagnosis, incorporate often arduous and lengthy treatments into their lives and reflect on, and reassess their future plans and goals.

In just under 40% of cases social work contact was either at the recurrence or end stage of the disease. The knowledge of incurable disease, loss of hope and confronting end of life care and decision-making are times of enormous distress for patients and families. Social work intervention includes assisting adjustment, engaging families in difficult conversations, mobilising resources and coordinating ongoing care arrangements. These are reflected in Section 6 Social Work Interventions.

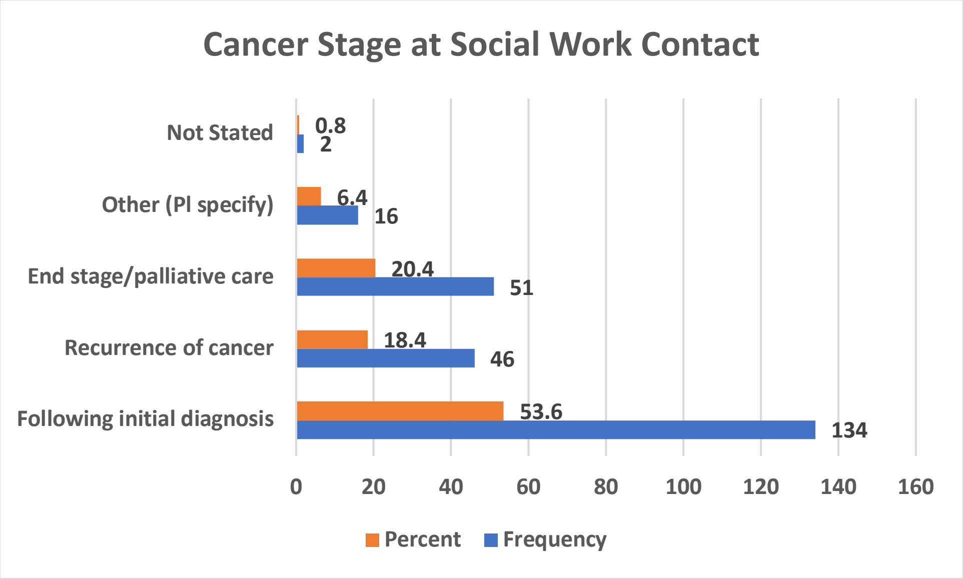


Figure 2.7

Social Work Contact by Cancer Site and Stage

Social Work Contact (N=250)	Following initial Diagnosis	Recurrence	End stage/Palliative care	Other/ Not stated
Brain	5	0	2	2
*Breast	28	5	4	5
*Colorectal	18	6	6	0
Gynaecological	2	1	2	0
*Haematological	26	10	5	6
Head & Neck	15	7	2	1
Liver	2	0	1	0
*Lung	16	5	14	2
Melanoma	0	3	2	0
Pancreatic	6	2	4	0
Prostate	3	1	1	2
Skin	2	1	0	0
Upper GI	5	1	4	0
Urological	6	4	4	0
Total	135 (54%)	46 (18.4%)	51 (20.4%)	18 (7.2%)

Table 2.8

Table 2.8 and Figure 2.8 The most frequent cancer stage for social work contact occurred following initial diagnosis across the spectrum of cancer sites.
The highest occurrence of first social work contact at the end stage of the disease was with lung cancer. This may be due to late diagnosis or a higher incidence in rural and remote areas before treatment is sought. This needs further investigation.

In the four most common types of cancer sites in the study, *Haematological, *Breast, *Lung and *Colorectal the social work contact was following initial diagnosis. Patients from regional, rural and remote locations were also highest in these groups. This seems to suggest that residential location is a risk factor for early social work referral.

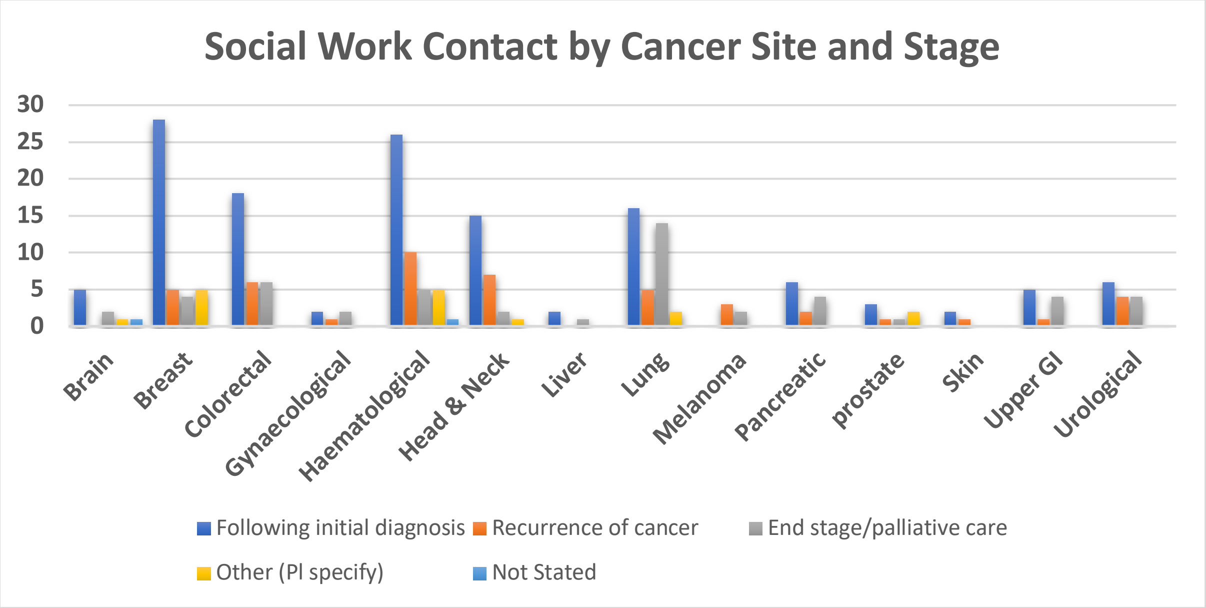

Social Work Contact by Cancer Site and Stage
30
25
20
15
10
5
0
Brain
Breast
Colorectal
Gynaecological
Haematological
Head & Neck
Liver
Lung
Melanoma
Pancreatic
prostate
Skin
Upper GI
Urological
Following initial diagnosis
Recurrence of cancer
End stage/palliative care
Other (Pl specify)
Not Stated

Figure 2.8

Referral to Social Work

Source of Referrals to Social Work

Referral to Social Work (N=250)		
	Frequency	Percent
Patient Self-referral	8	3.2
Relative/Carer referral	9	3.6
Oncologist /Medical Officer	51	20.4
Nurse	102	40.8
General Practitioner	1	0.4
Multi-disciplinary team (MDT)	25	10
Other health professional	15	6
Community/health agency	2	0.8
Other unspecified	37	14.8
Total	250	100

Table 3.1

Table 3.1 and Figure 3.1 The majority of referrals to social work were made by nursing, medical and health professional staff. Of these, the majority were from nursing staff. Referrals from patients or family members were less than 7%. This may indicate a need for patient education and improvements in health literacy about social work practice in oncology.

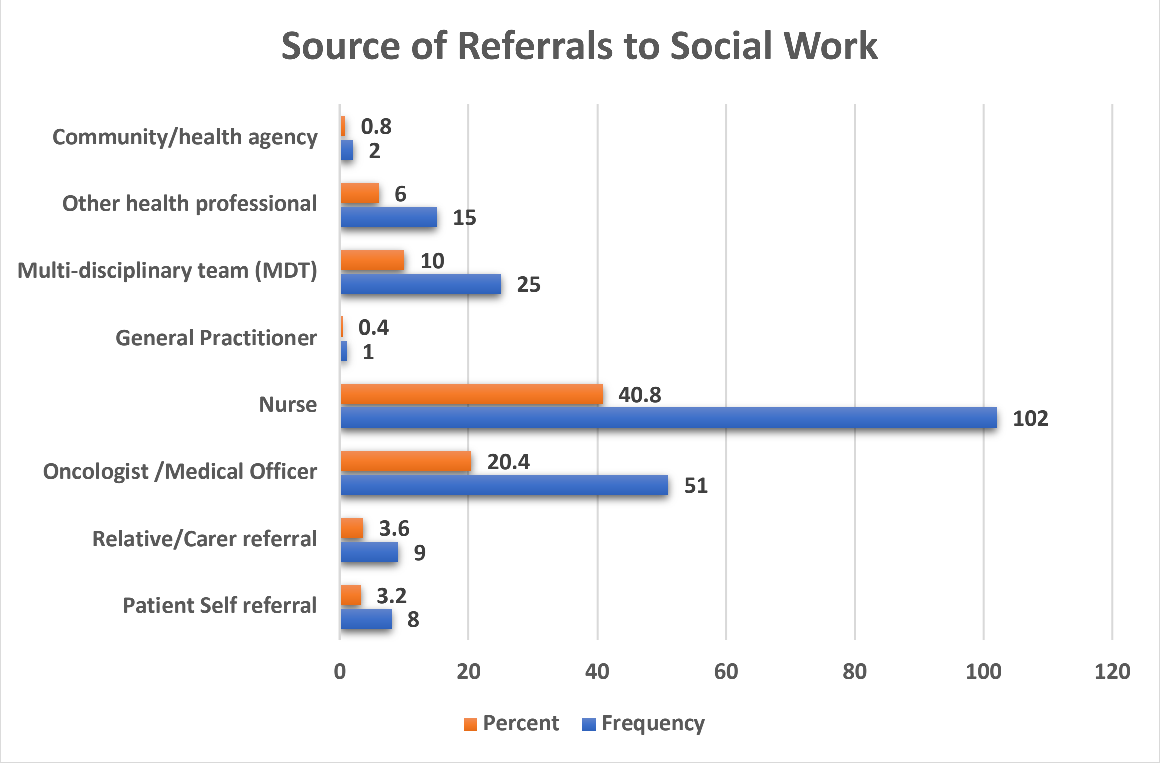


Figure 3.1

Other Sources of Referrals to Social Work

Referral to Social Work by Others (specified) (*n=62*)			
		Frequency	Percentage of Total Referrals
	Aboriginal liaison nurse	1	0.4
	Allied Health screening tool	1	0.4
	blanket referral	5	2
	CC clinic	1	0.4
	Centrelink SW	1	0.4
	clinical psychologist	2	0.8
	Dietician	2	0.8
	ED care coordinator	1	0.4
	electronic journey board	4	1.6
	Leukemia foundation	1	0.4
	OT	1	0.4
	Other - routine screen new patient	2	0.8
	other - routine social work screening	28	11.2
	Other - social worker	2	0.8
	other-cancer screen-oncology clinic	1	0.4
	other-routine referral Indigenous pts	1	0.4
	Physio	1	0.4
	radiation therapist	1	0.4
	receptionist cancer centre	1	0.4
	relative also	4	1.6
	self also	1	0.4
	Total	62	24.8

Table 3.2

Table 3.2 and Figure 3.2. These show the range of other referral sources to social work specified by coders and their percentage of total referrals. A wide range of sources indicates good engagement across the spectrum of health care providers. Social workers were able to receive referrals from any source and were not bound by medical referral protocols. The most frequent other referral source was from routine social work screening (11.2%). This involved the use of a Distress Thermometer as a screening tool or the assessment of patient information in the medical record (O'Donnell, 2013; Zebrack, 2012).

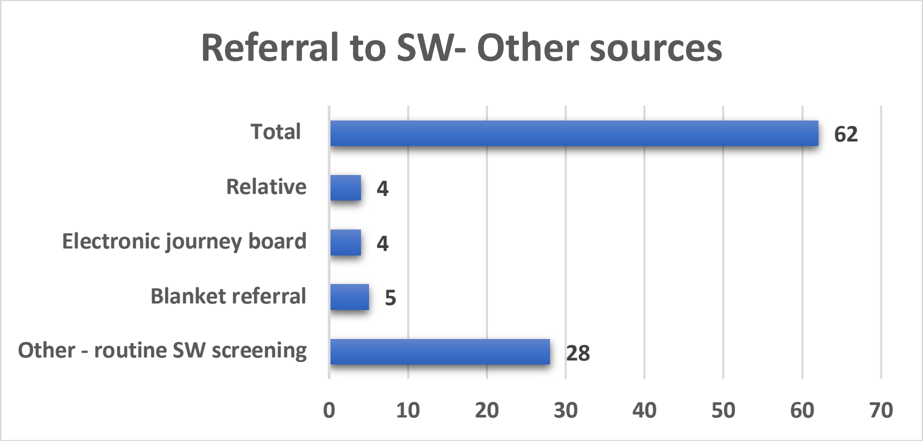


Figure 3.2

Referral Information

Referral information	Frequency	Percent
Referral reason specified	200	80
Referral information reason unspecified/general referral	50	20

Table 3.3 In 80% of cases, reasons for referral were specified in the referral to social work. The remaining 20% were for general referrals where the referrer had identified a need for social work involvement but did not specify the reasons.

Range of Reasons Specified in Referral to Social Worker from Others

Reason for referral	Code	Includes	Frequency	Percent
*Adjustment to illness/disability	ADJ	**-Psycho-social assessment -New diagnosis -Anxiety re treatment and future plans -Emotional support -Young age of patient Patient distress**	74	29.6
*Financial & Material assistance	FMA	**Financial (51) Parking/Transport (11)**	62	24.8
*Discharge/community care issues	DC	**Includes home supports/services**	43	17.2
Carer Issues	CAI	**Carer stress, support**	16	6.4
Homelessness/housing/ accommodation	HAC	**-Emergency accommodation, -Overseas family members' accommodation**	14	5.6
Child/parenting issues	CPI	**Young families, single parents, care of children**	11	4.4
End of Life issues	EOI	**For patient, family, carers**	8	3.2
Behavioural, cognitive or mental health	BMH	**Mental health issues specified**	5	2
Legal issues	LI		5	2
Immigration/refugee Issues	IMR		4	1.6
Other Social	OS	**Assistance with decision-making re treatment, pre-operative counselling**	4	1.6
Residential aged care placement	RAP		2	0.8
Social Isolation	SI		2	0.8
Total			250	100

*Often referred together

Table 3.4

Table 3.4 and Figure 3.4

When a reason for referral was given the highest percentage (29.6%) were referrals relating to the adjustment of the patient to their illness or situation. Adjustment issues, financial and material assistance and discharge/community care issues accounted for 71.6% of referrals. These were often referred together. These show a good understanding by referrers of the type of work undertaken social workers.
The sites reflected different patient demographics and types of cancer services however the consistency of the social work referrals across sites indicates that the scope of the work is similar. The specified reasons noted on the Data Collection Sheets have been coded using the Reasons for Intervention Codes used in the study.

The means of making referrals wasn't investigated in the study. Across the sites, referrals may have been made in person, by electronic referral systems or in some other way. In the case of electronic referrals, the drop-down codes for referral may also force choices by those referring. To begin the electronic referral process referrers may also select the first option as a default referral. However, the methodology used in the study of social workers coding the medical records of their own cases suggests that this is an accurate finding of the reasons for referral by others.

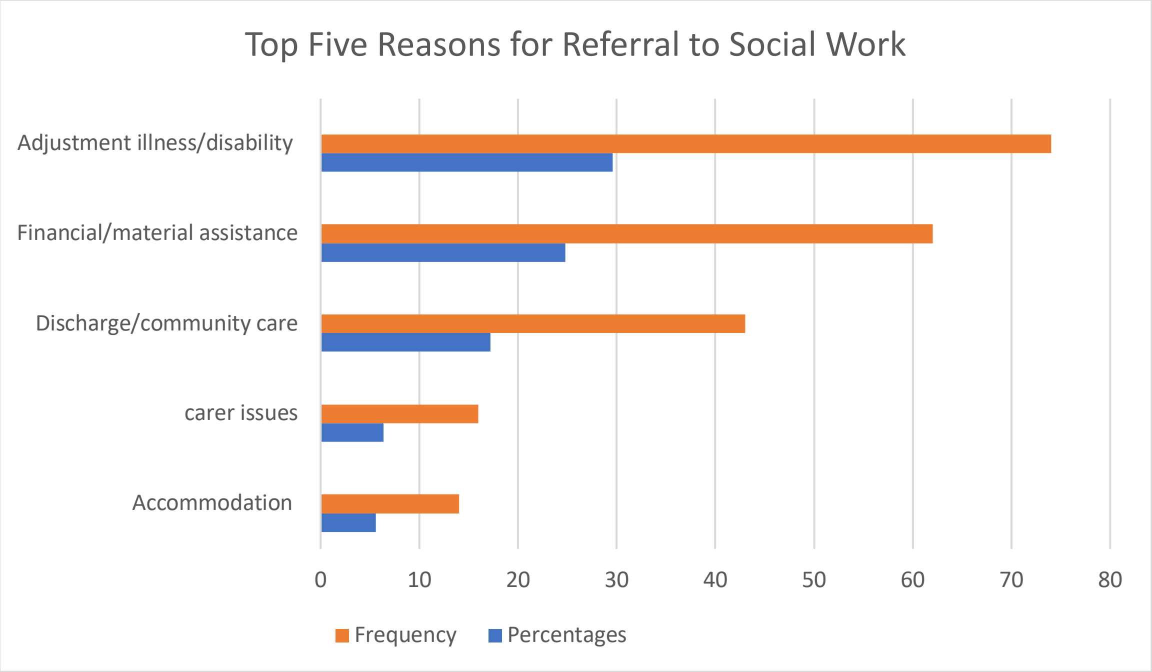


Figure 3.5

Social Work Contact

The contact type is the 'mode' or way in which the intervention activities were conducted. Variations occurred at each site in the collection and coding of this data so the tables and figures indicate trends only.

Social Work Contact Type with Patients

SW contact type	Frequency
Individual Interviews	219
Telephone consultation	100
Family Interview (patient also present)	93

Table 4.1

Table 4.1 and Figure 4.1 show the main modes of contact with patients. Individual patient interviews are the most frequent type of contact with patients followed by telephone consultations and family interviews with the patient present, demonstrating a high level of interpersonal engagement by social workers in delivering interventions.

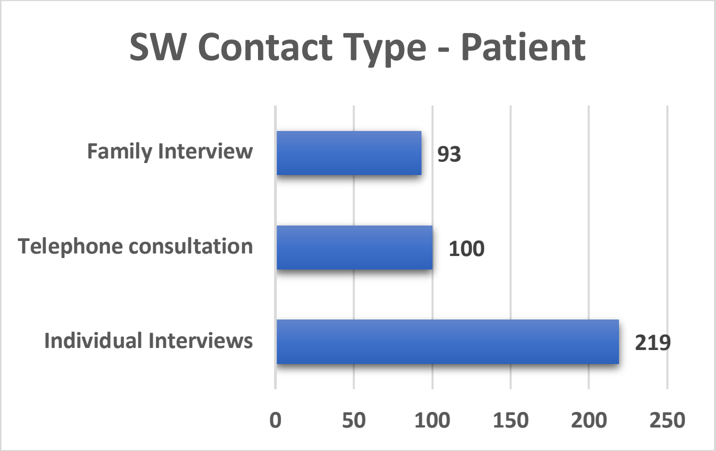


Figure 4.1

Social Work Occasions of Service with Patients

The frequency of contact by social workers has been counted using occasions of contact however this wasn't specifically defined in the study. Health sites and state health services involved in the study have different ways of defining this so it was left up to social workers to use their own site specific understanding of what it meant. No time unit was allocated to an occasion of contact.

The definition of Occasion of Service in the NSW *Allied Health Minimum Data Set: Coding Manual,* (NSW Directors of Allied Health, 2015) is as follows:

"A count of clinical activity evidenced by contact with the client/patient, therapeutic contact and date medical note documentation". (p.31)

Frequency of Social Work Contact with Patients

Frequency of contact (N=249)			
		Frequency	Percent
	1-3 occasions	61	24.4
	4-8 occasions	81	32.4
	9-11 occasions	24	9.6
	12+ occasions	83	33.2

Table 4.2

Table 4.2 and Figure 4.2. Almost a quarter of patients (24.4%) had 1-3 social work occasions of service with 42.8% having over 9 occasions of service. The average number of occasions of service was 8. A third of patients (33.2%) had over 12 occasions of service. Qualitative data by social work reviewers noted that cases with higher numbers of occasions of service indicated higher levels of case complexity.

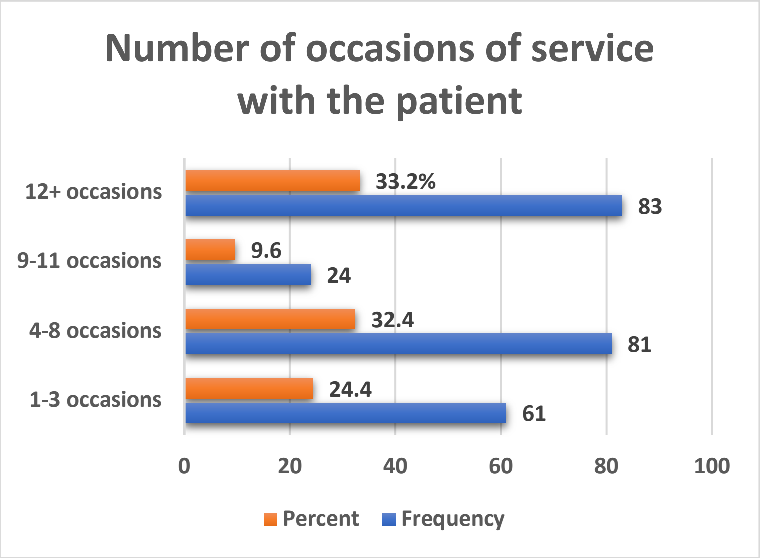


Figure 4.2

Social Work Contact Type with a Relative, Carer or Significant Other

SW contact type	SW Contact Relative/Carer/Significant other
Individual Interviews	59
Telephone consultation	86
Family Interview (patient not present)	106

Table 4.3

Table 4.3 and Figure 4.3. The main mode of contact with relatives, carers or significant others was family interviews, followed by telephone consultations and individual interviews. Family interviews without the patient present were the most frequent type of contact followed by telephone consultations and interviews with an individual family member, carer or significant person associated with the patient. As with patient contact types, social work contact with family members, carers or significant others demonstrates a high level of interpersonal engagement by social workers in delivering interventions.

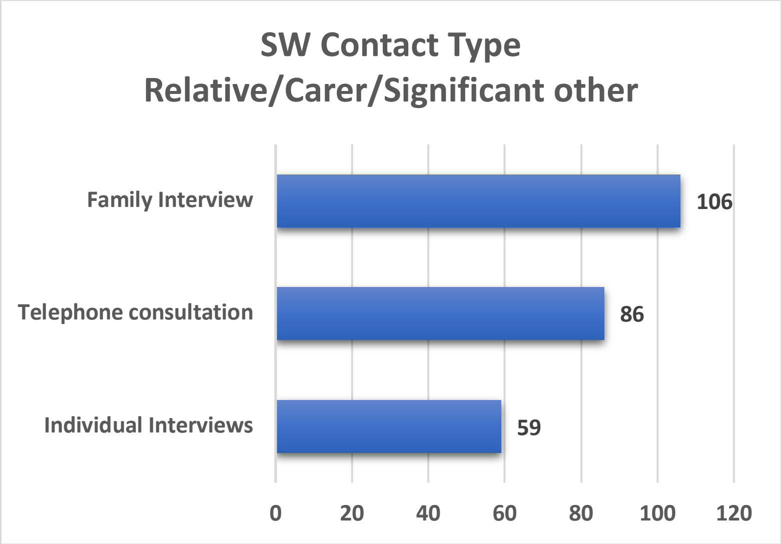


Figure 4.3

Frequency of Social Work Contact with Relatives, Carers or Significant Others

Frequency of contact (N=250)			
		Frequency	Percent
	1-3 Occasions	86	34.4
	4-8 Occasions	34	13.6
	9-11 Occasions	12	4.8
	12+ Occasions	9	3.6
	Total	141	56.4
Missing	System	109	43.6
Total		250	100

Table 4.4

Table 4.4 and Figure 4.4. In contrast to the frequency of social work contact with patients, the highest percentage of occasions of service with relatives, carers or significant others involved 1-3 occasions of service (34.4%). 48% of contacts were between 1-8 occasions of service.
The high 'missing' data may be accounted for as either no contact with this group by the social worker or family interviews being included in Table 4.2 in the patient data.

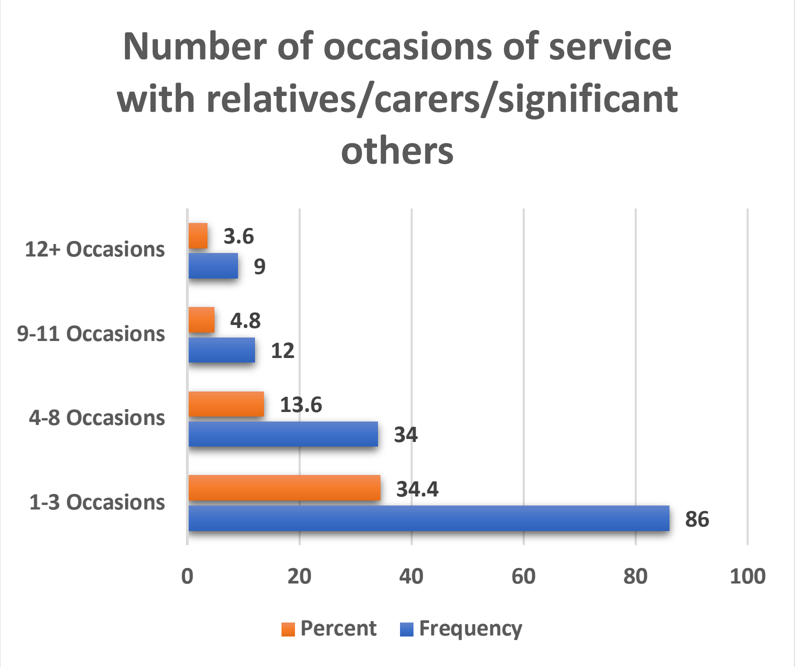


Figure 4.4

Social Work Contact Type with Others

This included contact types with others associated with the care of the patient who were not patients, relatives, carers or significant others.

