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ORIGINAL ARTICLE

# Unmet needs in breast cancer survivors are common, and multidisciplinary care is underutilised: the Survivorship Needs Assessment Project

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## Abstract

**Purpose** The transition from a breast cancer patient to a survivor can be associated with significant physical, psychological, and social challenges. Development of multidisciplinary evidence-based care during the post-treatment period is a key area of cancer research. This study examined survivorship issues, unmet needs and perceptions about care among a cohort of breast cancer survivors.

**Methods** Participants were 130 women diagnosed with breast cancer for at least one year, and attending a hospital breast or oncology outpatient clinic. They completed a series of self-report questionnaires assessing demographic and clinical characteristics, unmet needs, severity of survivorship issues, use of multidisciplinary services, clinical benchmarks, survivorship care satisfaction, and suggestions for service improvements.

**Results** There was an average of 4.9 unmet survivorship needs, with 67% of participants reporting at least one unmet need. Fear of cancer recurrence, stress, coordination of medical care and negative iatrogenic impacts of hormonal treatments were key concerns. The cancer support team typically consisted of medical and nursing staff, and family/friends, and most were satisfied with their survivorship care. There was minimal use of other multidisciplinary clinicians and support groups. Provision of additional dietary and cancer recurrence education, and a written treatment plan were identified as key areas of service improvement.

**Conclusion** Despite high satisfaction ratings, survivorship issues and unmet needs were relatively common, particularly among younger participants. Use of multidisciplinary care was inconsistent and overall underutilised.

**Implications for cancer survivors** Ongoing specific evaluation and optimisation of existing models of multidisciplinary survivorship care are essential in meeting the complex needs of breast cancer survivors.

**Keywords** Breast cancer · Survivorship · Supportive care · Unmet needs

## Introduction

Breast cancer is one of the most commonly diagnosed malignancies, and its incidence, survival rates and impact on hospital and community resources continue to increase worldwide [1–3]. There are now effectively far more breast cancer survivors than patients undergoing active treatment, at any given point in time. The transition from a breast cancer patient to a survivor can be associated with significant physical, psychological, and social challenges, and associated unmet needs. For example, in comparison to women with no history of cancer, breast cancer survivors are at increased risk of experiencing anxiety, fear of cancer recurrence, depression, suicidal behaviours, sexual dysfunction, and relationship issues [4, 5]. Negative iatrogenic impacts of cancer treatments on quality of life, functioning and future treatment decisions are well-documented and can persist long after primary treatments have ended, even after accounting for the contribution of the aging process [6–8]. Older breast cancer survivors are particularly susceptible to

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the negative cognitive, functional and psychological impacts, yet remain under-represented in health outcomes and intervention studies [6, 9, 10]. Other studies have shown that younger breast cancer survivors are relatively more likely to report higher levels of emotional distress, and distinct concerns with fear of cancer recurrence, body image, sexuality, fertility, menopause, weight gain and spirituality [8, 11].

To achieve optimal survivorship care outcomes, the available services and resources need to be carefully and comprehensively matched to the specific patient concerns and needs, integrated across all service levels, accessible, and equitable [12]. However, there remains a considerable variation in the implementation and evaluation of breast cancer survivorship models of care [13, 14]. Traditional medical follow-up and surveillance tends to overlook psychosocial concerns, and risks failing to meet key supportive needs of cancer survivors [15]. This is further accentuated by the limited guidance regarding the use of most appropriate needs assessment tools in breast cancer survivors [16]. Additional challenges to cancer survivorship research include the wide range of survival definitions and time frames, limited data on longitudinal changes in survivorship needs, inconsistencies in measuring and reporting emotional distress and unmet needs, heterogenous samples of cancer survivors, and limited evaluations of the survivorship care benchmarks and patient preferences with regard to the care they wish to receive [17–20].

The aim of this study was to explore and better understand the perceptions of breast cancer survivors with regard to their ongoing survivorship issues, unmet needs, care benchmarks, and satisfaction with and use of survivorship care providers in local hospital and community settings. This broad assessment approach was chosen to make inferences about how well-matched the available service and resources are to the ongoing survivorship needs. It was hypothesised that survivorship issues and unmet needs would be relatively more prevalent among participants that are younger and undergoing hormonal treatments. The cut-off of 65 years of age was used to identify the older group, consistent with clinical practice guidelines [21]. Relevance of recency of diagnosis and recency of completion of treatments were also explored. Suggestions were also sought from participants with regard to future development of survivorship care services.

