

Telehealth during COVID-19: The perspective of alcohol and other drug nurses

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Funding information

This project was funded by the Drug and
Alcohol Nurses of Australasia (DANA),
the professional body for nurses with an
interest in alcohol and other drug issues in
Australia and New Zealand.

Abstract

Aim: This study aimed to explore the experiences of alcohol and other drug nurses transitioning to telehealth due to the COVID-19 pandemic.

Background: COVID-19 has caused immense disruption to healthcare services, and to reduce viral transmission, many services moved to off-site care delivery modalities such as telehealth.

Design: We used a qualitative descriptive design for this study.

Methods: Secondary analysis of semistructured interviews with alcohol and other drug nurses from Australia and New Zealand ($n = 19$) was conducted in July and August 2020. Data were analysed using thematic analysis and reported using COREQ guidelines.

Results: Three were identified: "All our face-to-face contact ceased with clients": Changing service delivery', "How do I do my job when I can't see you?": An anxious shift in service delivery' and "A lot of Indigenous people don't like the FaceTiming and all that": Challenges to delivery of services through telehealth'.

Conclusion: Participants in our study reported challenges in transitioning to telehealth modalities. The perceived loss of therapeutic communication, difficulties in assessing risks to healthcare consumers such as domestic violence and challenges delivering telehealth care to a marginalized consumer cohort need to be overcome before telehealth is considered successful in alcohol and other drug treatment. However, telehealth was a successful adjunct to existing practices for nurses working with consumers in regional or remote areas or where consumers preferred this method of service delivery.

Impact: Nurses in this study described substantial issues with the delivery of alcohol and other drug treatment via telehealth, including a perception that telehealth was a barrier to addressing risks to consumers who use alcohol and other drugs, and difficulties working in a therapeutically beneficial way via telehealth. Telehealth is a means to reduce viral transmission through a reduction in face-to-face contact, and although it may be useful for some service functions, it may be detrimental to the clinical services nurses provide.

KEYWORDS

alcohol and other drug (AOD) nursing, COVID-19 pandemic, nursing workforce, substance use disorders, telehealth, telemedicine

1 | INTRODUCTION

The COVID-19 pandemic has caused significant disruption to the delivery of healthcare services worldwide. Despite having a lower rate of infection than several parts of Europe and the United States, Australia has been subject to lockdowns, 'work from home' orders, border closures and a reduction in face-to-face healthcare delivery designed to reduce community viral transmission of the COVID-19 virus (Adekunle et al., 2020; Beck et al., 2020). Although many nurses have often physically remained in healthcare services due to their role, specialist nurses working in areas not considered essential, including alcohol and other drug (AOD) treatment services, have been required to reduce or eliminate physical delivery of services and transition to telehealth (Searby & Burr, 2021).

The move to telehealth has been used to reduce face-to-face contact associated with viral transmission of COVID-19 (Smith et al., 2020). The rationale for such a shift is to reduce, or in some cases eliminate, healthcare consumers physically attending services. Telehealth modalities have also been used to triage healthcare consumers with respiratory symptoms to determine risk factors for COVID-19 and have replaced many community and mental health services that frequently would be delivered face to face (Chavis et al., 2020; Monaghesh & Hajizadeh, 2020). In this paper, we define telehealth as the use of telephone, videoconferencing or Internet platforms such as Skype or Zoom to deliver care.

2 | BACKGROUND

A global outbreak of the COVID-19 virus began in early 2020. The virus itself was believed to have originated in Wuhan, China, and spread rapidly due to the international movement of infected individuals around the world (Guo et al., 2020). Quickly, it was determined that measures were required to control the spread of the outbreak, with physical distancing measures implemented in many countries to prevent transmission (Rothan & Byrareddy, 2020). Interventions such as physical distancing, face mask use and the use of eye protection are supported by meta-analysis and became established in many clinical facilities providing healthcare services (Chu et al., 2020).

Prior to the onset of the COVID-19 pandemic, a systematic review showed good efficacy for telehealth service delivery for the treatment of alcohol use disorder, noting that increased access to services, reduced travel times to appointments and a reduction in stigma were key reasons for consumer satisfaction with telehealth service delivery (Kruse et al., 2020). However, the overarching aim of telehealth prior to the COVID-19 pandemic was considered to be an adjunct to face-to-face service delivery (O'Cathail et al., 2020). The aforementioned need to implement strategies to reduce contact, and potential viral transmission of COVID-19, meant that a rapid implementation of telehealth was established in many healthcare services (Dosaj et al., 2020). The need to move to telehealth modalities of service delivery was even more pronounced once aggressive

measures to control COVID-19 were widely implemented, such as lockdowns, 'work from home' directions and the cessation of public gatherings.

In Australia and New Zealand, nurses form a large proportion of the AOD treatment workforce (Skinner et al., 2020). Also known as addiction nurses around the globe, nurses in this specialty work in a variety of settings, performing essential roles such as physical and mental health monitoring, establishing, administering and monitoring specialist medications (such as opiate substitution therapies including methadone and buprenorphine) and a wide range of psychotherapeutic interventions (Searby & Burr, 2020). As many of the nursing roles in the AOD specialty require a physical presence, a rapid move to telehealth essentially meant that many of these roles had to be quickly adapted to delivery over the telephone or virtually.