SW contact type - Other	Frequency	Percent
Case conference	65	21
Ward rounds/team consultation	126	40.5
Written communication	120	38.5

Table 4.5

Table 4.5 and Figure 4.5. Consultations within the multidisciplinary team that included routine care planning accounted for the highest number of occasions of service with others associated with the case. Written communication which included reports, letters and all other written communications for the case were slightly lower with formal case conferences being the lowest contact type. This may be a site specific factor as not all sites hold formal case conferences.

NB. Not all case coding sheets had this category completed. These activities may also be included in 'patient', and 'relatives, carers and significant others' categories. For example, an occasion of service that was an individual interview would also include writing case notes in the medical record.

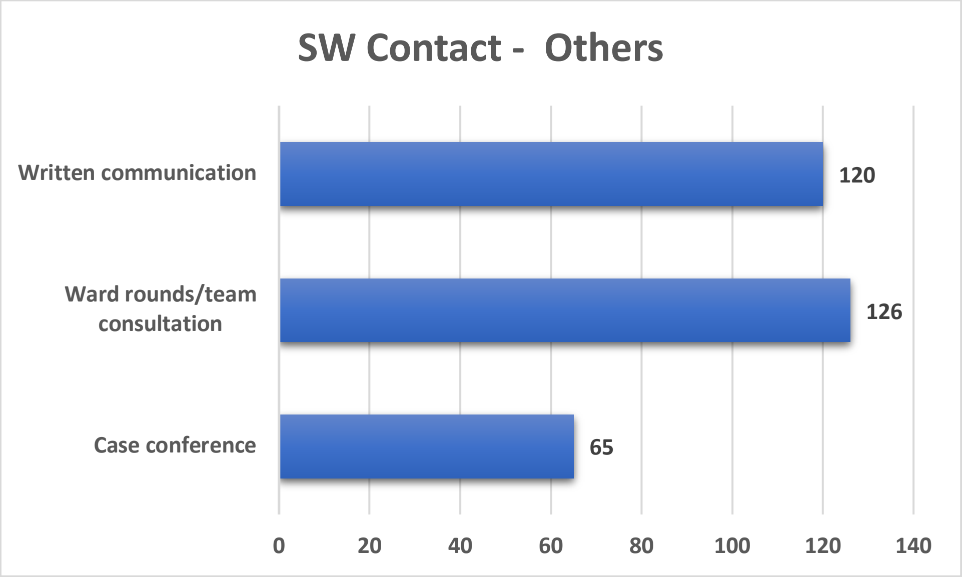


Figure 4.5

Occasions of Service, Gender, Relationship Status, and Child Status

Gender and Occasions of Service

N=250
(In calculating the total occasions of service, the higher figure in each range was used rather than the median as it is likely that OOS were under-reported due to differences in definition at each site. The occasions of service are in bold text.)

Occasions of Service		**1-3**		**4-8**		**9-11**		**12+**	Total M/F	Total OOS
Males	22	**66**	46	**368**	16	**165**	40	**480**	123	**1,079**
Females	39	**117**	34	**272**	9	**99**	38	**456**	120	**944**
Total	61		80		25		78		243	
Missing									7	
Total OOS		**183**		**640**		**264**		**936**		**2,023**

Table 4.6

Table 4.6 and Figure 4.6 In three of the four groupings of occasions of service, males received slightly more occasions of service than female patients

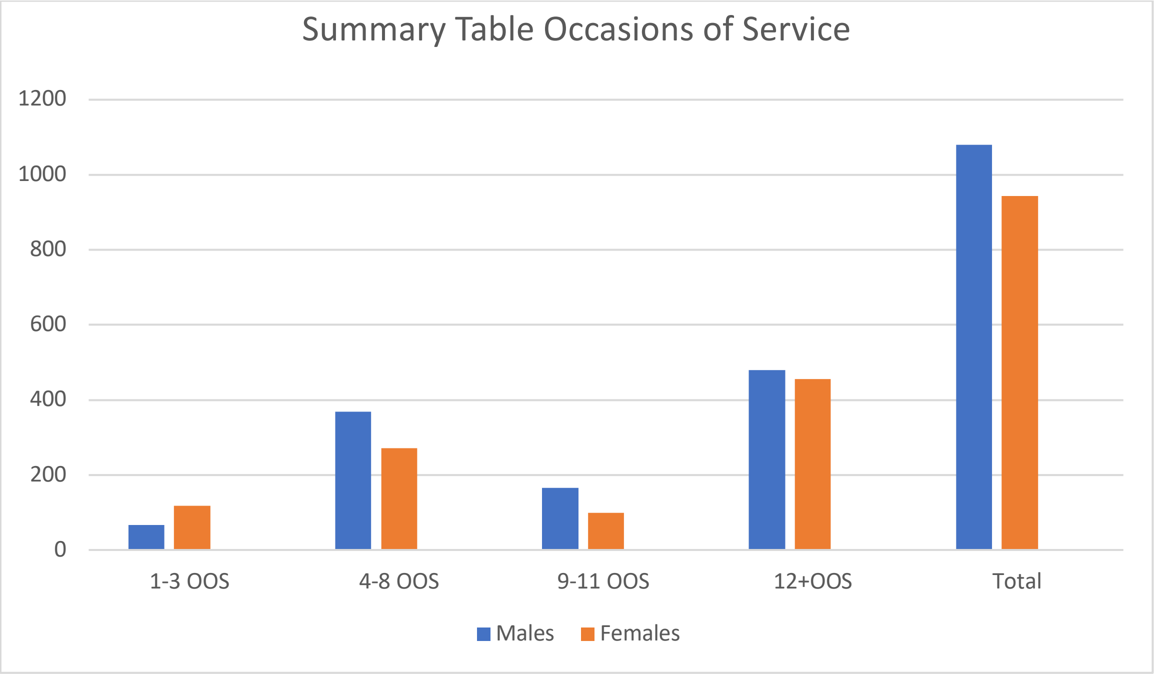


Figure 4.6

Relationship Status and Occasions of Service

	Total number	Total OOS	Percent
Males	70	599	57.2
Females	56	448	42.7
Total	126	1,047	

Table 4.7 Partnered and occasions of service. The average number of Occasions of Service is 8 for both males and females in this category

	Total number	Total OOS	Percent
Males	53	480	49.1
Females	64	496	50.8
Total	117	976	
Missing/not stated	7	0	

Table 4.8. Non-partnered and occasions of service. The average number of Occasions of Service is 8 for both males and females in this category

Relationship Status, Children and Occasions of Service

Occasions of Service		**1-3**		**4-8**		**9-11**		**12+**	Total M/F	**Total OOS**
Males	6	**18**	22	**176**	3	**33**	11	**132**	42	**359**
Females	9	**27**	8	**64**	3	**33**	6	**72**	26	**196**
Total	15		31		6		17		68	
Total OOS		**45**		**240**		**66**		**204**		**555**

Table 4.9 Partnered with Adult Children and Occasions of Service. A higher number of male patients, who were partnered with adult children were seen compared with partnered female patients with adult children.

Occasions of Service		**1-3**		**4-8**		**9-11**		**12+**	Total M/F	**Total OOS**
Males	4	**12**	7	**56**	4	**44**	6	**72**	21	**184** *(51%)*
Females	7	**21**	6	**48**	3	**33**	6	**72**	22	**174**
Total	11		13		7		12		43	*(48.6%)*
Total OOS		**33**		**104**		**77**		**144**		**358**

Table 4.10. Partnered with Dependent Children and Occasions of Service. Equal numbers of male and female patients who were partnered with dependent children were seen receiving almost equal occasions of service. (51% for males and 48.6% for females)

Occasions of Service		**1-3**		**4-8**		**9-11**		**12+**	Total M/F	**Total OOS**
Males	2	**6**	2	**16**	2	**22**	1	**12**	7	**56** *(41.7%)*
Females	1	**3**	2	**16**	1	**11**	4	**48**	8	**78** *(58.2%)*
Total	3		4		3		5		15	
Total OOS		**9**		**32**		**33**		**60**		**134**

Table 4.11. Partnered, No Children and Occasions of Service. Female patients who were partnered with no children received slightly more occasions of service (58.2%) than males (41.7%).

Occasions of Service		**1-3**		**4-8**		**9-11**		**12+**	Total M/F	**Total OOS**
Males	3	**9**	10	**80**	3	**33**	8	**96**	24	**218** *(43.7%)*
Females	16	**48**	11	**88**	0	**0**	12	**144**	39	**280** *(56.2%)*
Total	19		21		3		20		63	
Total OOS		**57**		**168**		**33**		**240**		**498**

Table 4.12 Non-partnered with Adult Children and Occasions of Service. A higher number of female, non-partnered patients were seen and received higher occasions of service (56.2%) than male patients (43.7%) in this category

Occasions of Service		**1-3**		**4-8**		**9-11**		**12+**	Total M/F	**Total OOS**
Males	1	**3**	0	**0**	1	**11**	3	**36**	5	**50** *(24%)*
Females	3	**9**	3	**24**	2	**22**	8	**96**	16	**151** *(75%)*
Total	4		3		3		11		21	
Total OOS		**12**		**24**		**33**		**132**		**201**

Table 4.13 Non-partnered with Dependent Children and Occasions of Service. Three times as many female patients with dependent children were seen than males receiving 75% of the total occasions of service for this category.

Occasions of Service		**1-3**		**4-8**		**9-11**		**12+**	Total M/F	**Total OOS**
Males	6	**18**	5	**40**	2	**22**	11	**132**	24	**212** *(76.5%)*
Females	3	**9**	4	**32**	0	**0**	2	**24**	9	**65** *(23.5%)*
Total	9		9		2		13		33	
Total OOS		**27**		**72**		**22**		**156**		**277**

Table 4.14 Non-partnered, No Children and Occasions of Service. Three times as many non-partnered males with no children were seen than non-partnered females receiving 76.5% of the total occasions of service for this category.

Table 4.10 and Table 4.13 show the total number of either partnered or unpartnered patients with dependent children was 64 (43 partnered and 21 unpartnered) which accounted for 26.3% of the total patients. The average occasions of service for the total number of patients was 8 however the average OOS for this group was 11.4 indicating higher levels of social need and case complexity. Of particular significance is that three times as many unpartnered female patients with dependent children (16) were seen than males (5) receiving 75% of the total occasions of service in this category.

Table 4.12 shows a higher number of female, non-partnered patients with adult children were seen and received higher occasions of service (56.2%) than male patients (43.7%) in this category.

Table 4.14 shows nearly three times as many non-partnered males with no children (24) were seen compared with non-partnered females with no children (9) receiving 76.5% of the total occasions of service for this category.

These findings suggest that female patients with dependent children and non-partnered males without children were social risk factors warranting referral to social workers.

Reasons for Intervention Following Social Workers' Assessment

Social workers were asked to identify up to five reasons for intervention following their assessment. The reasons for intervention activities are based on the social work assessment. Reasons selected answer the question: 'What is it about this patient/client situation that I am aiming to address with my intervention?' (Woodruff, Fitzgerald and Itsiopoulos, 2000).

Reasons for Intervention: Frequency of Coding by Social Workers

Reasons for intervention	Frequency of coding
Adjustment to illness/disability	**198**
Financial & Material assistance	**125**
Carer Issues	**96**
Discharge/community care issues	**88**
Family/relationship issues	**57**
End of life Issues	**51**
Behavioural, cognitive or mental health	**49**
Other social	**47**
Homelessness/housing/ accommodation	**41**
Bereavement	**29**
Legal Issues	**29**
Child/Parenting issues	**28**
Ageing Issues	**13**
Residential aged care placement	**12**
Social isolation	**12**
Immigration/refugee Issues	**10**
Domestic Violence	**6**
Drug & Alcohol issues	**6**
Guardianship/financial management	**6**
Sexuality/sexual health and wellbeing	**4**
Child Protection	**3**
Elder Abuse	**2**
Pregnancy adjustment/issues	**1**
Trauma	**1**
Sexual Assault	**0**
Stillbirth/miscarriage	**0**
Victim of Crime	**0**

Table 5.1. This table shows the frequency of coding of the possible reasons for social work intervention listed in the Allied Health Minimum Data Set: Coding Manual (NSW Directors of Allied Health, 2015). Sexual assault, stillbirth/miscarriage and victim of crime indicators are not reported however these three areas are within the scope of social work practice and may be identified in other cohorts of patients. Similarly, some of the reasons coded may be under reported in this study with a higher incidence in other samples of patients. This is due to the opportunistic sampling method used in the study.

Top Five Reasons for Referral to Social Work from Others

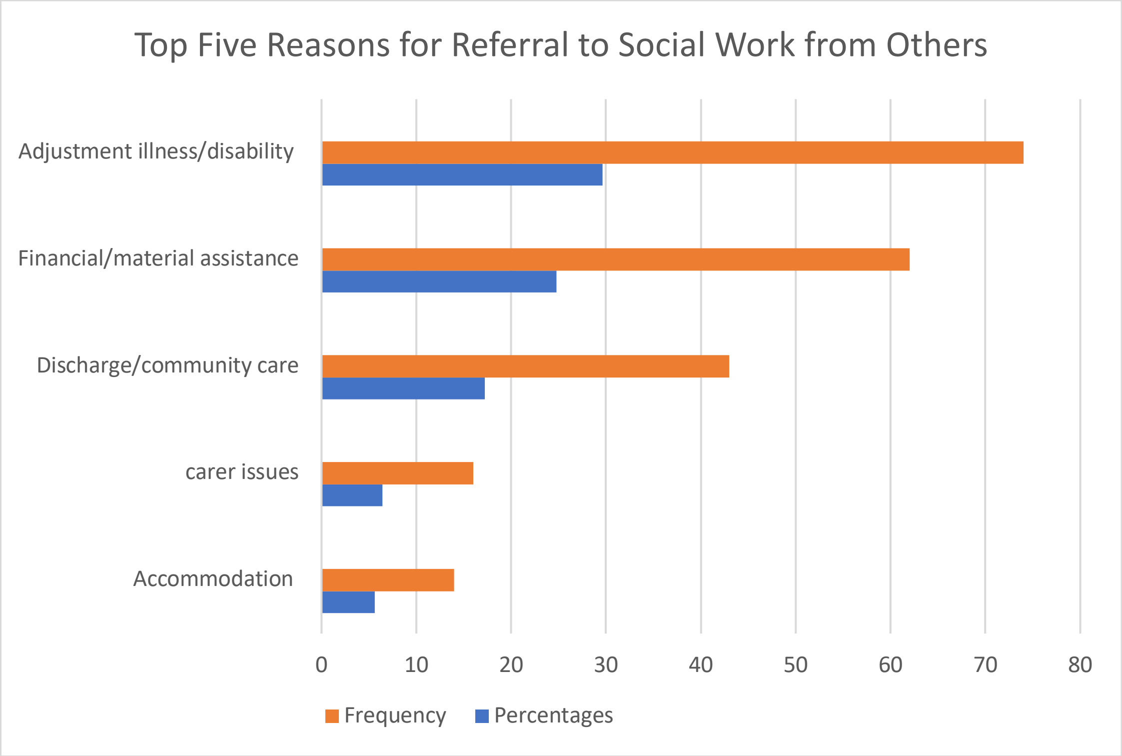


Figure 5.1

This Figure also appears as Figure 3.5 and is repeated here to show the comparison between the reasons for referral to social workers by others and the reasons for intervention identified by social workers. The findings suggest good congruity between the two in the top five reasons.

When a reason for referral was given by others for social work intervention the highest percentage (29.6%) were referrals relating to the adjustment of the patient to their illness or situation. Adjustment issues, financial and material assistance and discharge/community care issues accounted for 71.6% of referrals. These were often referred together.

In the reasons for intervention identified by social workers, adjustment to illness/disability, financial and material assistance, carer issues, and discharge/community care issues accounted for the most frequently identified reasons for intervention. While accommodation issues were listed as the ninth most frequently identified reason, it is possible that there was some overlap with discharge/community care issues identified by social workers. The latter involving a more comprehensive indicator. These reasons for referral are both patient and hospital/health setting focused as they impact on the hospitals’ and health services treatment and care planning for patients.

These similarities show a good understanding by referrers of the type of work undertaken by social workers although the ways social workers understand them has wider and more sophisticated scope and depth that leads on to intervention. The reasons for intervention that result from the psychosocial assessment also include other reasons that reflect more profession-specific understandings of psycho-social issues.

Choice of Reasons for Intervention

The following tables and figures illustrate the reasons for intervention and the internal choices within each.

Reasons for intervention – Choice 1

	(N=250)	Frequency	Percent
	Adjustment to illness/disability	160	64
	Financial & Material assistance	34	13.6
	Carer issues	13	5.2
	Behavioural, cognitive or mental health	7	2.8
	End of life Issues	7	2.8
	Child/Parenting issues	5	2
	Homelessness/housing/accommodation	4	1.6
	Residential Aged Care Placement	3	1.2
	Ageing issues	3	1.2
	Family/Relationship issues	3	1.2
	Bereavement	3	1.2
	Other social	2	0.8
	Discharge/community care issue	2	0.8
	Domestic Violence	1	0.4
	Drug & Alcohol issues	1	0.4
	Immigration/refugee issues	1	0.4
	Not supplied	1	0.4
	Total	250	100

Table 5.2

Table 5.2 and Figure 5.2 Adjustment to illness/disability was the most frequent first choice of reason for intervention. Financial and material assistance was the second most frequent first choice and carer issues were the third most frequent first choice.

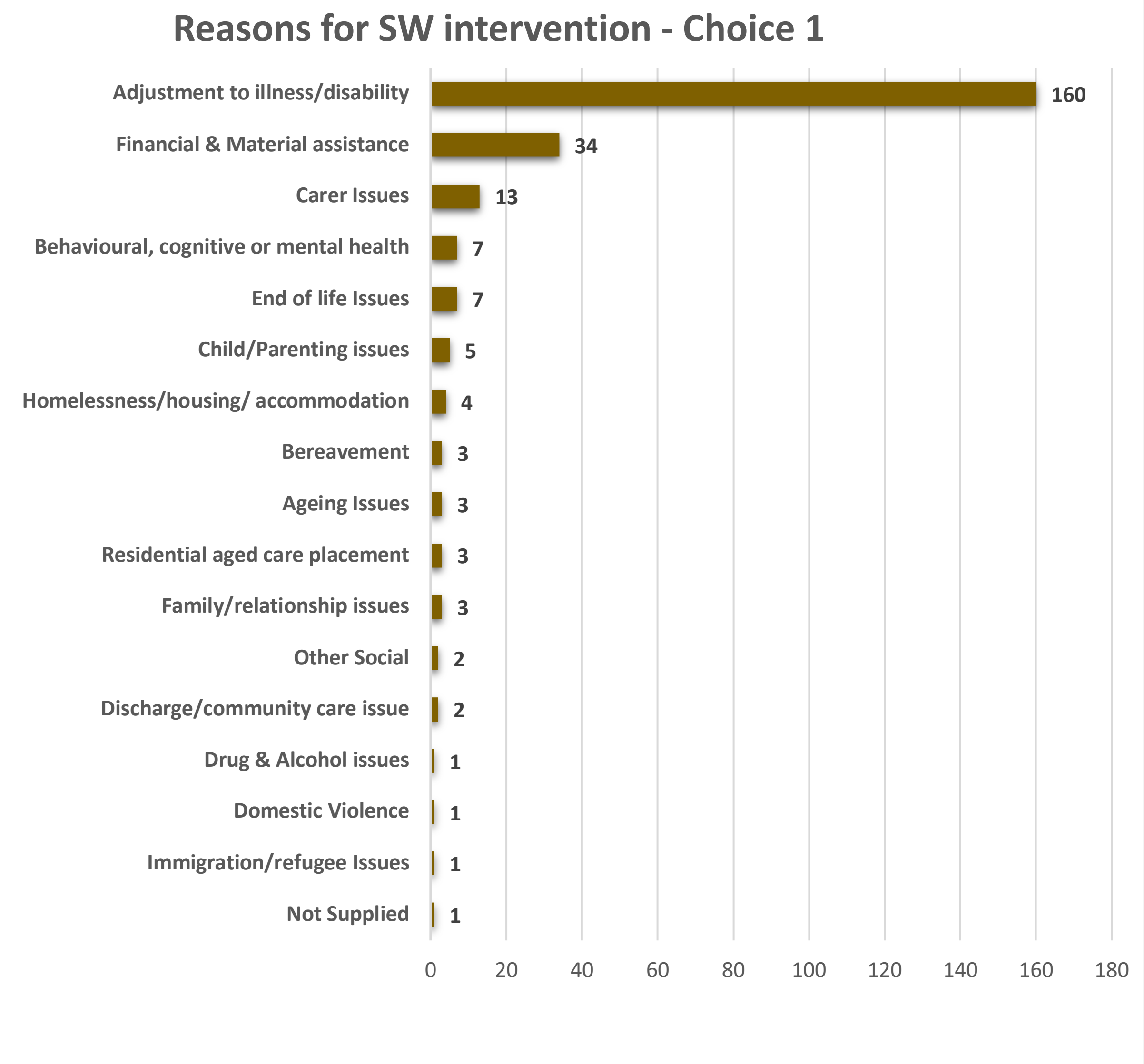

Reasons for SW intervention - Choice 1
Adjustment to illness/disability
160
Financial & Material assistance
34
Carer Issues
13
Behavioural, cognitive or mental health
7
End of life Issues
7
Child/Parenting issues
5
Homelessness/housing/ accommodation
4
Bereavement
3
Ageing Issues
3
Residential aged care placement
3
Family/relationship issues
3
Other Social
2
Discharge/community care issue
2
Drug & Alcohol issues
1
Domestic Violence
1
Immigration/refugee Issues
1
Not Supplied
1
0
20
40
60
80
100
120
140
160
180

Figure 5.2

Reasons for intervention – Choice 2

	Frequency	Percent
(N=250)		
Carer Issues	38	15.2
Financial & Material assistance	33	13.2
Discharge/community care issue	28	11.2
Family/relationship issues	23	9.2
Behavioural, cognitive or mental health	20	8
Adjustment to illness/disability	17	6.8
Not Supplied	16	6.4
Bereavement	13	5.2
End of life Issues	12	4.8
Child/Parenting issues	10	4
Homelessness/housing/ accommodation	9	3.6
Legal Issues	5	2
Ageing Issues	5	2
Other Social	4	1.6
Immigration/refugee Issues	3	1.2
Residential aged care placement	3	1.2
Drug & Alcohol issues	3	1.2
Guardianship/financial management	2	0.8
Social isolation	2	0.8
Child Protection	2	0.8
Elder Abuse	1	0.4
Domestic Violence	1	0.4

Table 5.3

Table 5.3 and Figure 5.3. The most frequent second choice of reason for intervention was carer issues (15.2%). The second most frequent second choice was financial and material assistance (13.2%) and the third most frequent second choice was discharge/community care issues (11.2%).

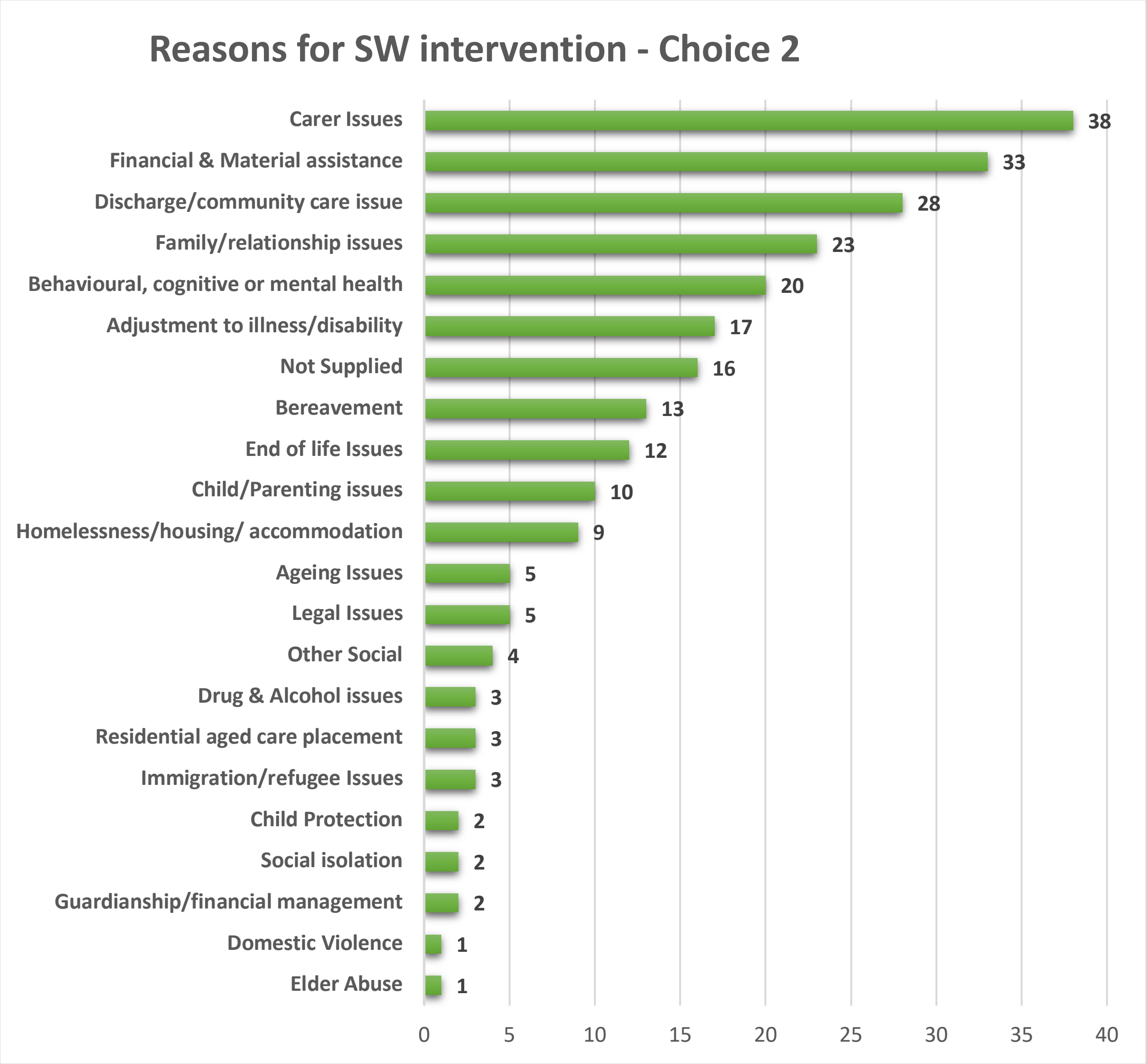

Reasons for SW intervention - Choice 2
Carer Issues
38
Financial & Material assistance
33
Discharge/community care issue
28
Family/relationship issues
23
Behavioural, cognitive or mental health
20
Adjustment to illness/disability
17
Not Supplied
16
Bereavement
13
End of life Issues
12
Child/Parenting issues
10
Homelessness/housing/ accommodation
9
Ageing Issues
5
Legal Issues
5
Other Social
4
Drug & Alcohol issues
3
Residential aged care placement
3
Immigration/refugee Issues
3
Child Protection
2
Social isolation
2
Guardianship/financial management
2
Domestic Violence
1
Elder Abuse
1
0
5
10
15
20
25
30
35
40

Figure 5.3

Reasons for intervention – Choice 3

	Frequency	Percent
(N=250)		
Not Supplied	52	20.8
Financial & Material assistance	30	12
Carer Issues	29	11.6
Discharge/community care issue	25	10
Family/relationship issues	17	6.8
End of life Issues	15	6
Other Social	15	6
Adjustment to illness/disability	13	5.2
Homelessness/housing/ accommodation	13	5.2
Legal Issues	8	3.2
Behavioural, cognitive or mental health	7	2.8
Child/Parenting issues	7	2.8
Residential aged care placement	4	1.6
Immigration/refugee Issues	3	1.2
Bereavement	3	1.2
Domestic Violence	3	1.2
Guardianship/financial management	2	0.8
Pregnancy adjustment/issues	1	0.4
Sexuality/sexual health and wellbeing	1	0.4
Child Protection	1	0.4
Drug & Alcohol issues	1	0.4

Table 5.4

Table 5.4 and Figure 5.4 List the most frequent third choice of reasons for intervention. Twenty percent of cases didn't make a third choice meaning that the first and second choices fully captured the reasons for intervention. Financial/material assistance (12%), carer issues (11.6%) and discharge/community care issues (10%) were ranked as the most frequent third reasons.

