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Effectiveness and accessibility of virtual Cognitive Behavioural Therapy Skills Group medical visits during COVID-19

Mental health virtual group sessions during the first year of the pandemic showed improved accessibility, equity, and acceptability compared with previous in-person visits and allowed for program expansion across the province.

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ABSTRACT

Background: The COVID-19 pandemic amplified the need for community mental health supports—particularly for people with pre-existing health inequities—and social distancing mandates made in-person mental health groups inaccessible. The pandemic forced the Cognitive Behavioural Therapy Skills Group program to rapidly transition from in-person to virtual group delivery for the first time.

Methods: From March to December 2020, patients with mild to moderate mental health conditions were referred to the virtual groups. Participants completed online self-report measures (Patient Health Questionnaire-8 and Generalized Anxiety Disorder-7) prior to the first session and after the final session and provided measures of satisfaction and confidence with the skills learned using a 5-point Likert scale. Before and after program results were compared using paired *t* tests and Cohen's *d*. A theme analysis of the qualitative data was conducted.

Results: In 2020, the virtual program served 1773 participants through 170 groups. High levels of satisfaction with the virtual platform (4.6/5.0) and helpfulness of the program during the pandemic (4.7/5.0) were noted, and the no-attendance rate was 4.7%. Forty-three percent of participants who had previously completed in-person groups preferred the online modality.

Conclusions: Virtual groups had equivalent effectiveness, safety, and attendance as prior in-person groups but improved accessibility, equity, and acceptability. Balancing competing values of accessibility, group cohesion, and confidentiality pose ongoing challenges. With the success of the online modality, there is increased accessibility to smaller communities and opportunities for collaboration with care providers across BC.

Background

Prior to the COVID-19 pandemic, mental health conditions were the leading cause of disability in Canada,[1] with one in five Canadians experiencing a mental health condition each year, and one in two Canadians affected by the age of 40 years.[2] In British Columbia one in four people experience a mental health condition each year.[3] Family physicians were managing up to 80% of the mental health care needs because it was the only accessible option for most citizens. Specifically, Canadians reported counseling to be their highest mental health care need, though it was the least likely to be met.[3,4]

COVID-19 effects

When the COVID-19 pandemic began in 2020, it added to the pre-existing needs for mental health supports and highlighted the lack of sustainably funded programs.[5]

By the end of 2021, 37% of Canadians and 41% of British Columbians noted deteriorating mental health since the start of the pandemic,[6] which disproportionately affected people who were already experiencing health inequities prior to the pandemic: women, LGBTQIA2S+ people, individuals with likelihood of job loss or inadequate financial resources, newcomers to Canada, racialized communities (especially South Asian, Black, and Filipino people), Indigenous people, people with disabilities, and workers in precarious or low-income employment or living in low-income housing, shelters, or communal housing.[6-10] Youth between the ages of 15 and 24 and parents of children under 18 years of age were also most severely affected.[7] Fifty-six percent of those with a pre-existing mental health condition reported high levels of anxiety, worry, stress, loneliness, sadness, and depression.[6,10]

Anxiety became the number one reason for visits to family physicians, increasing by 34% during the pandemic; in at least one region, anxiety and depression accounted for 91% of all virtual visits.[11]

Transition to virtual care

Public health restrictions put in-person mental health services on hold. While virtual technologies had been used sparsely prior to the pandemic,[12] programs and clinicians across the province quickly moved to virtual care, many for the first time.

