Natural Resources for Human Health
eISSN: 2583-1194

Original Research

Received 09 May 2025
Revised 12 May 2025
Accepted 25 June 2025

Natural Resources for Human Health 2025, Vol. 5 (4): 882–893

KEYWORDS:
Social Care, Oncology, Nurse–Social Consultant Model, Psychosocial Support, Cancer Patients, Emotional Well-Being

Social Care in Oncology: Nurse–Social Consultant Model for Psychosocial Cancer Support

Alanazi Fayez Suryan M[1], Alenezi Eid Nadaa R[2], Abdulaziz Mohammed Alfageeh[3], Mohamed Mothhi Thedan[4], Mohammed Qunayfith Alanazi[5], Alenezi, Nahar Manahi N[6], Muryifah Abdullah Alhazmi[7], Hanan Safaq Ghannam Alanazi[8], Reem Jalal Alanazi[9], Sarah Ali Mudhin Alanazi[10], Turkiah Ayed Sulaiman Alhazimi[11]

[1]Social Consultant – Northern Borders Health Cluster – Ministry of Health – Arar – Northern Borders Region – Saudi Arabia
Email: fize2008@hotmail.com
[2]Social Consultant – Northern Borders Health Cluster – Ministry of Health – Arar – Northern Borders Region – Saudi Arabia
Email: Nkd001@hotmail.com
[3]Senior Specialist, Social Service – Jazan Health Cluster – Ministry of Health – Jazan – Jazan Region – Saudi Arabia
Email: Aziz55577@gmail.com
[4]Social Specialist – Eradah and Mental Health Complex – Northern Borders Health Cluster – Ministry of Health – Arar – Northern Borders Region – Saudi Arabia
Email: mohmad1395ksa@gmail.com
[5]Senior Social Specialist – Northern Borders Health Cluster – Ministry of Health – Arar – Northern Borders Region – Saudi Arabia
Email: Abo_rakan6666@hotmail.com
[6]Social Specialist – Finance Department – Northern Borders Health Cluster – Ministry of Health – Arar – Northern Borders Region – Saudi Arabia
Email: nmalenezi@moh.gov.sa
[7]Nursing Technician – Al Aziziyah Primary Health Care Center – Northern Borders Health Cluster – Ministry of Health – Arar – Northern Borders Region – Saudi Arabia
Email: maalsulobi@moh.gov.sa
[8]Nursing Technician – Branch of the Ministry of Health in the Northern Border Region – Ministry of Health – Arar – Northern Borders Region – Saudi Arabia
Email: Hasalanazi@moh.gov.sa
[9]Nursing Specialist – Al Aziziyah Primary Health Care Center – Northern Borders Health Cluster – Ministry of Health – Arar – Northern Borders Region – Saudi Arabia
Email: rjalenazi@moh.gov.sa
[10]Nursing Specialist – Al Aziziyah Primary Health Care Center – Northern Borders Health Cluster – Ministry of Health – Arar – Northern Borders Region – Saudi Arabia
Email: saalalenezi@moh.gov.sa
[11]Nursing Specialist – Al Aziziyah Primary Health Care Center – Northern Borders Health Cluster – Ministry of Health – Arar – Northern Borders Region – Saudi Arabia
Email: Talhazimi@moh.gov.sa

Natural Resources for Human Health
eISSN: 2583-1194

ABSTRACT: The integration of psychosocial support into oncology care is essential for addressing the emotional, psychological, and social challenges faced by cancer patients. The Nurse–Social Consultant Model presents a collaborative approach to improving psychosocial cancer support, whereby oncology nurses work alongside trained social consultants to provide comprehensive care. This model acknowledges the multifaceted nature of cancer treatment, recognizing that emotional well-being significantly impacts patient outcomes. By fostering communication and collaboration between healthcare professionals, this approach ensures that patients receive tailored support designed to address their unique emotional and social needs. This team-based strategy cultivates a holistic care environment, promoting not only physical healing but also emotional resilience in patients and their families. Implementing the Nurse–Social Consultant Model can lead to improved patient satisfaction, reduced feelings of isolation, and better coping strategies among cancer patients. Social consultants contribute specialized knowledge in mental health, community resources, and family dynamics, enhancing the oncology nurse's ability to address complex psychosocial issues effectively. Together, they can create individualized care plans that encompass not only treatment adherence but also emotional support, family involvement, and social integration. This model emphasizes the importance of comprehensive care in oncology, highlighting that the psychosocial aspects of cancer treatment are just as crucial as the medical interventions. Ultimately, leveraging this collaborative model promotes a more inclusive approach to cancer care, advocating for the emotional well-being of patients as a fundamental component of their overall health.

INTRODUCTION

Cancer is no longer understood solely as a biological disease requiring medical treatment. The diagnosis and treatment of cancer produce profound psychological, social, financial, and existential consequences that unfold across the entire care trajectory, from the moment of diagnosis through treatment, survivorship, or end-of-life care. Distress, depression, anxiety, disrupted family roles, occupational loss, financial toxicity, and social isolation are not secondary concerns to be addressed after medical treatment is complete; they are core determinants of treatment adherence, quality of life, and even survival [1]. The recognition that psychosocial care is an essential component of comprehensive cancer care has grown substantially, yet the delivery of such care remains fragmented, under-resourced, and inconsistently implemented across oncology settings worldwide.