The third reason also sees an increase in the frequency of the code 'Other Social' (6%). Social workers were asked to describe these reasons. They included such reasons as the patient or family being dissatisfied with medical treatment and or hospital care; conflict with treating staff; planning for a return to work; reluctance to accept residential aged care placement; completion of exams and the care of pets at home.

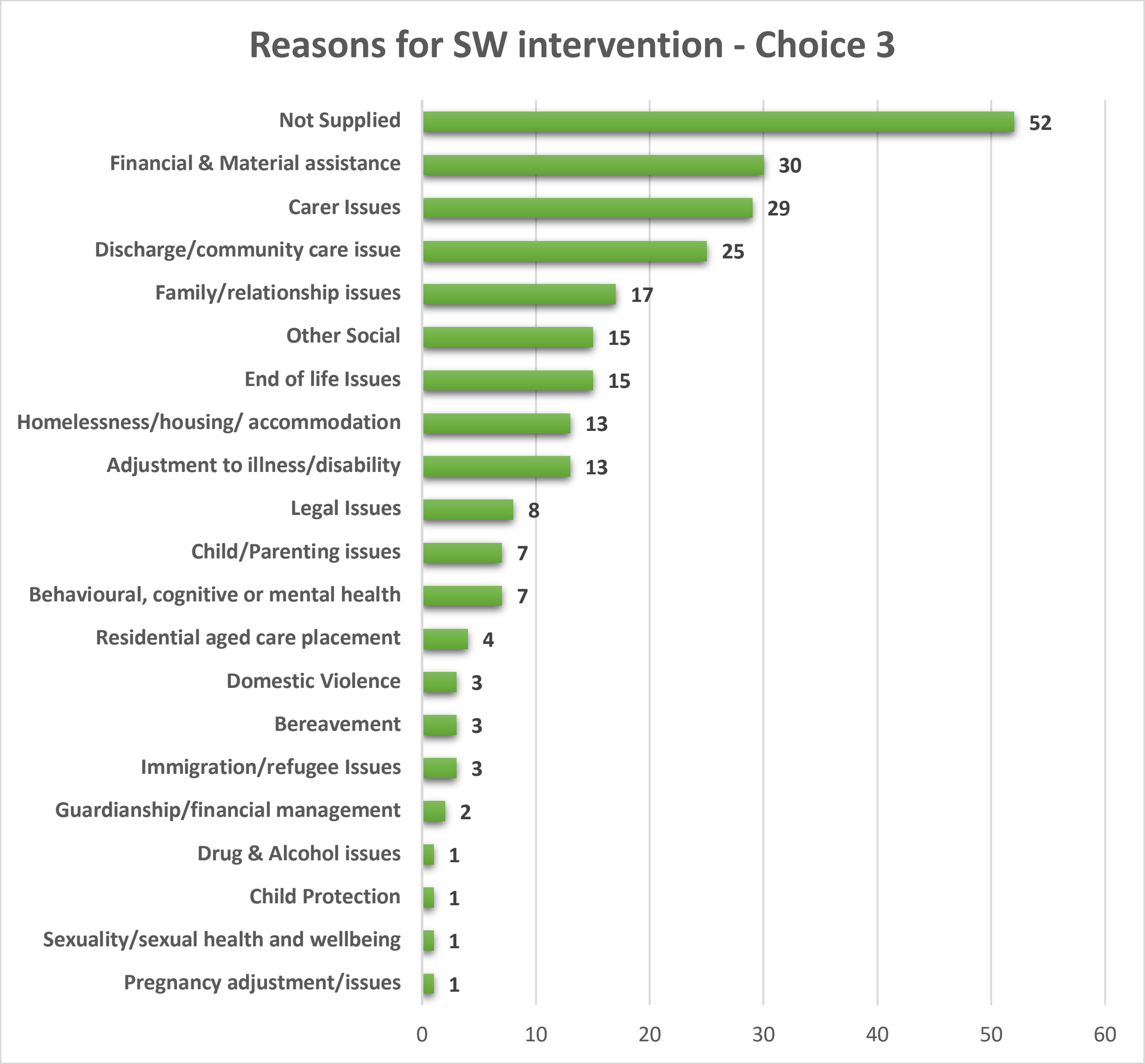

Reasons for SW intervention - Choice 3
Not Supplied
52
Financial & Material assistance
30
Carer Issues
29
Discharge/community care issue
25
Family/relationship issues
17
Other Social
15
End of life Issues
15
Homelessness/housing/ accommodation
13
Adjustment to illness/disability
13
Legal Issues
8
Child/Parenting issues
7
Behavioural, cognitive or mental health
7
Residential aged care placement
4
Domestic Violence
3
Bereavement
3
Immigration/refugee Issues
3
Guardianship/financial management
2
Drug & Alcohol issues
1
Child Protection
1
Sexuality/sexual health and wellbeing
1
Pregnancy adjustment/issues
1
0
10
20
30
40
50
60

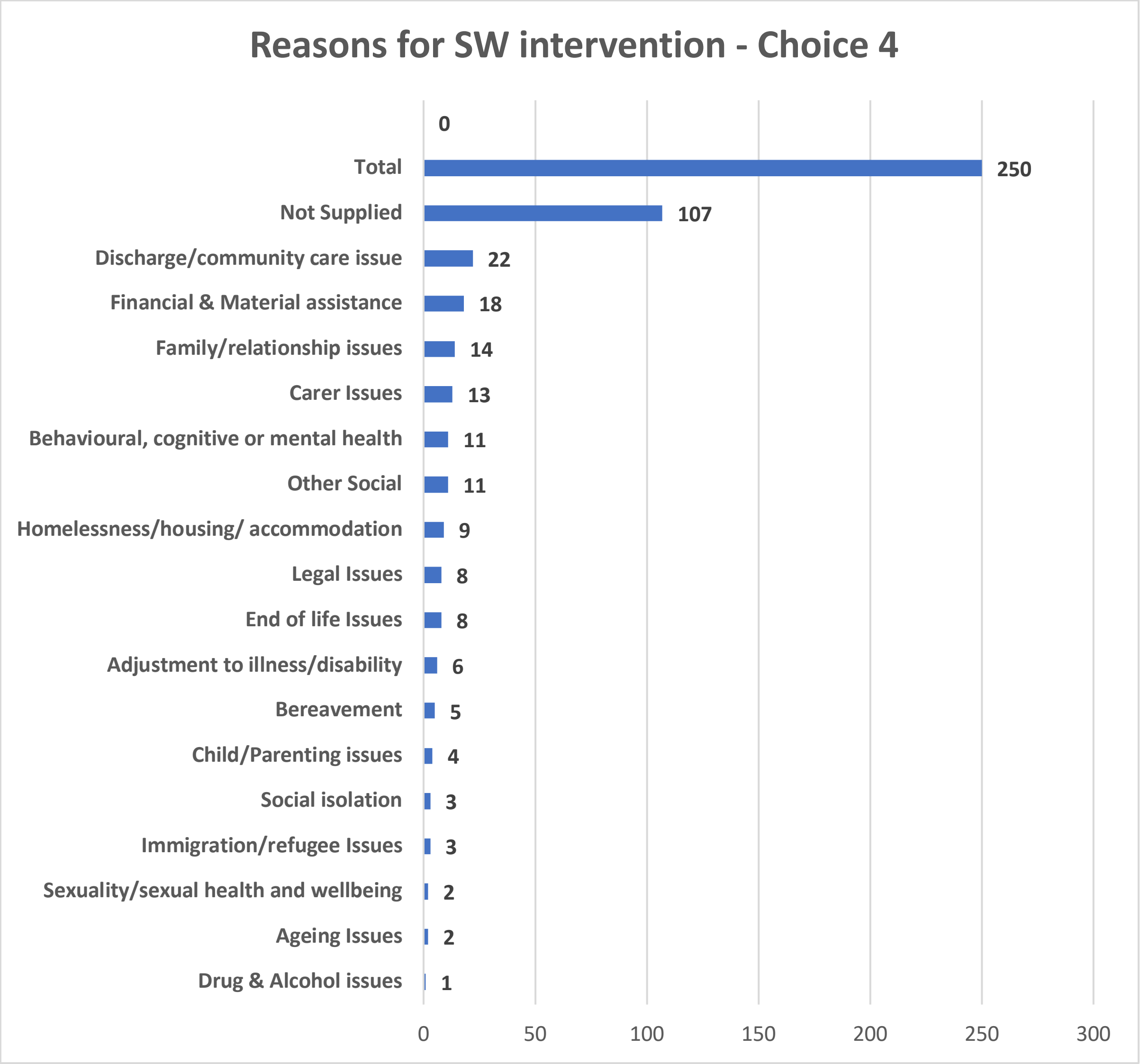
Figure 5.4

Reasons for intervention – Choice 4

(N=250)		
Not Supplied	107	42.8
Discharge/community care issue	22	8.8
Financial & Material assistance	18	7.2
Family/relationship issues	14	5.6
Carer Issues	13	5.2
Other Social	11	4.4
Behavioural, cognitive or mental health	11	4.4
Homelessness/housing/ accommodation	9	3.6
End of life Issues	8	3.2
Legal Issues	8	3.2
Adjustment to illness/disability	6	2.4
Bereavement	5	2
Child/Parenting issues	4	1.6
Immigration/refugee Issues	3	1.2
Social isolation	3	1.2
Ageing Issues	2	0.8
Sexuality/sexual health and wellbeing	2	0.8
Guardianship/financial management	1	0.4
Residential aged care placement	1	0.4
Domestic Violence	1	0.4
Drug & Alcohol issues	1	0.4

Table 5.5

Table 5.5 and Figure 5.5. List the most frequent fourth choice of reasons for intervention. In 107 cases (42.8%) a fourth choice was not made meaning that the first, second and third choices fully captured the reasons for intervention. Discharge/community care issues, financial and material assistance and family and relationship issues were the most frequent fourth choices.



Reasons for SW intervention - Choice 4
0
Total 250
Not Supplied 107
Discharge/community care issue 22
Financial & Material assistance 18
Family/relationship issues 14
Carer Issues 13
Behavioural, cognitive or mental health 11
Other Social 11
Homelessness/housing/ accommodation 9
Legal Issues 8
End of life Issues 8
Adjustment to illness/disability 6
Bereavement 5
Child/Parenting issues 4
Social isolation 3
Immigration/refugee Issues 3
Sexuality/sexual health and wellbeing 2
Ageing Issues 2
Drug & Alcohol issues 1
0
50
100
150
200
250
300

Figure 5.5

Reasons for intervention – Choice 5

(N=250)		
Not Supplied	151	60.4
Other Social	15	6
Discharge/community care issue	11	4.4
Financial & Material assistance	10	4
End of life Issues	9	3.6
Legal Issues	9	3.6
Family/relationship issues	8	3.2
Social isolation	7	2.8
Homelessness/housing/ accommodation	6	2.4
Bereavement	5	2
Behavioural, cognitive or mental health	4	1.6
Ageing Issues	3	1.2
Carer Issues	3	1.2
Adjustment to illness/disability	2	0.8
Child/Parenting issues	2	0.8
Elder Abuse	1	0.4
Guardianship/financial management	1	0.4
Residential aged care placement	1	0.4
Sexuality/sexual health and wellbeing	1	0.4
Trauma	1	0.4

Table 5.6

Table 5.6 and Figure 5.6 Indicate that in 60% of cases a fifth choice wasn't made indicating that choices 1,2,3 and 4 captured the reasons for intervention. Of those making a fifth choice, 'Other Social' was the highest category at (6%). 40% of cases involved a fifth reason demonstrating complexity of the case.

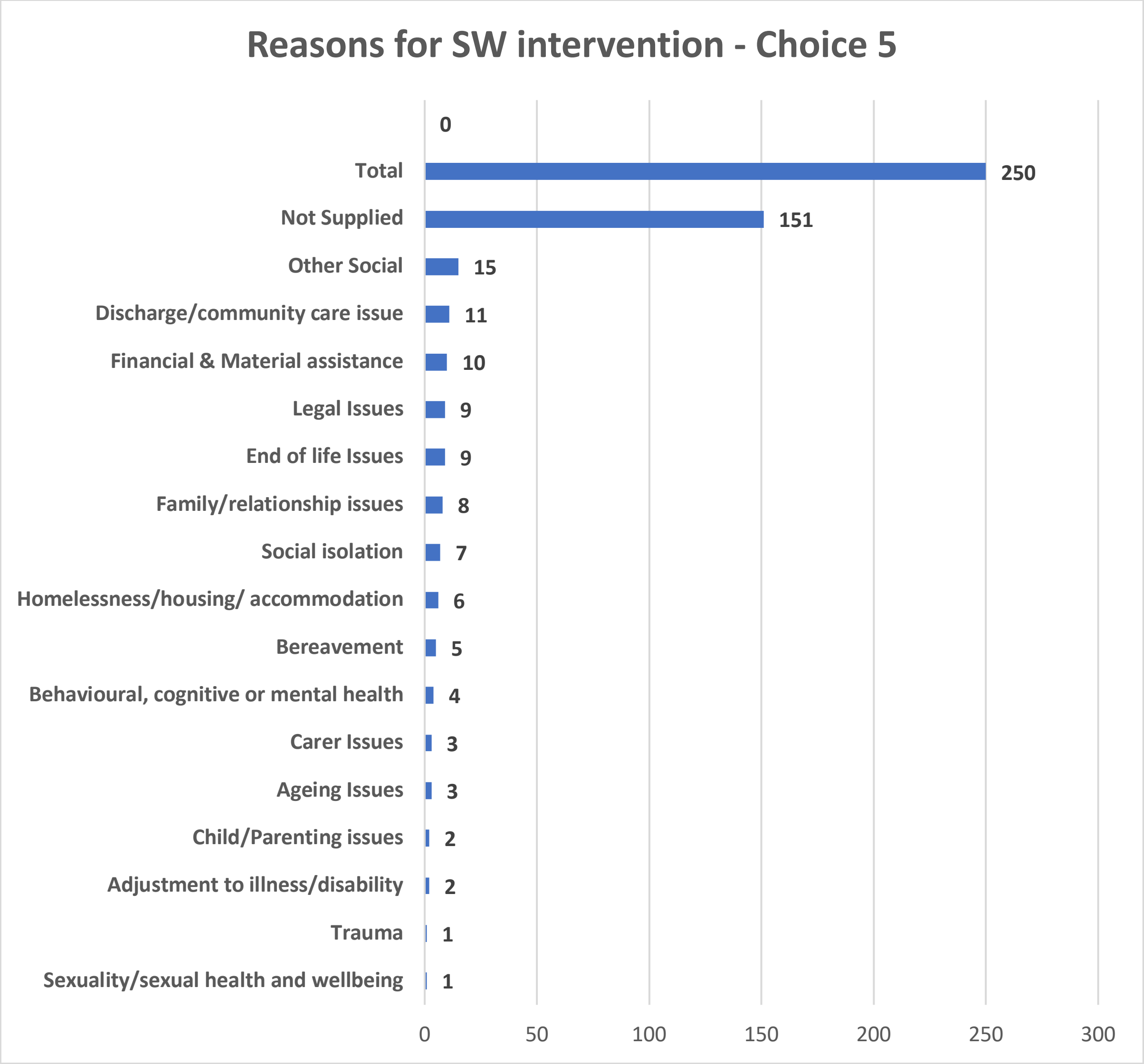

Reasons for SW intervention - Choice 5
0
Total
250
Not Supplied
151
Other Social
15
Discharge/community care issue
11
Financial & Material assistance
10
Legal Issues
9
End of life Issues
9
Family/relationship issues
8
Social isolation
7
Homelessness/housing/ accommodation
6
Bereavement
5
Behavioural, cognitive or mental health
4
Carer Issues
3
Ageing Issues
3
Child/Parenting issues
2
Adjustment to illness/disability
2
Trauma
1
Sexuality/sexual health and wellbeing
1
0
50
100
150
200
250
300

Figure 5.6

Cancer Primary Site and Reasons for Intervention

Cancer Primary Site and Reason for Intervention – Choice 1

Cancer Primary Site Vs Reasons for Intervention - Choice 1					
Cancer Primary site	Reason for Intervention				
	Adjustment to illness / disability	Financial & Material assistance	Carer Issues	End of Life issues	Behavioural, cognitive or mental health
Haematological	36	2	1	2	1
Breast	32	4	0	0	2
Lung	24	5	1	2	2
Colorectal	20	4	2	0	1
Head & Neck	12	9	2	0	0

Table 5.7

Table 5.7 and Figure 5.7 show the frequency of reasons for intervention as the first choice in the top five cancer sites in the study.

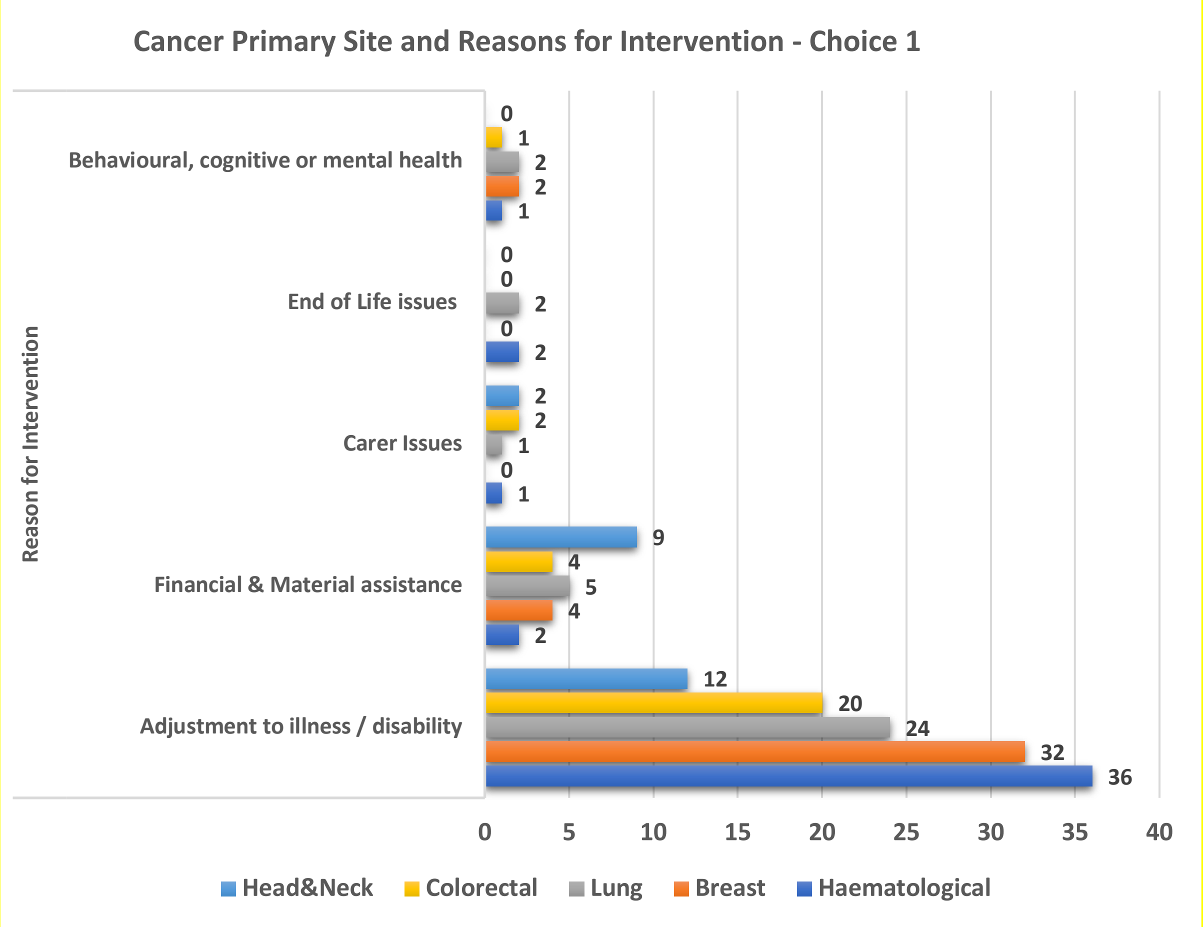


Figure 5.7

Cancer Primary Site and Reasons for Intervention – Choice 2

Cancer Primary Site Vs Reasons for intervention - Choice 2					
Cancer Primary Site	Reason for Intervention				
	Carer Issues	Financial & Material assistance	Discharge/ Community care issues	Family/ Relationship issues	Behavioural, cognitive or mental health
Haematological	11	11	2	3	5
Breast	7	3	8	3	4
Lung	4	4	7	3	2
Colorectal	4	4	4	3	3
Head & Neck	5	2	1	4	1

Table 5.8

Table 5.8 and Figure 5.8 show the frequency of reasons for intervention as the second choice in the top five cancer sites in the study.

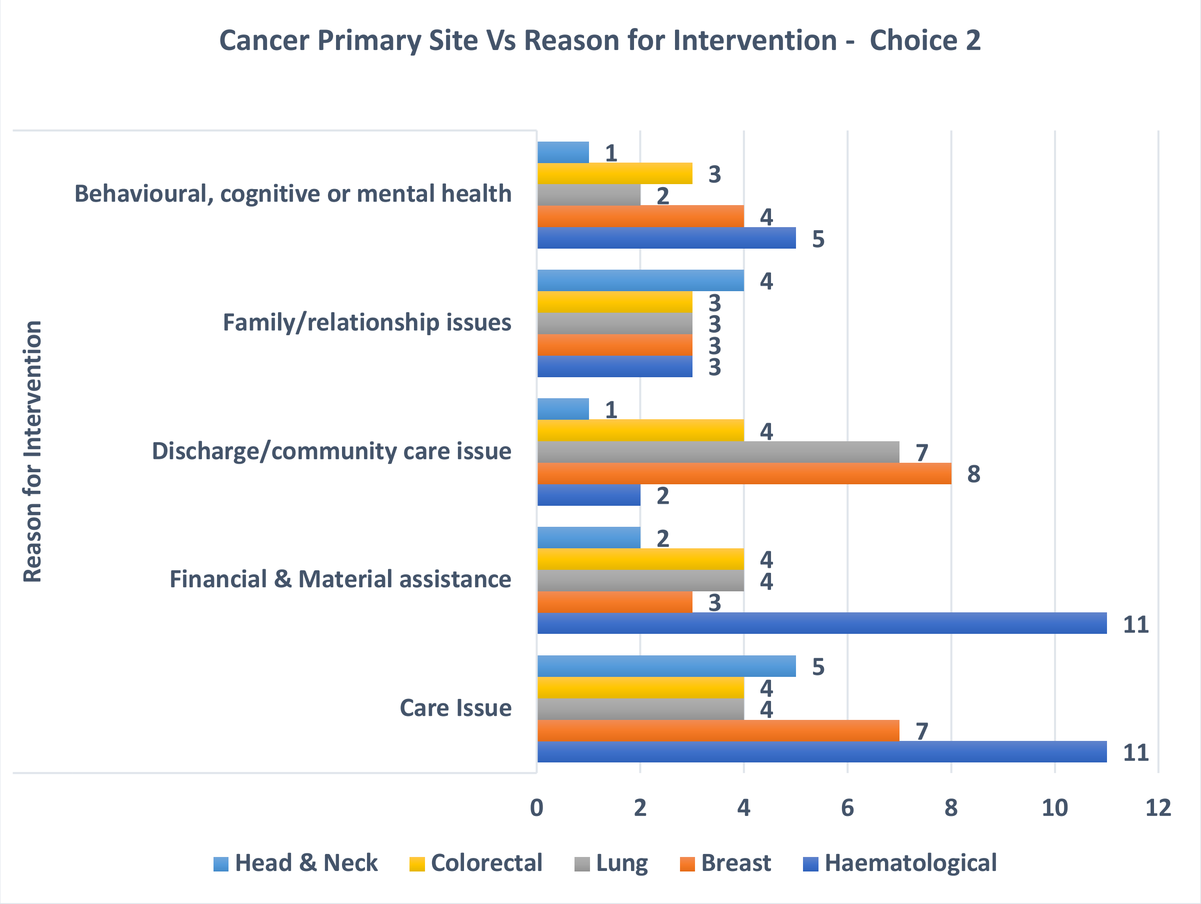


Figure 5.8

Cancer Primary Site and Reasons for Intervention – Choice 3

Cancer Primary site	Reason for Intervention					
	Financial & Material assistance	Carer issues	Discharge/ Community care issues	Family/ Relationship issues	End of Life Issues	Other Social
Haematological	9	10	3	3	2	1
Breast	5	5	3	4	0	5
Lung	1	3	4	1	4	5
Colorectal	3	4	1	1	2	1
Head & Neck	2	3	7	2	1	0

Table 5.9

Table 5.9 and Figure 5.9 show the frequency of reasons for intervention as the third choice in the top five cancer sites in the study.

