SCALE-UP OF PREVENTION AND MANAGEMENT OF ALCOHOL USE DISORDERS AND COMORBID DEPRESSION IN LATIN AMERICA

Supplement to the SCALA Training Manual

Adapting face-to-face training in SBI for primary health professionals in response to a health crisis

Author(s):	Silvia Matrai, Hugo López Pelayo, Rebecca Gordon

Contact: Silvia Matrai: SMatrai@clinic.cat

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Introduction

Purpose of this document

This document complements the SCALA training manual and was developed in response to the adaptations required due to the COVID-19 pandemic and its impact on primary health services. The overall training manual can be found on the SCALA web site.

SCALA Training Manual:
https://www.scalaproject.eu/images/00_EN_SCALA_Training_Manual__Annexes_Short_May_2019.pdf

Training primary health care professionals

The primary health care setting is routinely used for promoting healthy lifestyles, including alcohol use.[1] Population screening, prevention and health promotion activities are frequently undertaken in primary care. To maintain up-to-date skills and knowledge primary health care professionals undertake continuing professional education in areas related to screening, providing advice and brief interventions, referral and treatment (SBIRT) for lifestyle-related health risks and illnesses including those related to weight and physical activity, tobacco smoking, sexual health and alcohol use.[2]

Traditionally, much of the SBIRT training provided to primary health care staff has been delivered face-to-face but over recent years much effort has been put into using digital technologies to provide training to health care professionals,[3] and this process has been forced to accelerate with the COVID-19 pandemic and related restrictions.[4]

In general, even before the pandemic, distance learning for health care professionals was growing. For example, for many years students and health care staff in rural and remote areas have used videoconferencing and telehealth for continuing education and training and to provide access to healthcare services.[5]

Internet-based learning has been shown to be equally effective as traditional learning, and the question has long changed from does it work to 'how can it be implemented effectively and what are the appropriate contexts for using it?'.[6]

Impact of public health crises on primary health care

The term public health crisis refers to a situation where the health of a substantial portion of the population is compromised or in imminent danger because the existing mechanisms for safeguarding the public's health are overwhelmed or damaged, and risk being unable to cope with an emerging health threat. Such threats may overwhelm the system because of their unknown character, speed of spread, or magnitude of their health effects. They may emerge naturally (e.g. viruses), or be caused by a natural major incident (e.g. earthquakes, floods) or a human-made incident (e.g. nuclear accident, civil war). Public health crises can be anticipated but

1 Anderson P, O'Donnell A, Kaner E. Managing alcohol use disorder in primary health care. Current psychiatry reports. 2017 Nov;19(11):1-0.

2 Anderson, P, Manthey J, Jané Llopis E, Rey GN, Bustamante IV, et al.(2021). Impact of training and municipal support on primary health care–based measurement of alcohol consumption in three Latin American countries: 5-month outcome results of the quasi-experimental randomized SCALA trial. Journal of general internal medicine, 1-9.

3 Tanner TB, Wilhelm SE, Rossie KM, Metcalf MP. (2012). Web-based SBIRT skills training for health professional students and primary care providers. Substance abuse, 33(3), 316-320.

4 Washburn M, Zhou S, Sampson M, Palmer A. (2021). A Pilot Study of Peer-to-Peer SBIRT Simulation as a Clinical Telehealth Training Tool During COVID-19. Clinical Social Work Journal, 49(2), 136-150.

5 Berndt A, Murray CM, Kennedy K, Stanley MJ, Gilbert-Hunt S. (2017). Effectiveness of distance learning strategies for continuing professional development (CPD) for rural allied health practitioners: a systematic review. BMC medical education, 17(1), 1-13.

