

**The characteristics of oncology social work in Australia: implications for workforce
planning in integrated cancer care**

Short running title: Social work and integrated cancer care

Authors:

Rosalie Pockett PhD

Social Work & Policy Studies

Faculty of Education and Social Work A35

University of Sydney NSW 2006

Australia

Ph: +61 412 355 560

Fax: +61 2 9351 3783

rosalie.pockett@sydney.edu.au (*Corresponding Author*)

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Michelle Peate PhD

¹Psycho-Oncology Cooperative Research Group (PoCoG)

School of Psychology

C39Z - The Lifehouse, 119-143 Missenden Rd;

The University of Sydney NSW 2006 Australia

mpeate@unimelb.edu.au

Kim Hobbs MSW

Department of Gynaecological Cancer & Department of Social Work

Westmead Hospital, Westmead

Sydney NSW 2145 Australia

¹ Present Address:

Department of Obstetrics & Gynaecology

University of Melbourne

Royal Women's Hospital Level 7

20 Flemington Road

Parkville Vic 3052 Australia

mpeate@unimelb.edu.au

Kim.Hobbs@health.nsw.gov.au

Monika Dzidowska

²Psycho-Oncology Cooperative Research Group (PoCoG)

School of Psychology

C39Z - The Lifehouse, 119-143 Missenden Rd;

The University of Sydney NSW 2006 Australia

monika.dzidowska@sydney.edu.au

Melanie L Bell

³Psycho-Oncology Cooperative Research Group (PoCoG)

² Present Address:

Faculty of Pharmacy

A15 Pharmacy

The University of Sydney NSW 2006 Australia

³ Present address: Associate Professor, Biostatistics

School of Psychology

C39Z - The Lifehouse, 119-143 Missenden Rd;

The University of Sydney NSW 2006 Australia

melaniebell@email.arizona.edu

Brandi Baylock

Psycho-Oncology Cooperative Research Group (PoCoG)

School of Psychology

C39Z - The Lifehouse, 119-143 Missenden Rd;

The University of Sydney NSW 2006 Australia

Brandi.Baylock@sydney.edu.au

Mel & Enid Zuckerman College of Public Health

University of Arizona

USA (520) 626-2795

melaniebell@email.arizona.edu

Irwin Epstein

Helen Rehr Professor of Applied Social Work Research

Silberman School of Social Work

Hunter College, CUNY New York, USA

iepstein@hunter.cuny.edu

ABSTRACT***Aims:***

- To describe the demographics, professional characteristics, self-reported professional development needs and research involvement of oncology social workers in Australia
- To describe perceived barriers to provision of quality psychosocial care

Methods: A cross-sectional online survey was administered to social workers working in the oncology field who were contacted through three professional organizations; the Australian Association of Social Workers (AASW), Oncology Social Work Australia (OSWA) and the Psycho-oncology Co-operative Research Group (PoCoG), the University of Sydney. A snowball recruitment method was adopted to maximize the sample size.

Results: Two thirds of respondents had over ten years professional practice experience but with lesser experience in oncology settings. Twenty eight percent had post graduate qualifications. Professional development needs were reported as moderate or high by 68% of respondents. No association between professional needs and work setting was found. Years of experience in oncology practice and living in an urban area increased the likelihood of involvement in research. Barriers to psychosocial care included poor understandings of the social work role, time constraints and an inadequate number of social work positions.

Conclusion: In this first Australian study of the social work oncology workforce the results demonstrated active, well-qualified and experienced social workers providing frontline services to people with cancer and their caregivers in geographically diverse locations across Australia. Inadequate resources and a lack of integrated psychosocial care were identified as barriers to comprehensive cancer care. The need for Aboriginal and Torres Strait Islander social workers was identified as an urgent workforce priority.

KEYWORDS: Delivery of health care; Integrated; Social Work

INTRODUCTION

With continued advances in cancer treatment resulting in improved survival, there has been a

growing emphasis on the importance of psychosocial services in cancer care [1, 2, 3 4].

