

# Forthcoming events

4 - 5 December 2008, Leeds  
BPOS annual Conference

5 - 8 February 2009,  
at the Westin Charlotte in  
Charlotte, North Carolina, USA  
6th APOS Meeting

8 September 2008  
Note Abstract Submission  
deadline

7 May - 10 May 2009  
11th Congress of the  
European Association  
for Palliative Care  
[www.eapcnet.org/vienna2009/  
index.html](http://www.eapcnet.org/vienna2009/index.html)

21 - 25 June 2009,  
Vienna, Austria

11th World Congress  
of Psycho-Oncology

23 September -  
26 September 2009  
20th World Congress of  
Psychosomatic Medicine  
[www.icpm2009.com](http://www.icpm2009.com)

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## British Psychosocial Oncology Society 2008 Conference

### Reaching the Hard to Reach

4 - 5 December 2008  
Thorpe Park Hotel, Leeds

#### Featuring

- ◆ Keynote presentations
- ◆ Paper and poster sessions from new and experienced researchers
- ◆ Training session for PhD students

#### Keynote speakers confirmed

**Harry Burns**  
Chief Medical Officer for Scotland (Peter Maguire Lecture)

**David Cameron**  
Director of the National Cancer Research Network

**Barbara Monroe**  
Chief Executive of St Christopher's Hospice in London

BPOS aims to advance education and research in psychosocial oncology, including promoting knowledge in those working with people with cancer and their families. The conference is open to all researchers and clinicians with an interest in this area, not just members of the Society.

Registration opens 27 May 2008  
Early Bird registration by Friday 17 October 2008  
Abstracts are invited  
submission deadline Friday 19 September 2008  
outcome notified by Friday 4 October 2008

Visit [www.pogweb.org/bpos01.php](http://www.pogweb.org/bpos01.php) for more information

### Call for Articles

All copy for the BPOS Newsletter  
should be sent to the Editor:  
Alex Mitchell  
([alex.mitchell@leicspart.nhs.uk](mailto:alex.mitchell@leicspart.nhs.uk))  
I also welcome ideas for future  
issues, and user and carer stories.

#### Rates

Advertisements for training events etc  
will be printed at the discretion of the  
Executive, at a rate of £3.00/column inch  
(3 col/page) for BPOS members or £5.00/  
column inch for non-members  
(£50 half page).

Cheque made payable to the "British  
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# BRITISH PSYCHOSOCIAL ONCOLOGY SOCIETY

Summer 2008 Newsletter



### Welcome to the late summer edition of BPOS newsletter.

This edition follows the exciting and successful 10th IPOS conference in May 2008 and we present here a brief article highlighting the key conference events. The new IPOS Federation of the national psycho-social oncology societies had its first annual business meeting during the conference. Over 20 national societies have joined the Federation. BPOS is in the process of applying for membership and you will soon receive an email request for consent to provide membership contact details to IPOS Federation. The Federation is a major step forward in co-ordinating efforts of different national societies towards development of better psycho-social care nationally and internationally. It is hoped it will support co-ordinated efforts towards implementing and establishing policies for psycho-social care in different health care systems.

The IPOS meeting is just over and we are looking forward towards BPOS own annual conference which is taking place on 4th and 5th December 2008 in Leeds. Please visit the conference website ([www.pogweb.org/bpos01.php](http://www.pogweb.org/bpos01.php)) and send us your abstracts. We are looking forward to organising an exciting and stimulating conference, aiming to bring together multi-disciplinary researchers from oncology, clinical psychology, psychiatry, nursing and allied healthcare professionals.

Between the conferences the executive committee has been busy focusing on key organisational issues. We are in the process of re-designing and improving the BPOS website. We have been actively discussing with the British Psychological Society SIGOPAC (Special Interest Group in Oncology and Palliative Care) opportunities to have joint meetings and work more closely together. Nick Hulbert-Williams is taking over the editorship of the newsletter from the next edition. I wish to express here our enormous gratitude to Dr Alex Mitchell for his excellent work making this newsletter a success over the years.