6 Wong G, Greenhalgh T, Pawson R. (2010). Internet-based medical education: a realist review of what works, for whom and in what circumstances. BMC medical education, 10(1), 1-10.

not necessarily prevented, and emergency response plans need to be prepared in advance to palliate their impact on the delivery of health care services in general and on the training of health care professionals. [7]

The primary health care (PHC) system is distributed across geographic areas and provides services where the population can access information and care related to the major health threat. PHC staff have deep knowledge of their population, including specific vulnerabilities and risk factors, and of other health, social and community care resources in their catchment area. Thus, PHC system naturally ends up playing a crucial role in responding to and managing major public health incidents at all stages, i.e. from prevention and preparedness to response and recovery. In particular, as primary health care clinicians are prepared to deal with a wide range of diseases, the PHC system has the ability to filter and deal with the simple cases and to preserve the capacity of hospitals and specialised centres for severe cases.

This brief is intended to provide basic guidance for adapting a primary care training programme on health promotion activities, taking as an example the SCALA study (Scale-up of Prevention and Management of Alcohol Use Disorders and Comorbid Depression in Latin America) where a SBIRT training programme was implemented with PHC professionals.[8] Initially, a standard onsite training package was tailored to suit local conditions in three Latin American cities (Bogota, Mexico City, Lima), the training package had to be adapted both in format and content due to the COVID-19 pandemic.

Methods

This brief has been elaborated using the following sources of information:

- A rapid scan of formal and grey literature, using PubMed, Google Scholar, and Google, and the search terms including 'SBIRT, primary health care, continuing education, professional training, public health crisis, COVID-19'. Also consulted were the reference lists of the identified publications and their relevant citations
- Review of selected publications from previous work already known to the authors
- Experiences reported by the SCALA partners in Latin America, and the SWOT analysis undertaken by these partners to identify a number of factors related to the impact of a crisis situation on providing training in primary care and adapting face to face training to an online format
- Expert and experiential knowledge of the authors (SM, HL) in dealing with major public health threats.[9]

Adapting a conventional training for healthcare professionals during a prolonged public health crisis entails addressing the following domains:

1. The deployment of the training programme
2. The delivery format of the training sessions
3. The content of the training sessions

Adapting the deployment of the training programme

Within the frame of the SCALA project, the COVID-19 pandemic has taught us lessons on how to adapt the training of primary health care professionals to prevent alcohol-related harm in the general population. There are also lessons to be learned from other crises and disasters (e.g. natural disasters, conflict and humanitarian disasters). Adapting health care professional training in these situations requires changes to both content and

7 Nelson C, Lurie N, Wasserman J, & Zakowski S. (2007). Conceptualizing and defining public health emergency preparedness.

8 Jané-Llopis E, Anderson P, Piazza M, O'Donnell A, Gual A. et al. (2020). Implementing primary healthcare-based measurement, advice and treatment for heavy drinking and comorbid depression at the municipal level in three Latin American countries: final protocol for a quasiexperimental study (SCALA study). BMJ open, 10(7), e038226.

9 Baillergeau E & Duyvendak JW (2016) Experiential knowledge as a resource for coping with uncertainty: evidence and examples from the Netherlands, Health, Risk & Society, 18:7-8, 407-426,

delivery format, which reflects local conditions and resources and considers the specific impact of the crisis situation on both the local health care system and the professionals and the population they care for.

We propose a number of dimensions to be addressed when adapting the deployment of a primary health care training during a crisis situation:[10,11, 12]

