

## - Supportive Care Project Report to Advisory Group-

<p><b>Project Title:</b></p> <p>Answering the unanswered questions about psychosocial screening in the cancer setting</p>	<p><b>Date of report :</b></p> <p>22 January 2010</p>
<p><b>Organisation &amp;/or Tumour Group:</b></p> <p>St. Vincent's Health</p>	<p><b>Start Date:</b></p> <p>May 2009</p>
<p><b>Project Manager:</b></p> <p>Dr. Carrie Lethborg</p>	<p><b>Completion date:</b></p> <p>June 2010</p>
<p><b>Progress to date:</b></p> <p>Though there have been some challenges with this project we have also had some gains that have balanced out our progress. The nurses that we had discussed doing much of the recruitment for us have all had very busy times with their own clinical work and buying out backfill time has not been possible. This has meant that our research assistant – Rosie Brown – has done more recruiting than we had planned. On the plus side we reached our target for phase one early and ended up with more participants than we had expected. We decided to take the advisory committee's advice and focus on measuring distress at a single time point rather than attempting to follow-up participants at three time points. It has become clear that repeating measures of distress over time adds a variable that should be considered in a separate study and would confuse the specific outcomes we should focus on.</p> <p>We thus have a complete data set for Phase one for 137 participants. Rosie is focusing on recruitment for phase two and we have employed a social worker in a small locum position to also recruit one afternoon a week. Our aim is to get a similar number for this phase and complete data collection by March 2010. Stage 2 data collection is concentrated on Breast, Haematology and Lung tumour streams as these groups yielded the greatest amount of psychosocial data in Stage 1.</p> <p>The most complex data to date has been looking at clinical activity in relation to the patient risk data we have. These two data sets have not been put together before and we have been able to see the relationship between high risk of distress and clinical involvement using risk factor screening. We will now look at clinical involvement with risk factor screening + Distress thermometer + alerting psychosocial staff to 'at risk' patients. Comparing both outcomes will be fruitful indeed.</p> <p>We have incorporated a second question to the Distress Thermometer &amp; problem checklist asking people to rate the amount of assistance they need to address the problems they identify. This was adopted from work on the Emotion thermometer (A. J. Mitchell et al, <i>Psycho-Oncology</i>, 2009, DOI 10.1002/pon.1523). We believe this is a crucial consideration in planning and resourcing.</p>	

Finally, after much beta testing the psychosocial oncology database is working well and automatically sends alerts for all patients with risk factors to be assessed. Data is entered into the psychosocial database by Rosie as it is collected.

**Next actions:**

**Other Comments:**

Please see attached report – Early outcomes for clinical involvement.

If you have any queries about the project please contact the Project Manager Dr. Carrie Lethborg on 9288 3179.

**Early outcomes for clinical involvement (psychosocial) in relation to psychosocial risk factors**

**Wednesday, 20 January 2010**

The following table illustrates the clinical activity provided by psychosocial professionals to participants over a five month period. Each participant was given a score that represented the number of psychosocial risk factors identified per participant. A score of one or 2 was not considered high enough to raise an alert – this accounted for 36% of participants. Thus, 63% had 3 or more risk factors and raised an alert on the psychosocial oncology database (however as we wanted the care team to be blind to risk factors they were not told these scores).

We were interested to know if those who had more than two risk factors were picked up by the psychosocial staff even if they were not alerted to do so. In fact, this ‘at risk’ group were found to receive more than twice as many visits from a psychosocial professional and receive almost twice as many hours of care than those deemed ‘not at risk’.

Participants with more than two risk factors were seen an average of 7 times during the five month period of recruitment (as opposed to 3 times for those with 2 or less risk factors) and were given an average of 7 hours of care from a psychosocial professional over this time (as opposed to 4 hours of care for those with 2 or less risk factors).

The range of scores (numbers of risk factors) that did raise an alert were from 3 to 11. However there was negligible difference between those that had 3-6(52%) risk factors and those that had 7-11 (11%) risk factors.

