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In this issue

For the treatment of symptoms of carcinoid syndrome[1]

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lanreotide

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Editorial

The *AJCN* aims to provide a forum where debate and the exchange of views can take place. We welcome papers on contemporary professional policy or practice issues of concern and interest to cancer nurses.

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Our mission

The CNSA is committed to achieving and promoting excellence in cancer care through the professional contribution of nurses.

To achieve our mission of promoting excellence in cancer care, the CNSA will act as a resource to cancer nurses around Australia, no matter what their geographical location or area of practice.
The CNSA will be the link between cancer nurses in Australia, the consumers of cancer nursing services and other health professionals involved in cancer care.

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Editorial

Breast cancer in Australia: supporting patients, families and health professionals

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Breast cancer is the third most common cancer in Australia after prostate and bowel cancer, and the fourth most common cause of cancer death after lung, bowel and prostate cancer[1]. In 2010, 14,680 Australians (fewer than 100 of them men) were diagnosed with breast cancer and 2864 died from their disease[1]. The five-year relative survival, however, has improved from 72% for 1982–1987 to 89% for 2006–2010[1].

Nurses have a pivotal role in the treatment and support of women and men with breast cancer and their families. The four papers in this edition of *AJCN* describe different aspects of support for patients, partners, families and the breast cancer nurses themselves.

The paper by Lisa Fodero and colleagues describes an evaluation of the highly successful initiative of the McGrath Foundation, funding specialist breast care nurses (BCNs) to support women undergoing treatment for breast cancer. Women who had access to a McGrath BCN, particularly in rural areas, were found to have a greater awareness of available information and local support and rehabilitation services and felt that access to a McGrath BCN had enhanced their quality of life.

A cancer diagnosis affects not only the individual living with the disease, but also their extended family members who are invariably the most common source of support. However, in providing the affected individual with support, the needs of family members may be overlooked. Elisabeth Coyne's paper examines the strengths and resources (such as social, spiritual and health professional support) used by families of young women with breast cancer. The findings provide nurses with practical information about communication styles which influence family functioning and the consequent ability to cope with a diagnosis of breast cancer. Insights are provided about which women might experience greater levels of distress and, therefore, may benefit from referral for more formal psychosocial support.

While the male partners of women with breast cancer can suffer from significant psychosocial distress, their support needs are often overlooked[2]. Male caregivers can be more reluctant to share feelings, be it with their spouse, extended family, male friends or health professionals. However, in seeking psychosocial support, they can improve the wellbeing of themselves and their spouse[3]. The paper by Kathryn Wallace and Elisabeth Coyne describes the evaluation of a facilitated support group for the male partners of women with breast cancer. The success of the programme was attributed to the participants' preference for this model of facilitated face-to-face group support over individual support from health professionals, or via a telephone or online support service.

The final paper by Elisabeth Black highlights the professional support needs of specialist cancer nurses in order to enhance skill development and promote workforce retention. The example of specialist BCNs is used to highlight strategies such as specialist training and education, mentoring, networking, peer support and clinical supervision.

While all these papers are written around the theme of breast cancer, all of the strategies and interventions are easily transferable and readily applicable for nurses caring for all people living with cancer, regardless of their specific malignancy or the practice setting.

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Evaluation of the McGrath Foundation's Breast Cancer Nurses Initiative

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Abstract

The McGrath Foundation's Breast Cancer Nurses Initiative (the Initiative) was evaluated in 2012, and found to be an evidence-based model for improving the quality of care for women with breast cancer. The model promotes a patient-centred, multidisciplinary approach to cancer care, improving care coordination between health care professionals in metropolitan and regional cancer centres and is broader than a hospital-specific role. From an economic perspective, the Initiative has had a positive impact on improving patient safety. Stakeholders interviewed believed the Initiative has been able to reduce hospital readmissions and/or unnecessary emergency department visits; reduce the time surgeons, oncologists and allied health staff need to spend with patients; and reduce costs to the mental health system. From a quality of life perspective, women surveyed who had access to a McGrath breast care nurse (BCN) were unequivocal in their view that the McGrath BCN has enhanced their quality of life.

Introduction

The McGrath Foundation was co-founded by Jane McGrath and her cricketing husband Glenn after Jane's personal experience with breast cancer. It was this experience that led her to believe that the McGrath Foundation should raise money to place McGrath breast care nurses (BCNs) in communities right across Australia and to increase breast awareness in young Australian women.

The Commonwealth of Australia is a supporter of the McGrath Foundation and the Breast Cancer Nurses Initiative (the Initiative) was established in 2008 following the execution of a funding agreement between the Department of Health and Ageing (DoHA) and the McGrath Foundation. Under the agreement, DoHA provided funding of approximately $12.6 million for the recruitment, training and employment of new specialist BCNs across Australia.

The increased burden on women with breast cancer in rural Australia, including lower survival, is well documented[1]. A study in 2004 found that when compared to metropolitan areas, people with cancer who lived in remote areas of New South Wales were 35% more likely to die within five years of a diagnosis[2]. Contributing to this is evidence that suggests the quality and availability of breast cancer services directly influence survival rates of people with breast cancer[3], demonstrating the importance of the Initiative and the relevance of the McGrath BCN model.

The model adopted by McGrath BCNs is one that promotes a patient-centred, multidisciplinary approach to cancer care. The model provides improved coordination of care between health care professionals in metropolitan and regional cancer centres. It is a community-based role, broader than a hospital-specific one. McGrath BCNs are able to engage at a community level with both health care professionals and patients and they are not restricted to a hospital campus location. McGrath BCNs understand the particular burdens of families in rural Australia experiencing breast cancer and can tailor their delivery of care accordingly.

The aim of the Initiative was to improve the quality of care received by women diagnosed with breast cancer in Australia, with a particular emphasis on those women residing in rural and regional areas.

The objective of the Initiative was to recruit, train and employ 30 new specialist BCNs (23 full-time equivalent positions) throughout Australia over four years, enabling an increased number of women diagnosed with breast cancer, especially those in rural and regional areas, to access nurses with specialist breast care skills and training. While the objective was to employ 30 McGrath BCNs, the Foundation ended up funding 44 using the funding allocated for 23 full-time equivalent McGrath BCN positions.

Methodology

The McGrath Foundation engaged HealthConsult to independently evaluate the Initiative. While the Initiative period was from June 2008 until January 2014, the evaluation included the period June 2008 to June 2012. The methodology used by HealthConsult to evaluate the Initiative involved six stages:

1. A detailed project planning period. This included receiving an initial briefing; finalising the parameters for the project, including the communication process; establishing stakeholders to be consulted; identification of data and information sources, dates for project meetings and submission of deliverables.
2. A documentation and literature review. This involved reviewing the documentation that related to the Initiative as well as that which described other relevant programmes and projects. Literature on best practice in breast cancer care coordination and its impact on service delivery and patient outcomes and on measuring return on investment for similar initiatives was sourced.
3. An evaluation framework was established. This included defining the key evaluation areas, identifying the required data (qualitative and quantitative) to answer each evaluation question, defining the performance indicators to be generated and the strategies for collecting the necessary data.
4. The development of the data collection infrastructure involved three components:
    a. A survey to gather supplementary qualitative and quantitative data from McGrath BCNs funded under the Initiative.
    b. Three service-level case studies were selected where McGrath BCNs were located. The service level case study sites were in Wagga Wagga (NSW), Berri (SA) and Bunbury (WA).
    c. Six patient-level case study sites were selected. Three patient-level case study sites were where a McGrath BCN was located, Wagga Wagga (NSW), Berri (SA) and Bunbury (WA) and three sites that did not have a McGrath BCN or similar role, Scone (NSW), Pinaroo (SA) and Karratha (WA).
5. Gathering the evaluation data involved the following:
    a. Distributing an invitation to McGrath BCN incumbents funded under the Initiative to complete an online survey.
    b. Interviews were conducted with health professionals at the service-level case study sites.
    c. Interviews with women who had been diagnosed with breast cancer were organised at the patient-level case study sites. Focus groups were also organised. The purpose of the interviews and focus groups was to understand the experiences of women with breast cancer.
    d. Interviews were conducted with key stakeholder groups from the breast cancer and cancer fields.

Two HealthConsult consultants visited each site to conduct the case study interviews. In parallel with this process, meetings were conducted with the agreed key stakeholder groups to gather information about the impact of the Initiative at the health system level.

Throughout the data collection process approximately 60 individuals were consulted. The response rate for the McGrath BCN survey was 93% (41/44). Together these processes produced a comprehensive set of data, which enabled a qualitative assessment of the impact of the Initiative.

6. The evaluation data analysis and final report involved the systematic analysis of the gathered data to identify the evaluation findings.

The evaluation was a qualitative study and the content addressed in this article focuses on the sections of the evaluation that addressed the:

- appropriateness of the Initiative;
- the effectiveness of the Initiative; and
- the efficiency of the Initiative.

Findings

APPROPRIATENESS OF THE INITIATIVE

The appropriateness of the Initiative was assessed by determining whether the Initiative was an appropriate model for improving the quality of care of women diagnosed with breast cancer; whether there were any gaps in the Initiative and whether any improvements could be made.

The appropriateness of the Initiative was assessed by reviewing other BCN models which also aim to improve the quality of care of women diagnosed with breast cancer. The views of key stakeholder groups including Cancer Australia, Westmead Breast Cancer Institute, Breast Cancer Network Australia and the Department of Health and Ageing were also sought.

The evaluation found that while there were similar BCN positions funded in each state and territory, there were a number of differences identified including:

- The Foundation is the only national funder of BCNs.
- The Foundation funds and supports the largest network of BCNs in Australia.
- McGrath BCNs, unlike other BCNs, are not bound by the setting in which they are based.
- McGrath BCNs are annually supported to undertake specialised training and continuing professional development activities.
- All McGrath BCNs attend an annual workshop and/or conference where they share processes and learnings which support the development of a nationally consistent BCN workforce.

From a quality of life perspective it was clear from the health professional and stakeholder consultations that the McGrath BCN role filled a significant gap in health services by supporting patients in a way that has a positive impact on the quality of life of these patients.

Most stakeholders found it difficult to identify gaps in the Initiative, instead suggesting opportunities to extend the Initiative. Suggestions included more McGrath BCNs in the private sector and metropolitan hospitals and in existing locations where McGrath BCNs are located and experiencing an excessive workload. Stakeholders also thought the Foundation should broaden its scope of BCN support and provide opportunities to non-McGrath BCNs to access the support and training provided to Foundation-funded McGrath BCNs. The gaps identified by stakeholders included backfill support to McGrath BCNs and formal provision of emotional support to McGrath BCNs, (particularly the McGrath BCNs located in geographically isolated areas), were found to be being addressed through strategies implemented by the Foundation.