## Methods

### Setting and participants

This cross-sectional prospective cohort study was conducted within the Gold Coast Hospital and Health Service (GCHHS), which is one of Queensland's largest clinical, teaching and research organisations. Participants were recruited from outpatient clinics of two regional public hospitals that comprise the Gold Coast Breast Service. This service provides on-site specialist breast and reconstructive surgery, medical oncology and radiation oncology services, as well as nursing and other multidisciplinary cancer care. Inclusion criteria were aged 18 years or older, breast cancer diagnosis at least one year prior to participation, and ability to provide informed consent. Participants were excluded if they had not yet completed primary cancer treatments, if disease had progressed to the terminal stage, or if they were unable or unwilling to provide informed consent. A total of 185 patients were approached, of which 130 enrolled in the study (response rate 70.2%).

### Measures

A demographics questionnaire was used to collect information on gender, age, diagnosis, time frame of completion of primary treatment modalities (surgery, chemotherapy and/or radiation therapy), and details of additional hormonal therapy if applicable. No other identifiable information was collected.

Unmet needs were assessed by the Cancer Survivors Unmet Needs Questionnaire (CaSUN; [22]). CaSUN is a self-report measure that consists of 35 items measuring unmet needs in cancer survivors, six items measuring positive changes, and one open-ended question. When present, unmet needs are additionally classified as weak, moderate or strong. CaSUN is one of the most comprehensive measures of its kind and has established reliability and validity for use with breast cancer survivors [16, 22, 23].

Participants also completed a series of self-report questionnaires specifically developed for use in this study through a three-round Delphi process involving the breast service clinical leads [24]. The Delphi process began with benchmarks from existing national guidelines [12] and previous Australasian research [13, 15, 19, 22] which were then recursively revised to reflect the full range of survivorship issues encountered in the local setting. Intensity of breast cancer survivorship issues in the month prior was assessed by 24 items, on the following five-item Likert response scale: None, Not Applicable, Mild, Moderate, and Severe. Satisfaction with current survivorship services was assessed by 13 items on a five-item Likert response scale, ranging from Strongly Disagree to Strongly Agree. Survivorship care benchmarks regarding medical and nursing appointments were assessed by 15 items on a three-item response scale Yes, No, N/A. Ongoing use of survivorship care providers was assessed by 17 items, on a four-item Likert response scale ranging from Not at all to A lot. Participants additionally completed the following open-ended question on service development: "If I was asked to design a service to support breast cancer survivors, and had an unlimited budget, I would…".

### Procedure

Patients that attended outpatient Breast Service clinics (breast or reconstructive surgery, medical or radiation oncology, breast care nursing and other allied health clinic) were identified by clinical or administrative staff as potentially eligible for participation, and were provided a Patient Information Sheet. Consent to participate was implied when patients expressed their wish to proceed with the study. Verbal consent was sought from participants that had additional questions about the study. Participants were then provided a paper questionnaire for completion at a time suitable for them. Completed questionnaires were returned in a reply-paid envelope or collected on-site by relevant staff. This study was conducted with an approval by the GCHHS human research ethics committee (HREC/17/QGC/329).

### Statistical analyses

Questionnaires were scored, entered into a database and analysed with SPSS software (Version 21). Frequency, percentages, median (Mdn) and interquartile range (IQR) were used to describe categorical variables, whilst mean and standard deviation (SD) were calculated for normally-distributed continuous variables. A priori comparisons between groups were conducted using either the independent samples *t* tests or non-parametric Mann–Whitney *U* tests or chi-squared tests, where a *p* value of ≤ 0.05 (two-sided) denoted statistical significance. These comparisons were conducted across age (≤ 65 vs. > 65 years), hormonal treatments (Yes vs. No), recency of diagnosis and completion of primary treatments.

## Results

Participants were 130 females with a history of breast cancer diagnosis. Figure 1 shows the count of participant age groups and ongoing hormonal treatments.

Seventy participants were still undergoing one or more of the following hormonal treatments: Anastrazole/Letrozole (36%), Tamoxifen (15%), Exemestane (2%), and Goserelin (1%). Remaining participants stated that hormonal treatments were either not applicable to them (22%), they decided not to take them (9%), started but stopped due to side effects (7%), started but stopped due to other reasons (5%), or they previously completed at least five years of hormonal treatment (3%). There was a mean of 37.3 months (SD = 27.1) since breast cancer diagnosis, and 27.4 months (SD = 22.7) since completion of primary treatments.

