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Adapting evidence-based group therapies following COVID-19 restrictions

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Abstract
Aim: The COVID-19 pandemic has created barriers to the running of group therapies due to the need to maintain social distance. This paper aims to describe modifications of existing therapeutic groups delivered to people diagnosed with serious and enduring mental illnesses (SMIs) to enable the therapies to continue in an online format due to the COVID-19 restrictions.
Conclusions: Therapists and consumers were motivated to find a way to continue the therapies described despite the context of the restrictions imposed due to COVID-19. This paper describes what was involved in 'pivoting' to a new mode of practice and modifications that were required over time and as new regulations were put in place. Formal research is required to establish an evidence base if these therapies were required to be regularly delivered in an online mode.

Keywords: social cognition interaction training, cognitive remediation, dialectical behaviour therapy, vocational rehabilitation, telehealth

The evidence for individual therapy delivered online is encouraging with some caveats about higher rates of attrition if there is no therapist input.[1,2] There is less evidence for online group therapies.[3] The limited evidence existing for online group therapy is encouraging with a recent systematic review that included six randomised controlled trials showing that video conferencing therapy groups were feasible and had similar treatment outcomes to in person group therapy.[3] No study included people diagnosed with psychotic disorders or people with severe personality disorders such as borderline personality disorder.

The modes of online therapy groups can differ. There can be a single point of delivery from a therapist to a group in a distant site or multiple point where there are individual remote sites.[3] There are different issues with each mode (Table 1).

With the changes to mental health service delivery consequent to COVID-19, face-to-face individual appointments and groups were cancelled. Rapid adaptation of groups previously designed for in-person delivery became necessary to continue to provide the service. Of necessity, this occurred prior to any formal evaluation or evidence of whether these groups were feasible or effective in this mode.

This article describes the adaptions made to three therapies to enable delivery via video conferencing. One therapy, social cognition interaction training (SCIT) was delivered in a single-point mode with the therapist at a distant site to a small group of four participants in a large therapy room that enabled social distancing. The other two groups were delivered in a multiple-point mode, a dialectical behaviour therapy (DBT) group and a vocational training group with embedded cognitive remediation (CR), Employ Your Mind (EYM)

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Table 1. Single versus multiple point delivery

Single point	*Multiple point*
Ability to control the connectivity	Potential connectivity challenges
Limited location options	Multiple locations possible
Single connection	Multiple connections
More group interaction	Less group interaction
Technology supplied	Participant needs their own technology
Group	Reduced options of platforms showing all participants
Group still needs to be allowed to travel and sit together	Convenient access – no travel; available in quarantine situations Variance in quality across connections

Considerations of the therapists when moving a group-based intervention to an online format

There are publications where some of the issues that need to be considered in online therapy groups have been described.[4]

a. Therapeutic alliance (TA). A systematic review of the therapeutic relationship in e-therapies in mental health found the evidence is limited.[5] There was the indication that TA is integral to the outcome of therapy and that the TA in online therapies is comparable to that found in face-to-face therapies.[6]

b. Participant acceptance of online therapy. Rates of computer literacy vary in all populations, including those people accessing services for their mental health.[7]

c. Group facilitation. The group facilitator needs to acclimatise to being able to set and monitor the tone and mood of the group in a new mode.[4]

d. Confidentiality. The group rules need to be re-negotiated for the online therapy delivery.[4]

Social Cognition Interaction Training

SCIT was designed as a 20–24 session group therapy programme for people with psychosis who identified challenges in social functioning and had difficulty in social cognition (i.e. emotional recognition, social perception, attribution bias and theory of mind deficits).[8] SCIT is a therapy routinely run each 6 months in the residential rehabilitation services managed by one of the authors (FD). It incorporates the use of online photos and videos to illustrate various social situations.

The group is usually run by two trained facilitators. The ability to run an SCIT group at a residential rehabilitation unit was compromised by the loss of trained staff and restrictions on other trained staff travelling to assist. A trained facilitator at a distant site worked with an onsite peer support worker and occupational therapist not trained in the therapy to deliver the programme. The group was limited to four participants due to social distancing restrictions in the therapy room available and the need to accommodate the two onsite co-facilitators. One participant failed to engage and discontinued after two sessions. Another participant self-discharged from the residential facility and did not return to the group.