EFFECTIVENESS OF THE INITIATIVE

The effectiveness of the Initiative was assessed by its impact on patients, on the health service and on the health system.

Impact of the Initiative on women diagnosed with breast cancer

The most important component of the evaluation was measuring the impact of the Initiative on women diagnosed with breast cancer. This was measured by patient interviews in locations where patients had access to a McGrath BCN compared to where McGrath BCNs were not located.

The evaluation found that women with access to a McGrath BCN were well supported throughout their entire cancer experience. As McGrath BCNs are connected within the communities in which they work, women with access to a McGrath BCN were more aware of available services compared to women who did not have access to a McGrath BCN.

The McGrath BCN was also key in the provision of emotional support, particularly in regional and rural areas where access to psychologists is either limited or costly.

The McGrath BCN had a strong positive impact on patients' experience and their families and the women surveyed could not imagine how difficult their experience would have been without the McGrath BCN. Women with a McGrath BCN who were interviewed were unequivocal in their view that access to a McGrath BCN has enhanced their quality of life.

Five out of the nine control interviews did not have access to a BCN or McGrath BCN and, in comparison, these women diagnosed with breast cancer had greater difficulty accessing information and support and often utilised more ad hoc methods including through referral from fellow patients, community members and breast cancer support groups. These women also expressed how they struggled to cope with the emotional burden of cancer, how and where to access services, and the impact of breast cancer on their family. They also felt that there was no one dedicated to helping them through the experience by assessing their needs and referring them to the most appropriate service. Most reported relying on the information packs provided to them when they left hospital, but identified that this did not inform them of the local services and meant the onus was on them to identify services appropriate to their needs.

Delays in access to treatment or services were more evident in areas where BCNs were not employed. Four out of the five of these women expressed, "frustration with the time, energy, and, in some cases, cost required to access services such as lymphoedema treatment, garments and prostheses".

Impact of the Initiative on health services

The evaluation sought to determine whether the Initiative had been effective in ensuring McGrath BCNs were seen as a source of knowledge and had expertise in breast cancer care; that McGrath BCNs improved the coordination of care of women with breast cancer, and that McGrath BCNs used evidence-based clinical guidelines and models of care when providing their service to women diagnosed with breast cancer.

The McGrath BCN survey asked McGrath BCNs about the types of services they provided to women with breast cancer and the findings demonstrate that McGrath BCNs provide a range of services that support the patients' emotional and physical wellbeing, including knowledge of their diagnosis, treatment and services available to manage side effects.

The breadth of services provided by McGrath BCNs was also reported by patients, other clinicians and services managers during the site visits. These findings were consistent with the McGrath BCN survey results.

The McGrath BCN survey asked McGrath BCNs whether they follow the specialist breast nurse (SBN) model of care developed by the former National Breast Cancer Centre[4]. The majority of McGrath BCNs, (60%), reported they follow this model with about a third reporting they followed a different clinical pathway model. Geographical location was identified as a factor in the adaptation of the clinical pathway with McGrath BCNs reporting that whilst utilising the pathway as a framework they adapted it to enable them to provide patient-centred care in the context of the location that they were practising in.

Although clinicians and McGrath BCNs consulted recognised the clinical pathway as best evidence-based practice, some felt that the SBN model of care was too rigid and prescriptive, and given it was developed over 10 years ago, most felt it was time to conduct the research again to ensure it still represents current evidence-based practice.

Multidisciplinary team involvement

McGrath BCNs were asked about their involvement in multidisciplinary teams (MDT). The evaluation found that McGrath BCNs are active participants of MDTs. Table 1 demonstrates that 76% of McGrath BCNs have been active in establishing positive working relationships with MDT members. Seventy-one per cent participated in MDT meetings and 71% built support or referral networks for breast cancer clients via MDTs.

Education

When assessing the knowledge and expertise of McGrath BCNs, the evaluation found the McGrath BCNs funded under the Initiative are highly educated, skilled and knowledgeable professionals dedicated to making a difference to the quality of care received by women diagnosed with breast cancer. This is not surprising given that McGrath BCNs are required to have five years' post-registration experience in oncology or breast cancer, along with a Graduate Certificate in Breast Cancer Nursing. Where nurses do not have qualifications, the Foundation provided funding for nurses to up-skill and complete a Graduate Certificate in Breast Cancer Nursing.

Impact of the Initiative on the health system

The evaluation sought to determine whether the Initiative had increased the capacity of the system to provide women with breast cancer access to a nurse with specialist breast care skills and training, and if the Initiative had an impact on emergency room or hospital admissions.

In most instances, McGrath BCNs funded through the Initiative were located in areas where BCNs previously did not exist. Given this, the Initiative has improved the access of women diagnosed with breast cancer to a BCN. A total of 11,073 women (during the reporting period) had access to a McGrath BCN as a direct result of the Initiative during the evaluation period.

The frequency of McGrath BCN contacts suggests the need for the resource. The evaluation found that, on average, women diagnosed with breast cancer had contact with their McGrath BCN about 12 times across their treatment trajectory, made up of direct and indirect contacts.

Impact on unplanned emergency or hospital admissions

The stakeholders consulted suggested they expected McGrath BCNs would have an impact on reducing hospital admissions or readmissions and/or unplanned emergency department (ED) visits. Unfortunately quantitative data was not available to verify this perception. However, most McGrath BCNs believe the Initiative had either a high (49%) to some (46%) positive impact on reducing hospital readmissions and/or ED visits of their patients. This is further collaborated with most other stakeholders consulted agreeing the Initiative had been able to reduce ED presentations, particularly for those that are postoperative. Again both McGrath BCNs and consulted stakeholders concur this is difficult to measure.

Health professionals identified a range of areas where McGrath BCNs have improved or established cancer networks. Stakeholders reported the McGrath BCN role had been instrumental in developing positive working relationships with a broad range of providers responsible for delivering care to patients diagnosed with breast cancer. The strong collaborative and coordinating components of the role were highlighted as another benefit of the Initiative, with these benefits extended to both the patient and the broader health care system.

EFFICIENCY OF THE INITIATIVE

The evaluation sought to determine the extent to which the Initiative duplicates other BCN Initiatives and whether the Initiative is cost beneficial.

Initiative seen as a complementary one

Whilst BCN positions existed prior to the Initiative, the evaluation found the Initiative to be complementary and not duplicative as

Table 1: Role of McGrath BCNs in promoting multidisciplinary care within their local health care organisation

Region	Assist in the development of MDT meetings	Participate in MDT meetings	Establish working relationships with MDT members across the continuum of care	Building referral/ support networks for breast cancer clients via MDTs	Ensuring that outcomes from MDT meetings are incorporated into patient care plans	Ensuring that outcomes from MDT meetings are discussed with patients and their carers
Metropolitan	43%	86%	86%	71%	43%	57%
Regional	47%	93%	93%	87%	67%	60%
Rural	42%	47%	58%	58%	37%	42%
Total (average)	**44%**	**71%**	**76%**	**71%**	**49%**	**51%**

Source: HealthConsult McGrath BCN survey. Note: Patients identified as 'regional' accessed a McGrath BCN in either an 'inner regional' or 'outer regional' location as defined by the ABS Remoteness Area Classification. Patients identified as 'rural' accessed a McGrath BCN from a 'remote' or 'very remote' location.

Table 2: Number of women receiving support from the McGrath BCN by location type

Region	Measure	2008–09	2009–10	2010–11	2011–12	Total
Metropolitan	Total contacts by McGrath BCNs[β]	485	6,589	8,696	10,862	**26,632**
	Total patients seen by McGrath BCNs[β]	172	774	658	694	**2,298**
Regional & rural	Total contacts by McGrath BCNs[β]	2,028	21,488	38,225	42,110	**103,851**
	Total patients seen by McGrath BCNs[β]	702	2,522	2,764	2,787	**8,775**
National	Total contacts by McGrath BCNs[β]	**2,513**	**28,077**	**46,921**	**52,972**	**130,483**
	Total patients seen by McGrath BCNs[β]	**874**	**3,296**	**3,422**	**3,481**	**11,073**
	Ave McGrath BCN contacts per patient	**2.9**	**8.5**	**13.7**	**15.2**	**11.8**

Source: McGrath BCN contacts database developed by the Foundation. Note: The number of contacts was not reported until the 4th quarter of 2008–09; therefore, contacts made in this financial year have been multiplied by four. β McGrath BCN contacts database developed by the Foundation.

there remains a demand for more McGrath BCNs. Under the Initiative, McGrath BCNs provided a service in a location where there was either no service, or a need for increased services. This allowed for increased capacity of service provision, supporting a demonstrated need consistent with the increasing incidence in breast cancer.

McGrath BCNs were viewed by patients as a central point of contact that proactively provided information and referral services such as psycho-social support, rehabilitation services, lymphoedema management and breast cancer programmes.

The economic benefit

Whether the Initiative has been cost beneficial was a challenging question to answer without the required quantitative data. Qualitatively, McGrath BCNs, health service managers, other clinicians and cancer peak bodies believe the investment in the Initiative has produced positive results for women who have had access to their services. Although baseline data was not available to undertake a cost/benefit analysis some indicators have been produced on the cost of delivering some of the Initiative outputs. Table 3 shows that based on 11,073 women that had access to a McGrath BCN funded by the Initiative, the average cost per contact with the McGrath BCN is $94 and the average cost per patient is $844.

As a means of assessing whether the Initiative has been efficient, it would have been valuable to compare the Initiative's outputs to the outputs of other initiatives. A literature review to identify such outputs was unsuccessful due to the lack of economic evaluation of similar initiatives.

The role of McGrath BCNs providing support to patients was also noted by a number of stakeholders as important in reducing costs to the mental health system. Although it is not possible without the required data to measure the impact of McGrath BCNs on improving patient quality of life, anecdotal evidence gathered during the evaluation suggested that McGrath BCNs and patients believe the role has made a positive impact in this regard.

Further, qualitative evidence gathered from surgeons, oncologists, allied health professionals and community nurses indicated that McGrath BCNs save them direct patient contact time as well as logistics and administration time. Hard evidence such as a measure of the amount of time saved could not be generated within the time and resources available for this study. However, time saved by clinicians as a result of the McGrath BCNs is an important finding and would certainly allow time for clinicians to see additional patients, thereby improving access.

To put a value on this saving, the data recently published by the Independent Hospital Pricing Authority (IHPA)[5] on the prices (which equal the arithmetic average cost) to be used to fund public hospitals for outpatient services under activity-based funding was used. The average of the published prices for medically led outpatient breast surgery, medical oncology and radiation oncology consultations is $258. In this study it was estimated that the cost per McGrath BCN contact is $94. So, conservatively for the 11,073 patients who have accessed a McGrath BCN since the Initiative began there has been a benefit (in terms of medical time saved only) of $2,856,834. This saving alone recovers 31% of the total funds allocated.

