Challenges of virtual talking therapies for substance misuse in New Zealand during the COVID-19 pandemic: an opinion piece

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ABSTRACT

The COVID-19 pandemic requires us to rethink how virtual approaches might work for people who use alcohol and other drugs. Are virtual clinics only suitable for clients with whom clinicians have already formed a therapeutic relationship? How well would virtual clinics work for new clients presenting to services, for clients in acute distress, and for those with complex problems? Addressing the sustained change required to maintain substance-free lives or a safe substance-use life requires robust psychotherapeutic approaches, which have traditionally been delivered through physical contact, whether they are one-to-one or group-based interventions. The challenge during this time of the COVID-19 pandemic is to deliver effective talking therapies while avoiding physical contact. How then should services continue to offer counselling and support in such an environment? How can we learn from the COVID-19 situation to deliver treatment to individuals who may have difficulties attending traditional clinic-based care, such as those in more rural areas with transport difficulties? This article focuses on identifying practical issues and providing some solutions.

In November 2019, the world was hit by a novel coronavirus, SARS-CoV-2 (referred to as COVID-19). The first cases emerged from Wuhan in China, but rapidly spread across the world.[1] On 11 March 2020, The World Health Organization classed the COVID-19 global situation as a pandemic—affecting all people including individuals and whānau/families struggling with addictions.

In New Zealand, confirmed COVID-19 cases initially steadily increased, with a reduction in the rate of increase as New Zealand moved through different alert levels, flattening the peak of COVID-related demand on the New Zealand health system. District health boards and other health service providers across New Zealand, although 'essential services', are still required to operate within the boundaries of the various alert levels. The requirement to maintain physical distancing has had a significant impact on the standard in-person forms of treatment delivery. In response, many primary-care and secondary-care consultations are now being conducted virtually where appropriate and possible. How does this change in health service delivery affect clinicians working with people who use alcohol and other drugs?

Treatment providers for substance misuse

Treatment providers for substance misuse, including non-governmental organisations (NGOs) and other community providers, also fall under the class of 'essential services' and have continued to provide treatment. A number of national bodies such as National Association of Opioid Treatment Providers (NAOTP), National Committee for Addiction Treatment (NCAT), Health Promotion Agency

(HPA) and many other district health board and NGO agencies continue to provide a coordinated approach, providing guidance to people who use alcohol and other drugs, their whānau, clinicians and leaders, on how to continue receiving and providing effective treatment.

For some people using alcohol and other drugs, the immediate treatment need is pharmacological. Practical concerns such as access to pharmacotherapies, safer injecting equipment and guidance on safer drug use practices, dealing with lack of access to street drugs, etc, emerge during times of national crisis. The New Zealand Drug Foundation has acted quickly, providing online advice and support for people who use alcohol and other drugs, their whānau and treatment providers (http://www.drugfoundation.org.nz/covid-19).

However, pharmacological treatment is often only one component of the treatment package for people who use alcohol and other drugs. Most treatment interventions are 'talking therapies', generally provided in person.[2] Addressing the sustained change required to maintain substance-free lives or a safe substance-use life requires robust psychotherapeutic approaches which have traditionally been delivered through in-person contact, whether they are one-to-one or group-based interventions. The challenge during this time of the COVID-19 pandemic is to deliver effective talking therapies while avoiding physical contact. How then should services continue to offer counselling and support in such an environment? How will the current use of technology impact on ongoing service provision in the long term? This article focuses on identifying practical issues and providing some solutions.

Virtual clinics: our 'new' model of care

Telehealth, video consultations and online treatment have emerged over the past few years as novel ways of working, reaching both the population engaged, as well as those not engaged, in treatment services. Such virtual approaches are also useful for providing clinician-to-clinician support, consultation and advice (www.digital.health.nz).[3–5]

Several studies on virtual approaches (both video and non-video) to delivering treatment for substance misuse indicate that virtual clinics are an acceptable way of providing treatment, with high levels of satisfaction reported by both clients and staff.[6–10] In addition, the resources needed to deliver such services are considerably less and therefore less costly than more traditional ways.[11] However, a limitation of these studies is that they include cohorts of clients who are relatively stable (or not in an acute stage/experiencing a disorganised lifestyle).[12] In addition, the reported success of these virtual clinics is in the context of having such clinics running alongside traditional in-person clinics. Would they be as successful if virtual clinics were the only source of care provided? Would they be as successful if they did not have a parallel traditional system to deal with the more acute or complex cases?

