Routine outcomes in psycho-oncology: problems and possibilities

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Introduction

There is little consensus with regards to routine outcome evaluation within psycho-oncology. One barrier may be the lack of resources in investing in a sustainable infrastructure and sharing data publicly.

Maggie's provides free practical and psychosoclal support to people affected by cancer in the UK (www.maggiescentres.org). Each Centre within the network has a professional team that includes Cancer Support Specialists with nursing and radiotherapy backgrounds, a Clinical Psychologist and Benefits Advisor. The Maggie's programme of support offers a useful platform to implement routine outcomes and to pilot the implementation of a cost-effective infra structure to support routine outcome and audit in psycho-oncology.

ACT in oncology is still in its infancy. However, early data suggest that it can be effective in groups and individual therapy (Hulbert-Williams et al., 2015). As such it also seemed timely to look at the routine effectiveness of ACT within this population.

Aims

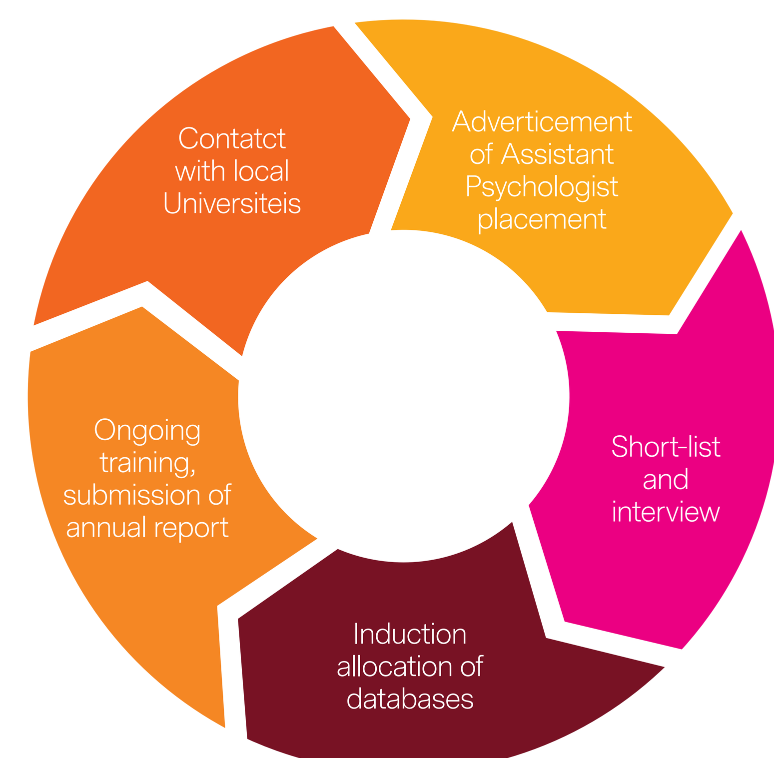
1) to test the feasibility and utility of an innovative and cost effective approach to auditing and

2) to explore clinical outcomes and the fidelity of ACT in community psycho-oncology.

Method

Step 1:
Recruitment of voluntary assistant psychologists via two local universities.
The process is briefly illustrated in figure 1.

Figure 1: Assistant psychologist recruitment cycle



Step 2:
Explore routine outcome data through SPSS using a pre-post design. Audit data was pooled from routine outcomes collected over three years. Initial referrals came from allied health professionals and self-referrals.

The following routine outcome measures were used:

Distress Thermometer
(DT: Roth et al., 1998). A validated screening tool in oncology using a 0-10 point distress scale. 5-10= moderate to severe levels of distress.

Clinical Outcome in Routine Evaluation
(CORE-OM: Evans et al., 200). A validated 34-item likert scale measuring global distress and 4 subscales. Clinical cut off = 1.

Acceptance and Action Questionnaire-II
(AAQ-II: Bond et al., 2011). A 7-item likert scale measuring psychological flexibility. Indicative of clinical distress mean = 28.3 versus non-clinical mean = 18.51.

Results

Demographics:

Age 22 - 78 (under 18 excluded) (m=51.6, Std.= 13.1)

Male

32.1%

Female

67.9%

Figure 2: Client sample characteristics.