Table 3: Total initiative cost per patient with breast cancer, 2008–09 to 2011–12

Measure	2008–09	2009–10	2010–11	2011–12	Total
Total cost of the Initiative[Ω]	$734,902	$2,803,167	$2,798,316	$3,008,662	**$9,345,047**
Total patients seen by McGrath BCNs[β]	874	3,296	3,422	3,481	**11,073**[π]
Total number of direct patient contacts[β]	2,513	27,412	32,305	37,369	**99,599**
Initiative cost per new patient seen	$841	$850	$818	$864	**$844**
Initiative per direct patient contact	$292	$102	$87	$81	**$94**

Source: Ω Consolidated progress reports produced by the Foundation and β McGrath BCN contacts database developed by the Foundation. Note: π Foundation's 8th progress report cites a slightly lower number (10,669 unique patients) due to timing differences in the submission of reports by McGrath BCNs.

Conclusion

The evaluation of the Initiative was a qualitative one and sufficient data was gathered to show that the Initiative has had a positive impact on women diagnosed with breast cancer that have had access to a McGrath BCN; on health services where McGrath BCNs have been located and on the health system.

The Initiative was recognised as an evidence-based model for improving the quality of care of women diagnosed with breast cancer. Since the model is evidence-based and similar models exist in Australia and overseas, it is considered to be an appropriate model for improving the quality of care of women diagnosed with breast cancer.

The evaluation found the Initiative was effective in terms of outcomes. The McGrath BCN role has filled a significant gap in health services supporting patients in a way that has had a positive impact on their quality of life.

The Initiative was efficient as it was considered complementary and not duplicative of other BCN initiatives; however, there remains a demand for more McGrath BCNs throughout Australia.

The qualitative evidence gathered through the evaluation suggests the Initiative has produced economic benefits; however, qualitative data would quantify the economic benefits of the Initiative.

Future evaluations of the Initiative would benefit from gathering quantitative and qualitative data before a McGrath BCN is funded and then after the position has been funded for two to three years. Collection of this data would enable a more precise measure of the impact of the McGrath BCN. These concepts are currently being implemented by the Foundation.

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The strengths and resources used by families of young women with breast cancer

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Abstract

Background The family provides the main support network when a young woman is diagnosed with breast cancer, yet few studies investigate the experience of family support. This research examined the strengths and resources used by families of young women (under 50 years of age) with breast cancer.

Method Using the Resiliency Model of Family Stress, a quantitative analysis of family strengths and resources was undertaken using a composite survey. The sample consisted of 111 participants: 64 family members and 47 women with breast cancer recruited from five oncology units in hospitals in Queensland.

Results Family members and the women displayed similar strengths and resources. Family strengths were closely associated with the family use of resources. Influencing factors were communication and family commitment and the age of family members.

Conclusion Family strengths influenced the family's use of resources. The family's use of external resources was altered by family communication styles and how the family worked together.

Keywords: breast cancer, psychosocial, family, nursing.

Introduction

The diagnosis of breast cancer is both unexpected and distressing for a young woman, and many rely on their family for support[1,2]. The support role of the family is increasingly acknowledged in the published literature, although little research has explored the depth and range of family members' responses to understand this role from their perspective. Family theorists argue that the major influence of family support is in providing a protective buffer for the woman as she copes with side effects from treatment[3,4]. However, in providing this supportive role, family members themselves can be left with unmet needs and distress[5-7]. The adjustment process for the family has numerous challenges as they experience positive and negative responses during changes in treatment and disease progression[8,9]. Some families are better able than others to work together to overcome each hurdle along the way[3,4]. This poses a question as to what enables some families to survive and do well in the supportive role, while others find the experience a major struggle. To address this gap in knowledge, the current research investigated the strengths and resources of the family in response to adversity such as a diagnosis of breast cancer that can provide insight into how the family works and the dynamics of family support. This information has the potential to provide direction for guiding families of breast cancer patients.

Background

Breast cancer is the most common cancer diagnosis worldwide, with one in eight women diagnosed under the age of 75 years[10]. About one-quarter of all breast cancer diagnoses are in young women under 50 years of age[11]. The treatment schedule tends to be aggressive and includes surgery, chemotherapy, radiotherapy and hormonal therapy[12,13]. Researchers have established that women under 50 years are particularly vulnerable to psychological and physical effects of treatment[8,14]. Families, which includes a spouse or partner, parents, siblings and/or, in the case of younger women, primary school-aged or teenage children[11,15] play an important role in helping women through the treatment trajectory and beyond. The types of family psychological and physical support for a woman with breast cancer has been identified as household assistance, pain and side effect management, and emotional support[16,17]. Because of the impact of treatment, breast cancer also influences the woman's support network, often creating physical and psychological stress, which leaves family members and supporting friends needing support and direction themselves[13,18]. Assessing the processes of family support and the strengths that families bring to this task is crucial to ensuring that both the family and patient needs are adequately addressed and supported[7].

Having a family member diagnosed with cancer creates adversity for the entire family, especially when it is a young family member. Family scholars have identified characteristics of families which enable them to move forward in the face of adversity; collectively these are called family strengths[4,19,20]. Family strengths are characteristics such as displaying a commitment to family, open and positive family communication, positive appraisal of the adversity, and cohesive family functioning[19,21]. Families who are able to work together are likely to build strength within the family and find solutions to problems through their commitment[21]. In fact, family commitment brings a sense of not being alone when facing adversity and is a significant element of family strengths[21]. Family commitment tends to be associated with styles of communication between family members; the sharing of distress and personal concerns. Previous research has found that information sharing is one of the influencing factors in helping alleviate an individual's distress within a family[22,23].

Appraisal of the breast cancer is a fundamental influence on family communication and reaction to the breast cancer. When family members can see a positive aspect of the breast cancer, they are more likely to work together to overcome the adversity[24]. Northouse and colleagues' significant research from 2001 to 2012 has found that family appraisal influences the overall family functioning and the ability of the family to work out solutions[3,7,25,26]. Appraisal sets the stage for the type of resources families use to provide support and their capacity to access assistance and manage the situation[27]. The availability and timing of resources has also been found to influence overall family adaptation[7,28], as is the way families manage resources[29]. According to McCubbin[19] and Walsh[20], resources can be grouped into three main areas, including social support, spiritual support and health professional support. Social support has been defined as support provided by the immediate family members and those considered within the close family circle[20,30]. Spiritual support relates to the individual's use of an external medium such as religious affiliations, personal meditation or other ways of finding meaning in life, all of which help her reappraise the adversity positively[31-33]. Research suggests that health professional support includes internet information, community groups, counsellors, nurses and doctors[34]. Although there are various ways of examining how family members cope in the supportive role, the conceptual framework outlined below provides a guide to measuring support from the perspective of the family as a 'unit'.

Conceptual framework

Using a family stress and coping framework provides a way to explore the family as a group of interacting individuals rather than as a group of independent family members. The Resiliency Model of Family Stress, Adjustment and Adaptation[28] offers a model for exploration of the family response to adversity with scales for measuring this response as a collective family response. Key aspects of this framework include family functioning (roles), communication, coping strategies and adjustment. The Resiliency Model of Family Stress recognises that the family response is influenced by factors such as extended family, culture and community. This suggests that for family researchers focusing on the family, data should be collected from multiple family members to provide a comprehensive perspective of how women and their families use strengths and resources at this significant time in their lives.

The majority of research exploring the family response to cancer has used individuals with cancer or a dyad approach using couples[35,36]. Using a dyad approach is helpful to some extent but it does not reflect the complex nature of family[37,38]. Several studies noted the dyad approach to be a limitation due to the narrow focus of the data[25,39]. The current study addressed this lack of depth and breadth by using Resiliency Model of Family Stress as a family framework to capture the perspectives of multiple family members on family strengths and resources. Three research questions were explored:

1. What are the strengths and resources the young women and their family members use during treatment for breast cancer?
2. What are the family attributes that influence strengths and resources used by the women and their family members during treatment for breast cancer?
3. Is there a change in the strengths and resources used by the young women and their family members during active and maintenance treatment?

Method

This study used a two-phase mixed-method approach to examine the types and levels of strengths and resources used by families of young women with breast cancer. Qualitative data on family members' perspectives of strengths and support were collected using personal interviews and reported in a previous article[16]. Quantitative data was collected in two phases to measure the types and levels of strengths and resources used by the families over the course of treatment: Phase 1 during active treatment, seeing the oncologist at least every three months and Phase 2 after active treatment, seeing the oncologist at intervals greater than three months.

Sample

In Phase 1 women with breast cancer under the age of 50 years were recruited from five ambulatory oncology units in Australia: four metropolitan and one regional hospital. The study received ethical approval from all participating hospitals and the University Research Ethics Committee. All data are stored according to guidelines by the National Health and Medical Research Council[40]. Information leaflets were displayed with an invitation for interested women to contact the researcher by telephone. Those who responded were given a verbal explanation of the study and its ethical implications. An information sheet, consent form and questionnaire were then mailed to individual participants, including family members, with individual reply-paid envelopes to provide consent, which was obtained from all participants. Confidentiality and anonymity was assured, with questionnaires containing no identifiable information. Phase 2 of the research was undertaken after the participating women with breast cancer had completed Phase 1 questionnaire and were seeing an oncologist at intervals greater than three months. A single telephone call from the researcher was made to each woman with breast cancer completing Phase 1 prior to the sending of Phase 2 questionnaires to the women and their family members. This study had a dropout rate of 40% of participants between Phase 1 and Phase 2. This level of dropout rate has been noted in previous research due to the psychological distress from revisiting the stressful event[41,42].

Inclusion criteria for the young women was a confirmed diagnosis of breast cancer within the first year, aged under 50 years, currently undergoing a regimen of active treatment for breast cancer, seeing an oncologist at least every three months and being supported by family members. Family was defined as a group of individuals bound by strong emotional ties, a sense of belonging, and a commitment to being involved in one another's lives, calling themselves 'family'[4,43]. The women with breast cancer were invited to nominate up to four family members over the age of 18 years to be involved in the study.

The final sample in Phase 1 who completed the composite questionnaire included 111 participants: 47 women with breast cancer and 64 family members. This included 36 families from within the 111 participants. A participation rate of 66% of women with breast cancer and 49% of recruited family members was achieved with one follow-up telephone call by the researcher. The Phase 2 sample consisted of 67 participants from Phase 1 who completed the questionnaire a second time; 28 women with breast cancer and 39 family members.