The findings from this study were drawn from a larger qualitative research project exploring the experiences of AOD nurses and care provision during the initial COVID-19 pandemic in Australia and New Zealand (Searby & Burr, 2021). During this study, all participants reported their experiences using and transitioning to telehealth; therefore, we determined these data to be worthy of secondary analysis and further exploration. We also felt that given the interest in the ongoing use of telehealth for service delivery beyond the COVID-19 pandemic, it was worthwhile to examine the utility of this approach for nursing specialties caring for marginalized consumers.

3 | THE STUDY

3.1 | Aim

The aim of this study was to explore the experiences of alcohol and other drug nurses transitioning to telehealth due to the COVID-19 pandemic.

3.2 | Design

The methodology used was qualitative description, a design that allows 'a comprehensive summary of events in the everyday terms of those events' (Sandelowski, 2000, p. 334). Qualitative description, a naturalistic approach, aims to produce a description of participant experiences that is presented in a similar language to their own as opposed to the development of concepts and interpretive analysis. Given some degree of analysis is involved in qualitative studies, the literature on qualitative description describes this process as 'low-inference interpretation' (Neergaard et al., 2009). The ontological assumptions of qualitative description include an in-depth understanding of the subjective reality participants ascribe to events under investigation and allowance of a relatively thorough investigation where time is limited (Bradshaw et al., 2017). With these considerations in mind, we used the qualitative descriptive approach to allow a timely analysis of the rapidly evolving situation that was the early onset of the COVID-19 pandemic in Australia.

3.3 | Participants

A purposive sampling approach was used in this study to ensure that participants had experience of the subject on investigation, in this case AOD nurses who had experienced the impact of COVID-19 on their work, using a maximum variation sampling approach (Palinkas et al., 2015). Maximum variation sampling, where key dimensions of the sample are identified (in this case healthcare setting and geographical area) and attempts made to identify participants from dimensions that differ from each other as much as possible, was used to target potential participants from a wide range of health service settings (Benoot et al., 2016). Inclusion criteria for this study were nurses who were currently registered with the Australian Health Practitioner Regulation Agency and who were currently working in an AOD nursing role. Exclusion criteria were clinicians from disciplines other than nursing and not working in AOD settings. No prior relationship existed between the research team and potential participants. The inclusion criteria were verbally confirmed with participants prior to the interview commencing.

The project was advertised through the social media channels of the national association for AOD nurses in Australia and New Zealand, the Drug and Alcohol Nurses of Australasia (DANA). Invites were also distributed to the DANA mailing list, targeting the DANA membership base. Participants who chose to participate in the study were asked to click a link on the email or social media posts, which directed them to a Qualtrics (Qualtrics, Provo, UT) survey page to provide a contact email address for the purposes of arranging an interview. The Qualtrics page also provided the participant with a copy of the Participant Information Form (PIF). The second author (D.B., female) contacted participants by return email to arrange a suitable time to conduct the interview.

3.4 | Data collection

Semistructured interviews were conducted by telephone in July and August 2020 by the second author (D.B.), a trained research assistant with experience in interviewing for similar qualitative studies; the research assistant had completed postgraduate research using qualitative methodology and had been mentored through similar large qualitative projects by the lead researcher. The semistructured interview guide was developed by conducting a literature scan of emerging literature related to the COVID-19 situation and was additionally informed by using disaster preparedness literature related to the nursing workforce (Wong et al., 2010; World Health Organization & International Council of Nurses, 2009). The semistructured interview guide was piloted with two members of the professional association's (DANA) management committee to ensure clarity of language used in the semistructured questions (Table 1), with only minor changes made to phrasing of questions at this point. The interviewer also used probing questions and statements (such as 'how come?', 'tell me more about that' and 'why was that?') to generate discussion and further explore topics arising during the interview process, as well as encouraging an open style of discussion

TABLE 1 Semistructured interview questions

Semistructured interview questions

Do you believe your organisation was adequately prepared for issues related to COVID-19?

How did your organisation change once restrictions reached [the highest level in area]?

How did your role change once restrictions reached [the highest level in area]?

How did you maintain continuity of care during the highest level of restrictions?

What has the response been from consumers/staff to strategies implemented to manage COVID-19 social distancing/lockdown?

How has your employer handled the transition back to 'business as usual' (if applicable)?

Have there been lasting changes to your role or employment?

Do you think AOD services will be adequately prepared for a repeat of a similar event in the future?

Have you observed an impact on service need/do you foresee an increase in service need after COVID-19?

How do you think AOD services could be better prepared for similar events in the future?

Abbreviation: AOD, alcohol and other drug.

where participants were able to elaborate on issues they felt important (Way et al., 2015). Both researchers regularly met after reviewing interview audio and transcripts to discuss interview progress and to refine the interview style as the study progressed.

