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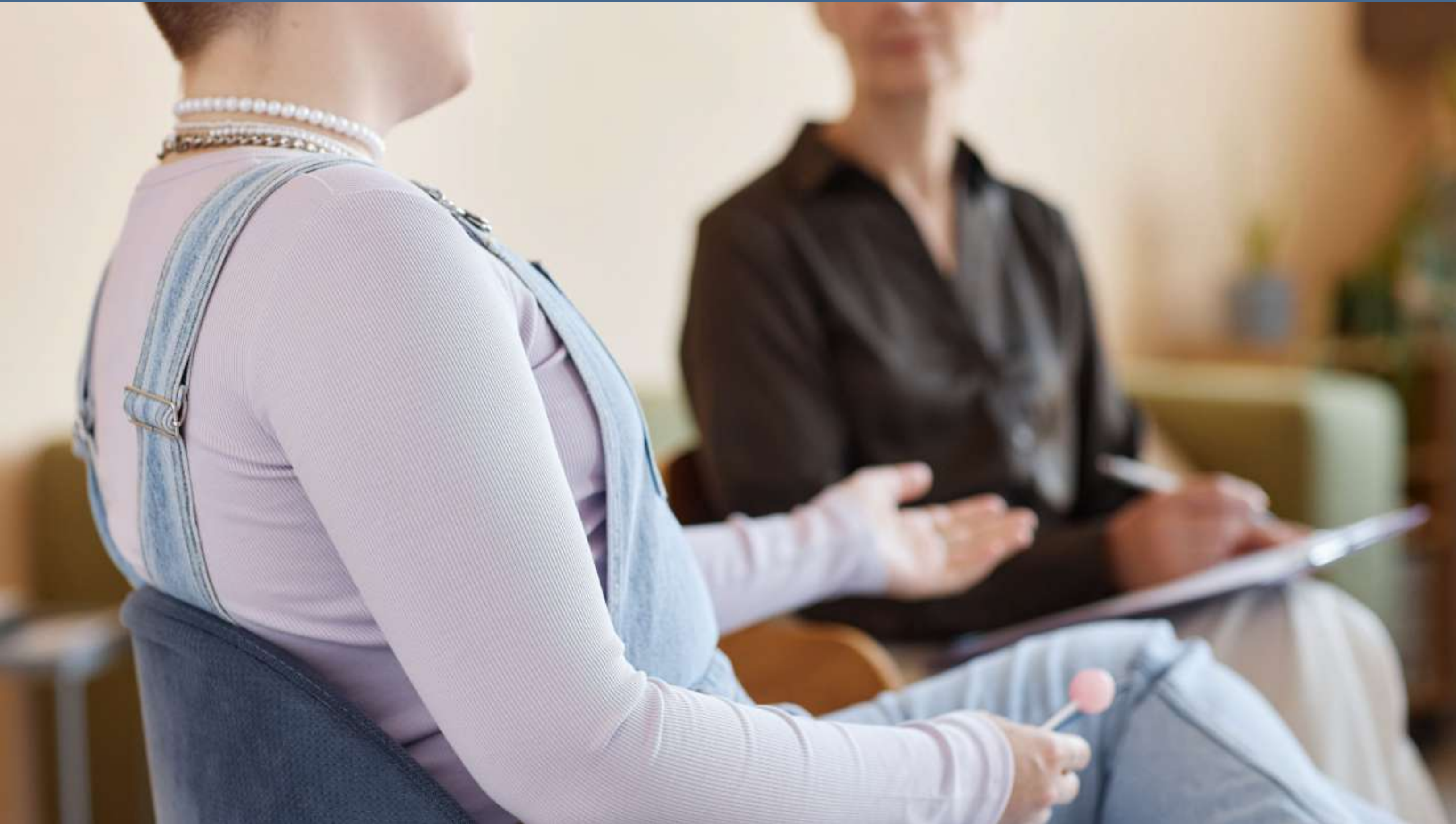
Clinical Assessment in Oncology Social Work



Section 1: Introduction

References: 1, 3, 11, 17, 20, 23, 24, 62, 90, 93

According to the U.S. Centers for Disease Control and Prevention (CDC) (2025b), more than 1.8 million people were diagnosed with cancer in the U.S., and over 610,000 people died from the disease in 2022 (the most recent data available). Since 2022, estimates in the annual American Cancer Society’s Cancer Facts and Figures reports show a steady increase in the number of people who will be diagnosed with cancer. This number was expected to exceed 2 million for the first time in U.S. history in 2024, and it remained at a similar level in the 2025 report. The increase in these numbers is attributed to the ongoing population growth, including among older adults (American Cancer Society, 2025; Collins, 2024).

The American Cancer Society also publishes a "Facts and Figures" report focusing solely on cancer treatment and survivorship. The most recent version of this report estimated that there are over 18 million cancer survivors in the U.S. as of January 2025, which means that about 1 out of every 18 Americans has a history of cancer. The number of cancer survivors is expected to exceed 22 million people by 2035. The increase in cancer survivors is also attributed to a growing and aging population, as well as advances in cancer screenings and treatments that have improved survival (Wagle et al., 2025).

In addition to the number of people who have been diagnosed with cancer, there are caregivers, family members, friends, neighbors, co-workers, and other people who are impacted by the disease because they are connected to the person living with the diagnosis. Though data was not found on the number of people affected by a cancer diagnosis, there is some data on informal cancer caregivers. Estimates from the National Alliance for Caregiving and the National Cancer Institute (as cited in Applebaum, 2018) indicate that the number of people caring for individuals with cancer in the U.S. ranges from approximately 3 million to over 6 million people. Considering these numbers, there are millions of people in the U.S. who are not only diagnosed with cancer but are caring for them and are a part of their support system.

Not only is cancer impacting a significant number of people in the U.S., but it can also change many areas of an individual's life. People living with the disease and their loved ones often face many challenges in both the short and long term. There can be physical issues from the cancer itself and side effects from the treatments, both of which may change a person's ability to function day to day. Physical problems can include pain, neuropathy, fatigue, weakness, nausea, lymphedema, and cognitive issues (Cleveland Clinic, 2024). These physical issues can increase an individual's care needs, in turn placing greater responsibility on a caregiver. Psychosocial concerns are also prevalent, which are defined by the National Cancer Institute (n.d.), encompassing the "mental, emotional, social, and spiritual effects of a disease" (para. 1). Psychosocial problems can include anxiety, depression, changes in relationships and roles, financial stressors, and existential distress (Adler & Page, 2017). Both patients and their loved ones typically have their own psychosocial experience of cancer, making these concerns a considerable part of their lives as well.

To focus more on psychosocial issues, studies have shown that about half to two-thirds of cancer patients experience considerable psychosocial distress during the course of their illness (Zingler et al., 2025). The National Cancer Institute (2025) defines psychosocial distress as:

> *"A multifactorial unpleasant experience of a psychological (i.e., cognitive, behavioral, emotional), social, spiritual, and/or physical nature that may interfere with one's ability to cope effectively with cancer, its physical symptoms, and its treatment. Distress extends along a continuum, ranging from common normal feelings of vulnerability, sadness, and fears to*

> *problems that can become disabling, such as depression, anxiety, panic, social isolation, and existential and spiritual crisis"* (para. 9).

As noted in the definition, psychosocial distress is a normal response to a cancer diagnosis. Patients often experience distress at specific time points throughout the disease trajectory. First, they frequently have distress around the time of their diagnosis, but as time goes on, they typically adapt and find a new equilibrium as they adjust to living with cancer (Caba et al., 2024). However, some people experience distress throughout their treatment.

There can be differences in distress for people who are living with metastatic disease and those who are not. According to Caba et al. (2024), patients who are in the survivorship phase of their illness may experience distress again after treatment. During this time, people typically try to cope with the fear of recurrence and a sense of lack of control. They are also trying to figure out who they are now and what they want their future to look like. If a recurrence occurs, patients may experience distress again and make attempts to adapt to living with the illness once more (Caba et al., 2024).

Patients living with metastatic cancer may also experience distress at the time of their diagnosis, throughout treatment, at times of disease progression, and when they have transitioned to solely receiving palliative or hospice care. As the definition notes, psychosocial distress can intensify and develop into a mental health condition, such as anxiety or depression, or cause people to feel that they are in crisis at different times in their illness.

With the increasing number of people impacted by cancer and the prevalence of cancer-related distress, oncology social workers continue to be an essential part of cancer care in assessing and addressing the psychosocial needs of patients and their loved ones. Since assessing psychosocial issues throughout the disease trajectory is a critical skill for oncology social workers, this course will build on the one titled “Assessing Psychosocial Needs in Oncology” and review additional core competencies of clinical assessment, including the following:

- Conducting an assessment of a patient’s risk of substance use, as well as suicidal and homicidal thoughts and behaviors, and referring to appropriate services, as well as creating safety plans as necessary.
- Evaluating a patient’s decision-making capacity in collaboration with the healthcare team.
- Assessing ethical/moral dilemmas within patient care and advocating within the medical team.
- Identifying and promoting communication strategies for patients, caregivers, and family members, including talking with children about cancer, talking to a child with cancer about their disease, and talking to siblings of a child with cancer about cancer.
- Knowing processes for and being able to document clinical encounters properly.

Section 1 Key Terms

Informal caregiver - “any relative, partner, friend, or neighbor who has a significant personal relationship with, and provides a broad range of assistance for, an older person or an adult with a chronic or disabling condition. These individuals may be primary or secondary caregivers and live with, or separately from, the person receiving care” (Family Caregiver Alliance, n.d., para. 6).

Psychosocial distress - an unpleasant experience of psychological (i.e., cognitive, behavioral, emotional), social, spiritual, and/or physical issues that can impact a person’s ability to cope with different aspects of a cancer diagnosis. Distress extends throughout the continuum of care, from initial diagnosis to survivorship or end-of-life, encompassing a range of common feelings to problems that can become disabling (National Cancer Institute, 2025).

Section 1 Reflection Question

What types of patient and caregiver issues do you see most commonly in your practice?

Section 2: Substance Use Risk Assessment and Referral

References: 10, 14, 40, 48, 51, 52, 57, 67, 68, 69, 70, 72, 73, 76, 82, 86, 92, 93

A substance use disorder is a complex condition. The American Psychological Association (2023) defines it as “a cluster of physiological, behavioral, and cognitive symptoms associated with the continued use of substances despite substance-related problems, distress, and/or impairment” (para. 1). Substances include several classes of drugs, from caffeine, tobacco, and alcohol to stimulants and hallucinogens.

People who have been diagnosed with cancer are not immune to substance use disorders (McNally & Sica, 2021). McNally and Sica (2021) state, “patients with current or past substance use disorders may develop cancer, and a substance use disorder may also develop during cancer treatment” (p. 740). According to Jones et al. (2024), “people diagnosed with cancer may use substances, including prescription opioids, to cope with cancer-related distress, which in some cases may lead to a substance use disorder” (p. 384). Substance use may have begun before the diagnosis or started after it. If a patient was already using substances before their diagnosis, the added stress from it can lead to increased or worsening abuse (Nicholas, 2016).

Data on the prevalence of substance use in cancer patients varies. One study found that 2% to 35% of cancer patients reported substance use, with about 18% of patients using opioids and about 25% of patients using alcohol, on average (Yusufov, 2019). Another study that used data from the National Survey on Drug Use and Health found that about 4% of cancer survivors had an active substance use disorder. It was most prevalent in people diagnosed with head and neck cancer, esophageal and gastric cancer, cervical cancer, and melanoma. Alcohol was found to be the most common substance used in head and neck cancer, cervical cancer, and melanoma. Cannabis use disorder was most prevalent among people diagnosed with esophageal and gastric cancers (Jones et al., 2024).