Virtual therapy can be effective for symptom reduction, is cost-effective,[13] and allows for satisfactory care.[12] However, care providers have had concerns about adapting to new technology, the availability of fee codes, and a lack of effectiveness, data security, and coverage through insurance.[14]

Cognitive Behavioural Therapy Skills Groups

In 2015, a group of psychiatrists and family physicians based in Victoria, BC, developed and implemented Cognitive Behavioural Therapy
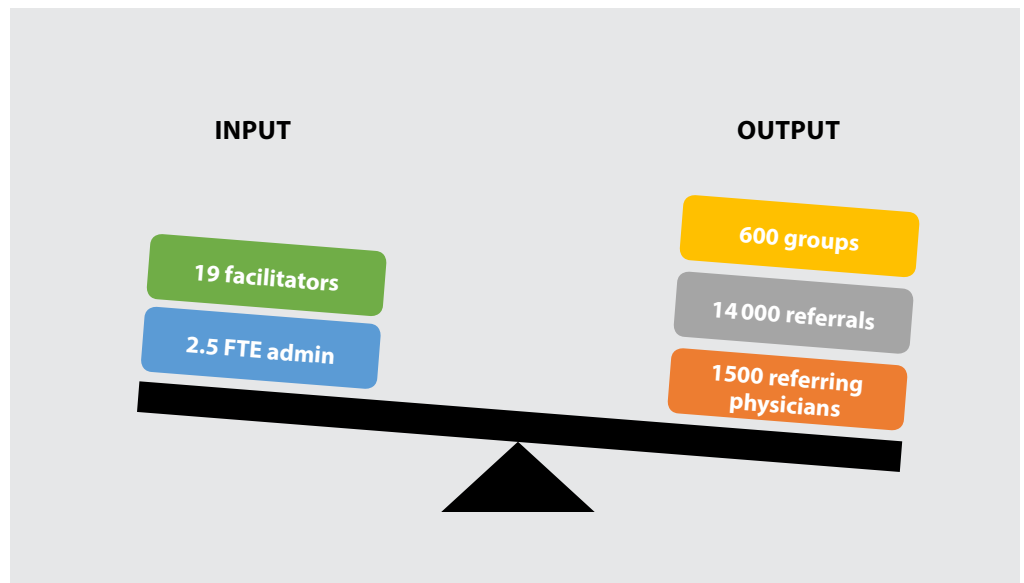
FIGURE 1. Sustainable administrative structure indicates input and output between 2015 and 2020 for Victoria and Vancouver Cognitive Behavioural Therapy Skills Groups.
FTE = full-time equivalent.

(CBT) Skills Group medical visits to address aspects of the mental health crisis and provide care that is timely, destigmatizing, accessible, equitable, and evidence based.[15]

Between 2015 and 2020, the program received 14 000 referrals from family physicians and served more than 9000 patients by developing a sustainable administrative structure [Figure 1]. Continual evaluation of the in-person program showed consistent results over time, with a mean trend toward symptom improvement for both anxiety and depression. Qualitative themes highlighted patients' experiences of reduced mental health stigma and of feeling better equipped to manage mental health symptoms and feeling less alone.[15]

After the pilot, the program was extended from Victoria to Vancouver, Nanaimo, and Salt Spring Island. Many additional communities in BC requested access to the program, yet geographic barriers were a major obstacle to training family physicians from more distant communities.

Adaptation to the COVID-19 pandemic

When the pandemic began in 2020, 14 in-person groups involving approximately 210 patients were put on hold. Doctors of BC announced that MSP fee codes for all appointments, including CBT Skills Group medical

visits, could be used for virtual care. Thus enabled, physician facilitators equipped themselves with Zoom for Healthcare accounts provided by the Provincial Health Services Authority and increased their technical capacities. Patient consent forms were modified to include virtual care security considerations, and the confidentiality agreement was modified to highlight new safeguards necessitated by remotely delivered groups. An online survey tool (Checkbox) was purchased to collect symptom questionnaires and anonymized evaluations.

Virtual groups were offered within 1 week of in-person groups being canceled, and within 2 months, physicians were providing the service for approximately 510 patients. Facilitators paid particular attention to promoting a culture of psychological safety within online groups. In the past, patients had frequently reported that the most transformative aspects of their experience were their interaction with other participants and the sense of universality and destigmatization that cultivated. To preserve the feeling of being "in the room" with each other, participants were asked to be on camera throughout the sessions unless this interfered with accessibility. This promoted a sense of group belonging and provided reassurance about the confidentiality of the space from which each person was joining. Participants were reminded to wear

headphones if there was any chance of someone in their environment overhearing what others were sharing. The group structure was altered to allow for more use of breakout rooms for participant interaction, and participants were made aware of breakout room functions to promote a sense of safety and control. The minimum size of breakout rooms was set at three.