Each participant took part in a single interview, with all interviews lasting between 32 and 47 min in duration. After consenting, all participants completed the interviews. Demographic information was ascertained from participants prior to the semistructured interview guide being administered and is outlined in Table 2. Interviews continued beyond theoretical data saturation (the point at which few new themes were identified during the interview process) to attempt to gather responses from a wide geographical area (Guest et al., 2020). After transcription, data from each interview were uploaded to the NVivo software program (QSR International, Version 12) for thematic analysis and coding.

3.5 | Ethical considerations

The study was reviewed and granted approval by the relevant university ethical review board prior to commencement. Participants were able to view the PIF when registering their interest in the project. A verbal consent script was read to participants by the researcher when commencing the telephone interviews. At this point, participants were able to request further information about the project and informed about their right to withdraw from the study at any time or to decline to participate. All participants who expressed their interest in participating verbally consented to taking part in the telephone interview process, and all participants completed the interviews. Any information that may identify the participants was

TABLE 2 Participant demographic profile

Participant	Gender	Role	Setting	State/country
1	Female	Clinical nurse	Pharmacotherapy clinic	New South Wales
2	Female	Clinical nurse	Residential AOD service	New Zealand
3	Female	Manager	Aboriginal health service	New South Wales
4	Male	Nurse practitioner	Consultation-liaison/prison	New South Wales
5	Female	Clinical nurse consultant	Substance use in pregnancy and parenting service	New South Wales
6	Female	Clinical nurse consultant	Community health service	New South Wales
7	Female	Clinical nurse	Mental health service	Australian Capital Territory
8	Female	Clinical nurse	Youth health service	New South Wales
9	Female	Clinical nurse consultant	Tertiary hospital	New South Wales
10	Female	Clinical nurse	Tertiary hospital	Western Australia
11	Female	Manager	Pharmacotherapy clinic	New South Wales
12	Female	Clinical nurse consultant	Consultation-liaison	New South Wales
13	Female	Nurse practitioner	Tertiary hospital	New South Wales
14	Female	Clinical nurse	Pharmacotherapy clinic	New South Wales
15	Male	Nurse practitioner (transitional)	Consultation-liaison	New South Wales
16	Female	Clinical nurse	Pharmacotherapy clinic	New South Wales
17	Female	Clinical nurse	Inpatient withdrawal unit	Australian Capital Territory
18	Female	Clinical nurse	Youth health service	Queensland
19	Female	Clinical nurse	Medically supervised injecting facility	New South Wales

Abbreviation: AOD, alcohol and other drug.

removed after transcription, including health service names, which are reported generically in this paper.

3.6 | Data analysis

The qualitative data arising from the semistructured telephone interviews were analysed using Braun and Clarke's (2006) method of thematic analysis, which outlines six steps to coding qualitative data: familiarization with the data, generating initial codes, searching for themes, reviewing themes, defining (naming) themes and producing the report. As outlined in Figure 1, the initial stages of this process were conducted by each researcher independently, with both researchers coming together to cooperatively complete the final stages of coding. To achieve consistency on preliminary themes, meetings were conducted where each author was required to discuss their rationale for selecting codes; initial codes were developed when consensus was reached on these preliminary themes (Hemmler et al., 2020).

3.7 | Validity and reliability

This study is reported accordance with the Consolidated Criteria for Reporting Qualitative Research (COREQ) (Tong et al., 2007). During

interviews, the interviewer (D. B.) made detailed notes, documenting her perception of the interview and also outlining any assumptions made during the interview; these were discussed and addressed by both researchers during the initial coding process (Mealer & Jones, 2014). Interviews were recorded verbatim by a professional transcription agency, with comparison made between all transcripts received and the original audio recording to ensure accuracy. As outlined in Figure 1, both researchers familiarized themselves with the data, making preliminary notes on emerging themes prior to meeting to discuss, justify and defend these decisions. Hemmler et al., (2020) report that this method of interrater comparison and collaboration allows for agreement and reliability in coding decisions made in the analysis of the data. Documentation for all decisions made during the data analysis phase was retained to ensure that the process was recorded and transparent.

4 | FINDINGS

Nineteen ($N = 19$) nurses participated in this study, 17 females and two males. The majority ($n = 14$) were from the Australian state of New South Wales. Ten participants were working as clinical nurses, four as clinical nurse consultants, three as nurse practitioners (one candidate) and two as managers. As shown in Table 1, participant

