





## ORIGINAL ARTICLE

# Promise unfulfilled: Implementing web-based psychological therapy in routine cancer care, a qualitative study of oncology health professionals' attitudes

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## Abstract

**Background:** Web-based mental health interventions (e-Mhls) show promise for increasing accessibility and acceptability of therapy for cancer patients.

**Aim:** This study aimed to elicit health professionals' (HPs) views on optimal models for including e-Mhls within standard cancer care.

**Materials & Method:** Cancer HPs who worked in a service where an e-Mhl was available to patients, and multi-disciplinary HPs interested in supportive care, were invited to participate via email. In semi-structured phone interviews, participants' views on e-Mhls were elicited. They were then presented with five model vignettes varying in local and centralised staff input, and asked to indicate their preference and views on each. A thematic analysis was applied to the data.

**Results:** Twelve nurses, nine psychologists, seven social workers, and three oncologists participated. Four key themes were identified: looking after patients, relationships and multidisciplinary care, trust, and feasibility, all contributing to a meta-theme of tension. Participants were motivated to ensure optimal patient outcomes and thus needed to trust the intervention content and process. They believed personal relationships increased patient engagement while affording greater work satisfaction for HPs. Most participants preferred a fully integrated model of care involving local HP assessment and design of a tailored therapy incorporating some e-Mhl components where appropriate, but recognised this gold standard was likely not feasible given current resources.

**Discussion and Conclusion:** Co-design with local staff of optimal models of care for the content and process of implementing e-Mhls is required, with due consideration of the patient group, staffing levels, local workflows and HP preferences, to ensure sustainability and optimal patient outcomes.

**Clinical Trial Registration:** The ADAPT Cluster RCT is registered with the ANZCTR Registration number: ACTRN12617000411347.

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**KEYWORDS**

cancer, cancer care professionals, implementation, models of care, oncology, routine care, web-based psychological therapy

## 1 | BACKGROUND

The need for assessment and management of anxiety and depression in cancer patients, due to the high prevalence of these conditions<sup>1–4</sup> and evidence of improved outcomes from psychological interventions, is internationally recognised.<sup>5–7</sup> Clinical practice guidelines for cancer-related anxiety and depression, such as those from Australia,<sup>8</sup> the US,<sup>9</sup> and Canada,<sup>10</sup> have evolved in response. Due to the large burden of need and limited psycho-oncology workforce, such guidelines recommend access to online mental health interventions (e-Mhls) to increase access to psychological treatment, particularly for those in remote or regional locations and those unable to attend hospital-based services due to ill health or transport issues.<sup>11</sup>

In primary care, five e-Mhl models have been identified,<sup>12</sup> involving increasing human involvement, ranging from *promotion* by providers of entirely self-directed e-Mhls to *integrated and comprehensive treatment*, where providers make a comprehensive therapeutic assessment and intervention incorporating an e-Mhl.

Self-directed e-Mhls specifically for cancer patients have recently shown efficacy in immediate and short-term outcomes.<sup>13–17</sup> However, little is known about how best to implement them in routine care. Most research on e-Mhl implementation in the general population has focused on use as a component of treatment delivered via online clinics.<sup>18–20</sup> A recent systematic review<sup>21</sup> ( $n = 11$  studies) reporting on uptake and/or usage of seven e-Mhls in real world settings found only 1%–28% of users completed all modules and less than 42% completed 60% of modules. When evaluating routine implementation of an anxiety and depression e-Mhl (self-directed) in cancer care, we also found limited uptake (44% of self-referred patients and 0% patients referred by health professionals).<sup>22</sup>

In a systematic review of health professionals' (HPs') experiences and views of e-Mhls,<sup>23</sup> we found very low rates of familiarity with, and high rates of concern about, e-Mhls. The only study of provider perceptions of a cancer-specific e-Mhl,<sup>24</sup> found that providers viewed the increased accessibility of a cognitive behavioural therapy program positively but highlighted it may not be appropriate for all patients. However this study did not explore preferences for the format and delivery of e-Mhls.

Given the complex and multi-disciplinary nature of cancer treatment, cancer HPs are likely to be key referrers influencing access to e-Mhls. Thus, this study aimed to elicit their views on optimal models for e-Mhls within standard cancer care, and barriers and facilitators to successful implementation.

