Videoconference-delivered Group-Delivered Acceptance Commitment Therapy for Perinatal Mood and Anxiety Disorders: Facilitators views and Recommendations

Objectives

To examine, in depth, the perspectives of facilitators of a videoconference-delivered group Acceptance Commitment Therapy (ACT) intervention for perinatal women with moderate-severe mood and/or anxiety disorders.

Design

Qualitative study.

Methods

Thematic analysis was used to analyse semi-structured interviews with seven facilitators, and post-session reflections with six facilitators.

Results

Four themes were generated. Firstly, there are barriers to accessing psychological therapies in the perinatal period and improvements are required. Secondly, COVID-19 has accelerated the provision of remote therapies, including videoconference-delivered group therapy, enabling a continuity of service, and facilitating diversification of treatment access and choice. Thirdly, there are benefits of videoconference-delivered group ACT in the perinatal period, with reservations. Attending a group via videoconference is perceived to be less exposing, and offers normalisation, social support, empowerment, and flexibility. Facilitators held reservations, perceiving videoconference-delivered group therapy may not be prioritised by service users, concerns about limited non-verbal cues and therapeutic alliance, reporting a lack of an evidence base, and technology challenges when working online. Finally, facilitators offered recommendations for videoconference-delivered group therapy best practice in the perinatal period, including the provision of equipment and data, contracts for engagement and suggestions to maximise engagement and group cohesion.

Conclusions

This study raises important considerations regarding the use of videoconference-delivered group ACT in the perinatal context. There are opportunities afforded by videoconference-delivered group therapies, which is important and timely given the increased drive towards improving access to perinatal services and psychological therapies and the need for 'COVID-proof' therapies. Recommendations for best practice are offered.

Keywords: Perinatal mental health, Acceptance Commitment Therapy, ACT, Group therapies, online-delivered, remote therapy, facilitators' views, NHS

Word count = 3592 (Including references)

Introduction

NICE strongly recommends psychological interventions to treat perinatal mood and anxiety disorders (NICE, 2014). Timely treatment tailored to the perinatal context is required for pregnant and postnatal women who often present with symptoms crossing diagnostic categories (Cymru, 2017; Howard et al., 2014; NICE, 2014). Acceptance and Commitment Therapy (ACT) is one approach that is considered suitable for women with moderate-to-severe perinatal mood and anxiety disorders (Bonacquisti et al., 2017). ACT aims to promote psychological flexibility and reduce experiential avoidance through six core processes: acceptance, cognitive defusion, self as context, present moment awareness, values, and committed action (Hayes et al., 2011). Recently, a group-delivered ACT intervention (ACT-PNMH) has been found to be feasible, safe, and effective for perinatal women with mood and/or anxiety disorders (Waters et al., 2020).

Since the COVID-19 pandemic, remote psychological therapies have become increasingly important (Békés & Aafjes-van Doorn, 2020; Shore et al., 2020). A drive towards improving access to psychological therapies was evident pre-pandemic, with an increasing number of internet-based interventions with and without therapist assistance

in use. Including individually delivered internet-based ACT and Cognitive Behavioural Therapy (CBT) for a range of mental health conditions (Brown et al., 2016b)Digital interventions have been prioritised to widen access to evidence-based psychological therapy services in the UK (Wakefield et al., 2021).

Online and remote therapies offer flexibility for individuals unable to commit to in-person sessions due to difficulty getting time off work, reduced mobility, financial and geographical restraints, or barriers such as fear and stigma (Lovell & Richards, 2000; Maercker & Knaevelsrud, 2007; Taylor & Luce, 2003). Not least, internet-based therapies can offer greater choice and control (Hollis et al., 2018). Remote interventions, including on-line delivered group therapy, may be particularly relevant for women in the perinatal period, however the evidence base is limited. Some individuals may not be able to access childcare to attend in-person sessions, and some perinatal women may be required to isolate due to vulnerabilities—pertinent recently with pregnant women placed in the COVID-19 'vulnerable group' and required to self-isolate in the last trimester (RCOG, 2000). Another consideration is the potential for on-line group therapy to offer social support, important in the perinatal period, and particularly so when there is reduced access to social support due to social distancing and isolation (Esegbona-Adeigbe, 2020).