Our Society has a stable membership but we need new blood. May I ask you to encourage young researchers and PhD students to come to our conference and join the society. BPOS provides an excellent forum for learning research skills, discussing ideas with colleagues and developing research career in psycho-oncology.

I hope you enjoy this issue of the newsletter and look forward to seeing you in December 2008 in Leeds.

**Galina Velikova**  
Chair of BPOS

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British Psychosocial Oncology Society

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# Conference Report: IPOS

IPOS this year reached its 10th year and there were some special events to commemorate this. In particular, Jimmie Holland received a lifetime achievement award.

It's worth remembering that she edited the first major book on the subject in 1989 in the form of *"the Handbook of Psycho-Oncology"*. 2009 will see a new edition of the definitive multi-author "Psycho-oncology" from Oxford University Press. During IPOS at a meet the expert session Jimmie gave a personal and entertaining account of her life at the forefront of psycho-oncology. One message was work hard to win over the oncologists.

IPOS was held this year in Madrid at the huge Feria de Madrid, some way out of town but easily commutable. The venue was excellent with an ideal amount of space dedicated to sessions and posters. As usual there was a preceding IPOS Academy held at the NH Eurobuilding hotel. I did not attend as I find these too expensive, an issue for IPOS as a whole in fact, but Chris Hosker from Leeds said he found most of the academy worthwhile and gave reasonable choice with 19 workshops to choose from. One nice feature was that at least one concurrent session was held in Spanish and this seemed to encourage local attendees. In fact attendance was good with over 700 I am told, although personally it seemed somewhat lower than London 2007.

What then were the highlights of the IPOS and what was new? I can only give a somewhat biased personal view. For me the poster sessions are always good value with cutting edge research and the option to speak with the presenters. This year there were three poster sessions with 91, 111 and 120 presentations respectively. This is an amazing amount of annual research within our field and I would encourage anyone to submit posters to IPOS (and BPOS) on pretty much any subject as almost everything can be accommodated. Several new themes are beginning to emerge in psycho-oncology research and were



much in evidence. These are a. Clarity of unmet need and its measurement b. Better conceptualisation of subtypes of depression and anxiety including minor and subsyndromal varieties c. working with culturally diverse groups (essentially this was the formal theme of the conference) and d. Quick screening enhancements – that is methods that may improve upon the distress thermometer. On the latter topic, our group chose IPOS08 to launch the new Emotion thermometer tool which can now be accessed online ([www.psycho-oncology.info](http://www.psycho-oncology.info)).

Many excellent presentations were given in platform presentations and symposia although time was often limited to 10 minutes which became a challenge to fit everything in. From these oral sessions, here I pick ten outstanding presentations (sorry if I missed your work!) which are worth summarizing here for those that could not attend.

## [1] 5L-5 The Prevention of Psychological Distress in Newly Diagnosed Lung Cancer Patients

**Erna Wilkie et al University of Dundee, Dundee, Scotland**

This was an innovative attempt to reduce distress in apparently well-adjusted newly diagnosed lung cancer patients. 73 patients approached took part in the study of whom 36 were treated with Venlafaxine. There were no statistically significant differences (Mann Whitney U Test) with regards to anxiety or depression and a high refusal rate but nevertheless this study is of interest.

## [2] 8L-2 Communicating with Cancer Patients: What Physician Assistants Report as Their Most Challenging Encounters

**Patricia Parker et al The University of Texas M. D. Anderson Cancer Center, Houston, TX, United States**

301 Physician Assistants completed demographic and practice-related information and items assessing perceived difficulty (1 "not at all difficult" to 5 "extremely difficult") and skill level (1 "poor" to 5 "excellent") in handling 8 different communication tasks. They rated "intervening with angry patients or family members", "intervening with patients or family members in denial", and "telling patient he/she has cancer or disease has progressed" as most difficult. They also reported being least skilled at "discussing DNR orders"

