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Oncology social work practice behaviors: a national survey of AOSW members

Elizabeth Y. Perlmutter, DSW[a], **Freida B. Herron, DSW**[a], **Elizabeth A. Rohan, PhD**[b], **Elizabeth Thomas, PhD**[a]

[a]College of Social Work, University of Tennessee, Knoxville, Tennessee, USA

[b]Division of Cancer Prevention and Control, Centers for Disease Control and Prevention, Atlanta, Georgia, USA

Abstract

Purpose: Few studies have examined the practices of U.S. oncology social workers since the implementation of distress screening. This study presents data about oncology social work practice behaviors, including participation in distress screening and interdisciplinary team integration.

Design: Using a cross-sectional survey design, Association of Oncology Social Work (AOSW) members were invited to complete the anonymous web-based survey between June and September 2019.

Sample: AOSW members ($N = 1116$) were invited through email and listserv posts to participate in the survey with 533 (47.8%) responding.

Methods: A quantitative on-line survey was used to investigate demographics, distress screening roles and other practice behaviors. Descriptive analyses were conducted on the data.

Results: Respondents engaged in a range of practice behaviors consistent with the Standards and Scope of Practice published by AOSW, primarily engaging in patient-focused work. They reported viewing their role as integrated with the interdisciplinary team. Respondents were highly involved in distress screening processes, primarily receiving referrals from distress screening but also collecting/reviewing screening results and referring patients to other providers based on those results.

Implications for Psychosocial Providers: Knowledge about the ways that oncology social workers enact their role across settings and locations could be useful to those developing effective and integrated psychosocial oncology programs, especially distress screening protocols. Specific knowledge about the practice behaviors of oncology social workers in the U.S. may also help to delineate the role from the work of other interdisciplinary oncology team members.

CONTACT Elizabeth Y. Perlmutter, DSW perlmutter@bellsouth.net College of Social Work, University of Tennessee, Knoxville, TN 37996, USA.

Disclosure statement

No potential conflict of interest was reported by the authors.

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Keywords

distress screening; interdisciplinary oncology care; oncology social work; practice behaviors

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Oncology social workers have historically performed a wide range of services to support cancer patients from diagnosis through long-term survival.[1,2] Working within frameworks informed by the biopsychosocial model and person-in-environment ecological theory, oncology social workers have supported cancer patients and their families via screening and assessment of cancer-related problems; providing direct individual, family and group psychotherapy related to adjustment to illness; provision of resource referrals and discharge planning services; and advocacy for patient and family needs at the micro and macro levels.[2]

As is well established in the research literature, many cancer patients experience heightened levels of psychosocial distress as a result of their diagnosis, symptoms of illness, difficulties with treatment, and other psychosocial effects of a serious illness.[3] In some patients, psychosocial distress can elevate to levels that meet diagnostic criteria for depression,[4] anxiety,[5] suicidality,[6] and trauma-related disorders such as acute stress disorder and post-traumatic stress disorder (PTSD).[7]

These psychosocial symptoms associated with a cancer diagnosis can negatively impact treatment adherence[8] and outcomes of medical care.[9] Cancer survivors with mental health diagnoses also incur higher health care costs than those without mental health diagnoses,[10] and higher healthcare costs than individuals with mental health diagnoses but without cancer.[10] Psychosocial struggles of cancer survivors with both primary symptoms and difficulty adjusting to post-treatment survivorship can extend years beyond their diagnosis and treatment.[11]

Guidelines and standards

Greater attention to addressing the psychosocial needs of cancer patients began in earnest with the 2008 publication of the Institute of Medicine (IOM; now the National Academy of Science, Engineering, and Medicine) report *Cancer Care for the Whole Patient: Meeting Psychosocial Health Needs.*[12] Cancer centers accredited by the American College of Surgeons Commission on Cancer (CoC) have been mandated to screen cancer patients for psychosocial distress since program guidelines became fully effective in 2015 in an effort to improve the detection and treatment of distress.[13] Additional treatment guidelines related to psychosocial cancer care have been published by the National Comprehensive Cancer Network (NCCN),[14] and American Society of Clinical Oncology (ASCO)[15] for treatment of distress, depression, and anxiety in cancer patients in an effort to improve psychosocial care of oncology patients.