Oftentimes, it is difficult for the patient and their oncology team to complete a treatment plan if the substance use is not being addressed simultaneously. For example, certain medications (opioids) and procedures (surgery), administering chemotherapy, or receiving a bone marrow transplant, may be contraindicated if certain substances are being used. As another example, using substances can impact treatment adherence or cause treatment delays, leading to disease progression, increased symptoms, and possibly death (Yusufov, 2019). Therefore, having knowledge of substance use, screening for it, and conducting a clinical assessment are essential for an oncology social worker to make appropriate recommendations and referrals that support a patient. All of these topics are discussed in this section.

Risk Factors for Substance Use Disorders

Certain risk factors are linked to substance use disorders. Of note, mental health conditions often co-occur with a substance use disorder. In the general population, about 30% to 75% of people who have substance use disorders also have a mental health condition, such as anxiety, depression, or post-traumatic stress disorder (Prevention Network, n.d.). A similar trend exists in cancer patients, as McNally and Sica (2021) state, “patients with cancer and substance use disorders often have mental illness, and substances may be used in response to psychological distress” (p. 742). As noted above, a range of 2% to 35% of cancer patients report substance use (Yusufov, 2019). Distress and mental health conditions are also prevalent in cancer patients. About two-thirds of cancer patients experience distress, approximately 30% of cancer patients have symptoms of anxiety, and about 25% of patients experience symptoms of depression (Naser et al., 2021, as cited in Caba et al., 2024; Zingler et al., 2025).

In addition to distress and mental health conditions, risk factors for substance use disorders that could be related to the experience of living with cancer include:

- Difficulty controlling emotions
- Lack of coping or problem-solving skills
- Losses related to physical health conditions or disability
- Current or past trauma
- Social isolation
- Lack of social support
- Loss of important relationships
- Employment stress and/or job loss (Prevention Network, n.d.)

Other risk factors for substance use that may be present in a person’s life include:

- Poor attachment history

- Physical, sexual, emotional abuse, or neglect
- Witness to violence
- Family conflict/dysfunction
- Family members with mental health and/or substance use disorders
- Incarceration or legal involvement
- Prejudice/discrimination (Prevention Network, n.d.)

Screening for Substance Use Disorders

This section will outline some of the practical tools that oncology professionals can use in their clinics and/or the inpatient setting to screen for substance use disorders. It is important to keep in mind that screening is a brief process that can identify if a patient potentially has issues with substance use. If a patient is considered at risk, they need to be assessed by a healthcare professional, such as an oncology social worker (Mahoney et al., 2006).

Brief Screening Tools

The following brief screening tools are commonly used in the ‘Screening, Brief Intervention and Referral to Treatment (SBIRT)’ model, which is an evidence-based approach to identify people who use substances at risky levels (Office of Addiction Services and Support, n.d.). As it relates to cancer, the SBIRT model is noted in the American Psychosocial Oncology Society’s pocket guide for substance use, among other screening tools (Passik & Bolin, n.d.).

- Alcohol Use Disorders Identification Test-Concise Test (AUDIT-C) - A 3-item questionnaire that assesses how often a person has a drink containing alcohol, the number of drinks consumed on a typical day, and how often they have had six or more drinks on one occasion in the past year.

- Drug Abuse Screening Test (DAST 1) - A single question that asks if a person has used drugs other than those needed for medical reasons in the past year (Office of Addiction Services and Support, n.d.).
- NIAAA Single Alcohol Screening Question (SASQ) - A single question that inquires how often a person has had 5 (male) or 4 (female) or more drinks on one occasion (National Institute on Alcohol Abuse and Alcoholism, 2025; Office of Addiction Services and Support, n.d.).
- NIDA Single Question Screening Test for Drug Use - A single question that asks about the number of times a person has used an illegal drug or prescription medication for non-medical reasons.
- Substance Use Brief Screen (SUBS) - A single question that inquires about the number of times a person has used a recreational drug or prescription medication for non-medical reasons (Office of Addiction Services and Support, n.d.).

Full Screening Tools

If a person screens positive on a brief screening tool, the following tools can be administered to gather more information about their substance use. These tools can also be administered in a clinical assessment if the clinician identifies substance-use related concerns (Office of Addiction Services and Support, n.d).

- Alcohol Use Disorders Identification Test (AUDIT) - A 10-item questionnaire to identify those who participate in high-risk, hazardous, or harmful alcohol use.

- Drug Abuse Screening Test (DAST) - A 28-item measure to identify people who are misusing drugs and the impact of the misuse.
- Alcohol, Smoking, and Substance Abuse Involvement Screening Test (ASSIST) - An 8-item questionnaire that screens for different levels of substance use risk. The risk score determines the intervention.
- Tobacco, Alcohol, Prescription medication, and other Substance use (TAPS) - A 4-item questionnaire that identifies the frequency of using the substances named in the last year. If a person answers 'yes' to any item, the tool has a second part that evaluates the risk level for the substance(s) that are being used.
- Cannabis Use Disorders Identification Test - Revised (CUDIT-R) - An 8-item measure that screens for cannabis use disorders (Office of Addiction Services and Support, n.d.).
- Opioid Risk Tool - A 5-item tool that assesses personal and family history of substance abuse, history of preadolescent sexual abuse, mental health, and age, all of which are related to risk of opioid abuse. This tool has been used in the cancer population specifically as opioids may be prescribed for cancer-related pain (Barclay et al., 2014; National Institute on Drug Abuse, n.d; Passik & Bolin, n.d.).

Clinical Assessment of Substance Use Disorders

Oncology social workers have a critical role in assessing substance use risk and disorders and referring patients for appropriate services. Possessing knowledge of substance use, including risk factors and symptoms, as well as the impact on the cancer experience, is essential. It is beneficial to clinical practice if oncology social workers also know how to administer and interpret screening tools. Conducting a clinical assessment is another vital skill for oncology social workers.

Before the assessment begins, Mahoney et al.(2006) encourage social workers to be mindful of the shame and stigma that can be associated with a patient's use of substances. They identify characteristics that clinicians should possess when conducting this type of assessment, including being empathetic and acknowledging that it may be difficult or embarrassing for a patient to talk about their substance use. If substance use is something that they have been struggling with for a period of time, they have likely been criticized by family members, friends, and possibly other clinicians, which may be triggering for them. Therefore, taking an empathetic approach and having an appreciation for the challenges that come with substance use and changing behavior is essential. Furthermore, the clinician "needs to be able to discriminate between the person and his or her substance-using behavior" (Mahoney et al., 2006, p. 397). This statement means that the clinician should convey respect and acknowledge the patient's worth, while also not dismissing their problematic behaviors related to substance use (Mahoney et al., 2006).

Mahoney et al. (2006) recommend gathering information from multiple sources, including:

- The patient themself
- Involved family members and friends
- Other healthcare providers involved in the patient's care
- The patient's medical chart, including reviewing any screening tools they may have completed

They also recommend that patients understand the purpose of gathering substance use-related information, which is to identify the associations between substance use and the patient’s cancer diagnosis, any other health problems they have, and any social issues that exist (Mahoney et al., 2006).

During the assessment, it is critical to ask about which substance(s) a person is using, the frequency and amount of use, the pattern of use, whether it is connected to any specific circumstances, and the consequences of use. It is also helpful to ask about substance use in any close family members because of the genetic component of substance dependence (Mahoney et al., 2006). Mahoney et al. (2006) recommend using an established screening tool in the clinical interview, as the ones listed above can help an oncology social worker gather this information. For example, if assessing alcohol use, the social worker can start with a single question, “Do you drink alcohol?” If a patient answers “no,” the follow-up question should be “What made you decide not to drink?” If a patient answers “yes,” the follow-up questions should be about frequency and amount. The AUDIT screening tool can be used to gain a deeper understanding of the patient’s alcohol use, and the total score of the tool will help determine the level of risk.

Mahoney et al. (2006) state that questions about frequency and amount are essential for identifying whether a person is at risk. Questions about any consequences of use can be effective in determining if a disorder is present.

Additionally, assessing other psychosocial issues, including mental health conditions, exposure to trauma, living situation, relationships, employment status, financial situation, and legal problems, is important to the assessment process. While these factors cannot predict whether a person will have issues with substance use or not, assessing for them can provide the oncology social worker with information to consider risk further and what types of interventions would be helpful to the patient (Mahoney et al., 2006).

Diagnosing a Substance Use Disorder

For a diagnosis, the DSM-5-TR criteria state the following:

- The presence of 2 to 3 symptoms is considered a mild substance use disorder.
- The presence of 4 to 5 symptoms indicates a moderate substance use disorder.
- The presence of 6 or more symptoms indicates a severe substance use disorder.

Symptoms of substance use disorders fall into the following four categories:

- Impaired control
    - Taking the substance in larger amounts or over a longer time than intended.
    - Unsuccessful attempts or a continuous wanting to cut down or stop the use of a substance.
    - Spending much time obtaining, using, and recovering from the effects of a substance.
    - Having ongoing cravings, a strong desire, or urges to use the substance at any time.
- Social impairment
    - Not being able to manage roles and responsibilities at work, school, or home due to substance use.
    - Continuing to use the substance regardless of recurrent social or interpersonal issues.

  - Reducing or stopping participation in social, recreational, or occupational activities due to substance use.
- Risky use
  - Continuing to use a substance even when it causes dangerous situations.
  - Continuing to use a substance despite knowing about a physical or psychological problem that is possibly being made worse by the substance.
- Pharmacological effects
  - Increasing the amount of the substance used to achieve the desired effect (tolerance).
  - Developing withdrawal symptoms when the use of the substance stops. These symptoms are relieved by using more of the substance.

The DSM-5-TR recognizes ten different classes of drugs:

- Caffeine
- Alcohol
- Cannabis
- Hallucinogens
- Inhalants
- Opioids
- Sedatives
- Hypnotics

- Stimulants
- Tobacco (Hartney, 2024)

Brief Interventions and Referral to Services

After the assessment is complete, the oncology social worker can provide brief interventions if they determine that a patient is at risk for substance use problems or if they meet the criteria for a substance use disorder. Brief interventions are a part of the SBIRT model and “provide a means by which social workers talk with clients about risk related to their use and enhance their motivation to take positive steps toward addressing their substance use problems” (Mahoney et al., 2006, p. 403). The Substance Abuse and Mental Health Administration (1999) defines brief interventions as:

> *“Those practices that aim to investigate a potential problem and motivate an individual to begin to do something about his substance abuse, either by natural, client-directed means or by seeking additional treatment. The basic goal of any intervention is to reduce the likelihood of harm that could result from continued substance use. The specific goal for each individual client is determined by his use and by the setting in which the brief intervention is delivered”* (p. 5).

The first step is to provide feedback on the results of the screening tool the patient completed. Feedback should be provided “promptly, in a direct and nonjudgmental manner, and framed in a way that conveys respect, relates to the client’s medical health, and is delivered with cultural competence” (Mahoney et al., 2006, p. 403). Discussing the screening tool results with the patient can help them understand the status of their substance use. In addition to providing this information, the oncology social worker can discuss the effects of these interactions and their consequences with the patient. For example, alcohol can worsen side effects from chemotherapy and increase the risk of additional cancers (Underferth & Van Thomme, 2024). As another example, smoking marijuana after a bone marrow transplant can put an immunocompromised patient at a higher risk for infection (National Marrow Donor Program, n.d.).

The next step is to discuss with the patient that changing their behavior is their responsibility. According to Mahoney et al. (2006), “it is important for the client to know that while the professional is concerned and interested in his welfare, ultimately it is the decision and responsibility of the client to make changes in his substance use behavior” (p. 404). During this time, the oncology social worker can support the patient so they do not feel alone or as if they are to blame, while also respecting the patient’s self-determination and decision.

The third step involves the oncology social worker guiding the patient, after obtaining their permission, to help them change their behavior. The type of guidance will vary based on the patient and their decision to change. Still, it can range from providing education and sharing past experiences to engaging the patient in behavior change.