Psychosocial care delivered through a range of interventions including cognitive/behavioural based interventions; communication and patient education approaches; and patient navigation have been shown through clinical trials to alleviate and improve psychosocial distress and improve patients' experiences with oncology services [5, 6, 7, 8, 9, 10]. However, despite clear indications for its role in clinical practice, access is limited, particularly in underserved populations. Health inequalities and disparities amongst individuals, groups and communities account for higher mortality rates and poorer outcomes for Australians living in lower socioeconomic areas, those living in rural and regional communities and Aboriginal and Torres Strait Islander communities. These groups experience higher mortality rates from all cancers combined [11, 12, 13]. Furthermore, evidence reported by the Australian Institute of Health and Welfare indicates that psychosocial outcomes are variable for these groups [14]. A 2009 Australian study of regional hospitals administering chemotherapy found that only 39% of hospitals reported having dedicated oncology counselling services [15]. Furthermore, only 50% of these reported the availability of a social worker and 30% reported the availability of a psychologist as part of the service [15].

., The two key professions providing psychosocial care in oncology are psychologists and social workers with each discipline having different skills and practice perspectives. In Australian clinical practice guidelines for the psychosocial care of cancer patients, clear evidence is presented on the effectiveness of psychosocial care and support for cancer patients and their families. Many of these interventions are delivered by members of the multi-disciplinary team that includes psychologists and social workers [16, 16a, 16b, 17]. The Underhill et al research [15] is also particularly interesting, as it

appears that the onus of psychosocial care falls largely on social workers, with oncology clinics reporting greater access to social workers compared to psychologists. A literature exists on psycho-oncology practice and research by psychologists [18, 19, 20, 21 for example], however less is known about social work.

It has been argued that social workers are the primary providers of psychosocial services in oncology because of their practice versatility [22]. Anecdotally, social workers in oncology settings report that they are usually the 'first port of call' for psychosocial support in cancer care. In an oncology setting, the social worker undertakes a range of psychosocial interventions including psychosocial assessment; interventions related to issues of adjustment, crisis, loss and bereavement; survivorship care; coordination of appropriate social and community supports; and liaison and referral to other services. Social work contributes to care across the cancer continuum, supporting the well-being of individuals, families, caregivers and communities. This is consistent with the social work role in wider health care and is often supported by an integrated multi-disciplinary team approach that is fundamental to the delivery of care, with a focus on striving for equity of access and outcomes across all communities [23]. We postulate that social workers are in a prime position to support, triage and advocate for the psychosocial care of the cancer patient.

To best understand the barriers to delivery of psychosocial care in clinical practice, research into the delivery of these services is needed. A focus on the role of social work could provide insight into possible improvements to increase access to care. However, little is known about the Australian oncology social work workforce and there is limited,

peer-reviewed research addressing practice interventions by oncology social workers.

The challenges of defining and quantifying the Australian oncology social work workforce has been highlighted by Health Workforce Australia (HWA) as part of developing a National Cancer Workforce Strategic Framework (NCWSF)[24]. A data inventory of the oncology workforce to identify multiple characteristics of professional groups found that “in contrast to other professional groups there is a lack of published data (both national and state-based) regarding the oncology social worker workforce” (p. 47), indicating the need for more research in this area.

The aim of this study is to profile oncology social work practice in Australia. The study describes the demographics, professional characteristics, work settings, professional development needs and involvement in research by oncology social workers and explores their perceptions of barriers to the provision of quality psychosocial care.

METHODS

Participants

Participants in this study were social workers, defined as those who were eligible for membership of the Australian Association of Social Workers (AASW). To be eligible for membership, social workers must meet the qualifications for practice set down by the association. These are either the completion of an accredited four year bachelor’s degree in

social work (BSW) or an accredited two year post graduate qualifying Masters degree in social work (MSW – Q). The association is responsible for the accreditation of social work courses, the professional code of ethics, minimum practice standards, special interest groups and colleges of advanced practice. In order to target social workers specialising in oncology, further inclusion criteria were that participants were providing services to cancer patients as part of their practice and that cancer related work accounted for more than 25% of their workload.