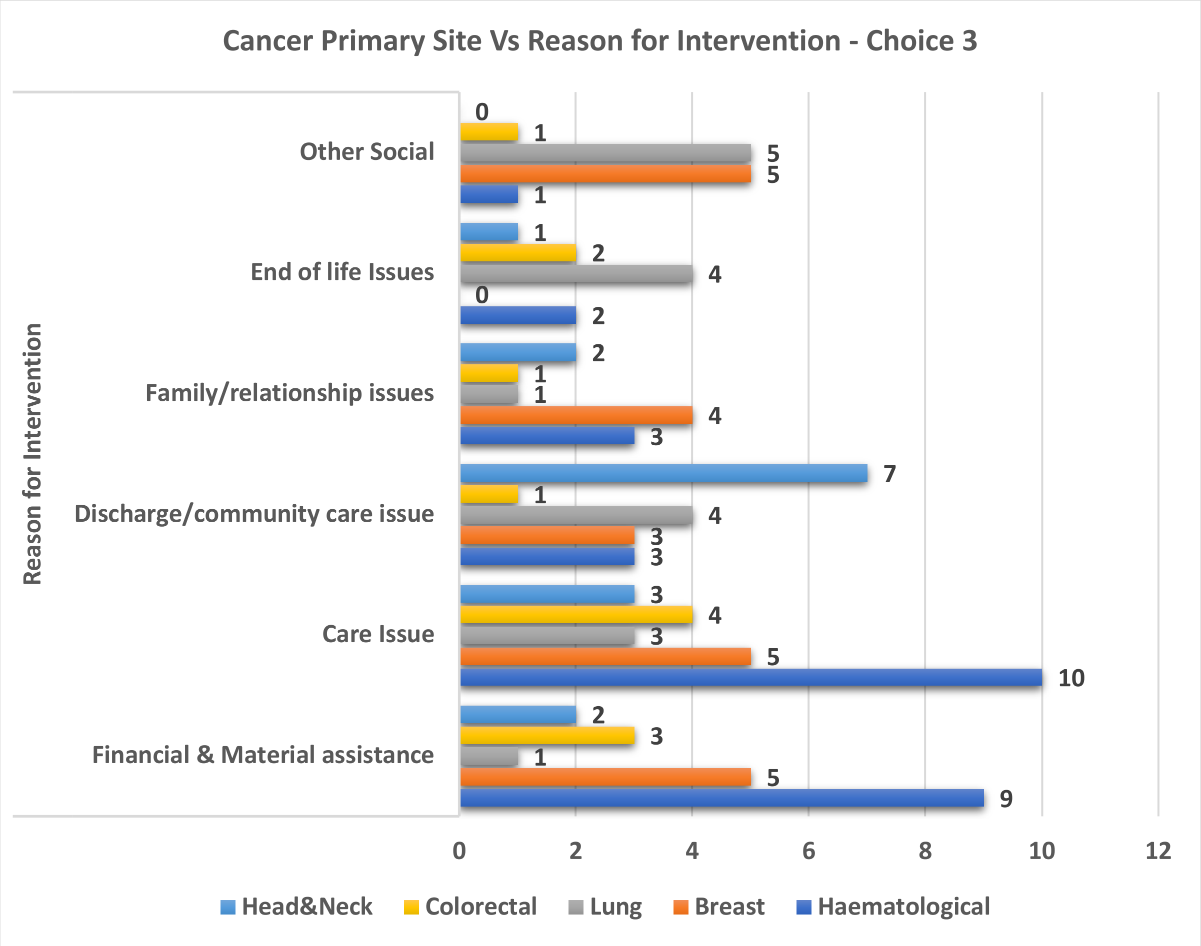


Figure 5.9

Cancer Primary Site and Reasons for Intervention – Choice 4

Cancer Primary site	Reason for Intervention				
	Financial & Material assistance	Family/ Relationship issues	Carer Issues	Behavioural, cognitive or mental health	Other Social
Haematological	6	5	0	3	4
Breast	1	2	1	1	1
Lung	4	2	2	0	4
Colorectal	2	1	1	3	0
Head & Neck	3	7	2	1	0

Table 5.10

Table 5.10 and Figure 5.10 show the frequency of reasons for intervention as the fourth choice in the top five cancer sites in the study.

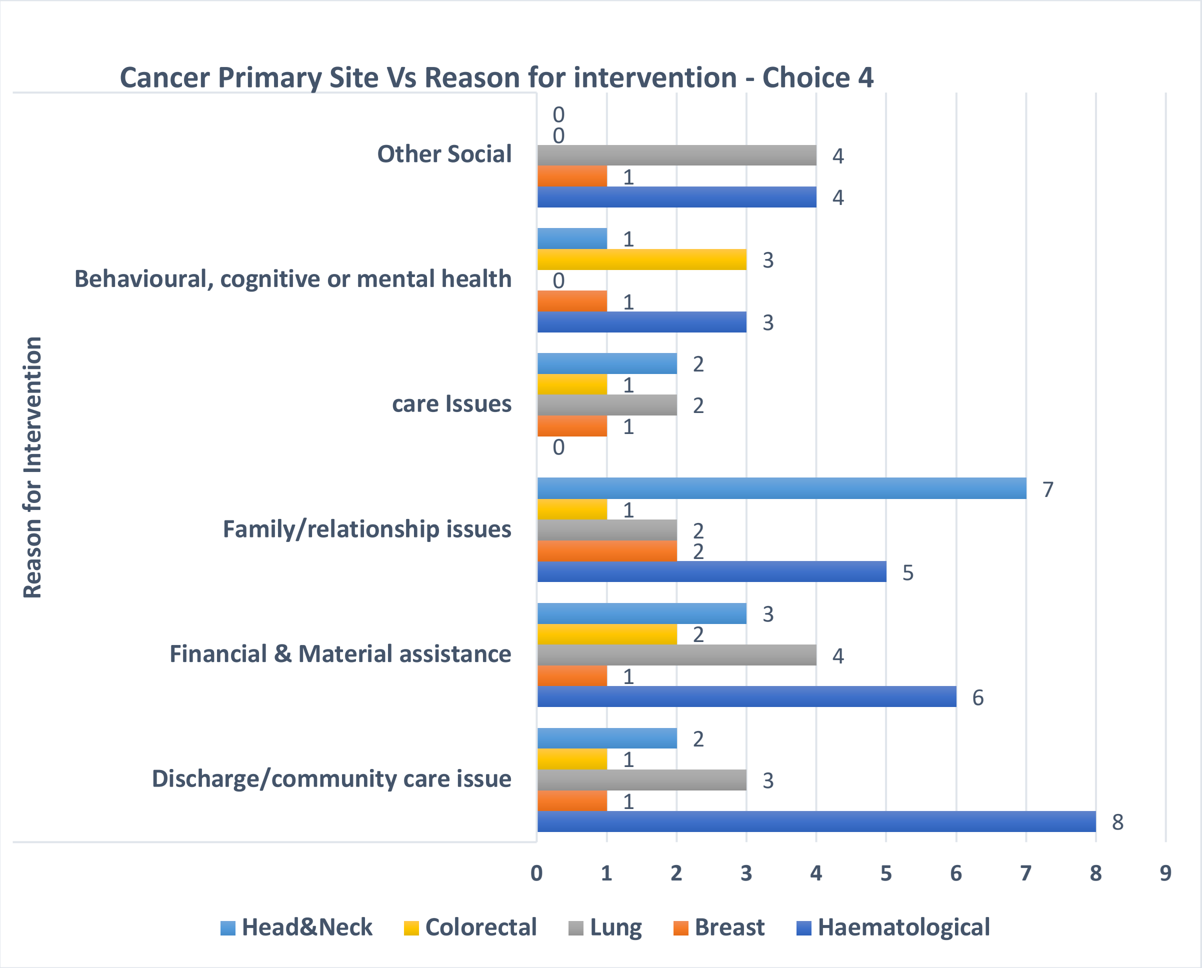


Figure 5.10

Cancer Primary Site and Reasons for Intervention – Choice 5

Cancer Primary site	Reason for Intervention					
	Other Social	Discharge/ Community care issues	Financial & Material assistance	Legal issues	End of Life issues	Family/ Relationship issues
Haematological	1	3	3	2	2	2
Breast	2	2	1	0	1	0
Lung	2	0	2	1	1	0
Colorectal	2	0	1	2	0	1
Head & Neck	1	1	2	1	3	2

Table 5.11

Table 5.11 and Figure 5.11 show the frequency of reasons for intervention as the fifth choice in the top five cancer sites in the study.

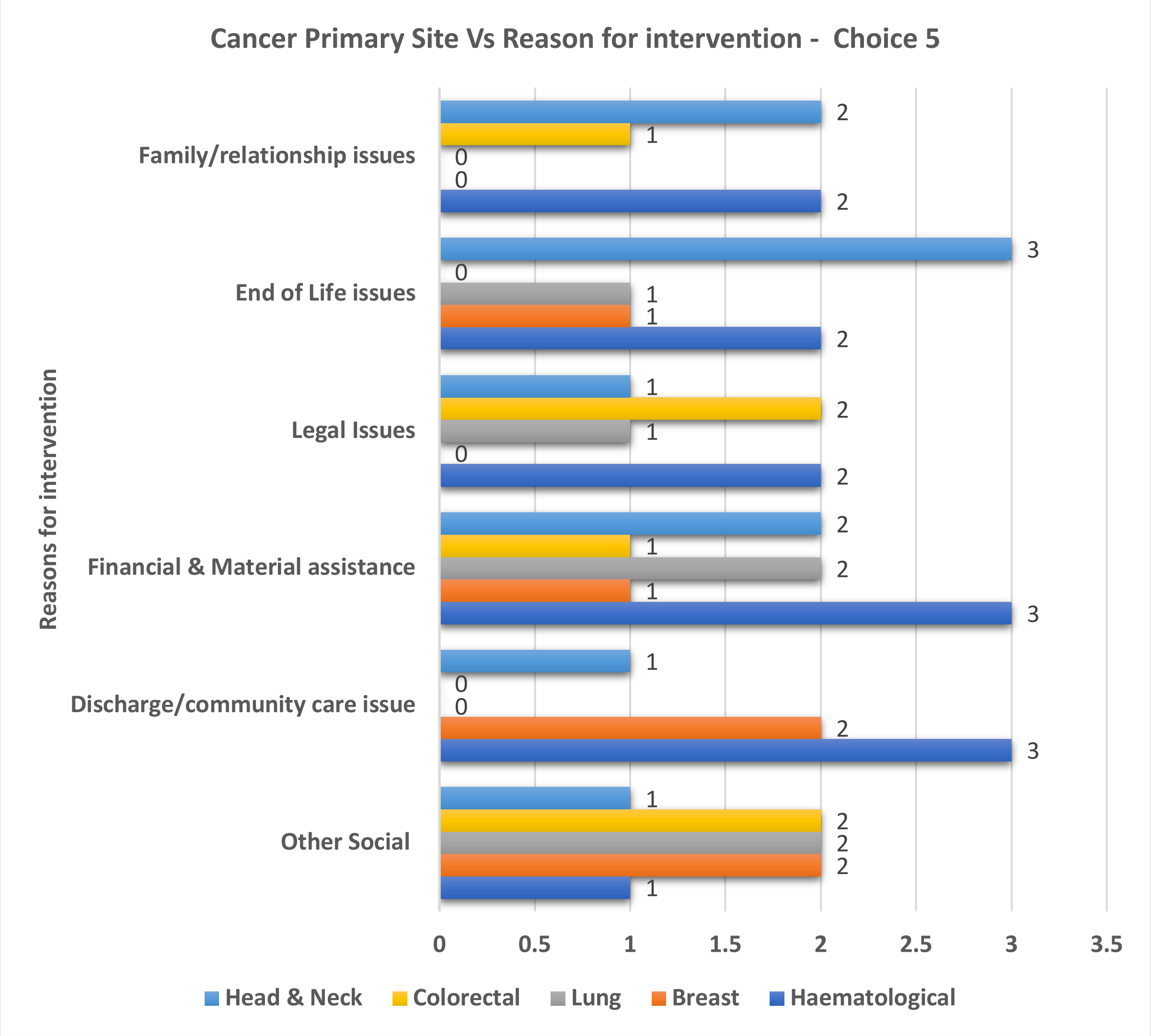


Figure 5.11

Mapping the Indicators for Intervention Coded by Social Workers to the IFI Domains (Allied Health Minimum Data Set v2.0)

An indicator for intervention is the specific reason for the social work intervention as determined by the social worker. Indicators for all allied health disciplines are classified in three domains; functional; psycho-social and environmental. Each domain contains sub domains providing more detailed information of patients' situations and the reasons for social workers' intervention.

A Level (domain)	Frequency of Coding	B Level (sub domain)	Frequency of Coding	C Level (Detail)	Coded Yes/No	Frequency of coding	Choice Number
Functional	222	Adjustment to illness/disability/ health condition	198	Adherence issues	Y	198	Choice 1
				New Diagnosis	Y		
				Ongoing	Y		
				Life Limiting Illness	Y		
		Risk of Harm	23	Abuse of Older Persons	Y	2	
				Domestic Violence	Y	6	
				Child at Risk	Y	3	
				Sexual Assault	N		
				Vulnerable Person	Y	12	
				Self-harm	N		
		Management of trauma reactions	1	Crisis	Y	1	
				Long term	Y		
				Disaster	N		
				Victims of Crime	N		
Psycho-social	381	End of Life (EOL)	80	Sudden Death	Y		
				Grief and Loss	Y	29	
				Pregnancy Loss	N		
				End of Life	Y	51	

		Relationship dynamics	85	Conflict	Y		
				Stressors	Y		
				Family, Relationship Issues	Y	57	
				Other	Y	28	
		Carer issue	96	Carer Capacity	Y	96	Choice 2
				Stress	Y		
		Psychosocial wellbeing	120	Social	Y	47	Choice 5
				Behaviour	Y	49	
				Cognitive	Y		
				Emotional	Y		
				Psychological	Y		
				*Drug & Alcohol added		6	
				*Pregnancy, Adjustment added		1	
				*Ageing issues added		13	
				*Sexuality, sexual health added		4	
Environmental	311	Home situation	53	Coping	Y		Choice 4
				Residential Care	Y	12	
				Accommodation issues	Y	41	
				Homelessness	Y		
		Access to resources	213	Practical Resources			Choice 3

				*Financial & Material Assistance added	Y	125	
				Referral to Support Agencies	Y	88	
		Legal support	45	Guardian-ship, Alternate Decision-Making	Y	6	
				Compens-ation	Y		
				Legal Orders	Y		
				Legal – other	Y	29	
				Family Law	Y		
				Immigration	Y	10	

Table 5.12

In the 250 case files reviewed, social workers identified indicators for intervention across the three domains and all ten of the sub domains. 36 of the 41 level C indicators or 87.8% were coded by social workers demonstrating the breadth of practice knowledge and skills required in practice. Those not coded were sexual assault, self-harm, victim of crime and pregnancy loss which were not present in this opportunistic sample of patients however they are sub domains which may be present in other cohorts of patients with whom social workers practice.

Although 'Adjustment to illness/disability, health condition' was the most frequently coded reason for intervention and was coded most frequently as the first choice, when all the codes are mapped to the IFI table the reasons for intervention identified by social workers in their social work assessments a slightly different picture emerges. As raw frequencies, the reasons for intervention in the psycho-social domain were most common followed by those in the environmental domain. The functional domain was the third domain. This illustrates the scope of social work practice which has a primary focus on 'the person in environment'. The relationship with social systems that are external to the health sector and patients' medical treatment is a feature of social work practice.

Social Work Intervention

Social workers were asked to code up to five interventions undertaken in each case. The interventions are listed in the ICD-10-AM (International Classification of Diseases Version 10 Australian Modified) Code Set for Interventions, Allied Health Minimum Data Set v2.0 (NSW Directors of Allied Health, 2015).

Social Work Intervention Undertaken: Frequency of Coding by Social Workers

Intervention	Frequency of Coding	Percent
Psychosocial assessment	**151**	**17.8**
Service co-ordination	**117**	**13.7**
Advocacy	**100**	**11.7**
Financial management counselling or education	**66**	**0.077**
Other psychosocial counselling	**64**	**0.075**
Self care/maintenance counselling or education	**45**	**0.053**
Resource education	**35**	**0.041**
Relationship counselling	**24**	**0.028**
Grief/bereavement counselling	**23**	**0.027**
Situational/occupational/environmental counselling or education	**23**	**0.027**
Other counselling or education	**21**	**0.024**
Systems therapy	**20**	**0.023**
Supportive psychotherapy, not elsewhere specified	**18**	**0.021**
Self care/self maintenance assessment	**17**	**0.020**
Situational/occupational/environmental assessment	**17**	**0.020**
Health maintenance or recovery assessment	**16**	**0.018**
Counselling or education on health maintenance or recovery activities	**15**	**0.017**
Crisis situation/event counselling	**13**	**0.015**
Home management assessment	**13**	**0.015**
Narrative therapy	**11**	**0.012**
Social work not elsewhere specified	**10**	**0.011**
Preventative counselling or education	**4**	**0.004**
Counselling or education on preparing for parenthood, parenting skills or family planning	**4**	**0.004**
Physical abuse/violence/assault counselling	**4**	**0.004**
Other psychotherapies or psychosocial therapies	**4**	**0.004**
Ageing assessment	**3**	**0.003**
Substance addiction counselling or education	**3**	**0.003**
Parenting skills assessment	**2**	**0.002**
Alcohol and other drug assessment	**2**	**0.002**
Psychological skills training	**1**	**0.001**
Psychodynamic therapy	**1**	**0.001**
Cognitive Behavioural Therapy (CBT)	**1**	**0.001**
Gambling or betting addiction counselling or education	**0**	
Behaviour therapy	**0**	
Couples therapy	**0**	
TOTAL	**848**	

Table 6.1 shows the frequency of the full list of possible interventions undertaken by social workers. This indicates a comprehensive range of interventions delivered through intensive interpersonal engagement, counselling and education with patients, families, carers, members of the health team and community agencies.

Choice of Intervention provided

The following tables and figures show the intervention undertaken and the internal choices within each.

Social work intervention provided - Choice 1

	Frequency	Percent	ICD-10 Code
Psychosocial assessment	108	43.2	96032-00
Self-care/maintenance counselling or education	20	8	96075-00
Self-care/self-maintenance assessment	17	6.8	96021-00
Financial management counselling or education	16	6.4	96078-00
Counselling or education on health maintenance or recovery activities	15	6	96076-00
Grief/bereavement counselling	10	4	96085-00
Advocacy	10	4	96108-00
Service co-ordination	9	3.6	96107-00

Table 6.2

Table 6.2 and Figure 6.2 indicates that Psychosocial assessment was the most frequent first choice of intervention for 43.2% of cases. The second most frequent first choice was Self-care/maintenance counselling or education and the third most frequent first choice was Self-care/self-maintenance assessment.

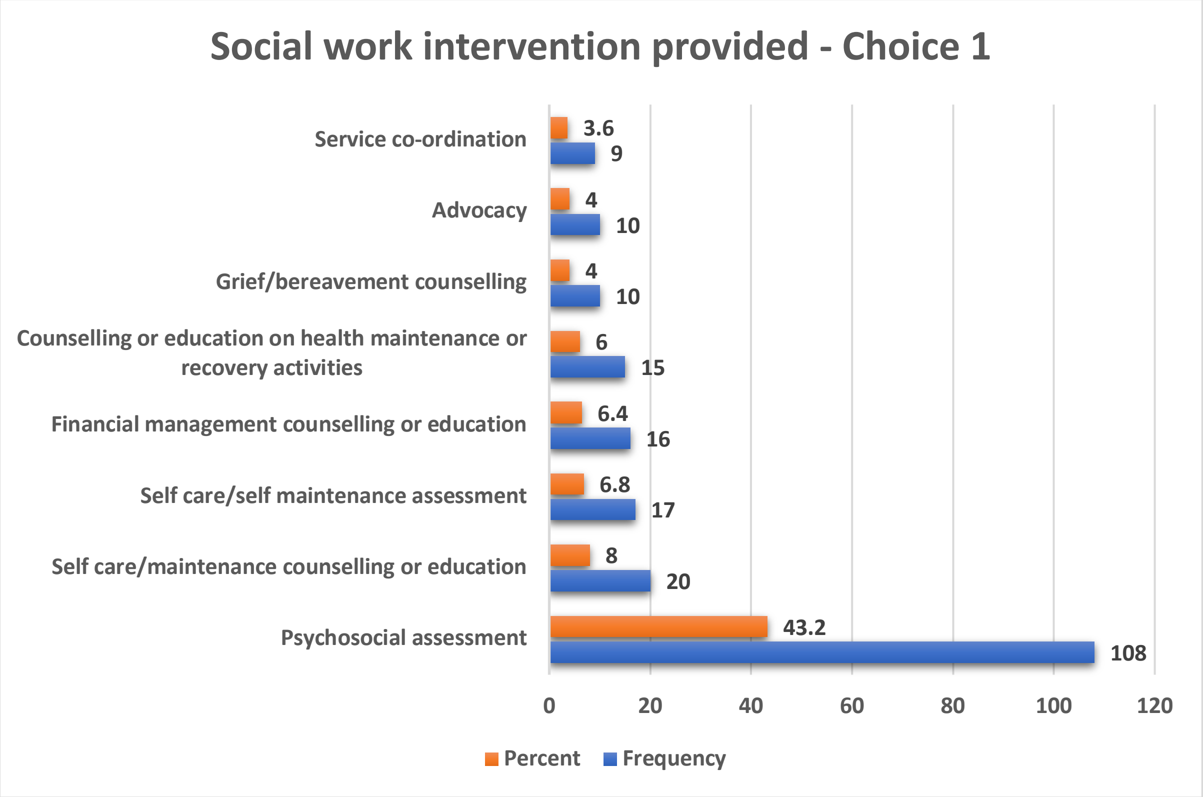


Figure 6.2

Social work intervention provided – Choice 2

	Frequency	Percent	ICD-10 Code
Financial management counselling or education	32	12.8	96078-00
Psychosocial assessment	29	11.6	96032-00
Self-care/maintenance counselling or education	25	10	96075-00
Advocacy	18	7.2	96108-00
Other psychosocial counselling	17	6.8	96086-00
Service co-ordination	14	5.6	96107-00
Crisis situation/event counselling	13	5.2	96082-00
Grief/bereavement counselling	13	5.2	96085-00

Table 6.3

Table 6.3 and Figure 6.3 indicate that Financial management counselling and education was the most frequent second choice. Psychosocial assessment and Self-care/maintenance counselling or education were the second and third most frequent second choices of interventions undertaken.

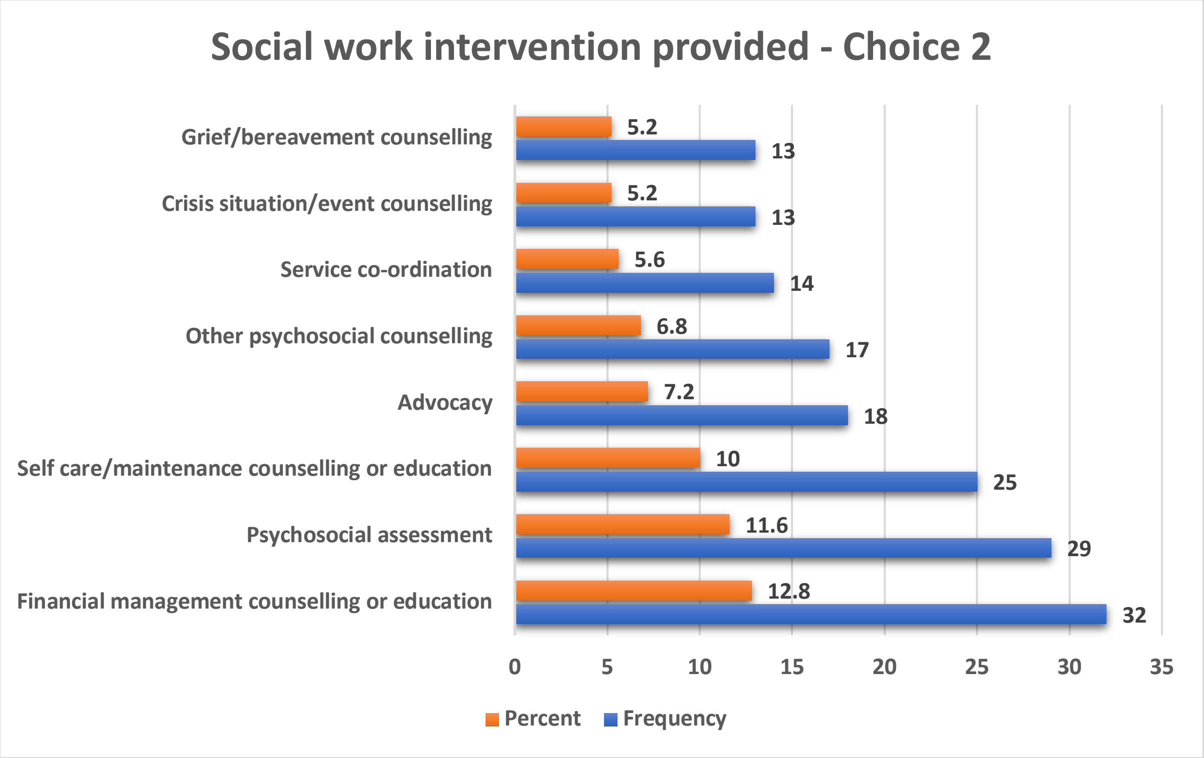


Figure 6.3

Social work intervention provided – Choice 3

	Frequency	Percent	ICD-10 Code
Service co-ordination	32	12.8	96107-00
Advocacy	23	9.2	96108-00
Financial management counselling or education	18	7.2	96078-00
Grief/bereavement counselling	18	7.2	96085-00
Other psychosocial counselling	17	6.8	96086-00
Resource education	14	5.6	96089-00
Psychosocial assessment	14	5.6	96032-00

Table 6.4

Table 6.4 and Figure 6.4 The most frequent third choice was Service co-ordination. Advocacy and Financial management counselling or education were the second and third most frequent third choice of intervention undertaken.