Dimension	**Considerations**
Relevance of the specific training programme in the context of the crisis situation	Document the impact of the crisis on the course of the condition to address (in our case, alcohol use) and the overall medical, psychological and socioeconomic situation of the target population Assess the differential impact of the crisis on vulnerable population groups in terms of alcohol use How relevant is alcohol use from the perspective of the healthcare system during the crisis? If not relevant, could it be framed as part of a broader priority which is relevant (e.g. mental health, health promotion)? Are there any elements of the intervention in which you intend to train the professionals that may provide useful tools in their daily practice during the crisis? (e.g. motivational techniques) Can the training and the intervention be framed to enhance the sense of control of the professionals in the crisis situation? Are there any essential clinical activities that could be linked to the health promotion intervention (e.g. brief alcohol advise to include on discharging patients affected by the health threat)? Are there any non-essential healthcare activities put in place or planned to start/resume that could be linked to the alcohol programme?
Roles of the professional profiles to train in the management of the crisis situation	Assess the dissonance between the 'role perception' (i.e. professionals' own views of their role in the situation) and the 'role expectations' from the healthcare system and patients in the professionals to train: • Is their task allocation during the crisis in accordance to their professional and personal profile (in terms of knowledge, skills, age, gender)? • Have they been appropriately resourced for their additional tasks during the crisis (in terms of equipment, guidelines, collaborators, skills, knowledge)?

10 Al-Jazairi AFH. (2020). Role of Primary Health Care System in Response to a Major Incident: Challenges and Actions. In Topics in Primary Care Medicine. IntechOpen.

11 Rieckert, A, Schuit, E, Bleijenberg, N, Ten Cate, D, de Lange, W. et al. (2021). How can we build and maintain the resilience of our health care professionals during COVID-19? Recommendations based on a scoping review. BMJ open, 11(1), e043718.

12 Turner S, Botero-Tovar N, Herrera MA, Kuhlmann JPB, Ortiz F. et al. (2021). Systematic review of experiences and perceptions of key actors and organisations at multiple levels within health systems internationally in responding to COVID-19. Implementation Science, 16(1), 1-13.

	• Is the scheduling and organisation of their work during the crisis reasonable in terms of length of the shifts, resting time, rest and meal facilities, conciliation between work and family life?
Reorganisation	Is there a major incident response plan in place? If so, • Are the target healthcare workers (i.e. trainees) familiar with the major incident response plan?>>>to assess the sense of control the professionals to train may have over the crisis situation • What changes have been foreseen in the responsibilities and activities of the professionals who are expected to implement the intervention?>>>contrast with reality check (see next point) for mismatch between plan and reality Map actual changes (reality check) in the daily clinical practice due to the major incident andconsider how the intervention can be adjusted/integrated accordingly, in terms of • workload: number and profile of the patients seen • staff: already trained workers may not be available, high turnover of potentially less experienced replacement staff • physical environment: layout and repurposing of facilities; switching to telemedicine. Consider how to best grant access to the training and intervention material • distributing printed/offline material may not be possible • heavy files of online material may not be transmitted through overloaded internet/mobile networks • check for conciseness and self-explanatory approach in the materials. Consider possible training delivery formats and timings • for online formats, check the preferred virtual meeting tool for each setting where you intend to train • prepare for continuing the training without visual material in case of failure of video/ screen connection • prepare for diverse trainee group sizes, including individual training • prepare for organising a training at short notice. Adapt the content of the training for relevance of the condition (i.e. alcohol use) in the situation of the major incident: • consider additional skills and updating knowledge to implement the intervention under the crisis circumstances (virtual implementation, reorganised healthcare resources and pathways, availability of self-management resources for patients, etc.) • prepare for training less experienced replacement workers.

Resilience	Healthcare workers and the target population: equipping them with psychosocial skills and resources (adaptation of the content of the training) Have the target healthcare workers been trained in the major incident response plan, including knowledge of the psychosocial impact and management of the major incident? • Acknowledge the extra effort of the professionals in relation to the intervention and the training • Offer additional module on psychosocial self-care (resilience training); • Include additional knowledge and skills to deal with crisis-related psychosocial care for patients • Allow time for briefing with the professionals on the relevance of fitting the intervention into their daily practice and as part of the essential care during the crisis • Allow time for debriefing with the professionals on their experience specifically related to the intervention during the major incident* in subsequent training sessions • Identify and promote peer support opportunities among the professionals. **Note*: The latest guidance recommends 'watchful waiting' rather than psychological debriefing which may increase post-traumatic symptoms in the medium and long term.[13]

13 National Institute for Health and Care Excellence (2018). Post-Traumatic Stress Disorder NICE Guideline [NG116]. London: NICE.

