

Distress Screening in Patients with Cancer (United States)

What We Know

- › Standards of care set by the American College of Surgeons (ACoS) Commission on Cancer mandate that all patients with cancer be screened for distress^(10,14,16,20,24)
 - The standards require that a psychologist, social worker, or other mental health professional oversee the distress screening process at each institution⁽²⁴⁾
 - This mandate ties facility accreditation to the successful implementation of distress screening protocols⁽²⁴⁾
 - Guidelines recommend that a patient be screened a minimum of one time at what is determined to be a pivotal medical visit. This may be an initial appointment with an oncologist, a post-surgical visit, or the first visit after starting chemotherapy, for example. The distress screening results should not be mailed or phoned in by the patient but discussed in person⁽¹⁰⁾
 - The ACoS does not recommend that cancer centers implement a screening program if they do not have a plan in place to review results and manage patients whose scores indicate a clinical level of distress⁽¹⁶⁾
- › The National Comprehensive Cancer Network proposed the use of the term “distress” when referring to the psychosocial, spiritual, and existential concerns and interpersonal challenges faced by patients with cancer that may interfere with their ability to cope effectively with the cancer, its physical symptoms, and its treatment^(8,15,18,20)
 - Use of the term distress was found to be more acceptable than more emotion-laden terms for patients with cancer, who were reluctant to be labeled with a psychological problem⁽⁸⁾
 - Use of the term distress removes barriers for patients with cancer who may be reluctant to ask for help and opens up dialogue on psychosocial concerns between the patient and members of the treatment team⁽⁸⁾
 - Distress may include normal feelings of vulnerability and fear related to the cancer diagnosis or may extend to more severe problems such as depression, anxiety, isolation, and spiritual crisis⁽⁹⁾
- › Many healthcare providers refer to distress as the sixth vital sign alongside pulse, temperature, respiration rate, blood pressure, and pain, which along with the others should be assessed at every appointment^(2,6)
- › Persons with cancer often experience high levels of psychosocial distress. Members of racial minority groups experience higher levels of distress than their White counterparts and have lower rates of access to follow-up treatment^(4,9,11)
 - In a 12-week study of newly admitted patients to an oncology ward investigators found that 51% of patients screened reported high levels of distress, 47% of whom had not received psychosocial support prior to the screening⁽¹¹⁾
 - Nearly two thirds of patients with cancer in inpatient settings report clinically significant levels of psychosocial distress⁽⁴⁾

ICD-9
V62.89

ICD-10
Z73.3

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- Racial minority patients with cancer report a lower overall quality of life when compared to cancer patients who are White⁽²⁾
- › Distress levels can be influenced by physical and practical concerns⁽²⁰⁾
 - Significantly distressed patients across all ethnic groups report higher numbers of physical problems such as fatigue and pain, as well as practical concerns such as family problems and finances, indicating that psychosocial distress may be caused by a wide range of factors^(4,11,20)
- › Routine distress screening using a standardized tool can improve overall cancer care as well as maximize healthcare resources^(11,18)
 - Routine distress screening significantly increases referrals to psychological and social work support services⁽¹¹⁾
 - Healthcare professionals often underestimate psychological distress in their patients and either do not utilize screening tools or use them without providing any follow-up for positive results⁽²⁾
 - Use of distress screening tools, when accompanied by appropriate follow-up, results in lower levels of depression, a decrease in reports of physical symptoms, increased patient satisfaction with the healthcare system, and patient perception of greater emotional support from medical providers⁽⁹⁾
- › In a national survey of members of the Association of Oncology Social Workers, 77% of respondents reported that they screen for psychosocial distress and 54% reported using a screening tool. The majority felt competent in screening patients for distress and reported that they found screening beneficial. Social workers who found screening beneficial and perceived fewer institutional barriers to screening were more likely to screen patients for distress⁽¹⁾
- › Barriers to screening include lack of funding for both screening and treatment of patient psychosocial needs, poor reimbursement rates, a lack of knowledge by service providers about the availability of screening tools, lack of belief in the usefulness of screening, and concerns about increasing the number of referrals to already overburdened social and psychological service providers^(3,13,14,15)
 - Even when healthcare professionals feel that screening is important, there may be confusion over roles and responsibilities: when managing distress is a responsibility shared by multiple disciplines, members of the care team may assume that other team members are addressing the patient's needs⁽¹⁵⁾
- › Screening tools should be brief, standardized, easily integrated into the clinical setting, and address three domains of distress: psychosocial, physical, and practical^(14,20)
 - The Hospital Anxiety and Depression Scale (HADS) is a short, 14-item self-report which takes between 2 and 5 minutes to complete⁽¹⁸⁾
 - The HADS can be scored quickly, making it immediately usable in clinical settings⁽¹⁸⁾
 - The HADS is available in 15 languages, making it suitable for patients from a large range of linguistic backgrounds⁽⁹⁾
 - The HADS is expensive to purchase, making it potentially unsuitable for some clinical settings⁽¹⁸⁾
 - The HADS addresses only depression and anxiety, not the domains of physical or practical problems⁽²⁰⁾
 - The Brief Symptom Inventory-18 (BSI-18) is a short, 18-item self-report which takes approximately 2 minutes to complete
 - The BSI-18 can be administered manually or electronically⁽¹⁸⁾
 - The BSI-18 is complicated to score, making it unavailable for immediate use in a clinical setting⁽¹⁸⁾
 - The BSI-18 is available in English and Spanish⁽¹⁸⁾
 - The BSI-18 includes measures for somatization, depression, and anxiety⁽¹⁸⁾
 - The BSI-18 is expensive, making it inaccessible for some clinical settings⁽¹⁸⁾
 - The Distress Thermometer (DT) is a single-item self-report instrument that measures a patient's distress over the past week^(8,18)
 - It is often accompanied by a Problem Checklist designed to identify the source of the patient's distress and facilitate referral to the appropriate follow-up assessment professional⁽⁸⁾
 - Results are available for immediate clinical use⁽¹⁸⁾
 - Limited resources are needed to score the tool⁽¹⁸⁾
 - It is available at no cost, making it accessible for most clinical settings⁽¹⁸⁾