Despite the wide dissemination of the above accreditation standards and clinical guidelines, psychosocial oncology care remains unevenly implemented across cancer centers in the U.S.[16] Implementation of distress screening processes has increased over time, with 86% of NCCN member institutions reporting routine screening for distress in 2018,[17] but consistent provision of assessment, referral, and intervention for identified psychosocial distress by well-trained and qualified mental health practitioners remains a work in progress.[16]

In the United States, social workers are the most common psychosocial care providers in oncology care.[18,19] The Association of Oncology Social Work (AOSW) has published on their website the scope and standards of oncology social work practice.[20,21] These practice standards identify a wide variety of oncology social work practices ranging from providing resource referrals and assistance with finances to individual, family, and group psychotherapy.

Previous surveys of oncology social workers

A previous survey of AOSW members published in 2008[22] examined oncology social workers' self-reported competence in 33 practice topic areas including promoting patient coping skills, addressing end of life issues, facilitating support groups, and alleviating financial distress. The authors also asked respondents to estimate what percentage of their time was spent on various practice behaviors. Participants reported spending an average of 64.2% of their work time in direct practice (broadly defined as psychosocial assessment and counseling interventions, as well as case management and discharge planning duties), 13.7% in administration, 12.0% in patient education, and 6.1% in research activities. While results were informative about oncology social work practice, there are two limitations of this study when applied to a contemporary practice context. First, the survey was conducted in 2005–2006, which preceded the publication of the IOM report *Cancer Care for the Whole Patient* in 2008 and the changes in psychosocial care that subsequently occurred with the introduction of distress screening as a requirement for CoC accreditation. Second, when examining how social workers spend their workday, this survey categorized all direct practice services into one item and was therefore unable to provide a more detailed picture of the ways that social workers practice. These practice details are important in the current climate of psychosocial oncology care, as some studies have identified barriers to the greater integration of psychosocial care as a lack of appropriately trained staff to provide interventions to patients in need.[23–25]

Surveys of oncology social workers have also been conducted outside of the United States. Pockett et al.[26] surveyed oncology social workers in Australia, examining workforce characteristics, involvement in research, and professional development needs. The authors found an experienced workforce who felt well prepared for psychosocial care delivery. Although the health care structure in Australia is different than in the U.S., which limits the generalizability of results to a U.S. oncology social work population, Pockett et al.[26] found that oncology social workers in Australia felt that their skills were not as well utilized or understood by the treatment team as a whole, which could indicate a lack of integration of social workers into medical teams. Integration of psychosocial oncology care with routine medical care has also been challenging in the U.S.[27] despite this being a stated goal of the IOM report.[12] Information about the level of integration of oncology social workers in the U.S. with routine cancer care is lacking in the current literature.

Another survey of oncology social workers was conducted in Sweden.[28] This study also describes an experienced workforce, and respondents reportedly spent most of their time (75%) in direct patient care, primarily assisting patients in adjustment to their illnesses and providing psychotherapy. The social workers surveyed expressed frustration about overlap of their role with other disciplines (particularly nursing) and lack of support for additional training. As with the Australian study,[26] the generalizability of this study is questionable given the large differences in overall health care structure between Sweden and the U.S. However, it raises questions about the distinction of the social work role from other disciplines and the potential need to be more explicit when describing the unique qualities social workers bring to the oncology treatment team.

A greater understanding of what comprises oncology social work direct practice in application in the field is lacking in the current literature. This lack of understanding also extends to the need to better understand the role that oncology social workers play in the distress screening process. Although the CoC has encouraged social workers to be active members of their institution’s cancer committee in the role of Psychosocial Care Coordinator and to participate in the design and implementation of distress screening programs,[13] the standards are vague as to what steps comprise screening for distress. This leaves room for significant variation not only in the timing, choice of screening instrument, and frequency of distress screening, but also the role that different members of the treatment team may play in accomplishing an effective screening program. The role of oncology social workers in delivering distress screening to patients is currently not well understood.

Thus, the literature regarding U.S. oncology social work practices is outdated with respect to more recent advances in cancer program standards such as distress screening. Additionally, these changes may have impacted the workflow of U.S. oncology social workers resulting in changes to the time spent on various practice behaviors in the oncology setting which affects the ways in which psychosocial care is delivered to oncology patients. More recent studies have only been conducted in Australia and Sweden, which do not necessarily describe the experiences of oncology social workers in the U.S. or apply to the needs of patients in the U.S. healthcare system. Therefore, an updated study of the practice behaviors of oncology social workers in the U.S. is needed to inform the development of best social work practices in psychosocial oncology care for U.S. oncology patients.