Next, the oncology social worker can discuss options with the patient to help them facilitate change in their life. It is essential to discuss each option with the patient to understand their perspective on the situation and the types of support available to them. This type of discussion can help the client feel supported as they make an informed decision about any next steps (Mahoney et al., 2006). Some of the patient’s options likely include the oncology social worker making referrals to appropriate services. For example, if a patient is at risk for substance use or meets the criteria for a substance use disorder, the social worker can discuss the option of having a further evaluation with a provider who treats substance use. Depending on the resources available at the cancer center and/or within the patient’s area, they can also discuss the option of a referral to a psychiatrist, psychologist, or a palliative care provider (for symptom and side effect management). It is helpful for the oncology social worker to explain the roles of these providers and the types of support and treatment they can provide. A patient may also have the option of a referral to a chemical dependency program for evaluation and a recommendation of the appropriate level of care to treat their substance use.

The last two steps of brief intervention include the oncology social worker being empathetic, respectful, warm, and caring towards the patient throughout their discussions and relationship. Additionally, the oncology social worker should help patients enhance their self-efficacy by fostering hope and optimism and recognizing their strengths (Mahoney et al., 2006).

The final part of the SBIRT model is a referral to treatment. Treatment may include motivational interviewing, cognitive behavioral therapy, or a twelve-step program. Medication and its management may also be part of treatment, including a plan to help the patient with compliance, such as frequent visits, limiting their pill supply, and drug testing (Passik & Bolin, n.d.). As noted above, the patient may have a variety of providers that they can see for support and treatment related to their substance use. After the oncology social worker discusses options with the patient, they can make recommendations and referrals to additional services and providers, provided the patient agrees. To promote continuity of care, once the patient starts treatment, the oncology social worker can communicate with other providers involved in the patient's care.

All of these efforts outlined in this section can support the patient throughout their cancer experience, as they also consider dealing with substance use problems, and hopefully guide them to a positive outcome.

Documentation

The National Association of Social Workers (2013) has published standards for working with clients with substance use disorders. The record-keeping standard states the following:

> *"Social workers shall maintain appropriate and accurate data and records that are relevant to planning, implementation, and evaluation of social work services, in accordance with professional ethics and local, state, and federal mandates.*
>
> *Interpretation:*
>
> *Social workers shall maintain timely, accurate, and confidential records that document social work services, demonstrate outcomes, and promote accountability. Social workers shall comply with applicable regulations regarding client records. Records shall be maintained according to federal, state, and local laws. Ethical considerations shall be guided by the NASW Code of Ethics"* (National Association of Social Workers, 2013, p. 13).

Documentation can include the patient's risk factors, the screening tool(s) that the patient completed and/or that were used to guide the assessment (if appropriate), information learned during the evaluation, including the substance(s) being used, severity of use, symptoms, complications from use, interventions that took place during the assessment, including referrals, and the social work plan of care. The oncology social worker can also address these items in progress notes as they continue to work with the patient, reassess, and intervene.

Section 2 Key Terms

Substance use disorder - a complex condition defined as "a cluster of physiological, behavioral, and cognitive symptoms associated with the continued use of substances despite substance-related problems, distress, and/or impairment" (American Psychological Association, 2023, para. 1).

Risk factors for substance use - characteristics that increase the likelihood that a person will develop a substance use disorder.

Screening, Brief Intervention and Referral to Treatment (SBIRT) - a "comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders. Primary care centers, hospital emergency rooms, trauma centers, and other community settings provide opportunities for early intervention with at-risk substance users before more severe consequences occur" (Substance Abuse and Mental Health Services Administration, 2024b, para. 1 & 2).

Section 2 Reflection Questions

- What is your experience working with cancer patients who are at risk for a substance use disorder and/or meet the criteria to be diagnosed with one?
- What challenges do you face when working with these patients?
- Which substance use-related screening tools are used in your work setting, if any?
- Do you use any specific screening tools in your individual clinical practice?
- What aspects of brief intervention do you provide to patients in your practice?

- Where do you typically refer patients for substance use evaluation and treatment?

Section 3: Suicide and Homicide Risk Assessment and Intervention

References: 2, 4, 5, 6, 8, 9, 13, 15, 17, 18, 19, 21, 22, 26, 27, 30, 32, 33, 34, 36, 37, 38, 39, 42, 44, 45, 46, 47, 50, 54, 55, 60, 61, 64, 66, 71, 74, 75, 77, 78, 81, 83, 85, 91

In the general population in 2023 (the most recent data available), cancer was the second leading cause of death in the U.S., with just over 613,000 people dying from the disease. Suicide was the eleventh leading cause of death, with close to 50,000 people dying by suicide that year (Centers for Disease Control and Prevention, 2025c; National Institute of Mental Health, 2025). Not only did suicide take this many lives, but close to 13 million adults seriously thought about suicide, over 3.5 million made a plan, and 1.5 million attempted suicide (Centers for Disease Control and Prevention, 2025d).

Additional data from 2023 shows that the suicide rate among males was close to 4 times higher than among females. Men aged 75 and older had the highest suicide rate among their gender, while for females, the rate was highest for women aged 45-64. When looking at race and ethnicity, American Indian/Alaskan Native, non-Hispanic males and females had the highest rate of suicide, followed by white, non-Hispanic males and females. Firearms are the most common method used among both males and females. Young adults, aged 18-25, had the highest prevalence of serious suicidal thoughts and suicide attempts (National Institute of Mental Health, 2025).

Homicide is another leading cause of death and took the lives of close to 23,000 people in the U.S. in 2023 (Centers for Disease Control and Prevention, 2025a). Young adults, ages 20-24, are the most likely to die by homicide, followed by those who are ages 25-34. Black males and females are most likely to be homicide victims when compared to those who are white. Firearms continue to be the most used method in homicides. Additionally, when looking at the victim-offender relationship, police have been unable to determine a relationship in more than 50% of homicides. However, many are acquaintances, followed by family members, with strangers being the least common type of relationship. Furthermore, in the majority of homicides, the circumstances are unknown, but many are caused by arguments, followed by their occurrence during a felony (Council on Criminal Justice, 2023).

Suicide

In taking a closer look at suicide rates in the general population in the U.S in the same year, the age-adjusted rate was 14 per 100,000 people (American Foundation for Suicide Prevention, n.d.c). For people diagnosed with cancer, the rate is estimated to be double that of the general population rate, approximately 28 per 100,000 (Zaorsky et al., 2019, as cited in Liu et al., 2024).

Trends in suicide deaths in the general population show that rates increased from 2000 to 2018, then decreased slightly from 2018 to 2020, but returned to their peak in 2023 (the most recent data available) (Centers for Disease Control and Prevention, 2025d). When comparing the general population to those with cancer, one study looked at trends in cancer-related suicide among people diagnosed with the disease in the U.S from 1975 to 2017. They found that there was a gradual increase in suicide rates from 1975 to 1989, followed by a gradual decrease from 1989 to 2013, and from 2013 to 2017, there was a marked decrease. This data shows that there has been a downward trend for people with cancer compared to the general population, which may indicate that improvements in psycho-oncology care and greater access to it, as well as advancements in cancer prevention, treatment, and symptom and side effect management, are contributing factors to this trend (Caba et al., 2024; Liu et al, 2024).

Suicide Risk Factors

Risk factors of suicide are “characteristics or conditions that increase the chance that a person may try to take their life” (American Foundation for Suicide Prevention, n.d.b, para. 2).

Certain risk factors are associated with the risk of suicide in the general population, and others are more specific to the cancer experience. An oncology social worker needs to be aware of the various factors, as this information can complement a clinical assessment.

The Centers for Disease Control and Prevention (2024) notes that suicide rarely happens after a single event or circumstance. The American Foundation for Suicide Prevention (n.d.b) supports this statement and adds the following:

> *“There is no single cause for suicide. Suicide most often occurs when stressors and health issues converge to create an experience of hopelessness and despair. Depression is the most common condition associated with suicide, and it is often undiagnosed or untreated. Conditions like depression, anxiety, and substance problems, especially when unaddressed, increase the risk for suicide”* (para. 1).

The risk factors in the general population fall into a range of levels that include individual, relationship, community, and societal, as follows:

Individual Risk Factors

- Previous suicide attempt(s)
- History of depression and other mental health conditions
- Substance use
- Severe physical health conditions, including pain
- Criminal and/or legal problems
- Job loss and/or financial problems
- Impulsivity and aggressiveness
- Hopelessness
- Prolonged stress
- Stressful life events
- Childhood abuse, neglect, or trauma
- Being a victim and/or perpetrator of violence

Relationship Risk Factors

- Family history of suicide
- Loss of relationships
- Relationships with a lot of conflict and/or violence
- Social Isolation

Community Risk Factors

- Limited access to healthcare
- Assimilating into a different culture

- Community violence
- Discrimination
- Generational trauma

Societal Risk Factors

- The stigma that can come with mental illness and/or seeking help
- Access to lethal means, including firearms and drugs
- Exposure to another person's suicide, such as through the media (American Foundation for Suicide Prevention, n.d.b; Centers for Disease Control and Prevention, 2024)

Studies have examined suicide risk factors associated with cancer patients in the U.S. One study found that suicide risk in cancer patients was 26% higher compared to the general population (Hu et al., 2023). The following are specific contributors to being at a higher risk of suicide in the cancer population:

- Older age, especially older men
    - One study found that the age-adjusted suicide rate in people with cancer aged 80 to 84 was close to double the rate of the general population.
- The male gender, though females have higher rates of suicidal ideation and more attempts
- White race
- Single, divorced, or widowed status
- Living in a rural area

- Low socioeconomic status
- Hispanic or American Indian, Alaska Native, Asian, or Pacific Islander ethnicities (likely because of barriers to care, structural racism, and challenges with navigating the healthcare system).
- Being uninsured, or having Medicare before age 65, Medicaid, or VA insurance.
- Being diagnosed with a distant stage cancer (stage 4 or metastatic) and/or aggressive disease.
- Recent diagnosis; the highest risk occurs 3-6 months after diagnosis; the risk persists throughout the first year
    - One study found that the highest suicide risk occurred in cancer patients during the first 6 months after a diagnosis, in which the risk was 7 times the suicide risk of the general population.

- Cancer diagnoses with a poor prognosis (less than 5 years) and high symptom burden. Patients diagnosed with head and neck cancer, esophageal cancer, stomach cancer, brain and other nervous system cancers, pancreatic cancer, and lung cancer are at higher risk of suicide within the first 2 years after a diagnosis.
- Cancer diagnoses with physical and psychological long-term and late effects, functional impairments, and quality of life issues (head and neck cancer, breast cancer, uterine cancer, bladder cancer, and leukemia) are at higher risk 2 years or more after their diagnosis.
- Uncontrolled pain and other physical symptoms
- Decrease in functional and performance status

- Comorbid depression, anxiety, and/or substance use
- Psychopathology that predates the cancer diagnosis
- Feeling hopeless
- Demoralization
- Aggression and not being aligned with the healthcare team
- History of suicide attempts
- Family history of suicide
- Lack of social support
- Feelings of being a burden due to loss of independence, and the guilt that comes with those feelings (Grobman et al., 2023; Hu et al., 2023; National Cancer Institute, 2024)

It is important to note that “the presence of a suicide risk factor does not mean that a person will engage in suicidal behavior; however, if a person is experiencing numerous factors, the risk may increase” (Engstrom, 2006, p. 226). It is beneficial to clinical practice for an oncology social worker to know these risk factors and to consider them when working with patients who are at risk of suicide.