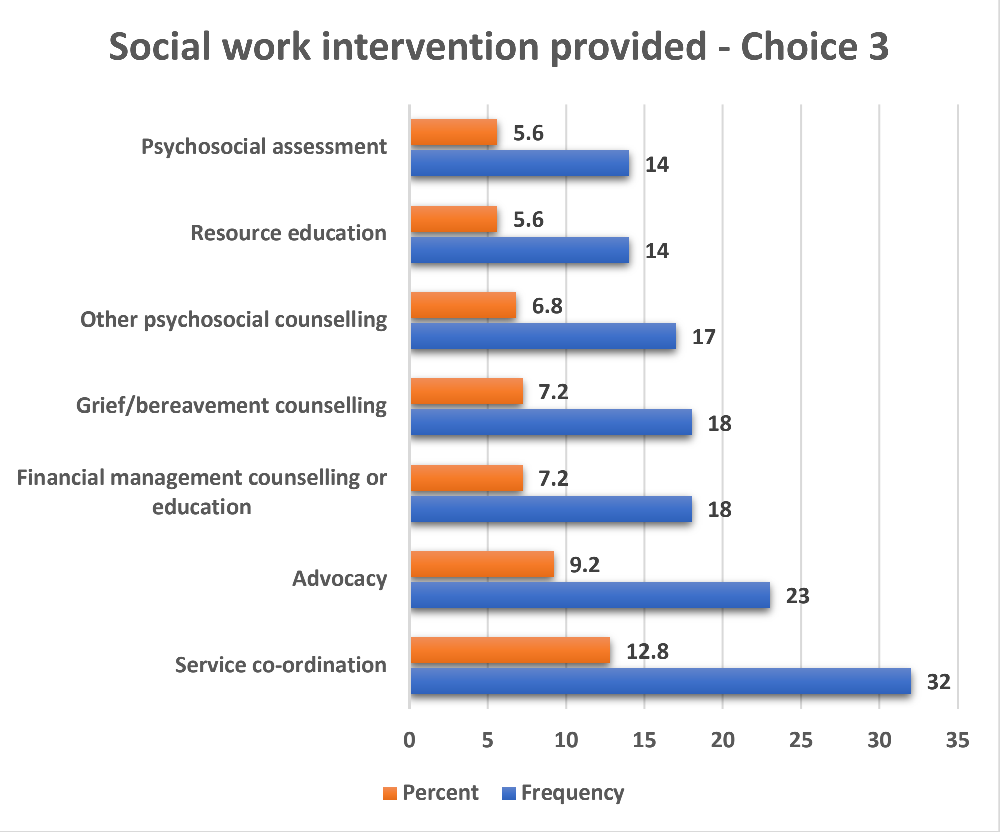


Figure 6.4

Social work intervention provided – Choice 4

	Frequency	Percent	ICD-10 Code
Service co-ordination	46	18.4	96107-00
Resource education	21	8.4	96089-00
Other psychosocial counselling	15	6	96086-00
Advocacy	14	5.6	96108-00

Table 6.5

Table 6.5 and Figure 6.5 indicate that the most frequent fourth choice was Service co-ordination. Resource education and Other psychosocial counselling were the second and third most frequent fourth choice.

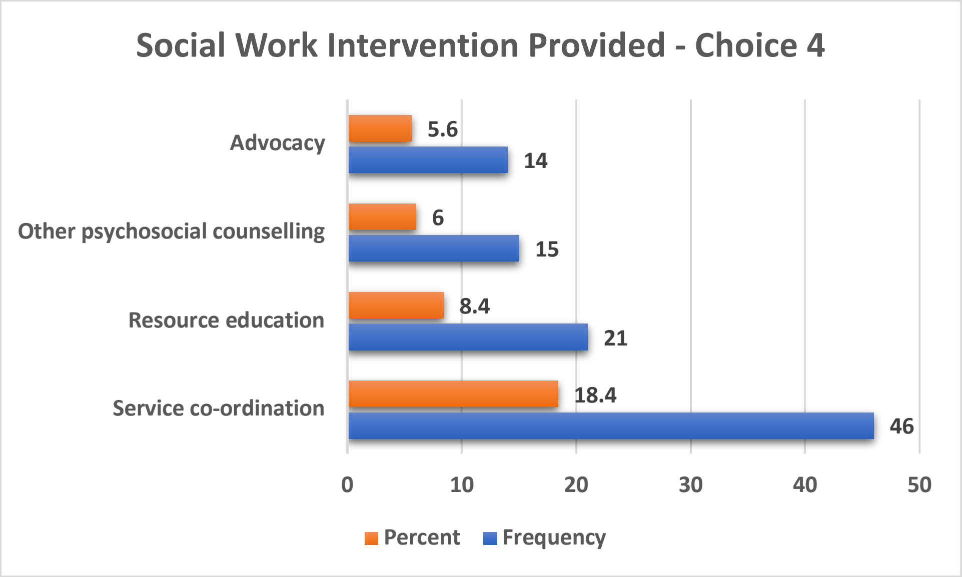


Figure 6.5

Social work intervention provided – Choice 5

	Frequency	Percent	ICD-10 Code
Advocacy	35	14	96108-00
Service co-ordination	16	6.4	96107-00
Other psychosocial counselling	15	6	96086-00
Social work not elsewhere specified	10	4	95550-01

Table 6.6

Table 6.6 and Figure 6.6. The most frequent fifth choice was Advocacy with Service co-ordination and Other psychosocial counselling was the second and third most frequent fifth choice.

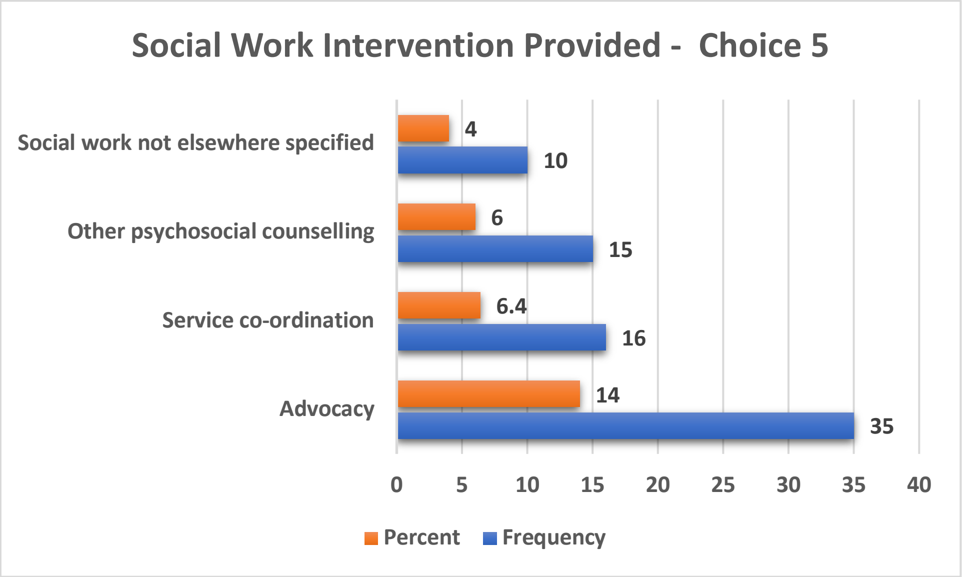


Figure 6.6

Service Co-ordination

Social workers often anecdotally report that co-ordinating resources is a large part of their work. A closer examination of this intervention was undertaken.

Service Co-ordination [ICD-10 Code 96107-00]	Frequency
SW intervention - Choice 1	9
SW intervention - Choice 2	14
SW intervention - Choice 3	32
SW intervention - Choice 4	46
SW intervention - Choice 5	16

Table 6.7

Table 6.7 and Figure 6.7 indicate the frequency of the choice of Service Co-ordination which was the most frequent third and fourth choice of interventions provided.

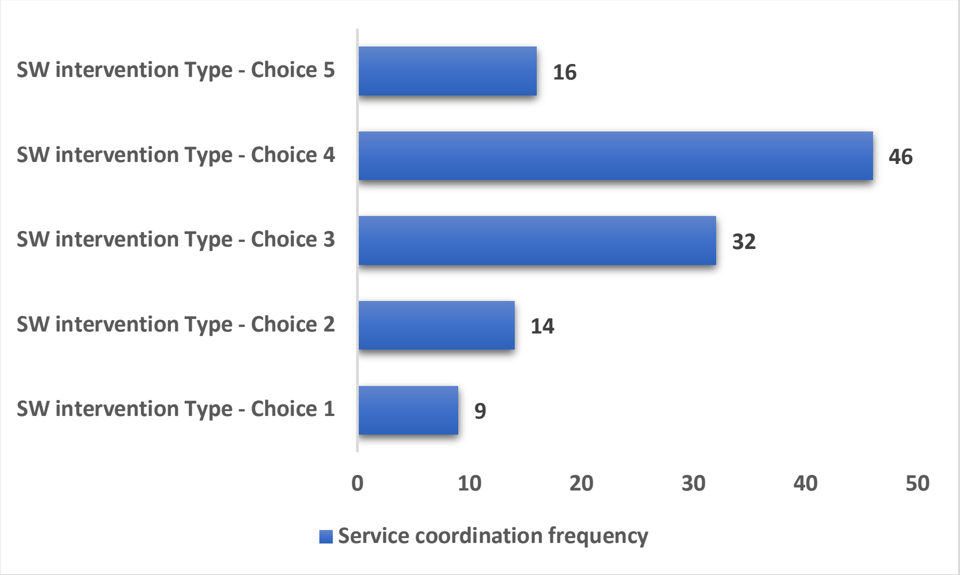


Figure 6.7

Analysis of the five choices of interventions for all patients combined indicated that the most frequent first choice of intervention was Psychosocial assessment; the second most frequent intervention was Financial management counselling and education. The third and fourth most frequent intervention was Service co-ordination and the most frequent fifth choice of intervention was Advocacy.

An analysis of the top five cancer primary sites in the study was largely consistent with all patients combined however there were some slight variations between cases.

In the top five cancer primary sites in the study, Psychosocial assessment was the first choice of intervention consistent with that of all patients combined.

The second most frequent choice in the total cases combined was Financial management counselling and education however this was only the case in Head & Neck and Colorectal cases. In Haematological cases it was Other psychosocial counselling, in Breast cancer it was Advocacy and in Lung cancer it was Self-care/maintenance counselling or education.

There were similarities in the third and fourth choices with Service co-ordination being combined with grief and bereavement counselling in Haematological cases and with Advocacy in Lung cancer, Head & Neck and Breast cancer cases. In the fourth choices, Service co-ordination was the same as for all cases combined except for Head & Neck cases where Resource Education was chosen.

In all cases combined the fifth most frequent choice was Advocacy and this was the same for Haematological and Colorectal cases. In Breast cancer, Lung cancer and Head & Neck cases, Other psychosocial counselling was the most frequent fifth choice.

These are shown in the Tables 6.8 to 6.12.

Social Work Intervention and the Top Five Cancer Primary Sites in the Study

Social Work interventions – Choice 1

	Haematological	Breast	Lung	Colorectal	Head & Neck
Psychosocial assessment	26	11	14	14	15
Self-care/maintenance counselling or education	4	5	3	4	0
Self-care/self-maintenance assessment	4	3	4	1	0
Financial management counselling or education	0	4	1	1	3
Counselling or education on health maintenance or recovery activities	3	4	3	2	1

Table 6.8

Table 6.8 and Figure 6.8 In the top five cancer primary sites in the study, Psychosocial assessment was the first choice of intervention. For patients with a diagnosis of breast cancer, haematological or colorectal cancers Self-care/maintenance counselling or education was the next most frequent first choice.

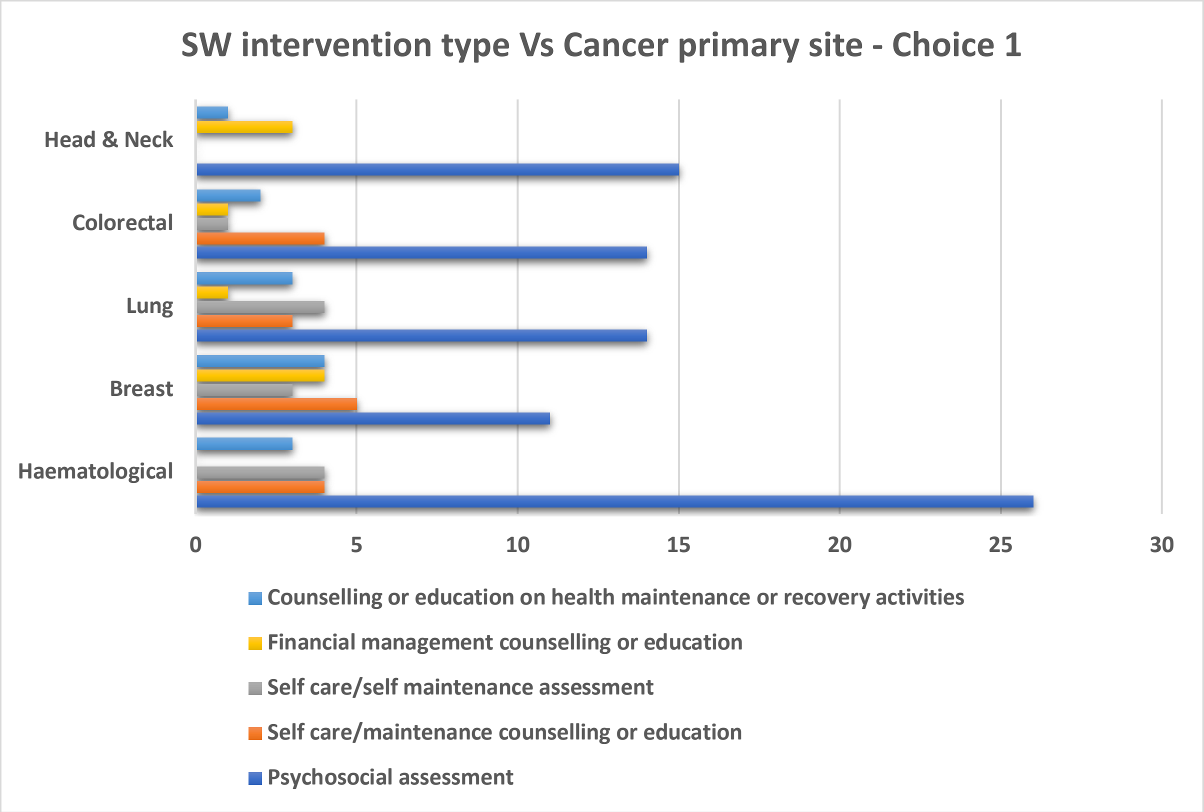


Figure 6.8

Social Work interventions - Choice 2

	Haematological	Breast	Lung	Colorectal	Head & Neck
Financial management counselling or education	6	1	3	6	10
Psychosocial assessment	5	5	4	3	1
Self-care/maintenance counselling or education	3	4	5	4	1
Advocacy	3	7	4	0	0
Other psychosocial counselling	10	1	1	0	1

Table 6.9

Table 6.9 and Figure 6.9 The second most frequent choice in Head & Neck and Colorectal cases was Financial management counselling or education. In Haematological cases it was Other psychosocial counselling, in Breast cancer it was Advocacy and in Lung cancer it was Self-care/maintenance counselling or education.

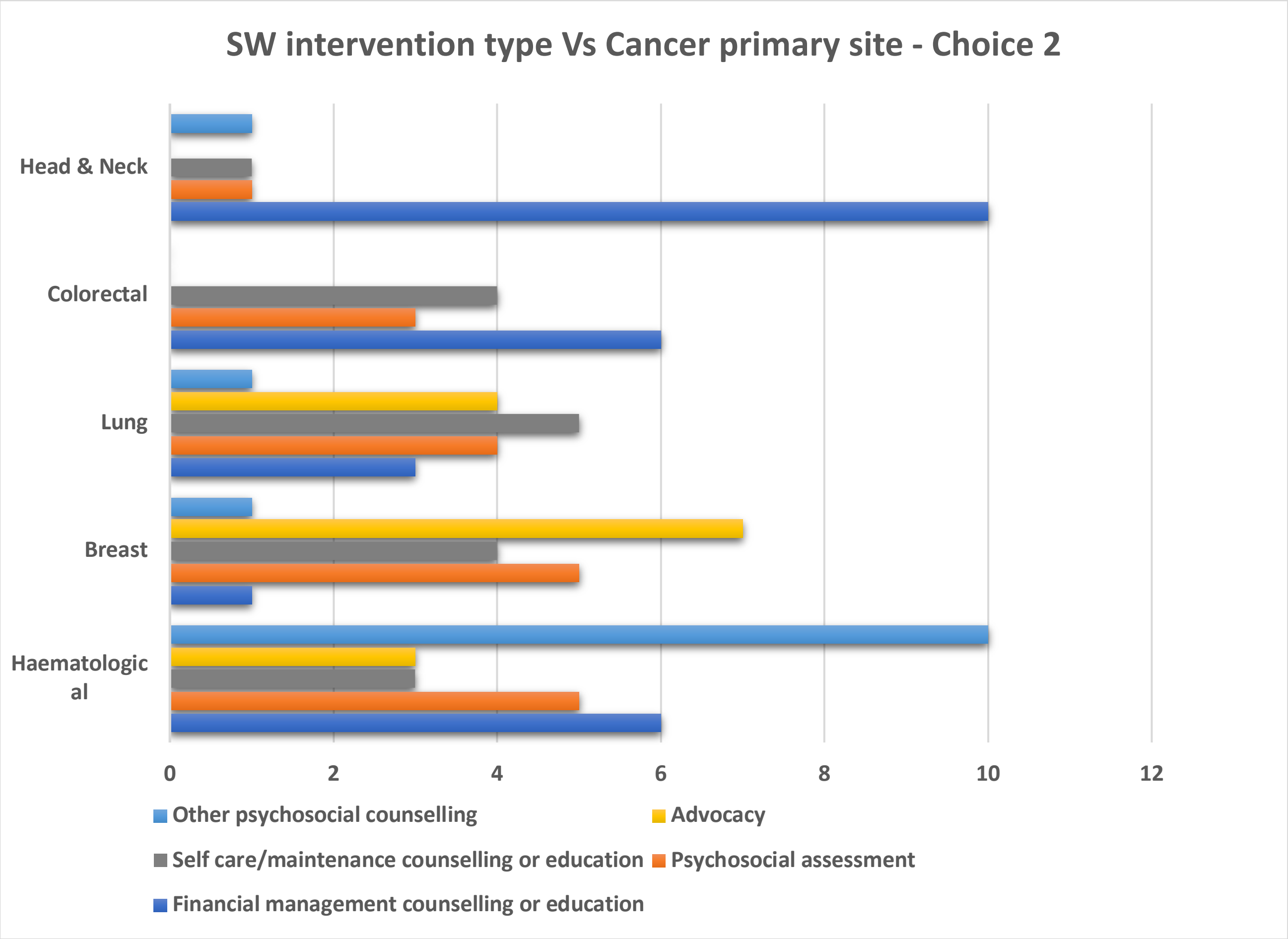


Figure 6.9

Social Work interventions - Choice 3

	Haematological	Breast	Lung	Colorectal	Head & Neck
Service co-ordination	6	4	9	2	4
Advocacy	2	4	4	4	5
Financial management counselling or education	4	2	3	1	2
Grief/bereavement counselling	6	1	2	3	1
Other psychosocial counselling	4	3	0	4	1

Table 6.10

Table 6.10 and Figure 6.10. The third most frequent choice in the top five cancer sites were Service co-ordination and Grief/bereavement counselling in Haematological cases and Service co-ordination and Advocacy in Lung cancer, Head & Neck and Breast cancer cases.

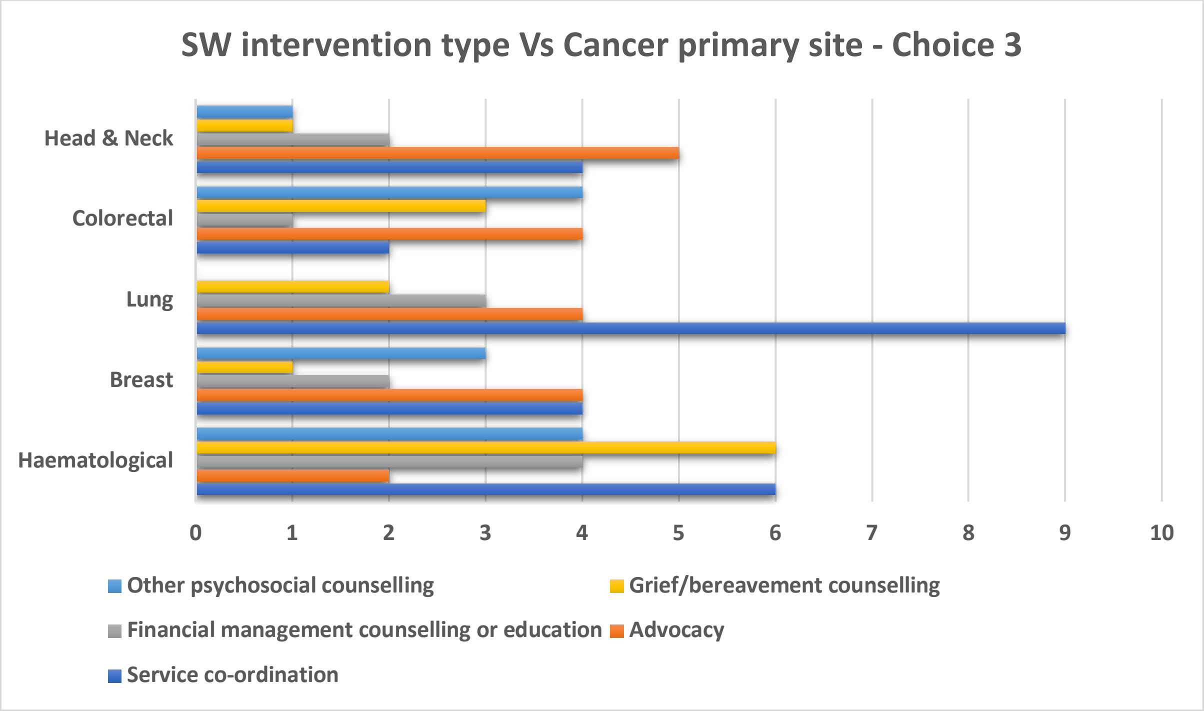


Figure 6.10

Social Work interventions - Choice 4

	Haematological	Breast	Lung	Colorectal	Head & Neck
Service co-ordination	15	6	7	3	5
Resource education	3	5	4	5	1
Other psychosocial counselling	5	3	1	1	3
Advocacy	3	0	2	1	2
Financial management counselling or education	2	1	2	3	0
Social work not elsewhere specified	1	1	3	1	1
Psychosocial assessment	2	4	1	1	1

Table 6.11

Table 6.11 and Figure 6.11 The fourth most frequent choice was Service co-ordination in Haematological cases, Breast, Lung and Head & Neck cases and Resource education for Colorectal cases.