## 2 | METHODS

### 2.1 | Participants

Fifty-six cancer HPs (psychologists, social workers, doctors, nurses) in 7 cancer services in New South Wales (NSW) and South Australia

who could refer patients to one of two self-directed e-Mhls for patient with cancer (iCanADAPT Early<sup>14</sup> and Finding My Way (FMW)<sup>15</sup>) were invited to participate in the study via email. In addition, 1088 members of the Psycho-Oncology Cooperative Research Group (PoCoG), a network of multi-disciplinary cancer HPs interested in supportive care, were also invited to participate via email, with an eligibility requirement of having used or having interest in online therapies. Overall, recruitment emails were sent from August 2018 to August 2020 to over 670 psychologists, 175 social workers, 300 nurses and 240 medical staff (including 140 oncologists). Interested participants were contacted to confirm consent and arrange a phone interview. Recruitment continued until thematic saturation was reached at 31 participants.

### 2.2 | Data collection

Semi-structured interviews were conducted by a clinical psychologist trained in qualitative research methods, exploring participants' perceived barriers and facilitators to use of e-Mhls in routine cancer care, and their thoughts about five model vignettes (A–E) of evidence-based online therapies, based on Reynolds et al.<sup>12</sup> (see Table 1 for models and Supporting Information for vignettes). Participants commented on each model, presented in order, and nominated their preferred model and rationale for this choice. Interviews were audio-recorded and transcribed verbatim.

TABLE 1 Models of care

Model	Model details
A	<b>Promotion of self-directed e-Mhl</b> –any cancer team member can refer patients to e-Mhl. Patients complete program independently with no assessment, monitoring or follow-up.
B	<b>Case-management of self-directed e-Mhl with local assessment and local monitoring</b> –local cancer psychosocial team refers patients to e-Mhl after assessment, and monitors their progress and distress with follow-up if needed.
C	<b>Case-management of self-directed e-Mhl with local assessment and central monitoring</b> – same as B, but monitoring and follow-up is conducted by a central e-Mhl psychosocial practitioner/team.
D	<b>Local assessment with central monitoring and coaching</b> –same as C, but central e-Mhl psychosocial practitioner/team also coaches the patient through the e-Mhl.
E	<b>Integrated, comprehensive face-to-face and online treatment by the local team</b> –local cancer psychosocial team assesses the patient and then uses the optimal combination of face-to-face and online treatment to suit the patient.

## 2.3 | Analysis

A thematic analysis guided by Braun & Clarke's theoretically-flexible approach to analysing qualitative data<sup>25</sup> was conducted to identify initial and higher-order themes. Two researchers independently coded three randomly chosen transcripts to generate an initial coding schedule. Coding disagreements were discussed until consensus was achieved. The coding schedule was then applied to subsequent interviews, and updated as new themes emerged after discussion with the wider research team. Finally, higher order themes were identified.

## 3 | RESULTS

### 3.1 | Demographics

Twelve nurses (including 10 cancer care nurses), nine psychologists, seven social workers, and three oncologists participated. Thirteen participants were familiar with iCanADAPT Early,<sup>14</sup> 6 with FMW,<sup>15</sup> and 12 were PoCoG members. Responses to recruitment emails were low across all disciplines ranging from one to four percent. However, within the sample attained, theoretical saturation was achieved. As no differences in perspectives were detected between discipline groups, the data were combined into one dataset for thematic analysis. Most participants reported minimal to no direct experience with e-Mhls, despite access to these interventions in their clinical practice.

### 3.2 | Main themes

We identified four key themes in cancer HPs' considerations of e-Mhl models for use in cancer care: looking after patients, relationships and multidisciplinary care, trust, and feasibility, all contributing to a meta-theme of tension. Quotes are identified by profession; source (ADAPT, FMW or PoCoG); and personal ID.

#### 3.2.1 | Looking after patients

##### *Offering safe, accessible treatment*

Participants were positive about having immediately accessible e-Mhls to provide support to patients, especially for those unable or reluctant to attend face-to-face sessions.

*"There are always benefits to having that kind of resource available... that we can draw on for each individual situation." (Nurse:ADAPT\_P08)*

Participants' preferences regarding models of care were rooted in concern for patients. They wanted to ensure patients would be monitored for deterioration, and referring providers would receive

feedback about patient progress and identified issues. Participants hence viewed e-Mhls with some level of monitoring or therapist involvement (Models B-E) as "safer" and "more secure". (Nurse: PoCoG\_P17).