Suicide Risk Screening

In July 2019, as a part of the National Safety Goal, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) implemented a new standard that requires patients to be screened for suicide using a validated screening tool when they are being evaluated or treated for a behavioral health condition. This standard states the following:

> *"Screening patients for suicide risk with secondary diagnoses or secondary complaints of emotional or behavioral disorders is encouraged but not required. It is important for clinicians to be aware that patients being treated primarily for a medical condition may also have behavioral tendencies that, if triggered, may lead to self-harm. For example, changes in health status resulting in a poor prognosis, chronic pain resulting from injury or illness, etc. Psychosocial changes, such as sudden loss of a loved one, broken relationships, financial hardship, etc., can also trigger self-harm behaviors. These patients may also be at risk for suicide; therefore, it is important for clinicians to properly assess these individuals for suicidal ideation as part of their overall clinical evaluation, when indicated"* (Joint Commission on Accreditation of Healthcare Organizations, 2023, para. 1 & 2).

Since psychosocial changes after a cancer diagnosis are well acknowledged within the field, many cancer centers have implemented suicide risk screening policies and procedures based on JCHAO's standard and research in the field that has shown the importance of screening cancer patients for suicide. There is some consistency in the evidence-based tools used in the oncology setting, including the following:

- Columbia Suicide Severity Rating Scale (C-SSRS)
- Suicide Intent Scale (SIS)
- Beck Hopelessness Scale (BHS) (National Cancer Institute, 2024)
- Patient Health Questionnaire-9 (PHQ-9)
- Ask Suicide-Screening Questions (ASQ)
- Computerized Adaptive Screen for Suicidal Youth (CASSY)

- Patient Safety Screener-3 (PSS-3)
- SAD PERSON (Austin-Valere, 2025)

While cancer centers can use any of these tools to screen and assess patients for suicide risk, Hlubocky & Dokucu (2023) state that “single items drawn from validated measures, including distress instruments, are the preferred and most frequently used method for initial assessment. Therefore, preliminary comprehensive patient-reported distress assessments that include a single suicide item are vital for use to identify warning signs for formal suicide assessment and intervention (p. 388).”

For example, a cancer center may administer the National Comprehensive Cancer Network’s Distress Thermometer and Problem List, along with the Patient Health Questionnaire-2 (PHQ-2) or the first two questions of the Columbia Suicide Severity Rating Scale (C-SSRS). The Distress Thermometer and Problem List measure distress on a scale of 0 to 10, and the Problem List allows patients to self-report areas of concern, including physical, emotional, practical, and spiritual (National Comprehensive Cancer Network, 2024). The PHQ-2 screens for depression, and those who screen positive should be further evaluated with the PHQ-9 (American Psychological Association, 2020). The first two questions of the C-SSRS assess if a person has wished they were dead and if they have had thoughts of killing themself. If the screen is positive, the person should be evaluated with the four additional questions in the tool. If the screen is negative, the person should still be asked the following question: “Have you ever done anything, started to do anything, or prepared to do anything to end your life” (The Columbia Lighthouse Project, 2016)?

The National Comprehensive Cancer Network (2024) recommends routine screening for distress, particularly during periods when it is more likely to occur. These time periods include the diagnostic phase, the period before and during treatment, and the end of treatment, when a person transitions to survivorship or end-of-life care. Depending on a cancer center's policies and procedures, distress screening will be done at specific time points, and screening for depression and suicide could be done alongside it.

If a patient's responses on any of the above screening methods indicate that they are in distress and/or at risk for suicide, the next step is a clinical assessment by an oncology social worker.

Clinical Assessment of Suicide Risk

Suicide risk assessment happens frequently throughout the disease trajectory. Components of the assessment include the following:

- An evaluation of risk factors
- Assessing the patient's mental state
- Gaining an understanding of social context
    - The American Psychological Association (2018) defines social context as "the specific circumstance or general environment that serves as a social framework for individual or interpersonal behavior. This context frequently influences, at least to some degree, the actions and feelings that occur within it" (para. 1).
- Nonverbal signs (poor eye contact, agitation, slow speech or movement) (National Comprehensive Cancer Network, 2024)

The first step in suicide assessment is identifying if suicidal ideation is present (Englestrom, 2016). According to the National Comprehensive Cancer Network (2024), when a patient has suicidal ideation, they may be contemplating suicide and have thoughts, ideas, wishes, or preoccupations with death and suicide. Some patients may have passive suicidal ideation, which is a general wish to end their life, but they do not have a plan. The oncology social worker's questions should help them gain an understanding of whether the patient has thoughts about being dead or if they have wished they were dead, and whether they have had thoughts of killing themself. If a patient completed a screening tool before the assessment, it can guide the conversation. Any of the screening tools listed above can also be used.

The oncology social worker will want to be attuned to a patient's expressions of hopelessness, an inability to see a solution to a problem, statements that they are a burden or that people would be better off without them, saying that they want to give up, or that their circumstances are insurmountable (Englestrom, 2006, p. 227). They will also want to be attuned to any feelings or statements related to demoralization or to a sense that a patient has lost their meaning in life (National Comprehensive Cancer Network, 2024).

If the patient reports suicidal ideation, they require further assessment. The next part of the assessment should gather more information about the ideation (frequency, intensity, duration), if they have thought about how they would harm themself (the method), if they would act on those thoughts (intention), if they have started to think in more detail about how to harm themself (a plan) and their intention for carrying out a plan, and if they have ever done anything or are preparing to do something to end their life (behaviors). All of this information can help the oncology social worker determine the risk level. Risk increases if a patient reports ideation and a plan, and further increases with the extent of lethality in the plan. A lethality assessment includes learning about a patient's access to the method to harm themself, the extent to which the means are reversible, and the proximity of help. Imminence of risk increases if the following factors are present:

- A plan that has been thought out and developed, with a focus on plans that involve violence or are irreversible.
- The patient has access to the means they need to carry out their plan.
- There is an intention to harm themself or carry out the plan.
- The patient is considering how they can remain uninterrupted or undetected during the act.
- The patient is working on or has completed a suicide note.
- The patient is using alcohol and/or substances.
- The patient is having psychotic symptoms, such as hallucinations.
- Hopelessness (a strong predictor of suicide)

It is essential to rule out any underlying causes, such as a depressive illness or anxiety, as well as any underlying reasons for hopelessness, such as symptoms that are not being managed, or if there are fears around death. It is also important to understand the patient's support system and protective factors (Englestrom, 2006; National Comprehensive Cancer Network, 2024). Conducting a comprehensive psychosocial assessment can be beneficial in this instance to gain a clearer picture of the patient's situation.

After the assessment, the oncology social worker will consider all of the information and use their clinical judgment to determine the patient's risk level. The Substance Abuse and Mental Health Services Administration (2024a) offers the following risk levels:

- Low risk
    - Manageable risk factors and strong protective factors.

  - Thoughts about death, but there is no plan, intent, or behavior.
- Moderate risk
  - Multiple risk factors and some behavioral health symptoms are present, along with a few protective factors.
  - Suicidal ideation is reported with a plan, but there is no intent or behavior to support it.
- High risk
  - Severe behavioral health symptoms are present, or an acute precipitating event has occurred.
  - Suicidal ideation with a plan, method, and intent is expressed.

Intervention

When determining the intervention, the oncology social worker should be aware of their institution's policies and procedures, as well as any state laws and regulations. They can also seek consultation from a colleague or supervisor (Englestrom, 2006).

Using the risk levels listed above, the following are possible interventions:

- Low risk
  - Outpatient referral with a warm handoff. This referral may be to a mental health provider, such as a psychologist or counselor, or to a psychiatrist or palliative care provider for symptom management. Depending on the oncology social worker's role, they may be able to provide mental health treatment.

    - Treatments or therapies for suicidal thoughts and behaviors focus on psychological changes, such as managing the thoughts and changing the behaviors associated with them. Effective therapies include:
        - Cognitive Behavioral Therapy (CBT)
        - Dialectical Behavior Therapy (DBT)
        - Attachment-Based Family Therapy (ABFT)
        - Prolonged Grief Therapy (PGT)
    - Medication can also be beneficial for the patient based on a thorough evaluation. The quantity may need to be limited.
- Give the patient emergency/crisis numbers to call for additional support.
- Engage in safety planning. Safety planning is a collaborative intervention between the patient and the oncology social worker. The plan should be personal to the patient and something they can reference and use to provide options when they feel like there are none. The patient should receive a copy of their safety plan. It includes:
    - Warning signs that a crisis may be developing
    - Specific activities or places that will distract attention away from suicidal thoughts
    - People who can help the patient with distraction
    - People who they can talk to about their thoughts and feelings, and who will help them feel heard and supported

    - Professionals who are available for support, and when
    - Emergency contacts, such as crisis lines
    - Ways to reduce access to lethal means
    - Hopes for the future, reasons for living, and things that are meaningful to the patient

- Moderate risk
  - Someone should stay with the patient at all times in the clinic setting. If the contact is by phone, the oncology social worker should remain on the phone with the patient. They may need to rely on a colleague to contact a patient's family member or friend, or to contact emergency services if an unsafe situation is unfolding.
  - Inpatient admission may be necessary depending on the extent of risk factors.
  - Give the patient emergency/crisis numbers to call for additional support.
- High risk
  - Inpatient admission for safety and treatment may be necessary unless there is a significant change that reduces risk.
  - Intervention should focus on physical safety.
  - To the extent possible, the oncology social worker can pursue their interventions from a place of empowerment and collaboration, rather than disempowering the patient by taking an action that does not allow for their input. This approach enables a discussion with the patient about their safety options and allows them to take action,

such as deciding to move forward with an inpatient admission. If the patient is not able to make a decision that preserves their safety, the oncology social worker or another healthcare provider should intervene as appropriate (American Foundation for Suicide Prevention, n.d.a; Englestrom, 2006; National Comprehensive Cancer Network, 2024; Substance Abuse and Mental Health Services Administration, 2024a).

Documentation

Documentation can include the patient's risk factors, the screening tool(s) the patient completed and/or that were used to guide the assessment, and the information learned during the evaluation. The patient's risk level and rationale should also be documented. Furthermore, interventions conducted during the assessment, including referrals and the social work plan of care, should be documented (Substance Abuse and Mental Health Services Administration, 2024a). The oncology social worker can address these items in progress notes as they continue to work with the patient, reassess, and intervene.

Homicide

As noted above, the number of people who died in a homicide in the U.S. was 23,000 in 2023. The rate in the general population is 5.9 per 100,000 people (Centers for Disease Control and Prevention, 2025a). Data related to people living with cancer and the prevalence of homicide in the U.S. was not found.

One study out of the United Kingdom analyzed domestic homicide review reports in which either the perpetrator or victim was diagnosed with cancer. The researchers reviewed 24 reports total, which covered 27 domestic homicides or domestic abuse-related suicides over the course of 8 years. Out of the 24 reports, the perpetrator had cancer in 8 cases, the victim had cancer in 15 cases, and in one case, both people had cancer. Researchers found that victims were older, with 67 being the median age, and that they were primarily women. Most of the people were killed by their intimate partner, though nine victims were killed by their adult children. Researchers also found that most of the homicides or suicides happened within 3 years of the cancer diagnosis (Dheensa et al., 2025).

Intimate partner homicide-suicide (IPHS) is reviewed in this section. IPHS is a “tragedy where a person, their children, or other victims (e.g., a woman’s new partner) are killed by their current or former intimate partner, and the intimate partner then attempts or dies by suicide” (Everytown for Gun Safety Support Fund, 2024, para. 4). Intimate partner violence (IPV) can lead to IPHS. There are typically warning signs and a pattern of abuse escalation in IPV that can lead to a homicide occurring (Pizzaro, 2024).

Homicidal ideation is also reviewed in this section.