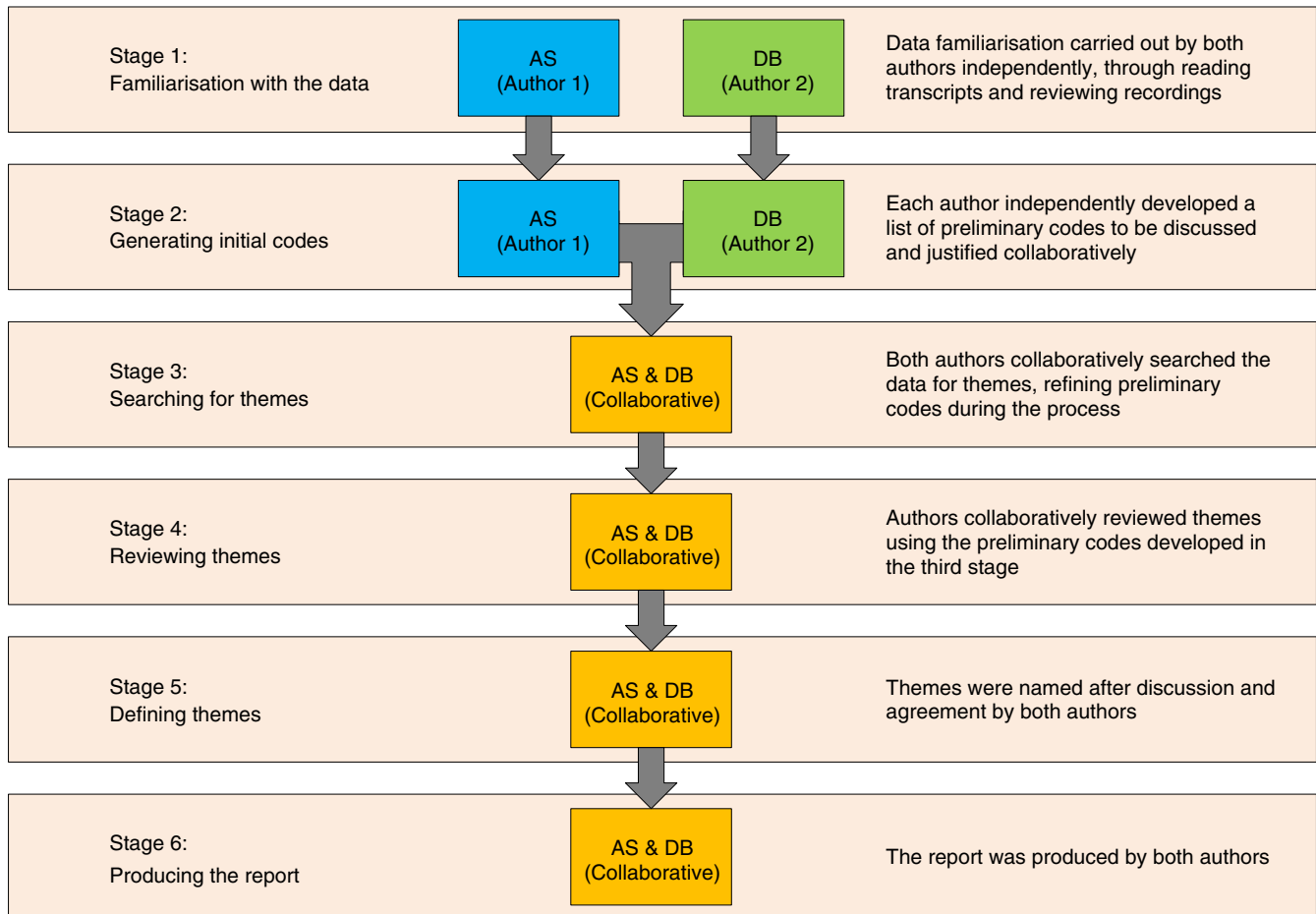


FIGURE 1 Coding flow diagram

work settings were diverse and ranged from tertiary hospitals to substance use in pregnancy services and Aboriginal medical services.

Participants described several challenges in the transition to telehealth, mostly related to the rapid move from face-to-face service provision to telehealth as the pandemic emerged. These challenges also related to a perceived increase in risk associated with nurses not being able to visually assess consumers, which was also noted to make the assessment of risks such as domestic violence difficult. Further, nurses felt that telehealth meant a shift to 'holding patterns', where the primary aim of care became monitoring, as opposed to providing genuine therapeutic interventions. Nurses also mentioned that marginalized consumers experienced issues with the transition to telehealth, including poor Internet connections, broken mobile (cell) phones and a lack of available funds on their phones to make calls to clinicians when needed.

Analysis of the data produced three parent themes with sub-themes emerging from them. These parent themes were "All our face-to-face contact ceased with clients": Changing service delivery', "How do I do my job when I can't see you?": An anxious shift in service delivery' and "A lot of Indigenous people don't like the FaceTiming and all that": Challenges to delivery of services through telehealth'. The coding tree, showing parent themes and emerging subthemes, is shown in Figure 2.