Established State, Territory and Commonwealth Government databases (for example, The Australian Institute of Health and Welfare online metadata repository [METeOR] (Australian Institute of Health and Welfare, 2012), the Australian government 'My Hospitals' website and State based sites such as Canrefer [25, 26, 27] were reviewed but could not be used for recruitment due to such factors as incompleteness, inconsistencies and a lack of confidence in the accuracy and currency of data across a range of data collection elements relating to inpatient, day-patient and outpatient service delivery. It was also unclear whether a social worker was a team member; was employed in the wider facility or was only available by referral. This resulted in the sample group for the study being accessed through the three key professional associations for social workers working in oncology; the Australian Association of Social Workers (AASW); Oncology Social Work Australia (OSWA) and the Psycho-Oncology Co-operative Research Group, (PoCoG). A convenience sampling method was adopted using their electronic mailing lists. In addition, a snowballing technique enabled participants to send on the survey to others whom they knew were working in the field and at the time of the study there was a reasonable level of confidence in the final sample being representative of social workers working in cancer services in Australia. This recruitment method made it difficult to determine a sample size representative of the study population. At the time of the study the AASW

reported their membership as 6000 but the proportion of the members practising in settings where cancer patients constituted part of their client group was unknown. The social work membership of OSWA was 170 and PoCoG 74.

Sample size calculations

The survey aimed for a sample size of at least 120 respondents that gave a 95% confidence interval of width 13% (+/- 6.5%). A sample size of 200 would give a 95% confidence interval of width 10% (+/- 5%). As well as being feasible, these sample sizes provided precision sufficient for the purpose of this study. A total of 211 respondents accessed the online survey and of these, 156 participants completed the survey.

Measures

A cross-sectional, descriptive online survey was purposively developed to assess the characteristics of oncology social workers. The measures were presented in multiple choice and Likert Scale formats and included a final open-ended question on perceived barriers to providing psychosocial care. Items were collected about the following:

- i) **demographic characteristics:** including age; gender; country of birth; highest qualification in social work and number of years practising in social work
- ii) **work setting:** including years working with cancer patients; percentage of clinical load; type of oncology setting; clients referred; most common reasons for referral; source of

referrals

- iii) ***self-reported professional needs***: respondents were asked to rate their level of need ranging from no need; low need; moderate need to high need against a list of professional development activities drawn up by the researchers
- iv) ***involvement in research***: including previous and current research roles and activities and the number of studies participated in
- v) ***work related training, professional development and supervision***: including access to supervision, frequency and whether it was internal or external; costs involved; discipline background of supervisor; satisfaction with supervision; existence of a social work department; membership of professional networks
- vi) ***perceived barriers to the provision of quality psychosocial care***: participants were asked an open-ended question regarding the perceived barriers for providing quality psychosocial care in their clinical setting.

Procedure

An invitation was sent to members of the organizations that contained a link to the survey and an attachment containing the Participant Information Sheet. The survey remained open for just over a month and a reminder was sent to members prior to the survey closure. Consent was obtained online prior to entering the survey. Inclusion and exclusion criteria were confirmed at the start of the survey, with ineligible participants thanked for their time and exited from the survey.

Analysis

Survey data were analysed using the statistical analysis program Stata. Descriptive statistics including means, frequencies, standard deviations, and confidence intervals were used for the primary analysis. A secondary analysis examined the association between the outcomes of professional experience, research involvement, and access to professional training and development and the explanatory variables of years in practice, work setting, level of professional qualifications and location using χ^2 tests. Linear regression (for self-reported professional needs) and logistic regression (for research involvement) were also performed using the above explanatory variable. A thematic analysis of free text answers was also undertaken using the Attride-Stirling framework for qualitative research [28]

Permissions

The study received approval from the Human Research Ethics Committee of the University of Sydney and endorsement from the Australian Association of Social Workers (AASW) National Research Committee, the Psycho-Oncology Co-operative Research Group (PoCoG) Scientific Advisory Committee and the Management Committee of Oncology Social Work Australia (OSWA). There were no conflicts of interest identified in the completion of the study.

RESULTS

Demographic characteristics and work setting

Participant demographics and work setting are shown in Table 1. Participants were experienced social workers with over two thirds (71%) having more than 10 years practice experience.

Participants had less experience working in cancer services specifically with just over half (52%) having six or more years experience working in cancer services. Twenty-eight percent of respondents held post-graduate qualifications including Masters degrees and PhD's and having a post-graduate qualification was associated with the years working in oncology (Table 2).

Insert Table 1

Insert Table 2

Respondents worked in the six states of the Commonwealth with the majority being in the larger states of New South Wales (46%) and Victoria (27%). Queensland and Western Australia had equal numbers of respondents (10.3%) with smaller numbers from South Australia (4%) and Tasmania (1%). No respondents were identified from the two Territories, (Northern Territory and the Australian Capital Territory, ACT).