Homicide Risk Factors - IPHS

Research conducted on IPV and with survivors of IPHS has identified the following risk factors for this type of violence:

- Access to a firearm
- Perpetrator gun ownership
- Prior verbal, emotional, and/or physical abuse in the relationship
- Past use or threats with a weapon, including a threat to kill
- Threats against children and family members
- History of trauma

- Suicidal ideation, attempts, or threats
- Divorce or separation
- Jealousy
- Stalking
- Abuse using technology
- Substance abuse
- Isolation

Additional risk factors include the following:

Individual Risk Factors

- Childhood physical abuse and/or emotional neglect
- Witnessing intimate partner violence of a parent
- History of suicidal behavior
- Perpetrator unemployment

Relationship Risk Factors

- Unhealthy family relationships
- Possessiveness
- Increase in the severity of violence
- Recent separation

Community Risk Factors

- High rates of violence and crime

- Minimal support services/community resources
- Limited intervention against intimate partner violence (e.g., law enforcement does not intervene in violent situations)

Societal Risk Factors

- Stigma related to intimate partner violence and suicide
- Traditional gender norms
- Racial discrimination
- Sexism (Everytown for Gun Safety Support Fund, 2024; Pizzaro, 2024)

Firearm access is the main factor involved in IPV and IPHS. If a male perpetrator has access to a gun, they are 4 to 5 times more likely to kill their female partner, and approximately 90% of gun suicides end in death (Everytown for Gun Safety Support Fund, 2024; Pizzaro, 2024).

Homicide Risk Screening - IPHS

There are brief assessment tools to identify intimate partner violence (IPV), which can lead to IPHS. These tools include:

- Hurt, Insult, Threaten, Scream (HITS) - A 4-item questionnaire to identify the frequency of IPV.
- Partner Violence Screen (PVS) - A 3-item measure to assess physical IPV in the last year and current safety.
- Partner Screening Questionnaire (PSQ) - A 3-item questionnaire to assess the occurrence of physical IPV and fear in the last 12 months.
- Woman Abuse Screening Tool (WAST) - An 8-item measure to assess physical and emotional IPV.

- Humiliation, Afraid, Rape, Kick (HARK) - A 4-item questionnaire to assess physical and emotional IPV in the last 12 months (Feltner et al., 2018).

Clinical Assessment of Homicide Risk - IPHS

If the patient screens positive for IPV, the next step is a clinical assessment. The assessment should be done when the patient is alone, which may take some coordination among interdisciplinary team members in the clinic or inpatient setting. Questions related to IPV and IPHS are sensitive, making therapeutic communication even more critical during patient interactions. Therapeutic communication includes being at eye-level with the patient, making eye contact (not looking at a computer or tablet), not invading personal space, thanking the person for sharing information, and checking in throughout the conversation (Paterno & Draughon, 2018). Confidentiality and privacy, including their limitations, should also be reviewed before the assessment (Alberta Council of Women's Shelters, 2019).

The Danger Assessment tool can guide the evaluation. It is a tool that can help clinicians, including oncology social workers, "determine the level of danger an abused woman has of being killed by her intimate partner" (Johns Hopkins School of Nursing, 2025a, para. 1). It is the only intimate partner violence risk assessment tool to predict lethality specifically (Messing & Thaller, 2014). The tool includes a 20-item questionnaire and a calendar.

- The 20-item questionnaire lists multiple risk factors for intimate partner homicide, and the woman answers yes or no to each one (Johns Hopkins School of Nursing, 2025b). The total number of yes responses is determined after the questionnaire is completed, and a specific number is assigned to questions 2-9. The range of danger levels includes variable risk, increased danger, severe danger, and extreme danger (Alberta Council of Women's Shelters, 2019).

- On the calendar, a woman will mark the days when abusive incidents occurred and rank the severity of the incident on a scale of 1 to 5 (1 = slap to 5 = use of a weapon or wounds from it). The calendar intends to help the woman become more conscious of the abuse and reduce any denial they may be experiencing (Johns Hopkins School of Nursing, 2025b).

The oncology social worker can use the tool and ask more in-depth questions to understand the level of danger better. For example, if the patient has been threatened with a lethal weapon, the oncology social worker can ask additional questions about the type of weapon and what the threat entailed.

If the Danger Assessment tool is not used during the clinical assessment, the oncology social worker will still need to ask questions about the patient's relationship with her partner and the presence of risk factors to understand the level of risk and danger the patient may be in.

Intervention - IPHS

Interventions are often based on the level of risk or danger and the patient's consent to receive help. If a patient is considered variable or lower risk based on their responses to items in the Danger Assessment, a mental health professional can introduce safety planning, and safety needs to be monitored over time. Safety planning should be implemented if the patient is at increased risk. At the severe or extreme danger levels, safety planning should be assertive and continuous (Alberta Council of Women's Shelters, 2019). If a patient is in extreme danger, the oncology social worker can begin to "identify the systems and individuals that will support her to mobilize to increase her safety" (Alberta Council of Women's Shelters, 2019, p. 31). These individuals and systems can include people in her support system, local resources (such as shelters), and national hotlines. Law enforcement may need to be contacted in certain situations as well.

People are at high risk of serious harm or death if the following have occurred or are occurring (among other risk factors):

- History of violence by the perpetrator
    - “Homicide is rarely a random act and often occurs after repeated patterns of physical and/or sexual abuse and psychologically coercive and controlling behavior” (Northern Territory Government, n.d., para. 3).
    - Escalation (frequency and severity of abuse increasing)
- Firearms are easily and readily accessible
- Strangulation, choking, or suffocation
- A person is in the process of leaving or has left their partner/abuser (Gonsalves, n.d.; Northern Territory Government, n.d.)

When determining appropriate intervention(s), it is crucial to be mindful of factors that pose a grave danger to people, including those listed above.

Safety planning helps women plan and prepare for future abuse by increasing their awareness of the risks in their relationship that trigger fear, threat, and danger. It also helps them identify steps they can take to ensure their own safety and the safety of any children in the home. A safety plan should be co-developed with a mental health professional, such as an oncology social worker, and the patient to capture the individual situation. It should include strategies for escaping, avoiding, and surviving violence, as well as ways the patient can increase their support and resources, and their awareness of patterns of abuse escalation. It should also address the potential barriers the woman will face (Alberta Council of Women’s Shelters, 2019).

Safety plans typically include ways to increase safety in and out of the home, during a violent event, when preparing to leave, with a protection order in place, and when substances are involved. It may also address emotional health, items to take when leaving, and important phone numbers (Substance Abuse and Mental Health Services Administration, 1997; Shelter for Help in Emergency, n.d). One example can be found here.

Homicidal Ideation

A patient may express violent or homicidal ideation to an oncology social worker; therefore, it is important to have an understanding of this topic, including risk factors, screening, assessment, and intervention.

According to Watt (2017), homicidal ideation "involves imagining physically killing another person. Such thoughts may be temporary following the experience of acute stress or perceived provocation. In other cases, thoughts of wanting to kill others may be pervasive, detailed, and associated with heightened arousal" (p. 1687).

Though not specific to homicide, one study looked at violent cancer patients in an attempt to determine underlying variables that may be causing this type of behavior. They found that about 5% of the cancer patients they studied in the inpatient setting displayed violent behavior. Having cognitive limitations, being bedbound, having a diagnosis of a non-terminal cancer, and having strong feelings of helplessness or subjection were associated with aggressive behavior. Aggressive behavior was also correlated with not finishing the diagnosis process, as well as not completing treatment (Grube, 2012).

Homicide Risk Factors - Perpetrators of Violence

Certain risk factors are associated with people who commit violent acts, including homicide. These risk factors are divided into two categories: static and dynamic. Static risk factors are things from a person's history that do not change. Dynamic risk factors are changeable and offer an opportunity for intervention (National Collaborating Centre for Mental Health, 2015).

Static Risk Factors

- History of violence and/or aggression (criminal history)
- History of suicide attempts
- Age at the time of the first violent event
- Adverse childhood experiences such as child abuse, exposure to violence or trauma, bullying, or being bullied
- Family history of violence and psychopathology
- Legal issues/arrests/civil commitments/failed parole or conditional release
- Cognitive impairment
- Trait anger
- Non-compliance with treatment

Dynamic Risk Factors

- Anti-social and/or hostile behaviors
- Identifies with violent groups (ex., gangs)
- Relationships and limited social support
- Impulsivity

- Obsessiveness
- Adverse responses to authority
- Perceives injustices
- Anger and/or aggression
- Hopelessness
- Recent substance misuse
- Mental health disorders, including substance use disorders, antisocial personality disorder (with patterns of behaviors that violate others), and psychotic disorders (schizophrenia and psychosis)
    - Substance use disorders have the strongest link to homicide
    - Psychotic disorders are less linked than antisocial personality or substance abuse.
    - To an even lesser degree, depression, traumatic brain injury, and other personality disorders (borderline, narcissistic, and histrionic) are linked to homicide.
- Suicidal or homicidal ideation
- Unemployment (Beltrani, n.d.; Constans & Nanney, 2017; National Collaborating Centre for Mental Health, 2015; Schouten, 2021)

Homicide Risk Screening - Perpetrators of Violence

A few violence risk assessment tools that the National Institute for Occupational Safety and Health (2024) recommends are:

- **Triage Tool** - A 5-item questionnaire that assesses a patient’s potential danger from others to themself, which could become an issue in the healthcare setting.
- **Indicator for Violent Behavior** - A 5-item list of observable behaviors that could indicate violence in patients and the people who accompany them. The behaviors use the acronym “STAMP” - Staring and eye contact, Tone and volume of voice, Anxiety, Mumbling, and Pacing.

Additional screening tools that require training include the HCR-20, Violence Risk Appraisal Guide (VRAG), Workplace Assessment of Violence Risk (WAVR-21), Classification of Violence Risk (COVR), and CTAP-25 (Schouten, 2021).

Clinical Assessment of Homicide Risk - Perpetrators of Violence

If there are concerns that a patient may be a perpetrator of violence and is going to harm someone, or that they are experiencing homicidal ideation, the following risk assessment questions are some examples that an oncology social worker can ask during a clinical assessment. There is no single time that is more appropriate than another to complete a risk assessment for harm and/or homicidal ideation. Still, questions can be asked during an initial evaluation or when a concern arises (Ensora Health, 2021). The clinician will likely receive the most honest and straightforward information when the patient is alone during an interview.

Identifying stressors associated with harm

- How are things going for you (insert area - at home, work, or school, for example)
- What are your current relationships like with family, friends, or other important people in your life?
- What are some things in your life that are stressful right now?

- Has anything in your life changed recently? If so, when?

Identifying thoughts of revenge

- Is there someone who has upset you lately?
- If so, what is it like for you to feel angry?
- How do you respond when you are angry?
- If you could respond however you wanted, what would that look like?
- Have you ever had thoughts of hurting someone else or yourself?

Understanding use and access to weapons

- Have you ever seen or used a weapon before?
- If so, describe that time and why.
- When might you use a weapon?
- Do you have access to weapons?

Assessing for depression

- What has your mood been like recently?
- How are you feeling right now?
- Have you ever felt hopeless or helpless?
- Have you lost interest in things that bring you joy?
- What do you imagine when you think about the future?

Identifying homicidal ideation

- Have you ever had thoughts of hurting someone else?

- If yes, what did you think about doing it?
- What have been your past experiences related to hurting someone who has hurt you?
- Have you ever thought about killing someone?
- How often do these thoughts cross your mind?
- Do you have a plan for hurting that person? Tell me about the plans you have made.
- How easy would it be for you to do this?

Identifying protective factors

- What are some reasons that would prevent or stop you from hurting another person?
- What are some of the things happening in your life or likely to happen in your life right now that would make you less likely to hurt someone?
- How would people who know and love you react to you hurting someone in this way? What would they say, think, or feel?
- What would be some of the consequences of your actions? (Ensora Health, 2021; Merrill, 2013)

Intervention - Perpetrators of Violence

Interventions are often based on the level of risk that a patient may harm another person. A clinician frequently uses their professional judgment to make this determination. Supervision and interdisciplinary teamwork are often helpful in these situations. Merrill (2013) writes that the current risk level can be determined by the severity and specificity of the ideation, presence of risk and protective factors, and recent and/or anticipated stressors. Risk can be weighted as low, moderate, or high.