4.1 | 'All our face-to-face contact ceased with clients': Changing service delivery

The emerging COVID-19 pandemic caused a shift in service delivery, which included moving face-to-face delivery to other methods such as telehealth. Participants reported that this was done to reduce physical and close contact, with the rationale that this would in turn increase social distancing and reduce the chance of viral transmission. In many areas, ceasing face-to-face service delivery was dictated at a high level:

The only direction that was really clear was that ambulatory clinics were to be phased out. It was all to be telehealth. (Participant 9)

The level of service reduction was varied according to participants. For example, one participant reported that 'All our face-to-face contact ceased with clients' (Participant 5), whereas other health services reduced face-to-face service to what was considered 'essential' service:

Unless it was essential that I was there I didn't go anywhere physically, everything was done on the phone,

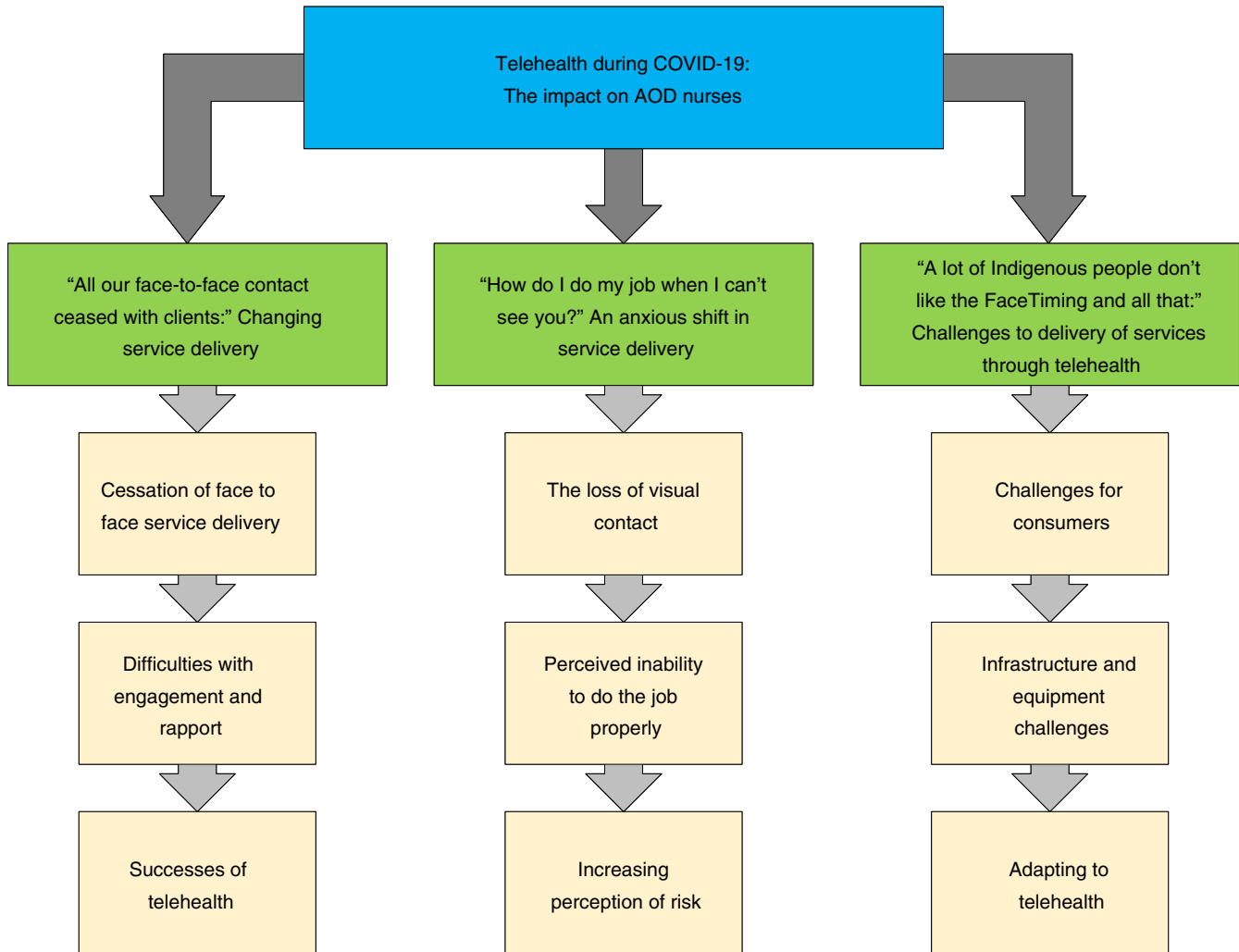


FIGURE 2 Theme tree. AOD, alcohol and other drug

Zoom meetings ... If it wasn't essential ... we just didn't go. There's no two ways about it. (Participant 7)

One participant expressed a belief that this was important to preserve personal protective equipment (PPE) for 'more important' roles:

At times we did phone consults and satellite consults with nursing staff just to minimise the use of PPE and conserve it for kind of more important roles. (Participant 10)

Another participant described the experience of nurses being the only profession left to work on-site; although everyone else had moved to telehealth to deliver services, the participant recounted that nurses were left on-site to continue 'nursing work'. This participant described a broad change to alcohol and other drug services, with little impact on the nursing staff who continued to work as normal:

Counsellors and the doctors ... [are] doing a lot less face to face, doing more phone contact. The

counsellors are doing pretty much all phone contact. That's not the nature of nursing, you can't really do nursing via a phone so that hasn't changed our model. But more broadly it's changed the model of drug and alcohol services. (Participant 12)