- It has been adapted for use across multiple cultures and languages and is visual in nature, thus making it accessible for low-literacy patients⁽¹⁸⁾
- The Distress Thermometer, when accompanied by the Problem Checklist, accurately screens for all three distress domains: psychosocial, physical, and practical⁽²⁰⁾
- The Emotions Thermometer (ET) is a patient-rated scale that is an adapted version of the DT⁽¹⁹⁾
 - The ET was designed to address areas of anxiety and depression that the DT may not detect
 - It consists of four scales that assess emotional upset (distress, anxiety, depression, and anger) and three outcome domains (burden, duration, and need for help)
- The Edmonton Symptom Assessment System (ESAS) screens for nine common symptoms experienced by patients with cancer⁽²³⁾
 - The ESAS has been found to be accurate for individuals across the cancer treatment spectrum, from initial diagnosis to remission⁽²⁰⁾
 - The ESAS screens for psychosocial and physical concerns, but not practical concerns⁽²⁰⁾
 - It is free and available in multiple languages, making it practical for use in most clinical settings⁽²⁰⁾
- The CancerSupportSource (CSS) is a distress screening program developed for outpatient cancer care centers and oncology practices to assist in screening patients for distress while also providing referrals and links to resources. The program uses the CSS-25 screening tool⁽¹²⁾
 - This tool has 25 items covering physical, psychological, and practical areas of distress as well as a 4-item depression scale
 - The greatest discriminatory value has been found on the items related to changes or disruptions in the workplace, school, or home; feelings of sadness or depression; fatigue and inability to complete necessary activities and desired activities; concerns about the future; and feelings of fear and anxiety
- The European Organisation for Research and Treatment of Cancer has developed a quality of life questionnaire, the EORTC QLQ-C30⁽⁵⁾
 - The screening tool is available in 81 languages and has been extensively validated
 - It can be supplemented with specific modules for symptoms related to specific cancer diagnoses
- › Screening alone is not sufficient to identify distress in cancer patients. Screening should be followed up with more comprehensive assessment with an appropriate professional and links to services and/or referrals when needed^(7,13,18,20)
- In a study, patients hospitalized with breast or gynecological cancer were screened with the DT tool. Any patient who scored above the cut-off score on the DT, who self-referred, or who was referred by staff for support received psycho-oncological counseling at the bedside⁽⁷⁾
 - Most of the patients were referred to counseling via the distress screening tool. Only 3.2% self-referred. For those patients who received counseling, 65.8% shared that they felt there was a significant benefit from the mental health support. In contrast, of the patients who did not receive counseling, only 5.6% indicated to the researchers that they thought there would have been a benefit from the counseling⁽⁷⁾

What We Can Do

- › Learn about distress screening so you can accurately assess your client's personal characteristics and mental health education needs; share this information with your colleagues
- › Develop an awareness of your own cultural values, beliefs, and biases and develop knowledge about the histories, traditions, and values of your clients. Adopt treatment methodologies that reflect the cultural needs of the client^(17,21,22)
- › Advocate for increased Medicaid and private insurance reimbursement for both distress screening and follow-up psychosocial services for patients with cancer⁽¹⁴⁾
- › Become knowledgeable about established guidelines for distress screening
- › Establish clear protocols on how and when distress screenings are to be administered in your facility or agency
 - Determine who is responsible for the screening process, which screening tools are to be used, at what points in treatment they are to be used, and how results of the screenings are to be followed up. Communicate these protocols to staff^(11,14,18,20)
- › Investigate the ethnic and cultural backgrounds of your clients and provide access to culturally sensitive distress screenings⁽⁹⁾

- Identify and use tools validated for use with the patient's cultural or ethnic group if available⁽⁹⁾
 - Select linguistically appropriate screening tools⁽⁹⁾
- › Utilize a two-phase screening process in which a short, standardized screening tool is used to identify initial levels of distress, followed by a more comprehensive screening of diagnostic concerns⁽¹¹⁾
- › Offer a continuum of care of supportive programs to accommodate the variety and severity of client needs identified in the distress screening⁽¹⁸⁾
- Implement psychoeducation programs, crisis intervention, and support groups, as well as short- and long-term psychotherapy, into your service system⁽¹⁸⁾
 - Address physical and practical concerns of patients as well as psychosocial concerns

Note

Recent review of the literature has found no updated research evidence on this topic since previous publication on January 8, 2016

Coding Matrix

References are rated using the following codes, listed in order of strength:

M Published meta-analysis	RV Published review of the literature	PP Policies, procedures, protocols
SR Published systematic or integrative literature review	RU Published research utilization report	X Practice exemplars, stories, opinions
RCT Published research (randomized controlled trial)	QI Published quality improvement report	GI General or background information/texts/reports
R Published research (not randomized controlled trial)	L Legislation	U Unpublished research, reviews, poster presentations or other such materials
C Case histories, case studies	PGR Published government report	CP Conference proceedings, abstracts, presentation
G Published guidelines	PFR Published funded report	

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