Serendipitously, as the virtual model was established, the regional programs also completed a planned amalgamation, with administration for all being coordinated by the non-profit CBT Skills Groups Society of Victoria. Unconstrained by regional mandates and equipped with a virtual service, the physicians began to invite family physicians from across BC to refer their adult patients.

We examine the experience of participants in virtual groups and compare it with previously gathered data from in-person groups to explore accessibility, effectiveness, safety, and acceptability of the virtual adaptation.

Methods

Patient population

All patients were referred for virtual groups from March to December 2020. Patients were selected by referring primary care providers in their communities and had diagnoses of mild to moderate mental health conditions. Patients may have been from any BC community, but most were in Vancouver and on Vancouver Island, where the program is well known. This group also included patients who were repeating the course for maintenance treatment or to manage relapse in symptoms.

Exclusion criteria included those with severe depression, active risk of harm to self or others, cognitive impairment, impairing level of substance use, personality disorder that might interfere with group process, and active psychosis, mania, posttraumatic stress disorder, or dissociative symptoms.

Measurement

Virtual care participants completed online self-report measures prior to session 1 (Patient Health Questionnaire-8 [PHQ-8] and the Generalized Anxiety Disorder-7 [GAD-7]). The PHQ-8 scores all *Diagnostic and Statistical Manual of Mental Disorders* criteria for depression from 0 to 3, omitting the final question on suicidal ideation, and is commonly used in self-report studies. The original validation studies for the PHQ showed identical thresholds for the scoring of depression severity in both PHQ-8 and PHQ-9.[16] The GAD-7 scores symptoms of generalized anxiety from 0 to 3 and has high internal reliability and validity.[17] After the final session, all participants received an evaluation to repeat the symptom measures. They also provided measures of satisfaction and confidence with the skills they learned using a 5-point Likert scale and gave qualitative feedback. The Arecci tool determined the project as quality improvement and involving minimal risk, thus not requiring further ethics review or consultation.[18]

Data analysis

All participant responses were converted into nonnominal data. Results from PHQ-8 and

GAD-7 completed by participants before and after the program were compared using paired *t* tests and Cohen's *d*. Demographic data were gathered based on referrals and participant data. Retention rates were obtained, with "full attendance" defined as attendance for 6 to 8 sessions, "partial attendance" as attendance for 1 to 5 sessions, and "no attendance" when patients attended 0 sessions. Retention rates were analyzed only for Victoria participants because data for Vancouver participants were not obtained for 2015–2019. Trends noted in the in-person and virtual models were compared.

A theme analysis of the qualitative data was completed. Data from five qualitative questions were reviewed. Codes were created to identify preliminary themes in the data, which covered general experience with the group format, as well as specific comments about the pandemic, etiquette, accessibility of and comfort with the virtual platform, sense of connection to others, including facilitators, and concerns about privacy. Using these codes, data were summarized to highlight themes.