The current study

The current study aimed to provide more specific detail about the direct practice behaviors of oncology social workers in the U.S. via a survey of AOSW members in current practice. Participants reported information about their role on medical teams and level of perceived integration with the medical treatment team. Additionally, this study updates the literature with regard to the roles that oncology social workers in the U.S. are currently performing in the distress screening process, since the previous survey of AOSW members[22] was conducted prior to the widespread introduction of screening for psychosocial distress and mandates for distress for CoC accreditation.

Methods

With the permission of the AOSW Research Committee, AOSW members were recruited to participate in the survey regarding psychosocial oncology practice behaviors. A 53-item survey was administered online via QuestionPro. All AOSW members who receive electronic communication ($N = 1116$ as of September 2019) were invited to participate in the survey via both an email announcement sent to all AOSW members and a post of the study flyer on the AOSW Social Work Oncology Network (SWON) listserv. Invitations to participate in the survey were sent via email three times from late June 2019 until late September 2019 approximately one month apart, an the study flyer was posted on the SWON listserv twice during that time.

Participants were asked to complete a 53-item questionnaire created by the authors and based on the scope and standards of oncology social work practice published on the AOSW website.[20,21] Participants reported general demographic information including their gender/gender expression, ethnicity, race, highest degree held, licensure status, years of social work and oncology experience, and geographic region of their employer. Respondents then provided information about how their job is categorized in their organization including the type of cancer center where they work (academic, community, NCI designated, etc.), who they consider to be their team, participation in interdisciplinary team meetings, tumor board meetings, and cancer committee meetings. The social worker role in the distress screening process was assessed through participant responses indicating whether patients on their caseload are currently screened for distress and then choosing which tasks they perform from a list of tasks inherent in distress screening, assessment, and referrals. Finally, respondents provided an estimate of the percent of work time over the past month that they spent completing certain practice behaviors, as derived from the AOSW Standards of Practice.[21]

The study, including all study materials, was approved by the University of Tennessee Institutional Review Board. An informed consent statement preceded the survey questions, and participants who clicked on “I agree” following the statement and then continued to the survey questions were viewed as having consented to participate. No identifying information was available to the researchers. Anonymized survey responses were analyzed using SPSS Version 26 software.

Results

Participant demographics

A total of 533 (47.8%) participants responded to the survey. Survey respondents were overwhelmingly female (96.3%), identified as White (89.5%), and reported their highest level of education as a master’s degree in social work (91.5%). Participants reported on average 18.4 years of social work experience ($n = 507$, $SD = 11.0$, range: 0.1–45 years, IQR = 10–27) and 10.9 years of oncology social work experience ($n = 507$, $SD = 9.1$, range: 0.1–42 years, IQR = 4–15). Regarding licensure, 95.6% of respondents reported possessing a state-endorsed license with 75.8% reporting holding an independent clinical or advanced generalist license ($n = 501$, see Table 1).

Organizational and job information

All geographic regions in the U.S. were represented in the sample. When asked if they provided direct social work services, such as case management, resource referrals, psychotherapy/counseling and similar services, to oncology patients, 93.6% replied that they did so (*n* = 499). The majority of respondents (57.3%, *n* = 420) reported that they worked in either a Community Cancer Center (38.3%) or an Academic Medical Center (19.0%). Within these organizations, 73.2% worked in the outpatient setting (*n* = 463). The mean number of social workers reported in each participant's workplace was 7.0 (*n* = 448, *SD* = 10.4) with a range of 1–90 (IQR = 1–9), and participants reported working exclusively with oncology patients 93.0% of their work time on average (*n* = 449, *SD* = 16.7). Respondents reported that they typically see a mean of 28.9 patients per week (*n* = 442, *SD* = 19.0), and this number ranged from 0 to 200 patients per week (IQR = 19.3–35).