Distress has been described as the sixth vital sign in oncology and warrants routine screening because it is a multifactorial unpleasant emotional experience that may interfere with the ability to cope effectively with cancer and its treatment [2]. Institutional frameworks for psychosocial oncology have been developed to guide the planning of services and the allocation of resources, but the translation of these frameworks into routine practice remains uneven [3]. Interdisciplinary cancer treatment teams are often proposed as a feasible solution for psychosocial care, yet studies of team functioning show that role ambiguity, hierarchical communication, inadequate information sharing, and limited resources continue to constrain collaboration [4]. These barriers are not merely administrative; they shape whether patients receive timely emotional support, practical assistance, and coordinated follow-up.

In many cancer centers, nurses have become the de facto providers of psychosocial support, screening for distress and referring patients to specialized services when available. However, relying on nurses alone to absorb the psychosocial burden of cancer care is neither sustainable nor optimal. Nurses carry heavy clinical workloads, and the emotional labor of psychosocial care, when added to existing responsibilities without structural support, contributes to burnout and turnover. Conversely, oncology social workers possess specialized training in psychosocial assessment, counseling, resource navigation, and advocacy, but their numbers are often insufficient, and their integration into oncology teams varies widely [5]. The result is a care gap: patients with significant psychosocial needs may be screened but not adequately served, while professionals work in silos that inhibit coordinated, continuous support. Care coordination models that embed social work and nurse coordinators within oncology

patient and family support programs have shown that structured collaboration can deliver a high volume of interventions across emotional, practical, and resource domains [6].

Multidisciplinary psycho-oncology pathways in tertiary cancer centers demonstrate that structured referral and follow-up systems can improve the consistency of psychosocial care [7]. Stepped-care models, which match intervention intensity to patient need, have demonstrated efficacy in reducing cancer-related symptoms including psychological distress, fatigue, and insomnia, while also showing potential for cost-effectiveness [8]. The nurse–social consultant model seeks to balance the accessibility and continuity that nurses provide with the expertise and depth that social work consultants contribute, thereby creating a scalable and sustainable structure for psychosocial care delivery.

The Psychosocial Burden of Cancer and the Rationale for Integrated Care

The psychosocial consequences of cancer are pervasive and clinically significant. Systematic reviews and meta-analyses have consistently documented elevated rates of depression, anxiety, and cancer-related distress among patients across tumor types and stages [1]. Distress, as defined in oncology guidelines, is a multifactorial unpleasant emotional experience that may interfere with the ability to cope effectively with cancer and its treatment, and it is now recognized as the sixth vital sign requiring routine screening [2]. The bidirectional relationship between psychological distress and medical outcomes is well established: depression is associated with poorer treatment adherence, increased symptom burden, longer hospitalizations, and higher mortality. Distress also compounds social and financial hardship, as patients who are psychologically overwhelmed are less able to navigate complex healthcare systems, access resources, and maintain supportive relationships. Studies of multidisciplinary teamwork in adolescent and young adult oncology care identify similar facilitators and barriers, including the importance of clear roles, mutual respect, and shared understanding of psychosocial priorities [9].

Psychosocial interventions, however, can mitigate these burdens. A systematic review of psychosocial interventions for adults with incurable cancer found that such interventions, most often delivered by professionals with backgrounds in psychology, nursing, or social work, improved health-related quality of life and emotional well-being [1]. A Cochrane review of psychosocial interventions for newly diagnosed cancer patients examined combinations of nurse, social worker, psychologist, and physician delivery, finding evidence of benefit for quality of life and emotional outcomes. Stepped-care models have demonstrated efficacy in reducing cancer-related symptoms including psychological distress, fatigue, and insomnia, while also showing potential for cost-effectiveness [8]. These findings support the premise that psychosocial care should be structured, evidence-based, and delivered through coordinated models rather than ad hoc referrals. Universal distress screening conducted by a dedicated social worker among gynecologic oncology patients significantly improved screening completion rates compared with screening by office staff, suggesting that clear role assignment enhances screening fidelity [10]. Longitudinal assessment using electronic health record–based distress tools has also shown that social work intervention can be tracked against changes in distress over time, enabling more responsive care [11].

Despite this evidence, the implementation of psychosocial care in routine oncology practice remains inconsistent. A qualitative study of frontline professionals in China found that while nurses were the dominant force in screening, intervening, and referring survivors with psychosocial needs, the absence of institutional frameworks for psychosocial oncology left these professionals overburdened and unsupported [4]. The authors argued that oncology social workers, as a crucial supplement, could address the diverse and complex psychosocial needs of cancer survivors, but that the current framework of oncology social work was not institutionally authorized in many settings. Similar barriers have been identified in interprofessional oncology teams, including role ambiguity, hierarchical communication structures, inadequate information sharing, and limited resources [9]. Integrating social determinants of health screening into community cancer practice has been proposed as one way to improve oncology patient outcomes, because financial, housing, transportation, and social support concerns are often inseparable from emotional distress [12]. A trauma-informed and ecological framework for integrating caregivers into oncology care further emphasizes that psychosocial support must extend beyond the patient to the family system, recognizing caregiver distress as a core component of cancer care [13]. These findings underscore the need for models that clarify roles, establish communication pathways, and embed psychosocial care within the structural fabric of oncology services.