*"I don't think you could ethically leave people to their own devices...someone would have to be monitoring, and if someone indicated suicidality or high levels of distress, there is an ethical obligation to follow that up." (Psychologist:PoCoG\_P24)*

##### *Not for everyone*

Participants noted not all patients were able to access or comfortably use e-Mhls. They felt e-Mhls were most appropriate for: younger, self-motivated patients, with milder distress, from regional/remote locations, who required flexible delivery options due to work or illness, or did not want to engage with face-to-face support (e.g., due to privacy concerns or stigma).

*"Our young breast cancer patients, who are all over the technology... would welcome that... being able to sit down after hours and address things rather than having to make appointments, take time off work..." (Nurse:FMW\_P26)*

*"[Our patients] who [don't] find it easy to open up and would find it really confronting and challenging to speak about how they feel, would find it beneficial to be able to go through a program online" (Psychologist:ADAPT\_P13)*

However, participants were concerned that e-Mhls may be less appropriate for other patients, including those older, with lower literacy or from non-English speaking backgrounds, with limited access to digital technology, or who lacked energy/motivation to engage due to treatment side-effects or high distress.

*"It's having time and inclination to do it... After chemo you go home and sometimes you don't feel like it." (Nurse: FMW\_P26)*

##### *Flexibility is key*

Participants emphasised the importance of tailoring treatment to changing patient needs, preferences and capabilities, by selecting relevant topics, offering different therapy modes, and adapting treatment over time, rather than a "one size fits all" approach (Social Worker:PoCoG\_P20). The blended therapy (Model E) was therefore favoured by many.

*"It would have to be very flexible, in terms of \... tailoring the online therapy to that person's needs and presentation." (Psychologist:PoCoG\_P24)*

### 3.2.2 | Relationships and multidisciplinary care

#### *Supports engagement*

Participants emphasised the importance of the therapeutic relationship and therapist support in helping patients to identify issues and engage in treatment.

*"...majority, if you actually went up to them and said, do you want therapy? They'd be going, ah, no... You sit and build the rapport and get them to the space where they feel comfortable enough to disclose it and talk to you... face-to-face" (Social Worker:PoCoG\_P19)*

Face-to-face contact was thought to provide a sense of accountability and facilitate tailoring the therapy to the specific patient, particularly needed for more distressed patients or those reluctant to engage with therapy.

*"When you're having appointments with someone... there's more initiative of the person to attend and complete their homework, because they know there's actually another human being on the other end asking them questions." (Oncologist:PoCoG\_P15)*

#### *Beneficial to patients and staff*

Participants (particularly psychologists) believed face-to-face interaction gave patients a sense of support and personal connection (*"the comfort of... talking to another human being"*; Psychologist: ADAPT\_P05). These interactions were also beneficial for care providers; non-verbal cues helped them to *"complete a picture"* (Nurse: PoCoG\_P17) which could inform treatment planning, and face-to-face interaction enhanced work satisfaction.

*"The therapists in my team... all enjoy enormously that face-to-face and telephone contact... being able to talk to and interact with people. I would imagine there would be a little less satisfaction with the online work." (Psychologist: PoCoG\_P24)*

Some participants were concerned that separating psychological treatment from cancer care (for self-directed or centralised models) would dilute multidisciplinary care.

*"Our psychologists here are... part of the multidisciplinary team... we've all got close ties, everyone knows each other.... We lose any of that if... they were engaging in a purely [online program]." (Nurse:PoCoG\_P17)*

### 3.2.3 | Trust

#### *Trust in therapist involved*

For models of care requiring monitoring or therapist involvement (both local and centralised), participants felt the therapist should

have experience in cancer care and a background in counselling/psychology. This would provide contextual clinical oversight to manage clinical issues and monitor risks.

*"You can't have people who have no training in counselling for people who have cancer." (Psychologist:PoCoG\_P25)*

Centralised models required trust in the central e-Mhl therapist to monitor patients and provide feedback to the treating centre, as well as effective relationships and *"good communication"* (Nurse: FMW\_P31),

*"I would be needing to put my trust in the process in the back end to make sure those things happened" (Social Worker:PoCoG\_P16)*

Some psychosocial staff raised concerns that a centralised therapist, who was *"removed"* and *"separate"* (Psychologist:ADAPT\_P07) from the treating team, may lack understanding of that specific patient population's needs and resources, and day-to-day changes in patients' care which were necessary to inform treatment decision-making.