Interdisciplinary meeting participation

With regard to measures of integration of oncology social workers with the interdisciplinary team, most participants reported that they primarily considered themselves to be a part of the interdisciplinary medical team (75.1%, *n* = 437) rather than a team of only social workers (15.1%) or other allied health professionals (6.9%). Interdisciplinary team meetings reportedly occurred either daily or weekly for a total of 68.0% of respondents (*n* = 438). Psychosocial issues were reportedly discussed in interdisciplinary team meetings either often (55.9%) or sometimes (39.8%) for a total of 95.7% (*n* = 347) of respondents indicating that psychosocial issues were a part of interdisciplinary care meetings in their workplace. Participants reported attending tumor board meetings either often (*n* = 437, 30.7%) or sometimes (23.1%) for a total of 53.8% reporting at least some attendance, although 43.2% reported that they do not attend tumor board meetings at all. Of those who attended tumor boards (*n* = 235), 12.8% reported that psychosocial issues were discussed routinely in these meetings and 67.2% reported that psychosocial issues were discussed occasionally. Membership in cancer committees was reported by 53.8% of respondents (*n* = 435), and 85.5% of those who were cancer committee members reported that psychosocial issues were discussed at those meetings (*n* = 235).

Distress screening participation

Examination of distress screening participation and practices reveals that 90.4% (*n* = 446) of participants report that their organization is screening patients for distress. Nearly three-quarters of respondents report that they receive referrals based on distress screening results (74.9%). Approximately half of respondents (49.6%) report that they collect and/or review the screening instrument results and 56.1% of participating social workers report providing referrals to others based on information from the screening instrument. Only 2.6% of respondents report that they are not involved in the distress screening process in any way. Full details about distress screening participation can be found in Table 2.

When asked about the percentage of time spent on a range of oncology social work practice behaviors in the past month, participants report spending the most time completing psychosocial assessments (*M* = 15.8%, *SD* = 12.9%) followed by psychotherapy/counseling (*M* = 12.7%, *SD* = 15.0%), providing direct assistance for financial, transportation, lodging or similar needs ($M = 10.5\%$, $SD = 11.4\%$), and community resource referrals ($M = 10.2\%$, $SD = 8.7\%$). Additional detail regarding how participants report engaging in various practice behaviors can be found in Table 3.

Discussion

The current study examined the demographics of oncology social workers in the U.S., the self-perceived integration of oncology social workers within the medical treatment team, and the practices of oncology social workers since the implementation of distress screening mandates. Oncology social workers in the current study were asked to report their practice behaviors in greater detail than in previous surveys of oncology social workers in order to provide a more complete picture of oncology social work in the modern era.

Our respondent sample was an overwhelmingly homogenous sample of White females with master's degrees and clinical or advanced state-endorsed licensure. The racial and ethnic identification of participants in this study are similar to the diversity statistics reported by AOSW on their website where 90.4% of members identified as White in 2016.[29] Responding participants spend the vast majority of their practice time focused on work with oncology patients (93%) rather than being split between different patient populations. This may indicate that social workers who support oncology patients as only a part of their job duties may be less likely to identify as oncology social workers and therefore not pursue membership in AOSW, thus excluding them from this survey. These social workers who work with other populations in addition to oncology patients may have very different practice behaviors than those whose job duties are focused exclusively on the oncology population. Future research examining oncology social work practices should include this part-time population and could compare the practice behaviors of full-time oncology social workers with those who work with oncology patients as well as patients with other medical illnesses.

As compared to the previous survey of AOSW members,[22] the current survey found that AOSW members had a similar amount of oncology social work experience ($M = 10.9$ years in the current survey versus $M = 11$ years in the previous survey). The current survey respondents reported a higher rate of master's-prepared social workers (91.5% vs. 79%) as well as a higher rate of state licensure (95.6% vs. 84%).

Surveyed oncology social workers reported viewing themselves as part of the interdisciplinary medical teams with whom they work rather than part of a team of social workers or other ancillary disciplines. Additionally, they reported a high level of inclusion of psychosocial issues in interdisciplinary treatment team meetings. Both of these results would seem to indicate a more robust integration of psychosocial care with routine cancer care than suggested by the available literature.[16] Participants reported lower rates of participation in tumor board and cancer committee meetings than interdisciplinary team meetings. This is somewhat intuitive given that tumor board meetings are often focused on collaboration of medical providers to resolve medical cases that present unclear treatment paths and may not address issues related to a more holistic view of the patient. Additionally, cancer committees may limit the membership of individual disciplines so that there is broad interdisciplinary representation, which could limit the number of social workers participating in cancer committee meetings. Nonetheless, the moderate to high levels of reported social worker participation in these meetings and commonplace discussion of psychosocial issues on the agendas is encouraging in a highly medicalized field where psychosocial care has struggled to be recognized as important to routine cancer care. More research examining indicators of integration of psychosocial care in oncology settings is needed to further explore the trends suggested by these preliminary data.