The challenge for the therapist was trying to enhance engagement from a distance and the limited nonverbal social cues available when multiple participants were on a screen. The use of onsite co-facilitators and feedback from each session helped to address this issue (Table 2).

Cognitive remediation

EYM is a 6-month programme that integrates CR with vocational rehabilitation for people with mental illness. It is delivered by WISE Employment as part of the WISE Ways to Work programme based in Melbourne.

CR is an intervention targeting cognitive deficits such as attention, memory, executive function, social cognition and metacognition.[9,10] Research has demonstrated improvements in cognition are enhanced when combined with other modalities such as vocational rehabilitation.[11]

EYM was originally developed by Fife Employment Access Trust (FEAT) in Scotland (and was adapted and developed for use in Australia in 2017 by WISE Employment. EYM is delivered in four 6-week phases over the course of 6 months. Sessions are facilitated individually once a week in Phase 1, then twice weekly in groups for the remainder of the programme. Individual and group sessions address self-exploration, assessment, goal setting, communication, problem solving, cognitive health and computer-based CR via Happy Neuron (https://www.happyneuronpro.com/en/).

Table 2. COVID-19 adaptations

COVID-19 adaptations	*Outcome(s)*	
Cognitive remediation (CR)		
• Preparations included telehealth investigation, risk assessment, brochure development and informed consent • Remote facilitation of programmes including cognitive assessment • Increasing email/phone contact between sessions • Hardcopy material distribution • Exclusive use of online CR (Happy Neuron) vs. options such as pen/paper as with face-to-face delivery • Postponement of 'work orientation' (<20 h volunteer work with partner employer) component of programme	Positive: • EYM remains a rehabilitation option with minimal disruption to service provision • Access to 'break out rooms' for focus groups and individualised discussion • Improved group distraction management (i.e. ability to 'mute' microphones and turn off videos) • Lower group attrition rates (this could be due to choice/comfort of environment, not reliant on travel or travel support, ease of access, more contact out of hours by facilitators) • Participants acquiring/developing IT skills • Improved rates of individual CR 'homework' outside of group -> increased CR dosage	Negative: • Reduced cognitive assessment capability (4/8 assessments suitable for remote implementation) • Unpredictable technical difficulties (i.e. internet connection, external programmes) • CR occurs independently with strategy coaching taking place after the session vs as the session progresses • Vocational trajectory possibly disrupted by work orientation postponement
SCIT		
• Preparations prior discussion with co-facilitating staff, dissemination of participant manuals • Remote teleconferencing – single point	Positive: • Single-point delivery enabled staff at the remote site to manage the technology and equitable access to technology • SCIT remains a therapy option delivered in this mode • Continued support to staff at residential unit • Trains staff at residential unit to deliver programme in vivo	Negative: • Some aspects of the programme involving 20-question game were difficult to deliver when remote staff were not familiar with the task • Challenges engaging patients with fluctuating symptoms with exit of one participant and hospital admission of a second patient • The effectiveness of this mode of delivery needs to be researched in the future
DBT		
• Remote teleconferencing • Increased use of different modalities (i.e. videos) • Increasing email/phone contact between sessions from group facilitators • Use of SMS communication during sessions • Group members initiating a peer support social media group	Positive: • DBT therapy not interrupted and trajectory intact • Improved overall group rates of attendance, but increased partial attendance (i.e. arriving late, leaving early) • Ability to assist clients to adapt their skills to unusual circumstances of lockdown • Amelioration of negative emotional effects of lockdown due to consistency in positive contact • Ability to welcome new participants into group successfully • SMS coaching facilitated increased re-engagement during sessions • Emails between sessions enhance skills generalisation and sense of ongoing support	Negative: • Increased client partial completion of sessions (i.e. leaving early, arriving late) • Technical difficulties (i.e. poor connection and lag) affecting client belonging, participation and communication. Self-blame often problematic • Reduction of informal group interactions leading to breaches of COVID restrictions (i.e. in-person gathering of participants) • Teleconferencing platform design not able to fulfil the needs of group session delivery (i.e. dynamics and alliance lost) • One participant failed to commence secondary to anxiety caused by online environment • Multiple barriers to overcome regarding the transition to telehealth due to lack of prior infrastructure (i.e. private spaces, access to video enabled devices, allowed IT platforms)

Note. DBT = dialectical behaviour therapy; EYM = Employ Your Mind; SCIT = social cognition interaction training.