## [3] 8L-4 Breaking Bad News: Communication Preferences, Experiences and Distress in Advanced Cancer Patients

**Claudia Lehmann et al University Medical Center Hamburg-Eppendorf, Department of Medical Psychology, Hamburg**

Patients completed self-report questionnaires during their stay at the oncology unit and three months later. Measure of Patients' Preferences (MPP), Distress Thermometer, PHQ and Supportive Care Needs Survey were used to assess communication preferences, distress and needs. Results of the first assessment point are presented. 58% received the bad news at hospital, 25% at the doctor's office, 8% by phone. 62% rated the diagnosis, 13% the poor prognosis and 10% chemotherapy as worst news. Patients indicated telling the best treatment option, telling the bad news directly, being honest about the severity of the patient's condition and telling the news in person were most important. st mismatches (up to 60%) between patients' preferences and physicians' behaviour were found regarding supportive aspects. 35% were not satisfied with the physician's communication behaviour at all.

## [4] 11L-8 Introducing Routine Psychosocial Screening for Newly Diagnosed Rural Cancer Patients. Does it Lead to Better Outcomes for Patients and Multidisciplinary Care?

**Belinda Thewes et al 1Cancer Services, Greater Southern Area Health Service, New South Wales, Australia**

83 newly diagnosed adult cancer patients recruited at one of 3 rural outpatient oncology clinics participated in this study. 43 participants were screened using the DT. Screening with the DT did not significantly increase the rate of appropriate referrals to psychosocial support staff. However, there was some evidence to suggest it may reduce time to referral. Contrary to what was hypothesised, the screened group reported significantly greater unmet needs.

## [5] 14S-3 Screening for Perceived Need for Help Using the Latest Screening Tools – What Do We Know about Who Wants Help?

**Elena A Baker-Glenn and Alex J Mitchell**

**1 University of Nottingham, and University Hospitals of Leicester NHS Trust, Leicester, United Kingdom**

130 patients participated and only 20% said they wanted professional help for psychosocial issues including 36% of those distressed on the distress thermometer wanted help. Only 3/26 of those wanting help had no identifiable condition compared with 40/104 of decliners, meaning that 62% of those refusing help may have a potentially serious psychosocial condition. Baker-Glenn examined the kind of help requested. 19% wanted medication whilst 31% wanted self-help guidelines and/or group therapy. 56% wanted information about their illness. The most popular requests for help were face-to-face psychological support (62%) and complementary therapies (58%). The most popular sources of help were nurse specialists (54%) and the least popular were psychiatrists (4%). The most common reasons for refusing help were "getting help elsewhere" (57%), "feel well" (41%), and "coping on my own" (31%).

## [6] 18L-1 Predictors of Return to Work in Cancer Survivors

**Anja Mehnert et al 1Department of Medical Psychology, University Medical Center Hamburg-Eppendorf, Hamburg**

This was a study of 1193 patients (85% women) with mixed tumor diagnoses. Advice to return to work was given by 46% of physicians, 53% of employers, and 61% of partners. Results at T2 show that 67% of the sample returned

to work. Among these patients, 81% returned to their former work place, 19% changed their position/work place within the company or changed the company; 25% report mild to severe impairments at their daily work. Patients with hematological cancers (91%) and colon/rectum cancer (84%) were most likely to return to work, whereas head/neck (56%) and lung cancer patients (36%) had the lowest return rates ( $P < 0.001$ ,  $p = 0.18$ ). 50% of the sample returned back to work immediately after rehabilitation, the average time until return to work was 11 weeks. Regression analysis showed intention to return to work at T1, overall job satisfaction at T0, months since diagnosis, depression at T0 and age as significant predictor.

## [7] 22S-3 What Has Been Done with the Distress Thermometer in Cancer Patients in China? The Benefits and Issues.

**Lili Tang et al The School of Oncology Peking University, Beijing Cancer Hospital, Beijing, China**

5,036 cancer patients attending their first inpatient appointment at the Beijing Cancer Hospital completed the Chinese version of the Distress Thermometer. Those scoring  $>4$  on the Distress Thermometer, and whose distress was caused by mood problems were interviewed by a psychologist to assess their mental state. The incidence of distress on screening was 17.41%. The main causes of distress in descending order were; worry, pain, fatigue, nervousness, insurance/ financial concerns, memory/ concentration difficulties, eating, bathing/dressing and nausea. 2. Of those patients interviewed by the psychologist, 13.33% were subsequently diagnosed with mental disorders.