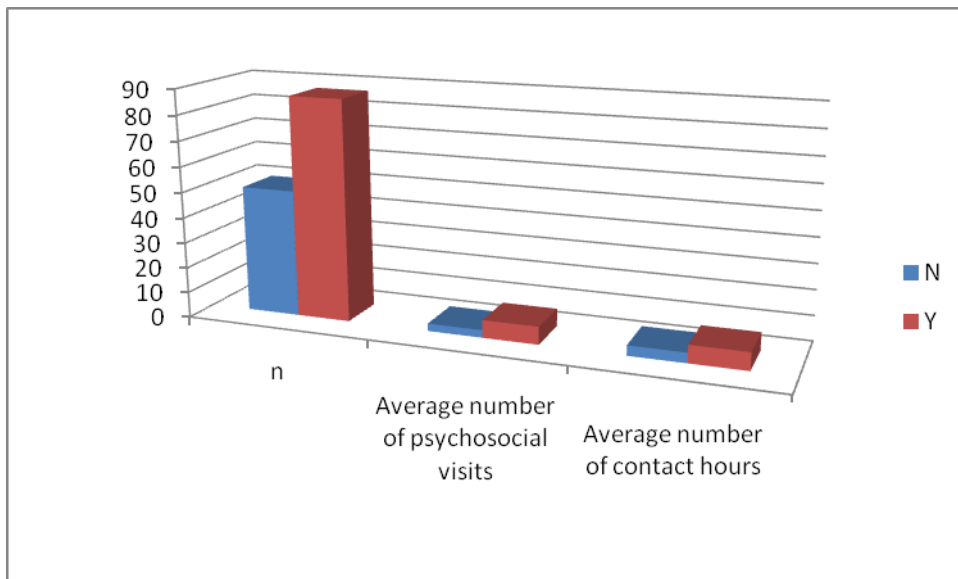
**Table 1: Average number of psychosocial visits and hours provided to participants by number of psychosocial risk factors identified\***

Number of psychosocial risk factors identified	<i>n</i>	Average number of visits – psychosocial	Number of psychosocial visits by range	Average number of hours – psychosocial	Number of psychosocial hours by range
1	15	3	1-8	3	1-7
2	35	4	1-14	5	1-19
3	28	4	1-22	4	1-24
4	27	5	1-15	6	1-16
5	14	6	1-35	6	½-33
6	2	12	7-17	16	8-23
7	5	7	2-11	8	1 ½ -15
8	5	6	3-10	9	4-13
9	2	5	5	7	6-7
10	2	7	6-9	10	9-10
11	2	2	1-4	3	2-3

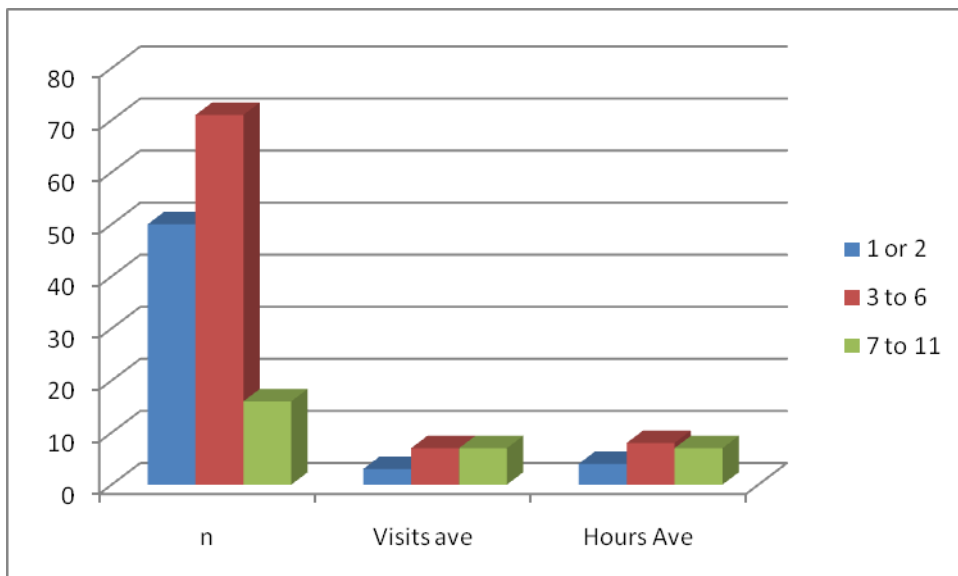
\*Note – shaded area represents those with a score of less than 3 – deemed not needing an alert sent to the psychosocial team

## Answering the unanswered questions about psychosocial screening in the cancer setting

The graphs below illustrate the difference between those participants who would have triggered an alert (Y) and those who wouldn't have (N) (in relation to psychosocial involvement) and the same data broken down for scores of 2 or less, 3-6 and 7-11.



n = number of participants, N= 2 or less risk factors, Y= 'at risk'



n = number of participants, 1 or 2 risk factors would not raise an alert, 3-6 or 7-11 risk factors would raise an alert.