Patients are considered low risk if they have no thoughts of harming others, or if they have momentary thoughts of harm, but never made a plan. Patients are regarded as moderate risk if they have thoughts of harm and a history of homicidal ideation and behavior. If they have thoughts of harm and have considered a plan, but are not sure they will carry it out, patients could be regarded as moderate to high risk. Patients are at high risk if they have thoughts of harm, a detailed action plan, and access to weapons (Ensora Health, 2021).

The following are possible interventions based on the level of risk:

- Low risk
    - Provide support, affirmation, and hope without invalidating the person.
    - Help improve coping strategies related to stressors.
    - Help the patient avoid, minimize, or respond differently to their stressors.
    - Engage a family member, friend, and community support.
    - Develop a basic safety plan. An example safety plan can be found here.
    - Discuss a referral to psychiatry for a more in-depth mental health assessment and medication recommendation, and/or other mental health services.
    - Reassessment should occur periodically.
- Moderate risk

  - In addition to the above, the clinician can consider the following:
  - Involving more people from the patient's support system.
  - Developing a more specific safety plan that includes crisis management resources.
  - Working with the patient to have them surrender access to lethal means.
  - Encouraging structure and routine.
  - Getting a second opinion from a colleague.
  - Reassessing frequently.
- High risk
  - In addition to the above, the clinician can consider the following:
  - Arranging for an in-depth crisis assessment by a mobile crisis unit or at an emergency room.
  - If the patient poses a danger to identifiable people, make efforts to reach them. Only disclose information that is necessary, such as the specific threat, plan, or intent, who is making the threat, and the rationale for the determination of risk level. Police may also need to be notified.
  - Monitor the patient closely and reassess often (Merrill, 2013).

Documentation

Documentation can include the patient's risk factors, the screening tool(s) completed and/or used to guide the assessment, and the information learned during the evaluation. The patient's risk level and rationale should also be documented. Furthermore, interventions conducted during the assessment, including referrals and the social work plan of care, should be documented (Substance Abuse and Mental Health Services Administration, 2024a). The oncology social worker can address these items in progress notes as they continue to work with the patient, reassess, and intervene.

Section 3 Key Terms

Suicide risk factors - characteristics that increase the chance that a person may try to take their life. Certain risk factors are associated with the risk of suicide in the general population, and others are more specific to the cancer experience.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) - a non-profit organization that accredits and certifies healthcare organizations in the U.S. to ensure high-quality standards for patient care and safety.

Intimate partner violence (IPV) - a type of domestic violence where a person's current partner or ex-partner engages in certain behaviors to gain power, maintain it, and control the other person. The abuse can be physical, emotional, sexual, digital, or financial. IPV can lead to IPHS. There are typically warning signs and a pattern of abuse escalation in IPV that can lead to a homicide occurring.

Intimate partner homicide-suicide (IPHS) - a "tragedy where a person, their children, or other victims (e.g., a woman's new partner) are killed by their current or former intimate partner, and the intimate partner then attempts or dies by suicide" (Everytown for Gun Safety Support Fund, 2024, para. 4).

Homicide risk factors - characteristics that increase the chance that someone will be a perpetrator of violence and/or be killed by another person.

Homicidal ideation - "involves imagining physically killing another person. Such thoughts may be temporary following the experience of acute stress or perceived provocation. In other cases, thoughts of wanting to kill others may be pervasive, detailed, and associated with heightened arousal” (Watt, 2017, p. 1687).

Section 3 Reflection Questions

- Think of a time that you worked with someone who was at risk for suicide or homicide.
- How did you identify these types of concerns? Did you (or your work setting) use a screening tool?
- What was the clinical assessment like for you and the patient?
- Were there specific questions that provided you with the most important information you needed to determine the patient’s risk level?
- What interventions did you put in place after the assessment, in both the short and long-term?

Section 4: Case Study

Daniel is a 45-year-old caucasian male diagnosed with stage 3 invasive ductal carcinoma (breast cancer). His breast cancer is hormone receptor-positive and HER2-negative. He had a mastectomy followed by chemotherapy. He is currently on hormone therapy, which he has been taking for a few months, and will need to take for a total of 5-10 years. He presents to the clinic for a 3 month follow-up appointment with his oncologist.

After Daniel checks in for his appointment, he is given a tablet and directed to complete a couple of questionnaires, including the PHQ-9 and the National Comprehensive Cancer Network’s Distress Thermometer and Problem List. During his intake in the clinic, the medical assistant reviews the results of these screening tools. She sees that Daniel has screened positive for depression and indicated that he has thoughts that he would be better off dead several days out of the week. He also rates his distress as moderate, and he checked several problems on the problem list. He agrees to meet with the social worker, Sarah, who has worked with him since the time of his diagnosis, for further assessment and support.

Sarah receives the referral and begins reviewing Daniel's chart while he speaks with his oncologist. She reviews his screening results and prior documentation in his medical record. She recalls that Daniel has a history of depression predating his cancer diagnosis, but that overall, he coped well with his diagnosis and had strong social supports in his life. At their last visit, during Daniel's final chemotherapy treatment, he was looking forward to getting back to some normalcy in his day-to-day life, while also feeling concerned about taking hormone therapy long-term. He also shared some concerns with Sarah about his job, as the company had been laying off several people, but he was unsure whether he would be affected. Overall, he was hopeful about the future and felt positive about how he managed his cancer treatment thus far.

Sarah speaks with Daniel's oncologist before meeting with Daniel. She learns that he has been taking hormone therapy for a few months, and as a result of the medication, he has ongoing hot flashes, loss of sex drive, and often feels nauseous. He also has some ongoing pain and numbness from his surgery that are quite bothersome to him and impact his sleep. Since he has ongoing issues from surgery and will be on hormone therapy for many years, Sarah and Daniel's oncologist talk about a referral to the palliative care clinic for cancer survivors at their cancer center. Sarah agrees to talk with Daniel about this option to help manage his side effects and shares that she will assess him for the other concerns noted on the screening tools he completed.

Sarah then meets with Daniel in the clinic. He presents as pleasant and engaging; he makes eye contact, but she notices that his affect seems flatter than usual. Daniel talks with Sarah about the ongoing physical issues that he is experiencing, and together, they discuss a referral to palliative care. Sarah shares information about the type of support that palliative care can provide and expresses his oncologist's support of this referral. Daniel seemed grateful to learn about this option and agreed to a referral, which his oncologist made after the visit.

Regarding psychosocial concerns, Sarah learns that Daniel recently lost his job. He is not only concerned about his finances but also about his insurance coverage. He seems appropriately discouraged and frustrated by the layoffs. He is currently interviewing for other positions and is confident that he will find another job soon. Daniel also shares that in addition to the stress from his job loss, he and his significant other recently ended their relationship, which he somewhat attributes to the quality-of-life issues that he has been experiencing in survivorship. He has not been spending as much time with his friends lately, and notes that he sometimes feels isolated, but his family continues to be very supportive of him. Though his family is supportive, they do not talk about how they are feeling emotionally when dealing with difficult things in their lives, which sometimes makes Daniel feel more isolated.

Daniel goes on to share that he has been struggling with some body image issues. Through an assessment of his mental health, Sarah identifies that he is also likely experiencing depression and anxiety. She reviews the PHQ-9 with him and addresses the question about suicide ideation. She learns that Daniel sometimes feels like a burden to others because of the issues that he is experiencing in survivorship, and as a result, occasionally has thoughts that he would be better off dead. He does not have a plan to harm himself or access to a weapon. He also feels hopeful about the future.

As they talk through Daniel’s concerns, Sarah provides supportive counseling and determines that he is at low risk of suicide. They work through some of the practical and social issues during the visit. They also engage in some safety planning, and she provides the phone number for a crisis lifeline. Since Daniel’s next clinic visit with his oncologist will not be for another 3 months, Sarah suggests a referral to a counselor in his community for ongoing counseling and a referral to a psychiatrist for an assessment to determine if medication would help his mood. Daniel agrees to these referrals and plans to contact Sarah with any needs before his next appointment. They decided to meet during that visit to check in as well.

After the visit, Sarah communicates her assessment and plan to the oncologist. She also documents his screening tool results, her assessment, and the plan of care in his medical record.

Section 5: Case Study Review

Sarah follows the appropriate steps to assess Daniel for suicide risk and other psychosocial concerns. Daniel’s risk factors for suicide include being a single caucasian male, having a cancer diagnosis with long term physical and psychological impacts, financial stress, and mental health concerns. Sarah determines that he is at low risk because he does not have an intent or plan to harm himself. He also has social support and is agreeable to referrals that will provide ongoing mental health support and side effect management.

Section 6: Assessing Decision-Making Capacity

References: 16, 49, 56, 59, 88, 89

What is Decision-Making Capacity?

Certain situations in cancer care may warrant assessing a patient’s decision-making capacity. For example, concerns are typically raised when an oncologist recommends a treatment with clear benefits and the patient refuses it, or when a patient readily agrees to an invasive treatment or one with long-term impacts without engaging in a discussion with their doctor. Another example happens when a patient wants to leave the hospital against medical advice (Burns et al., 2023).

According to the U.S. Department of Justice (2022), clinical capacity is defined as:

> *“The functional determination by a clinician of whether an individual has the ability to adequately make a specific decision. Decision-making capacity involves the ability to take in information, understand the ramifications of that information through appreciation and reasoning, and then use that information to make a rational, self-interested decision that is consistent with their goals. Clinical capacity alone does not change the legal status of an individual”* (p. 5).

Clinical capacity is also on a continuum —from lacks capacity to diminished capacity to has capacity (U.S. Department of Justice, 2022). Professionals who are authorized by law use their clinical judgment to determine a patient’s capacity. Clinical decision-making capacity is different from competency, which is determined by a court (Moss, n.d.).

Healthcare providers, including oncology social workers, should understand some key points about decision-making capacity before an assessment takes place, including:

- Adults are presumed to have decision-making capacity.

- It is decision-specific, meaning a person can have capacity in one area, but not in another.
- It is fluid and may fluctuate over time and across contexts.
- Assessment techniques differ depending on the type of decision being evaluated.
- It is more than being alert and oriented, though this is a part of it.
- Having dementia or a mental health condition does not automatically determine that a person does not have capacity, though these conditions can compromise it.
- A determination should not be made on interviews and tests alone (U.S. Department of Justice, 2022).

Assessing Decision-Making Capacity

Oncology social workers, who are clinically trained to practice, may assess patients' decision-making capacity (U.S. Department of Justice, 2022). This type of assessment often happens collaboratively with various interdisciplinary team members, such as a physician, nurse practitioner, psychologist, psychiatrist, and/or ethicist. An oncology social worker should be aware of the laws and regulations in their state regarding their participation in this type of assessment, as well as the policies and procedures at their place of employment. Additionally, they should consider the National Association of Social Workers’ (2021) Code of Ethics, which states that social workers must respect and promote a client’s right to self-determination. If a client lacks decision-making capacity, the social worker must take reasonable steps to protect the client's interests and rights.

Before completing an evaluation, the oncology social worker can discuss the patient's situation with interdisciplinary team members to obtain information about their encounters with the patient and their perspectives, and complete a thorough chart review. They may also want to prepare questions they plan to ask the patient, depending on the decision at hand.