Videoconferencing group-psychotherapy has been attempted since 1961 (Wittson et al., 1961), yet there is a limited evidence for videoconference-delivered group therapy. Internet-based group-delivered CBT is effective compared to waitlist for depression in adolescents and young adults (van der Zanden et al., 2012). A video-conferencing group-delivered positive psychotherapy intervention for female cancer survivors has been shown to be as engaging and effective as its face-to-face counterpart in reducing emotional distress and promoting post-traumatic growth (Lleras de Frutos et al., 2020). There is also a small body of research for *blended* group therapy. Schuster and colleagues (Schuster et al., 2019) evaluated a blended group-delivered on-line intervention for depression based on ACT and behavioural activation. This study focused on the feasibility of the intervention, including therapist views, reporting increased engagement and therapeutic alliance, increased workload, and data issues. Whilst not a replacement for psychological therapy, online support groups have been running for over 25 years (Barak et al., 2008). Some of the literature refers to the

Online Disinhibition Effect (Suler, 2005), whereby individuals express themselves more openly online compared to in the face-to-face world, and has been suggested to have positive outcomes in the sense that group bonding may result from increased honesty and disclosure (Tanis, 2007).

At the onset of the COVID-19 pandemic, a videoconference-delivered group ACT intervention was developed for women with moderate-severe perinatal mood and/or anxiety disorders who were accessing a specialist Perinatal Community Mental Health Service (PCMHS), providing support for women from pregnancy up to one-year post-natal. The intervention was based on an in-person group-delivered programme (Waters et al., 2020), with adaptations for delivery via videoconference. All materials, skills and exercises that were used in face-to-face sessions were possible via videoconference, providing individuals would be willing and able to participate in group discussions via their online audio-video device, such as a smartphone, tablet, or laptop. For example, group discussions such as feeding back on homework practice were facilitated by inviting individuals to raise their hand either physically, or by using functions on the screen, such as adding something to the chat function. All exercises such as mindfulness exercises were possible, with individuals invited to remain seated in front of their device, to ensure that individuals were participating. The effectiveness of the intervention has been evaluated from the perspective of service users, which will be reported separately. In the current study we aimed to gain an in-depth understanding of facilitators' views and experiences of providing group-delivered ACT-PNMH on-line. The shift to videoconference group-delivered ACT-PNMH provided a unique opportunity for the collection of a rich set of data to contribute to the growing evidence base for the remote delivery of psychological interventions (Wild et al., 2020), and to make sense of the changes to psychotherapy practice brought about by the pandemic (Fisher et al., 2015). We aimed to understand views and experiences and gather recommendations for best practice in the unique perinatal context through a mixture of semi-structured interviews and post-session reflections—a practice encouraged by the psychological professions.

Materials and Methods

We used qualitative methodology to gather in-depth facilitator views via post-session reflections and semi-structured interviews. The study was reviewed and approved by the host NHS organisation. Participant's provided written informed consent prior to participation.

Participants and Procedure

Participants were NHS staff working in a specialist PCMHS who were co-facilitating videoconference-delivered ACT-PNMH. Post-session reflections for up to 30 minutes, between two co-facilitators, were gathered between May-September 2020. During the reflective session facilitators held in mind the following questions: What adaptations are we making for on-line delivery? What is, and is not, going well? What could we be doing more of? We aimed to interview all facilitators of ACT-PNMH (N = 7) for sufficient information power, based on several considerations, including the specific study aim and sample specificity (Malterud et al., 2016).

Participant characteristics

All facilitators of ACT-PNMH during the study period (two male and five female) were interviewed, six of whom also provided post-session reflections. The mean post-session reflection and interview lengths were 15:20 (SD=0.25), and 27:44 (SD=0.30), respectively. All were white British and educated to degree level or above.

Data collection and analysis

XX (Author 1 initials) conducted semi-structured interviews with participants in confidential NHS settings, in-person (n=2), and via videoconference (n=5). The interview followed a topic guide (see online appendix A). Questions broadly invited discussion of the following: current psychological treatment for perinatal mental health; face-to-face and videoconference-delivered group therapies; prior experience facilitating online interventions; and experience facilitating ACT-PNMH via videoconference. Interviews were audio recorded and field notes were written immediately after interview.

