Providing virtual suicide prevention groups for people experiencing suicidality: Pivoting service delivery during the COVID-19 pandemic

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Abstract
Skills for Safer Living is a 20-week group intervention for people with recurrent suicide attempts. This article details how it pivoted from in-person to virtual groups due to the COVID-19 pandemic. Concerns of privacy, client safety, and how to deliver the program virtually are explored, along with lessons learned.

Keywords
COVID-19, online peer support, suicide ideation, suicide intervention, suicide prevention, virtual groups, virtual support

COVID-19 has seriously impacted how mental health professionals provide service. Widespread physical distancing and partial lockdowns have significantly reduced the delivery of mental health services. Critical changes to services have placed people with pre-existing mental health challenges at further risk of decline and suicidality (De Pedraza Garcia et al., 2020; Mukhtar, 2020).

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Risk factors for suicidality have been exacerbated during this pandemic. Anxiety, depression, isolation, loneliness, job loss, and financial stresses are on the rise (Gunnell et al., 2020). Two protective factors thought to aid in preventing suicide – meaningful social interactions and a sense of belonging – are being interrupted through prolonged social distancing (Joiner, 2005; Killgore et al., 2020). Mental health professionals are in a unique position to intervene and to deliver innovative programming that addresses this gap in service delivery (Lubben et al., 2015). This article highlights the lessons learned by The Skills for Safer Living (SfSL) team in the transition of service delivery from a comprehensive, in-person 20-week intervention, to a virtual delivery model after all in-person group work was immediately halted in March 2020 due to the COVID-19 pandemic.

SfSL – A suicide intervention group

SfSL is a 20-week psychosocial/psychoeducational group intervention originally developed with, and for, people with recurrent suicide attempts (Bergmans, 2016). Several different streams of service provided by SfSL target certain demographics. The core group is inclusive of all genders with people ages 18+ who have attempted suicide one or more times. Groups are offered separately for adolescent youth and their caregivers, young adults, and those who have suicide ideation only. An aftercare group, called Peers for Safer Living, is provided for people who have completed the full 20-week program. Weekly clinical supervision for the team (two full-time and five part-time staff – who identify as peers) serves to ensure fidelity to the intervention, and is focused on clinical and administrative issues.

At the time of lockdown, two groups were ending, assessments were being completed for three upcoming groups, and one group had begun the day prior. Within 24 hours, the program was left with the perplexing issue of how to move forward and continue services for this high-risk population who were suddenly left without services and support.

Pivoting to meet the need

Within the first week of lockdown, the team began to offer telephone support to individuals who had been scheduled to start groups and for people on the waitlists. Approximately 30 to 50 people were provided with weekly telephone support and/or general wellness checks. The degree of suicidal ideation and anxiety intensified in the support calls during this time. Mounting fatigue and worry held by facilitators resulted in calls moving to a rotating model whereby team members would take it in turn to offer an individual support that week. Key concerns, strategies, and skills raised during support calls were discussed in weekly supervision meetings. Common concerns for clients included heightened anxiety and suicide ideation. These calls required a focus on strategies that were validating and humanizing the collective experience. No suicide attempts were reported and three clients identified presenting to their local hospital due to unrelenting suicide ideation during this time.

One month into the pandemic the team began to shift efforts once more. Growing comfort with working from home, along with increased capacity with technology, led to discussions around delivering traditional SfSL groups virtually. Weekly team discussions explored the logistics of virtual care and more importantly, provided a platform for facilitators to express their concerns and fears on embarking into the unknown territory of virtual service delivery. In early April, the team decided to pilot three 8-week virtual SfSL groups using Microsoft Teams. Each group would have three facilitators, a primary and secondary facilitator, and a third facilitator to offer technological and additional support. Scheduling flexibility on the part of team members was necessary. For example, during this period, three team members went on personal leave and other team members stepped into those facilitation roles seamlessly. The willingness to support one another enabled groups to
continue uninterrupted with minimal impact on participants. The group start dates were staggered by two weeks in an effort to build on the accumulated experiences and learnings of each group.

**Lessons from the field**

The pilot phase of the program engendered daily novel challenges, struggles, and learnings. A literature review provided little guidance on how to navigate the delivery of virtual groups to people with experiences of suicidality. In a virtual world, the team had to re-envision how to maintain the therapeutic factors of providing groups (Yalom and Leszcz, 2005), wondering how to promote strong and healthy group formation (Tuckman, 1965), and yet relinquish familiar ways of navigating group delivery.