According to Libby et al. (2023), the foundation of a clinical capacity assessment is the mental status exam that includes the following:

- **Appearance** - whether the patient appears older or younger than their stated age, whether they make eye contact, how they are dressed, and their grooming and hygiene.
- **Overall behavior** - whether the patient is cooperative, agitated, avoidant, refusing to talk, or challenging to redirect.
- **Motor activity** - speed of movements (normal, slow, or fast), facial expressions, restlessness.
- **Speech** - rate, volume, fluency, tone, the amount of verbalization, and whether other people can understand them.
- **Mood** - the way the patient describes their feelings in their own words.
- **Affect** - the clinician's interpretation of the patient's inner emotional state based on observed behaviors. Some examples include happy, bright, elated, sad, irritated, angry, restricted, flat, anxious, or bizarre.
- **Thought process** - the way the patient organizes their thoughts. For example, linear, tangential, or a flight of ideas.
- **Thought content** - the subject matter of the patient's thoughts. Some examples include preoccupation, suicidal ideation, homicidal ideation, delusions, or phobias.

- **Perceptual disturbances** - what the patient perceives and whether they have hallucinations
- **Sensorium** - the level of consciousness and its stability
- **Cognition** - whether the patient is alert/attentive, oriented, able to concentrate, recall memories, and engage in abstract reasoning. The provider conducting the evaluation can use the Mini-Mental Status Examination (MMSE) or the Montreal Cognitive Assessment (MOCA) screening tools to assess a patient's cognition.
- **Insight** - the patient's understanding of their illness and the doctor's recommendations. It is often described as poor, limited, or fair.
- **Judgment** - the patient's ability to make good decisions. One way to learn about this is by asking the patient about specific scenarios and how they would respond or how they did respond. It is usually rated as poor, limited, or fair (Voss & Das, 2024).

All of these components are essential for accurately determining a patient's capacity to make medical decisions (Libby et al., 2023).

The following are examples of questions a clinician can ask a patient to assess their decision-making capacity. These questions are mainly for treatment-related decisions and can also help learn about a patient's treatment goals and help them plan their care in advance (Moss, n.d.). Still, these questions can be adapted to different scenarios:

- "As you understand it, what is your medical problem?
- How serious is your illness?
- What will happen if you are not treated?

- What do you think caused your illness, and why did it start when it did?
- Why are you being tested and treated as you are?
- Are there other treatment options besides the one you are receiving?
- How has your illness affected you?
- What is the most important thing to you in receiving treatment for your illness?
- What would you want to avoid in the treatment of your illness?
- What is your understanding of the meaning of your illness?
- Is God or religion important to you as you face your illness?
- What are your sources of strength?
- What role does faith play in your life, if any?
- How does faith influence your thinking about your illness?
- Are there religious practices that are particularly meaningful to you?
- Are there issues in your spiritual life that are troubling you now?
- Would you like to talk to someone about these issues?
- Help me understand how you see your family (or other significant relationship)
- What are your thoughts about their concerns, or your worries about them?” (Moss, n.d., p. 3).

Some additional example questions include:

- “What is your understanding of your condition?

- What is it that you are being treated for?
- What are the options for your situation? Or, what do you understand that your providers have told you about your situation, and what are your options?
- What could we do to help you feel more comfortable, or to help you make the decisions that we are advising you to make?
- What criteria do you use when you make decisions about your health?" (Burns et al., 2023, para. 17 & 18)
- What is the importance of...?
- What would happen if...?
- What are the benefits of...?
- What are the risks of ...?
- Tell me more about how you arrived at this decision.

A healthcare provider, including an oncology social worker, can also use the teach-back method when talking with a patient about their situation, meaning they can ask the patient to tell them in their own words what the provider just told them (Burns et al., 2023). This method can help the healthcare provider determine whether a patient understands what is being communicated.

Determining Decision-Making Capacity

In the medical setting, a patient has decision-making capacity if they can demonstrate the following:

- Understanding of their condition and the relevant information for the decision in question.
- Ability to weigh risks and benefits, and explore alternative options.
- Judge the relationship between their options, benefits, risks, and their values, preferences, and goals.
- Ability to reason and deliberate.
- Communicate clearly with healthcare providers about the decision in question, provide an explanation, and state their decision.
- Consistency in their logic and decision-making throughout the encounter (Libby et al., 2023; Moss, n.d.).

Documentation

The oncology social worker must document all aspects of the mental status exam, as well as the information learned during the encounter regarding the patient's understanding, abilities, and decision-making process. It is also essential that they document their capacity determination and discuss it with the healthcare team members involved in the patient's care. Collaborating on this aspect of a patient's care is critical so that team members can work together to understand the complete picture of the patient's situation and the decisions they are making about their care, and to provide the patient and their caregiver(s) with the appropriate support.

If it is determined that the patient lacks decision-making capacity, this must be documented. The plan for making the decision should also be documented, including whether the patient has a health care power of attorney and who will reach out to the person or people listed on the form to make decisions for the patient. If no one is available or the person does not have a healthcare power of attorney, the healthcare professional can use the decision-making hierarchy in their state. Ultimately, if a decision-maker cannot be found for the patient, the physician can decide in good faith (Burns et al., 2023).

Section 6 Key Terms

Decision-making capacity - a person's ability to make a specific decision appropriately. It is determined by professional judgment and is based on a continuum from lack of capacity to diminished capacity to having capacity. A patient may have decision-making capacity in one area and not in another.

Section 6 Reflection Questions

- What types of situations do you see most often in your practice that require an assessment of decision-making capacity?
- Which interdisciplinary team members do you typically work with in these situations?
- How do you communicate your assessment to the team and advocate for the patient?

Section 7: Assessing Ethical and Moral Dilemmas within Patient Care

References: 25, 28, 31, 87

Types of Ethical Issues and Moral Dilemmas

There are a variety of ethical issues and moral dilemmas that can arise in cancer care, and as interdisciplinary team members, oncology social workers are often involved in them. Some themes related to ethical issues and moral dilemmas are outlined below.

Communication

- An oncologist communicates cancer treatment recommendations. They typically aim to cure a disease or extend life, minimize symptoms and side effects, and achieve other goals of medicine, such as helping their patients maintain a sense of quality of life. Along with recommending treatment, an oncologist will review the goal of the treatment, its risks and benefits, how it will be administered, and potential side effects.
- Treatment goals can become misaligned between a patient and their healthcare provider when the patient's goals are not attainable due to the nature of their diagnosis or its progression, leading to conflict (Eckel et al., 2024).
    - For example, a patient may have a goal to be at their granddaughter's high school graduation in 5 years, but their cancer may be progressing and aggressive. The oncologist may be able to recommend a treatment to extend their life, but not for this entire time period. The patient may request treatments or interventions they researched on their own, but the oncologist may not consider them beneficial or safe. A conflict now exists within this vital relationship, and it may become difficult to navigate this patient's care going forward.

- Healthcare providers may struggle to communicate a difficult prognosis or the deterioration of a medical condition to a patient. They may fear that the patient will lose hope or give up. They may also be uncomfortable discussing these sensitive topics (Crico et al., 2022; Eckel et al., 2024).

- When communication is unclear or not straightforward, the patient may not fully grasp their situation, which can affect self-determination and ultimately compromise a patient's autonomy in decision-making. According to Eckel et al. (2024), "withholding or glossing over such discussions does not honor patients' abilities to make informed decisions about their future" (p. 298). Their future does not only include making decisions about their medical care. It can also involve taking a leave of absence from work or retiring, engaging in estate planning, and making decisions about who will care for minor children after their death.

- The discrepancy between provider communication and the patient's understanding of their disease can cause team members, including oncology social workers, to experience moral distress. Moral distress may increase when team members witness their colleagues providing false hope to a patient (Crico et al., 2022; Eckel et al., 2024).

End-of-life Care

- Advance care planning involves discussing and documenting a patient's healthcare preferences, so that their loved ones and medical team are aware of them in the event the patient is unable to make healthcare decisions for themselves. To engage in advance care planning, the patient should have a clear understanding of their prognosis, treatment options, and their right to refuse unwanted medical interventions in the future, such as artificial nutrition and hydration or resuscitation. They must also be willing to engage in the process and have the capacity to do so.

- When a patient has not engaged in advance care planning, healthcare providers are often left with little to no guidance on the patient's goals and wishes when they have become incapacitated. Then, family members, friends, and the healthcare team are burdened by having to make decisions without knowing the patient's goals or wishes, often leading to ethical and moral concerns about withdrawing therapies (Crico et al., 2022).
- Additionally, some jurisdictions have made medical aid in dying available to adult patients who are terminally ill (with six months or less to live) and mentally capable to decide that they can self-ingest medication to die peacefully in their sleep (Compassion & Choices, n.d.). Some healthcare providers may hold values that differ from those of patients seeking medical aid in dying, creating ethical and moral dilemmas when providing oncology care (Crico et al., 2022).

Social Work Assessment and Intervention

Communication

An oncology social worker can assess a patient's understanding of their illness, treatment options, and prognosis throughout the disease trajectory. They can also discuss the patient's future goals and how they hope to accomplish them.

If the oncology social worker determines at any point that the patient does not have a good understanding of their condition, they can share their assessment with the medical team and work collaboratively with them to improve the patient's understanding of their situation. They can serve as advocates for self-determination and patient autonomy in decision-making about their future care and plans, while emphasizing the importance of the patient understanding their condition. The oncology social worker may want to attend a clinic visit (or visits) to learn more about what the oncologist, nurse practitioner, or other healthcare provider is communicating to the patient and to facilitate the discussion between them. The oncology social worker may also arrange a family meeting with the patient, their loved ones, and certain members of the medical team to discuss these concerns and work together to help the patient better understand their condition.

If a conflict arises between the patient's goals and available treatment options, the oncology social worker can provide emotional support and help the patient process any grief related to the possibility that they may not achieve their goals. According to Eckel et al. (2024), "to mitigate or avoid ethical situations in which patients and providers may be at odds, social workers can maintain open lines of communication between the patients and health care team members" (p. 297). They can also help the patient and the medical team navigate care going forward.

End-of-life Care

Oncology social workers support patients, their loved ones, and interdisciplinary team members in end-of-life situations. Their role includes assessing patients' and family members' understanding of the illness and its trajectory, discussing advance care planning, and revisiting it throughout treatment.

> *"Social workers can introduce advance care planning, discuss and document the patients' treatment preferences and values, and then review these during treatment. Facilitating the completion of advance care planning documents supports the normalization of this process as a part of the treatment plan. When these documents need to be used, such as when patients are incapacitated and decisions must be made, surrogate decision-makers (those tasked with speaking on behalf of the patient) can feel the weight of the responsibility. Social workers can assess the surrogate's understanding of the disease and treatment, help them explore their*

> *feelings about the decision-making process, and facilitate meetings between the team and the surrogates*" (Eckel et al., 2024, p. 297).

The oncology social worker can discuss their advance care planning conversations with patients with the medical team and document them in the medical record. They can also ensure that any documents are scanned into the patient's medical record so they are available to anyone providing care to the patient.

If the patient does not complete advance care planning documents before they become incapacitated, this can present challenges, especially if the patient has not had any conversations with their loved ones or medical team about their goals and wishes. In this instance, the oncology social worker can provide support to the patient's loved ones and help them navigate a challenging situation. They may also advocate for a referral to palliative care for additional support.

Even if the patient did not complete advance care planning documents, if the oncology social worker has had conversations with the patient and their loved ones about their goals and wishes, this information can still be beneficial in supporting a patient through an end-of-life situation. Oncology social workers can serve as advocates for their patients and their loved ones—helping them understand the cancer as much as possible, bringing their voices forward, and collaborating with the medical team to help them understand any wishes and preferences the patient and their loved ones may have expressed.

Section 7 Key Terms

Moral distress - can occur when a healthcare provider knows the morally correct action to take but cannot take it because of constraints. It is a psychological response that may include anger, frustration, sadness, guilt, and/or confusion. There can also be physical responses, including sleeplessness and headaches.

Moral distress can cause conflict on interdisciplinary teams (University of Rochester Medical Center, n.d.).

Section 7 Reflection Questions

- What types of ethical issues and moral dilemmas do you see in your practice?
- How do you navigate through them?
- Have you experienced moral distress? If so, how did you deal with it?