## [8] 25L-2 Agreement Between Cancer Patients' and Nurses' Perceptions of Patients' Emotional Distress, Coping Resources and Quality of Life?

**Gunilla Mårtensson et al University of Gävle, Gävle, Sweden**

The aim was to examine differences, associations and agreement in cancer patients' and their nurses' ratings of cancer patients' emotional distress, coping resources and quality of life amongst 90 individual patient-nurse pairs. Interestingly nurses systematically overestimated patients' emotional distress and underestimated patients' coping resources and quality of life. Nurses who were in consistent agreement with their patient had a higher education level, and were more likely to have had earlier responsibility for the patient's care.

## [9] 27L-1 Measuring Distress in Couples Facing Cancer with the Distress Thermometer (DT)

**Diana Zwahlen et al 1 University Hospital Zürich, Department of Psychiatry, Zürich**

The purpose of the study was to measure couples' distress in order to quantify distress for patients and partners and to examine patterns of distress in 225 couples using the Distress Thermometer (DT) as a measure of negative psychological effects. They found reported distress was found to be higher for partners than for patients (41% of partners and 33.0% of patients achieved clinically significant scores). Examining matched pairs (i.e. couples) they found that 51.4% (107) of couples were affected, with one or both individuals reporting distress; most of these distressed patient and partner pairs (23.6%) were mutually significantly distressed.

## [10] 46L-6 Using Touch Screen Technology to Bring People Closer Together

**Karen Clark et al 1City of Hope, Duarte, CA, United States, 2Moore's UCSD Cancer Center, La Jolla, CA, United States, 3San Diego State University, San Diego, CA, United States**

1,313 outpatients completed the touch screen version of the "How Can We Help You and Your Family" screening instrument, available in both English and Spanish. This technology is also used to triage patient responses to the appropriate health care team members in real time via e-mail and to identify patients interested in clinical trials. Over half of the patients (64.5%) rated themselves as beginner or intermediate level computer users, the majority (96%) of the patients rated the survey very easy or easy to use. This method holds promise as a rapid screening for unmet needs, help and distress.

Finally, for those that want to catch up with what went on, an overview is available on the IPOS website and in addition, the full abstract listing is

on the Wiley Psycho-oncology website (although a password may be required).

**Alex Mitchell**  
Consultant in  
Psycho-Oncology,  
Leicester



## The creation of the IPOS Federation

Whilst attending the 2008 IPOS conference, I attended the first annual business meeting of the IPOS Federation of National Societies. The meeting was led by the new Federation Chair, Luiggi Grassi (IPOS past-president).

IPOS have been working on the proposal to form the Federation since the 2006 meeting in Venice where it was acknowledged that communication between the numerous national societies around the World can be difficult.

### The Federation is an attempt to improve communicative and collaborative links

*"compellingly in a unified voice the message that all cancer patients and their families through the World should receive optimal psychosocial care at all stages of disease and survivorship"* (Policy for the IPOS Federation).

Any multi-disciplinary society of psycho-oncology professionals is eligible to apply for membership to the Federation and already, over 20 national societies have done so. BPOS is likely to follow this trend and become an official member shortly. Aside to participation and voting rights on the Federation, potential benefits to BPOS are numerous and include:

- ◆ Improved intra-federation communication
- ◆ Space on the IPOS website
- ◆ Use of the IPOS logo in national society promotion
- ◆ Improved links with IPOS and their linked organisations
- ◆ Improved opportunities for development of international research
- ◆ Input into the discussion of international standards of training for, and guidance related to, psycho-oncology.

The Federation Policy documents were accepted and ratified at the meeting. We will keep BPOS informed about developments related to the Federation over the coming months.