Conceptual Foundations of the Nurse–Social Consultant Model

The nurse–social consultant model is grounded in principles of interprofessional collaboration, stepped care, and role complementarity. Interprofessional collaboration in oncology is not merely the coexistence of multiple professions within a

treatment team; it requires deliberate structures for communication, mutual respect, and shared decision-making that allow each profession to contribute its distinctive expertise [4]. The model proposed here situates the oncology nurse as the continuous, relational anchor of psychosocial care—the professional who sees the patient most frequently, administers distress screening as part of routine clinical workflow, and maintains ongoing awareness of the patient's emotional and social state. The oncology social worker, in turn, functions as a consultant: not a distant specialist accessible only through formal referral, but an embedded team member who receives screened patients, conducts specialized psychosocial assessment, delivers or supervises evidence-based interventions, and advises the nursing and medical team on complex social, financial, and family dynamics.

This division of labor reflects the distinct training and scope of practice of each profession. Oncology social work is defined by the Association of Oncology Social Work as providing psychosocial services to patients, families, and significant others facing the impact of cancer, including stress and symptom management, care planning, case management, system navigation, education, and advocacy [5]. Social workers are trained in ecological assessment, family systems, crisis intervention, trauma-informed practice, and resource coordination—competencies that extend beyond the screening and supportive communication skills that nurses typically acquire. Nurses, conversely, possess clinical knowledge of disease and treatment that allows them to recognize when psychosocial symptoms may be intertwined with medical complications, medication side effects, or pain. The nurse–social consultant model leverages these complementary competencies rather than collapsing them into a single role. The model also responds to financial toxicity, which is increasingly recognized as a psychosocial domain requiring structured screening and referral [14], and to the broader evidence that financial hardship in cancer care requires multidisciplinary responses [15].

The model is also consistent with stepped-care frameworks, which organize psychosocial support into tiers of increasing intensity based on patient need [8]. In a stepped-care approach, all patients receive universal screening and low-intensity support; those with moderate needs receive targeted interventions; and those with complex or severe needs are referred to specialist psychosocial care. The nurse–social consultant model operationalizes this logic: nurses deliver universal screening and foundational supportive care, while social work consultants provide the targeted and specialist tiers. This structure prevents the overburdening of specialist services with patients who can be adequately supported at lower levels of intensity, while ensuring that patients with complex needs are identified and escalated appropriately. Practical guidance for social workers in oncology emphasizes that effective psychosocial care requires both structured assessment and flexible resource navigation, because patients' needs shift across the treatment trajectory [16]. Delineation of the core roles of oncology social workers in inpatient settings further supports the consultant function, showing that social work expertise is most valuable when it is deployed for complex assessment, family intervention, resource coordination, and advocacy rather than for tasks that can be safely delegated to other team members [17].

Roles and Responsibilities in the Nurse–Social Consultant Model

The nurse's role in the model encompasses several interconnected functions. The first is universal psychosocial screening. Oncology nursing staff administer standardized screening tools—most commonly the Distress Thermometer, often supplemented by depression and anxiety measures—as part of routine patient assessment [2]. Screening should occur at critical transition points: at diagnosis, at the initiation of treatment, at treatment completion, at survivorship entry, and at any point of significant change or crisis. The nurse's clinical judgment is essential in interpreting screening scores alongside observed behavior, family reports, and clinical context, recognizing that a numerical score alone does not capture the full picture of a patient's psychosocial state. Evidence from social work–led screening programs shows that dedicated role assignment can improve screening completion, but it also shows that screening must be linked to follow-up rather than treated as a stand-alone administrative task [10]. Electronic health record–based distress tools can support this linkage by making scores visible to the team and by documenting social work responses over time [11].

The second function is initial supportive communication and psychoeducation. Nurses provide brief, evidence-informed supportive interventions: active listening, normalization of distress, information about expected emotional responses, and basic coping strategies. They also educate patients and families about the availability of psychosocial services and the process of accessing them, reducing stigma and encouraging help-seeking. This foundational layer of support is not a substitute for specialized social work intervention, but it addresses the needs of many patients whose distress is mild and situational. The third function is triage and consultation request. When screening reveals moderate to severe distress, or when the nurse identifies complex social, financial, or family concerns, the nurse initiates a consultation request to the social work consultant. The request

should include the screening results, relevant clinical information, and a concise description of the observed concerns. This triage function is critical: it ensures that social work resources are directed toward patients most likely to benefit from specialized intervention, while avoiding unnecessary referrals that would overwhelm limited social work capacity.