Section 8: Promoting and Facilitating Family Communication

References: 12, 24, 29, 41, 43, 79, 80

Since cancer is often a disease that patients cannot manage alone, it is common for oncology social workers to work with caregivers, family members, and other loved ones throughout the disease trajectory. Providing clinical services to cancer survivors, families, and caregivers is included in the Association of Oncology Social Work's Scope of Practice. Some of the goals of clinical practice with survivors, families, and caregivers are to foster coping and adaptation to cancer, navigate healthcare systems, and mobilize new or existing resources. Some of the functions of clinical practice with them are to screen for people in need of social work services (for example, distress screening), complete psychosocial assessments to determine strengths and needs, develop a multidisciplinary care plan, and use a range of therapeutic and other interventions to address issues in each phase of the illness (Association of Oncology Social Work, n.d.).

A critical aspect of providing clinical care to patients and their loved ones is understanding their dynamics and communication styles, both before and after the cancer diagnosis. Some patterns may be established, while others may change over time. According to Collins et al. (2010), communication serves two functions: conveying information and revealing the nature of the relationship between the speaker and the listener. If the oncology social worker has the opportunity to observe family members as they communicate, it can provide valuable insights into their relationships. If the oncology social worker does not have the chance to observe communication, they can ask patients and their loved ones questions to gather this information. As oncology social workers gain an understanding of dynamics and communication styles, they can help promote, foster, and facilitate communication about the impact of living with cancer.

Social Work Assessment and Intervention

Assessment

The following are examples of some questions that oncology social workers can ask to assess a patient’s family system, dynamics, and communication styles.

- Tell me who you consider your family to be.
- What is the structure of your family, meaning the roles, boundaries, etc.?
- Who will be involved in your cancer care?
- What is your relationship like with (enter person)?
- How often do you communicate with them?
- What is your communication like with them? Both verbal and nonverbal.
    - Is it direct, open, and honest?

    - Is it unpredictable or unsafe?
    - Is it passive-aggressive in nature?
    - Is it one-way or two-way communication?
- Have you noticed any changes in your communication since your diagnosis?
- What are some positives about your relationship and communication?
- What are some challenges or things that you would like to improve?
- When you are communicating with them, how do they make you feel?
- What is their understanding of your situation?
- In addition to the cancer diagnosis, are there other issues or concerns you are dealing with?
- How do you typically work through issues and resolve conflicts? Do you make decisions together? (Collins et al., 2010; Smith, n.d.)

Intervention

After learning more about communication within a family, the oncology social worker can build on their strengths and, if appropriate, help them improve their communication. One intervention is helping people understand their own communication style and patterns, and their role in relationships. Once they have that understanding, they can work on improving areas that would benefit themselves and others (Smith, n.d.). For example, if a patient is typically avoidant and does not express how they are feeling, the oncology social worker may help them understand their style and pattern. They can also work with the patient on how to communicate differently with their family, as people typically need to know how the patient is feeling physically or emotionally throughout the cancer experience to better support them.

Patients may also need to set boundaries with others regarding communication. Boundaries can help patients take care of themselves better and put themselves first. They can also help patients maintain significant relationships while distancing themselves from people who may negatively impact their lives. Oncology social workers can help patients set boundaries and support them in their communication with others (Hill Schnipper, 2020).

Communicating with Children

When children are involved in the family system, there are other considerations for communication, such as their age, developmental level, their relationship to the person with cancer, and their understanding of the situation. If the child has cancer, the same considerations apply, except that when thinking about relationships, it is important to consider their relationships with other people who will be a part of their care. The following sections review how to talk with children about an adult's cancer, their own cancer, or their sibling's cancer.

Talking with Children About an Adult's Cancer

When an adult is diagnosed with cancer, it is common for their first concern to be how they will talk with their children or grandchildren about it. Before speaking with their children or grandchildren, families should consider their current communication styles, how the child typically wants information, and how the child processes it. For example, some children may want to know information right away, in smaller, more manageable pieces. In contrast, others can process more information at once and prefer to have as much of it as possible. Depending on the situation, a parent or grandparent may tell a child or children about the diagnosis right away, or some may wait until they have more information about the cancer and treatment plan.

The following are some other considerations for adults before they have a conversation with their child/children or grandchild/grandchildren about their cancer diagnosis:

- Take time to prepare.
    - People do not have to follow a script, but they may benefit from having some of what they would like to say ready.
        - They will likely need to consider the child/children's age and developmental level to identify appropriate, understandable language.
        - They can provide key information, including:
            - Using the word cancer and giving a general, age-appropriate description of it.
            - Talk about what causes cancer and provide reassurance that the child/children did not cause it.
            - Let them know how it will be treated. Share any information about how much time they will be away from home. For example, if treatment is provided in the inpatient setting, they can share how long they will be in the hospital.
            - Talk about how the child/children will be impacted, and what the plan is to have the impact on their lives be as small as possible.

    - Children will also likely ask if their parent or grandparent is going to die, so it can help to have an answer prepared for this question.
    - It can be helpful to acknowledge that the situation is scary and validate their feelings.
    - It can also be helpful to have a plan in mind for how often they will check in as a family, and to reiterate that the child/children can talk to the adult anytime about how they are feeling.
  - As part of the preparation, people will want to think about who they would like to have present during the initial conversation and those that follow.
  - People should also schedule a time for the discussion, if possible. There should be ample time for discussion and questions. The adult can check in with the child/children throughout the conversation. The child/children will likely need time to absorb the news. It is acceptable to check in and either stop the conversation and talk more later, or continue as the child/children feel comfortable.
- Accept that there is a need to tell the child or children that something is wrong.
  - If children are not informed, they will pick up on certain things and imagine the worst, which may be scarier than the diagnosis. They will likely also overhear something in a conversation or learn about it from someone else in their life.
- Acknowledge that it may not be possible to discuss everything in one sitting, and all of the answers may not be available.

    - It is acceptable to have multiple conversations when people are ready, and it is fine to say, “I don’t know. That is a good question. I will find out the answer for us both.”

- Patients can try to have a conversation with a child or children when they are feeling less shocked or upset. This does not mean they should not be emotional at all, but some people need time to process, or they may want to lean on another person to lead the conversation (Dana-Farber Cancer Institute, n.d.).

At the end of the initial conversation, the adult can ask the child/children how often they would like to check in, and they can take some of the steps outlined above for subsequent conversations to prepare and communicate appropriately.

An oncology social worker can provide guidance and resources to help adults talk with their children, so it is essential to have knowledge and skills in this area of psychosocial care.

Talking with a Child about Their Cancer

When a child becomes sick, everyone in the family is affected. Adults may consider trying to protect their child from the diagnosis and the fear they may be experiencing, but children can be even more afraid of things they do not understand. Therefore, being honest and talking about what cancer is and what it means to them can help them feel less anxious.

When talking with the child, it is recommended that adults use the word cancer and other general terms they may hear, such as hospital or side effects. It is also recommended to divide topics into smaller conversations to help the child feel less overwhelmed.

Cancer and related topics need to be explained in an age-appropriate manner. For example, cancer could be described to young children as “bad cells” and the treatment “fights” them. School-aged children can understand a bit more about cancer, but they may be afraid that they did something wrong to cause it or that it is contagious. They may have also heard about certain people dying from cancer, so they will likely be fearful of that happening to them. Cancer can be explained to them in more detail, using medical terms, with the acknowledgment that there are many different types of cancer and treatments for it. Teenagers can understand even more about cancer than school-aged children, and they may want more details about their diagnosis. It can also be helpful to talk with them about the challenges they may face, such as hair loss or school absences, so the adult and teenager can start thinking through how they will address them. They can also identify who they want to talk with about their diagnosis, so it is important to check in with them regularly to allow them to ask questions and talk about what they are experiencing.

An oncology social worker can provide guidance and resources to help adults talk with their child about their cancer diagnosis, so it is essential to have knowledge and skills in this area of psychosocial care. An oncology social worker can also help the parent understand common reactions and behaviors children may experience based on their age, and provide support to each family member to help them cope with the cancer diagnosis individually and as a family (Holland, n.d.).

Talking with a Sibling of a Child with Cancer

An entire family is affected when a child becomes ill. It is crucial to keep open lines of communication with a sibling of a child with cancer and to support them throughout the cancer experience.

The following are some considerations for adults when communicating with siblings of a child with cancer.

- Be open and honest. Talk about cancer and its treatment in an age-appropriate manner.
- Acknowledge the unknown, check in for understanding, and clear up any misinformation.
- Validate their feelings and experiences, especially tough emotions such as anger, fear, sadness, loneliness, jealousy, guilt, embarrassment, confusion, and a sense of loss of control.
- Try to keep life as normal as possible and make time for siblings. Routines can be helpful as they provide stability. Family members or friends may need to be involved to maintain a sibling's routine. Tell the sibling about how their routine might change. As part of the routine, talk about fun ways they can spend one-on-one time with a parent or sibling so they feel important and connected to the family.
- Prepare them for uncomfortable situations. Talk about what their sibling who is ill might look like or how long they might be away from home. Discuss how other people might react, and in return, how the sibling can respond to these reactions (St. Jude Children's Research Hospital, 2024).

An oncology social worker can provide guidance and resources to help adults talk with their children about childhood cancer and the impact on siblings, so it is essential to have knowledge and skills in this area of psychosocial care.

Section 8 Reflection Questions

- How do you assess communication within families in your clinical practice?
- What types of interventions do you use to promote healthy communication strategies?

- What is your experience working with patients who have children and/or grandchildren? Or, if you are a pediatric social worker, what is your experience working with children with cancer, their siblings, and their parents?
- What types of tips and strategies do you find help families the most?

Section 9: Documenting Clinical Encounters

References: 58

In the National Association of Social Workers' "Standards for Social Work Practice in Health Care Settings" (2016), there is a standard for record keeping and confidentiality that states the following:

> *"Social workers practicing in health care settings shall maintain timely documentation that includes pertinent information regarding client assessment, intervention, and outcomes, and shall safeguard the privacy and confidentiality of client information.*
>
> *Interpretation*
>
> *Clear, concise, and ongoing documentation of social work services in health care settings facilitates effective communication with other health care providers and organizations, thereby promoting continuity of services. Documentation serves as a foundation for care planning and for practice and program evaluation. In addition, professional documentation is often required for services reimbursement, utilization, or legal review, and demonstration of organizational accountability to payers or funding sources. The purpose of documentation is to foster strong working*

relationships with, and services for, clients in a health care setting” (p. 34-35).

Documentation must also be “prepared, secured, and disclosed in accordance with regulatory, legislative, statutory, and organizational requirements”(National Association of Social Workers, 2016, p. 35).

Documentation of clinical encounters is considered high-quality when it includes the following:

- The patient’s identifying information.
- Results from any screening tools they may have completed.
- Initial and subsequent biopsychosocial and spiritual assessments.
- The psychosocial care plan including how it will be monitored and how progress towards goals will be quantified. The services provided and any other information about plan implementation should also be included.
- Referrals to or from other providers, organizations, or resources, including the rationale for them.
- Dates, times, and descriptions of contact with the client, people from their support system, and other healthcare providers or organizations.
- When appropriate, written permission from the patient to release and/or obtain information.
- When supervision or consultation was sought or provided to enhance services.
- Documentation of compliance with confidentiality and the patient’s privacy rights.

- The transfer or termination of services (National Association of Social Workers, 2016).

The healthcare social worker should also inform patients of confidentiality requirements and services before initiating services. This discussion is necessary to ensure the client provides informed consent and understands how the social worker may disclose their information to other healthcare professionals, as well as how the hospital responds to requests for information from external sources. Additionally, technology should also be considered and used professionally and appropriately. Lastly, social workers should be familiar with the organization's electronic medical record and demonstrate competency in its use. They should also be knowledgeable about the Health Insurance and Portability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (National Association of Social Workers, 2016).

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