The biggest concern with the reduction of face-to-face contact expressed by participants was that engagement with the service and ongoing rapport with consumers would be adversely affected. Participants noted that engagement was particularly difficult, especially with new consumers referred to their services:

It's very difficult to engage people in drug and alcohol [services] via telephone particularly if they're a new referral and a new client. (Participant 5)

One participant described an example of the transition to telehealth impacting on rapport with a consumer. In this instance, the participant described the consumer's preference for face-to-face interaction rather than telehealth. Although this preference contradicted

service directions to stop all face-to-face contact, in this case, it was essential to the ongoing well-being of the consumer:

I had a young man who was doing an alcohol withdrawal and I referred him to our counsellor, and he was only able to access her by the phone. He'd come to see me every second day, and he couldn't see the counsellor, only on the phone. He said, 'Stuff's not working' and he couldn't get an engagement with the counsellor on the phone. He said, 'I don't know, it's just not working', so he disengaged from that treatment, which was a shame. He just said he needed a personal connection with somebody, and the phone just didn't do it. (Participant 13)

This participant went on to reflect that if they were in the same situation, it would be very difficult to attain rapport with a clinician:

I can't imagine having someone treating me on the phone, especially if I haven't met them. It would be different if you'd met them and then ... you'd know the person, but not just a phone call, no. (Participant 13)

Despite this reflection, most participants reported that it was common practice for consumers to be introduced to the service through telehealth, most often through assessment. Typically, initial assessments are a consumer's initial contact with an alcohol and other drug treatment service and provide an opportunity to gain rapport with consumers and increase treatment engagement (Yang et al., 2018). As one participant noted, consumers were to be assessed by phone unless 'absolutely vital':

Phone assessments, not having them actually come in ... unless it was absolutely vital. So, that was very directed, that was quite clear. (Participant 9)

Further, the reduction in face-to-face service delivery was detrimental to some consumers, who used the physical clinic and interaction with clinicians to seek help when needed:

They will show up randomly at the clinic, say hey I've relapsed, I need help. Or I've got this problem, I need help. And they couldn't do that. (Participant 9)

Physical contact was also noted to cause disengagement among groups of consumers, particularly those already under the care of the service and having to transition to telehealth when the pandemic started, as noted by one participant. This participant also reflected that this broken engagement may be difficult to reattain:

Once we stopped visiting them and they weren't seeing us anymore they dropped away, and it's been

very hard to re-engage those women. I think once you break that engagement it's very hard to get back. (Participant 5)

Although these accounts paint a picture of the failures of telehealth in the alcohol and other drug treatment space, participants also provided accounts of the successes of telehealth. As one participant reported, there has been a distinct shift from the perception that, before COVID, using telehealth modalities was 'bad' care delivery to a recognition that there was room to use these ways of working in future:

It was probably frowned upon if you were calling a patient, 'Why you doing that? You should be seeing them. That's not safe'. It is okay if you know the patient and if you've seen them already. A direct phone call, you can still ascertain a lot from that. (Participant 13)

Mostly, in instances where telehealth was described as successful, it was used to overcome distances for either consumers or clinicians to travel either to attend services or to visit consumers. Often, this made it easier for participants to continue to engage:

Yes, and the success of telehealth has been quite mixed. Some clients are very happy with it ... I have got a Mum who has four children under four and she lives about an hour away from [regional town] and so it's convenient for her to have a telehealth appointment, but then other clients have said I don't want to be on a video screen and the technology doesn't work for them. (Participant 5)

Participants also reported that a shift to telehealth was a strategy for removing barriers for consumers who may previously had not been able to access the health service:

I think it's been an interesting time and we've been thrown an opportunity to reach out to people that weren't available, that couldn't get out to see us, that were elderly or too unwell to get out to see us, and it was like, 'Oh well, we'll see you when you can get in' and now, I think, the barriers are gone. They're not there anymore. We can reach a lot more people than what we did before, we just have to be a bit more proactive. (Participant 13)

However, another participant reiterated that the ongoing use of telehealth was dependent on consumer preference. There are several reasons for telehealth use that go beyond the choice of the consumer, but participants noted that the ongoing use of telehealth needed to provide a service that was acceptable and suited to the consumer:

Some people really need to be seen face to face, and other people are quite able to be seen via

videoconference. I'm still happy to use it for people that are reluctant to come to a drug and alcohol clinic but need interventions. I'll give interventions however they'll take them. Because someone just needs a phone call once a week, I'm happy to just do a phone call once a week. (Participant 9)

4.2 | 'How do I do my job when I can't see you?': An anxious shift in service delivery

Anxiety was the biggest challenge in transitioning to telehealth reported by participants, usually related to the reduction of interactions to a telephone call or fixed videoconferencing screen, removing the ability to assess the environment and receive visual cues from consumers. This so-called eyeballing of consumers was deemed to be a vitally important part of the role of the AOD nurse, and its loss was attributed to several issues in providing care as outlined in the following example:

