Systemic Barriers to Implementing a FACT Intervention in Racially and Income Diverse Youth with Diabetes and their Caregivers during COVID

Rivian K. Lewin, Mary E. Keenan, Jessica L. Cook, Katherine Semenkovich, Adora E. Choquette, Kristoffer S. Berlin, Amy R. Murrell, & Angelica R. Eddington

Aim

The current study aimed to assess the acceptability and feasibility of a group-based focused acceptance and commitment therapy (FACT) psychological intervention for a sample of racially diverse teens with Type 1 Diabetes (T1D) and their caregivers using a telehealth format during the COVID-19 pandemic.

Background

Pediatric T1D is a prevalent and costly disorder associated with substantial medical and psychological morbidity that differentially impacts low-income and minority youth and their families (Mayer-Davis et al., 2017). In addition to pre-existing barriers to treatment access, the COVID-19 pandemic has posed increase limitations (e.g., access to technological resources). Increasing quality of life in youth with T1D often requires personalized interventions tailored to individual characteristics (e.g. race, gender, age, family resources). FACT is promising for this population, as FACT follows whole person care (including medical and behavioral health) through brief, targeted clinical interactions guided by client needs. Further, though research in youth with T1D is scant, one study of adolescents living with type 1 or 2 diabetes found that mindfulness-based interventions including ACT were associated with less distress and higher health self-efficacy (Moazzezi et al., 2015).

To promote wellness among adolescents with T1D and their caregivers, a group telehealth FACT intervention with parallel adolescent and caregiver groups was developed. Implementation was planned in a Mid-south outpatient endocrinology clinic and feasibility and acceptability was assessed.

Method

Intervention: THRIVE (Toward Health Resilience by Increasing Values Engagement) is a 3-session telehealth intervention that included parallel adolescent and caregiver groups. Adolescents with T1 and their caregivers were screened for eligibility and considered ineligible if there were concerns of suicidality, homicidality, or psychosis.

Implementation and Feasibility Assessment: THRIVE was introduced to teens and their caregivers through referrals from their endocrinologists. Clinicians calling referrals collected information about their interest in the treatment as well as barriers to joining THRIVE.

Results

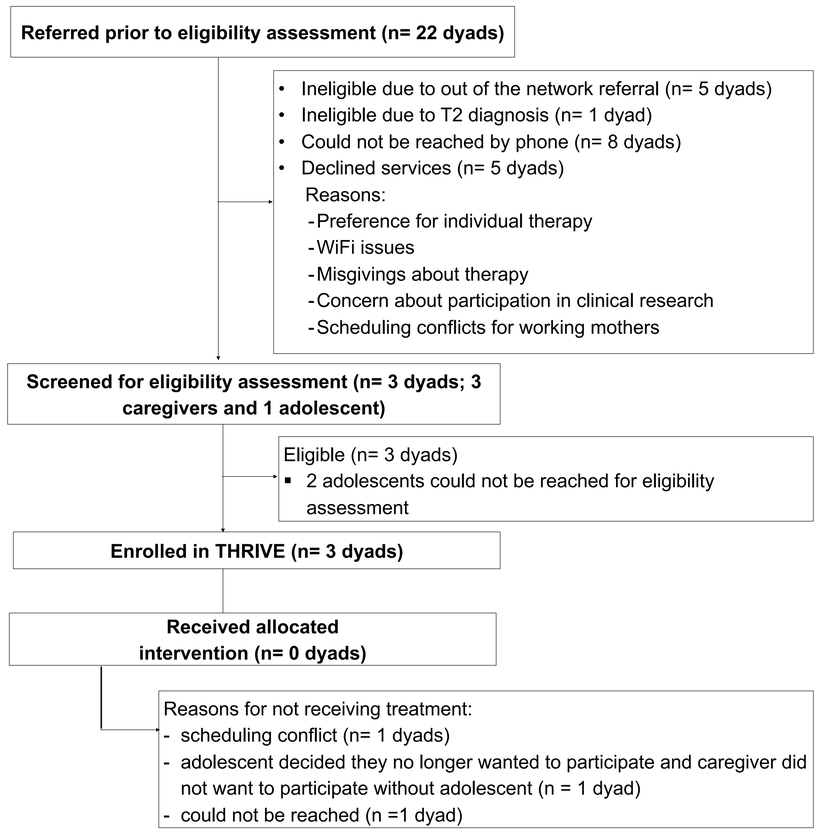

Figure 1. Flow diagram of THRIVE participation

As can be seen in Figure 1, engagement in this clinical resource progressed slowly, with 22 dyads referred over the course of 5 months. Furthermore, feasibility information showed that barriers included slow/out-of-network referrals from physicians, logistical conflicts (e.g., scheduling), technical concerns (WiFi availability for telehealth sessions), variable interest level among caregivers and teens, among others

Implications

Challenges implementing this intervention underscore the need for person-centered approaches tailored to this population that embody cultural humility and workable modalities for treatment delivery. Significant barriers to accessing care already present in the Black community in the Mid-South required additional focused attention to systems of oppression especially within the context of a worldwide pandemic. Additionally, responses indicate a broader concern about participation in clinical research, underscoring the need for culturally responsive and humble approaches to both clinical intervention and its evaluation.

References

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