Interviews and post-sessions reflections were transcribed verbal verbatim and prepared for analysis (e.g. assigning participant pseudonyms and removing identifiable details). Transcripts were imported into QSR NVivo 12. We used Thematic Analysis and an inductive approach to identify commonalities and differences in the data and to systematically map emerging codes and sub-themes (Braun & Clarke, 2021; Gale et al., 2013). XX (Author 2 initials) generated codes for 100% of the transcripts, identifying segments that were analytically intriguing, and XX (Author 1 initials) double-coded 100% of the transcripts. XX (Author 1 initials) and XX (Author 2 initials) met regularly to develop an analytic coding framework. XX (Author 1 initials) who has prior experience of thematic analyses, and XX (Author 2 initials) met with XX (Author 3 initials), a senior supervisor of qualitative research methods, to discuss coding and themes, and with the intention to reconcile inter-rater coding discrepancies, though this was not required.

Results

Four overarching themes were generated: barriers accessing psychological therapies in the perinatal period; benefits of videoconference-delivered group therapy in the perinatal period, with reservations; the COVID-19 impact and acceleration of videoconference-delivered group therapy; and benefits and challenges of delivering ACT-PNMH via videoconference. The overarching themes and sub-themes are presented in Table 1.

[Insert Table 1]

Theme One: Barriers accessing psychological therapies in the perinatal period

[Insert Table 2]

Theme Two: COVID-19 impact and acceleration of videoconference-delivered Group therapy

[Insert Table 3]

Theme Three: Benefits of videoconference-delivered group therapy in the perinatal period, with reservations

[Insert Table 4]

Theme Four: Recommendations for best practice for videoconference-delivered group therapy in the perinatal period

[Insert Table 5]

Discussion

Facilitators highlighted four main themes: barriers to accessing psychological therapies in the perinatal period; COVID-19 impact and acceleration of videoconference-delivered interventions; benefits of videoconference-delivered group therapy in the perinatal period, with reservations; and recommendations for best practice. The findings suggest an overall acceptability of videoconference-delivered group ACT from the perspective of NHS staff facilitating its delivery as part of routine perinatal mental health care. Furthermore, findings indicate that videoconference-delivered group

interventions can improve access to psychological therapies during the perinatal period, providing a 'COVID-proof' treatment option.

Facilitators considered barriers to treatment access, including service capacity issues, in line with the literature elsewhere (Simon et al., 2021). Similarly, facilitators highlighted the impact of stigma and shame in seeking psychological support during the perinatal period which is consistent with wider literature (Kantor et al., 2017). All reflections and interviews were conducted during the COVID-19 pandemic and facilitators reflected on the impact of increased isolation and restrictions on perinatal women. This is reflected in findings of a systematic review suggesting the COVID-19 pandemic significantly increased anxiety among perinatal women (Hessami et al., 2020). Facilitators spoke of service continuity enabled by videoconference-delivered ACT-PNMH, and how remote therapies improved access and treatment choice and would be continued beyond the pandemic. In support is literature which describes COVID-19 as a turning point for mental healthcare and increased digital health; the 'black swan' (Wind et al., 2020).

Overall, facilitators viewed videoconference-delivered group ACT positively, aligning with findings from a recent survey of psychotherapists' attitudes to online psychotherapy (Békés & Aafjes-van Doorn, 2020). Some facilitators perceived participants to feel less exposed with videoconference-delivered group therapy, which facilitated openness, and is consistent with the literature on the Online Disinhibition Effect (Suler, 2005). Facilitators spoke highly of the flexibility and accessibility afforded by the remote approach to therapy, consistent with findings elsewhere (Lovell & Richards, 2000; Maercker & Knaevelsrud, 2007; Simon et al., 2021; Taylor & Luce, 2003). Reservations included having inadequate access to a service user's non-verbal cues, and a limited therapeutic alliance highlighting the challenges to establishing a therapeutic environment in internet-based psychological therapies (Simon et al., 2021; Thew, 2020). These views are not however supported by the available evidence where equality of alliance has been demonstrated for online and face-to-face therapy (Andersson et al., 2012; Berger, 2017; Hadjistavropoulos et al., 2017).