#### Nick Hulbert-Williams

Lecturer in Applied Psychology, University of Wolverhampton

## Special Article

### Exploring the personal impact and health & well-being of conducting research in oncology: Call for Participants

With an increase in the incidence of cancer, oncology research is a vital area for investigation in order to inform treatment, care and support for cancer patients.

Oncology is frequently reported as an inherently pressurised occupation for health professionals (Graham & Ramirez, 2002) with high levels of stress and burnout. The reasons behind this work-related stress may include the workload (i.e. increasing prevalence of the disease), time pressures, inadequate staffing, patient dependency, emotional labour and the regular exposure to suffering and dealing with patient mortality (Barnard et al., 2006; Graham & Ramirez, 2002; Peeters & Le Blanc, 2001; Grunfeld et al., 2005).

The research in this area indicates that oncology professionals may benefit from specific training on how to cope with the emotional demands of their work. *But what about those working in cancer research?*

Little is known about the health and well-being of oncology researchers. While it is certainly rewarding and stimulating on the one hand, it can also be emotionally and cognitively demanding and can be conducted in a relatively isolated research environment. Mainly anecdotal reports describe the difficult challenges that researchers can face when working in sensitive and emotional areas such as oncology (Ragor, 2005; Lalor et al. 2006). The value of exploring the work experiences of researchers working in this area who, due to the nature of the work, may have some quite unique needs and requirements is clearly highlighted.

In recognition of this, a project has been set up by a team from Goldsmiths, University of London, the University of the West of England (Bristol) and Loughborough University, who are now calling for individuals who are interested in participating in the research.

Specific aims of the research project:

- ◆ To explore the experiences of work, and the health & well-being (including emotional stress), of those conducting research in oncology
- ◆ To identify factors that are effective in enhancing health & well-being and preventing or reducing work-related stress
- ◆ Explore and recognise best practice for relevant support, training and resources for oncology researchers

**Phase 1** is currently underway (semi-structured interviews), but in relation to this phase we are still seeking oncology researchers who have a clinical background or who are based in a clinical setting (e.g. research nurses).

This will be followed by **Phase 2** - an online survey to further explore oncology researchers' experiences. **Any** individuals who are actively conducting research that involves collecting data directly from oncology patients or survivors are invited to take part in the second phase. This might include MSc/PhD students, research assistants/fellows, clinicians, research nurses, academics, and psychologists, working in areas including psychosocial, palliative, and medical trials.

All research will adhere to strict standards of confidentiality and anonymity, and is approved by the university ethics committee.

**If you would like to participate or receive further information, please contact:**

#### Miss Fiona Kennedy

Trainee Health Psychologist, University of the West of England  
Tel: 0117 3281890; fiona2.kennedy@uwe.ac.uk, or

#### Dr Joanna Yarker

Chartered Occupational Psychologist, Goldsmiths College, University of London  
Tel: 07941 253 256; j.yarker@gold.ac.uk

## Education Section

### Research Summary: Are psychological interventions beneficial for women with metastatic breast cancer?

Although almost uniformly fatal, metastatic breast cancer is treatable and patients often live for long periods of time with good quality of life (Leonard, Rodger & Dixon, 2000; Smith, 2006). Whilst there is agreement within the literature that psychological co-morbidity following cancer diagnosis is common and high (Sellick & Crooks, 1999), most studies focus on early stage, not metastatic cancer diagnosis (Edelman, Bell & Kidman, 1999; Fulton, 1999). Findings of individual trials of psychological interventions to reduce these distress levels and their consequences have been conflicting.

In this update of a 2003 Cochrane review, we re-searched five electronic databases (Medline, CINAHL, PsychInfo, SIGLE & The Cochrane Breast Specialised Register) for papers published up to, and including, September 2007. Follow-up searches also included checking of bibliographies, hand searching relevant journals and contacting known leading authors in the field. Psychological interventions (educational, individual psychotherapy, cognitive behavioural training, or group interventions) were included so long as outcome data on women with metastatic breast cancer as an exclusive participant group were available. Relevant outcome measures included symptom scores (e.g. Pain Rating Scale, Brief Symptom Inventory), patient-based outcome measures (e.g. Impact of Events Scale, Global Adjustment to Illness Scale), condition specific outcomes (e.g. Rotterdam Symptom Checklist, Cancer Rehabilitation Evaluation System), generic health status outcomes, (e.g. SF-12/36), generic psychological outcomes (e.g. Hospital Anxiety and Depression Scale, Ways of Coping Scale), social support measures (e.g. Yale Social Support Index, Social Support Questionnaire), and/or survival data.