### Unmet needs

On the CaSUN questionnaire, 87 participants (66.9%) reported having at least one unmet need, with a mean of 4.9 unmet needs. Table 1 shows the mean number of items endorsed as unmet, met or having no need for all participants and across the two age groups. Younger participants had a significantly higher number of total unmet needs, including

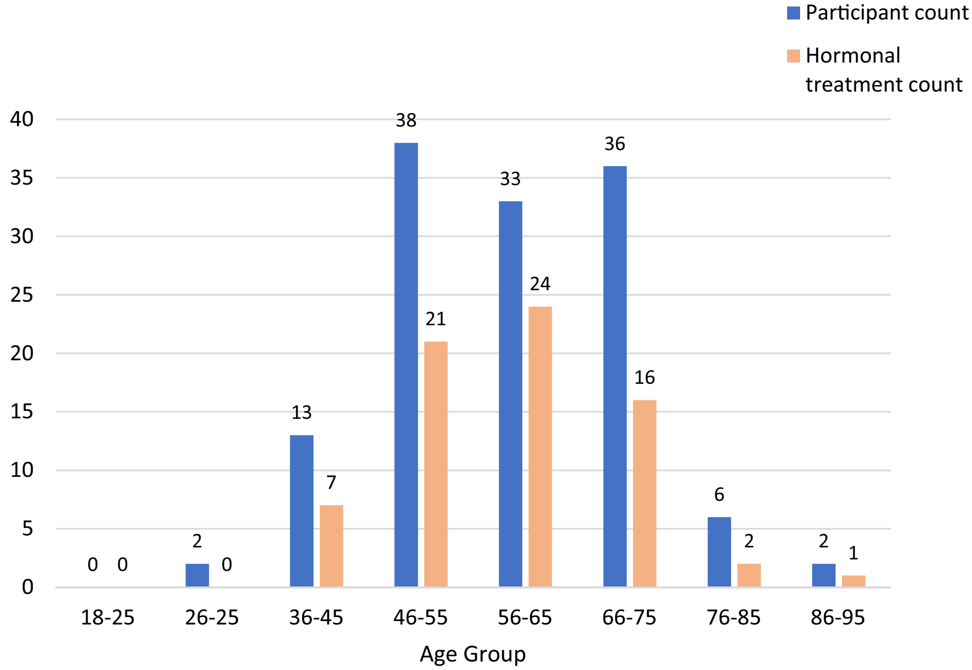

**Fig. 1** Participants age groups and hormonal treatments

**Table 1** CaSUN mean number of items endorsed as "unmet", met or no need

| CaSUN (35 items) | Mean (SD) endorsed items | | | t (df)[a] | p value[a] |
|---|---|---|---|---|---|
| | All ($n = 130$) | Age ≤ 65 ($n = 86$) | Age > 65 ($n = 44$) | | |
| Unmet need (all) | 4.4 (6.3) | 5.2 (6.9) | 2.5 (4.3) | 2.33 (125) | 0.021 |
| Unmet need (strong) | 1.7 (2.9) | 2.3 (3.4) | 0.7 (1.5) | 2.76 (126) | 0.007 |
| Unmet need (med) | 1.4 (2.4) | 1.6 (2.4) | 0.9 (2.2) | 1.61 (126) | 0.110 |
| Unmet need (weak) | 0.9 (2.5) | 0.9 (2.6) | 1.0 (2.2) | − 0.35 (125) | 0.724 |
| Need met (total) | 3.4 (4.5) | 4.4 (5.0) | 1.6 (2.5) | 3.37 (126) | 0.001 |
| No need (total) | 18.5 (10.4) | 18.4 (9.7) | 18.9 (11.8) | − 0.27 (128) | 0.791 |

[a] Independent samples *t* test, 2-tailed, for differences between the two age groups

medium and strong needs, but also needs that were met by the service. CaSUN scores did not significantly differ across the hormonal treatments, and there were no significant correlations with time since diagnosis, and time since completion of primary treatments.