The social work consultant's role is correspondingly multidimensional. The first function is specialized psychosocial assessment. Upon receiving a consultation request, the social worker conducts a comprehensive assessment that explores the patient's emotional state, coping resources, family and social support, financial situation, housing and transportation access, spiritual and existential concerns, and any history of trauma or mental health difficulty [5]. This assessment is ecological in orientation, recognizing that the patient's distress is shaped by the interaction between individual factors and the social environment, including systemic barriers such as poverty, discrimination, and inadequate insurance coverage [16]. The second function is evidence-based intervention. Depending on the assessment findings, the social work consultant may deliver brief structured interventions—such as problem-solving therapy, behavioral activation, or supportive counseling—or may coordinate more intensive psychotherapy or psychiatric consultation when indicated. The social worker also addresses concrete needs: connecting patients with financial assistance programs, disability benefits, transportation resources, housing support, and community-based services [14]. This dual focus on emotional and material support reflects the reality that psychosocial distress in cancer is rarely separable from social and economic hardship [15].

The third function is team consultation and capacity building. The social work consultant is not only a direct service provider but also a resource for the broader oncology team. The consultant advises nurses and physicians on managing complex patient interactions, contributes to multidisciplinary team meetings, and provides informal training and supervision on psychosocial topics [17]. This consultative function extends the reach of social work expertise beyond the individual caseload, strengthening the psychosocial capacity of the entire team. Scaling supportive oncology innovations from pilot projects to routine practice requires attention to role clarity, workflow integration, and leadership support, because the consultant role is most effective when it is embedded in everyday team operations rather than added as a separate service [18].

Table 1 summarizes the division of roles and responsibilities between nursing and social work in the model, organized by function and by the level of care intensity.

Function	**Oncology Nurse**	**Social Work Consultant**
Screening	Administers standardized distress and needs screening at defined intervals; interprets results in clinical context	Reviews screening data; identifies patterns and populations requiring targeted outreach; advises on tool selection and workflow
Initial support	Provides brief supportive communication, psychoeducation, and normalization; addresses mild distress and informational needs	Provides consultation to nurses on managing challenging interactions; steps in when initial support is insufficient
Triage and referral	Initiates consultation requests for moderate to severe distress or complex social needs; communicates relevant clinical and social information	Receives and prioritizes consultation requests; determines level of social work involvement required
Specialized assessment	Contributes medical and nursing perspectives to the assessment process	Conducts comprehensive ecological psychosocial assessment, including family, financial, housing, and trauma history
Intervention	Reinforces coping strategies and treatment adherence; monitors ongoing emotional status	Delivers evidence-based psychosocial interventions; coordinates financial, legal, and community resources
Care coordination	Maintains continuity across treatment transitions; communicates psychosocial concerns to medical team	Coordinates with community agencies, financial assistance programs, and specialty mental health services; advocates for patient needs

Team capacity building	Participates in multidisciplinary meetings; shares nursing observations	Provides consultation, informal training, and supervision to nursing and medical staff on psychosocial care

Operational Mechanisms: Screening, Consultation, and Care Pathways

The operational success of the nurse–social consultant model depends on clearly defined workflows that specify when, how, and by whom psychosocial concerns are identified and addressed. The first mechanism is universal screening embedded in routine workflow. Screening should not be an additional administrative burden imposed on nurses but an integrated component of patient assessment, analogous to vital sign measurement. The use of electronic health record–integrated screening tools facilitates this integration, and evidence from early integration of psycho-oncology services in cancer care shows that structured pathways can improve patient-related outcomes when screening is connected to timely intervention [19]. In one community oncology program, oncology nursing staff administered the electronic Distress Thermometer as part of normal patient rooming protocol and alerted providers when distress levels were elevated, automatically generating social work referrals [11]. This workflow demonstrates that screening can be embedded in existing routines without requiring separate appointments or significant additional staff time. A dedicated social work team conducting universal screening among gynecologic oncology patients significantly improved screening completion rates compared with screening by office staff, suggesting that clear role assignment enhances screening fidelity [10].

The second mechanism is tiered consultation and intervention. Not every patient who screens positive for distress requires the same level of social work involvement. The model proposes a tiered response structure aligned with stepped-care principles [8]. Tier 1 includes patients with mild distress or isolated practical needs; these patients receive brief supportive communication from the nurse, written resource information, and a follow-up check at the next visit. Tier 2 includes patients with moderate distress or multiple social needs; the social work consultant conducts a focused assessment, delivers brief problem-solving or supportive intervention, and connects the patient with relevant resources. Tier 3 includes patients with severe distress, complex trauma histories, major mental health disorders, or overwhelming social crises; the social work consultant provides intensive case management, coordinates with psychiatry and psychology, and may involve the multidisciplinary complex case council. This tiered structure ensures that social work resources are allocated proportionally to need and that the model remains sustainable under caseload pressures. Interprofessional collaboration has been shown to enhance the capacity of outpatient oncology services to address complex psychosocial needs, particularly when team members have clear referral pathways and shared documentation [20].