Learning from the SCALA experience: key considerations for adapting the training

The authors conducted a SWOT (strengths, weaknesses, opportunities, and threats) analysis with the SCALA country partners from Colombia, Mexico and Peru. The table below shows the key SWOT elements raised by the partners based on their experience of adapting and deploying a standard programme to train primary health care providers to implement screening and brief intervention for harmful alcohol use and depression. The deployment of the programme coincided with the outbreak of the COVID-19 pandemic. [14,15]

	HELPFUL	HARMFUL
INTERNAL	**STRENGHTS** **In relation to the training material** - Simplicity and accessibility for varying professional profiles - Easily tailorable to varying delivery needs including virtual, small group and individual formats, shortened versions - Modelling for learning by observing others through videos - Interactive elements for interaction and exchange of experiences between trainees - Using simple and validated screening and brief intervention (SBI) tools **In relation to the deployment of the training** - Efficient communication between local study coordinators and health care centres	**WEAKNESSES** - Modelling videos not fully suitable/ relevant for local contexts - Lack of information on previous knowledge of the health issue in the trainees - Uneven skills to administer SBI tools across different professional profiles - High dependence on paper-based material both for onsite training formats and face to face SBI - Interactive training elements may result time-consuming
EXTERNAL	**OPPORTUNITIES** - Highlight the relevance of the health issue to address (alcohol use and depression in SCALA) in the context of a public health crisis - Highlight contents of the training that can be useful/ complementary to the reorganisation of activities during a public health crisis - Complement the training with contents for self-care and basic psychosocial care for patients during a public health crisis - Map the context for ongoing public health priorities and activities to (re)frame the training	**THREATS** - Social perceptions and cultural beliefs about alcohol use, and stereotypes of alcohol and drinkers in professionals and patients may hinder the uptake of the training and intervention programme - Limited local digital connectivity and IT resources for conversion to virtual/online training and intervention formats - Perceived bureaucratic burden of the programme and competing workload may result in prioritising other activities with less administrative workload in the centres - Barriers to implementation raised by local workers' union and ageing healthcare workers **Specifically in relation to a major incident** - Disruption of communication with local study coordinators and healthcare workers may impede the organisation and follow-up of the programme - Worker turnover and job reallocation may require repeated, shortened , individualised training occasions - Disruption of workers' agenda and cancellation of patients' appointments may impede the deployment of the intervention

14 Haldane V, De Foo C, Abdalla SM. et al. Health systems resilience in managing the COVID-19 pandemic: lessons from 28 countries. Nat Med 27, 964–980 (2021)

15 Hernández Rincón EH, Pimentel González JP, Aramendiz Narváez MF, Araujo Tabares RA, Roa González JM. Description and analysis of primary care-based COVID-19 interventions in Colombia. Medwave. 2021 Apr 7;21(3):e8147.

The SCALA country partners in Colombia, Mexico and Peru reported a number of key issues and adjustments related to the **deployment of the training** in the primary health care workers during the COVID-19 pandemic.

Issue for consideration	**How it is impacted by the crisis**	**Possible outcomes and solutions**
Availability of staff, time to undertake training	Staff may be redeployed to COVID-19 activities or covering for those who have been seconded to work on COVID-19 activities	Training may need to be shortened or rescheduled
Location of staff	Staff may be working in other locations or in home lockdown	Training may need to be done online or via phone Training methods may need to be amended e.g. role plays and other interactions may not be possible
Space available for training	Physical distancing requirements, repurposing of usual training/ meeting spaces	Split/ repeat training sessions in smaller groups Training may need to be done online or via phone
Availability of digital technologies	Limited access to computers, poor internet connection, internet overload in the primary care centres or in home lockdown Uneven digital skills in primary care providers	Consider using less resource intensive mobile tools, social media platforms Design shorter virtual (telecall, phone call) role play and interactive activities Provide easy-to-use short digital guides for less skilled trainees
Digital training material	Limited access to computers, poor internet connection, internet overload in the primary care centres or in home lockdown may limit access to large size and/ or computer-based material	Adapt the size and format of digital material for mobile devices e.g.: – convert videos files to images – use subtitles for videos – provide online video viewing – use only audio files – convert presentations (e.g. PowerPoint) to PDF files with scripts

