

Implementing Screening for Distress: The Joint Position Statement From the American Psychosocial Oncology Society, Association of Oncology Social Work, and Oncology Nursing Society

In 2015, the American College of Surgeons (ACoS) Commission on Cancer (CoC) will require cancer centers to implement screening programs for psychosocial distress as a new criterion for accreditation.¹ Distress, an indicator of suffering and predictor of poor health and quality of life outcomes throughout the disease trajectory, is common and treatable.²⁻¹⁰ Emerging research suggests that screening for and addressing distress not only enhances quality of life but may also be associated with improved cancer outcomes.¹¹⁻¹³ Unfortunately, distress often goes unrecognized in oncology care, necessitating the development of systematic methods for its identification and management.^{14,15} Our organizations wholly endorse the new CoC standard 3.2 on psychosocial distress screening and recognize that it will help address unmet psychosocial needs and improve “cancer care for the whole patient.”¹⁶ While the CoC standard articulates basic components and processes that must be included in the implementation of screening, there remain some key issues that we believe are critical to quality patient care. This statement summarizes our position on these issues.

- It is imperative that CoC-accredited programs adopt a universal definition of distress. We concur with the National Comprehensive Cancer Network (NCCN) definition of distress as an “unpleasant emotional experience of a psychological (cognitive, behavioral, emotional), social, and/or spiritual nature that may interfere with the ability to cope effectively with cancer, its physical symptoms, and its treatment.”¹⁷
- A variety of tools exist for distress screening,¹⁸ and programs should select and use validated instruments, following published threshold values and ranges to identify distressed patients.
- Given that distress has multiple dimensions, instruments should screen broadly and not focus solely on one particular symptom.
- Distress can occur at multiple time points from a cancer diagnosis onward and may go unrecognized if screening is conducted at only one time.
- Processes need to be established for the results of every screen to be communicated to and reviewed by the patient’s treatment team in a timely manner. Similar to measuring vital signs, a medical assistant could administer a screening instrument, but clinicians trained in distress screening must interpret the results.
- If the score exceeds the distress threshold, a trained clinician should differentiate the cause of distress (i.e., depression, lack of transportation, shortness of breath, etc.) and ensure that an assessment by or referral to an appropriate qualified clinician is completed. Programs should follow the NCCN guidelines for the management of distress.¹⁷
- Referrals for the assessment and management of distress should be considered part of a patient’s routine medical care, and presented to the patient as such. Because the risk of suicide is elevated in individuals with cancer, patients whose screens suggest suicide risk should be asked about suicidal ideation as part of their clinical evaluation.¹⁹⁻²¹
- The required psychosocial representative on the cancer committee who oversees the screening program should have training in the identification and management of distress in patients with cancer. Programs without such a person should consider educating a current staff member. On-line

training opportunities are available through APOS (www.apos-society.org) and ONS (www.ons.org/CourseDetail.aspx?course_id=87 and www.ons.org/Research/PEP/). In the event that a cancer program does not have licensed mental health professionals on staff, we strongly encourage contracting with a professional psychosocial oncology expert or qualified community organization for referral and follow-up.

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Approved by the AOSW Board of Directors, 6/2013.
Approved by the APOS Board of Directors, 6/2013.



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