Results

The program had 3372 referrals from 658 primary care providers in 2020. For the pandemic portion, between March and December 2020, 1773 participants engaged in 170 groups run by 19 facilitators based out of Victoria and Vancouver. The program received an annual increase in referrals from 2015 to 2019 but slightly fewer referrals in 2020 compared with 2019, and more groups were offered each year [Figures 2 to 4].
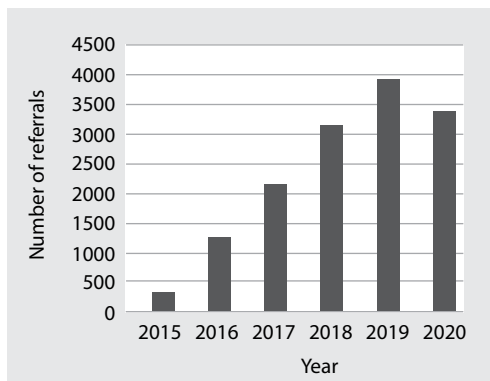
FIGURE 2. Number of referrals per year for in-person (2015–2019) and virtual groups (2020).
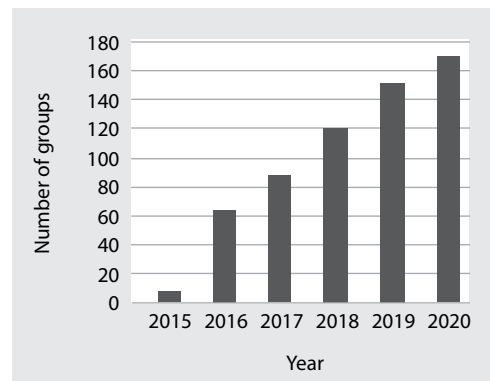

FIGURE 3. Number of groups organized per year for in-person (2015–2019) and virtual groups (2020).
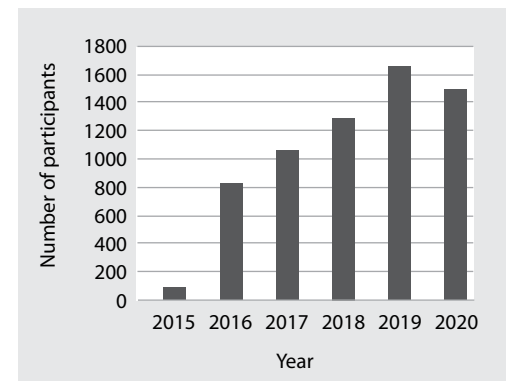
FIGURE 4. Number of participants per year for in-person (2015–2019) and virtual groups (2020).

Most patients were female (70.1%), and the average age of all patients was 41 years (range 19 to 78 years). Forty-one percent of patients (n = 458/1116) had done the course in person before and were repeating it online. Retention rates of Victoria participants were generally similar across years; in 2020, 73.6% of participants (n = 1064/1446) had full attendance, 21.7% (n = 314) had partial attendance, and 4.7% (n = 68) did not attend any sessions [Figure 5].
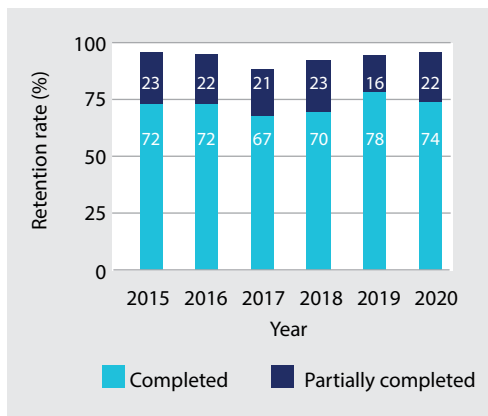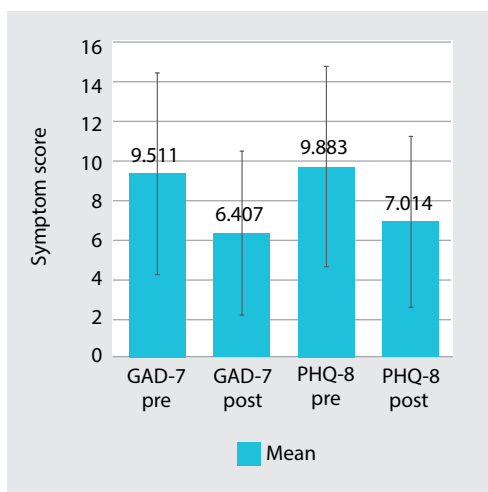

FIGURE 5. Retention rates per year for in-person (2015–2019) and virtual (2020) groups.