A core feature of working in a group is making eye contact and being able to ‘read’ the energy and body language of individuals. Facilitators expressed concerns of missing vital cues and messages from group members on a virtual platform. As the groups continued, such apprehensions quickly melted away. The use of webcams significantly helped group members and facilitators alike, in direct conversation and to read other people’s body language. The use of gestures (e.g. heart-shaped hands, head nods, thumbs up/down) by group members assisted in the development of group cohesion and was encouraged by facilitators. Concerns regarding client safety were successfully navigated by the inclusion of a third facilitator. This third facilitator focused on monitoring people’s nonverbal communication and would complete follow-up calls if someone unexpectedly quit the online session. Apart from crisis intervention, this facilitator would also be on standby to offer assistance with any challenges with technology.

Technology presented both challenges and opportunities for virtual groups. Among the challenges was how to navigate privacy. Virtually, facilitators had less control over privacy during the group. Facilitators found it useful to offer a ‘coaching’ session before the commencement of the first group to help clients navigate the virtual format but also to discuss privacy expectations and how the individual could protect it. These sessions not only helped to reinforce the importance of privacy, they also afforded an opportunity to improve the quality of audio and visual connections. For example, headphones enhanced the audio, and sitting at a table without distractions improved focus. By articulating privacy concerns directly with the client, privacy risks were mitigated and new comforts within a virtual platform were created. An unforeseen advantage was the disclosure by some group members that a virtual format enabled them to participate in the program. Client mental health, physical co-morbidities, and access to transportation created barriers to accessing the group previously.

Prior to the commencement of groups, it was important for facilitators to familiarize themselves with the virtual platform that would host groups moving forward. It was helpful to explore how other applications can be used to complement Microsoft Teams during group. The use of PowerPoint slides, paint applications, videos, customizable digital games, and the sharing of the facilitators’ screens enabled enhanced group interaction and dynamic facilitation. None of the intervention content was compromised by delivering virtually using many of these outlets. By opening the meeting space 10 minutes prior to and after group allowed for ‘social’ time just as participants would have in person leaving the building.

**Discussion**

Suicide ideation during COVID-19 is reported to have increased by 3.5% (Canadian Mental Health Association, 2020) with some jurisdictions reporting an increase in deaths by suicide (Wang et al., 2020). Already working with a high-risk population, facilitators were eager to provide the SfSL group intervention, despite initial questions and concerns regarding how to proceed...
digitally. By meeting with participants prior to the group start, noted privacy and technological concerns (Renn et al., 2019) were addressed. Furthermore, for some, it appears that COVID-19 may have enhanced clients attending sessions. Isolation, anxieties, fears, uncertainty, and increasing ideation may have contributed to participation due to the overwhelming need for connection and support during these times.

The anxieties and concerns for facilitators surrounding online delivery of SfSL dissipated rather quickly. Clarity of the continuing purpose of SfSL and transparent weekly discussions facilitated adherence and fidelity to the intervention. Session handouts were provided via pdf or mail, according to client preference, and content delivery through screen sharing, paint, and games appears to have contributed to ongoing participation.

Unlike in-person groups, facilitators experienced less ‘storming’ (Tuckman, 1965) than usually experienced in group formation, potentially due to the unfamiliarity of the modality, the need for connection, or the fear of potential consequences if ‘best behavior’ was not maintained (Gleeson, 2020). Yalom’s therapeutic forces of groups (Yalom and Leszcz, 2005), universality, imparting information, altruism, belonging, catharsis all continued to occur. Group participants engaged in nonverbal communication with one another finding different strategies that included exaggerated hand, head, and facial responses.

Offering virtual groups removed geographical and travel barriers and felt emotionally safer for some participants (Good Therapy, 2020). To meet the parenting and caregiving needs of facilitators, flexibility in the time of day groups was offered, which allowed clients and facilitators the option of participating at a time of day that was best for them.

Social workers and mental health professionals, often at the front lines of working with the most vulnerable populations, have had to use their creativity and resourcefulness to adapt to the increasing needs during the COVID-19 pandemic (Berg-Weger and Morley, 2020). This reflection of the SfSL process in pivoting to meet the needs of our clients from in-person groups to virtual groups highlights that not only are mental health professionals adaptable and capable of providing alternate forms of service delivery for those at risk of suicide. We are all highly resilient to such adaptations.

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