Measures

Demographic data were collected on all participants including age, gender, family status, education level, occupation, treatment variations, ethnicity and postcode for geographic categorisation.

Family strengths were measured by the Family Hardiness Index (FHI), which was developed to measure the internal strengths and durability of the family unit and has been validated by several researchers[25,44-47]. The FHI is a 20-item instrument consisting of three interrelated subscales addressing family functioning, namely commitment, challenge and control. The FHI prompts respondents to rate their response to particular situations using a four-point Likert scale to indicate the degree to which each statement describes the family strengths. The scores are summed to generate the FHI; a higher score identifies increased levels of family functioning. Reported internal consistency reliability of the instrument is .82[47]. For this study the Cronbach's alpha coefficient was 0.81.

Family resources were measured by the Family Crisis Orientated Personal Evaluation Scales (F-COPES), which measures the problem solving and behavioural strategies families use to assist them through a stressful situation. The scale has been validated by several researchers[48]. The F-COPES scale includes 30 coping behaviour items focusing on how the family deals with internal and external problems. The items are rated on a five-point Likert scale indicating the extent to which they agreed or disagreed with the item. There are five subscales for the F-COPES: including social support, reframing, spiritual support, mobilising community support and passive appraisal. The scores are summed to provide subgroup scores and an overall coping score. Higher total F-COPES scores represent an increase in the number of coping strategies used and may lead to more successful adaptation. Reported internal consistency reliability of the instrument is .87[48]. For this study the Cronbach's alpha coefficient was 0.84.

The Walsh scale[20] is a non-validated scale with 33 questions rated on a four-point Likert scale, which provides an indication of how a family works together to maintain the family functioning. The Walsh scale has five subscales, namely challenge, spiritual support, family flexibility, resources and communication. These subscales all reflect the Walsh[20] conceptual framework. A factor analysis was performed on the Walsh scale which supported the original grouping of items. Additional investigation is warranted for future use of this scale. For this study the Cronbach's alpha coefficient was 0.95.

Data analysis

A non-parametric analysis was completed which included descriptive statistics to profile sample characteristics, strengths and resources used by the family. The Mann-Whitney U Test was used to assess differences related to family attributes. A nonparametric equivalent one-way ANOVA, the Kruskal-Wallis Test, was used to assess the relationship between family attributes and the subscales of strengths and resources. Family attributes of interest included age groups, treatment combinations, phase of life, education levels, occupation groups, and post codes. The Wilcoxon Signed Rank Test was used to assess group differences in terms of the subscales of strengths and resources in Phase 1 and Phase 2 of the study. A case summary analysis provided family group information on the 36 families in the study. Level of significance was set at $P < 0.05$.

Results

The response rate included 47 women with breast cancer having surgery, chemotherapy and radiotherapy, and 64 family members (Table 1). The family members included male and female partners, parents, children and extended family and friends of the women with breast cancer. Participating women with breast cancer identified type of treatment completed in three categories.

The preliminary analysis of the women with breast cancer and family members using Mann-Whitney U Test identified no statistical different between the scores of the women with breast cancer and the family members in the main scales (FHI $Z = -2.17$ $p < .030$) (F-COPES $Z = -.480$ $p < .63$) (Walsh $Z = -.94$ $p < .925$). Because of the similarity the family members and women with breast cancer were combined for the analysis, a technique successfully used in previous research[25,45,46]. Only one subscale showed a statistical significance, which was sense of control within the FHI scale ($Z = -3.96$ $p < .001$). This subscale investigates the way in which the participants feel they are in control of the situation, which can generally be due to treatment schedules.

Table 1: Demographics of women with breast cancer and family members

Characteristic	Phase 1 n=111 (%)	Phase 2 n=67 (%)
Age of women with breast cancer (WWBC) P1 (n=47) P2 (n=28)	29–50 mean 43	29–50 mean 44
WWBC without children	18 (38)	8 (29)
WWBC with children	29 (62)	20 (71)
Breast cancer details		
Surgery/chemotherapy/radiotherapy	26 (55)	16 (57)
Surgery/chemotherapy	9 (20)	3 (3)
Surgery/radiotherapy	5 (11)	5 (18)
Chemo/radiotherapy	2 (4)	1 (4)
Surgery only	3 (6)	2 (7)
Chemotherapy only	2 (4)	1 (4)
Total WWBC	**47**	**28**
Family members n=64		
Male family members P1 n=25 39%	18–79 mean 43 SD 14	
Female family members P1 n=39 60%	18–83 mean 49 SD 18	
Total sample		
Education level		
Secondary school	60 (54)	35 (52)
Diploma	27 (24)	16 (24)
Degree	15 (14)	10 (15)
Postgraduate	9 (8)	6 (9)
Occupation level		
Professional	42 (38)	29 (43)
Trade person	27 (24)	14 (21)
Home duties	42 (38)	24 (36)

To explore the strengths of the family the composite of subscales used were FHI Commitment, Challenge and Control (FHI); F-COPES Reframing and Walsh Challenge, Family flexibility and Communications (Walsh). From these subscales the analysis revealed that participants reported a strong commitment to the family (M = 20/24 SD = 3.2) and communication within the family (M = 24/30 SD = 5). The strengths of challenge, control, reframing and flexibility showed lower means highlighting these aspects as lesser family strengths (Challenge M = 12/18 SD = 2.9) (Control M = 13/18 SD = 7).

To explore the resources used by the family the composite subscales of F-COPES subscales (social support, spiritual support, mobilising, passive appraisal) and Walsh subscales (spiritual support, family) were analysed. The resources used were family and friends (social support M = 21/36 SD = 7) (family M = 6/9 SD = 2), health professionals (mobilising M = 10/16 SD = 3) and spiritual support (spiritual M = 5/16 SD = 5). The use of spiritual support scored low in the quantitative data although this was not reflected in the qualitative data.

The analysis highlighted the overall levels of strengths and resources. Families who reported a lower level of strengths and resources were highlighted to be at risk of maladaptation and coping problems (n = 8 FHI < 30/60) (n = 19 F-COPES < 60/116). Conversely, families with high levels of strengths and resources could be identified as having good skills in communication and positive appraisal and ability to direct resources for support. When the scores were examined across the trajectory of treatment Phase 1 to Phase 2 there was no statistically significant change in scores, although a slight increase was noted. See Table 2 for presentation of mean scores for three scales across the two phases.

Table 2: Presentation of scores for family strength and resources

Descriptive statistics for the measures of Family Hardiness Index (FHI) Family Crisis Orientated Personal Evaluation Scales (F-COPES) Walsh Scores Phase 1 and Phase 2

	Phase 1 n=108	SD	Phase 2 n=67	SD	Range
FHI	44	7.06	46	6.82	20–59
F-COPES	72	13.38	74	11.93	39–111
Walsh	74	14.12	76	11.23	24–99

The Spearman's Rank Order Correlation was used to investigate the relationship between strengths and resources. This analysis revealed significant positive correlations. Positive correlations were found between the FHI commitment and FHI challenge (r = .44, n = 108, p < .001); FHI commitment and F-COPES reframing (r = .51, n = 107, p < .001); FHI challenge and F-COPES social support (r = .46, n = 108, p < .001). These positive correlations indicated that the higher commitment within the family the more the participants reported seeing the breast cancer as a positive challenge, sought support from external family and were able to reframe the adversity into something positive.

The subscales within the F-COPES scale were also found to be positively correlated with the Walsh scale; particularly F-COPES social support and Walsh family flexibility (r = .51, n = 108, p < .001), Walsh resources (r = .62, n = 108, p < .001) and Walsh communications (r = .55, n = 108, p < .001). The results indicated that families who were able to communicate concerns were, in turn, more likely to use social support and external health professional support. These are significant findings, indicating a connection between the family appraisal of the breast cancer, communication between the family and the ability of the family to be flexible and seek support (Table 3).

Family attributes were analysed using the Kruskal-Wallis Test to explore the relationship between variables with one or more groups and the continuous variables from the three scales FHI, F-COPES and Walsh. The age of the family members was the main influencing factor for the family's use of strengths and resources as seen by the correlations with age across the three scales FHI (x^2 (4) 21.0, $p < .001$), F-COPES (x^2 (4) 15.5, $p < .004$), Walsh (x^2 (4) 12.7, $p < .01$). Treatment schedules, stage of life (with children, no children), education and occupation were found to have an influence on use of strengths and resources, although these associations were not strongly significant.

Discussion

This study investigated the strengths and resources family members and the young women use to cope with breast cancer. The combined family sample proved to be a unique way to explore the family experience, reinforcing the usefulness of combining McCubbin's and Walsh's frameworks. Overall, the study found that the women with breast cancer and their family members used similar strengths and resources as they responded to the breast cancer diagnosis. This result highlighted the cohesive nature of families when faced with adversity. Overall, these families do endeavour to work together and maintain family functioning, although some families struggled and displayed high levels of stress and maladjustment.

This research found that the level of strengths and resources used by the family did not increase significantly in the first year between Phase 1 and Phase 2, highlighting the difficulty of coping with breast cancer over a longer period of time. This finding concurs with other longitudinal research exploring women with breast cancer, which found that the first year's response and support influenced the woman's long-term adjustment[35]. The fact that the first year is influential in the long-term adjustment for the patient highlights the need for appropriate assessment and guidance for the woman and her family within the first year of her breast cancer diagnosis[49,50].

McCubbin *et al.*[28] hypothesised that in response to adversity the family will draw on their strengths to assist them maintain family functioning. The current study supports this hypothesis with the suggestion that the family aims to reach a new normal. Key strengths the family reported were a commitment to working together when faced with a breast cancer diagnosis. The family commitment was closely influenced by the family appraisal of the breast cancer. If family members were able to see some positive aspects from the breast cancer, they were more likely to use resources such as health professionals and cope as a family. The influence of appraisal of a health adversity was explored by Sears *et al.*[33], whose findings indicated that if the individual is able to identify the adversity as a positive challenge they are more likely to be able to work out how to deal with the challenges. Implications for health professionals are that they are in a position to provide guidance to the family members, as the family works through their feelings about the breast cancer. Health professionals need to assist the family to understand their appraisal of the experience to improve long-term adjustment for the women and their families.

Communication levels between family members were found to significantly influence the family strengths and use of resources in both Phase 1 and Phase 2. Types of communication ranged from open sharing to a closed response. Sharing feelings between family members was identified as a problem at times by lower scores on the communication subgroup items. This was probably an attempt to reduce the stress for the woman with breast cancer. Evidence suggests that an open style of communication where feelings are disclosed and discussed as a family will benefit the overall functioning of the family[23,51]. In times of stress, communication between family members was reported as difficult; this is similar to Forrest *et al.*[23]. The communication between family members was one of the main factors influencing a family's ability to identify concerns and work through them. Support from the health professional in providing safe avenues for the family members to express concerns is an important step to being able to guide the family through challenges of breast cancer treatment.