Over the years, virtual novel approaches for people who use alcohol and other drugs have been gradually increasing in both number, popularity and utility.[10–13] The COVID-19 pandemic has required us to rapidly adopt such approaches, which begs the question of how virtual approaches might work.[14,15] For example, are virtual clinics only suitable for clients with whom clinicians have already formed a therapeutic relationship? How well would virtual clinics work for new clients presenting to services, for clients in acute distress, and for those with complex problems?

Virtual talking therapies for substance misuse problems: the challenges

Talking therapies for substance misuse problems range from educational and supportive to more structured therapeutic approaches (such as motivational interviewing, brief interventions, 12-step programmes). The majority of talking therapies were designed to be provided in person, either one-to-one or in group sessions, following well-tested practice guidelines.[2] Shifting talking therapies into the virtual space is a major change that is transformative and exciting, but also raises some concerns. Many of these concerns are the same regardless of whether virtual sessions are delivered one-to-one or in group sessions or whether the virtual therapies are video, non-video or other online approaches.

Safety

Virtual talking therapies are safer in terms of transmission of COVID-19, but how safe are they in the detection of high-risk situations such as suicidal ideation? The virtual nature of the therapeutic intervention could present difficulties in picking up visual or other sensory cues. An assessment of an individual's mental state is essential in understanding the psychological space they might be in, and in capturing the individual's readiness to change and support they might require. During traditional face-to-face sessions, the assessment is based on observation of an individual's general behaviour and interaction, as well as the responses to assessment questions. However, assessing an individual's behaviour and interaction virtually could be a challenge—and could result in inappropriate interpretation—particularly if the session is not video-enabled.

Transparency

Talking therapies assume transparency. Therapies facilitate a safe space for experiences, thoughts, feelings, fears and intentions to be shared with the counsellor or other healthcare professional, or with other clients if within a group session. The therapeutic relationship and peer relationships (in group sessions) foster a sense of trust, optimism and mutual respect. Facilitating such a safe space virtually could be challenging.

In addition, individuals under the influence of substances while attending a talking therapy session would generally be asked to leave the session and to re-engage with the next session. Within in-person sessions, the healthcare professional would be able to observe behaviours and be exposed to sensory stimuli (eg, smell), indicative of intoxication. Within a virtual session, assessment of intoxication may be possible if both video and sound was enabled. Without video, the clinician would be only reliant on verbal expression by the client.

Inclusion

People routinely hold meetings using video-conferencing tools, such as Zoom™ or Skype™. Delivering group-based talking therapies to people who use alcohol and other drugs would therefore be possible using such video-conferencing tools. Efforts would need to be made to ensure all parties in the meeting feel included and have equal opportunity to share their views.

Virtual approaches also enable more distant access, potentially improving specialist help for rural populations, those whose transport options are limited, and others who have difficulties attending, such as those with childcare commitments. Ensuring privacy and data protection could make it possible for such populations to be reached.[16]

Equity

Although the majority of individuals in New Zealand possess smartphones, the minority who do not might need talking therapies the most. People without smartphones could have access to library computers, and with headphones, could potentially engage in therapy. However, such options could be limited during pandemic times. In addition, using smartphone technology requires a strong internet connection, which also generally utilises large amounts of data—this might not be an option for those from lower socioeconomic backgrounds. In this light, virtual provision may not be equally accessible giving rise to health inequities.

Cultural issues

Culturally appropriate talking therapies are respectful of various cultural beliefs. In New Zealand, it is important to ensure that the mode of delivery of talking therapies do not inadvertently disadvantage Māori and Pasifika peoples and other cultural groups. Ensuring that virtual delivery is culturally appropriate is new territory to most counsellors and clinicians,[17] and good cultural guidance from Māori and Pasifika elders and other leaders from other cultural groups is required.