Strengths and weaknesses.

Videoconference-delivered, or teletherapy-delivered ACT has been examined in other routine health contexts (Brown et al., 2016a; Trindade et al., 2021; Wood et al., 2021),

however this is the first study to examine a videoconference-delivered group ACT intervention in routine perinatal mental health practice. The findings will be relevant to perinatal service contexts across the UK, and wider, particularly in light of a drive towards improving access to psychological therapies and perinatal services, and the growing need for remote and accessible interventions. All reflections and interviews were conducted during the COVID-19 pandemic, offering a unique insight into a time-period of innovation and uncertainty in perinatal mental healthcare. The inclusion of post-session reflections and semi-structured interviews allowed for openness and reflection, enabling the emergence of new topics and the collection of a rich dataset. All reflections and interviews were double coded.

Caution should be exercised when considering the generalisability of the findings to other perinatal mental health services, since perspectives were collected from facilitators in just one service. Nonetheless, the population that falls within the boundaries of the NHS service where this research was conducted is relatively geographically and socioeconomically diverse. All facilitators were white British, which limits generalisability. It is important to note that several of the views provided by facilitators were based on their perceptions and assumptions of how service users may be experiencing the intervention. For example, facilitators perceived limited chances for service users to reflect when engaging in videoconference-delivered therapies from their home, though we cannot be certain that this is the case without hearing the perspectives of the service users themselves.

Research Implications.

Several perceptions raised by facilitators require further research. Some facilitators perceived that videoconference-delivered group therapy may not be prioritised by service users in the same way as face-to-face group therapy. It would therefore be beneficial to conduct research examining adherence for videoconference-delivered versus face-to-face group therapy, including gathering perspectives from service users. Some facilitators highlighted the importance of providing service users and facilitators alike with access to equipment and mobile data for inclusivity. This is in line with findings highlighting a tendency for digital technologies to increase inequalities (Azzopardi-Muscat & Sørensen, 2019; Ennis et al., 2012). Yet we must acknowledge

the value of digital health interventions in offering opportunities to increase availability and equitable resources for mental health care globally, potentially addressing unmet needs (Olff, 2015).

Some facilitators drew attention to their concerns for the lack of evidence for videoconference-delivered group therapy, that they were 'taking a leap of faith' when embarking on this new approach in the unique perinatal context. The findings of research evaluating the effectiveness of videoconference-delivered group therapy in the perinatal period from the perspective of service users in receipt of the intervention will be disseminated. Further research will be required, including consideration of the acceptability of the treatment approach, including whether therapeutic alliance can be established and maintained and how this compares with face-to-face group therapies.

Clinical Implications.

Recommendations are offered for best practice when delivering videoconference-delivered group therapy for women in the perinatal period including: equitable provision of equipment and mobile data; consulting available guidance; developing contracts for engagement; co-facilitating groups; practising with equipment before delivery; and practical methods to maximise engagement and group cohesion.

Declaration of interests: None to declare

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Tables

Theme 1: Barriers accessing psychological therapies in the perinatal period	Small window of time to access perinatal mental health services
	Long therapy waiting lists due to staffing capacities
	Service inequalities when engaging with a diversity of individuals
	Perceived service user stigma and shame in seeking psychological support
	Perceived work commitments, childcare, and breastfeeding needs, impacting on therapy access
	Perceived exhaustion impacting on therapy access

Theme 2: Theme Two: COVID-19 impact and acceleration of videoconference-delivered Group therapy	Isolation due to lockdown restrictions
	'COVID-proof' therapies for a continuity of service
	Diversifying treatment access and choice
Theme 3: Benefits of videoconference-delivered group therapy in the perinatal period, with reservations	Lack of evidence of videoconference-delivered group therapy
	A source of social support but there may be less chance to connect compared to in person
	Flexible and accessible, enabling engagement for a broader diversity of people
	Challenges with technology and internet connection
	Videoconference-delivered therapies may not be prioritised
	Limited non-verbal cues challenging conversational flow, movement through topics, and containment, but nods were helpful
	Limited therapeutic alliance
Theme 4: Recommendations for best practice for videoconference-delivered group therapy in the perinatal period	Provision of equipment and mobile network data for inclusivity
	Co-facilitate groups
	Practise with the equipment and content prior to running or joining the videoconference-delivered group
	Maximise engagement and cohesion through session length, group size, directive communication, and interactive elements.
	Draw on guidance
	Develop a contract to address governance and risk concerns