From 4112 abstracts, 21 papers from five primary studies (see end of article for details) were included. All five reported data from group-based psychological interventions: two cognitive-behavioural (CB) group interventions, and three supportive-expressive (SE) group therapy interventions. All included studies scored reasonably high on

a standard methodological quality score. However, numerous potential methodological weaknesses were identified including problems with allocation concealment, and participant blinding, indicating the necessity for interpretative caution.

Meta-analysis of survival data from four of the five studies did not demonstrate clear evidence of survival benefit from the psychological intervention at either one, five or ten years of follow-up, although an intervention effect could not be ruled out (SE<sup>3,5</sup> was more likely to result in significant survival effect than CB intervention<sup>1,2</sup> in data at one year follow-up). There was, however, evidence of short-term benefit on psychological outcome measures, but in many cases this effect did not last beyond a few months. Although statistical meta-analysis was limited by the lack of homogeneity in format of extractable data (i.e. different formats of the same scale, different data format etc.), meta-analysis of some cross sectional data was possible. Where one SE intervention demonstrated POMS improvement at one-year follow-up<sup>5</sup>, neither the other SE intervention<sup>3</sup> nor the CB interventions report beneficial effects lasting beyond six months<sup>1,2</sup>. SE Group therapy was also found to statistically reduce reported pain levels<sup>3,5</sup>. Meta-analysis of anxiety outcomes was not significant in either direction (i.e. whilst no statistical benefit was found, there was also no harm involved in support group participation)<sup>2,3</sup>.

A range of other outcomes was also assessed within individual papers. Trauma measures (Impact of Events Scale), and scores on both the Courtauld Emotional Control Scale and the Weinberger Adjustment Inventory were all improved following SE group therapy in one study<sup>4</sup>. The other SE trial assessed quality of life outcome (EORTC C-30) but reported no overall change<sup>3</sup>. From the CB interventions, no statistically significant changes in functional living index<sup>1</sup> or self-esteem<sup>2</sup> were demonstrated.

Available data were insufficient to assess the potentially modifying effects of disease extent at diagnosis, age, family history, medical

complications and other concurrent health conditions, and adequacy of familial support.

Whilst it is possible that our conservative choice of statistical methods may have minimised the likelihood of finding overall statistically significant changes in this small dataset, the results seem to indicate that effects on survival are unlikely, and that beneficial effects on psychological outcomes are not sustained. Pending further, more methodologically sound trials, the current literature is insufficient to advocate that group psychological therapies be routinely offered to all women diagnosed with metastatic breast cancer. Further research should particularly focus upon other intervention frameworks, for example, educational, individual psychotherapy, or some of the newly developed third-wave CB therapies. An improvement in methodology is recommended across the board for future trials of psychological interventions for this patient population. We also support the view expressed by Goodwin, Black, Bordeleau and Ganz (2003) that the failure to detect long-term psychological benefits may be an issue not of absence of effect, but one of psychometric assessment, and that rigorous qualitative research may lead to a clearer understanding of the long-term impacts of intervention participation.

#### Nick Hulbert-Williams

University of Wolverhampton

#### Adrian Edwards, Richard Neal

Cardiff University

The full article is available via the Cochrane Library:

Edwards AGK, Hulbert-Williams NJ & Neal RD (2008). Psychological interventions for women with metastatic breast cancer. Cochrane Database of Systematic Reviews, 2008, Issue 2. Art. No. CD004253.