Adapting the delivery format of the training sessions

Remote training in SBIRT skills

Web-based SBIRT training on alcohol, tobacco and other drugs has been found to be effective with primary care providers.[16,17] The evidence indicates that multimedia SBIRT training formats may be appealing to target audiences and they do not need to be elaborate or complex. More experienced primary care providers seem to be able to readily assimilate SBIRT training into their clinical knowledge and patient counselling experience. Providing links to standard SBIRT training materials (e.g. PAHO[18]) and informing on the time estimated to complete them may be an effective approach. SBIRT capacity in primary care relies on interprofessional teamwork and may be enhanced through interprofessional training. Interactive e-learning approaches to interprofessional training in primary health care have been found to:

- improve knowledge and skills
- produce positive changes in attitudes and perceptions
- promote a collaborative community within the participating professionals
- be perceived as a flexible, less time-consuming, more wide-spread, inclusive (in terms of professional profiles and geographic reach) and accessible training format for professionals.[19]

Although the initial investment may raise concerns, e-learning can be considered a low cost, efficient, high reach training approach. This justifies allocating resources to convert ongoing onsite training to online format during public health crises to ensure continued implementation of prevention programmes and contribute to sustainable interprofessional learning beyond the crisis.

Online courses can be provided in a synchronous or asynchronous format. Online content usually includes a mechanism to deliver readings, lectures and assessments, and a component for group interaction, peer-to-peer role play and/or peer-to-peer simulation. For training in brief interventions (BI) online simulation appears promising allowing trainees to work with a simulated patient. These can be self-directed and at one's own pace. Online simulation with emotionally responsive virtual patients has been found an effective way to learn motivational strategies to better manage SBIRT conversations,[20,21] and online training with realistic patient avatars has been accredited for continuing education in health professionals.[22]

Differences between role play and simulation[23]

Role play	Simulation
Shorter duration (3-5 minutes)	Longer duration (15-20 minutes)
Spontaneous, with minimal preparation	Role preparation in advance based on information on the client/ patient to simulate
Usually peer-to-peer between the trainees in the classroom	Simulated client/ patient may be a peer trainee in the classroom, or a peer who already completed the class, or an actor

16 Stoner SA, Mikko AT, Carpenter KM. (2014). Web-based training for primary care providers on screening, brief intervention, and referral to treatment (SBIRT) for alcohol, tobacco, and other drugs. Journal of substance abuse treatment, 47(5), 362-370.

17 Kelly P, Gotham HJ, Knopf-Amelung S, Kohnle K, Kuofie, A. (2018). Distance Versus On-Site Educational Strategies for Competency-Based Screening, Brief Intervention, and Referral to Treatment Education. Journal of addictions nursing, 29(4), E1-E8.

18 https://www.campusvirtualsp.org/es/curso/curso-de-capacitacion-en-el-paquete-audit-dit-para-el-manejo-de-los-problemas-relacionados-con (Spanish) https://www.campusvirtualsp.org/en/course/virtual-course-audit-sbi-primary-health-care (English)

19 Reeves S, Fletcher S, McLoughlin C, Yim A, Patel KD. Interprofessional online learning for primary healthcare: findings from a scoping review. BMJ Open. 2017 Aug 4;7(8):e016872.