*"Somebody centrally located again, is not aware of... where [the patient is] up to, in terms of their other cancer care... And doesn't have the ability to liaise just day-to-day, with other multidisciplinary team members." (Psychologist: ADAPT\_P10)*

#### *Trust in the program*

Referral to e-Mhls also required care providers to trust they were evidence based, developed or endorsed by a reputable team/organisation, and with proven therapeutic benefits for patients. Familiarity with and belief in the efficacy of the e-Mhl were thought to increase HPs' comfort in referring and ability to assess its suitability/relevance for patients.

*"It's important that... it's from a reputable source." (Nurse: PoCoG\_P05)*

*"The clinician who refers the patient needs to be familiar with what the [online] intervention does, what it doesn't do and decide whether it's a suitable approach for the patient." (Oncologist:FMW\_P30)*

Participants perceived consumers also needed to trust e-Mhls and computers – lack of trust was identified as a barrier to patient engagement.

*"If... they don't trust computers, or they think... it's not worthwhile... they won't even use a computer." (Social Worker:ADAPT\_P01)*

*"Some people would say, oh, it's just an online video... how would that help me? So- as opposed to a professional*

*sitting across a table and talking to them.” (Oncologist: PoCoG\_P23)*

### 3.2.4 | Feasibility

#### *Therapist workload*

Some participants believed e-Mhls may reduce patient referral rates to the psychosocial team, decreasing wait times and freeing up psychosocial staff to treat complex patients. However many were concerned that models which require local monitoring or therapist involvement (Models B and E, respectively) would exceed local capacity.

*“If we're going to do that [monitoring and follow-up] we've got to make sure we've got the staff and the ability to actually give what we promised” (Social Worker:PoCoG\_P19)*

One participant commented that *“more elaborate models”* (Oncologist:PoCoG\_P23) may need to be restricted to those with more needs (e.g., for those with high distress) to reduce cost and resources required. Some participants were concerned that a self-directed or centralised model of care, if proven effective, would legitimise decreased resourcing to psychosocial support in cancer centres.

*“Psychologists in hospitals are low enough as it is, we don't want to give them any other reason to lower the numbers even further” (Social Worker:PoCoG\_P19)*

#### *Referral motivation and skill*

Participants also acknowledged that for e-Mhls to be successful, referral would need to become part of routine care conversations, requiring changed work practices, training, and professionals *“understand[ing] that it fits within the remit of their role.”* (Nurse: PoCoG\_P21)

*“I think the lack of awareness of these tools is a huge barrier for health professionals. A lot of medical oncologists, they wouldn't even think of it.” (Oncologist: PoCoG\_P15)*

*“Some people... have affinity for that sort of discussion, and they do it more. They have more belief that this is worthwhile...[others] either don't and therefore do not recommend or they make a referral that is very simplistic and basic and doesn't engage the patient.” (Oncologist: FMW\_P30)*

### 3.3 | Tension as a meta-theme

A meta-theme present in the data, was the tension between *Feasibility* and one or more of the other themes. Tension between

*Feasibility* and *Looking after patients* and *Relationships and multidisciplinary care*, occurred where achieving the best outcomes for patients and enacting professionals' preferences for therapist support, face to face communication and good multidisciplinary care, were seen as too costly or resource intensive.

Tension also appeared between *Trust* and *Feasibility* where the involvement of local clinicians was trusted more than a central model but was also seen as less practical in terms of workload. Finally, preferences for blended treatment (*Relationships and Multidisciplinary care*) conflicted with concerns about workload (*Feasibility*) and the potential for expanding waitlists (*Looking after patients*).

*“The advantages of having [monitoring] locally is that you have the whole care team in the one place. You're able to give feedback, liaise about those issues... even just formulation and intervention. But then... thinking about staffing and resources is... always an issue” (Psychologist: ADAPT\_P10)*

### 3.4 | Views on models of care

A summary of comments specifically related to each of the five models of care is provided in Table 2. No participant who indicated a preference ( $n = 24$ ) nominated the self-directed model A and only two nominated model B (with some modification). Fourteen indicated a preference for integrated therapy model E. Many endorsed multiple models for different reasons. Model A (self-directed-only) was disliked primarily due to the lack of assessment and monitoring. There was also concern about engagement with this model.