Prior to COVID-19 restrictions, EYM sessions were delivered face-to-face using blended treatments (i.e. hardcopy worksheets, online CR, and some online assessments). To adapt to online delivery, facilitators investigated requirements for telehealth delivery (specifically group delivery). Supporting documents were developed that included:

- participant-focused telehealth education brochure
- orientation checklist
- informed consent form
- risk assessment form
- staff telehealth checklist

Second-hand laptops were provided to participants who did not have a suitable device at home. Resources for sessions were emailed or posted to participants prior to sessions (according to preference); participants were provided 1:1 telehealth orientation (via Zoom); and sessions were either delivered via Zoom (groups and 1:1) or by telephone (1:1). All adaptations were trialled by staff (i.e. role-played or talked through), and informal participant feedback was sought.

All participants and facilitators used Zoom from their homes (i.e. multiple point delivery), which allowed facilitators to demonstrate activities and strategy coaching using real-time screen-sharing. Zoom provided many helpful functions for the CR component of EYM (Table 2).

Over the course of the extended lockdowns experienced in Melbourne, two cohorts of EYM groups were facilitated online, providing group telehealth to a total of 12 participants.

Dialectical behaviour therapy skills group

DBT is an intervention designed to treat people with borderline personality disorder and associated conditions such as deliberate self-harm, suicidal behaviour and substance misuse.[12] Comprehensive DBT treatment involves four concurrent treatment modalities – individual therapy sessions, skills group training sessions, phone coaching and therapist's consultation group. In May 2020, the leading training organisation for DBT, Behavioral Tech, disseminated advice on how to move a skills group online (https://behavioraltech.org/how-to-get-dbt-skills-group-online-corona/).

At the time of COVID-19 restrictions being placed on group work in March 2020, there were nine people enrolled in the programme and attending the skills group. Within a week, the therapists as a group decided to move the skills group online rather than cease this component and hence the therapy. The decision to adapt the therapy was influenced by concerns that this population group was especially vulnerable to emotional stressors and the interpersonal effects of isolating in the home.

One group facilitator took the lead role in this adaptation. Issues around delivering DBT online safely and effectively were addressed, such as having home contact details immediately available to facilitators in case of suicide crisis. Agreement to move online delivery was obtained from each attendee (only one was unsure and after trying it had no further concerns) and technical issues resolved for moving to online attendance. Consent was obtained from each attendee to use email and SMS to facilitate online groups. Time was given in the first online session to teach the use of the platform. The group rules were renegotiated with participants as a group to account for issues related to the online mode – largely around confidentiality via a private space.

Initially, Zoom was used as the platform with successful transition. Due to security concerns, the platform changed to Microsoft Teams after 4 weeks.

The largest barrier was only seeing four participants at any one time, and the lack of group cohesion and connection that resulted was damaging to the group process and alliance.

Having a key person with capacity for adapting and supporting other clinicians and participants to adapt to the change and preparing resources was essential in a pressured public service. This person completed:

- background research on online delivery
- prepared documents – participant guide the online delivery and
- working guidelines for group facilitators and therapists
- problem solving using MS Teams with external participants confidentially

The sharing of participant emails with facilitators allowed the sharing of supportive resources such as skills to use for coping with the pandemic and physical distancing generally and specifically. This increased contacts from facilitators with group participants between sessions. There was also a greater use of text messaging and allowing troubleshooting of issues that arose – for example, mothers of young babies struggling to be attentive when their babies cried knowing they were home.

Specific DBT skills were flagged as especially helpful in adjusting to changes, and some time was spent in initial weeks coaching in keeping participation while physically distant.

Conclusion

The current pandemic has provided an impetus of the necessity to change the mode of delivery of evidence-based psychosocial therapies. Formal research and evaluation are required to establish the effectiveness of these interventions.

Disclosure

The authors report no conflict of interest. The authors alone are responsible for the content and writing of the paper.

Previous presentation

This paper has not been presented for publication previously.

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