Forty-four percent of participants identified their work setting as a tertiary referral cancer centre and 27% identified the setting as a district or local hospital. The Accessibility/Remoteness Index of Australia (ARIA) [29] calculated from postcodes, categorised work settings into Major Cities, Inner/Outer Regional Centres and Remote/Very Remote. In terms of the location of the work setting, 82% worked in a major city, 11.5% in an inner regional centre, 4.5% in an outer-regional location and 1% in a remote setting. More than 90% worked in publicly funded health facilities, reflecting the structure of the Australian health care

system.

Referrals to Social Work

Respondents reported that the majority of their referrals came from nursing colleagues (50%), followed by multi-disciplinary team meetings (21%), oncologists (15%) and from other professional staff (4.5%). Approximately 9% of referrals were self-referrals from patients.

The five most common reasons for referral are shown in Figure 1 and include Psychological wellbeing (83%); Accessing resources (81.4%); Carer issues (69.2%); Death/bereavement/end-of-life issues (64%); and issues concerning Illness/disability and health condition (63.5%).

Insert Figure 1.

Other reasons for referral to social workers included issues concerning patient/family dynamics (59%), home situation and accommodation needs (49.4%), legal matters (21.8%) and concerns relating to trauma (7.7%).

Self-Reported Professional needs for ongoing training and professional development

More than two thirds of the respondents (68%) reported moderate or high professional development needs. The most highly rated areas for ongoing professional development needs were for addressing psychosexual concerns, (62%), the use of a range of specific counselling techniques (58%), survivorship issues (57%) and the use of complementary and alternative practices (52%). Multiple linear regression indicated trends of professional development needs decreasing with years of experience in oncology (regression coefficient, -0.15, 95% confidence interval (CI)-0.46, 0.16) and a higher degree qualification (-2.4, 95% CI -5.5, 0.8).

There was no evidence of an association between self-reported professional development needs and work setting location. While those who worked in a non-urban setting tended to report a need with screening for patient distress more often than those who worked in an urban setting, this association was not significant. (Table 3)

Insert Table 3

Professional practice supervision

The majority of respondents (83%) indicated that they received professional practice supervision and this was associated with work setting (Table 4). The majority of supervisors (93%) were from the social work discipline. The remaining 7% were from Psychology (3.9%); Nursing (1.6%) Medicine (0.78%) or were unspecified (0.78%). Monthly internal agency supervision was most common (82%) with the remaining respondents self-funding private, external supervision. The majority (80%) was either satisfied or very satisfied with their supervision. Three quarters of respondents indicated that they either usually, or always attended multi-disciplinary meetings. A further 11% indicated they would attend sometimes, or when invited, or when a particular case was being discussed. Eighty-three percent of respondents indicated that they were part of a social work department, 5% indicated that there was a department in the work setting but they were not part of this group and 12% were working in settings where there was no social work department structure. Nearly 80% of respondents indicated that they were members of professional or peer support groups in the field of oncology social work practice including the three organizations involved in this study.

Insert Table 4

Involvement in research

In response to a list of typical research activities listed in the survey 44% of the respondents

indicated that they were currently involved in a range of research activities. Of the 115 respondents who indicated they had either been involved in research in the past or were currently involved in research, 107 (93%) had been involved in up to 5 studies, 6 (5.2%) in up to 10 studies and 2 (1.7%) had been involved in more than 10 studies. Logistic regression showed that years of experience in oncology practice (odds ratio (OR) = 1.19 per year; 95% CI 1.03, 1.38) and living in an urban area (OR = 3.12; 95%CI 1.08, 8.55) increased the likelihood of involvement in research.

Barriers to provision of quality psychosocial care

A thematic analysis of responses to the final open-ended question identified a range of barriers to the delivery of care that were consistently reported by respondents. Central to these was the relationship of the social worker to the patient and to the treating team. The role of social workers in oncology was frequently reported as being poorly understood by both patients and health professionals. This lack of understanding of the role included views that social workers were only concerned with discharge planning, case management and the provision of practical assistance or welfare type services. Social workers' skills and training to deliver complex psychosocial interventions were inconsistently recognized by both patients and members of multidisciplinary teams. Examples of comments include:

'...there is a lack of awareness from other staff that social work has something to offer in terms of psychosocial care for oncology patients' (participant 36 - NSW)