There's a lot of problems with a phone model ... not seeing, eyeballing people, people can sound quite good on the phone ... one of the [health service] counsellors was saying that she was speaking to a guy on the phone and he sounded like he was holding it together, things were going okay and she happened to run into him when he was at the clinic and said he'd lost about 15 kilograms in a really short period of time. He was back using a lot of methamphetamine, she thought on the phone he was holding it together, so she had no idea of it. (Participant 12)

Participants who described anxiety related to not being able to visualize a consumer or their surroundings and believed this had an impact on engaging consumers in the service and building rapport. Participants also described a belief that telehealth was a barrier to free disclosure, as indicated in this example:

Personally, I have anxiety when I can't actually visualise a patient and I can only talk to them on the phone. I also feel that it impacts on building of rapport. I don't think it's appropriate for the patients. They may not feel safe being able to disclose things to us over the phone rather than actually seeing us in person. I think it depersonalises our role in some context. (Participant 10)

When queried further, participants often came back to anxiety around not being able to visualize consumers they were assessing or providing care to. Further, the participants also described telehealth as being a barrier to providing basic nursing skills such as reassuring a consumer. One participant went further, reporting that the lack of visual contact was a significant barrier to being able to fulfil their role as an AOD nurse:

I think what has given me the most anxiety is ... how do I do my job when I can't see you? I can't look at your arms. I can't see your eye colour or be that person who's close to you and can actually comfort you. You just can't. That was a lot of my anxiety ... how do I do my job properly? Like this, I can't do it. (Participant 13)

When asked to elaborate further, the participant responded:

I feel very inadequate in what I'm doing. I don't feel like I'm doing anywhere near my job if I'm not [physically] seeing somebody. (Participant 13)

Difficulties in assessment when using telehealth were a theme among many participants, and perceived risk was a driver of anxiety among the AOD nurses in this study. Participants described difficulties in assessment in several areas that carry high risk in AOD services:

We can't do anything with domestic [violence] ... you can't even screen someone with domestic violence over the phone. (Participant 4)

Several participants described a change in their assessment practices, particularly when working in consultation-liaison roles or tertiary hospitals where consumers had been seen by other medical teams, nursing and allied health professionals. As described in the following account, this led to a process whereby plans were formulated without physically assessing or meeting the consumer:

Well in terms of interviewing ... there were times when we did phone consults or we spoke with nurses and we just reviewed, rather than actually visualising the patients, we would have to just review what the nurses had documented in terms of their [alcohol and/or drug] withdrawal and then make a plan from that, so there was that disruption. (Participant 10)

Another participant described a shift in techniques used when interacting with consumers due to the loss of non-verbal cues during the interaction, a process where there was a 'learning curve'. This participant also reiterated the notion of assessing risk via telehealth, in this case suicide:

Whether the client's in front of you or not they're going to say what they're going to say and they're going to use whatever skills they have and ... they may not tell you the truth regardless, okay, but we found that with the telephone counselling it took a bit to get used to it because you didn't have those non-verbals, do you know what I mean? You had to probably explain things a lot more and try to explain something that you might show visually in word form and it really

made you think about what you do and why you do it. There was definitely a learning curve when it comes to doing telephone health or Telehealth because it wasn't until the first client was suicidal that I suddenly thought, where exactly are they? (Participant 18)

From these examples, it is apparent that a shift from physical service delivery to telehealth, either via telephone or videoconference caused a significant amount of anxiety for clinicians. This anxiety was even more pronounced when considering the challenges of assessment, such as assessing for intimate partner (domestic) violence, suicidality or even attempting to ascertain a consumer's patterns of alcohol and other drug use. Although participants were able to adapt to using telehealth delivery methods, responses indicated that most considered this means of service delivery to be suboptimal and not doing their job properly.

4.3 | 'A lot of Indigenous people don't like the FaceTiming and all that': Challenges to delivery of services through telehealth

The final theme emerging during the interview process was that of challenges to the delivery of services through telehealth. For participants in this study, challenges related to technological issues transitioning to telehealth (particularly online methods), consumer preferences relating to face-to-face activities and issues related to consumer access to technology. As one participant outlined, the rapid shift to telehealth was forced rather than happening by choice, with the perception that little preparation at health service level had occurred for such a radical departure from usual service delivery:

No, I don't think that they were prepared for this. I don't at all. I'm aware that they have all their disaster management plans and so forth, but I don't think they were prepared for this, but I wonder who was really. (Participant 4)

As this participant went on to describe, there were several challenges to this instruction, including poor infrastructure and a lack of training clinicians in telehealth technologies:

[We] were told you really need to start offering Skype, telehealth and so on. And that was a considerable issue because many hadn't been trained, there wasn't necessarily the equipment, there wasn't the space to provide all that in. (Participant 4)

Like many other organizations affected by the pandemic, several staff were transitioned to working from home to reduce contact. Although this was a strategy that worked in many other industries, our participants reported that it was particularly problematic:

All our face-to-face contact ceased with clients, that was very tricky because as far as IT goes, we weren't set up to work from home, there were lots of issues with accessing the network, computers, email, all that kind of stuff. (Participant 5)