Table 2 shows the ten most commonly reported unmet needs. Fear of cancer recurrence was the most prevalent unmet need followed by stress, coordination of care, hospital parking, information provision, and availability of a case manager. The least frequent unmet needs were items relating to fertility problems (2%), handling the topic of cancer in social or work situations (7%), spiritual beliefs (7%), developing new relationships (8%), and making life count (9%). Compared to the senior group, younger participants reported significantly higher ratings of the following unmet needs: stress, [$\chi^2$ (1, $N = 116$) = 7.18, $p = 0.007$]; adjustment to quality of life changes, [$\chi^2$ (1, $N = 120$) = 6.70, $p = 0.01$]; employment [$\chi^2$ (1, $N = 114$) = 6.15, $p = 0.013$]; and decision-making [$\chi^2$ (1, $N = 116$) = 4.41, $p = 0.036$]. There were no other significant group differences.

## Breast cancer survivorship issues in the prior month

The most frequent survivorship issues that were rated as moderate or severe in the month prior to study participation were fatigue (40.5%), fear of cancer recurrence (39.9%), sleep disturbance (37.4%), menopausal symptoms (34.7%), muscle/joint aches and pains (34.4%), weight gain (31%), depression or anxiety (29.8%), and cognitive difficulties (29.5%). The least frequent issues rated as moderate or severe were lymphoedema (14.8%), cardiotoxicity (5.9%), menstrual irregularities (4.2%), external breast prostheses (3.3%), trouble with wigs (1.7%), and difficulties falling pregnant (0%). A Mann–Whitney test indicated that, in comparison to the senior group, younger participants had significantly higher concerns about menopausal symptoms (Mdn = 3 vs. Mdn = 2, $U = 629$, $p = 0.005$), and body appearance issues (Mdn = 1.5 vs. Mdn = 1, $U = 1261$, $p = 0.02$). Participants receiving hormonal treatments (Mdn = 2) had significantly higher concerns than participants not receiving hormonal treatments (Mdn = 1) about arm movement limitations ($U = 683$, $p = 0.002$), weight gain ($U = 1192$, $p = 0.004$), external breast prostheses ($U = 1464$, $p = 0.021$), osteopenia/osteoporosis ($U = 1265$, $p = 0.022$), surgical site ($U = 1415$, $p = 0.025$), lymphoedema ($U = 1461$, $p = 0.036$), and muscle or joints aches/pains ($U = 828$, $p = 0.044$). There were no other significant group differences.

**Table 2** Ten most frequently reported unmet needs (CaSUN)

| Rank | Item | %[a] |
|---|---|---|
| 1 | I need help to manage my concerns about the cancer coming back… | 41.1 |
| 2 | I need help to reduce stress in my life… | 31.6 |
| 3 | I need to know that all my doctors talk to each other to coordinate my care… | 29.9 |
| 4 | I need more accessible hospital parking… | 29.1 |
| 5 | I need information provided in a way that I can understand… | 26.1 |
| 6 | I need an ongoing case manager to whom I can go to find out about services whenever they are needed | 25.8 |
| 7 | I need help to adjust to changes in my quality of life as a result of my cancer… | 25.2 |
| 8 | I need help to manage ongoing side effects and/or complications of treatment… | 24.1 |
| 9 | I need access to complementary and/or alternative therapy services… | 24.1 |
| 10 | I need to feel like I am managing my health together with the medical team… | 23.8 |

[a] Percentage of participants endorsing the item

## Use of survivorship care providers

Figure 2 shows the relative use of the top 10 most frequent survivorship care providers in hospital and community settings.

Members of the cancer support team that were most commonly utilised were family or friends, breast surgeon, medical oncologist, breast care nurse and other cancer survivors. On the other hand, relatively least utilised professions or services were prosthesis/bra fitter (23.2%), occupational therapist (19.4%), radiation oncologist (15.6%), psychologist (12.4%), dietitian (16.3%), telephone helpline (8.6%), and social worker (5.3%). There were no significant group differences in ongoing use of survivorship care providers.

## Satisfaction with current survivorship services

Majority (91.3%) of participants were satisfied or highly satisfied with their overall breast cancer care. Aspects of care rated from highest to lowest on a five-item Likert response scale (1 = Strongly disagree, 5 = Strongly agree) were: clinical area cleanliness ($M = 4.44$, SD = 0.68), respect ($M = 4.42$, SD = 0.76), admission/check-in process ($M = 4.38$, SD = 0.75), safety of personal information ($M = 4.32$, SD = 0.78), care coordination ($M = 4.27$, SD = 0.82), involvement in discussions and decision-making ($M = 4.25$, SD = 0.87), sharing of information ($M = 4.20$, SD = 0.81), ease of travel ($M = 4.20$, SD = 0.90), team consistency ($M = 4.13$, SD = 0.94), inclusion of support persons ($M = 4.01$, SD = 0.90), future care planning ($M = 3.96$, SD = 1.05), and reasonable waiting times ($M = 3.74$, SD = 1.13). No other significant groups were found.