'.....there is limited support from people in the medical field who have limited understanding or support for the inclusion of social work in patient care..... (participant 202 – QLD)

'.....patients' misconceptions about social workers can mean they refuse psychosocial support' (participant 191 – NSW)

'.....it is often assumed that social workers in cancer care only do welfare work... as the only social worker in a team of of clinical psychologists this is particularly challenging.....(participant 1 – WA)

'....the environmental and work-place culture limit some opportunities to providing optimal psychosocial care.....'(participant 162 – QLD)

Time constraints, an inadequate number of social work positions and lack of integration of psychosocial services within the cancer treatment team further exacerbated difficulties in delivering psychosocial interventions efficiently and effectively.

'.....there is an increasing demand to do more with less i.e. increased patient numbers but not increased resources. In the end we are having to provide a bandaid type service in order to get to

everyone....'(participant 119 – VIC)

'...time and a lack of psychologists...time given for social work covering a huge geographical area in 19 hours a week, distance and contracted positions.....' (participant 209 – NSW).

'...not enough social work FTEs (full time equivalents) to screen and follow-up patients, carers and families....' (participant 185 – SA)

DISCUSSION

The results of this national survey of social workers in cancer services in Australia present a previously unknown picture of their demographic characteristics, work place settings, types of referrals, professional development needs and involvement in research. State and territory spread, distribution across rural and urban regions and public and private services are consistent with the location of oncology units identified in the National Minimum Data Set [13]; thus this sample is likely to be representative of the range of practice settings for social workers in oncology. The study has identified the difficulties in obtaining accurate information about the location of social workers and psychosocial support services. Consistent with other studies such as Underhill et al [15], access limitations to psychosocial care are evident and rural communities in particular are not receiving the psychosocial care they need with the likely result of

poorer psychosocial health and well-being.

. The survey demonstrated an active, well-qualified and experienced workforce purposefully engaged in professional supervision and well linked to professional networks. The types of practice being undertaken were consistent with psychosocial intervention documented in the literature. The majority of social workers were practising in metropolitan centres but interestingly the reported barriers to the provision of quality psychosocial care crossed metropolitan and regional areas.

Perhaps unsurprisingly, considering the reasons for referral, the top five areas of professional development needs were psychosocial. Ongoing and targeted professional development programs in areas including psychosexual concerns, survivorship issues, specialised counselling techniques, the use of complementary and alternative practices and grief and bereavement counselling need to be considered. The relevance and importance of these professional needs are exacerbated by the reported barriers including a lack of understanding of the social work role by clients and colleagues, and the need for improved integration of psychosocial care into overall patient engagement with the facility. These results are consistent with clinical practice guidelines in the Australian literature that tend to emphasise the practical nature of social work interventions in psychosocial care without an appreciation of the 'person in environment' focus of social work, and the need for more specialised training in areas of complex psychosocial interventions [16, 16a, 16b].

The absence of an integrated approach to the provision of psychosocial services by

appropriately trained professionals is of concern. Inadequate resources need to be addressed, delineation of the social worker role in oncology is needed and professional supports need to be put in place. Such initiatives are clearly supported by studies that have demonstrated improved psychosocial outcomes that can result. To determine the most effective strategies, further research needs to be undertaken in this area. The absence of Aboriginal and Torres Strait Islander social workers in the field is also of concern given the poor health outcomes of the indigenous population. This requires further investigation and priority setting in workforce planning. In addition to increasing the number of Aboriginal and Torres Strait Islander social workers, culturally specific training for all cancer service providers that focuses on cross-cultural communication and culture specific needs in conjunction with wider systemic change have been identified as necessary to improve the Aboriginal disadvantage in cancer outcomes [30].

Of particular interest was the reported level of participation in research activities. With our data supporting the argument that social workers play a primary role in providing psychosocial care, it was interesting to note that less than half of participants reported being actively involved in research. This suggests that there is little engagement, awareness or opportunity in regards to collaborating on research. This is further supported by the data showing that most engagement occurs with those who have post-graduate training (which may reflect that these social workers are most likely to actively pursue research) or work in urban areas (where social workers may be more involved in multi-disciplinary teams and thus have access or be accessible to researchers). This finding is consistent with a 2013 study that investigated social work practitioner research capacity in Northern Queensland [31]. The prime positioning of social

workers in oncology services potentially provides good patient access for psychosocial research.