This study found that the age of the participants and the age of the family members influenced the strengths and use of resources. Families who had younger aged members reported lower levels of strengths. This finding was related to the other stresses that these families were dealing with. These results are consistent with previous research, which has explored only the women's response[1,35]. Bloom *et al.*[35] contend that the younger the woman with breast cancer, the higher levels of distress she displays due to conflicting life stresses.

Another finding was that if the family was able to see the breast cancer as something they could deal with they were more likely to access external support. External support obtained was health professional support, including counsellors, oncology nurses

Table 3: Presentation of significant correlations between the subscales of strengths and resources

	F-COPES reframing	Walsh communications	Walsh challenge	Walsh flexibility	Walsh family resources
FHI commitment	$.514^{P}$	$.562^{P}$	$.690^{P}$	$.587^{P}$	$.356^{P}$
F-COPES reframing		$.548^{P}$	$.647^{P}$	$.514^{P}$	$.269^{P}$
Walsh communication			**$.772^{P}$**	**$.733^{P}$**	$.443^{P}$
Walsh challenge				**$.822^{P}$**	$.423^{P}$
Walsh family flexibility					$.479^{P}$

$P < .001$ n=108

and internet information. Conversely, families who had trouble identifying positives from the breast cancer reported less use of external health professional support. This association highlights the need for health professionals to identify families with low family strengths and poor appraisal of the breast cancer so they can be provided with guidance to access appropriate information and support.

The family framework and data from a range of family participants ensured this study makes a significant contribution to the current knowledge of the family trajectory through breast cancer. The data provided an understanding of the complex interaction within a family in response to adversity. A young woman with breast cancer travels her journey supported and sharing with her family and nurses need to continue to gain information about how her family is functioning in order to assist her longer term adjustment. The use of a family assessment tool provides the health professional with information about the family members' strengths and resources and would benefit the longer term adjustment of the women with breast cancer.

Conclusion

This study has highlighted several important aspects of family strengths and resources as families cope with the treatment for breast cancer. Commitment to work together as a family is one of the strengths of the young women's supporting family and it is important to engage the family in discussion around support needs. The family's appraisal of the breast cancer and styles of communication influenced the family's overall responses. Communication specifically influenced the sharing of concerns and acquiring appropriate external support to maintain family functioning. Provision of family guidance regarding communication with family members and their children could therefore help to improve family functioning.

Limitations

Despite the evidence provided by this study, several limitations need to be acknowledged. The collection of basic treatment information from the patients was noted as a problem as it reduced the ability of the study to identify the influences of treatment. The study had a range of family members; however, the collection of data from more family groups would improve the depth of family data. The conceptual and theoretical focus of this study was on the family unit; limitations of the analysis of family data must be noted. The analysis of the data as groups rather than individuals provided a perspective of the family; however, due to the small family numbers it was difficult to demonstrate individual differences between family groups. The sample was mainly collected from participants living in metropolitan areas; a range of rural and remote families would provide information from this more diverse setting. These aspects would strengthen the information around the family experience of breast cancer.

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Supporting Blokes — providing support for male partners of women diagnosed with breast cancer

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Abstract

Background There is considerable evidence indicating poor coping strategies and increased psychological distress in the male partners of women diagnosed with breast cancer. Research suggests that the needs of male partners of women with breast cancer were not being addressed. A support group for male partners was evaluated to identify its effectiveness in addressing specific needs of those within the group.

Method A descriptive study was completed exploring the value of a male support groups. Evaluations completed after attendance at the support groups provided qualitative data.

Results The feedback received supports the premise that a formalised programme can provide male partners with the opportunity to share experiences, enhance relationships and improve coping strategies.

Conclusion The Supporting Blokes programme has the potential to be used as a template for all health care workers in providing psychosocial support to partners of women affected by cancer.

Introduction

Recent literature suggests that male partners of women diagnosed with breast cancer are at increased risk for severe depression, psychological distress and poor quality of life[1]. Furthermore, the evidence indicates that the lack of support provided for partners may contribute to feelings of disempowerment and a decreased ability to cope. A male partner's health can decline during the course of the woman's care and can be negatively influenced for years after the cancer diagnosis and completion of treatment[2]. Caregivers are the hidden patients; they provide support and guidance, attend appointments with their spouses, yet very few health professionals ask how the caregiver is doing[3]. The family's social support fails to acknowledge the distress of the male partner during their role as caregiver for the woman with cancer[4]. Research findings demonstrate that the male partners of women with breast cancer experienced physical and psychological symptoms including fatigue, stress, insomnia, depression, guilt, grief, isolation and, in more severe cases, substance abuse-related and affective disorders[5]. The provision of support to spouses can have the added benefit of improving overall wellbeing of both themselves and their partner[6].

Based upon the literature, it appears that improved support provided to the male partner of a woman diagnosed with breast cancer may in turn improve the physical and psychological outcomes for both the patient and the partner[7]. In this paper, the term male partner can also be extended to include any primary male caregiver including a father or brother. More research is needed to explore support group attendance to understand the benefits and problems associated with them. This paper highlights the challenges and frustrations experienced by male partners as well as the benefits of receiving face-to-face support through regular meetings.

Background

When a woman is diagnosed with breast cancer she is often supported by a male partner who is at a high risk of increased stress and depression[5,8]. There is a relationship between the lack of physical, psychological and economic support given to male partners and their reduced ability to cope[9]. Northouse *et al.*[6] suggest that guidelines need to be developed to address the mental health and coping strategies of cancer patients' loved ones, recommending screening partners for depressive symptoms and advocates for integrating spouses in the clinical treatment of cancer.

A 13-year, longitudinal study of over 20,000 men whose partners were diagnosed with breast cancer showed a 39% increase in the likelihood of hospitalisation associated with an affective mental disorder as compared with men whose partners did not have breast cancer[5]. Further evidence suggests that the partner's social support may overlook his need for support as opposed to his role as caregiver. A study conducted by Hasson-Ohayon *et al.*[4] showed that spouses reported more psychological distress than the patients and this may be linked with decreased social support. A review of literature on the psychological impact on the male partners when caring for a patient with cancer suggested that the support network is an important factor in reducing the distress experienced[10]. Further literature supports the premise that caregivers can only benefit in their role if support is directed towards them as well as the patient[3,11,12]. Male partners have indicated that they internally struggle with the inability to process information and this had a direct impact on their ability to manage the situation[13]. Themes highlighted in a study of 15 husbands revealed that men have questions and concerns throughout the trajectory of the disease and lack of information created difficulties[14]. Fitch and Allard[14] concluded that more support from health professionals throughout this time would be of benefit. What is important to highlight here is that male caregivers' concerns and challenges may differ from those of female caregivers[14]. There are gender-specific attitudes that may prevent the male partner from expressing their concerns, thereby limiting their ability to engage support[13]. Research has explored this aspect of the woman's support with limited studies on the understanding of a male caregiver's experience[9].

In 2011 the National Breast Care Nurses' Conference was conducted in Melbourne. As part of the conference programme, a partner panel had been organised to highlight some of the issues that both male and same-sex partners were dealing with in terms of caring for their partner's breast cancer diagnosis and treatment. The panel was facilitated by a trained psychologist and the audience consisted of breast care nurses (BCNs) and other health care providers involved in breast cancer care and support. The panel represented a demographic ranging from metropolitan and rural areas and included a woman in a same-sex relationship. One of the main themes that emerged from the panel discussion was that partners felt left out of the conversation when it came to the care and treatment of their spouses. Not knowing what questions to ask or having limited resources in terms of literature and social support made the experience for them both isolating and confusing.

Based on this information and the knowledge that no face-to-face support groups existed for male partners of women diagnosed with breast cancer in the Melbourne metropolitan region, a plan was developed to ascertain the feasibility of conducting a regular support group. This paper reveals some of the male partners' personal experiences of attending a male support group.

Method

A descriptive study was completed exploring the value of a male support group. An initial forum was organised to specifically address the needs of the male partners of women with breast cancer. Approximately 100 invitations were sent out to metropolitan BCNs and treatment centres. Of these, 20 responded, with 14 attending the opening forum held at the Living Centre in March 2011. Support groups were subsequently held quarterly and evaluated after each meeting. To date there have been nine sessions in total.

Written evaluation forms including consent were distributed at each support group. The support groups were facilitated as part of the role of the senior BCN consultant at the Think Pink Foundation — The Living Centre. Participants were informed of the evaluation aims and their participation was voluntary. Ethics clearance was included within the Think Pink Foundation — The Living Centre evaluation of programmes. The BCN was trained in group management and ongoing support. Meetings were co-facilitated by health professionals who were able to respond appropriately and provide support and acknowledgement. Those requiring additional support were referred back to their general practitioner. Follow-up calls were made by the BCN when any issues around distress or group dynamics were identified.

Initial forum results

From the initial forum, nine of 14 (64%) responded to the evaluation and all indicated the desire for ongoing meetings. The evaluation contained a needs analysis to determine interest in future meetings and frequency. One hundred per cent indicated the desire for future meetings during the week in the evening, with 77% preferring the frequency to quarterly as opposed to bimonthly (22.2%). None of the respondents were interested in the monthly option.

The main points raised in the qualitative data from the initial forum included: lack of support; poor social networks; limited literature for partners; communication difficulties and managing circumstances under stressful conditions. The male partners cited the opportunity to mingle informally with other men experiencing similar circumstances and to be able to meet and listen to a health profession (BCN) who could identify common themes that male partners were experiencing.

Support group 2011 to present

Since the initial forum held in March 2011 there have been nine meetings (participants n=80). Attendance has been consistent with numbers averaging eight for each meeting (range from 14 to 3). Whilst each meeting attracted new members, there was a core group of four men who attended most meetings.

Evaluations were sent electronically the day following each meeting with an average response rate of 60%. The evaluation forms included age, residential area, highlights of the meeting, stage of partner's diagnosis, referral source and what prompted them to attend. There was also the opportunity to comment on guest speakers, topics and recommendations for future meetings. See Appendix 1 for the evaluation form.

Support group participants over the two-year period 2011–2013 were aged between 28 and 73 years with all age groups evenly represented. Participants were mainly from the Melbourne metropolitan region. Neither age nor place of residence appeared to influence attendance rates, with all verbalising similar experiences and challenges across the trajectory of their partner's breast cancer journey. All spoke English as their main language.