*“One of the benefits is people don't have to leave home... but also I think it's a Catch-22 because... people then don't do it because they can do it anytime and then they put it off.” (Nurse:FMW\_P28)*

The case-management with monitoring models (B/C) elicited slightly different views depending on whether monitoring was done by local staff or a central team. Overall, participants raised more concerns about central monitoring, while recognising the resourcing implications of local monitoring. The remaining, more intensive models were preferred for *looking after patients* but also raised several concerns around communication, care coordination and the resources involved (*feasibility*). The integrated model (E) was seen as *gold-standard, ideal, wonderful* and as a *win-win* but too resource-heavy.

*“The patient is getting the Rolls Royce treatment there, right... but I guess resourcing a program like that, certainly in our organisation, it would be difficult” (Nurse: FMW\_P29)*

TABLE 2 Feedback on models of care

	Promotion of self-directed (A)	Case management with local monitoring (B)	Case management with central monitoring (C)	Local assessment with central monitoring (D)	Integrated (E)
Looking after patients	Suitability Some but not all patients	Case management with local monitoring (B) Availability is resource-dependent	Case management with central monitoring (C)	Local assessment with central monitoring (D) Patients still need to attend some face-to-face sessions	Integrated (E) Most patients, as treatment can be tailored Most appropriate for highly-distressed patients
Accessibility	Readily available	Availability is resource-dependent			
Flexibility for patients	Patients can complete in own time/space				
Monitoring, triage, follow up	None	Patients monitored, with triage and follow-up only if distressed		Patients monitored and followed-up irrespective of distress	
Patient support	Patient not supported	Patient only supported if distressed Monitoring does not indicate if treatment meeting patient needs		More comprehensive, patients more supported	
Relationships and multidisciplinary care	Local team involvement None	Monitoring by local psychosocial team	Minimal involvement of local treating team; they only receive feedback from centralised service Centralised service may lack local knowledge		Treatment directed by local psychosocial team
Engagement	Lack of contact with therapist means poorer engagement Engagement requires patient to be self-motivated			Ongoing contact with therapist increases engagement, however completing online component still requires self-motivation	
Personal connection	Lacks personal connection			More personal connection, however centralised therapist may feel removed	Face-to-face sessions offer personal connection
Trust in the therapist involved	No clinician involvement	Trust local clinician to monitor and feedback appropriately	Requires trust in qualifications of centralised clinician and communication between centralised and local services.	Trust local clinician to lead and tailor therapy	
Resourcing	Any team member can refer	Requires local resourcing, however less than blended model (E)	Treatment occurs without burden on local resources; may decrease local workload and free-up resources However, requires centralised resourcing		Resource intensive and expensive if offered to everyone May exceed local capacity
Referral straight-forward	Referral straight-forward				
Requires no additional resourcing	Requires no additional resourcing				

## 4 | DISCUSSION

This study examined cancer HPs' views regarding use of e-Mhls for cancer patients experiencing mental health issues. Views were reflective of HP views on e-Mhls in general<sup>23</sup> with additional concerns specific to the cancer context, such as the need to fit within multidisciplinary care and for HPs involved in delivery of e-Mhls to have cancer-specific knowledge. We identified four key themes— looking after patients, relationships and multidisciplinary care, feasibility, and trust, that contribute to a meta theme of tension.

HPs were highly motivated by ensuring optimal care for patients, reflecting the increased focus on patient-centred, holistic care in cancer policy and practice.<sup>26,27</sup> Thus any feature of e-Mhls perceived to threaten quality of care was a concern, and HPs felt their ability to trust the quality of the program and those delivering it was vital. HPs felt that maintaining a personal relationship with the patient contributed to optimal outcomes, from initial referral, to engagement with and retention in therapy. Furthermore, strong HP-patient relationships were seen to enhance their own work satisfaction and role within the multidisciplinary team. HP desire to maintain relationships with their clients has been widely reported in other studies examining clinician attitudes to e-Mhls,<sup>23</sup> thus building in feedback (possibly automated) on patient progress to referring HPs and ensuring both HPs and patients can reconnect while the e-Mhl is being used, are likely strategies that may facilitate uptake.