20 Albright G, Bryan C, Adam C, McMillan J, Shockley K. Using Virtual Patient Simulations to Prepare Primary Health Care Professionals to Conduct Substance Use and Mental Health Screening and Brief Intervention. J Am Psychiatr Nurses Assoc. 2018 May/Jun;24(3):247-259

21 Gavarkovs AG. Behavioral Counseling Training for Primary Care Providers: Immersive Virtual Simulation as a Training Tool. Front Public Health. 2019 May 9;7:116

22 https://www.sbirtcolorado.org/online-training

23 Washburn M, Zhou S, Sampson M, Palmer A. (2021). A Pilot Study of Peer-to-Peer SBIRT Simulation as a Clinical Telehealth Training Tool During COVID-19. Clinical Social Work Journal, 49(2), 136-150.

Adapting the content of the training

Meeting the changing needs of the target population: the health issue to address

The field of disaster mental health focuses on psychopathology related to natural disasters; human-made non-intentional technological disasters (e.g. nuclear accident), intentional acts (mass violence, terrorism) and epidemics, and the impact of ongoing stressors on vulnerability to post-disaster psychopathology.[24] Although some evidence indicates that human-made non-intentional and intentional incidents may result in a more pronounced psychological impact than natural disasters, from a population health perspective it may be more convenient considering the characteristics of the incident rather than its cause.[25]

Both alcohol use and depression have the potential to be impacted by a crisis situation[26] such as COVID-19 which has created the need for limiting social interaction with measures such as lockdowns. In the case of people being treated for alcohol use or mental health issues this interrupts their therapy as they can no longer attend face to face appointments. It also isolates many people, leaving them at home alone with little social interaction.

This can, in some cases, lead to a worsening of their illness with increased drinking or worsening anxiety or depression. There may be some people who are not be able to access alcohol and suffer dangerous withdrawal symptoms as a result of stopping drinking abruptly without adequate healthcare support.

This has implications for how health professionals deliver interventions for these people, and creates a need to adapt both the content of the intervention, and the content of the training for the professionals who will deliver the intervention, so that they can deliver the adapted intervention successfully.

In relation to the population targeted by the intervention the professionals receive training in, the content of the training should be revised to include information on:

- the impact of the major incident on the health issue(s) targeted by the intervention in the general population
- the differential impact of the major incident on the health issue(s) targeted by the intervention in vulnerable groups
- specific sociodemographic and health risk factors affecting the health issue(s) during the major incident.

Adapting the intervention to the crisis situation

During crisis situations interventions will need to be adapted to accommodate the changes mentioned earlier, such as moving to online or telephone delivery, changes in available resources and infrastructure, changes in professional roles and capacity. In terms of adapting the content of the intervention (on which the health professionals are being trained), some guidelines for screening and managing alcohol use state that during crisis situations where normal services are disrupted, patients with alcohol dependence should be provided with additional information on self-management. For example, how to recognise withdrawal symptoms, what to do if they occur, when and where to seek help (i.e. locally available medical, psychological and social aid resources, both onsite and digital) and with brief preventive advice related to physical and mental health in

24 Raphael B & Maguire P. (2012). Disaster mental health research: Past, present, and future. In Neria Y, Galea S & Norris FH (Eds.), Mental health and disasters (pp. 7–28). Cambridge University Press

25 Goldmann E, Galea S. Mental health consequences of disasters. Annu Rev Public Health. 2014;35:169-83.

26 Alexander AC, Ward KD. Understanding Postdisaster Substance Use and Psychological Distress Using Concepts from the Self-Medication Hypothesis and Social Cognitive Theory. J Psychoactive Drugs. 2018 Apr-Jun;50(2):177-186.

general.[27,28] In order to effectively deliver the intervention the content and format of the training should aim to provide health professionals with new skills and knowledge relevant to the crisis situation, specifically:

1. Skills and resources to deliver the adapted intervention during the crisis situation
2. Guidance for using screening tools in crisis situations

1. Equipping professionals to deliver the intervention during a crisis situation

Digital skills for care delivery via telehealth

Virtual care delivery has dramatically increased during the COVID-19 pandemic and are expected to become part of usual practice in health care. Thus, professionals need to be equipped with the right skills and knowledge to deliver high quality care and interventions via telehealth.

