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Short communication

Feasibility and acceptability of VA CONNECT: Caring for our nation’s needs electronically during the COVID-19 transition

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ABSTRACT

COVID-19 has transformed day-to-day functioning and exacerbated mental health concerns. The current study examines preliminary feasibility and acceptability of a VA CONNECT – a novel 10-session, manualized telehealth group intervention integrating skills training and social support to develop a Safety & Resilience Plan for Veterans experiencing COVID-related stress. Data from the first 20 participants support the intervention’s feasibility and acceptability. Strengths, limitations, and suggestions for improvement of the intervention are noted. Collaboration with other VA researchers would aid in protocol dissemination and evaluation of VA CONNECT’s utility for reducing COVID-19-related stress, loneliness, and mental health symptoms.

1. Introduction

The Coronavirus disease 2019 (COVID-19) sparked a monumental global reaction. The associated health crisis transformed daily functioning for many, with physical distancing, travel bans, and quarantine mandates that increased risk of social isolation, economic instability, and abuse (Banerjee et al., 2020). The COVID-19 pandemic also had an alarming, psychological toll and drove changes in accessibility and availability of mental health care. In November 2020, 37% of Americans reported clinically elevated anxiety and depression (Centers for Disease Control and Prevention [CDC], 2020). Similarly, pandemic stresses are implicated in the 800% increase in suicide hotline calls across major U.S. cities and marked increase in COVID-19-related suicides (Banerjee et al., 2020; Shelton, 2020). Because these adverse effects are most pronounced for socially and economically disadvantaged groups (CDC, 2020), Veterans – many of whom are lower income and from racial/ethnic minority groups – are likely particularly impacted by this pandemic.

Compiling these concerns, physical distancing mandates required most mental health providers transition to online platforms for service delivery. Despite efficacy comparable to face-to-face treatment, adoption of tele-mental health was limited before the COVID-19 pandemic (Wind et al., 2020). The present study piloted a novel telehealth group-based intervention for Veterans experiencing acute stress related to COVID-19, titled VA Caring for Our Nation’s Needs Electronically during the COVID-19 Transition (VA CONNECT), and examined feasibility and acceptability data.

2. Method

2.1. Intervention

VA CONNECT is a 10-session group delivered twice weekly followed by four optional, weekly sessions. VA CONNECT integrates elements of cognitive behavior therapy, dialectical behavior therapy skills, psychoeducation, and peer support to promote effective coping, emotion management, and stress relief pertaining to COVID-19 distress. Each session balances manualized skill instruction with opportunities for Veterans to share concerns, exchange information, and provide peer support. Throughout treatment, Veterans apply learned skills to develop a personalized “Safety & Resilience Plan,” a written compilation of coping skills used to combat COVID-19-related stresses. See Table 1 for a summary of session content. A group format was specifically chosen to mitigate loneliness, increase belongingness, and recreate the protective
Within this subsample of participants, 25% were previously diagnosed with COVID-19 and 50% self-identified as high-risk for contracting COVID-19. All reported taking COVID-19-related safety precautions (e.g., social/physical distancing, sheltering-in-place, mandatory quarantine, and/or working from home). Nearly half (45%) lived alone, while 30% reported active caretaking of a loved one. Consistent with the various pandemic-related difficulties, many endorsed food scarcity concerns (45%) and most experienced nightmares during the pandemic (65%).

3.2. Feasibility and acceptability

Feasibility. Results suggest VA CONNECT to be feasible as a group-based, telehealth intervention for VHA-serviced Veterans. Interventionists spent only 2.3 hours/session on average, supporting VA CONNECT being both cost- and time-efficient. All referred Veterans expressed interest in VA CONNECT and consented, suggesting strong recruitment ability. Attendance and retention were also strong, with 95% attending ≥7 of the core treatment sessions (M=9.3 sessions, SD=1.95, range=2-10).

Acceptability. Participants’ perceptions of intervention acceptability (AIM, M=17.35, SD=2.21), appropriateness (IAM, M=17.05, SD=2.33), and feasibility (FIM, M=17.25, SD=2.17) were very high, suggesting participants enjoyed and approved of the intervention and found it suitable, applicable, and easy to use. Correspondingly, open-ended responses suggested positive participation experiences. A third of participants reported subjective stress and/or symptom reduction. A majority (75%) noted participation increased interpersonal connection and reduced isolation. For example, one Veteran shared, “Relating to my fellow Veterans and talking about experiences and family made me feel less isolated. You don’t have to be alone at home... I feel freer and not alone when I’m in the group talking about shared experiences.”

Although feedback was overwhelmingly positive, participants noted participation challenges and recommendations for improvement—most notably technological and connectivity issues (65%) and discomfort with participating in a virtual group with strangers (25%). One participant shared, “In person would be better because you can grab their hand, hug them, see their faces clearly when they are talking. Making a physical connection is important and [you] can’t do that over VVC.” Recommendations for intervention improvement included ensuring proper internet connection, increasing group size and session time. Flexibility was required for clinicians’ roles, which often included troubleshooting technological difficulties.