While we aimed to elicit views on an optimal model of care to integrate e-Mhls into cancer care, our participants found it difficult to endorse any one model, due to perceived competing advantages and disadvantages. An integrated model of treatment was preferred as it looks after patients, retains direct local relationships with patients and the multidisciplinary care team, and is more likely to be trusted by clinicians. Specific elements endorsed were assessment and referral by the local team, ongoing monitoring and feedback to the local multidisciplinary team, face to face therapist support for those patients that need/want it, and flexibility within the model of care. Nevertheless, most participants saw this “gold standard” approach as unachievable within current service resources.

This awareness of the tension between *feasibility* and optimal care suggests that models of care need to be flexible and tailored to the particular service context - what is feasible in one cancer care service may not be feasible in another, a concept widely recognised and reported in implementation frameworks and studies.<sup>28,29</sup> Consideration needs to be given to workload and changed work practices required in the local context; availability of psycho-oncology and social work services on and offsite; and whether staff role descriptions and responsibilities incorporate tasks required within the intervention or are amenable to adaptation. Intervention flexibility, carefully and systematically planned in a process involving stakeholders<sup>30,31</sup> is widely endorsed to accommodate context and ensure sustainability, but must be done carefully to avoid compromising validity and outcomes.<sup>32</sup>

Most of our study participants were unfamiliar with e-Mhls, as has been reported in other studies,<sup>23</sup> suggesting any model of care will require accompanying education and support to implement new skills and change work practices. Furthermore, as familiarity increases, the optimal initial model may evolve and change. Thus, review and revision of the model of care utilised may be needed as services gain experience in using and integrating e-Mhls into cancer care.

### 4.1 | Study limitations

Because many participants lacked direct experience with e-Mhls, we sought their views on hypothetical scenarios rather than their professional experience, even though most participants worked within services that had e-Mhls available. However, this reflects real-world barriers to implementing web-based therapies, with most clinicians still unfamiliar with this mode of intervention. While we endeavoured to recruit even numbers of each discipline group, most doctors and nurses we approached did not respond, perhaps due to their lack of familiarity with online therapies. Therefore, there is some risk that their views were under-represented in the results, although we did not detect thematic differences between discipline groups. While it may have useful data, we did not enquire of participants why they themselves had not referred patients to the web based mental health interventions to which they had access. This study focused on the views of HPs. Further research on cancer patients' preferences for different models integrating e-Mhls into their care would be useful. While we included a range of vignettes to aid discussion we did not include all possible options, and this may have limited responses to some extent. Furthermore, while we presented concrete scenarios to our participants, we did not explore in depth the fine detail of how e-Mhls could be best integrated into cancer care. Future research could expand on the current findings through more in-depth exploration of these issues.

### 4.2 | Clinical implications

The results of this study have significant implications for clinical practice. Development of e-Mhls without due consideration of the model of care and implementation processes that will be used to deliver them, is unlikely to be successful in terms of referral, uptake and engagement. Co-design with local staff with due consideration of the patient group, staffing levels, local workflows and HP preferences is required. Guidelines to facilitate this process are already available.<sup>33</sup> It could be argued we are currently in a “teachable moment” with regards to e-Mhls, given that psycho-oncology services across the world have had to rapidly pivot to telehealth during the COVID-19 pandemic. Views regarding e-Mhls may now be more positive, as familiarity with these mediums has increased and clinicians have had personal experience of their positive outcomes.<sup>34</sup> If e-Mhls are to



realise their promise, finding models of care that are acceptable, feasible and sustainable is vital.

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## CONFLICT OF INTEREST

The authors declare no conflicts of interest.

## ETHICS STATEMENT

Ethical approval for this study was provided by the University of Sydney HREC (2018/936) and the Southern Adelaide Clinical HREC (LNR/20/SAC/125). This study also includes data collected within the ADAPT CRCT, a study of the ADAPT Program, funded by the CINSW (14/TPG/1-02). The ADAPT CRCT was approved by the Sydney Local Health District Human Research Ethics Committee, Protocol X16-0378 HREC/16/RPAH/522.

## DATA AVAILABILITY STATEMENT

The data that support the findings of this study are available from the corresponding author upon reasonable request.

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#### SUPPORTING INFORMATION

Additional supporting information may be found in the online version of the article at the publisher's website.

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