

Brief Engagement and Acceptance Coaching for Community and Hospice Settings (the BEACHeS Study):

Development and pilot testing of an evidence-based psychological intervention to enhance wellbeing and aid transition into palliative care

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Background

Cancer causes more than one in four of all UK deaths (Cancer Research UK, 2018). Finding out that cancer is no longer curable can be psychologically distressing for patients and their families, and the transition into specialist palliative care services can be a time of uncertainty and fear. Effective interventions are needed to meet the psychological and supportive care needs of palliative cancer patients (Willig & Wirth, 2018).

Acceptance and Commitment Therapy (Hayes et al., 2011) has a good evidence base for the type of psychological problems often reported by patients with cancer, including anxiety and depression (A-Tjak et al., 2015), but robust evidence for effectiveness in palliative cancer populations is lacking (Hulbert-Williams et al., 2014; Hulbert-Williams et al., 2018). Within this setting, ACT may support people to identify what is important to them and to live a life of quality and value, regardless of how short that life might be.

Our primary aim is to develop a brief ACT-based intervention to support people with an incurable cancer diagnosis who are transitioning into specialist palliative care services.

Some ACT research suggests possible mechanisms underlying improvements following ACT interventions (e.g. increased psychological flexibility) (Arch & Mitchell, 2016; Aguirre-Camacho et al., 2017), but how these relate to specific therapeutic components is not well understood. This is a priority for psychosocial intervention research (Stanton et al, 2013; Hulbert-Williams et al, 2018).

As a secondary aim, we will explore mechanisms and processes of improvement in patient wellbeing through the intervention to enable further content refinement for subsequent research and clinical use.

Method

Design and Setting: Our study tests the initial effectiveness of the intervention using a single-case experimental design. Facilitators will deliver the manualised five-session intervention to 14-20 participants across two clinical sites:

- * **Session one:** information gathering and baseline assessment.
- * **Sessions two to four:** a focus on either awareness, openness, or engagement, with ordering tailored to participants' therapeutic needs.
- * **Session five:** follow-up session to discuss how the intervention content has influenced participants' daily living.

Sessions one to four are delivered weekly, with session five delivered after a four-week break. All intervention delivery takes place within a specialist palliative care service. Participants are initially identified and recruited by Clinical Nurse Specialists at their initial assessment session and referred to the research team for informed consent.

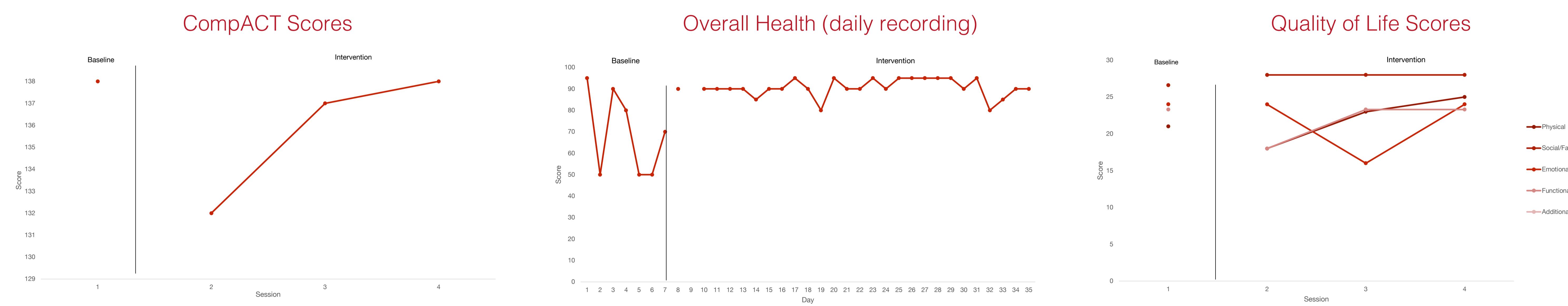
Measures: Weekly self-report questionnaires assess **quality of life** (FACIT-Pal; Lyons et al., 2009), **distress** (Distress Thermometer; Roth et al., 1998), and changes in **ACT therapeutic processes** (CompACT; Francis, Dawson & Golijuan-Moghaddam, 2016). This is supported by daily diary recordings using the Brief Acceptance Measure (BAM: Assmann, Pasi & Gillanders, *in prep*) and a single-item question of overall health. A qualitative interview conducted two weeks after the follow-up session will explore whether or not the intervention is feasible and acceptable in this setting.

Analysis: Data will be analysed according to a single-subject design protocol, including visual analysis, exploration of percentage of non-overlapping data between-condition phases, and mean score calculations between-condition phases. Qualitative data will be analysed thematically using Framework analysis (Smith & Firth, 2011).

Progress to date and preliminary findings

Recruitment began in June 2018 at our Scotland site. Of 24 referrals (in a two-week period), 8 people were eligible for the study (33%). Three of these (37.5%) consented to take part, but one has since withdrawn from the study due to deteriorating illness. At present, one participant has received sessions one and two, and one participant has received sessions one to four. The data for that participant are presented below as an illustration of preliminary data.

Daily recordings of the BAM show a ceiling effect, with high levels of acceptance from baseline across to intervention (scores of 9 or 10). Data for the Distress Thermometer show a floor effect, with low levels from baseline across to intervention (scores of 0). The CompACT measures ACT processes, with higher scores indicating higher psychological flexibility: these scores show a slight improvement through intervention sessions, although the baseline score was relatively high to begin with. Overall health status, has become more stable during intervention than baseline, however, there are varying levels of responding on this measure. The Quality of Life measure shows relatively high levels of functioning across both baseline and intervention despite these variations in self-reported overall health status.



Conclusions

Our study seeks to determine whether or not this intervention is feasible and acceptable as a foundation for subsequent work that will then test the intervention in potentially more cost-effective formats, for example, non-specialist delivery. The current data show positive progress toward that goal. Further data are being collected and the study will complete in Spring 2019.

Our study will contribute novel data to the literature, both in terms of developing a timely intervention for this patient group, and in better understanding efficacy and mechanisms of ACT-based interventions for cancer populations.

Acknowledgements

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