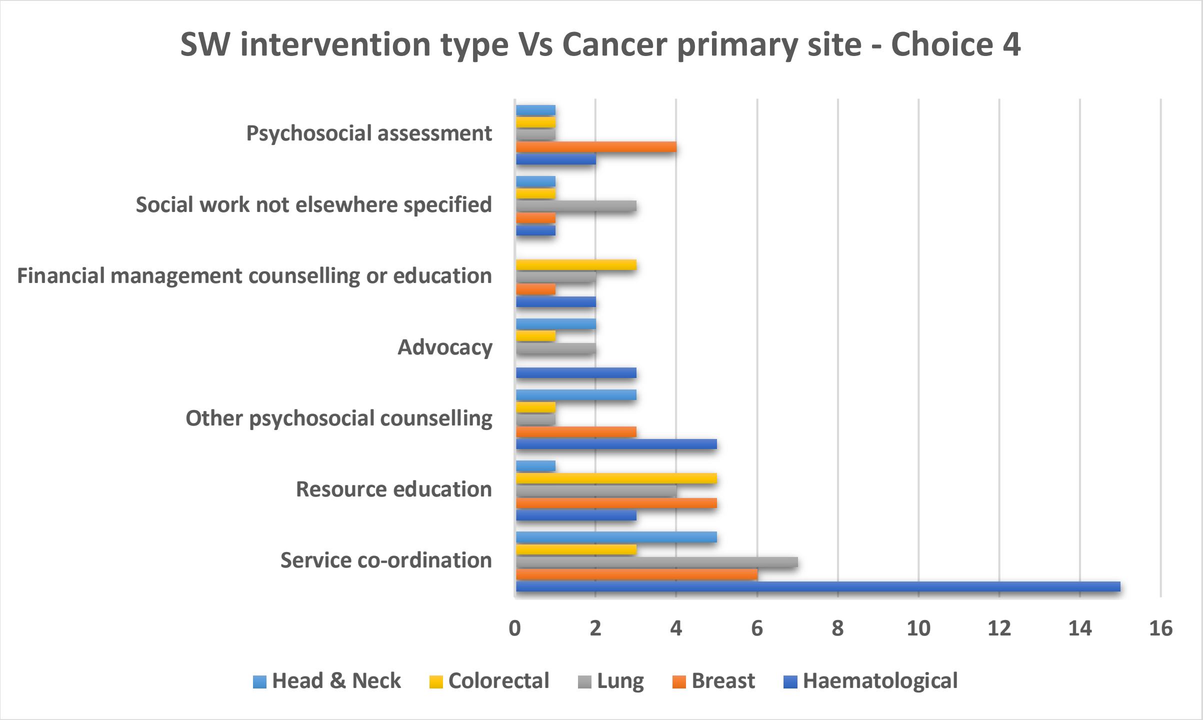


Figure 6.11

Social Work interventions - Choice 5

	Haematological	Breast	Lung	Colorectal	Head & Neck
Advocacy	14	4	3	8	2
Service co-ordination	2	2	2	2	0
Other psychosocial counselling	1	6	3	0	3
Social work not elsewhere specified	1	2	2	0	2
Supportive psychotherapy, not elsewhere specified	2	0	3	0	1

Table 6.12

Table 6.12 and Figure 6.12. The fifth most frequent choice was Advocacy for Haematological cases and Colorectal cases. In Breast cancer, Lung cancer and Head & Neck cases, Other psychosocial counselling was the most frequent choice.

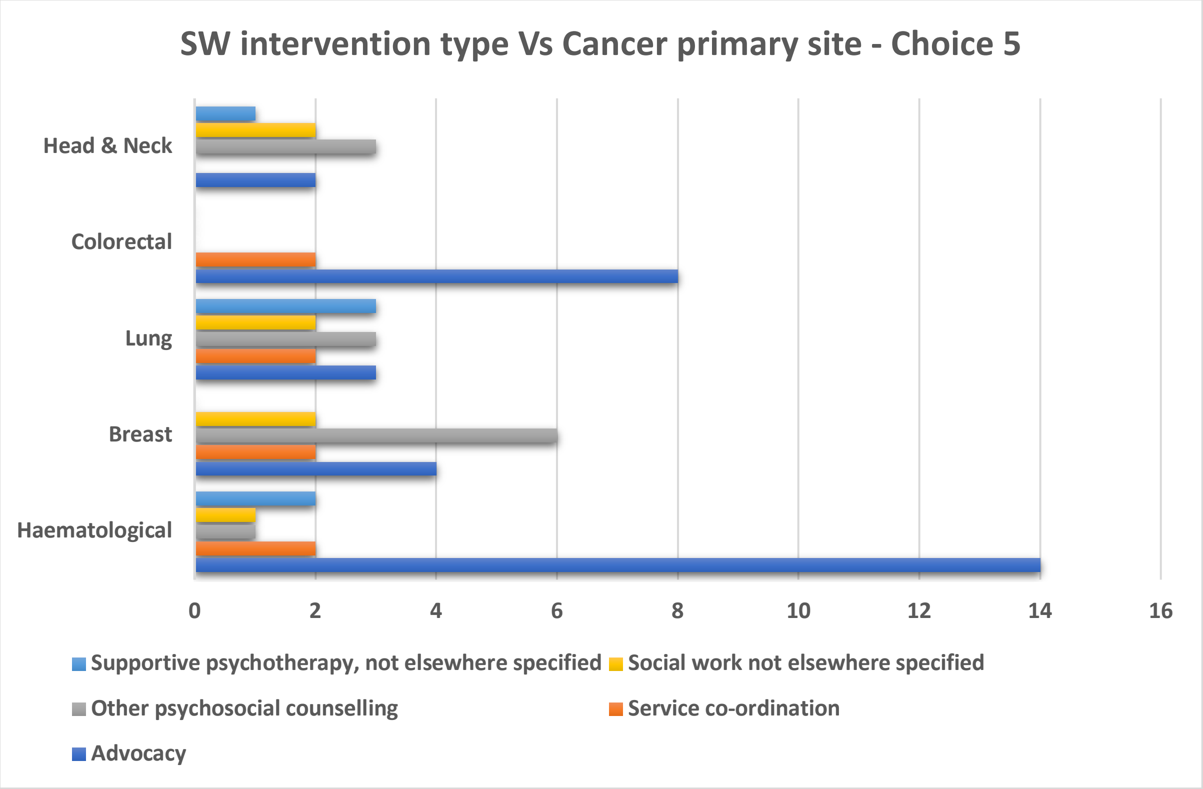


Figure 6.12

Mapping the most frequent five choices of intervention to the ICD-10-AM (International Classification of Diseases Version 10 Australian Modified) Code Set for Interventions (Allied Health Minimum Data Set v2.0)

		Frequency of Coding in all cases combined	**ICD-10-AM**
Most frequent first choice of intervention	Psychosocial assessment	**151**	96032-00
Most frequent second choice of intervention	Financial management counselling or education	**117**	96107-00
Most frequent third and fourth choice of intervention	Service co-ordination	**100**	96108-00
Most frequent fifth choice	Advocacy	**66**	96078-00

Table 6.13 Analysis of the five choices of interventions for all patients combined indicated that the most frequent first choice of intervention was Psychosocial assessment; the most frequent second choice of intervention was Financial management counselling and education. The most frequent third and fourth choice of intervention was Service co-ordination and the most frequent fifth choice of intervention was Advocacy.

In the 250 cases reviewed, social workers were asked to code up to five interventions in each case. The following table shows the full list of interventions used mapped to the ICD-10-AM codes.

Social Work Intervention	**Frequency of Coding**	**ICD-10-AM**
Psychosocial assessment	**151**	96032-00
Service co-ordination	**117**	96107-00
Advocacy	**100**	96108-00
Financial management counselling or education	**66**	96078-00
Other psychosocial counselling	**64**	96086-00
Self care/maintenance counselling or education	**45**	96075-00
Resource education	**35**	96089-00
Relationship counselling	**24**	96085-00
Grief/bereavement counselling	**23**	96021-00
Situational/occupational/environmental counselling or education	**23**	96076-00
Other counselling or education	**21**	96082-00
Systems therapy	**20**	95550-01
Supportive psychotherapy, not elsewhere specified	**18**	96185-00
Self care/self maintenance assessment	**17**	96021-00
Situational/occupational/environmental assessment	**17**	96079-00
Health maintenance or recovery assessment	**16**	96022-00
Counselling or education on health maintenance or recovery activities	**15**	96080-00
Crisis situation/event counselling	**13**	96082-00
Home management assessment	**13**	96028-00
Narrative therapy	**11**	96183-00
Social work not elsewhere specified	**10**	95550-01
Preventative counselling or education	**4**	96066-00
Counselling or education on preparing for parenthood, parenting skills or family planning	**4**	96080-00
Physical abuse/violence/assault counselling	**4**	96084-00
Other psychotherapies or psychosocial therapies	**4**	96180-00
Ageing assessment	**3**	96023-00
Substance addiction counselling or education	**3**	96073-00

Parenting skills assessment	**2**	96031-00
Alcohol and other drug assessment	**2**	96034-00
Psychological skills training	**1**	96001-00
Psychodynamic therapy	**1**	96100-00
Cognitive Behavioural Therapy (CBT)	**1**	96101-00
Gambling or betting addiction counselling or education	**0**	96074-00
Behaviour therapy	**0**	96176-00
Couples therapy	**0**	96178-00
TOTAL	**848**	

Table 6.14 shows the frequency of all interventions combined. Not all cases had five interventions coded, and from a possible 1250 interventions a total of 848 interventions were coded using 32 of the possible 35 intervention codes provided.

The descending frequencies illustrate a range of counselling interventions (278) which account for 42% of the total interventions. Service coordination, Advocacy and Other types of social work counselling account for 227 interventions (34.6%). If Psychosocial assessment is not included, the proportion of counselling interventions is 278 or 55% and Service coordination, Advocacy and Other social work account for 227 interventions or 45%. Both calculations reflect patient attributable practice with patients, families and others.

Key Outcomes of the Study

The aims of the study were to improve understanding of the scope of oncology social work practice in hospital settings and this was largely achieved. Reasons for referral to social workers and types of interventions undertaken by social workers were identified and analysed against available classification systems. The study affirmed the contextual location of social work practice in the social determinants of health, health inequalities and health and wellbeing. Additional qualitative data captured the social context and complexity of cases. The findings inform ongoing psychosocial intervention with cancer patients and in particular, emphasize the key role of social work with families and with wider social systems. Of significance is the contextualization of the social domain of patients' experiences, contributing to the effective and meaningful delivery of cancer care. Social risk factors were identified indicating that social work practice is well positioned to provide responsive and meaningful interventions.

Social workers who reviewed their cases were very experienced in the cancer field and had in-depth knowledge of the disease, treatment options and impacts on psychosocial functioning. They worked with patients and families following initial diagnosis, at cancer recurrence and in end stage/palliative care indicating a breadth of skills and knowledge associated with the cancer spectrum and life stage factors all contextualised and understood through patients' individual experience.

The cohort of 250 patients represented an even spread of male and female patients clustered through the life span and indicative of the types of cancers commonly seen in these settings. There were higher than expected numbers of outpatient cases across the six sites and the majority of cases came from regional centres even though two of the sites were located in major cities. The high number of non-metropolitan patients in the study is only partly explained by the fact that some of the data collection sites were in regional and rural locations. Social workers in the tertiary referral centres in metropolitan areas also saw high numbers of people from outside their local areas. Two explanations are possible here;

a high proportion of those with a cancer diagnosis travelled to metropolitan centres for cancer services that weren't available in their regional area and secondly, referrers have identified this as a social risk factor requiring referral to social work. These patients are likely to have higher needs for social work assistance due to managing the logistics of receiving treatment far from home, financial disadvantage and distance from their usual supports.

There was a lower than expected number of Aboriginal and Torres Strait Islander patients. Cancer incidence and mortality is higher in Aboriginal and Torres Strait Islander people due to late presentations with more advanced disease. This is at least partly related to geographical isolation, poorer access to health care services, lower participation rates in screening programs and lifestyle risk factors. Survival rates are lower, distress levels are higher and access to resources is more limited (ABS, 2019b). This may also be understood as a reflection of entrenched and systemic disadvantage experienced by First Nations peoples.

Gender, relationship status, parental status and occasions of service illustrated the importance of family supports and the risk factors that prompted referral to social work.
A higher number of female, non-partnered patients with adult children were seen and received higher occasions of service than male patients and nearly three times as many non-partnered males without children were seen compared with non-partnered females with no children suggesting that female patients with dependent children and non-partnered males without children were identified as social risk factors warranting referral to social workers.

In the present study just over a third of patients were either in full time or part time employment or were self-funded at the time of their diagnosis. Almost half were receiving Centrelink benefits at the time of diagnosis and this increased to 60% at the time of the case review. Given the working age range of the majority of patients, this high incidence of income support is an indicator of social risk and the likelihood of patients being referred to social work.

The majority of referrals to social work were made by members of the health team, in particular referrals from nursing staff. The interdisciplinary range of referrers to social work indicates that social workers are well integrated and accessible in cancer services across the cancer settings. In some settings, a blanket referral process was in operation where social workers saw every patient admitted to the service and in other areas social workers were actively involved in 'case-finding' through a process of pre-assessment of patient information and the identification of indicators for intervention such as age, a lack of family and social supports, financial status and the potential need for discharge planning and community care. Few sites were using the Distress Thermometer in assessments (O'Donnell, 2013; Zebrack, 2012). Social work screening accounted for just under half of other sources of referral. This indicates good levels of engagement by social workers with cancer treating teams. Referrals by patients and relatives were low indicating the need for increased patient education and other programs associated with health literacy and the role of social work (Nutbeam, 2018).

In 80% of cases, those making referrals to social work specified reasons. The five main reasons for referral to social work from others were: adjustment to illness/disability; financial and material assistance; discharge/community care; carer issues and accommodation. The first three reasons were often specified together in referrals.
Not all indicators for intervention (IFIs) were mapped in this process. Only 13 of the possible 27 IFIs in this classification scheme were used in the mapping. This may be explained by the fact that referrers tend to specify only more general information when making a referral to social work. The degrees of specificity in the IFIs list is more likely to be used by social workers in assessing the reasons for intervention following their assessment.

Social work practice was primarily delivered through individual interviews with patients, with family members and carers, and in family interviews. The frequency of occasions of contact was on average 8 occasions of service with individual patients with over one third of patients receiving over 12 occasions of service. This raw figure also goes some way in capturing case complexity as the more routine cases tended to receive lower than average or average occasions of service. Social work practice included the delivery of interventions to individual patients, family members, carers and others, with significant liaison with multidisciplinary team members and community agencies.

Although adjustment to illness/disability was the most frequently coded reason for intervention and was coded most frequently as the first choice, when all the codes were mapped to the IFI table the reasons for intervention identified by social workers in their social work assessments presented a slightly different picture. As raw frequencies, the reasons for intervention in the psychosocial domain were most common followed by those in the environmental domain. The functional domain was the third domain. This illustrates the scope of social work practice which has a primary focus on 'the person in environment'. The relationship with social systems that are external to the health sector and patients' medical treatment is a feature of social work practice located in the context of the social determinants of health. In the interpretation of their impact on patients' situations and experiences, social workers bring a range of theoretical knowledge and evidence informed practice to their assessments and interventions.

Analysis of the qualitative data provided a more rounded picture of other reasons for intervention that could not be captured in the classification system. An example is where social workers became involved in mediation and the provision of support to other members of patients' treating teams. This may have been in situations where the team had difficulties accepting a patient's decision to decline ongoing treatment which may have been life-lengthening; the unexpected deaths of patients which were sometimes premature, patient suicide, and situations where the patient was a high profile member of the community. The complexity of cases was also noted, for example patients with chaotic social situations; the urgent needs of dependent children; dysfunctional relationships with family members and conflict between family members and the treating teams. Overseas patients who were visiting Australia at the time of diagnosis and the repatriation home of deceased patients also had high levels of social work intervention involving multi-system, intergovernmental and international negotiation and liaison.

Social workers in the study provided the majority of interventions listed in the Allied Health Minimum Data Set with the exception of three; gambling or betting addiction counselling or education; behaviour therapy and couples therapy. The most frequent first choice of intervention was psychosocial assessment; the most frequent second choice of intervention was financial management counselling and education; the most frequent third and fourth choice of intervention was service co-ordination, and advocacy was the most frequent fifth choice of intervention. Psychosocial assessment was the single intervention delivered most frequently by social workers accounting for 23% of total interventions coded in the top five codes. A range of counselling interventions accounted for 42% of the total interventions with service coordination, advocacy and 'other social work' accounting for 34.6%. Psychosocial assessment can be seen as either a stand-alone intervention or one that is rolled up into other interventions where it is assumed to have been undertaken, informing the interventions that followed (Australian Association of Social Workers, 2015). If psychosocial assessment is not included, the proportion of counselling interventions was 55% and service coordination, advocacy and other social work accounted for 45% of interventions. Both calculations reflect patient attributable practice with patients, families and others. Interventions were delivered through intensive interpersonal engagement with patients, families, carers, members of the health team and community agencies.

The delivery of these interventions required high-level relationship-based skills with patients, families and the social systems with which they interact. Research-informed, knowledge for practice and a skill set necessarily situated at the intersection of multiple systems include interpersonal skills; inter and intra disciplinary skills and inter and intra organizational skills all of which were necessary to achieve meaningful service delivery outcomes.

Further areas of study have been identified including greater engagement of Aboriginal and Torres Strait Islander patients with social work services, the need for improved health literacy of patients about the role of social work in their cancer treatment, and the need for improved access to social workers and cancer services in rural and regional centres.

This study and the larger project have demonstrated the comprehensive and wide reaching nature of social workers' practice in oncology. This practice requires in-depth knowledge and high level skills to intervene in a range of social circumstances understood through theoretical, empirical, procedural and professional knowledge frameworks. Participating social workers in this study were experienced oncology practitioners demonstrating social work’s unique contribution of understanding patients’ experience beyond the bio-medical framework to a psychosocial framework and a conceptualisation of health and wellbeing through the lens of social and health inequalities.

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List of Appendices

Social Work Interventions in Cancer Care

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STATEMENT OF COMPLIANCE

This document is a protocol for a clinical research study. The study will be conducted in compliance with all stipulations of this protocol, the conditions of ethics committee approval, the NHMRC National Statement on Ethical Conduct in Human Research (2007) and the Note for Guidance on Good Clinical Practice (CPMP/ICH-135/95)

PROTOCOL SYNOPSIS

Title	Social Work Interventions in Cancer Care
Objectives	**Primary:** To improve understanding of the scope of oncology social work practice in hospital settings To investigate: • reasons for referral to social workers • types of interventions undertaken by social workers • documented outcomes of this intervention **Secondary**: To inform future psychosocial intervention with cancer patients and carers To inform more specific research investigating social work interventions and patient/carer needs
Study Design	Retrospective Medical Record review
Planned Sample Size	200 Medical Records across six sites (Two sites each in NSW, Qld & Victoria). In NSW: Royal North Shore Hospital (40- 50 Medical Records) Mid North Coast Cancer Institute, Coffs Harbour (20 -30 Medical Records)
Selection Criteria	Inclusion criteria will include: • Patients must be over 18 years of age • Have a diagnosis of cancer • Have been seen by oncology social workers in the previous 12 month period • Have received social work interventions that have been documented in the Medical Record

Study Procedures	Participating oncology social workers at the six sites will select cases from their caseload in the previous twelve month period that are representative of their work with cancer patients and carers. Each Medical Record reviewed will be allocated a unique identifier. The Principal Investigator at each site will hold a master list of MRNs and unique identifiers for the site in a password protected electronic file. At Royal North Shore Hospital this will be held on the NSLHD secure network. Data is reidentifiable if necessary but deidentified when aggregated with data from other sites participating in the study. A data collection sheet will be completed for each Medical Record using established social work codes.
Statistical Procedures	An opportunistic sample will be used. Each participating social worker will review Medical Records of previous patients. Data will be coded using the Coding Guide and entered onto a Data Collection Sheet. Data from the Collection Sheets will be entered onto an Excel spreadsheet. Statistical analysis will be undertaken using SPSS software. Descriptive statistical analysis will include percentages of each data element and cross analysis between data elements. A code-recode procedure will be included for randomly selected and coded medical records to ensure the robustness of the coding.
Duration of the study	12 months from approval

1 Study Management

1.1 Principal Investigator (RNSH)

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1.4 Other personnel

Social workers from the social work oncology team at each site will select cases and undertake the Medical Record reviews. The Principal Investigator at each site will continuously monitor the process.

1.5 Funding and resources

There are no funding sources for this project. Notional costs incurred will be related to the time involved for each social worker to review approximately 10 of their cases. Each file review is expected to take 60 – 90 minutes. The Social Work Departments at each site will absorb these time-associated costs. There are no costs associated with the involvement of the Principal Investigator and Associate Investigator from the University of Sydney. The study is an academic/practitioner partnership and part of academic community engagement.

2. INTRODUCTION AND BACKGROUND

2.1 Background Information

In the field of psycho-oncology little is known specifically about the role and scope of social work services, particularly in hospital settings in Australia. Hospitals are key service providers in cancer care and the likelihood of social work contact for cancer patients is highest through this setting, given the paucity of social work services available elsewhere for this group (HWA, 2012). This is particularly true of the Australian experience for rural, regional and socio-economically disadvantaged and marginalised populations (AIHW & AACR, 2012; AIHW, 2012; Butow, Phillips et al, 2012; Gunn, Turnbull et al, 2013; Hobbs, 2008; Underhill, Bartel et al 2009). Of particular significance is that Aboriginal and Torres Strait Islander communities experience entrenched, systemic difficulties accessing cancer services (Shahid, Finn et al, 2008; Treloar, Gray et al, 2013).

Social workers in health settings are often at the forefront of psychosocial support in cancer care however there have been few studies that have explored the types of social work interventions that are undertaken with Australian cancer patients (Lee, Katona et al 2010; Perry, 2000). Psychosocial services that can be provided by oncology social workers include distress screening, assessment, supportive counselling, survivorship care, referral to services and resources, care coordination, bereavement care and follow up (AASW, 2014; Deshields, Zebrack et al. 2012; Zebrack et al, 2008).

A national classification system for social work interventions across all fields of practice in health is now recognized as part of the Australian classification of health interventions (AIHW, 2014; Woodruff, Fitzgerald, Itsiopoulis, 2000) but not routinely used in formal data collection sets. The use of this classification system in the proposed study will enable social work practice that has been documented in Medical Records to be coded. This will result in a systematic review of interventions being routinely undertaken by oncology social workers.

The study will adhere to the ethical guidelines for human research set down in the National Statement on the Ethical Conduct for Research (NHMRC, ARC, AVCC, 2007); the Revised Statement & Guidelines on Research Practice (NHMRC, ARC, AVCC, 2007) and the NSW Supplement to the National Statement (NSW Health (2008).

2.2 Research Question

What are the main reasons for referring cancer patients and carers to social work and what types of interventions are undertaken by social workers?

In answering this question an improved understanding of social work practice in cancer care will be obtained. This will contribute to improvements in practice and patient care. The study will also enable useful data to be obtained as the basis for further research study.

2.3 Rationale for Current Study

Social workers are able to provide a range of skilled services to cancer patients and carers. Little is known about whether the scope of Australian practice in hospital settings is fully commensurate with the skills and approaches of social work practice. Improving patient access to social work services should result in the earlier and timely recognition of difficulties being experienced by cancer patients and provide a more holistic cancer service to meet the needs of patients and carers. This will have benefits for patients, carers and hospitals in meeting the objectives of providing high quality and responsive intervention to those with a diagnosis of cancer. The six sites included in the study will represent metropolitan, regional and rural settings in response to the identified lack of appropriate social work services in cancer care across the health system.

3. STUDY OBJECTIVES

To achieve the aims of the study and to provide an answer to the research question the primary and secondary objectives are:

3.1 Primary Objective

To improve understanding of the scope of oncology social work practice in hospital settings

To investigate:

- reasons for referral to social workers
- types of interventions undertaken by social workers
- documented outcomes of this intervention

3.2 Secondary Objective

To inform future psychosocial intervention with cancer patients and carers in health services

To inform the development of more specific research investigating social work interventions and patient/carer needs

4. STUDY DESIGN

4.1 Type of Study

The study will involve a retrospective file review of Medical Records at six health sites that provide social work services to cancer patients.

4.2 Study Design

The study will be a quality assurance type design following the principles of data mining using a specific data collection or audit tool designed for the project. The study is methodologically informed by the clinical data-mining approach used widely in practice-based research in social work and social science research (Dodd & Epstein 2012; Epstein, 2001).

The Principal Investigator from the University of Sydney has a research and publication track record using this methodology and all the named investigators are experienced practitioners with advanced expertise in hospital practice and research in the field (Pockett, 2009; Pockett, Walker & Dave, 2010).

Ethics approval will be sought for each State and site.
Within NSW, an LNR and SSAs will be made for the two sites; Royal North Shore Hospital as the lead site and the Mid North Coast Cancer Institute, Coffs Harbour.

4.3 Number of Participants

The total number of Medical Records to be reviewed in the full study is approximately 200 with proportional numbers at metropolitan, regional and rural sites according to the social work capacity to review files. In NSW it is expected that 40 – 50 Medical Records will be reviewed at Royal North Shore Hospital and about 20 will be reviewed at the regional site in the Mid North Coast Health Service.

4.4 Study sites

The study sites will include:

NSW

Royal North Shore Hospital Sydney (Lead site) (40 – 50 Medical Records reviewed)

Mid North Coast Cancer Institute, Coffs Harbour (20 -30 Medical Records)

Queensland

Cairns and Hinterland Hospital and Health Service (20 - 30 Medical Records)

Central Queensland Regional Integrated Cancer Care Service, Rockhampton Hospital and Health Service (20 -30 Medical Records)

Victoria

Yarra Ranges Health Easternhealth (20 - 30 Medical Records)

St Vincent's Hospital Melbourne (40 - 50 Medical Records)

All the sites will use the same inclusion criteria, data collection sheet and coding guide and the same study procedures.

4.5 Expected Duration of Study

The study should take approximately 12 months following the receipt of all Ethics approvals. As the Ethics approval process varies slightly for the three states it is anticipated that there will be a staggered start however the expected duration of the study is October 2015 – October 2016**.**

4.6 Primary and Secondary Outcome Measures

These will involve the achievement of the stated aims of the study and the analysis of aggregated data across the six sites. The aggregated data will provide a composite view of the scope of social work interventions being undertaken in the field. Comparisons between sites will not be made however the relevance of the type of site, i.e. metropolitan, regional or rural will be noted as access to services in regional and rural settings has been identified as a factor in improved patient outcomes (AIHW & AACR, 2012; AIHW, 2012; Butow, Phillips et al, 2012; Gunn, Turnbull et al, 2013; Hobbs, 2008; Underhill, Bartel et al 2009).

5. PARTICIPANT ENROLLMENT

5.1 Recruitment/Selection of Medical Records

Participating oncology social workers from each site will select cases from their cancer caseload in the previous twelve month period that are representative of their work with cancer patients and carers.