With regard to general practice behaviors, the current survey aimed to increase the granularity of knowledge about how oncology social workers are practicing in their role. Thus, while the previous survey [22] reported that 64.2% of participants' time was spent in direct services (including psychosocial assessment, counseling, case management, and discharge planning), the current survey asked respondents about a more detailed list of practice behaviors involved in direct practice. However, grouping together the average time spent engaging in psychosocial assessment, treatment planning, psychotherapy/counseling, support group facilitation, patient navigation, discharge planning, advance directive/end of life services, resource referrals and direct assistance for transportation, lodging, and financial needs results in a total of 72.1% for direct practice activities, an increase of 7.9% in time spent on direct practice activities. This total does not include distress screening activities, which were not a routine part of oncology social work practice at the time of the previous survey. If we include distress screening as a direct practice behavior since it is primarily focused on identifying unmet patient psychosocial needs, the total time that AOSW members are spending in direct practice increases to 81.6% which is a marked increase in patient-focused work over the previous report. By contrast, the amount of time that AOSW members report spending in other activities has decreased from the findings of the previous survey, notably administration (5.5%, down from 13.7%) clinical supervision (1.5%, down from 5.4%) patient education (6.4%, down from 12.0%) and research (.8%, down from 6.1%). Thus, there appears to have been a shift in oncology social work practice behaviors among those participants who provide at least some direct practice toward more patient-centered activities and away from activities directed at social workers themselves (i.e., administration, clinical supervision, and research).

These findings are similar to a recently published study examining a newly developed instrument for analyzing the work behaviors of oncology social workers. Oktay et al.[30] developed the Oncology Social Work Intervention Index (OSWii) to facilitate research into the role of oncology social workers. Developed from data collected in a previous study of distress screening processes[31] along with feedback from volunteer oncology social workers, the OSWii identifies five categories of oncology social work intervention ranging from no direct contact with patients or family members (Category 1) to social worker contact with patients but providing no clinical services (Category 2), education and/or resource referrals (Category 3), counseling/emotional support (Category 4) and a combination of both clinical intervention types (Category 5). The pilot study of the OSWii found that 73% of cases involved a Category 3, 4, or 5 response from the social worker, which is similar to the 72.1% of time that the respondents of our study estimated that they spent on direct practice activities. The OSWii could be an important tool in aiding future research efforts seeking to better understand the direct practice work of oncology social workers across different organizational types, geographical locations, and cancer types served. However, because the OSWii does not address non-direct practice work such as administrative duties, clinical supervision, community outreach, or research participation, these important functions of oncology social workers will still need to be captured in other ways in order to provide a complete picture of the multifaceted role of oncology social workers.

Most respondents reported participating in the patient distress screening process in some capacity at their institution. For approximately three-quarters of participants, distress screening results are driving referrals to social workers and just over half of social workers are making referrals to other disciplines due to the distress screening results. This would seem to indicate that patient psychosocial needs are being identified and addressed as a result of the distress screening process. However, it is difficult to say with the data available here if this represents a change in the rate of referrals from the time prior to the implementation of distress screening due to the cross-sectional study design. Additionally, only about a third of respondents report communicating distress screening results back to the medical team. It is unclear if this means that the medical team is not being informed of distress screening results or if other staff members are completing this task. Additionally, the method of communication of screening results (e.g., verbally, electronic medical record, etc.) is not addressed by the current survey but knowledge of these processes could also provide additional clarity about interdisciplinary communication regarding patient distress.

Recommendations for future research

This study focused on oncology social workers' reported practice behaviors but did not examine any further detail about the ways in which they engage in these practices. For example, with regard to support group facilitation, perhaps there are differences between different organizational types with regard to frequency of support groups, focus of support groups, or participation and discipline of any co-facilitators. Another possible area of investigation would be the ways that oncology social workers engage in psychotherapy and counseling. Who do they provide counseling services to, using what treatment modalities, and are they billing for some or all of these services? Future research might examine these more nuanced practice behaviors to determine if there are differences in the ways in which practices are being employed. Additionally, future research exploring distress screening participation by team members from multiple disciplines could be helpful to continue to illuminate the ways that distress screening standards have been implemented at different institutions and the factors that influence screening implementation.