The guest speaker was identified by 62% as a highlight, whilst 100% valued the addition of guest speakers at the meetings. To date there have been five guest speakers including a psychologist, breast surgeon, social worker, support group coordinator from the Victorian Cancer Council and relationship counsellor from Relationships Australia.

The evaluations also asked which category best described their partner's stage of diagnosis. The categories included recently diagnosed and currently receiving treatment, recently completed treatment (within six months), completed treatment six months or more and diagnosed with secondary breast cancer. Most of the participants (83%) indicated that their partner had recently completed treatment whilst the remaining participants were evenly distributed between the other categories. Of all the meetings, there were only two male partners whose wives had secondary breast cancer; however, they continued to attend meetings sporadically over the two-year period, dependent on how they were coping and what level of support they needed.

Qualitative results

Having the support groups on a quarterly basis meant that the stage of their partner's diagnosis and treatment was constantly changing and evolving. The regular attendees described the meetings as "helping them throughout the course of their partner's breast cancer journey no matter what the stage".

All of the participants said that meeting other males in similar circumstances was the highlight. This was evident in the support groups where a rapport was quickly established between the members, regardless of their age or stage of their partner's diagnosis and treatment. One male partner whose wife had advanced breast cancer felt that the group was of great benefit as it gave him the opportunity to express his grief and at times his anger in a safe and supportive environment. Other members were followed up with a phone call the next day to ascertain whether having men whose partners had advanced disease in the group was "too confronting". The response indicated that all were pleased to be able to support one another, regardless of stage of the breast cancer.

When asked the question as to what prompted the men to attend the meeting, 75% responded equally with the reasons to receive support and information and also meet other males. The participants (80%) found out about the sessions through their partners or the information flyers. It appeared that the motivation to attend was based on the peer support they needed rather than the need to please their partner. As one participant said:

> *It was great to share our experiences, confusion, learning and questions with an interested group. I felt a sense of relief through sharing my thoughts on the night which up until now have been hidden from family and friends … us blokes are supposed to be the tough ones!*

Some partners felt the need for support at the beginning of treatment whilst others felt most benefit at the conclusion of treatment when they felt disillusioned as to why life had not returned to the way it was prior to the diagnosis. Simultaneously, they verbalised that their partners also experienced a high level of anxiety at the completion of treatment associated with fear of recurrence and chronic fatigue. The repercussions of these frustrations influenced their relationship with communication and intimacy noted as a major challenge. The partners indicated that the meetings allowed them to normalise these feelings by speaking with other male partners who were experiencing similarities.

> *It was good to be able to talk about concerns I was keeping to myself so as not to upset my wife and get support from other carers dealing or having dealt with similar issues.*

For another whose wife was still having treatment:

> *For me, the next meeting will be around the time my wife starts her radiation treatment, so it will help me to tap into the other's experiences.*

These comments highlight the importance of shared experiences, in which each participant could relate to another. The men discussed how dealing with their emotions associated with their partner's breast cancer was a personal experience and that they did not feel comfortable sharing these feelings with outside friends or work colleagues. It was not uncommon to hear within the meetings that it was a great relief to know other male partners were feeling similar frustrations and this created a safe environment in which to share honestly and openly within the group.

The impact of the meetings for their partners was also evident with some positive verbal feedback indicating improved communication and understanding between the couple as a result of the guest speaker's information and the sharing of experiences. One woman phoned following a meeting and said she had felt relieved when her partner had attended because he met other blokes whose wives suffered "chemo brain". He had thought it was just a term that she had made up to get away with everyday forgetfulness. He discovered through the meetings that this was a condition that many of the men had experienced with their partners so was, therefore, able to be more empathetic to her concerns.

For others, the meetings have been a short-term solution for those initially experiencing difficulties in their relationships. One partner indicated that the initial meetings assisted greatly with issues around communication with his wife. He explained to the group that he never knew what to say or how to react to his wife's diagnosis but since attending the meetings, it had opened up the channels of communication for both of them and, therefore, improved their relationship considerably.

Discussion

The purpose of the current evaluation was to provide information on the male partners' experience and expectations of a partner support group. The support groups, which were facilitated by a BCN, provided a supportive environment for the male partners to share their experience. The evaluation identified that male partners wanted to share their experience with other males in a safe environment and the face-to-face meeting provided a supportive group.

The development of a specific support group to meet the needs of male partners was identified in the first forum and the continued attendance of the males at the support group highlighted the benefits of this type of group. The evaluation identified that meeting of other males with similar difficulties helped them to understand and express their own grief and anxiety.

One of the challenges that facilitators face with any group is sustainability[15]. Historically, a face-to-face group particularly for men appears to have a short life span, with interest in attending gradually subsiding. This may be due to repetition of information. The current group had new members and a core number of males who attended each meeting. Feedback from this evaluation indicated that guest speakers and a variety of topics led to sustained interest in attending. Some members actually verbalised their disappointment if they are unable to attend. Conducting the meetings on a quarterly basis was noted to maintain interest as varying stages of diagnosis and treatment bring with it new challenges.

The environment was important for the participants as it was a non-threatening, supportive group. Research has noted that the support groups are likely to be beneficial if the participants are linked by previous experience and match the learning styles of the individual[16]. The actual meeting place and connections influences the participants' anxiety, thus a non-clinical meeting area tends to have fewer negative connections for the participants[15]. Feedback also indicated that meeting in a centrally located, non-clinical environment was both non-threatening and conducive to feeling relaxed. As the participants arrive, light refreshments are served and this time gives regular and new members a chance to mingle and introduce each other. Previous research has identified that the setting and culture of the support group influences the participants' attendance[15]. The main reasons noted for continued attendance of the support group were having a feeling of connectedness to group, sense of community, hearing current medical information and good group leadership[15,17].

Another challenge that group facilitators can face is that of dominating members in the group. At times support groups can be dominated by members sharing their opinions. Facilitators can find it difficult to ascertain the most effective way of dealing with this scenario and efforts to close the conversation can be met with resistance. Reflection on group dynamics after each meeting can ensure flow and sharing between members[17]. Possible solutions to promote good group dynamics are to avoid open questions directed at particular members, limit introduction time and using name badges[17]. Other strategies include limiting the size of the group, with eight being noted as an optimal size and being aware of group dynamics to ensure all members of the group are included and supported[17]. Specific training in group facilitation has been identified as beneficial to allow a clear flow of information while not allowing group members to dominate the conversations[18].

One of the benefits of ongoing attendance at support groups is the building of information for the participants as they move along the trajectory of breast cancer. Butow *et al.*[15] noted that a support group which changes as the requirements of the participants change is more likely to have continued attendance than one which provided static information. One of the aims of the male support group was to provide not only information but useful contacts for the supporting male partners. The group facilitator was a senior BCN who was able to provide specific contact to BCNs who were able to inform and direct during the different stages of their partner's breast cancer journey.

The use of guest speakers who represented a range of professions was noted as an important feature and reason for continued attendance at the support groups. The guest speakers' expertise included supportive care after a traumatic experience, general cancer care, and psychosocial care to strategies for developing good coping mechanics. The guest speakers provided the men with information for their personal journey and new strategies to manage stress. Previous research has noted that most carers are aware of support groups but do not access them as they do not think that the information obtained from the group will help their journey[19]. The use of regular evaluation of the participants' needs and trajectory of breast cancer assisted the facilitation of appropriate guest speakers to maintain attendance.

The development of specific male support groups provided a safe environment for the male support people to have face-to-face contact in a facilitated group. The group allowed for support between members but also provided information and guidance as needed. The evaluation ensured ongoing needs of the support group were met. This provision of support has been found to benefit the male partners as opposed to one-on-one support with health professionals, phone support or online support. The facilitation of the group by a BCN ensured group dynamics and specific support needs were met.

Recommendations

The male partners' group can be used as a template for all tumour streams and not exclusively for partners of breast cancer. Furthermore, the success of the Supporting Blokes meetings raises the issue of support for other partners affected by a cancer diagnosis, including those in same-sex relationships. The face-to-face meeting enabled an open sharing of concerns. The facilitated groups allowed for conversation and exchange of ideas and experiences between partners in safe environment.

Conclusion

The Supporting Blokes meetings continue to provide support for male partners of women diagnosed with breast cancer. Numbers remain consistent, with both regular and new members attending each quarter. Guest speakers are organised in response to identified needs of the members. Responding to feedback and requests ensures that the meetings continue to stimulate and engage the participants in discussing both personal concerns and those that affect the group as a whole.

Whilst social networking and online services have become a popular way of connecting, face-to-face support appears to provide a stimulating yet safe environment to share personal stories and learn from other's experiences.

Limitations

This paper presents an evaluation of partner support group meetings. The findings are related to these meetings and may not be able to be generalised. However, the information may provide guidelines for future research exploring the partner's needs when supporting a woman with breast cancer.

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Appendix 1

Supporting Blokes … Evaluation form

Your feedback is very valuable and will help to ensure we provide the highest quality support here at The Living Centre.

livingcentre THINK PINK FOUNDATION

1. Is this your first Supporting Blokes meeting?
   ☐ Yes ☐ No
2. How did you hear about tonight's session?
   ☐ Partner ☐ Health professional
   ☐ Website ☐ Info flyer
   ☐ Other
3. What prompted you to attend the meeting?
   ☐ Partner's suggestion
   ☐ Support and Information
   ☐ To meet "other blokes"
   ☐ Guest speaker
   ☐ Other
4. Which category below includes your age?
   ☐ 21–29 ☐ 30–39
   ☐ 40–49 ☐ 50–59
   ☐ 60 or older
5. Which category best describes your partner's stage of diagnosis?
   ☐ Recently diagnosed and currently receiving treatment
   ☐ Recently completed treatment (within past six months)
   ☐ Completed treatment (six months or more)
   ☐ Diagnosed with secondary breast cancer
6. Did you find the presentation relevant to your circumstances?
   ☐ Not at all relevant ☐ Somewhat relevant
   ☐ Relevant ☐ Highly relevant
   ☐ Comment
7. What was the highlight of the evening for you?
   ☐ Meeting other "blokes" in similar circumstances
   ☐ Guest speaker ☐ Catering and venue
   ☐ Other (please specify)
8. Would you like guest speakers at regular meetings?
   ☐ Yes ☐ No
9. If "yes" to above. How often?
   ☐ Every meeting ☐ Biannually
   ☐ Annually
10. What topics would you be interested in for future meetings?