Table 1: Overarching themes and sub-themes

Small window of time to access perinatal mental health services	Rhodri talked about screening and detection, *"a barrier around detection… and screening so sometimes we get ladies quite late in pregnancy and then there's not enough [time] to… provide the intervention…"*
Long therapy waiting lists due to staffing capacities	*Kate said, "I think another is resource … women have been waiting a really long time… because we have less than a full time equivalent out of our qualified psychologists for a… geographically massive area."*
Service inequalities when engaging with a diversity of individuals	Paul said, *"it's really kind of diverse and that's not even then going into sort of*

	multi-cultural aspects which I would say that the service have found difficult to engage".
Perceived service user stigma and shame in seeking psychological support	Emily said, *"there might be stigma around asking for help and support, and kind of you know saying to someone actually I'm really struggling… you're supposed to feel all these happy feelings and actually to say that you're not might be quite exposing for some people."*
Perceived work commitments, childcare, and breastfeeding needs, impacting on therapy access	Paul said, *"stresses of them having to rush to an appointment, think about childcare, try to be on time, hold themselves present in the room whilst also considering a child or um a loved one depending on what's going on for them… I think there's an aspect as well as in if you are pregnant and working then it's trying to find the time to access services."*
Perceived exhaustion impacting on therapy access	*Julie said, "often they just don't feel up to it um through exhaustion or having a particularly difficult week or um going through a particularly difficult stage in pregnancy where they're nauseous or sickness…"*

Table 2: Theme One: Barriers accessing psychological therapies in the perinatal period

Isolation due to lockdown restrictions	Emily said, *"it [videoconference-delivered group therapy] was helpful… people did feel that they were not on their own… I don't know it that's a reflection of the times that we were in and with lockdown you know people feeling really alone and in isolation…"* *Paul said, "there are already restrictions on you which are kind of forcing difficult thoughts… for everybody to manage. So, I think one of the problems… have been some of the wider restrictions."* *Rachael reflected, "there's something about loneliness and being lonely in your house and actually being able to reach out to other people."*
'COVID-proof' therapies for a continuity of service	Paul reflected on the opportunity created by the pandemic in pushing along a different way of working with service users: *"I think making some of the rules about how we engaged would've taken years for us to get through; having online groups with multiple people sending them emails… yet due to a pandemic we*

	were able to push that through… a difficult time has allowed opportunities to demonstrate work." *Rachael said, "particularly because of COVID, people shielding or not wanting to leave the house it's still provided people with therapy".* Kate reflected *"I think the virtual fills a… gap… we need to be helping these women and we need to be reaching out to as many as we can".*
Diversifying treatment access and choice	Facilitators spoke of group therapies providing treatment for more people at a service cost reduction. For example, Julie said, *"a group is often more accessible… you can obviously give more access to more patients at once".* Paul said, *"I think that it [videoconference-delivered group therapy] has offered huge opportunities on how we can diversify the way that we work."* Julie suggested offering a combination of face-to-face and *videoconference-delivered* group therapy, beyond COVID, *"virtual has shown to have its place as well… if I was being asked what I thought should happen in the future, I'd say for a combination."* Cathy suggested expanding videoconference-delivered group therapies in the future *"it needs to go further… I think [videoconference-delivered group therapy for] couples would be good and evening ones as well."*

Table 3: Theme Two: COVID-19 impact and acceleration of videoconference-delivered Group therapy