Partially completed = 1–5 sessions attended;
Completed = 6–8 sessions attended.
Data for Victoria only.

Note that the y-axis in this figure has been corrected from a fraction, as it appears in the print version of this article, to a percentage.

FIGURE 6. Trends in symptom scores measured by the Generalized Anxiety Disorder-7 (GAD-7) and Patient Health Questionnaire-8 (PHQ-8) score before (pre) and after (post) the 8-week Cognitive Behavioural Therapy Skills Group training program.
n = 615.

Post-group evaluations were completed by 49.6% of patients in Victoria and 45.8% in Vancouver (n = 1116). Results of t tests showed a decrease of 3.10 points on GAD-7 ($P < .01$, Cohen's d effect size = 0.722, n = 615) and 2.87 on PHQ-8 ($P < .001$, Cohen's d effect size = 0.670, n = 615) [Figure 6]. All improvements were statistically and clinically significant.

On a 5-point Likert scale, participants rated satisfaction with the virtual experience at an average of 4.6, satisfaction with the course itself at 4.5, and overall helpfulness of the program in the context of the pandemic at 4.7. Further Likert analyses suggested that most participants reported confidence in managing their mental health better and were satisfied with the administrative support for the virtual groups [Figures 7 to 9].

Modality preference was assessed for those who had previously participated in in-person groups. Of those 458 repeat participants, 43% preferred the online format, 38% preferred in-person groups, and 19% had no preference.

Virtual groups were offered to all patients who were referred to the program every quarter, so each patient was free to choose a group, with a maximum wait time of 3 months.

Effectiveness

Themes from qualitative feedback centred on the usefulness of skills to manage difficult thoughts and feelings. Participants reported being more aware of emotional experiences and values and felt more equipped and empowered to respond in ways that were aligned with their values. They reported that weekly sessions were helpful in maintaining ongoing accountability and mental health checks. They developed a sense of common humanity and were able to relate to other participants' successes and challenges. The groups helped mitigate the isolation from the pandemic and promoted connections. Many participants reported that others were respectful and considerate during sessions.

Accessibility

Patients appreciated the convenience of attending from a personal space that felt safer, more comfortable, and less demanding of time and money in terms of travel and parking compared with in-person groups. The virtual platform was

especially helpful for participants living outside of large centres, those with employment and child care responsibilities, and persons with disabilities. It also mitigated concerns about exposure during a pandemic.

Acceptability and safety

Patients appreciated breakout rooms and online teaching tools. Many benefited from technical support.

Participants also noted that it was more difficult to feel connected, particularly without the "hallway conversations" before and after sessions. Some reported that 90 minutes in front of a screen was tiring. Some expressed worry about privacy, such as family members in the home overhearing or another participant recording the session. They also expressed anxiety about maintaining Zoom etiquette and the effort or disruption of unmuting and contributing to the group. Other technical concerns included lower quality Internet connections affecting some participants' overall experience of the group.

Some participants felt that the sign-up process for the group was cumbersome. They felt that either too many emails were sent throughout the process or not enough reminders were sent. They expressed concerns about the delivery and cost of the hard copy of the skills manual. Feedback about Zoom orientations was mixed: some felt it was helpful; others found it to be redundant.

Feedback also focused on a desire for more interactivity. The participants asked for an interactive online workbook, increased number of sessions per series to reduce the amount of content per session, and pregroup and postgroup gathering options or online platforms for discussions and homework reminders. They asked for more interaction, more breaks, and more question-and-answer time at the end of the sessions. They suggested adding booster sessions and follow-up check-ins 1 to 6 months after their series.