The third mechanism is structured communication and follow-up. The nurse–social consultant model requires reliable channels for information exchange. Daily or weekly interdisciplinary team meetings provide a forum for discussing patients with active psychosocial concerns, reviewing consultation outcomes, and adjusting care plans. Electronic health record–based communication tools—such as shared care plans, secure messaging, and standardized consultation notes—facilitate asynchronous coordination. Follow-up should be systematic: patients who receive social work intervention should have a documented plan for reassessment, and the nurse should be informed of the outcome so that ongoing monitoring can continue during routine clinical encounters. In a care coordination model embedding social work and nurse coordinators within an oncology patient and family support program, 1,280 interventions were delivered to 688 patients over six months, with coordination with other supportive services accounting for 22% of interventions, demonstrating the feasibility and productivity of structured nurse–social work collaboration [6]. Specialized psychosocial oncology teams that include patients and families as team members further illustrate how shared communication and mutual respect can extend the reach of psychosocial care beyond individual consultations [21].

Table 2 outlines the tiered consultation and intervention structure, specifying the criteria for each tier, the lead professional, the intervention components, and the expected follow-up.

Tier	Criteria	Lead Professional	Intervention Components	Follow-Up

Tier 1: Universal support	Mild distress (e.g., DT < 4); isolated informational or practical needs	Oncology nurse	Supportive communication, psychoeducation, written resources, normalization	Re-screen at next scheduled visit
Tier 2: Targeted consultation	Moderate distress (e.g., DT 4–6); multiple social needs; family or financial concerns	Social work consultant, with nurse collaboration	Focused psychosocial assessment, brief problem-solving or supportive intervention, resource linkage, benefits navigation	Social work follow-up within 2–4 weeks; nurse monitoring at each visit
Tier 3: Intensive intervention	Severe distress (e.g., DT ≥ 7); major mental health disorder; complex trauma; social crisis; safety concerns	Social work consultant, with psychiatry/psychology as needed	Intensive case management, trauma-informed intervention, coordination with specialty mental health, complex case council review	Frequent social work contact; multidisciplinary team review; documented care plan

Application Across the Cancer Continuum

The psychosocial needs of patients with cancer evolve across the care trajectory, and the nurse–social consultant model must adapt its focus accordingly. At diagnosis, the primary tasks are screening for pre-existing vulnerability, providing emotional containment, and beginning the process of resource assessment. The nurse administers baseline distress screening and introduces the patient to the psychosocial support available. The social work consultant assesses for history of mental health conditions, available social support, and immediate practical concerns such as insurance coverage and transportation to treatment. Standard frameworks for oncology navigation and survivorship care identify psychosocial support as a core category of service, which reinforces the need for systematic assessment at diagnosis and across transitions [22]. Early social work involvement is particularly important for patients with pre-existing severe mental disorders, who face disparities in cancer care and require coordinated psychiatric and oncologic management.

During active treatment, psychosocial needs often intensify as the cumulative burden of side effects, functional decline, financial strain, and disruption to work and family life accumulates. The nurse, seeing the patient at each treatment visit, is positioned to detect emerging distress through repeated screening and clinical observation. The social work consultant addresses emerging needs—managing financial toxicity, coordinating caregiver support, addressing housing or transportation barriers that threaten treatment adherence, and providing brief therapeutic intervention for anxiety or depressive symptoms [14]. The consultative function is particularly valuable during this phase, as the social worker advises the nursing team on managing complex patient presentations and contributes to treatment planning discussions. Financial hardship in cancer care requires multidisciplinary perspectives because the solutions are not purely psychological; they involve benefits counseling, insurance navigation, employer communication, and community resources [15].

At treatment completion and survivorship entry, the psychosocial focus shifts. Patients may experience anxiety about recurrence, grief over lost functioning, uncertainty about the future, and the withdrawal of the intensive support network that characterized active treatment. The nurse–social consultant model provides a structured transition: the nurse conducts a survivorship distress screening, and the social work consultant offers a survivorship-focused assessment addressing return-to-work concerns, insurance continuity, fertility and sexual health, and ongoing mental health needs. Survivorship care plans should explicitly document psychosocial history and recommended follow-up, ensuring that psychosocial concerns are not lost in the transition from oncology to primary care [22]. Scaling supportive oncology innovations across a cancer center requires survivorship pathways that preserve psychosocial continuity rather than treating survivorship as a purely medical phase [18].

At advanced disease and end-of-life, the model intersects with palliative care and bereavement support. The nurse provides ongoing emotional support and symptom monitoring; the social work consultant addresses advance care planning, family caregiver burden, legacy work, and grief support for patients and families. Integrating palliative care and social work into oncology in low-resource settings has shown that patient-centred support models can be feasible from diagnosis through survivorship or end-of-life care, even when resources are constrained [23]. The trauma-informed and ecological framework for

integrating caregivers into oncology care aligns with the social work consultant's role in recognizing and addressing caregiver distress as a core component of psychosocial care [13]. Social care nurse models, such as the OSCAR project, demonstrate that a designated social care nursing role can bridge psychosocial and practical support, although such models require clear boundaries and strong collaboration with social work to avoid role confusion [24]. A breast cancer nurse model combining continuity of care, psychosocial support, and social care further illustrates how nursing continuity can be paired with specialized psychosocial consultation to meet complex needs [25].