Flexible and accessible, enabling engagement for a broader diversity of people	Kate reflected, "*Online is working out ok because it doesn't disrupt their day as much, like you have to go to an appointment and all of the stress that comes with it especially post-partum."* Rachael said, "*When you're quite heavily pregnant you don't really want to be travelling around on your own."* Cathy said, "*All of them [videoconference-delivered group therapy service users] said they wouldn't have been able to talk face to face, and one because of transport, two because of childcare, and I think for many years we've not been able to get um the training to many people and they know that they've missed out and we are getting it to another set of people…"* Preconceptions that videoconference-delivered therapies would exclude socioeconomically disadvantaged people were

	challenged. Rhodri said, "*we were really concerned about access to technology, social inequalities, access to wifi, to data, to all those things that enable access… so far we've been really pleasantly surprised… and we did some really good work on a general smart phone um so I've been amazed at what can be done."* Videoconference may be less exposing than in person. Emily said, "*It maybe felt less exposing to kind of mention some things that they were struggling with because they were at home… rather than sitting in a room… some people you know… worry about meeting new people."*
Challenges with technology and internet connection	Julie said, "*I think the technology definitely challenged us… you know computers signal dropping off, especially in the first few weeks I was often losing contact… I think we were better at that at the end but to start with I found that really frustrating and I can imagine… patients were probably feeling frustrated with it."*
Concern that videoconference-delivered therapies may not be prioritised by service users	Rachael said, "*When you're in the home and all you need to do is kind of log on that doesn't feel as formal that doesn't feel as much of a priority potentially… even though it feels like getting to a group is almost harder in terms of like if you've got a baby… I wonder if it felt more formal so women would attend it… whereas just clicking on a button almost like you can just mute and just sit back like a lecture."* *then take the phone call"*
A source of social support but less chance to connect compared with in person therapies	Kate said, "*I think a lot of what a group offers is… connectedness… that feeling of belonging to a group and having that social interaction.*" Paul said*, "The level of interaction is lovely, they're really supportive of one and other."* Julie said, *"there was definitely chit chat at the start er as we were waiting for everybody to kind of arrive… the general kind of chit chat that… develops those relationships in in-person groups… we are still doing that in the [videoconference-delivered] groups… and halfway through we give people the opportunity for people to swap emails or phone numbers and they were straight away… communicating with each other..."* Kate said, "*when women are in the same room they tend to interact more with each other."* Julie said, *" For some people who have never used it [videoconference-delivered] before that could make something feel even more daunting… I wonder whether that overall lack of personal contact makes them a bit more apprehensive."* Cathy said, "*When we do it face to face um a lot of people have said it's really hard to leave the baby, but actually by week three,*

	four they're actually enjoying you know the space from the baby and being away… the downtime when they come out…. that travel home to reflect… whereas now they just… leave and… straight back into it." Emily reflected, "*They're preoccupied with whatever is happening within the house."*
Limited non-verbal cues challenging conversational flow, movement through topics, and containment, but nods were helpful	Rachael said, "*You don't have that natural body language I guess going on, or some people don't feel comfortable kind of being able to interject when they're online but might have been able to do it a bit more in person."* Kate said, *"The minute someone turns their camera off or they dip out of the session… have they dipped out because they're upset, do I need to follow this up, is everything ok and I think you get that feedback a lot more easily from a face-to-face… I worry I'm going to miss someone who is potentially finding something quite difficult."* Paul talked about the superiority of in person groups, "*It's difficult to work out what the dynamics are in the [videoconference-delivered] room… You do [in person group therapy] have opportunities to observe the client um in whole form and what I mean by that is that you can really look for those kind of body language cues and non-spoken cues."* Non-verbal active listening behaviours, such as nods, were perceived as helpful. Cathy said, "*The nodding of the head feels more interactive so you know if you start to say something you can see everybody enjoying it and nodding their head, you're thinking oh god people are getting it."*
Limited therapeutic alliance	Facilitators felt a therapeutic alliance was attainable with videoconference-delivered group therapy but was more easily attained in-person. Julie said, "*I bond better with the patients from that chit chat and that break halfway through to have a coffee and just gossip almost to just build a relationship a bit rather than it feeling very kind of didactic over the kind of screen."* Emily said, *"I think that's something that you really notice then when you're delivering a group online is it's missing those tiny little things that help to develop a relationship."*
Lack of evidence for videoconference-delivered group therapy	Rhodri said, *"I guess we had question marks about how… effective it would be… it felt like we are taking a leap in the dark... there's not much to base it on and there isn't an evidence base… so I need to have faith."*

Table 4: Theme Three: Benefits of videoconference-delivered group therapy in the perinatal period, with reservations