## Survivorship care benchmarks

The most frequent survivorship care benchmarks were: being asked about recent symptoms at each appointment (92.6%), discussions about family history of cancer (89.7%), having at least yearly screening tests (88.7%), awareness of who to contact for help or information (84.8%), regular physical examinations (84.7%), and being asked about smoking and/or offered help to quit (83.1%). This was followed by education about exercise and physical activity (76.6%), healthy body weight (70.3%), signs of cancer recurrence (65.3%), reconstructive or corrective surgery (64.4%), and reminders to continue screening for other cancers (60.2%). Relatively less frequent survivorship care benchmarks were: education on key symptoms to seek medical attention for (57.7%), offer of genetic counselling referral based on family history (51.1%), dietary education (45.9%), and having a written treatment plan or summary (31.4%). There were no significant group differences in survivorship care benchmarks.

## Suggestions on survivorship service development

Fifty-two participants (40%) responded to the open-ended question on suggestions for future service development if budget was unlimited. Most responses involved changes to specific aspects of their current or past treatments, such as having free scans/tests, additional bras, free parking, financial assistance, chemotherapy at home, reduced clinic wait

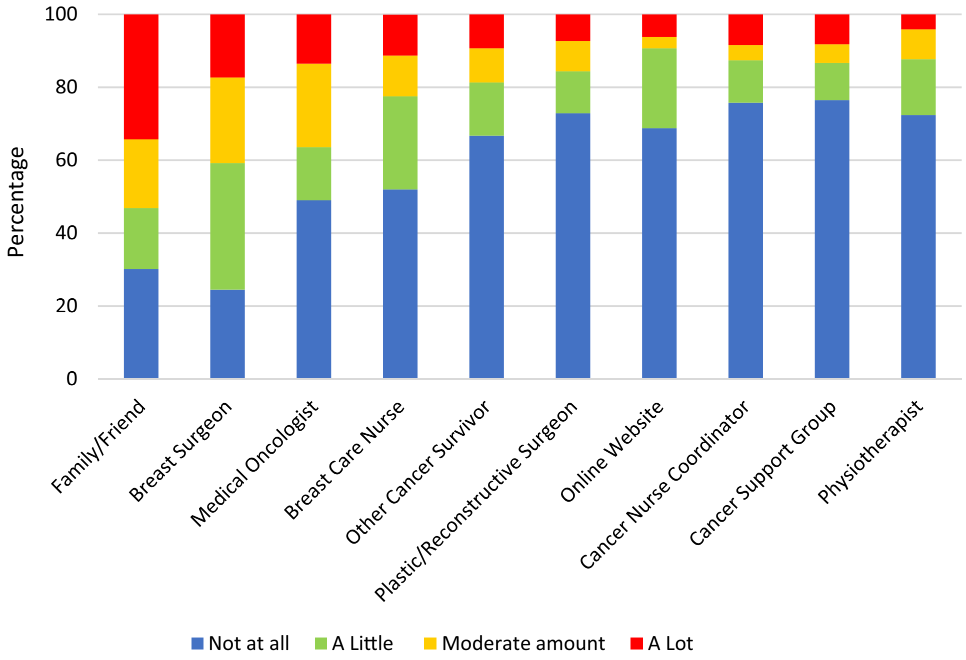

**Fig. 2** Relative usage of the 10 most frequent members of the cancer support team

times, more clinical time during each appointment, and having a "one-stop shop" to access all clinicians. Similarly, participants identified the need for more psychological or counselling support, and more breast cancer nurses and doctors. Nine participants stated they would not change any aspect of their care. The rest of responses included suggestions for improved education in the community and schools, and funding for alternative treatments.