In case the SBIRT intervention is expected/ needed to be delivered virtually during the crisis situation, the training should be complemented with essential information related to telehealth skills across a number of domains including: [29]

- Understanding and assessing the usability, appropriateness, feasibility, and acceptability of using telehealth care delivery services for the health issue(s) both in professionals and patients
- Obtaining, registering and managing clinical information in telehealth resources
- Effective communication and information exchange for care delivery via telehealth
- Good *webside* manners (telehealth etiquette)[30]
- Basic information technology skills: selecting, using, optimising and troubleshooting telehealth care delivery resources
- Good practices of patient privacy, security and confidentiality in care delivery via telehealth
- Recognising limitations and risks for patient safety in care delivery via telehealth
- Understanding and assessing the implications of using telehealth for the target population in terms of access to care and health equity.

2. Using screening tools in crisis situations

A number of screening tools are available for alcohol use. These include the Alcohol Use Disorders Identification Test (AUDIT) and its shorter form AUDIT-C which was used in the SCALA project. In SCALA patients who score 8+ are assessed and managed as appropriate and advised to reduce alcohol consumption. Those who score <8 are given a patient information leaflet. Depression was assessed using the Patient Health Questionnaire-2 (PHQ-2). Usually, these tools are used face-to-face in the primary care setting, opportunistically in general consultations. However, as with many other areas of health care, services and professionals have been forced to adapt with the COVID crisis.

In crisis situations such as the COVID-19 pandemic where face-to-face care is restricted or unavailable health promotion and screening activities may be ceased as other urgent issues take priority. As mentioned, it is important to maintain preventive activities in order to not lose momentum and face an influx of potentially avoidable new or worsening problems, or missed diagnoses once things return to normal. This has been

27 Phoenix Australia, Disaster Mental Health Hub, Alcohol use and misuse in the aftermath of disaster. https://www.phoenixaustralia.org/disaster-hub/toolkits/alcohol-misuse/

28 Centre for Effective Practice, Canada. Screening for and Managing At-Risk Drinking and Alcohol Use Disorder (AUD) During COVID-19. https://tools.cep.health/wp-content/uploads/2021/04/CEP_COVID19AUD_20210409.pdf?utm_source=link.cep.health&utm_medium=urlshortener&utm_campaign=audvc

29 Galpin K, Sikka N, King SL, Horvath KA, Shipman SA; AAMC Telehealth Advisory Committee. Expert Consensus: Telehealth Skills for Health Care Professionals. Telemed J E Health. 2021 Jul;27(7):820-824

30 https://www.wheel.com/blog/ways-to-improve-your-telehealth-webside-manner

demonstrated in the area of cancer where early diagnosis is critical and the pandemic has caused significant delays in screening, diagnosis and treatment; in Europe an estimated 100 million cancer screening tests were not performed as a result of the pandemic.[31]

In the case of alcohol screening, the use of questionnaires like AUDIT-C allows for online or telephone delivery when face-to-face is not available. Regarding the validity of using these tools in this way, some research has been done which demonstrates their validity as an online, self-administered tool in some populations.[32] However, further research is needed to identify key issues related alcohol use screening done by a health professional online or over the phone, and its effectiveness.