4. Discussion

This study examined the feasibility and acceptability of VA CONNECT, a manualized, telehealth group treatment for Veterans experiencing COVID-19-related stress. Quantitative and qualitative assessments suggest this intervention to be feasible and acceptable. Participant feedback was overwhelmingly positive and suggested it was particularly helpful for decreasing loneliness and increasing interpersonal connection. Participation results in development and refinement of a personalized Resilience and Safety Plan, adapted from evidence-based safety planning. In lieu of uncertainty of the COVID-19 pandemic, there is great value in accessibility of concrete plans for managing future stress and symptom exacerbation.

Nevertheless, challenges and recommendations—particularly related to technological issues—will be considered through ongoing development and dissemination efforts. Given these promising results, ongoing research will evaluate VA CONNECT’s efficacy and potential significant implications for mental health treatment within and beyond the VHA.

Table 1

| Session | Focus | Skill |
|---------|-------|-------|
| 1       | Veteran Introduction, Psychoeducation about Acute stress, COVID-19, Group Rules | Crisis Management Strategies, Introduction of VA CONNECT, Action Plan |
| 2       | Meditation, Mindfulness, Relaxation Techniques | Review relaxation strategies |
| 3       | Identification of Warning Signs Coping Strategies | Emotion Recognition, Distress Tolerance and Self-Soothing |
| 4       | Managing Interpersonal Conflicts | Review Communication and Problem-Solving |
| 5       | Maximizing Mental Health | Review Skills to Maximize Treatment Efficacy and Adherence |
| 6       | Physical Health Management | Importance of Sleep, Diet, Exercise, Pain Management |
| 7       | Dealing with Loss During COVID-19 | Emotional Reactions to Loss Strategies for Grieving and Alternative Commemorations |
| 8       | Building Positive Emotion | Gratitude and Reasons for Living Exercises |
| 9       | Recap | Review and Share Safety & Resilience Plan, Compile Resource List |

2.2. Participants

The first twenty Veterans to complete VA CONNECT were included in feasibility and acceptability analyses. Consistent with the broader Veteran population, participants were predominantly male (85%), racially heterogeneous (35% White, 30% Black, 25% Multiracial; 10% Other race), and represented a wide age range (M=54.2, SD=11.95, range=28-72 years). Inclusion criteria for participation included age ≥18; elevated COVID-19 related stress (≥14 on the Perceived Stress Scale, PSS; Cohen, 1988); concurrence from current mental health provider; English proficiency; and access to telehealth. Exclusion criteria included active psychotic disorder and inability to tolerate group therapy.

2.3. Procedure

Data collection was completed from June-December 2020. Recruitment was driven by VHA provider referrals. Admission was rolling after four Veterans were recruited for participation, allowing subsequent Veterans immediate access to treatment following informed consent and baseline assessments.

VA CONNECT was delivered to participants across a total of 70. To maintain physical distancing, all consent processes, assessments, and treatment participation were completed remotely via phone, Qualtrics, VA WebEx and/or VA Video Connect (VVC; encrypted, HIPPA-compliant VHA videoconferencing platform). All procedures were approved by the [REMOVED FOR PEER REVIEW] IRB.

2.4. Feasibility and acceptability measures

Intervention feasibility was assessed by (a) number of hours spent in preparation for and delivery of VA CONNECT (ease of implementation); (b) rate of successful referral to VA CONNECT (recruitment); and (c) rate of overall and session-specific attendance (attendance/retention). The Acceptability of Intervention Measure (AIM), Intervention Appropriateness Measure (IAM), and Feasibility of Intervention Measure (FIM; Weiner et al., 2017) yielded sum scores from four items rated on scale of 1-5, for a total range from 5 to 20. Additionally, open-ended questions assessed group format, telehealth delivery, content, and application of material to coping with COVID-19 stress (Appendix A).
system. VA CONNECT is provided in a group format via telehealth, which can be easily and cost-effectively implemented throughout the VHA with potential for widespread adoption. Our research team is highly experienced in delivering skills-based, group intervention; however, clinicians with a wide range of backgrounds can be trained to implement VA CONNECT as it is manualized and created to be disseminated to Veterans with a variety of clinical needs.

VA CONNECT has several strengths, notably timeliness for the ongoing COVID-19 pandemic. It equips Veterans with effective coping strategies and guides them through development of a personalized plan for managing COVID-19-related stress. Despite these strengths, limitations are present. All participants were recruited from a NYC-based VAMC, potentially limiting generalization to other geographic areas. Collaboration with other VA researchers would aid in protocol dissemination to other locations.

CRediT authorship contribution statement

Molly Gromatsky: Conceptualization, Investigation, Supervision, Writing - original draft, Writing - review & editing. Sarah R. Sullivan: Conceptualization, Investigation, Project administration, Writing - original draft, Writing - review & editing. Emily L. Mitchell: Writing - original draft, Project administration. Angela Page Spears: Writing - original draft, Data curation. Emily R. Edwards: Writing - review & editing. Marianne Goodman: Investigation, Supervision, Funding acquisition, Writing - review & editing.

Declaration of Competing Interest

Molly Gromatsky, Sarah Sullivan, Emily Mitchell, and Angela Page Spears have no conflicts of interest to declare. Dr. Marianne Goodman serves in an advisory role to the pharmaceutical company titled Boehringer Ingelheim.

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Supplementary materials

Supplementary material associated with this article can be found, in the online version, at doi:10.1016/j.psychres.2020.113700.

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