## Discussion

This study explored a wide range of perceptions of 130 breast cancer survivors with regard to their ongoing survivorship issues, unmet needs, care satisfaction and usage, care benchmarks, and service development suggestions. Majority of participants were aged 46–75 years, with an average of three years since diagnosis and two years since completion of primary treatments. Hormonal treatments were offered to 78% of participants, with just over half receiving hormonal treatments at time of participation. This was consistent with the Australasian National Breast Cancer Audit data showing 83% usage of hormonal treatment amongst the 71% of all hormone-positive invasive cancers [25].

There was an average of nearly five unmet needs with two-thirds of participants having at least one unmet need. This finding was somewhat lower compared to similar studies of breast cancer survivors [22, 26, 27], including an Australian study [28] that found that 76.5% of participants had at least one unmet need, with an average of 6.2 unmet needs. Our findings could be explained by high satisfaction with survivorship care, adequate care benchmarks, regular medical and nursing follow-up, and accessing support from family/friends and other cancer survivors. Higher satisfaction with care has previously been associated with more of the survivorship needs being met in this patient population [28].

Fear of cancer recurrence was the most common unmet need, and it occurred consistently across age groups, hormonal treatments, time since diagnosis, and time since completion of primary treatments. This reinforces the need for survivorship care to incorporate regular evaluation of psychological well-being and adjustment to fear of recurrence for all breast cancer survivors. Whilst there is evidence that fear of cancer recurrence is associated with anxiety and depression, further research is required in evaluating best practice models of care that address this key issue [22, 29]. Tools, such as survivorship care plans, can also assist in the management of these unmet needs, as long as they are tailored to the specific needs of each patient [28].

Consistent with hypothesis and prior studies [8, 11], younger participants had more unmet needs overall compared to senior adults, and specifically needs involving stress, adjustment, employment and decision-making. The younger group also had more unmet needs rated as medium or strong, more needs that were met by the service, and were more concerned with menopausal symptoms and body-image issues. As hypothesised, there were significant negative iatrogenic effects of hormonal treatments, including symptom distress and a range of functional issues. These findings emphasise the need account for age and treatment-related differences in evaluating quality of life and survivorship issues. In comparison, there were no group differences on any measures across recencies of diagnosis and completion of primary treatments. Of note is that our study delineated between survivorship issues and unmet needs. The former focused on symptom intensity over the previous month, whereas the latter assessed the extent to which a range of biopsychosocial needs are currently met or unmet. This delineation allowed for more nuanced inferences to be made from the data, given that survivorship needs can be both distressing and appropriately managed by the available internal and external resources.

As expected, family or friends, breast care clinicians and other cancer survivors were the most commonly utilised members of the cancer support team. The utilisation of breast care nurses demonstrates the importance of this role despite no requirement for perioperative cares and completion of the active treatment phase. On the other hand, there was minimal use of other outpatient multidisciplinary care providers including psychology, social work, dietetics and occupational therapy, despite ability to access such services at no cost. This could be due to some participants not being aware of availability or utility of these services, and survivorship issues/needs tools not being implemented as standard practice, thus resulting in fewer such referrals. This study did not distinguish between hospital, community and private providers of these services, so the actual use of hospital-based services attached to the breast clinics may be even lower. Furthermore, majority of participants were also dissatisfied with the lack of a written treatment plan or summary of care, and dietary education provided to them. These factors may help explain the emergence of fear of cancer recurrence as the key survivorship issue and unmet need in this study. This was closely followed by the need for treating teams to consistently and effectively communicate with each other in coordinating care.

Suggestions for service development greatly varied, though most focused on improving the subjective experience of both primary treatments and subsequent survivorship care. This included more coordinated and timely care, practical and financial assistance, and more funds for medical, nursing and counselling services. The feedback of some participants that no changes are required were consistent with generally high satisfaction with survivorship care.

## Strengths and limitations

This was one of the largest breast cancer survivorship studies carried out in Australasia to date. It was conducted within outpatient clinics of a high-volume Breast Service, with a comparatively homogenous sample of breast cancer survivors. It was comprehensive in that survivorship issues were measured separately from ongoing unmet needs, whilst also assessing satisfaction with survivorship care, care benchmarks and use of services and supports. One limitation is that it was conducted within a single health service so results may be difficult to generalise to other settings and tumour streams. Also, the cross-sectional study design provides a snapshot of the survivorship issues and unmet needs, with limited inferences about longitudinal changes in key variables and outcomes. The capture of relatively limited demographics data has precluded more specific analyses of demographic influences of survivorship issues and needs.