Challenges and Implementation Considerations

The nurse–social consultant model, while conceptually coherent, faces significant implementation challenges that must be addressed for it to function effectively. The first challenge is workforce capacity and role clarity. Oncology social work positions are not universally available, and in many settings, social workers are employed by external foundations rather than integrated into healthcare institutions, limiting their authority and continuity [3]. Even where social workers are present, their ratio to patients may be inadequate to support the consultation demands of a busy oncology service. Role ambiguity—uncertainty about which professional is responsible for which aspect of psychosocial care—can undermine collaboration and lead to gaps or duplication [4]. The model requires explicit role descriptions, collaborative agreements, and leadership support to establish the nurse–social work partnership as a legitimate and valued component of oncology care [17].

The second challenge is communication and hierarchy. Hierarchical communication structures in medicine can inhibit nurses and social workers from raising psychosocial concerns or challenging medical priorities [9]. The nurse–social consultant model depends on flattened communication pathways in which psychosocial information flows bidirectionally between nursing, social work, and medicine. Multidisciplinary team meetings, shared documentation, and interprofessional training can help to dismantle hierarchical barriers, but sustained effort is required to create a culture in which psychosocial expertise is treated as equal in importance to biomedical expertise [20]. Specialized psychosocial oncology teams that include patients and families can model shared decision-making, but they also require institutional support and protected time for team meetings [21].

The third challenge is financial sustainability and reimbursement. Psychosocial services are often poorly reimbursed or unreimbursed, creating financial disincentives for institutions to invest in social work staffing [15]. Financial toxicity screening and intervention, which are core functions of the social work consultant, may themselves be constrained by gaps in available resources and assistance programs [14]. Policy advocacy for reimbursement of psychosocial care, including social work services, distress screening, and caregiver support, is essential for the long-term sustainability of the model. Institutional commitment—reflected in budget allocation, staffing ratios, and quality metrics—is equally important. Practical guidance for social workers emphasizes that resource navigation is a skilled activity that requires time, relationships with community agencies, and institutional recognition of its value [16].

The fourth challenge is screening implementation and follow-through. Despite strong evidence for distress screening, implementation in routine practice remains inconsistent [2]. Barriers include competing clinical demands, lack of standardized protocols, insufficient training, and the perception that screening is an administrative requirement rather than a clinical tool. Screening without adequate follow-up—the "screen and forget" phenomenon—can be worse than no screening, as it identifies needs that are then left unaddressed [10]. The nurse–social consultant model must be implemented with robust follow-up mechanisms: every positive screen must generate a documented response, and every consultation must have a closed loop back to the referring nurse and the medical team [11]. Social determinants of health screening adds another layer of complexity, because positive screens for housing, transportation, or food insecurity require community resource linkages that may not be available in all settings [12].

Measuring Outcomes and Quality Indicators

The evaluation of the nurse–social consultant model should encompass process, patient, provider, and system outcomes. Process indicators include the proportion of eligible patients screened at defined intervals, the proportion of positive screens followed by social work consultation within a specified timeframe, the proportion of consultation requests with documented assessment and intervention plans, and the completion rate of follow-up contacts [10]. These indicators measure whether the model is being delivered as intended and can identify operational breakdowns that require correction. Electronic health record–based monitoring can support process measurement by making screening, consultation, and follow-up visible to the team [11].

Patient-reported outcomes include distress scores, health-related quality of life, patient satisfaction with psychosocial care, perceived social support, and financial toxicity measures [14]. Longitudinal assessment is essential: the model's impact may not be evident at a single time point but may manifest as reduced distress trajectories, improved treatment adherence, or better quality of life over the course of care. The use of electronic health record–integrated distress monitoring, as demonstrated in community oncology programs, enables longitudinal tracking without additional research infrastructure [11]. Social determinants of health screening can also be used to measure whether practical needs are being identified and addressed, rather than only emotional symptoms [12].

Provider outcomes include nurse and social worker burnout, moral distress, perceived collaboration quality, and role clarity [20]. The model is intended not only to improve patient care but also to distribute the emotional labor of psychosocial care more equitably and sustainably. If the model increases rather than reduces professional burden, it is unlikely to be sustained. System outcomes include healthcare utilization, emergency department visits, hospitalizations, unplanned treatment interruptions, cost of care, and referral patterns to specialty mental health services [18]. Stepped-care models have shown potential for cost-effectiveness by reducing unnecessary specialist utilization while directing resources to patients with the greatest need [8]. Specialized psychosocial oncology teams and interprofessional collaboration models provide additional evidence that team-based psychosocial care can improve coordination and patient experience when outcomes are systematically measured [20] [21].

Table 3 presents a framework of quality indicators for the nurse–social consultant model, organized by domain and specifying example measures and data sources.