Effectiveness

Virtual clinics have been linked with high satisfaction rates[8,9,18] and high demand rates,[19] but their efficacy in achieving sustained changes in use of substances remains questionable.[12,20–22] It is unclear whether they are as effective as traditional clinic-based care and whether the outcomes of traditional clinic-based care are equivalent or comparable to virtual clinics in the treatment of substance misuse. In addition, the impact of the potential 'reach' of virtual clinics as

compared to traditional clinics, on the overall burden of alcohol and other drug use on population health, remains unclear.[10,23]

Literature on virtual approaches for people with more acute or severe alcohol and other drug problems is sparse and often limited (eg, only reporting on brief interventions, small cohorts, significant drop out rates, etc), making it difficult to confidently state that virtual approaches are effective.[23,24] More research in this area is needed.

Motivational interviewing (MI) is a collaborative conversation style that is indicated for individuals with more severe problems, to help them strengthen their own motivation and commitment to change.[25] Studies report that MI for tobacco cessation can be delivered by phone[26,27] and that visual contact may increase visual cues and may add to client satisfaction;[18,28] however, it is unclear whether visual cues increase the impact of MI in this context. Ultimately, clinicians working from an MI framework ensure the spirit of MI is maintained while attending to the central processes that form the flow of MI—engaging, focusing, evoking and planning.[25] These processes may flow into each other, overlap and recur whether in traditional in-person or virtual clinic delivery. It could be argued that the effectiveness of the MI conversation would hinge on the ability of the clinician to navigate the MI processes virtually:

1. Engaging: This is the process by which both parties establish rapport and a collaborative working relationship—ensuring both parties feel comfortable, respected and involved. The quality of engagement is central to therapeutic outcomes. A virtual clinic has the added benefit of limiting external visual distractions and shifting the focus more pertinently onto the change language. This helps cultivate an environment of reflective listening where reflective statements are used to ensure less defensiveness and encourage greater exploration. Non-verbal facial expressions (such as nodding, eye contact) provide reciprocal clues about attention and understanding; however, poor virtual technical issues may limit some of this valuable interchange—an area that begs further research.

2. Focusing: Engaging leads to a focus on an agenda topic. It helps to develop and maintain a specific direction in the conversation about change. It is an ongoing process of seeking and maintaining direction while finding more specific achievable goals. Sometimes there is a clear single focus, sometimes there are multiple topics and sometimes there is uncertainty and further exploration is needed. No matter what the clinical environment (whether in person or virtual), the clinician needs to be alert to finding and maintaining the direction of the conversation.

3. Evoking: With a clear change goal as a focus, the process of evoking involves eliciting the client's own motivations for change. A virtual clinic may enhance physical distance that promotes a client to voice their own arguments for change by limiting the clinician's righting reflex to voice those arguments themselves. A clinician comes with an attitude of acceptance of what the client brings. This involves honouring the inherent worth of their client, taking an active interest in understanding their internal perspective, respecting the capacity of self-direction and affirming their strengths and efforts to move towards change. It can be argued that despite the clinical environment this will need a skilful clinician.

4. Planning: This marks a readiness to change; it encompasses both developing commitment to change and formulating a specific plan of action. It is a conversation about action that elicits a client's solutions. It promotes their self-efficacy by reflecting on their strengths and skills. It is an ongoing process that can be revisited, which is so often the case following relapse to substance use.

A virtual clinic could be just as well positioned to work collaboratively to revisit evoking in order to consolidate motivation and confidence to implement new plans. These areas are rich for further research to explore.

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Privacy and confidentiality

The privacy of the medium used for virtual consultation is of utmost importance. A number of platforms—eg, Zoom™—can be encrypted to ensure privacy of issues discussed. Another issue to consider is whether the client and the clinician are alone in the rooms when engaging in the session. This issue is especially pertinent in group sessions and in non-video consultations.

Technical qualities

The quality of virtual consultations is dependent on a number of factors, such as the ability of participants to use the technology appropriately, access to a computer with a camera and a microphone, stability of internet within geographical areas, access to timely technical support, licensing of technological platforms, etc. Such factors, as well as a quiet and private space, can be a challenge and hinder the effectiveness of talking therapies.

Some tips going forward

Having an awareness of mentioned challenges permits us to put in place processes to mitigate them and facilitates the development of good practice going forward. The following are some tips that could be useful. The tips are by no means exhaustive.

