Reviewer's report

Title: Feasibility of brief psychological distress screening by a community-based telephone helpline for cancer patients and carers.

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Reviewer: Kristi Graves

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Review for BMC Cancer:
Feasibility of brief psychological distress screening by a community-based telephone helpline for cancer patients and carers.
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The purpose of this study was to evaluate the feasibility of screening for distress and appropriate referral among cancer patients and their caregivers using the Distress Thermometer (DT) as administered through a community telephone helpline. The paper has a number of strengths, including the sample size, inclusion of caregivers (“carers”) within the sample, evaluation of the relationship between DT scores and referrals for care, and focus on a novel method of distress screening through a community helpline. In addition, the question posed by the authors is fairly well defined, the methods used are acceptable, and the authors appropriately describe and summarize the distress screening literature in the introduction. The paper would be further strengthened by some additional clarification and description, as noted in the sections below.

1. Abstract:
• Discretionary Revisions –
  o Clarifying that the cut-offs of 4 and 6 on the DT (for patients and carers, respectively) are “>” cut-off levels would improve precision.
  o The phrase “level of care in cancer patients” is unclear in the abstract without the context of the tiered model of care.

2. Background:
• Discretionary Revisions –
  o In the second sentence of the Background section, providing an operational definition of “ongoing” clinically significant distress would be useful. In the studies cited, how long did clinically-significant distress remain in cancer patients? Is this level of distress lifelong for some survivors? If so, what percentage of patients?
  o Remove “p. 2” from the quote from reference #6 toward the bottom of page 5.
  o It would be useful to provide information about the availability and use of other cancer helplines. If the model of using a community helpline for distress
screening is to be implemented in other areas, it would be helpful to know more about how many of these helplines exist (either in Australia or worldwide, if known).

• Minor Essential Revisions –
  o The information presented regarding validity of referrals based on DT cut-offs is not very compelling (e.g., 47% met DSM-IV criteria for a disorder). Additional justification is needed regarding the reasons behind or benefits of referring helpline callers to a certain level of care based solely on the DT score. Have prior studies evaluated the impact of referral based on DT scores alone? What are the pros and cons of this approach versus using the DT as a screening tool with individuals who score > the cut-off referred for more thorough psychosocial / psychiatric screening prior to referrals for actual care?

  o The introduction would be strengthened by describing the gap in the literature regarding whether screening for distress through the DT improves any long-term functional or psychosocial outcomes. We do not yet fully know whether implementing a distress screening program is actually effective in not only accurately identifying truly distressed individuals, but then providing appropriate referrals which may or may not result in overall improvements of physical (e.g., adherence to treatment, fewer treatment side effects, less pain) or psychosocial (e.g., fewer cases of anxiety, mood, or adjustment disorders; greater perceived social support, greater satisfaction with treatment and care, etc.) clinical outcomes. The present study is one step in this direction with the evaluation of whether helpline volunteers can provide referrals based on DT scores.

3. Methods:

• Discretionary Revisions –
  o Include the word “verbal” informed consent in the last sentence of the “Participants and Recruitment” section.

• Minor Essential Revisions –
  o Additional description of the Cancer Helpline would be useful. For example, how were the helpline operators trained regarding administration of the DT and Problem List? What is the catchment area for the Cancer Helpline? What is the typical call volume per week or per month? What are the typical concerns / issues relayed by helpline callers?

  o Was information about the stage of cancer collected? Were carers asked to describe their relationship (e.g., parent, sibling, friend) with the person they cared for? If so, were DT scores related these variables (stage, relationship)?

  o What was the exact wording used by the helpline operators to ask the DT item?

  o How do helpline operators present the various levels of care to callers? In addition to the operators’ clinical judgment, is a certain algorithm used for determining the appropriate level of care? What other clinical factors contribute to an operators’ determination of level of care? In terms of logistics, are callers provided with names and telephone numbers of health professionals within the
appropriate level of care? Do these care services exist within a formal medical center network, or are they individual health care practitioners?

- Is any data available regarding whether callers actually pursued the recommended level of care? If this information is available or attainable, it would significantly add to the literature by further describing the clinical utility of a screening and referral process.

4. Results

- Discretionary Revisions –
  - What was the mean age and SD of patients? carers? (These results are presented for the entire sample, but having this information by group would be useful).
  - What is the definition of “employed casually?” Does this mean employed part time?
  - The final sentence of the “Participants” section should include the phrase “compared to patients.”

- Minor Essential Revisions –
  - Providing some descriptive data of the “other” concerns reported would be useful, given that over ¼ of the sample reported additional concerns unable to be coded into PL categories.

5. Discussion

- Discretionary Revisions –
  - The first three sentences of the paragraph beginning “ROC analyses revealed” on page 16 are repetitive from the results section. The discussion section should provide interpretation of this data rather than serve as a place to repeat the results.

- Minor Essential Revisions –
  - The discussion of limitations should include a reference to the lack of a linkage between study data and clinical outcomes in the proposed sample.
Presenting the study conclusions within a broader context is needed. For example, what is the generalizability of this type of community-based cancer helpline model? What are the implications of the study results for clinical care with cancer patient and caregiver populations? How might routine DT screening and tiered models of referral impact the quality of overall cancer care?

**Level of interest:** An article whose findings are important to those with closely related research interests

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare that I have no competing interests.