Domain	Indicator	Example Measure	Data Source
Screening process	Universal screening coverage	Proportion of new patients screened with distress and depression/anxiety measures within 30 days of diagnosis	Electronic health record
Screening follow-through	Timely social work consultation	Proportion of patients with moderate or severe distress seen by social work within 7 days	Electronic health record, consultation logs
Assessment quality	Comprehensive assessment documentation	Proportion of social work consultations with documented ecological assessment	Chart audit
Intervention delivery	Evidence-based intervention	Proportion of Tier 2–3 patients receiving documented problem-solving or supportive intervention	Chart audit
Patient outcome	Distress reduction	Mean change in distress score from baseline to 3 months for patients receiving social work intervention	Electronic health record, patient-reported outcome measures
Patient experience	Satisfaction with psychosocial care	Patient-reported satisfaction with emotional and practical support	Survey
Provider outcome	Perceived collaboration	Nurse and social worker ratings of interprofessional collaboration and role clarity	Validated collaboration scale
System outcome	Resource linkage	Proportion of patients with identified financial or social needs connected to resources	Chart audit, resource referral logs

Recommendations for Practice, Policy, and Research

For practice, oncology programs should establish formal nurse–social work collaborative structures with written role descriptions, agreed-upon screening and consultation protocols, and regular interdisciplinary team meetings [4]. Screening should be embedded in routine workflow using electronic health record–integrated tools, and every positive screen should have

a defined response pathway [2]. Social work consultants should be integrated into oncology teams rather than positioned as external referral resources, enabling informal consultation, team capacity building, and continuity of relationships with patients and staff [17]. Training should be provided to both nurses and social workers on the model's workflows, screening tools, and tiered intervention protocols, with ongoing supervision and support [16]. Practical guidance for social workers in oncology should be adapted to local workflows so that resource navigation and emotional support are not treated as competing tasks but as integrated components of psychosocial care [16].

For policy, advocacy is needed for reimbursement of psychosocial care, including social work services and distress screening, across public and private insurance systems [15]. Institutional and national standards should specify minimum social work staffing ratios for oncology services, analogous to standards for nursing staffing [3]. The development of standardized oncology social work practice standards, as has been undertaken in some jurisdictions, provides a foundation for quality assurance and professional accountability [5]. Policies should also address the structural determinants of psychosocial distress, including insurance coverage, transportation access, and financial assistance for cancer patients [12]. Social care nurse models and breast cancer nurse models show that workforce innovation can expand psychosocial capacity, but they also show that such roles must be clearly linked to social work expertise rather than replacing it [24] [25].

For research, priorities include rigorous evaluation of the nurse–social consultant model through pragmatic trials and quasi-experimental designs, with attention to patient-reported outcomes, cost-effectiveness, and sustainability [8]. Research should examine the model's effectiveness across diverse populations, including patients with pre-existing mental health conditions, caregivers, and patients in low-resource settings [13]. Implementation research is needed to identify the contextual factors that facilitate or impede adoption, including organizational culture, leadership support, workforce availability, and reimbursement structures [18]. Qualitative research exploring the experiences of nurses, social workers, and patients within the model will provide essential insights into mechanisms of effect and opportunities for refinement [9]. Early integration of psycho-oncology services in government hospitals and low-resource settings offers a promising direction for testing adapted versions of the model where social work staffing is limited [19]. Integrated palliative care and social work models in rural settings further suggest that the nurse–social consultant model can be adapted to resource-constrained environments if roles and referral pathways are clearly defined [23].

CONCLUSION

The psychosocial dimensions of cancer care are essential and significantly influence treatment outcomes and quality of life. The nurse–social consultant model effectively delivers psychosocial support by combining the strengths of oncology nursing and social work. Nurses facilitate universal screening and supportive care, while social work consultants provide specialized interventions and resource coordination. This collaborative approach meets patient needs through a tiered care system, integrating psychosocial support into standard oncology practices. However, challenges such as workforce limitations and role ambiguity must be addressed to optimize this model. The strong evidence supporting psychosocial interventions highlights the need for their integration into comprehensive cancer care, necessitating rigorous evaluation and structural changes in healthcare practices.

References

[1] Mikkonen H, Hökkä M, Saarto T, Stenberg JH, Junttila K. Psychosocial interventions and health-related quality of life in adults with incurable cancer: systematic review. BMJ Supportive & Palliative Care. 2025;15(5):572-85.

[2] Riba MB, Donovan KA, Andersen B, Braun I, Breitbart WS, Brewer BW, Buchmann LO, Clark MM, Collins M, Corbett C, Fleishman S. Distress management, version 3.2019, NCCN clinical practice guidelines in oncology. Journal of the National Comprehensive Cancer Network. 2019 Oct 1;17(10):1229-49.

[3] Pirl WF, Greer JA, Gregorio SW, Deshields T, Irwin S, Fasciano K, Wiener L, Courtnage T, Padgett LS, Fann JR. Framework for planning the delivery of psychosocial oncology services: An American psychosocial oncology society task force report. Psycho-Oncology. 2020 Dec;29(12):1982-7.

[4] Tang YH, Zhang J. Clinical effect of enhanced recovery after surgery based on multidisciplinary collaboration model in postoperative gastric cancer surgery. World Journal of Gastrointestinal Surgery. 2025 27;17(7):105387.

[5] Zebrack B, Schapmire T, Otis-Green S, Nelson K, Miller N, Donna D, Grignon M. Establishing core competencies, opportunities, roles and expertise for oncology social work. Journal of Social Work. 2022 Jul;22(4):1085-104.