Key to included references:

1. Cunningham et al (1998). Cognitive behavioural; n=66; Canada
2. Edelman et al (1999). Cognitive behavioural; n=124; Australia.
3. Goodwin et al (2001). Supportive-expressive; n=235; Canada.
4. Koopman et al (1998). Supportive-expressive; n=125; USA.
5. Speigel et al (1989). Supportive-expressive; n=86; USA.

## Service Update

# Macmillan Benefit Helpline

One of the biggest worries that comes with a cancer diagnosis is around finances and that is why Macmillan Cancer Support, as part of its Direct Services, set up its national Benefits Helpline in 2003.

The team based in Bingley, West Yorkshire initially consisted of three welfare rights advisers and has now grown to ten advisers with three support staff including a Helpline Manager to cope with the ever increasing number of calls. The advisers have a wealth of experience in welfare rights and an understanding of cancer and the effects which cancer can have on everyday life and finances. Since the Helpline was launched in 2003 we have advised 20,000 clients and identified over £40 million in benefits and grants. Macmillan plans to expand the current team to at least 18 advisers by 2010 so that anybody affected by cancer who wants our help can access the service.

We take calls from cancer patients, carers, family members, friends, health and social care professionals. The advisers navigate people through the complexities of the welfare benefits system by offering a casework service which includes:

- ◆ to explain benefit criteria
- ◆ calculate actual benefit entitlement
- ◆ order claim forms and help people complete them
- ◆ liaise and negotiate with statutory bodies
- ◆ help clients challenge their benefit decisions
- ◆ identify and apply for Macmillan Grants
- ◆ Inform clients about other sources of help (such as prescription costs, dental treatment, blue badge parking permits, road tax exemption and so forth)

We offer a holistic approach to a client's situation and this can include advice on other charitable grants apart from Macmillan grants, as well as offering limited advice on debt, employment and housing.

As well as advising clients on benefit entitlement the advisers offer emotional support, sometimes just by listening. Many clients do not want to burden their families by



talking about their feelings and worries, but feel comfortable talking to the advisers who they know they will never meet face to face, and as there is no time limit on a call they are not rushed – many calls last two hours when completing a Disability Living Allowance form. We are still advising clients who first contacted us in 2003. We will advise and support clients during the changes in their cancer journey until they are in remission, return to work or we offer bereavement benefits advice.

As well as delivering advice we support Macmillan's campaigns by offering case studies relevant to the theme - an example of this was the 'hitting homes' campaign in 2006 which highlighted that 1 in 17 people affected by cancer would lose their home due to the impact of a cancer diagnosis.

As we are a national service we are regularly asked by our policy analysts for feedback/case studies on recurring benefits problems. We hear harrowing stories on all kinds of problems encountered by people affected by cancer - for instance clients having to miss or delay chemotherapy/ radiotherapy appointments because they cannot afford the travel fares to hospital

or delaying surgery as they cannot afford to lose their wages. By the advisers at the Helpline highlighting these common problems to our policy analysts they then in turn can try to influence changes and improvements to Government policy on benefit legislation. Based on some of these case studies Macmillan was responsible for winning some really important concessions for people with cancer/terminal illness and fast tracking for terminally ill patients onto the higher rates of the new Employment and Support Allowance. This new benefit will replace Incapacity Benefit/Income Support (paid on grounds of illness) from October 2008 for new claimants.

The Helpline is open from 10am until 5pm Monday, Tuesday Thursday, Friday and from 12 noon until 5pm on Wednesday. The number is 0808 801 0304 and we are more than happy to assist health and social care professionals with any benefit query.

**Kay Nichols**  
Macmillan Benefit Helpline Manager  
Macmillan Cancer Support  
15 Victoria Mew, Millfield Road,  
Cottingley Business Park, Bingley BD16 1PY

## BPOS Committee Contact Details - September 2008

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<b>Sue CATT</b> Open Dec 07 - Dec 10 Second Term	Cancer Research UK Psychosocial Oncology Group Brighton and Sussex Medical School University of Sussex Brighton BN1 9QG	T: 01273 873024 F: 01273 873022 E: s.l.catt@sussex.ac.uk
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<b>Palliative Care</b>	VACANT	VACANT