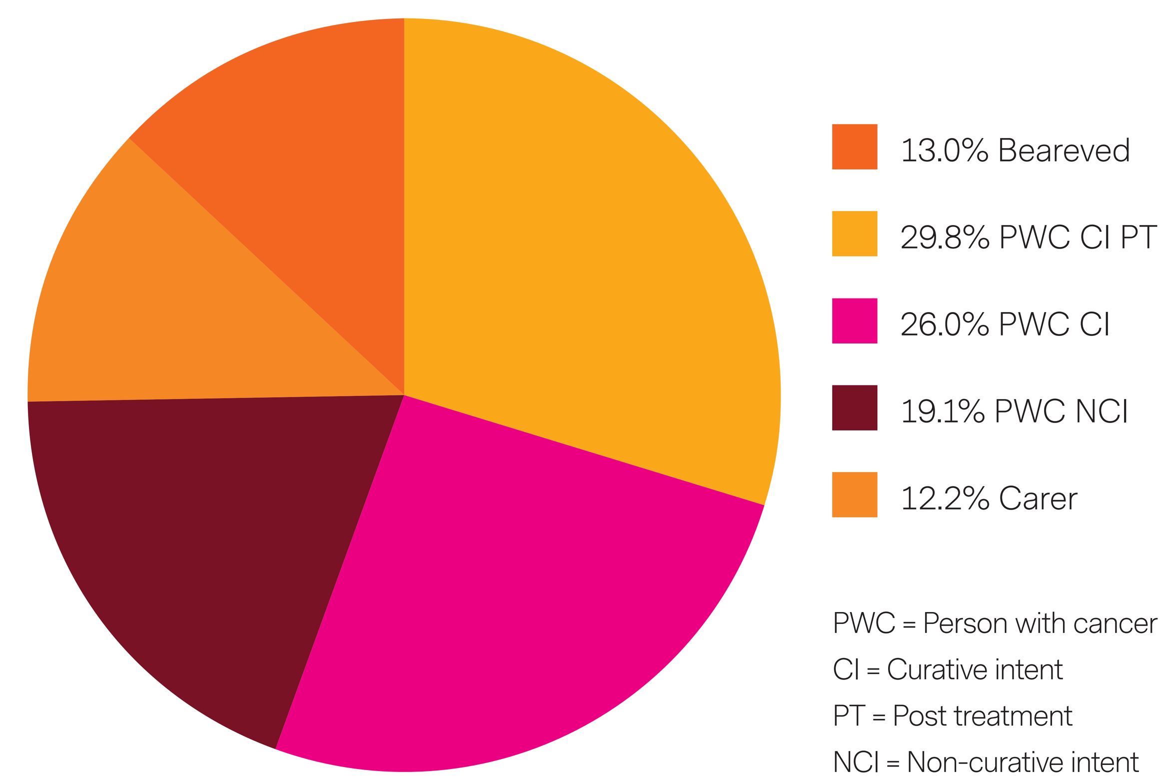


Table 1: Statistical

	Pre m (Std)	Post m (Std)	t-test	Effect size (Cohens d)
DT	6.00 (2.46)	2.58 (2.07)	t (112)=14.398, p=.000	1.36
CORE-OM	1.65 (0.63)	0.73 (0.48)	t (111)=17.230, p=.000	1.79
AAQ-II	29.92 (8.40)	18.50 (7.75)	t (122)=18.775, p=.000	1.55

ACT indicators (Therapy feedback):

Quotes are extracted from prompted written feedback by clients at the end of therapy.

Acceptance:

"Just being able to be present/experience genuine thoughts, feelings and behaviours."

"Learning to be with my feelings and not trying to problem solve all the time."

"Accepting fear like an unwanted guest."

"Accepting crying when it comes."

Present moment awareness

"Found mindfulness very helpful, together with more practical ways of looking at myself and my own mindset."

"Learning to try and live in the moment. To appreciate the time we have left and leave the unknown in the future."

Values

"Loving and valuing myself."

Committed action

"Creating plans and following them through."

"To be more proactive in choosing positive people or activities for myself. Giving some time to myself for myself and not feeling selfish for that."

Self as context

"I can manage my husband a lot better and my thoughts of my childhood are better."

"I feel I have been given great encouragement to live my life the way I would like and not to always be controlled by my illness."

Defusion

"I am having the thought that..... 3 min breathing. Identifying things I have avoided because of feelings and done them."

"Learning that thoughts are just thoughts and that they don't always have to be acted upon."

Conclusion

Systems for data collection, input and analysis has been proven to be sustainable for over three years in the pilot centre. Furthermore, of those completing data at start and end of therapy, clinical statistical improvements in distress and psychological flexibility was obtained with mean scores shifting from the clinical to non-clinical population average. Descriptive feedback supports that ACT concepts were learnt providing further support for the improvement in psychological flexibility.

Research Implications - Data needs to be compared across other centres and settings using ACT and other therapies to make any wider conclusions.

Clinical Implications - It may be worthwhile implementing uniform routine evaluation across Maggie's and encourage the reporting in multiple centres and settings to establish norms for cancer populations.