5.2 Eligibility Criteria

Inclusion criteria at each site will include:

- Patients must be over 18 years of age
- Have a diagnosis of cancer
- Have been seen by social workers in the previous 12 month period
- Have received social work interventions that have been documented in the Medical Record

6. Informed Consent Process

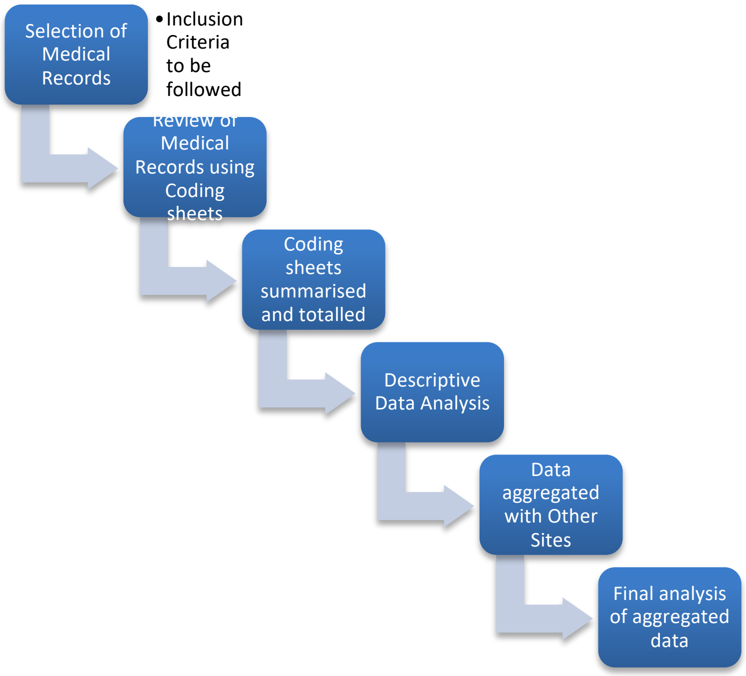
N/A

6.1 Participant Withdrawal

N/A

7. STUDY PROCEDURES SCHEDULE

Study Flow Chart



8. ADVERSE EVENT REPORTING

N/A

9. STATISTICAL METHODS

Statistical procedures will involve descriptive statistical analysis of collected data. A code-recode procedure will be included for randomly selected, coded Medical Records to ensure the robustness of the coding.

9.1 Sample Size Estimation

Opportunistic sampling will be used. The total number of Medical Records to be reviewed is up to 200 with proportional numbers at metropolitan, regional and rural sites according to the social work capacity to review files. In NSW it is expected that 40 – 50 Medical Records will be reviewed at Royal North Shore Hospital Sydney as the lead site and about 20 will be reviewed at the regional site in the Mid North Coast Health Service.

9.2 Population to be analysed

NSW

Royal North Shore Hospital Sydney (Lead site) (40 – 50 Medical Records reviewed)

Mid North Coast Cancer Institute, Coffs Harbour (20 -30 Medical Records)

Queensland

Cairns and Hinterland Hospital and Health Service (20 - 30 Medical Records)

Central Queensland Regional Integrated Cancer Care Service, Rockhampton Hospital and Health Service (20 -30 Medical Records)

Victoria

Yarra Ranges Health Easternhealth (20 - 30 Medical Records)

St Vincent's Hospital Melbourne (40 - 50 Medical Records)

Each participating social worker will review approximately 10 Medical Records of previous patients to whom they provided a service in the previous 12 months.

9.3 Statistical Analysis Plan

9.3.1 One Data Collection Sheet will be completed for each Medical Record. This will be entered into an Excel spreadsheet and analysed using SPSS software.

Data elements include:

Case description:

New and ongoing case

Inpatient, outpatient or both

Demographic data

Age range: Gender: Marital Status

Language spoken and ATSI status

Residential location: Metropolitan, Rural

Employment Status

Cancer Information

Cancer type and stage

Social Work Information

Source of social work referral

Reason for referral

Occasions of contact

Contact Types

Social Diagnosis/Reason for intervention

Social Work interventions

9.3.2 Data elements will be totalled and percentages obtained.

9.3.3 Cross analysis between the data elements will be undertaken including:

Demographic data and reasons for referral;

Demographic data and reasons for intervention;

Demographic data and social work interventions;

Cancer information and reasons for referral;

Cancer information and social work interventions;

Occasions of contact, contact types and social work interventions;

Reasons for referral and reasons for intervention

10. DATA MANAGEMENT

10.1 Data Collection

Data will be collected on the Coding Sheet for each Medical Record. These will be collected and checked by the Principal Investigator. Data will be entered into an Excel spreadsheet on the secure PC of the Principal Investigator.

10.2 Data Storage

The Principal Investigator at each site will hold a master list of MRNs and unique identifiers in a password protected electronic file. At RNSH this will be on the NSLHD secure network. Hard copy data sheets will be stored in a locked filing cabinet in a secure location in the office of the Principal Investigator at each site. Aggregated data from all sites will be secured on a password protected electronic file on the University of Sydney secure network and statistical analysis will be undertaken using SPSS software on the secure network. Data is reidentifiable if necessary but deidentified when aggregated with data from other sites participating in the study.

Aggregated data will be analysed by the Principal Investigator from the University of Sydney who will hold a secure master file of site-specific data for aggregation.

10.3 Study Record Retention

Data will be retained for 5 years post completion of the study and following the last publication from the study.

11. ADMINISTRATIVE ASPECTS

11.1 Confidentiality The master lists of MRNs and unique identifiers will be stored separately from the stored hard copies of data collection sheets at each site. Individual patient data will not be identified or associated with individual sites. Data is reidentifiable for the purposes of checking data for accuracy but when aggregated will be deidentified. The study will observe at all times the ethical guidelines in the relevant National Statements on the ethical conduct of research and the supplementary NSW Health Statement.

11.2 Independent HREC approval

This study has been approved by the Northern Sydney Local Health District HREC, reference number: TBA

11.3 Amendments to the protocol

11.4 Participant reimbursement

N/A

11.5 Financial disclosure and conflicts of interest

N/A. There are no conflicts of interest**.**

12. USE OF DATA AND PUBLICATIONS POLICY

The results of this study will be presented at professional development and scientific meetings at each participating site and at national and international conferences.

The Principal Investigator, University of Sydney will lead the publication of the study. The study results will be written up for publication in refereed professional journals. Principal investigators and Associate investigators at each site will be acknowledged and listed as researchers on the study. All social workers participating in the data collection will be acknowledged in publications. Consistent with scientific journal policies, authorship acknowledgement will be commensurate with contribution to manuscript development.

13. REFERENCES

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Research Office
Kolling Building, Level 13
Royal North Shore Hospital
St Leonards NSW 2065
Tel (02) 9926 4590 Fax (02) 9926 6179

NSW GOVERNMENT | Health
Northern Sydney
Local Health District

8 October 2015

Dr Rosalie Pockett
Faculty of Education and Social Work
The University of Sydney
Camperdown NSW 2006

Dear Rosalie

NSLHD reference: RESP/15/285
Study Title: Social work interventions in cancer care
HREC reference: LNR/15/HAWKE/393

Thank you for submitting the above project for review. Based on the information you have provided and in accordance with the NHMRC National Statement 2007 and NSW Health Policy Directive PD2010_055 Ethical and Scientific Review of Human Research in NSW Public Health Organisations, this project has been assessed as low/negligible risk and is therefore exempt from full HREC review.

This HREC has been accredited by NSW Ministry of Health as a Lead HREC under the model for single ethical and scientific review and Certified by the NHMRC under the National model for Harmonisation of Multicentre Ethical Review (HoMER).This lead HREC is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research* and the *CPMP/ICH Note for Guidance on Good Clinical Practice*. No HREC members with a conflict of interest were present for review of this project.

I am pleased to advise that the HREC, at a meeting of its Executive Committee held on **7 October 2015** has granted ethical and scientific approval of the above **multi centre** project.

You are reminded that this letter constitutes *ETHICAL* and *SCIENTIFIC* approval only. You must not commence this research project until you receive notification of Site Specific Assessment Authorisation from the Research Governance Officer. The LNRSSA submitted with this LNR application has been forwarded to the NSLHD Research Governance Officer for review.

The project is approved to be conducted at

- **Royal North Shore Hospital**
- **Mid North Coast Cancer Institute, Coffs Harbour**
- **Faculty of Education and Social Work, The University of Sydney**

If a new site(s) is to be added please inform the HREC in writing and submit a Site Specific Assessment Form (SSA) to the Research Governance Officer at the new site.

The following documents have been approved:

Document	Version	Date
Protocol	1	5 August 2015
Data collection sheet	1	5 August 2015
Coding Guide	1	5 August 2015

The Low and Negligible Risk Research Form reviewed by the HREC was **LNR AU/6/B090213**.

Please note the following conditions of approval:

- HREC approval is valid for **5 years** from the date of the HREC Executive Committee meeting and expires on **7 October 2020**. The Co-ordinating Investigator is required to notify the HREC 6 months prior to this date if the project is expected to extend beyond the original approval date at which time the HREC will advise of the requirements for ongoing approval of the study.

- The Co-ordinating Investigator will provide an annual progress report to the Institution beginning in **August 2016** as well as a final study report at the completion of the project using the template available on the Research Office website. An annual report is due **every year on 30 August**.
- The Coordinating Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including unforeseen events that might affect continued ethical acceptability of the project and any complaints made by participants regarding the conduct of the project.
- Proposed changes to the research protocol, conduct of the research, or length of approval will be provided to the HREC Executive for review, in the specified format.
- The HREC Executive will be notified, giving reasons, if the project is discontinued before the expected date of completion.
- Investigators holding an academic appointment (including conjoint appointments) and students undertaking a project as part of a university course are advised to contact the relevant university HREC regarding any additional requirements for the project.

Should you have any queries about your project please contact the Research Office, ph: 9926 4590, email NSLHD-Research@health.nsw.gov.au .

Please quote **NSLHD reference RESP/15/285** in all correspondence.

The HREC wishes you every success in your research.

Yours sincerely

[redacted]

Ellie Pratt
Research Ethics Manager
NORTHERN SYDNEY LOCAL HEALTH DISTRICT

cc. Raymond Araullo
RESD/15/6932

Research Office
Kolling Building, Level 13
Royal North Shore Hospital
St Leonards NSW 2065
Tel (02) 9926 4590 Fax (02) 9926 6179

NSW GOVERNMENT
Health
Northern Sydney
Local Health District

27 October 2015

Mr Ray Araullo
Department of Social Work
Royal North Shore Hospital
St Leonards NSW 2065

Dear Ray

NSLHD reference: RESP/15/285
Title: Social work interventions in cancer care
HREC reference: LNR/15/HAWKE/393 **SSA reference: LNRSSA/15/HAWKE/402**

Thank you for submitting an application for authorisation for a Low and Negligible Risk Research Site Specific Assessment (LNR SSA) project. I am pleased to advise that the delegate of the Chief Executive for Northern Sydney Local Health District has granted authorisation on **26 October 2015** for the above project to commence at **Royal North Shore Hospital.**

The version of the LNR SSA reviewed by NSLHD RGO was **AU/7/C090220.**

Ethical approval for this study was granted by the **Northern Sydney Local Health District HREC** at a meeting of the Executive Committee **held** on **7 October 2015.**

The documents authorised for use at this site are:

Document	Version	Date
Protocol	1	5 August 2015
Data Collection Sheet	1	5 August 2015
Coding Guide	1	5 August 2015

Site authorisation will cease on the date of HREC expiry **7 October 2020.**

You are reminded that, in order to comply with the Guidelines for Good Clinical Research Practice (GCRP) in Australia, and in accordance with additional requirements of NSLHD, the Chief Investigator is responsible for ensuring the following:

1. The HREC is notified of anything that might warrant review of the ethical approval of the project, including unforeseen events that might affect the ethical acceptability of the project.
2. Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project, and are submitted to the HREC for review, are copied to the Research Governance Officer.
3. Proposed amendments to the research protocol or conduct of the research which may affect the ongoing site acceptability of the project are to be submitted to the Research Governance Officer.
4. The annual report acknowledgment from the Lead HREC should be submitted to the Research Governance Officer.

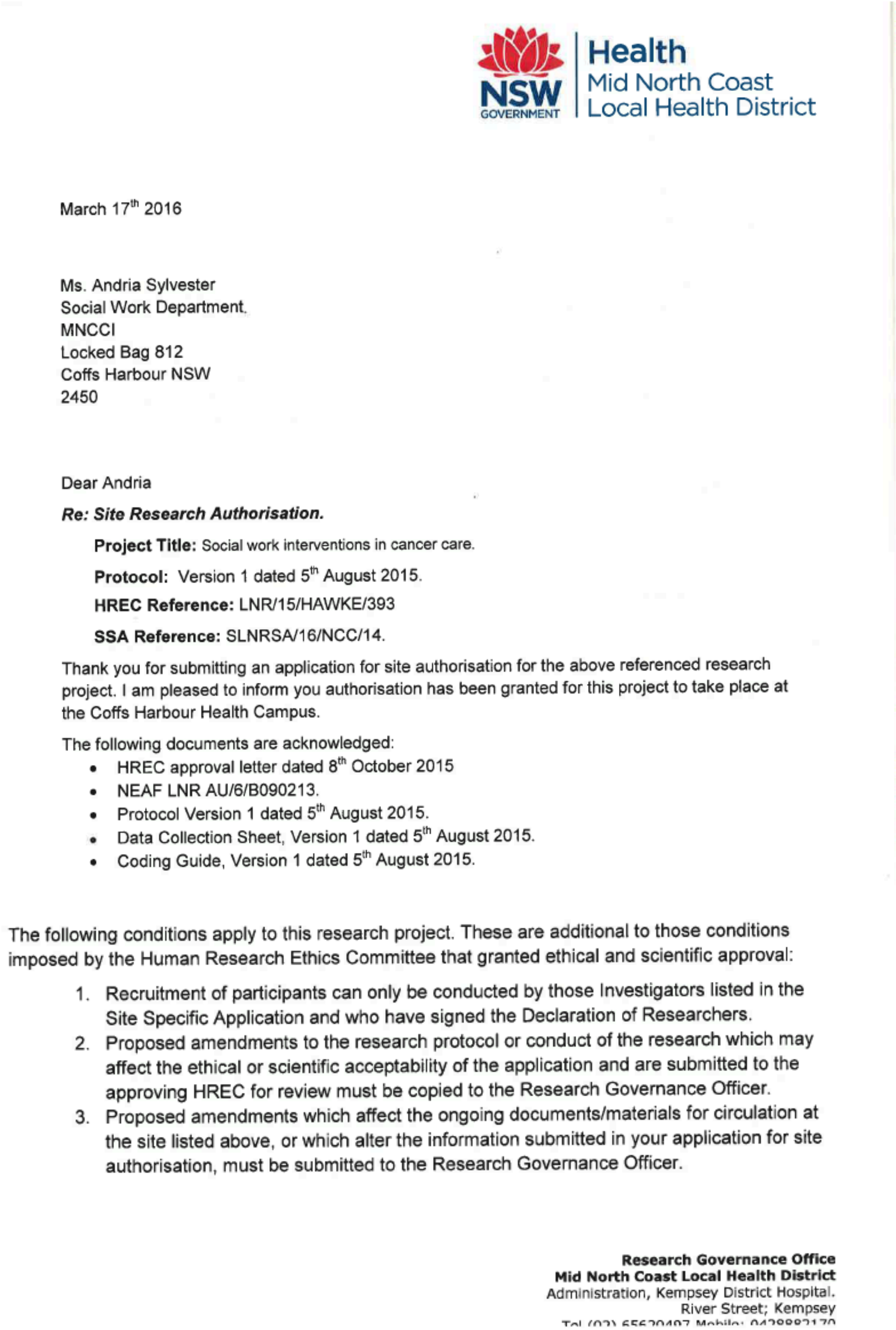
Standard forms and additional guidance documents are available on the Research Office Website: http://www.nslhd.health.nsw.gov.au/AboutUs/Research/Office

Yours sincerely

[redacted]

Kylie Becker
Research Governance Officer
Research Office
Northern Sydney Local Health District **RESD/15/7387**

Appendix 4



NSW GOVERNMENT
Health
Mid North Coast
Local Health District

March 17th 2016

Ms. Andria Sylvester
Social Work Department.
MNCCI
Locked Bag 812
Coffs Harbour NSW
2450

Dear Andria

Re: Site Research Authorisation.

Project Title: Social work interventions in cancer care.

Protocol: Version 1 dated 5th August 2015.

HREC Reference: LNR/15/HAWKE/393

SSA Reference: SLNRSA/16/NCC/14.

Thank you for submitting an application for site authorisation for the above referenced research project. I am pleased to inform you authorisation has been granted for this project to take place at the Coffs Harbour Health Campus.

The following documents are acknowledged:

- HREC approval letter dated 8th October 2015
- NEAF LNR AU/6/B090213.
- Protocol Version 1 dated 5th August 2015.
- Data Collection Sheet, Version 1 dated 5th August 2015.
- Coding Guide, Version 1 dated 5th August 2015.

The following conditions apply to this research project. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical and scientific approval:

1. Recruitment of participants can only be conducted by those Investigators listed in the Site Specific Application and who have signed the Declaration of Researchers.
2. Proposed amendments to the research protocol or conduct of the research which may affect the ethical or scientific acceptability of the application and are submitted to the approving HREC for review must be copied to the Research Governance Officer.
3. Proposed amendments which affect the ongoing documents/materials for circulation at the site listed above, or which alter the information submitted in your application for site authorisation, must be submitted to the Research Governance Officer.

Research Governance Office
Mid North Coast Local Health District
Administration, Kempsey District Hospital.
River Street; Kempsey
Tel (02) 65620497 Mobile: 0428882170

4. ***For drug or device trials:*** You agree that you will not commence the trial named above until the Clinical Trial Notification (CTN) has been submitted to the Therapeutic Goods Administration (TGA) using the online form. This site authorisation letter fulfils the documentation required to indicate the Approving Authority approval. A copy of the TGA acknowledgment of receipt of a CTN must be submitted to the MNCLHD Research Office as soon as it is available.
5. For any researcher who is not employed by the MNCLHD and is conducting the research on-site at any facility within this LHD are required to comply to site specific privacy, confidentiality, vaccination and identification processes.
6. Where appropriate, I recommend that you consult with your Medical Defence Union to ensure that you are adequately covered for the purposes of conducting this study.
7. *[if student involvement]* Site approval is granted on the assumption that all students and early career researchers are adequately supervised by the principal and senior investigators on a project. This supervision would ensure that all privacy concerns are met (including the completion of confidentiality agreements by participating students) and that both students and participants are supported in the conduct of the study in line with the approved research protocol.

Yours Sincerely

[redacted]

Ms Maureen Lawrence
Research Governance Officer
Mid North Coast Local Health District.

Cc. Dr. Rosalie Pockett, Usyd.

ST VINCENT'S HOSPITAL
MELBOURNE
A FACILITY OF ST VINCENT'S HEALTH AUSTRALIA

St Vincent's Hospital (Melbourne) Limited
ABN 22 052 110 755

41 Victoria Parade Fitzroy VIC 3065
PO Box 2900 Fitzroy VIC 3065

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20 June 2016

Dr Rosalie Pockett
Faculty of Education and Social Work
The University of Sydney

Dear Dr Pockett

LRR 097/16
Low Negligible Risk reference number: HREC/16/SVHM/84
Title: 'Social work interventions in cancer care: a quality assurance project'

Approval is given in accordance with the research conforming to the *National Health and Medical Research Council Act 1992* and the *National Statement on Ethical Conduct in Human Research (2007) and all subsequent updates.*

This HREC is organised and operates in accordance with the National Health and Medical Research Council's (NHMRC) National Statement on Ethical Conduct in Research Involving Humans (updated 2014), and all subsequent updates, and in accordance with the Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95), the Health Privacy Principles described in the Health Records Act 2001 (Vic) and Section 95A of the Privacy Act 1988 (and subsequent Guidelines).

Ethical approval is given for this research project to be conducted at the following sites:

- St Vincent's Hospital Melbourne
- Yarra Ranges Health Service, Easter Health Victoria

This approval will be ratified by St Vincent's Hospital (Melbourne) HREC at the next meeting. Ethics approval is granted for a period of 4 years from the date of this letter.

Approved documents
The following documents have been reviewed and approved:

Document	Version	Date
Low Negligible Risk Application	AU/13/B0C5210	28 April 2016
Social Work Interventions in Cancer Care	1	5 August 2015
Social Work Interventions in Cancer Care – Coding Guide	1	5 August 2015
Data Collection Sheet	1	5 August 2015

Approved Governance Documents

Terms of approval:

1. It is the responsibility of the Principal Researcher to ensure that all investigators are aware of the terms of approval and to ensure the project is conducted as specified in the application.
2. You should notify the Research Governance Unit immediately of any serious or unexpected adverse effects on participants or unforeseen events affecting the ethical acceptability of the project.
3. Amendments to the approved project: Changes to any aspect of the project require the submission of a Request for Amendment to the Low Risk Research Sub-committee and must not begin without written approval. Substantial variations may require a new application.
4. Future correspondence: Please quote the reference number and project title above in any further correspondence.
5. Annual Reports: An Annual Report is due on the anniversary of the date of approval
6. Final report: A Final Report must be provided at the conclusion of the project.
7. Monitoring: Projects may be subject to an audit or any other form of monitoring by the Research Governance Unit at any time.

Site-Specific Assessment (SSA)

SSA authorisation is required at all sites participating in the study. SSA must be authorised at a site before the research project can commence.

You are now required to forward this HREC approval letter with an electronic copy of the approved documents named above to the Principal Investigator(s) and the Research Governance Officer (s) at each participating site covered by this HREC approval. Each participating site must issue governance approval of the project before the study can commence at individual sites. (If applicable)

> ***Please note:*** *As the research project involves the collection, use and/or disclosure of identifiable health information without consent, the Victorian Health Records Act Statutory Guidelines for Research were applied by the Committee. A waiver of consent was granted for this study by the Executive of the Low Risk Research Subcommittee and will be ratified by the full HREC at their meeting on 6th July 2016 (for your information only).*

We wish you well with your project.

Yours sincerely,

[redacted]

Ms Eleisha Taylor
Administrative Assistant
Research Governance Unit
St Vincent's Hospital (Melbourne)

ST VINCENT'S
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MELBOURNE
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Telephone 03 9288 2211
Facsimile 03 9288 3399
www.svhm.org.au

11 October 2016

Mrs Sue Gorman
Social Work Department
St Vincent's Hospital (Melbourne)

Dear Mrs Gorman,

LNR HREC reference number: HREC/16/SVHM/84
LNR/SSA reference number: LNRSSA/16/SVHM/225
St Vincent's Local reference number: LRR 097/16

Study Title: 'Social work interventions in cancer care: a quality assurance project'

Thank you for submitting a Site Specific Assessment Form for Governance Approval at St Vincent's Hospital (Melbourne).

I am pleased to inform you that the aforementioned application has been approved.

This HREC is organised and operates in accordance with the National Health and Medical Research Council's (NHMRC) National Statement on Ethical Conduct in Research Involving Humans 2007 (updated May 2015), and all subsequent updates, and in accordance with the Note for Guidance on Good Clinical Practice (CPMP/ICH/135/95), the Health Privacy Principles described in the Health Records Act 2001 (Vic) and Section 95A of the Privacy Act 1988 (and subsequent Guidelines).

Approval Status: FINAL

Period of Approval: 12 October 2016 – 12 October 2020

Approved documents
The following documents have been reviewed and approved:

Document	Version	Date
Low Negligible Risk Application (AU/13/B0C5210)	1.1 (2014)	28 April 2016
Social Work Interventions in Cancer Care Protocol	1	5 August 2015
Social Work Interventions in Cancer Care – Coding Guide	1	5 August 2015
Data Collection Sheet	1	5 August 2015
Letter of Support from the Head of Department	N/A	27 May 2016
Research Collaboration Agreement	N/A	12 Oct 2016

Noted Documents

Document	Version	Date
CV – Mrs Sue Gorman	1	21 April 2016
CV – Ms Kim Maree Hobbs	1	14 Mar 2016
CV – Ms Kelly Pearson	1	27 Apr 2016
CV – Ms Andrea Mitchell	1	26 Apr 2016

Governance Approval is subject to:

- The Principal Researcher is to ensure that all associate researchers are aware of the terms of approval and to ensure the project is conducted as specified in the application and in accordance with the National Statement on Ethical Conduct in Human Research 2007 (updated May 2015)
- Immediate notification to the Research Governance Unit of any serious adverse events on participants.
- Immediate notification of any unforeseen events that may affect the continuing ethical acceptability of the project;
- Notification and reasons for ceasing the project prior to its expected date of completion;
- Notification of approved amendments to the study.
- Submission of an annual report, due on the anniversary date of approval, for the duration of the study.
- Submission of reviewing HREC approval for any proposed modifications to the project;
- Submission of a final report and papers published on completion of project;
- Projects may be subject to an audit or any other form of monitoring by the Research Governance Unit at any time.

If you have any matters that arise regarding conduct of the research at this site, please ensure you contact the Research Governance Unit on 03 9231 2394. Please quote the reference numbers above in all correspondence.

Please note: *As the research project involves the collection, use and/or disclosure of identifiable health information without consent, the Victorian Health Records Act Statutory Guidelines for Research were applied by the Committee. A waiver of consent was granted for this study by the chair of the Low Risk Sub-committee, and will be ratified at the next full HREC-Committee on 02 November 2016.*

We wish you well with your project.

Yours sincerely,

[redacted]

Azeezat Olusola Onipe
Senior Administrative Officer & HREC Secretary
Research Governance Unit
St Vincent's Hospital (Melbourne)

eastern**health**
GREAT HEALTH AND WELLBEING

Office of Research and Ethics
T 03 9895 3398
F 03 9094 9610
E ethics@easternhealth.org.au
W easternhealth.org.au/research-ethics
ABN 68 223 819 017
www.easternhealth.org.au

Commencement of Research at Eastern Health has been authorised

20 July 2016

Ms Gini Adcock
Yarra Ranges Health Day Oncology
25 Market St
Lilydale Vic 3140

Dear Ms Gini Adcock

Study title: Social work interventions in cancer care: a quality assurance project

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HREC Reference Number: HREC/16/SVHM/84
Eastern Health Local Reference Number: SERP30-2016
Protocol: Version 1, 05 August 2015

Principal Investigator: Ms Gini Adcock

Eastern Health Site: Yarra Ranges Health

Approval Period: On-going - subject to a satisfactory progress report being submitted annually.