Protocols/standard operating procedures

Adapting existing protocols and standard operating procedures for the new 'virtual' approach will help clarify expectation of practice for both staff and clients. The rapidity of measures adopted in New Zealand during the COVID-19 pandemic has resulted in service providers changing to virtual approaches quickly. It would be difficult in such situations to implement a co-design approach with clients and staff to develop protocols and standard operating procedures. However, transparency around the need to act without such consultation, and requesting feedback from staff through email communication and from clients during the virtual sessions, post, is acceptable.

Ensuring privacy and confidentiality

Staff should adopt virtual platforms suggested and supported by their IT departments. Personal client information will need safeguarding and security should be heightened.[4,5,29] In addition, a discussion between client and clinician around privacy and confidentiality is a fundamental part of the talking therapy session. Both parties need to understand and respect the importance of being strict around ensuring no third party is privy to the therapeutic virtual encounter. Prior to starting the session, it is advisable to disclose the clinician identity and to confirm the identity of the client (such as date of birth) to ensure that the person behind the phone or screen is who they say they are.

Furthermore, the rapid adoption of telehealth has occurred with some clinicians using personal devices to make calls. It is important to ensure that personal numbers are not displayed.

Support and supervision for clinicians

Most services have organisational structures based on clinical governance frameworks. These structures often provide clarity around accountability, support and supervision pathways. Despite the 'work from home' where possible and 'physical distancing' mandatory processes, it is important to ensure that support and supervision is available in-person or virtually.

Training for clinicians

With every new model of care, regular training is a necessity. The aim is not only to train on core principles and theory, but also to do 'on-the-job' training or coaching. This could be achieved by ensuring experienced clinicians are present during virtual sessions to observe the 'how'. Consent from the client/s will need to be sought.

Running group sessions

Running effective group sessions virtually can be challenging. Factors below could facilitate an effective session:[29]

- Have a phone conversation with each participant before inviting them to join the group. This would provide opportunity for the clinician to explain and request feedback for the group protocol or standard operating procedure; the 'rules' of the group; likely other participants in the group (not names); expectations of the group; and potential/likely outcomes.

- If a client is clearly intoxicated during the session or is finding the session difficult or challenging, suggest they exit the session immediately and re-engage in a one-to-one session later. Following the session the clinician should contact the client to ensure their safety.
- Communication:
    - Clinicians should adopt an empathetic, supportive and encouraging communication style, reflecting back—reinforcing and restructuring where appropriate.
    - Clinicians will need to manage communication. For interactions with individuals in the group the majority of communication should occur between the clinician and each client, with other clients prompted/invited to share/comment if necessary.
    - Allow each client at least three minutes to talk. This will ensure all clients are included in the session.
    - Free-form communication (ie, speaking without prompting) should be discouraged.
- Having a theme for each session facilitates the discussion.

The suggestions above could apply to family/whanau group as well as sessions with clients.

Acute/complex clients

A good assessment is an important part of all client interactions, and for those with acute or complex issues, a good assessment can identify urgent client needs. In the first instance, it is advisable to facilitate a virtual one-to-one session to clarify client needs, goals and immediate suitable treatment plan. Initially talking therapies are likely to take the form of empathic, supportive and educational communication, as opposed to more structured therapeutic options. Group-based approaches may not be indicated as a first-line approach. It may also not be feasible to continue providing treatment virtually, and in-person sessions (with appropriate physical distancing) may need to be considered.[2,30]

New clients

As with acute/complex clients, new clients will require careful assessment.[30] If their needs are acute, the process above will need to be followed. However, if needs are less acute, virtual sessions, one-to-one or group could be offered. It is important that the client is familiar with what is offered by the service, how it is offered and to ensure they are aware of how to alert the service of increased risks if such situations arise.

Some final thoughts

The novel virtual therapeutic approaches emerging during the COVID-19 pandemic are exciting and transformative. The need to adopt such approaches within a short period of time has created a unique opportunity for innovation and creativity. Being united against COVID-19 has also created a space within which we are all vulnerable (with some being more vulnerable than others) and within which we are seeking solutions together. Indeed, it is likely that such approaches will remain available regardless of availability of in-person treatment, in particular for clients for whom physical access to treatment is limited such as those in rural areas. This article highlights some practical ways of reducing the spread of COVID-19 while continuing to provide effective treatment. Research will be required to determine the effectiveness of such novel approaches, compared to traditional clinic-based approaches.

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