Provision of equipment and mobile network data for inclusivity	Rhodri said, *"ideally I would recommend that you can supply patients with a device that has data on it … if we are offering a service it needs to be accessible to all people, regardless of financial situation… we shouldn't make assumptions about… who might be living in poverty and who may have access, because you may have people who might own their own home but they might have no income and no internet… we also make judgements about peoples' living conditions that might then mean we may or may not invite them to things like this, and actually what I have learnt is, don't make those judgements."*
Co-facilitate groups	Emily said, *"we did have one person kind of sharing their screen in terms of two facilitators and then one kind of sort of you know watching how everyone is doing."*
Practise with the equipment and content prior to running or joining the videoconference-delivered group	Emily said, *"I think there's something definitely about practicing using the IT systems that you're going to use before you do and to help all parents that are attending to feel comfortable to do that as well themselves."* Rhodri said, *"it felt really important to myself and other really experienced members of the team to really run the first group and consider what adaptations need to be made to think about how it's going. To get a grasp of all the potential issues that might come up, before we sort of encourage more junior members of the team then to deliver those groups… I felt safe in that… it felt like we made those decisions together and we thought about them and it felt considered."*
Maximise engagement and cohesion through session length, group size, directive communication, and interactive elements.	Facilitators suggested 90 minutes was the optimal length of time before people lost concentration, whilst also allowing space and time for connection. Rhodri said, *"it felt really important actually to get space to think about COVID… normally the group would be two hours, but we condensed it to ninety minutes because we felt after a lot of thinking and talking, that ninety minutes was pretty much the maximum amount of time you can hold concentration and get anything beneficial out of [a videoconference-delivered] group."* Facilitators spoke of the importance of group size for engagement. Cathy remarked, *"when I did the first group it was large… too large."* Zoom was recommended, given that many people can be seen at once. Julie said, *"I think Zoom certainly is the only platform used since the COVID pandemic that um you're able to hold kind of*

	everybody in the room at once and keep an eye on the people that aren't speaking as well the ones that are." Using directive communication was another recommendation to facilitate engagement. Cathy suggested, *"I think you feel like you want to ask everybody you know by name to feel like you're not leaving people out."* Rhodri reflected, *"it feels like when you're doing it remotely that you really need to sort of go around your screen… go around every person and say… have you got anything you'd like to say so it feels like you need to be more mindful of being inclusive … that could work in someone's favour as well as being a deterrent you know, or off putting that someone is directing them to speak, but for some people that might be… just what they need actually."* Interactive elements including the chat function and tools such as online breakout rooms were also recommended. Rachael said, *"it's just trying to be really creative I think in how we engage people… as facilitators we need to be quite flexible… be typing in on the slides peoples' responses, using the breakout rooms if you've got large groups... Using videos 'cause they feel really accessible for people… the chat bar when you're doing Zoom… everybody seems to write on there instantly..."* Paul also talked about the value of video clips, *"what we learned on the second and third was there was a huge… need, to kind of break the session up with at least one or two clips."*
Draw on guidance	Rhodri said, *"the BPS guidance on remote working… for remote delivery of groups, dyadic interventions, group interventions and um I think that was really helpful…."*
Develop a contract to address governance and risk concerns	Paul reflected on the complexities of managing videoconference-delivered groups whilst also working from home, *"for both I think the therapist and the potential client, then there are complexities to that, how you manage that space, how you manage the security, the safety of the individual, equally how you remain present in your own house… while trying to work if you also have your family at home."* Emily spoke positively about the contract they had used and engaged service users with, *"the contracts that we use… help to set the expectations of what the group was and…confidentiality and how that might be a little bit different if you're using an online video… way of working, and thinking about who else may be in the house and trying to find your own quiet room to do the group in really kind of helps."* Facilitators discussed the importance of having a follow-up procedure to check in with service users who become distressed. Rachael talked about this, *"I have a work office phone that I keep*

	next to me, so if someone does feel distressed, they can just text that phone to let us know and then I will ring them um either in the group or following the group… I'd be able to flag that up then with the other facilitator and then take the phone call"

Table 5: Theme Four: Recommendations for best practice for videoconference-delivered group therapy in the perinatal period