It follows then that this is an under-utilised mechanism to tap into cancer populations or to identify key areas of psychosocial need.

This research skims the surface in profiling oncology social work practice. There are some limitations including the inability to determine the exact number of social workers working in oncology, limitations of the cross sectional design and the smallness of the sample in terms of statistically significant findings. However the strengths of the study include its originality of purpose both for Australian social work and also more widely for the oncology field. More focused research is needed particularly in relation to those groups where needs and outcomes are under reported. Increasing social workers' research activity and subsequent publications, will shed further light on the psychosocial needs of the cancer population with whom they are involved and strengthen the profile of social work intervention and its role in integrated cancer care.

CONCLUSION

This study makes an important contribution to understanding how psychosocial care is being delivered in Australia and to future workforce planning in integrated cancer care. The findings support the argument that social workers have a significant role in this provision. Despite playing a primary role, social workers report unmet needs for support in managing the psychosocial care of patients. Providing the best care is hampered by a lack of resources and

poor understanding of the social work role by clinicians and patients. An urgent priority is the need for Aboriginal and Torres Strait Islander social workers in the workforce. Surprisingly, social worker involvement in psychosocial research work is limited. Initiatives that build research capacity are needed, in particular those that are consistent with social work's 'person in environment' perspective [31]. Further research is also needed into social work interventions and patient outcomes. The role which social workers play in delivering psychosocial care in oncology provides a potentially rich resource for recruitment to psycho-oncology studies. A better resourced and distributed social work workforce has clear implications for improved psycho-social outcomes for individuals, groups and communities.

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Figure and Table Legend

Table 1: Demographic characteristics and work setting

Table 2: Postgraduate qualifications

Table 3: Self-reported professional development needs and work setting location

Table 4: Supervision

Figure 1: Most common reasons for referral

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Table 1: Demographic Characteristics and Work Setting

	Personal Characteristics (N = 156)		
		Participants n (%)	Mean (SD)
Age	20-29	21 (13.5)	43.8 (11.93)
	30-39	42 (26.9)	
	40-49	24 (15.4)	
	50-59	46 (29.5)	
	60-69	16 (10.3)	
Gender	Female	139 (89.1)	
	Male	17 (10.9)	
Country of Birth	Australia	125 (80.1)	
	United Kingdom	7 (4.5)	
	India	4 (2.6)	
	New Zealand	3 (1.9)	
	South Africa	3 (1.9)	
	Other	11 (7.1)	
	Unknown	3 (1.9)	
Aboriginal/Torres Strait Islander	No	155 (99.4)	
	Unknown	1 (0.6)	
Primary language spoken at home	English	137 (87.8)	
	Other	16 (10.3)	
	Unknown	3 (1.9)	
Highest Qualification in Social Work	Bachelors	103 (66.0)	
	Honours	2 (1.3)	

	Graduate Certificate/diploma	4 (2.6)	
	Postgraduate certificate/diploma	5 (3.2)	
	MSW (Qualifying)	7 (4.5)	
	Masters	31 (19.9)	
	PhD	3 (1.9)	
	Other	1 (0.6)	
Current employment status	Part-time/Casual	6 (3.9)	
	Casual/Sessional	2 (1.3)	
	Part-time	36 (23.1)	
	Full-time	112 (71.8)	
Years practicing as a social worker	Less than 10	45 (28.8)	15.9 (10.26)
	10-19	58 (37.2)	
	20-29	30 (19.2)	
	30-39	19 (12.2)	
	More than 40	4 (2.6)	
Years working in cancer	5 or less	75 (48.1)	7.1 (5.93)
	6-10	53 (33.9)	
	11-15	15 (9.6)	
	More than 15	13 (8.3)	
Primary clinical setting	Tertiary referral cancer centre	68 (43.6)	
	District/local hospital	41 (26.3)	
	Non-inpatient treatment centres	8 (5.1)	
	Non-hospital based	7 (4.5)	
	Palliative Care Unit	14 (9.0)	

	Other	18 (11.5)	
Years in current setting	5 or less	97 (61.5)	5.8 (5.41)
	6-10	39 (25.0)	
	11-15	13 (8.3)	
	More than 15	8 (5.1)	
Client referrals	Paediatric	15 (9.6)	
	Adolescent and young adult	5 (3.2)	
	Adult	90 (57.7)	
	Carers	1 (0.6)	
	A mix of the above	45 (28.9)	
Cancer population	General oncology	85 (54.5)	
	Palliative care	42 (26.9)	
	Haematology	11 (9.6)	
	Gynaecological	4 (2.6)	
	Other	14 (9.0)	