Discussion

The CBT Skills Group program transitioned rapidly to virtual group delivery during the pandemic. When data for the virtual groups were compared with previously gathered results from the in-person groups,[15] they suggested
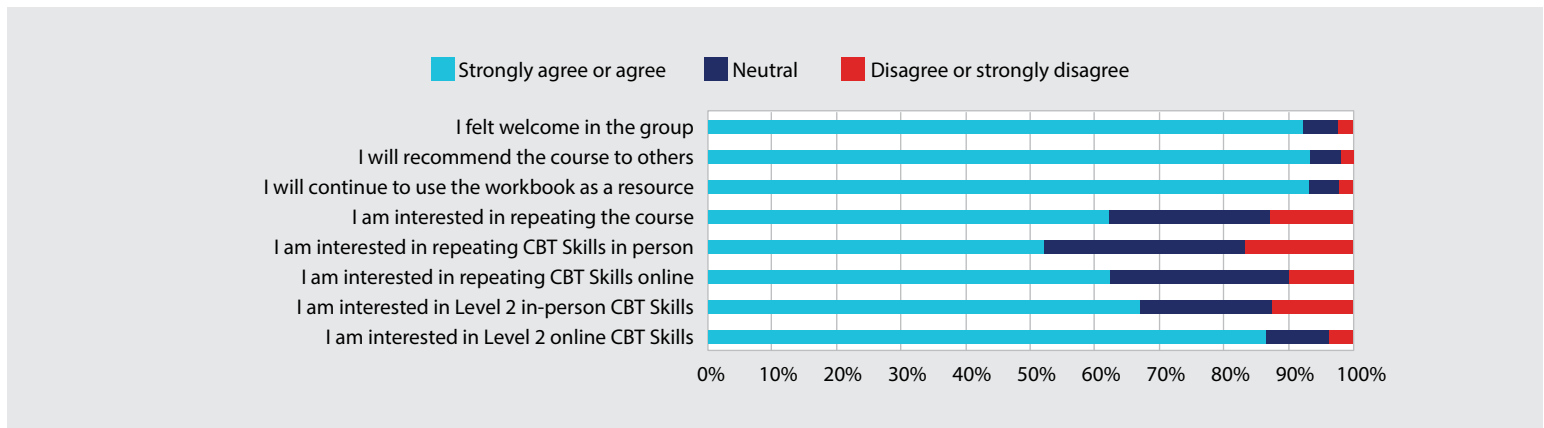
FIGURE 7. Participant experience with the Cognitive Behavioural Therapy (CBT) Skills Group in 2020 (virtual).
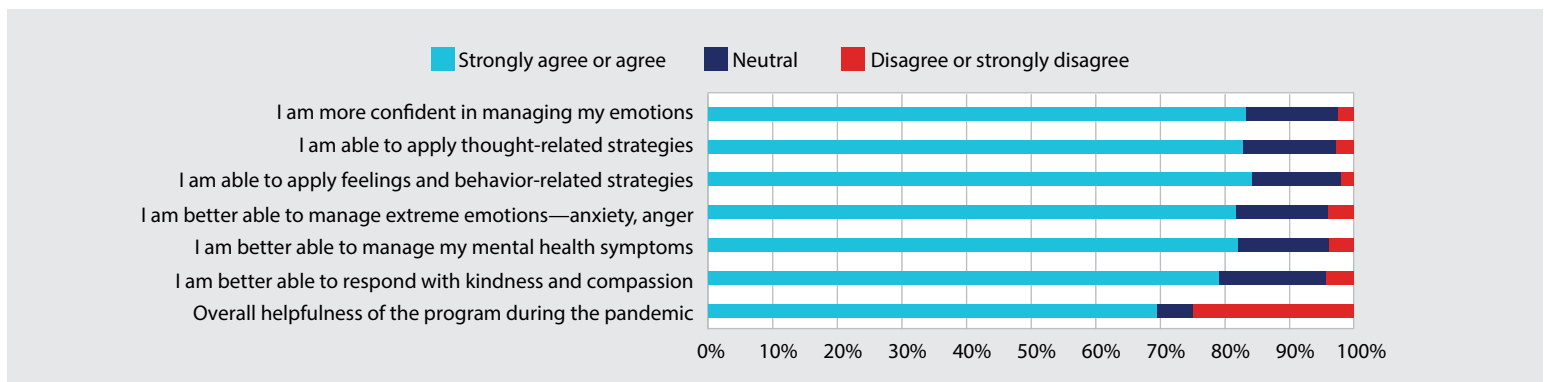
FIGURE 8. Participant confidence with self-management skills in 2020 (virtual group).
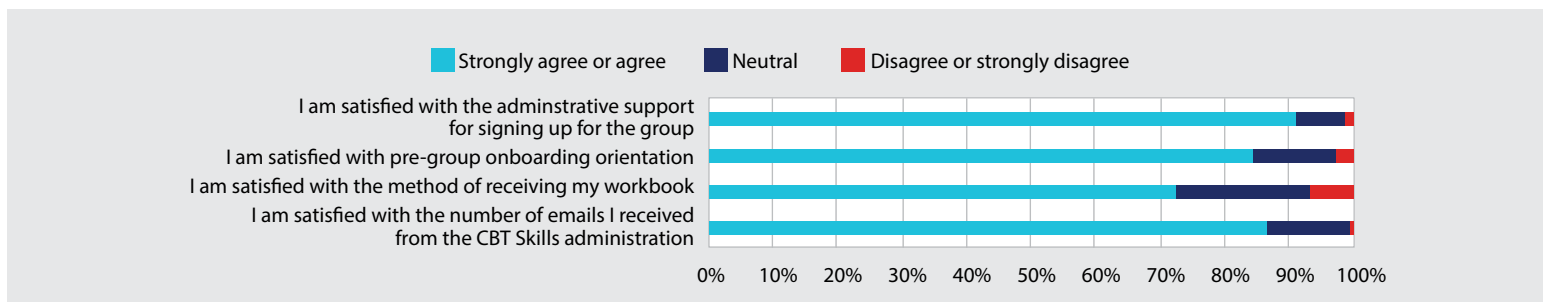
FIGURE 9. Participant experience with administrative support and the Cognitive Behavioural Therapy (CBT) Skills Group program in 2020 (virtual).

