Reviewer's report

Title: Expert opinion on detecting and treating depression in palliative care: A Delphi study

Version: 1 Date: 18 February 2011

Reviewer: Christine Kalus

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Review of:
Expert Opinion in detecting and treating depression in palliative care: A Delphi study.
Rayner et al.

This is a much needed paper, seeking as it does to explore a difficult and complex aspect of end of life care, and the authors present a good overview of the problems with detection of depression at this stage of life.

Unfortunately the paper fails to tell us anything new, and is disappointingly limited in both the choice of professionals who take part in the Expert panel (3 psychological practitioners and one each nurse, chaplain, social worker and pharmacist, as opposed to 10 psychiatrists and 12 physicians) and the literature that they cite as evidence for (or against) their argument, which is that this is a difficult condition to both assess and treat, and the evidence base for treatment(s) is limited. As with the inherent difficulties that this paper discusses, other reasons relate to the generic methodological problems in undertaking research at the end of life, unless one is involved in a multi-centre trial. This then gets into the problems of a lack of equity of psychological services resources across palliative and hospice care, and also the variety of approaches that these services provide such that one would not be comparing like with like (1).

There is also a disappointing lack of attention paid to the psychological literature that is available, and the authors appear to have concentrated on mainly on the medical and psychiatric domain of exploring and explaining (as far as is possible) depression in palliative care. There has been a greater attention paid to psychological assessment and intervention from within the psychological community in recent years, and the authors would have benefited from a review of some of this literature (2;3;4;5) some of which uses both the Gold Standard RCT methodology and also qualitative methodologies, which, despite their limitations, tend to give a richer picture of both the issues for the patient and family and also clinicians who are often struggling to find an appropriate way of working with patients and families.

It is also interesting to read one of the Expert panels' comments about Cognitive behaviour Therapy (CBT):
“Is there any evidence anywhere that any of the below are effective interventions and do no harm? Too much unproven ‘counselling’ has caused harm over decades that I would not want my patients and their carers exposed to this”

Similarly with Interpersonal Therapy:
“Probably too time consuming”

Both of these comments attest to the lack of knowledge of the respondents, and are disappointingly limited in their comments. A recent audit of referrals to a clinical psychology specialist palliative care service and a survey of applied psychologists working in the field demonstrate both the appropriateness of referrals and also the breadth and depth of work undertaken by the professionals approached (1:6:7). It is of interest that a number of the more senior, and one could argue more experienced psychological practitioners, work using interpersonal and/or systemic approaches, and have extensive training in these models. This is consistent with Level 4 interventions as discussed in NICE (2004) (8). All of the practitioners approached are aware of the strengths and limitations of the various therapeutic approaches they use, are accredited and trained in their therapeutic models of choice, will regularly audit their work, and are also highly experienced in the application of these approaches within palliative and specialist palliative care.

It is also of interest to note that since the NICE Guidance of 2004 (8) PCTs and commissioning bodies have chosen to invest in clinical and counselling psychologists across England and Wales, and there are now around 60 wte clinical psychologists working in specialist palliative care, and this figure probably approaches 150 if one takes into account people working in oncology and other health settings (e.g. CHD) and who provide services on a sessional basis (Tolosa Chair of Special Interest Group in Oncology and Specialist Palliative Care. Personal communication).

In summary, this is a paper which sets out to provide a steer from experts who work in palliative and specialist palliative care, and to the extent that it addresses the problems of assessment and treatment of depression at the end of life, it does this. However, it is disappointing that the authors have not extended their research to include more psychological practitioners in their Expert panel (there are a number across Europe and associated with the EAPC , if the authors were reluctant to approach too many British psychologists with the associated bias that this could bring to the study).

I sincerely hope that if this study is either replicated or developed the authors would take these comments into account, and at least refer to the psychological (as opposed to the bio-medical) literature as a means of providing a wider and richer picture of the possible ways in which people with psychological difficulties at the end of life, and their families, can be helped.

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1: Grant L & Kalus C (April 2010) A survey of applied psychologists in specialist palliative care: Settings, roles and approaches Clinical Psychology Forum

3: The Role of Psychologists in End of Life Care (2008). British Psychological Society

4: Sage et.al (2010) CBT for Chronic Illness and Palliative Care Wiley


6: Balls M and Kalus C A retrospective audit of referrals to a clinical psychology service in specialist palliative care Clinical Psychology Forum in press


8: NICE (2004) Improving supportive and palliative care for adults with cancer DoH