[6] Low S, Nakaji A, Irwin SA, Van der Gaag JK. Creating a proactive interdisciplinary approach to care: Embedding oncology care coordination within an oncology patient and family support program.
[7] Fann JR, Ruark J, Sharpe M. Delivering Integrated Psychosocial Oncology Care. Psycho-Oncology. 2021 Jan 22:385.
[8] Ferrier G, Filipovic A, Wasan H, di Pietro A, Mittal D, Kamath G, Kharawala S, Mehmud F. A targeted literature review on the impact of tailored interventions on patient outcomes in oncology. Oncogene. 2025 3;44(20):1439-51.
[9] Shin H, Seo JY, Choi ES, De Gagne JC. Facilitators and barriers to multidisciplinary teamwork in adolescent and young adult oncology care: a descriptive qualitative study. Journal of multidisciplinary healthcare. 2025 31:917-32.
[10] Chen YS, Li C, Pollinger B, Taylor N, Zighelboim I, Graul A. Universal distress thermometer screening by a social worker among gynecologic oncology patients improves the rate of distress screening. Gynecologic Oncology. 2024 Nov 1;190:S337-8.
[11] Couture L, Cropp BF, Taylor E, Robbins T, Remick SC, Sanyal A. Longitudinal assessment of cancer-related distress during cancer treatment using an electronic health record–based tool and impact of social work intervention.
[12] Rochat J, Delgado LL, Zinck L, Gor PP, Gabriel P, George L, Fidyk L, Herron A, McAnulty Zisa M, Pyle B, Severance
[13] C. Integrating social determinants of health screening to improve oncology patient outcomes in a community cancer practice within an academic health system.
[14] Budhu JA, Tin AL, Steele M, Doyle S, Gany F, Elshiekh C, Caramore A, Sokolowski S, Vega L, Sharma B, Blinder V. Screened but still struggling: challenges in delivering financial assistance after positive financial toxicity screens. JCO Oncology Practice. 2025;21(12):1868-75.
[15] Yeager KA, Zahnd WE, Eberth JM, Vanderpool RC, Rohweder C, Teal R, Vu M, Stradtman L, Frost EL, Trapl E, Gonzalez SK. Financial navigation: staff perspectives on patients' financial burden of cancer care. Journal of cancer survivorship. 2023 Oct;17(5):1461-70.
[16] Ostadhashemi L, Khoshnami MS, Javadi SM, Arshi M, Noruzi S, Yazdani A, Khalvati M. Practical Guide for Social Workers in Working with Cancer Patients: A Mixed Study. International Journal of Cancer Management. 2025 Jan 1;18(1):1.
[17] BrintzenhofeSzoc K, Guan T, Middleton A, Otis-Green S, Schapmire T, Rayton M, Nelson K, Grignon ML, Zebrack B. Delineation of core roles of oncology social workers in inpatient settings: a secondary data analysis. Social work in health care. 2024 Aug 8;63(6-7):473-88.
[18] Zebrack B, Schapmire T, Otis-Green S, Nelson K, Miller N, Donna D, Grignon M. Establishing core competencies, opportunities, roles and expertise for oncology social work. Journal of Social Work. 2022 Jul;22(4):1085-104.
[19] Bisht N, Singh S, Govind R, Kapoor A, Sarin A, Biju M, Jaiswal P, Dhingra R, Vats P. 1664P Early integration of psycho-oncology in cancer care: A model of care from a quaternary care government hospital in India and its patient related outcomes. Annals of Oncology. 2024 Sep 1;35:S1003.
[20] Aburizik A, Raque TL, Spitz N, Mott SL, McEnroe A, Kivlighan M. Responding to distress in cancer care: Increasing access to psycho oncology services through integrated collaborative care. Psycho-Oncology. 2023 Nov;32(11):1675-83.
[21] Feldstain A, Bultz BD, de Groot J, Abdul-Razzak A, Herx L, Galloway L, Chary S, Sinnarajah A. Outcomes from a patient-centered, interprofessional, palliative consult team in oncology. Journal of the National Comprehensive Cancer Network. 2018 Jun 1;16(6):719-26.
[22] Forsythe LP, Kent EE, Weaver KE, Buchanan N, Hawkins NA, Rodriguez JL, Ryerson AB, Rowland JH. Receipt of psychosocial care among cancer survivors in the United States. Journal of Clinical Oncology. 2013 Jun 1;31(16):1961-9.
[23] Totadri S, Bansal D. Addressing psychosocial support in children with cancer in low-and middle-income countries. The Indian Journal of Pediatrics. 2019 Feb 12;86(2):105-6.
[24] Porzig R, Neugebauer S, Heckmann T, Adolf D, Kaskel P, Froster UG. Evaluation of a cancer patient navigation program ("Onkolotse") in terms of hospitalization rates, resource use and healthcare costs: Rationale and design of a randomized, controlled study. BMC Health Services Research. 2018 Jun 5;18(1):413.

[25] Vandezande L, Reymen M, Raeymaekers B, Neven P, Christiaens MR. Abstract P1-12-02: Predictive variables of additional contacts with breast cancer counselors after sentinel lymph node negative breast conserving surgery in postmenopausal women. Cancer Research. 2013 Dec 15;73(24_Supplement):P1-12.