Thank you for submitting a Site Specific Assessment for authorisation of the above project. I can confirm that the submission was received on 13 July 2016.

I am pleased to inform you that authorisation has been granted for this project to be conducted at Yarra Ranges Health.

Conditions of Eastern Health Authorisation

The following conditions apply to this research project at Eastern Health. These conditions are additional to those imposed by the Human Research Ethics Committee that granted ethical approval:

Additional site specific assessment is required if future protocol amendments result in additional resource use at Eastern Health
All future documents that are submitted and approved by the reviewing Human Research Ethics Committee (HREC) at St Vincent's Hospital Melbourne should be forwarded to the Office of Research and Ethics via email (ethics@easternhealth.org.au), along with HREC approval certificate for authorisation prior to use.

Site specific Participant Information and Consent Forms should be submitted when updates to the Master PICF occur, after review and approval by the reviewing Human Research Ethics Committee (HREC) at St Vincent's Hospital Melbourne.
Local serious adverse events should be notified to the Office of Research and Ethics promptly for noting and reporting to hospital insurers.
A site specific annual progress report is required every **February** for the preceding calendar year.
A site specific final progress report is required on study completion.

Documents processed and approved by the Research and Ethics Office (Governance) are listed below:

Document	Version	Date
Site Specific Assessment (SSA) Form – Victoria	1	05 July 2016

Please refer to the Human Research Ethics Committee (HREC) approval letter dated 20 June 2016 from St Vincent's Hospital Melbourne for a listing of final approved documents.

If you have any matters that arise regarding conduct of the research at this site, please ensure you contact the Office of Research and Ethics.

Eastern Health wishes you and your colleagues every success in your research.

Yours sincerely

Daniela Bodemer

Daniela Bodemer
Research Governance and Ethics Officer
Eastern Health Office of Research and Ethics
On behalf of:

1. Eastern Health Human Research Ethics Committee (Ethics Approval)
2. Executive Director Medical Services and Research (Site Authorisation)

Confidentiality, Privacy & Research

Research data stored on personal computers, USBs and other portable electronic devices must not be identifiable. No patients' names or UR numbers must be stored on these devices.

Electronic storage devices must be password protected or encrypted.

The conduct of research must be compliant with the conditions of ethics approval and Eastern Health

16/QTHS/85_1
Human Research Ethics Committee
Townsville Hospital and Health Service

Queensland
Government

Townsville
Hospital and Health Service

5th May 2016

Dr Rosalie Pockett
Faculty of Education and Social Work
University of Sydney, NSW

Rosalie.Pockett@sydney.edu.au

Dear Dr Pockett,

HREC reference number: HREC/16/QTHS/85
Project title: Social work interventions in cancer care: a quality assurance project
Protocol number: 1.0 05/08/2015

Thank you for submitting the above project for ethical and scientific review. This project was considered by Townsville Hospital and Health Service Human Research Ethics Committee (HREC) Chairperson on 04/05/2016.

The Townsville Hospital and Health Service HREC is constituted according to the National Health and Medical Research Council's '*National Statement on Ethical Conduct in Human Research*' (NHMRC, 2007). The Townsville Hospital and Health Service HREC operates in accordance with the *'Values and Ethics: Guidelines for Ethical Conduct in Aboriginal and Torres Strait Islander Health Research'* (NHMRC, 2003); and the '*National Statement on Ethical Conduct in Human Research*' (NHMRC, 2007). Attached is the HREC Composition with specialty and affiliation with the Hospital (Attachment I).

The Human Research Ethics Committee has agreed to mutually accept ethics approval for this research project, based on the lead HREC's approval, Northern Sydney Local Health District reference LNR/15/HAWKE/393. The research proposal meets the requirements of the *National Statement on Ethical Conduct in Human Research 2007 (updated May 2015)*. The documents approved include:

Document	**Version**	**Date**
Protocol	1.0	05.08.15
Data collection sheet	1.0	05.08.15
Coding Guide	1.0	05.08.15
LNR Application Form (*AU/10/C6F4218)*		23.03.16
NSLHD HREC Approval letter		08.10.15
Curriculum Vitae – Rosalie Pockett	1.0	14.03.16
Curriculum Vitae – Ngaire Temoananui	1.0	14.03.16
Curriculum Vitae – Cas McIntyre	1.0	14.03.16
Curriculum Vitae – Kim Hobbs	1.0	14.03.16

The research project has ethical approval for the following sites:
Central Queensland Hospital and Health Service
Cairns and Hinterland Hospital and Health Service

Please note the following key dates for this study:
HREC approval expiry: **03/05/2021**
Annual report due: **03/05/2017**

You are reminded that this letter constitutes ethical approval only. You must not commence this research project at a site until separate authorisation from the Health Service CEO or Delegate of that site has been obtained.

A copy of this approval must be submitted to the Health Service Research Governance Officer/Delegated Personnel with a completed Site Specific Assessment (SSA) Form, supporting study documents and the Public Health Act approval letter for authorisation from the CEO or Delegate to conduct this research at the approved sites. Refer to the local THHS website for further information on Site Specific Assessment:
http://qheps.health.qld.gov.au/tville/district-executive/medical-services/mssu-ethics.htm

Appendix 8

Please be aware that you may be required to obtain Public Health Act approval for the use of identifiable or potentially re-identifiable confidential health information without the written consent of the person to whom the data relates. Please contact the Health Service Research Governance Officer/Delegated Personnel for more information and refer to section 150 of the Hospital and Health Service Board Act 2011.

Please note the following conditions of approval:

The Principal Investigator will immediately report anything which might warrant review of ethical approval of the project in the specified format, including:
- Unforeseen events: please notify the HREC if any occur that might affect continued ethical acceptability of the project;
- Serious Adverse Events: must be notified to the Committee as soon as possible. In addition the Investigator must provide a summary of the adverse events, in the specified format, including a comment as to suspected causality and whether changes are required to the Patient Information; and
- Consent Form: In the case of Serious Adverse Events occurring at the local site, a full report is required from the Principal Investigator, including duration of treatment and outcome of event.

Amendments to the research project which may affect the ongoing ethical acceptability of a project must be submitted to the HREC for review. Major amendments should be reflected in a revised online application form (accompanied by all relevant updated documentation and a cover letter from the principal investigator, providing a brief description of the changes, the rationale for the changes, and their implications for the ongoing conduct of the study). Hard copies of the revised application form, the cover letter and all relevant updated documents with tracked changes must also be submitted to the HREC coordinator as per standard HREC SOP. Further advice on submitting amendments is available from http://www.health.qld.gov.au/ohmr/html/regu/regu_home.asp

Amendments to the research project which only affect the ongoing site acceptability of the project are not required to be submitted to the HREC for review. These amendment requests should be submitted directly to the Research Governance Office/r (by-passing the HREC).

Proposed amendments to the research project which may affect both the ethical acceptability and site suitability of the project must be submitted firstly the HREC for review and, once HREC approval has been granted, then submitted to the RGO.

Amendments which do not affect either the ethical acceptability or site acceptability of the project (e.g. ypographical errors) should be submitted in hard copy to the HREC coordinator. These should include a cover letter from the principal investigator providing a brief description of the changes and the rationale for the changes, and accompanied by all relevant updated documents with tracked changes.

The HREC will be notified, giving reasons, if the project is discontinued at a site before the expected date of completion.

The Principal Investigator will provide an annual report to the HREC and at completion of the study in the specified format. The final report should include a copy of the results and/or publication, if not available at the time of reporting these must be provided in a timely manner.

The Health Service administration and the Human Research Ethics Committee may inquire into the conduct of any research or purported research, whether approved or not and regardless of the source of funding, being conducted on hospital premises or claiming any association with the Hospital; or which the Committee has approved if conducted outside the approved sites.

Should you have any queries about the HREC's consideration of your project please contact me on (07) 4433 1440. The HREC terms of Reference, Standard Operating Procedures, membership and standard forms are available from http://www.health.qld.gov.au/ohmr/html/regu/regu_home.asp

Once site specific authorisation to conduct the research has been granted, please complete the Commencement Form (Attachment II) and return to the office of the Human Research Ethics Committee.

The HREC wishes you every success in your research.

Kind regards

[redacted]

Dr Nikola Stepanov
Chairperson
Townsville Hospital and Health Service
Human Research Ethics Committee

Townsville Hospital and Health Service
Human Research Ethics Committee
Telephone +617 4433 1440
Email TSV-Ethics-Committee@health.qld.gov.au

Appendix 9

Queensland
Government

Department of Health

Enquiries to: Claudine Wilson
Health and Medical Research
Office of the Director-General
Telephone: (07) 3096 2047
Ref QCHO/009321/RD006411

Dr Rosalie Pockett
Social Work and Policy Studies
Faculty of Education and Social Work
Building A35
University of Sydney NSW 2006

Dear Dr Pockett

Research Title: **Social work interventions in cancer care: a quality assurance project**

HREC / Project Number: **HREC/16/QTHS/85**

I am writing to inform you that your request for access to confidential health information for the above project has been approved under the delegation of the Director-General. In accordance with Section 284 of the *Public Health Act 2005* the researchers listed in your application, received 12 July 2016 can access and use the specified confidential information, providing they act within the limits detailed in your submission.

This approval (RD006411) commences on the date of this letter and is valid to 3 May 2021.

This approval relates to information for the period from 1 June 2016 to 31 December 2017 from the following repositories:

- **Rockhampton Hospital medical record**
- **Cairns Hospital medical record**

The following researchers may be given the information as noted in the above application:

- **Dr Rosalie Pockett (all sites)**
- **Mrs Ngaire TeMoananui (Rockhampton Hospital)**
- **Ms Cas McIntyre (Cairns Hospital)**
- **Ms Suzanne Norton (Cairns Hospital)**

This approval means that you must undertake the responsibilities and obligations of confidentiality of the information under the provisions of the *Public Health Act 2005.* You must take all reasonable steps necessary to ensure that the confidential information is kept confidential, including storing or disposing of all data, information, documents and associated correspondence in a secure manner. Unauthorised use or disclosure of confidential information may incur a penalty under the laws of the Queensland Government.

These obligations include providing notification of any change in the names of persons who will be given the information for the research.

When conducting research within the Queensland public health system, a copy of this Approval Letter must be provided to the relevant Research Governance Officer as part of your research governance application.

Please note: This letter constitutes *Public Health Act 2005* approval only. The project cannot proceed until separate Research Governance authorisation has been obtained from the relevant authority.

Please display this letter and a copy of your application when requesting the confidential information from the relevant data custodian.

You are required to provide an annual progress report and a final report at the completion of your project, to Health and Medical Research, Office of the Director-General. Templates can be found on the web page
http://www.health.qld.gov.au/ohmr/html/regu/aces_conf_hth_info.asp

Should you wish to extend your research project beyond this time or amend the study protocol, you will need to seek approval of these amendments from the approving HREC and re-apply for approval of the release of confidential data. This includes disclosing this information to and recruiting additional people to this project. Please provide a copy of your HREC approval of the amendments when re-applying.

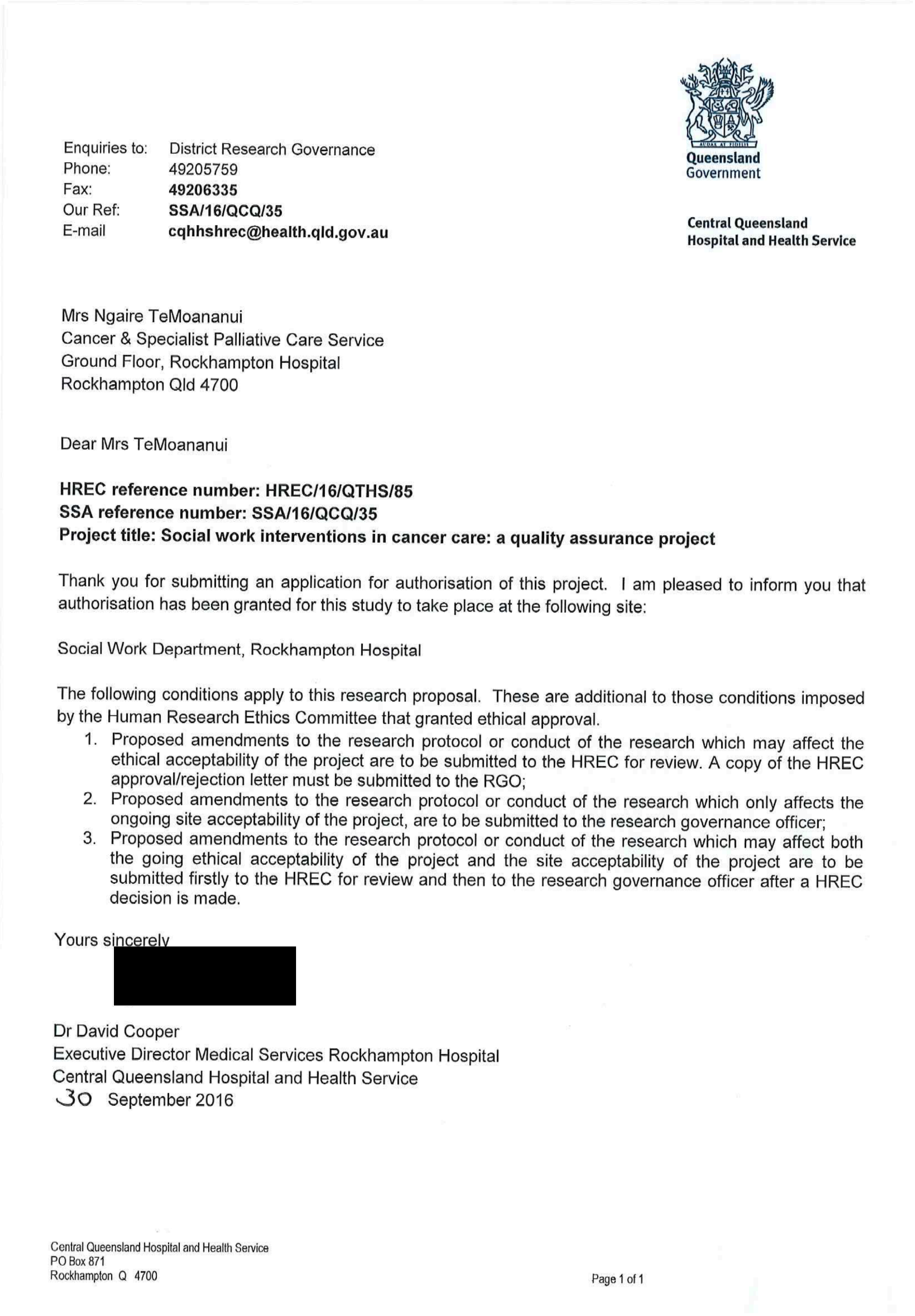
Please feel free to contact Health and Medical Research, Office of the Director-General on email PHA@health.qld.gov.au or phone 07 3096 2047 if you have any queries on this matter.

Yours sincerely

[redacted]

Louisa Cass
Senior Director
Office of the Director-General
21 / 7 /2016

Appendix 10



Queensland
Government

Central Queensland
Hospital and Health Service

Enquiries to: District Research Governance
Phone: 49205759
Fax: **49206335**
Our Ref: **SSA/16/QCQ/35**
E-mail **cqhhshrec@health.qld.gov.au**

Mrs Ngaire TeMoananui
Cancer & Specialist Palliative Care Service
Ground Floor, Rockhampton Hospital
Rockhampton Qld 4700

Dear Mrs TeMoananui

HREC reference number: HREC/16/QTHS/85
SSA reference number: SSA/16/QCQ/35
Project title: Social work interventions in cancer care: a quality assurance project

Thank you for submitting an application for authorisation of this project. I am pleased to inform you that authorisation has been granted for this study to take place at the following site:

Social Work Department, Rockhampton Hospital

The following conditions apply to this research proposal. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval.

1. Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project are to be submitted to the HREC for review. A copy of the HREC approval/rejection letter must be submitted to the RGO;
2. Proposed amendments to the research protocol or conduct of the research which only affects the ongoing site acceptability of the project, are to be submitted to the research governance officer;
3. Proposed amendments to the research protocol or conduct of the research which may affect both the going ethical acceptability of the project and the site acceptability of the project are to be submitted firstly to the HREC for review and then to the research governance officer after a HREC decision is made.

Yours sincerely

[redacted]

Dr David Cooper
Executive Director Medical Services Rockhampton Hospital
Central Queensland Hospital and Health Service
30 September 2016

Central Queensland Hospital and Health Service
PO Box 871
Rockhampton Q 4700

Appendix 11

Queensland
Government

Research Governance Office
Cairns and Hinterland
Hospital and Health Service

Telephone: (07) 4226 5512
Ref: *06.02: CD:mg*
Email: RGO_Cairns@health.qld.gov.au

Ms Cas McIntyre
Cairns Hospital
The Esplanade
Cairns Qld 4870

Dear Ms McIntyre

HREC reference number: HREC/16/QTHS/85
SSA reference number: SSA/17/QCH/20 – Lead 267
Project title: Social work interventions in cancer care: a quality assurance project
Protocol number: N/A

Thank you for submitting an application for authorisation of this project. I am pleased to inform you that authorisation has been granted at the following site(s):

Cairns and Hinterland Hospital and Health Service: Cairns Hospital

The following conditions apply to this research proposal. These are additional to those conditions imposed by the Human Research Ethics Committee that granted ethical approval.

1. Proposed amendments to the research protocol or conduct of the research which may affect the ethical acceptability of the project are to be submitted to the HREC for review. A copy of the HREC approval/rejection letter must be submitted to the RGO;
2. Proposed amendments to the research protocol or conduct of the research which only affects the ongoing site acceptability of the project, are to be submitted to the Research Governance Officer;
3. Proposed amendments to the research protocol or conduct of the research which may affect both the going ethical acceptability of the project and the site acceptability of the project are to be submitted firstly to the HREC for review and then to the research governance officer after a HREC decision is made.
4. Ensure that annual and final reports are sent to the Research Governance Officer in due course.

Yours sincerely

[redacted]

Clare Douglas 15/2/17
Chief Executive
Cairns and Hinterland Hospital and Health Service

William McCormack Place
Level 7
5 B Sheridan Street
PO Box 902
CAIRNS QLD 4870

List of social worker investigators at each site:

NSW

Royal North Shore Hospital St Leonards NSW
Ray Araullo
Kate Lindberg
Kevin Bloom
Anthea Murray
Denise Stevens
Nicole Loizou
Sharmin Khan-Christie
Lisa Ingles

Mid North Coast Cancer Institute, Coffs Harbour
Andria Sylvester
Robert Brangwin

VICTORIA

St Vincent's Hospital Melbourne Victoria
Sue Gorman
Kelly Pearson
Greer Peters

Yarra Ranges Health Easternhealth
Gini Adcock

QUEENSLAND

Cairns and Hinterland Hospital and Health Service
Cas McIntyre

Central Queensland Hospital and Health Service
Trilby Witton-Oates
Ngaire TeMoananui (Ethics Application)

CODING GUIDE

Definitions

Type of Case

A 'case' is a collective grouping of the episode/s of social work care
Social workers reviewing medical records should use their own judgment to determine what constitutes 'the case' for each record reviewed

A case may be one or more inpatient admissions in which social work care/intervention was considered a **new** case in each inpatient admission	**NCI** (New Case Inpatient)
A case may be one or more outpatient contacts in which social work care/intervention was considered a **new** case	**NCO** (New Case Outpatient)
A case may be multiple inpatient admissions in which the social work care/intervention was **ongoing** and considered as part of the same case	**OCI** (Ongoing Case Inpatient)
A case may be multiple outpatient admissions in which the social work care/intervention was **ongoing** but considered as part of the same case	**OCO** (Ongoing Case Outpatient)
A case may be a mixture of inpatient and outpatient admissions in which the social work care/intervention was **ongoing** and considered as part of the same case	**OCB** (Ongoing Case Both Inpatient and Outpatient)

Contact Type

The contact type is the 'mode' or way in which the intervention activities are conducted.

Contact Type	**Definition**	**Code**
Individual Interview	An interview held with one patient/client only	**II**
Family Interview	An interview held with more than one family member/carer or others	**FI**
Telephone consultation	Telephone consultation with patient/ carer or others connected with the case	**TC**
Home Visit	Visit to a patient/carer or	**HV**

	others place of residence	
Case conference	A scheduled meeting with others, involves care planning	**CC**
Ward rounds/team consultation	Routine care planning with other team members	**RC**
Written communication	Reports, letters other written communication required for the case	**WR**

Reasons for intervention
The reasons for the intervention activities based on the **social work** assessment Reasons selected should answer the question: 'What is it about this patient/client situation that I am aiming to address with my current intervention?' (Taken from NAHCC IFI Coding Manual 2006).

Reasons for intervention	**Code**
Adjustment to illness/disability	**ADJ**
Ageing Issues	**AGE**
Behavioural, cognitive or mental health	**BMH**
Bereavement	**BER**
Carer Issues	**CAI**
Child/Parenting issues	**CPI**
Child Protection	**CP**
Domestic Violence	**DV**
Drug & Alcohol issues	**DA**
Elder Abuse	**EA**
End of life Issues	**EOL**
Family/relationship issues	**FRI**
Financial & Material assistance	**FMA**
Guardianship/financial management	**GFI**
Homelessness/housing/ accommodation	**HAC**
Immigration/refugee Issues	**IMR**
Legal Issues	**LI**
Residential aged care placement	**RAP**
Discharge/community	**DC**

care issues	
Pregnancy adjustment/issues	**PR**
Sexuality/sexual health and wellbeing	**SH**
Sexual Assault	**SA**
Social isolation	**SI**
Stillbirth/miscarriage	**SMI**
Trauma	**TR**
Victim of Crime	**VOC**
Other social	**OS**

Social Work interventions

Interventions provide services to patients, relatives, carers and others to influence health status. They are the **type of work** undertaken.

Intervention	**Code**
Self care/self maintenance assessment	**1**
Health maintenance or recovery assessment	**2**
Home management assessment	**3**
Situational/occupational/environmental assessment	**4**
Parenting skills assessment	**5**
Psychosocial assessment	**6**
Alcohol and other drug assessment	**7**
Ageing assessment	**8**
Preventative counselling or education	**9**
Substance addiction counselling or education	**10**
Gambling or betting addiction counselling or education	**11**
Self care/maintenance counselling or education	**12**
Counselling or education on health maintenance or recovery activities	**13**
Financial management counselling or education	**14**
Situational/occupational/environmental counselling or education	**15**
Counselling or education on preparing for parenthood, parenting skills or family planning	**16**
Relationship counselling	**17**
Crisis situation/event counselling	**18**

Physical abuse/violence/assault counselling	**19**
Grief/bereavement counselling	**20**
Other psychosocial counselling	**21**
Resource education	**22**
Other counselling or education	**23**
Psychological skills training	**24**
Psychodynamic therapy	**25**
Cognitive Behavioural Therapy (CBT)	**26**
Systems therapy	**27**
Behaviour therapy	**28**
Couples therapy	**29**
Other psychotherapies or psychosocial therapies	**30**
Narrative therapy	**31**
Supportive psychotherapy, not elsewhere specified	**32**
Service co-ordination	**33**
Advocacy	**34**
Social work not elsewhere specified	**35**

DATA COLLECTION SHEET

Facility______________________________

Instructions for Medical Record reviewers

One Audit sheet is to be completed for each case

A 'case' is defined as a collective grouping of the episode/s of social work care. Social workers reviewing medical records should use their own judgment to determine what constitutes 'the case' for each record reviewed.

1. Type of Case: Please tick the best description of this case (Refer to Coding Guide)

NCI (New Case Inpatient)	
NCO (New Case Outpatient)	
OCI (Ongoing Case Inpatient)	
OCO (Ongoing Case Outpatient)	
OCB (Ongoing Case both inpatient and outpatient)	

2. Patient Information

Patient MRN	Allocated Identifier (Principal Investigator to allocate)
Age	
M/F	

Marital Status at diagnosis	Please tick
Married/De Facto	
Separated	
Divorced	
Widowed	
Single	
Not Stated	

Other (please specify)	

Child status at diagnosis	Please tick
Dependent children	
Adult children	
No children	
Not stated	

Country of Birth	
Language Spoken	
Aboriginal or Torres Strait Islander	Yes No

Residential Location and Post Code	Please tick
Metropolitan	
Rural/Regional	
Remote	
Other (please specify)	

Employment status at diagnosis	Please tick
Employed Full Time	
Employed Part Time	
Home Duties	
Student	
Centrelink	
Self-funded	
Other (please specify)	
Not Stated	

Employment status at time of audit	Please tick
Employed Full Time	
Employed Part Time	
Centrelink	
Self-funded	
Other (please specify)	
Not Stated	

3. Cancer information

Cancer : Primary Site	Please list

Cancer Stage at Diagnosis (if known)	
Early stage	
Recurrence	
End stage	
Other (please specify)	

Cancer Stage at Social Work contact	
Following initial diagnosis	
Recurrence of cancer	
End stage/palliative care	
Other (please specify)	

4. Social Work Referral

Referral to Social Work	Please tick
Patient Self referral	
Relative/Carer referral	
Oncologist /Medical Officer	
Nurse	
General Practitioner	
Multi-disciplinary team (MDT)	
Other health professional	
Community/health agency	
Other (please specify)	

Referral information	Please tick
Reason specified (Please state)	
Unspecified /General referral	

5. Social Work Contact (Refer to Coding Guide)

Social Work Contacts with service recipients	**Patient** List Contact Types	**Relative/Carer /Significant Other** List Contact Types	**Other** (please specify) List Contact types
1-3 occasions			
4-8 occasions			

9-11 occasions			
12+ occasions			

6. Reasons for intervention (Refer to Coding Guide)

List up to five reasons for the interventions

7. Social Work Interventions (Refer to Coding Guide)

List up to five interventions

Notes

Please note any aspects of the social work service that have not be captured by the audit.