Limitations of the current study

Restricting the population sample to only AOSW members may be a limitation of the current study. As previously stated, the sample was overwhelmingly homogenous and was primarily White, female, and master's prepared. Social workers who choose to become members of AOSW may be fundamentally different from the larger population of social workers who work with oncology patients or in oncological settings.

The cross-sectional study design is also a limitation, as it provides only a snapshot of oncology social worker behaviors rather than examining ways that workers practice over a greater period of time. Participants were asked to report on the amount of time that they engaged in different practice behaviors in the past month, which may have been unusual in some way.

Additionally, participants were asked to estimate a percentage of time spent on a list of practice activities in the past month and personal biases or differences in memory could have impacted participant responses. While this is an imprecise method of quantifying time spent in practice activities, it was a similar technique to that used in the previous U.S. survey [22] and allowed for some comparison between data reported by Zebrack et al. and the current study.

Conclusion

This study shows that oncology social workers are generally focused on direct practice with oncology patients including psychosocial assessment, resource referrals, end of life conversations, psychotherapy/counseling, and helping patients with direct assistance for transportation, lodging, and other practical needs. Participants reported less time spent on administrative, supervisory, and research tasks than they have in the past. Oncology social workers are actively engaged in facilitating the distress screening process at their institutions and are largely receiving referrals based on screening results as well as referring patients to other services. Perhaps most encouraging is that oncology social workers seem to view themselves as integrated within the interdisciplinary treatment team and report that psychosocial issues are a part of the discussions related to patient care and program development in their institutions. The current study offers a foundation of knowledge about oncology social work practice after the implementation of distress screening processes, and this may serve to stimulate further research about the ways that psychosocial oncology care is delivered. Future research examining more detailed information about the ways in which oncology social workers are delivering these direct services would be helpful as we continue to seek increased consistency within the oncology social worker role across different regions and organizational types to further distinguish the oncology social worker role from the roles of other disciplines on the treatment team.

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Table 1.

Sample characteristics.

	n (%)
Gender (*n* = 520)	
Female	501 (96.3)
Male/Trans Male	19 (3.7)
Race (*n* = 533)	
Asian	13 (2.4)
Black or African American	18 (3.4)
White	477 (89.5)
Other	16 (3.0)
Ethnicity – Hispanic Origin (*n* = 519)	
Yes	27 (5.1)
Education level (*n* = 519)	
BSW	11 (2.1)
MSW or MSSW	475 (91.5)
MA or MS	14 (2.7)
DSW/PhD in Social Work or another field	19 (3.6)
State license (*n* = 501)	
Independent Clinical or Adv. Generalist	380 (75.8)
Entry Level Master’s License	89 (17.8)
Bachelor’s Level License	10 (2.0)
No State License	22 (4.4)

Table 2.

Respondents participating in steps of distress screening process (n = 462).

Distress Screening Step	*n* Participating (%)
Identifying patients to be screened	112 (24.2)
Providing the screening instrument to patients	95 (20.6)
Collecting/reviewing the screening instrument results	229 (49.6)
Communicating screening results to the medical team	167 (36.1)
Receiving referrals based on screening results	346 (74.9)
Providing referrals to others based on screening results	259 (56.1)
I am not involved in the distress screening process	12 (2.6)

Table 3.

Estimated percentage of time spent on practice behaviors (n = 377).

Practice Behavior	Mean	Median	Std. Deviation
Psychosocial Assessment	15.8	15.0	12.9
Psychotherapy/Counseling	12.7	10.0	15.0
Direct Assistance	10.5	10.0	11.4
Resource Referrals	10.2	10.0	8.7
Distress Screening	9.5	5.0	11.2
Advanced Directives/EOL	7.4	5.0	7.1
Patient Education	6.4	5.0	9.3
Patient Navigation	5.6	1.0	8.6
Administration	5.5	0.0	11.0
Treatment Planning	4.8	0.0	7.2
Support Groups	4.6	2.0	8.5
Advocacy	3.8	3.0	4.5
Discharge Planning	1.6	0.0	6.5
Clinical Supervision	1.5	0.0	3.9
Outreach to Vulnerable Populations	0.9	0.0	2.6
Research	0.8	0.0	4.2