    ……………………………………………………………………………
11. Comments and suggestions

    ……………………………………………………………………………

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A review of strategies to support the professional practice of specialist cancer nurses

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Abstract

Specialist cancer nurses are effective in delivering safe and cost-effective cancer care. Nurses working at an advanced level require support, not only to undertake professional development and maintain their clinical skills and competency, but to prevent emotional burnout and remain in clinical practice. This paper examines mechanisms of professional support for nurses working in advanced roles and the range of support strategies recommended to encourage professional development and reduce the risk of professional burnout. Strategies discussed include specialist training, continuing professional development, mentoring, peer support, networking, clinical supervision and clinical leadership. The benefits of each type of support are discussed using the specialist breast care nurse (SBCN) as an example of an advanced nursing role requiring structured support for sustainability and career satisfaction.

Keywords: specialist cancer nurse, clinical leadership, continuing professional development, clinical supervision, mentoring, networking.

Introduction

Cancer remains a major health problem in Australia with one in two men and one in three women diagnosed with cancer before the age of 85[1]. Cancer causes significant psychological morbidity for many and adds a significant social and financial burden to our community. Specialist cancer nurses play a critical role in caring for those affected by cancer and the substantial contribution that nurses make in managing the burden of cancer in Australia has been acknowledged widely[2]. Specialist cancer nurses are effective in ensuring safe and cost-effective cancer care, improving psychological outcomes for those in their care, and minimising the effects of cancer and its treatment[3,4].

The role of the specialist breast care nurse (SBCN) has evolved rapidly in Australia, with SBCNs accepted as integral members of the multidisciplinary team caring for people affected by breast cancer. Evidence that SBCNs make a positive and tangible difference to health outcomes has led federal and state Australian governments to recognise nurses working in specialised oncology roles are not only cost-effective, but instrumental in improving outcomes for cancer patients[2].

Nurses working at advanced practice levels require formal support not only to enable professional development and skill maintenance, but to prevent emotional burnout and to retain them in clinical practice for as long as possible. This paper examines mechanisms of professional support for nurses working in advanced roles and the types of support recommended to encourage professional development and to reduce the risk of professional burnout.

Background

There is currently a worldwide shortage of cancer health professionals with these shortages projected to become more acute in the near future[5]. A combination of factors including an ageing nursing workforce, fewer people choosing nursing as a profession and fiscal restraints means cancer workforce issues are especially critical in nursing. Across nursing specialties, cancer nurses have a high risk of turnover[6,7]. Cancer nurses also have the highest risk for emotional burnout, with approximately 70% of respondents to a survey reporting "moderate to high levels of emotional exhaustion"[6]. In addition, the Australian nursing and cancer nursing workforce is rapidly ageing. The Health Workforce Australia report *Nurses in Focus* (2013) cites the average age of a registered nurse as 44.1 years in 2011, with 21.6% of that population over 55 years of age[8]. The short-term supply of nurses is stable, but by 2025 there will be a significant shortfall of more than 109,000 nurses and this chronic shortage of nurses will have significant implications for the cancer workforce[9].

The ageing nursing population raises many concerns for the future, particularly in combination with existing nursing shortages, the broader impacts of the ageing population and its demand for health services and fewer people choosing nursing as a profession[10]. Assisting Baby Boomer nurses to remain in clinical practice as they approach retirement age is critical to maintaining our workforce and it is imperative that the nursing profession develops innovative programmes and mechanisms of support that reflect the value systems of this particular group of nurses, and the cancer nursing workforce generally[11].

It has been known for many years that the expected future shortage of specialist cancer nurses is likely to have a significant impact on the quality of cancer care in Australia[2,9]. In 2003, a consultative report entitled *Optimising Cancer Care in Australia* identified the nursing shortage as one of the major difficulties that organisations faced and called for urgent national strategies to recruit and retain cancer nurses to meet the future workforce needs across the continuum of care[2].

Training specialised oncology nurses and developing generic roles based on the SBCN model were identified as key strategies due to the "evidence that specialist cancer nurses are cost-effective, acceptable to health professionals and highly valued by consumers"[2]. These are strategies that:

> *... facilitate the development of a sustainable cancer-nursing workforce, include increasing the future supply of nurses, increasing the capacity of the current workforce through education and providing infrastructure that supports nurses at the workplace and promotes retention[6].*

The National Cancer Nursing Education Project (EdCaN) was a government initiative that brought together national cancer nursing leaders to develop a cancer nursing framework designed specifically to outline the role expectations of cancer nurses and the educational standards to support their professional practice[11]. The framework has defined minimum standards for practice for generalist nurses working in cancer control, for specialist cancer nurses and cancer nurse practitioners with the associated learning resources being used to support the ongoing professional development of cancer nurses around the country[4].

The *Cancer Professional Development Framework* published in the same year was developed to provide a guide and framework for cancer service networks and organisations to build capacity and plan for the professional development of their cancer workforces with the aim of ultimately improving care and service delivery[12]. Importantly, the framework outlined what organisational support was required to build that capacity into the cancer workforce. Both frameworks have contributed significantly to the patient being the focus of cancer control programmes and have articulated the contribution that adequately prepared and skilled cancer health professionals (such as specialist cancer nurses) can make to ensuring patient needs and priorities are met[4].

The recently published *National Cancer Workforce Strategic Framework*[5] has called for a future cancer workforce that:

- is skills-based rather than role-based
- delivers multidisciplinary, consumer focused care
- readily promotes the uptake of information and communication technology
- delivers system-wide, evidence-based practice
- is flexible and able to adapt rapidly to change
- uses its health professionals as facilitators of self-care for consumers.

In seeking reform to workforce roles to improve productivity and support more effective, efficient and accessible care, the report calls for, amongst other strategies, the increased use "of specialist nurse practitioners and advanced practice nurses" to deliver that care[5]. Specialist cancer nurses have been proven to be effective in ensuring and delivering safe and cost-effective cancer care[3]. Importantly, cancer nurses have also demonstrated as a professional group, a ready capacity to adapt to rapidly changing models of practice that facilitate supportive and innovative approaches to care that meet the needs of patients and strengthen patients' capacity to be actively involved in their own care[13]. As such, they are well placed to respond to the many challenges that exist in the health care environment[4].

The need to support professional practice through a range of evidence-based strategies has again been emphasised throughout the *National Cancer Workforce Strategic Framework*[5]. The strategies aim to ensure a skilled, flexible and innovative workforce able to address the projected workforce shortages and to ensure the current (and future) cancer workforce can meet the incremental demands for services from an ageing population, with increasing levels of chronic disease and high community expectations[5].

What is meant by 'support'?

Many reports over the last 13 years have repeatedly highlighted the need for ongoing support of cancer nurses and for nurses working in advanced roles such as the SBCN role[2,5,12,14-17]. The reports identify a variety of strategies and mechanisms to support the professional practice of specialist cancer nurses including:

- commitment to specialist training
- education and continuing professional development
- mentoring

- clinical supervision and debriefing
- networking and peer support
- effective clinical leadership.

In 2009 a survey of the Australian oncology workforce was undertaken through the Clinical Oncological Society of Australia membership. Of the 740 respondents to the survey, 90.7% reported moderate (63%) to high (27.7%) levels of professional burnout[18]. One in three believed that the establishment of, and access to, support networks to be one of the best ways to combat burnout and 53% of the survey's respondents were cancer nurses. The strategies suggested to prevent professional burnout align with and support the recommendations of earlier reports[18]. For such strategies to be successfully implemented they require both individual and organisational commitment.

A commitment to specialist training, education and continuing professional development

Preparation for and ongoing support of clinical practice has been identified as an essential component of support[17,19]. This includes organisational support and funding to undertake continuing professional development through postgraduate study and clinical learning opportunities.

Continuing professional development of nurses is essential to ensure that nursing practice is evidence-based, meets best-practice standards and is congruent with the needs of contemporary society. Competence is dependent upon the continual updating of skills and knowledge and this should be considered an ongoing and career-long process[20].

The EdCaN competency standards for specialist cancer nurses are intended for those nurses who choose to become specialists in cancer control. Building on the competencies developed for the SBCN, these competencies can be applied to all cancer settings[11]. The competency standards articulate the need for oncology nurses to demonstrate a commitment to maintaining competence through participation in professional development activities relevant to cancer care and participate in professional clinical supervision and/or other peer-review processes for monitoring the appropriateness of personal and professional responses to patient care and service delivery[11]. Education has been identified as crucial in assisting SBCNs to maintain their skills and knowledge, and also as a mechanism of professional support[17]. It is considered by many SBCNs to be an essential element in supporting their role and their professional practice[16].

The need to support professional practice through a range of evidence-based educational strategies has been emphasised throughout the *National Cancer Workforce Strategic Framework*[5]. The current strategies aim to ensure a skilled, flexible and innovative workforce that is adequately prepared and has the appropriate mix of skills to deliver 21st century cancer care. Crucially, the framework recognises that cancer education and clinical training requires organisational support and the support of the clinical education workforce[5].

Mentoring programmes

Mentoring has been described as a "linchpin of recruitment and retention"[21] and is used worldwide as a strategy to retain skilled nurses in the workforce. Mentoring is a process that is designed to bridge the gap between "the educational process and the real world experience"[22]. The mentoring process in contemporary nursing practice offers health professionals the opportunity to provide guidance and support within a personal relationship[23]. It is an interactive process that gives individuals confidence in their abilities and can lead to professional and personal growth[21]. Mentoring relationships are often based on friendship and relationships established throughout working life[21,23] and these relationships can often act as catalysts for personal growth and development by providing a way of passing on experience and knowledge in order to motivate, support and enhance the personal and career development of colleagues[23].

While traditional models of mentoring suggest that mentors are older and more experienced, mentoring can take place within a group of peers and friends[24]. Mentors and mentees can be colleagues with a similar level of experience and able to respond to each other as equals but with differing skills[23]. Reports continue to emphasise that mentoring is a valuable method of professional and practical support for SBCNs[14,17].

A mentoring framework for Australian nurses in general practice was developed in 2005 and supported and funded by the federal government. The nurses involved in the mentoring programme reported the programme to be helpful for their personal development, professional relationships and role development[23,25].

The programme identified four key components that a nursing mentoring framework should encompass to be successful:

- choice
- relationships
- structures
- resources.

For those entering into a mentoring programme, relationships within the mentoring framework need to be examined to accommodate each individual nurse's learning needs[23,25].

The report recommends that:

- Participants should be offered a choice of mentoring contexts and roles.

A mentoring framework should be inclusive of existing networks, structures and relationships to assist with sustainability.

- Formal programmes should be promoted to ensure equity of access for all nurses and to assist with workforce issues.
- Programmes should be flexible, facilitate continuing education and promote a culture of professional development and ethical practice.
- Programmes require organisational support and an adequate allocation of resources such as time and technology and flexible communication methods to ensure the coordination of information and advice[23,25].