Table 2: Post graduate qualifications

Odds ratio of having a postgraduate degree with 95% Confidence Intervals and <i>p</i> -values		
	OR (95%CI)	<i>p</i> -value
Years Practicing as a social worker	0.97 (0.93 - 1.02)	0.289
Years working in oncology*	1.09 (1.01 - 1.18)	0.032
Clinic Type	1.26 (0.34 - 4.60)	0.727
Clinic Location	1.08 (0.36 - 3.18)	0.893
Supervision	1.92 (0.58 - 6.45)	0.291
Research Involvement	2.03 (0.75 - 5.49)	0.164
Cancer Population	0.80 (0.30 - 0.71)	0.365

* $\alpha < 0.05$

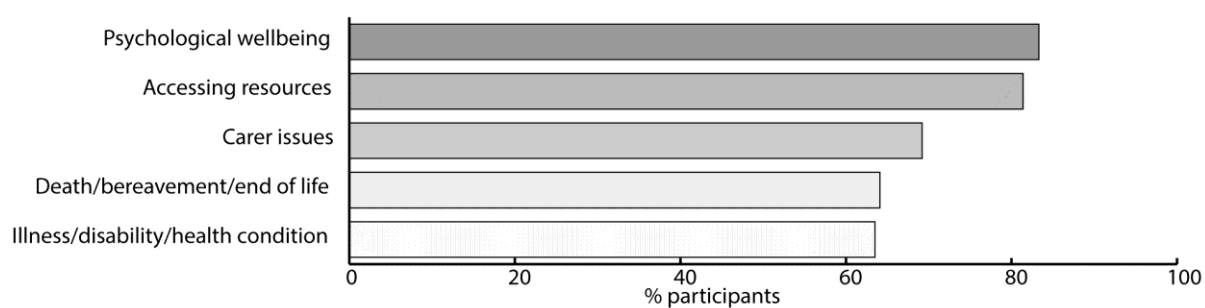
Table 3: Self-reported professional development needs and work setting location

Odds ratio of working in a non-urban area by self-reported professional needs with 95% Confidence Intervals and <i>p</i> -values		
	OR (95%CI)	<i>p</i> -value
Screening for patient distress	7.28 (0.95 - 56.03)	0.057
Addressing caregiver concerns	1.22 (0.53 - 2.80)	0.638
Support groups	0.76 (0.32 - 1.78)	0.522
Financial concerns	1.13 (0.49 - 2.61)	0.771
Accommodation/housing concerns	2.00 (0.64 - 6.20)	0.231
Legal concerns	2.31 (0.5 - 10.55)	0.278
Survivorship issues	1.32 (0.55 - 3.18)	0.529
Discharge care/planning	0.96 (0.42 - 2.20)	0.919
Domiciliary support services	0.77 (0.34 - 1.77)	0.536
Informing patients about range of services and entitlements	0.66 (0.27 - 1.61)	0.360
Addressing psychosexual concerns	1.03 (0.40 - 2.66)	0.946
Use of a range of counselling techniques	1.47 (0.47 - 4.61)	0.513
Use of complementary and alternative practices	2.45 (0.69 - 8.70)	0.166
End of life issues	1.52 (0.62 - 3.74)	0.360
Grief and bereavement counselling	3.01 (0.85 - 10.63)	0.087

Table 4: Supervision

Odds ratio of receiving supervision with 95% Confidence Intervals and <i>p</i> -values		
	OR (95%CI)	<i>p</i> -value
Years Practicing as a social worker	0.96 (0.91 - 1.02)	0.155
Years working in oncology	1.06 (0.95 - 1.89)	0.284
Clinic Type	2.43 (0.29 - 20.61)	0.415
Clinic Location*	4.88 (1.75 - 13.59)	0.002
Social Work Qualifications	1.86 (0.55 - 6.26)	0.318
Research Involvement	1.61 (0.54 - 4.79)	0.390

* $\alpha < 0.05$

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Author/s:

Pockett, R; Peate, M; Hobbs, K; Dzidowska, M; Bell, ML; Baylock, B; Epstein, I

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