Some key issues relate to professionals' skills in using technology and delivering interventions online (as mentioned earlier under 'Equipping professionals to deliver the intervention during a crisis situation'), how to establish rapport online or on the telephone, choosing and/or adapting the tool to suit the environment (e.g. it may be more useful to use a shorter version of the tool, or to include more preventive, self-management advice when offering advice). Some groups, such as the Canadian Centre for Effective Practice offer guidance for virtual and phone patient management and include recommendations such as screening more frequently and mailing or emailing screening questionnaires, and ways of determining if a video or telephone call is more suitable. They also note privacy issues for professionals such as blocking visibility of their mobile number if calling patients on a personal phone. [33]

Focusing on the wellbeing of the PHCC staff

Psychological outcomes for healthcare workers during a major public health crisis are largely influenced by:

- the level of uncertainty related to the healthcare response to the major incident, in terms of the existing knowledge of the nature, course, management and treatment of the health consequences (diseases, injuries) of the major incident, and the availability and organisation of the material and human resources required for their management
- the level of uncertainty related to the duration and chances of reappearance of the major incident in the short, medium and long term
- the impact of the incident, the increased healthcare workload and the resulting health risks (getting injured/infected, spreading infection) on the workers' close social network
- the level of professional training and experience of the worker
- the complexity of professional responsibilities rather than the worker's discipline
- the level of contact with patients affected by the health consequences (diseases, injuries) of the major incident (direct vs. indirect, number of patients seen).[34]

Most healthcare workers responding to the health consequences of a major incident are expected to experience some negative psychological outcomes including general psychological distress, stress, anxiety and depressive symptoms, but a much smaller subset will eventually be in need of specialised mental health support for post-traumatic stress disorder.

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[31] European Cancer Organisation (2021) Covid-19 & Cancer data intelligence. https://www.europeancancer.org/timetoact/impact/data-intelligence

[32] Ballester L, Alayo I, Vilagut G, Almenara J, Cebrià AI et al, on behalf of the UNIVERSAL Study Group. Validation of an Online Version of the Alcohol Use Disorders Identification Test (AUDIT) for Alcohol Screening in Spanish University Students. International Journal of Environmental Research and Public Health. 2021; 18(10):523

[33] Centre for Effective Practice. (2021) Enhancing Management of Chronic Conditions using Virtual Care during COVID-19: Telephone and Video. https://tools.cep.health/wp-content/uploads/2021/09/CEP_21-001_VirtualCare_Synchronous_r9-21.pdf?utm_source=link.cep.health&utm_medium=urlshortener&utm_campaign=covid-vc

34 Magill E, Siegel Z, Pike KM. (2020). The mental health of frontline health care providers during pandemics: a rapid review of the literature. Psychiatric Services, 71(12), 1260-1269.

Psychological debriefing used to be widely implemented after exposure to traumatic events, but research has repeatedly questioned its efficacy and suggested that it could even result harmful.[35] The latest guidance recommends not using psychological debriefing in respondents to traumatic events or in the general population,[36,37] and offer psychological first aid tools which are widely and freely available for different first line respondent professional profiles and also for the general population.[38,39,40]

Complementing the training package with a module on psychosocial self-care in primary healthcare workers trained during the COVID-19 pandemic in Peru was seen as a valuable contribution to preserving the well-being of frontline healthcare workers and their ability to continue providing care in general, and as an added value of the training in particular.

35 Rose S, Bisson J, Wessely S. Psychological debriefing for preventing post-traumatic stress disorder (PTSD). Cochrane Database Syst Rev. 2001;3

36 National Institute for Health and Care Excellence (2018). Post-Traumatic Stress Disorder NICE Guideline [NG116]. London: NICE.

37 https://www.who.int/teams/mental-health-and-substance-use/treatment-care/mental-health-gap-action-programme/evidence-centre/other-significant-emotional-and-medical-unexplained-somatic-complaints/psychological-debriefing-in-people-exposed-to-a-recent-traumatic-event

38 https://www.who.int/mental_health/world-mental-health-day/ppt.pdf

39 https://www.apa.org/practice/programs/dmhi/psychological-first-aid/resources

40 https://www.ottawapublichealth.ca/en/public-health-topics/resources/Documents/Psychological_FirstAid_HealthCare_COVID-19_Workbook_Final.pdf