## Implications for future research

Future studies need to (a) evaluate outcomes when individualised survivorship care plans are incorporated into standard clinical practice, (b) explore potential access issues to other multidisciplinary care and how this may impact survivorship issues and unmet needs, (c) incorporate additional data from partners or carers given their key supportive roles, (d) continue to delineate between perceived survivorship issues and needs, and (e) conduct longitudinal evaluations of outcomes associated with changes in clinical practice.

# Conclusion

This study makes a valuable contribution to the understanding of key survivorship challenges, concerns, and use and quality of care among breast cancer survivors. Fear of cancer recurrence was the key survivorship issue and unmet need, and multidisciplinary care appeared inconsistent and underutilised. This further emphasises the need for effective communication and coordination of available care and services, even when patients are overall satisfied with survivorship cares. Given the inherent variability in specific survivorship needs and the predicted consistent increase in the number of cancer survivors, it is essential to continue to evaluate and optimise the multidisciplinary survivorship models of care.

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## Compliance with ethical standards

**Conflict of interest** Dean Vuksanovic, Jasotha Sanmugarajah, Dominic Lunn, Raja Sawhney, Kelly Eu, and Rhea Liang declare that they have no conflict of interest. The authors have full control of all primary data, and agree to allow the journal to review this data if requested.

# Appendix A

## Questionnaire items measuring survivorship issue prevalence, service satisfaction, care benchmarks and service usage

### Ongoing survivorship issue prevalence

1. Concerns about the surgical site
2. Worries about how my body looks
3. Trouble with external breast prostheses
4. Trouble with wigs
5. Swelling of the arm (lymphoedema)
6. Heart trouble arising from cancer treatment (cardiotoxicity)
7. Weight gain
8. Trouble thinking or remembering
9. Fatigue
10. Depression or anxiety
11. Fear of the cancer coming back
12. Sleep disturbance
13. Weak or thinning bones (osteopenia or osteoporosis)
14. Ongoing pain at, or near, the surgical site
15. Limitation of arm movement
16. Aching or pain in muscles or joints
17. Difficulty walking or doing daily activities due to pain
18. Neuropathy (numbness or change of sensation)
19. Difficulty walking or doing daily activities due to neuropathy
20. Feeling sexually unattractive
21. Difficulty with personal relationships due to the effects of breast cancer care
22. Menstrual irregularities (irregular or heavy periods, spotting)
23. Difficulty falling pregnant
24. Menopausal symptoms (hot flushes, mood swings)

### Service satisfaction

1. Overall, I am satisfied with my care
2. It is easy to travel to breast cancer services
3. The admission/check-in process is straightforward
4. The waiting times are reasonable

5. The clinical areas are clean and pleasant
6. I am confident that my personal details are kept safe
7. I am treated with respect
8. My care is provided by a consistent team
9. I feel involved in discussions and decision-making
10. Information from the team is shared with me
11. My support persons (eg family, friends) feel included
12. My care is well coordinated
13. I am clear about my future care plan

### Survivorship care benchmarks

1. I am asked about my recent symptoms at every appointment
2. My surgical site and/or other parts of my body are examined at every appointment
3. I have had a discussion about the availability of reconstructive or corrective surgery
4. I undergo screening tests at least once a year
5. I have been educated about what signs I should look for in case my cancer comes back
6. I have had a discussion about my family history of breast cancer
7. I have been offered a referral to genetic counselling based on my family history
8. I am on hormonal therapy and am aware of what symptoms I need to seek medical attention for
9. I have been reminded to continue with routine screening for other cancers (eg. cervical screening for women under age 65, bowel cancer screening for all patients over 50)
10. I have been educated about healthy body weight
11. I have been educated about exercise and physical activity
12. I have been educated about what I should or shouldn't eat
13. I have been asked about smoking and/or offered help to quit
14. I know who to contact if I need any help or information
15. I have a written treatment plan or treatment summary

### Ongoing service usage

1. Breast care nurse
2. Breast surgeon
3. Cancer care coordinator
4. Cancer support group (in person or online)
5. Dietitian
6. Medical oncologist
7. Occupational therapist
8. Online website
9. Other cancer survivor
10. Physiotherapist
11. Plastic/reconstructive surgeon
12. Prosthesis/bra fitter
13. Psychologist
14. Radiation oncologist
15. Social worker
16. Support person (family or friend)
17. Telephone helpline

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