that both delivery formats had equivalent effectiveness, safety, and attendance, but the virtual groups had improved accessibility, equitability, and acceptability. Self-reports completed before and after the 8-week virtual group program showed symptom improvement trends comparable with those of the in-person group program.[15] These findings establish a trend but

cannot be generalized more widely to show causation because they are based on local quality improvement data with no randomization or comparator arm.

A large contingent of patients (41%) repeated the CBT Skills Group program, likely due to promotion of the program to previous participants at the beginning of the pandemic,

when fewer referrals from elsewhere were being made. In addition, patients may have recognized that they needed more help during the pandemic and had easy access to a program that would allow them to maintain their mental health while dealing with new stressors. This could explain why the mean symptom severity at entry for both PHQ-8 and GAD-7 was

lower than in previous analyses.[15] It also highlights the need for maintenance treatment, as it has been shown to reduce the risk of relapse by 32% with delivery of CBT during remission.[19]

Despite concerns about the therapeutic environment of an online group, satisfaction with the virtual format of the program was high and in keeping with the in-person ratings.[15] High levels of satisfaction with the helpfulness of the group and the content during the pandemic were noted.

Challenges

As the virtual program expands geographically, there are conflicts that reflect competing values. For example, the requirement that participants have a webcam on at all times to enhance group cohesion and provide reassurance of privacy and confidentiality may limit accessibility. Some participants shared that they value the hard copy of the workbook and found it difficult to use an online book in concert with an online group; however, the costs of printing and mailing the workbook is borne by patients who elect for a hard copy.