A successful mentoring programme has the:

> *... potential to attract and retain talent, improve employee commitment, retain corporate knowledge and enhance organisational culture, image and capacity as well make people feel valued through recognition of their individual contributions*[23, p.18].

In 2005, cancer-related mentoring projects across Australia were funded to evaluate strategies to link cancer professionals and services in regional areas to mentors in urban centres, improve access to best practice treatment and care for people with cancer living in rural and regional Australia. A review of the projects revealed that the mentoring projects' objectives of strengthening the links between regional, rural and remote areas and urban hospitals were achieved[26]. Two of these projects supported SBCNs and cancer nurses to deliver care in rural and remote settings.

Mentoring has recently been highlighted again as an important strategy to support emerging clinical leaders across cancer roles and specialties in the National Cancer Workforce Framework[5]. Unfortunately there are very few formal mentoring programmes available for specialist cancer nurses to access. Acknowledgement of the difference that mentoring can make to the professional development and support of nurses working in cancer care is required. As a professional group, SBCNs and cancer nurses need to use this evidence to support the development and implementation of sustainable mentoring programmes across the country. Cancer nurses have a responsibility to share their expertise and engage in mentoring programmes[11,17] to develop a flexible and adaptable workforce for the future that promotes a culture of professional expertise, ongoing professional development and contemporary ethical practice.

Peer support

Peer support has been highlighted in the literature as a valuable method of support for SBCNs[14,16,17]. A peer is usually considered to be someone of equal standing such as a professional colleague and peer support is gained through debriefing with colleagues and discussing difficult cases and workplace issues in a supportive environment. Rural and remote SBCNs are often professionally isolated due to their geographical isolation and greatly value the support of their professional peers.

The NBCC report *Specialist breast care nurses: an evidence-based model for Australian practice* found that the nurses who participated in the demonstration project reported that opportunities to access peer support were highly valued[14]. Girgis, Hansen and Goldstein suggest that access to peer support networks can be used as an important strategy for preventing stress and burnout for cancer nurses and the general oncology workforce[18].

Studies into multidisciplinary care have found that a multidisciplinary approach provides greater emotional and intellectual support for all team members[15,27]. The potential for a supportive environment to be fostered by a multidisciplinary approach cannot be underestimated. Effective communication, mutual respect and acknowledging the professional expertise, talents and beliefs of individual team members is essential to effective team functioning[28]. A well-functioning team confers many benefits for team members that includes a reduction in stress levels and feelings of enhanced professional satisfaction[15,28].

Whilst it is important to have collegial support from all the members of the multidisciplinary team, SBCNs clearly value the support of their nursing peers and find opportunities to meet with them and discuss their work helpful[14,16,17,27]. The EdCaN framework requires cancer nurses to reflect on and evaluate their current practice and to benchmark and measure it against contemporary nursing standards, practice and peers[11]. The EdCaN framework can be used as a guide for benchmarking professional practice. Cancer nurses have an enormous capacity to share their knowledge and expertise and it is critical that nurses, at every level, utilise and share this rich resource and create opportunities to gain access to peer support that will support their professional growth and development.

Networking

Networking with colleagues can provide support for people as they progress through their career[29]. Maintaining professional relationships and fostering networks offers an effective strategy for dealing with the balancing act of managing organisational work and home life[29]. Professional networking can provide new insight and up-to-date information, assist with career development and provide opportunities for gaining clinical advice and moral support from colleagues. Opportunities for teamwork and networking are shown to prevent professional isolation and burnout[18].

There are two types of networks:

- *Organisational membership networks*: consist of members who have organisational ties to their professional group and whose membership depends on their position[29]. This type of network supports those with a similar professional background; for example, clinical nurse consultants, cancer care coordinators, nurse-practitioners, SBCNs[29].

- *Core discussion networks*: Core discussion networks are usually less formal groupings. They are not dependent on organisational position or profession[29]. Examples of such groups in nursing include ethics groups, interest groups and journal groups[29].

Professional networking has been identified as a support mechanism that is valued by SBCNs in Australia[14,16,17,27]. Functional networks are an important strategy for attracting and retaining staff, particularly in regional, rural and remote areas[5,18]. Information and communication technologies play an important role in improving productivity and efficiency, especially when they are used to provide advice across campuses and regions, support networks and provide learning and mentoring opportunities between colleagues and peers[5,28].

There is a variety of professional cancer nursing groups that provide specialist cancer nurses with the opportunity to network with nursing colleagues with similar interests and professional background. The Cancer Nurses Society of Australia (CNSA) is Australia's only national cancer nursing organisation and it offers a range of benefits to its members including the opportunity to network with nursing colleagues through its regional groups and special interest groups (radiation, breast and gynaecological oncology). It also offers opportunities for education and continuing professional development and provides information and leadership on professional practice issues for nurses working in cancer control[30].

Clinical supervision

Clinical supervision is often defined as "an exchange between practising professionals to enable the development of professional skills"[31]. It has been recognised as a way to formalise the need of health professionals to talk to each other during work time in order to learn from each other, as well as support each other in professional practice. It is generally accepted that:

> *… clinical supervision is a designated interaction between two or more practitioners, within a safe and supportive environment, which enables a continuum of reflective, critical analysis of care to ensure quality patient services[31].*

It is described as a tool that can assist with the attraction and retention of staff by ensuring staff feel well supported in their roles[32].

Clinical supervision has been consistently identified as a mechanism of professional support for SBCN practice in Australia[14,17,27]. Emotional demands placed upon SBCNs can be considerable as they are dealing with women with significant concerns and high levels of fear and uncertainty[14]. It is felt that clinical supervision by a qualified mental health professional could ensure that SBCNs consolidate their psychological skills and assist with the identification of high-risk and highly needy women more effectively[14]. It is believed that this type of clinical supervision would assist with the development of self-confidence and lead to a reduction in the risk of emotional burnout[14] by attending to staff's psychosocial and training needs.

In 2009 Girgis, Hansen and Goldstein suggested ready access to professional supervision as a strategy that could be used to prevent professional burnout in the cancer care workforce[18]. The cancer care workers involved in the 2009 study:

> *… believe that strategies for addressing burnout should include improved access to leave, as well as attention to staff psycho-social and training needs, with the quantitative results emphasising the importance of regular communication skills training[18].*

Clinical supervision may also improve role effectiveness and increase job satisfaction as a result. It is important to note that there must be individual engagement by cancer nurses as well as organisational support for clinical supervision for it to be an effective workplace tool to support professional practice.

The National Breast Cancer Centre (now Cancer Australia) has consistently called for supervision models for SBCNs to be developed, along with the organisational support for their implementation[14,27]. This year Health Workforce Australia as part of its vision for the future national cancer workforce of Australia highlighted as a 'key' strategy the need to support the supervision capacity of the current generation of workers to ensure the development of the next generation of the cancer workforce[5].

It follows then, that clinical supervision for nurses should be considered a formal process of professional support where learning is supported by nursing management and organisations[31]. It is surprising to note anecdotally that clinical supervision remains a limited resource for the few and that clinical supervision is implemented in an ad hoc fashion across health services in Australia. It remains a challenge for cancer nurses to access this type of support and the expectation that it be made readily available to them either face-to-face or in teleconference mode is not often met.

To build greater capacity into the next generation of the cancer care workforce, urgent action is required to ensure systemic change and organisational commitment to implement formalised programmes of clinical supervision across the country.

Clinical leadership

Effective clinical leadership is known to be a critical factor for successful workforce innovation and reform[5]. Effective leadership builds a positive workplace culture and can lift individual and organisational performance. It also supports job satisfaction and organisational commitment. Supporting nurses and other clinicians to gain leadership skills themselves builds capacity and is strongly linked to effecting positive change in the workplace[5].

Specialist cancer nurses are known to use their technical knowledge and insight from patients' experiences to lead service redesign and to implement practice improvements that respond to changing patient needs[3]. They demonstrate leadership skills through:

- educating and mentoring the cancer workforce
- identifying and implementing service improvement and efficiencies
- determining measurable outcomes
- auditing practice and sharing knowledge
- expertise in clinical practice and innovation[3].

The expectation that specialist cancer nurses are able to demonstrate effective clinical leadership is fundamental to their role[11,17]. Enabling and facilitating cancer nurses to develop themselves and others as clinical leaders is also an expectation of advanced clinical practice[33]. Building capacity through the development of an organisational culture that supports continuous learning and development in leadership is crucial[5].

An effective organisational culture can be summarised as one that mandates:

- effective clinical leadership
- proffers a commitment to specialist training, education and professional development
- encourages mentoring
- provides clinical supervision and debriefing
- engages in and allows access to networking and peer support.

Such an organisation enables succession planning and allows the cancer workforce to build capability and capacity into the next generation of specialist nurses[33].

Effective leadership supports professional practice and developing leadership skills within the workforce fosters a positive workplace culture, which is then able to lift individual and organisational performance. It also supports job satisfaction and can be utilised as a strategy to assist in the retention of our existing workforce[5].

Conclusion

The effectiveness of cancer care is dependent on the availability of health care professionals to provide it. Specialist cancer nurses, like SBCNs, require supportive strategies to be in place to ensure their ongoing resilience in a rapidly changing and highly complex workplace. The current supply of specialist cancer nurses to work within our multidisciplinary cancer teams is predicted to worsen significantly in the coming years.

Strategies to train, retain and support cancer nurses have been identified and described. Nursing competencies such as the SBCN and EdCaN competency standards clearly articulate the need for nurses working in cancer care to have access to the supportive strategies discussed to support their professional practice. To date there has been limited uptake of the strategies and interventions described or organisational support for these activities to be undertaken in work time. Rather than the current ad hoc approach to professional support dependent on individual managers, a systemic approach and commitment to their implementation is required by organisations, combined with nurses' contribution and participation.

The nursing profession must ensure there is ongoing organisational commitment and dedicated time to implement these strategies to support professional practice, prevent emotional burnout and to retain our current nurses in the workplace. This is especially so for specialist cancer nurses where the impending shortage of nurses is combined with an increasing incidence of cancer, more people surviving cancer treatment than ever before, increasing levels of complexity, increasing levels of chronic disease and high community expectations.

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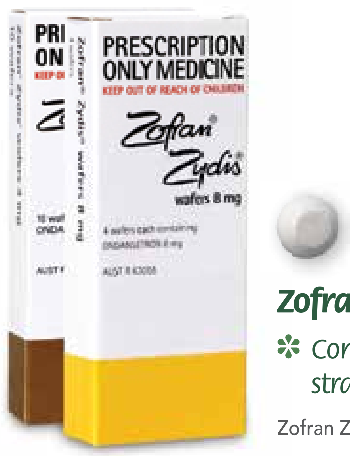

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