The program has prioritized accessibility by relying on referring clinicians to adequately screen and orient participants rather than having diagnostic and/or orientation sessions that might become bottlenecks. This necessitates that primary care clinicians are equipped with inclusion and exclusion criteria and a sense of who is well suited. The program is attempting to increase this awareness through information on the referral form and the website, direct feedback about referrals, and targeted information through Divisions of Family Practice. The program has received approximately 22 000 referrals to date and has served 12 000 participants, which suggests that referring physicians are selecting people who are likely to sign up and continue with the program. It is unclear whether the remaining 10 000 who chose to not sign up for a group are waiting for a better time to participate or are not suitable candidates for the program; this requires further assessment to optimize the current delivery model.

A related challenge is that the success of the program has been demonstrated only with those who have mild to moderate conditions. If those with higher morbidity and acuity are

referred, there are unknowns and potential risks for both individuals and group dynamics. For such individuals, the fast-paced classroom atmosphere may be invalidating and/or demoralizing if they are attempting to cope with crises, intense emotions, or severe symptoms. Facilitators have limited capacity to respond to significant emotional dysregulation, expressions of suicidality or self-harm, or significant interpersonal challenges that may arise, and this ability is even more limited in the virtual

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setting. The program is engaging in ongoing outcome evaluation to track potential involvement of those with higher acuity or morbidity and elucidate the extent to which these hypothetical risks are realized.

Benefits

Group therapy has been at least equal to individual psychotherapy in its power to provide benefit and enhance efficient use of mental health resources.[20] Connection with other members of the group capitalizes on therapeutic factors that are unique to group psychotherapy, such as universality of experience, altruism, and imitative behavior.[20] Groups also reduce stigma and isolation, which may be particularly important during the pandemic.

Virtual groups enhance accessibility for participants and family physicians from remote and smaller communities. These groups offer needed support for referring family physicians, who are often left managing patients on their own, and provide streamlined, effective, and timely care for patients. Furthermore, having family physicians deliver the services allows for collaboration and mentorship opportunities between psychiatrists and family physicians,

which expands physician knowledge and spurs program innovations.

Next steps

Physician training: In 2021, the Shared Care Committee funded facilitator training for members of the Campbell River and District, Comox Valley, and Rural and Remote Divisions of Family Practice to improve accessibility in anticipation of offering in-person groups in the future.

Other divisions and the Physician Health Program were looking for ways to support their members as physicians themselves began requesting self-management skill training to support their own well-being and that of their patients. The Shared Care Committee responded by forging a partnership between physicians from the CBT Skills Groups Society of Victoria and the UBC Office of Continuing Professional Development to offer similar groups to physician cohorts. For a limited time under this program, physicians from across BC can participate in peer groups free of charge and earn continuing professional development credits.

Program improvements: The CBT Skills Group team has committed to the quality improvement process, with data driving iterative program changes since its creation. Over the past 2 years of the pandemic, quality improvement processes have guided changes in the physician training program to improve equity, diversity, and inclusion, and to serve ongoing aims of accessibility, safety, and equity for BC's diverse population.

Patient experience has been streamlined with Zoom orientation on an as-needed rather than required basis. The online workbook is being improved with downloadable homework sheets so patients can print them for written practice. For those who prefer hard copies of the workbook, costs have been minimized as much as possible by creating local pickup sites in urban areas to avoid shipping costs.

Expansion: Physicians are exploring opportunities to partner with others and scale up the program to meet the specific needs of members of Indigenous communities, people of diverse cultural backgrounds, older adults, LGBTQIA2S+

people, and those coping with specific medical comorbidities. Virtual groups have been so popular that physicians intend to keep offering them, and quality improvement efforts will continue to focus on enhancing the safety and effectiveness of the group experience while also endeavoring to be as accessible as possible.

Conclusions

The CBT Skills Group program successfully transitioned to virtual delivery in 2020, and quality improvement evaluations suggest that virtual groups have equivalent effectiveness, safety, and attendance as the prior in-person groups but improved accessibility, equity, and acceptability. The success of virtual groups allows for training and collaboration with care providers across British Columbia, which will continue to further enhance accessibility, equity, and inclusion in the service of BC's diverse population. ∎

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