In some cases, these issues resulted in participants having to return to the workplace:

From that first week, we went to as many people working from home as possible. And then, of course, we ended up having a message from [health service] saying they didn't have enough bandwidth to allow people to work from home and had that many people remote accessing the server and so, we all came back. It was a little bit frustrating. (Participant 6)

Not only were technological challenges an issue in the transition to telehealth, but staff satisfaction with transitioning their care to a telehealth space was reported to be low. Beyond the previous theme, where anxiety was caused by not being able to be present with a consumer, several participants also described frustration and dissatisfaction with telehealth modalities:

That's not what they want to do, they don't want to be a telephone counsellor, they don't want to do telehealth, they love that clinical client contact and so they would have no job satisfaction. (Participant 5)

Beyond the technological challenges reported in organizations transitioning to telehealth, participants also described challenges faced by clients when attempting to assess services operating over telehealth:

What has affected me is that some clients ... you just lose them, you couldn't catch up with them because they'd run out of credit or their phone broke because they threw it or whatever, and you had no way of contacting them in that respect. (Participant 8).

These issues were also reported with marginalized consumers, such as those who were homeless or frequently changed address:

It's very difficult sometimes to track our clients down because they do have a habit of changing their phone numbers or, and their addresses. (Participant 15)

And because ... a lot of them are homeless they'd just fall off the face of the Earth. (Participant 8)

Participants who provided services in rural areas also spoke of difficulties related to the existing telecommunications infrastructure needed to implement reliable telehealth services:

There's also a lot of our clients that don't have phones, who don't have internet access, that are unable to operate Zoom or Skype or up in these regional rural areas, or they're not in a [mobile/cell phone] network area. (Participant 4)

A participant who worked in an Aboriginal health service spoke of difficulties in the acceptance of telehealth; this example highlights the notion that a transition to telehealth is dependent on the preference of the consumer and may not be culturally acceptable among consumer cohorts who have a preference for face-to-face service delivery:

It's very hard to provide a drug and alcohol service without group work and seeing people. A lot of Indigenous people don't like the FaceTiming and all that. We've asked them if they want to do that with our groups, but they don't want to. The alternatives are on the phone, and a lot of the clients don't have phones. There was potential that we were going to lose contact with a lot of people. In Indigenous communities, it's slightly different again, that one-on-one, that real community work is really the foundation of the success of a program, of a community-based program. (Participant 3)

Despite challenges occurring during the implementation of telehealth, participants also recounted instances where telehealth was successfully implemented. Initially, some participants reported an increase in their own productivity when moving to telehealth, mostly due to a reduction in travel time to attend meetings and consumer visits. In some cases, the initial shift to telehealth required a visit to the consumer's home to set up technology:

Some of the mental health team are going out to the patient's home and getting them started on their phone or home computer. (Participant 13)

Also, as telehealth continued, consumers had adapted to receiving service via these modalities, although the following example questions whether the acceptability of telehealth is due to missing the social contact associated with attending a physical service:

Before, it was always a bit tricky trying to get in contact with them, with private number and everything and they're unsure about who was calling, and maybe also issues with losing phones and things like that. But we've found it's actually easier to get in touch with the person now and they're more receptive to having a chat and everything. So maybe they're missing contact with the clinic through the social side, I'm not sure. (Participant 16)

As one participant who worked with young people noted, telehealth may be more acceptable to younger consumers of alcohol and other drug services. The following example indicates that telehealth could be useful to overcome individual difficulties in accessing services:

I think that can only help in the long run because it really makes the way that we're available to clients more varied and it's more client centred, rather than the majority of alcohol and drug services where you turn up here at this time and we'll have a chat with you. There are many reasons why people find it difficult to turn up to a service, especially young people ... How weird is it for them to walk into a government building and talk to an adult? (Participant 18)

5 | DISCUSSION

This study explored the experiences of alcohol and other drug nurses transitioning to telehealth due to the COVID-19 pandemic. Congruent with other areas of specialist healthcare delivery, our study found that a rapid transition to telehealth was required to reduce the spread of COVID-19 in line with evidence at the time. Often, healthcare services were ill-equipped to move staff off-site and to virtual or telephone methods of working, resulting in several 'teething' issues during the initial weeks of pandemic-related lockdowns and service closures. Our findings indicate that service delivery via telehealth is acceptable for some consumers due to factors such as distance in regional areas or family commitments. However, in many instances, telehealth was not culturally acceptable nor the preference of healthcare consumers seeking treatment for problematic alcohol and other drug use.

In our study, clinicians reported a loss of visual contact and physical presence with healthcare consumers as a significant driver of anxiety, resulting in a feeling of 'how do I do my job properly' using telehealth. Since our participants were interviewed, guidelines for the assessment of sensitive issues such as intimate partner (domestic) violence have been developed, which guide clinicians in this process (Jack et al., 2021); however, at the time of interview, many participants found asking questions around these issues difficult.

Although participants in our study noted that several consumers of their service wanted face-to-face contact to return, especially for group work, international research on the implementation of telehealth for alcohol and other drug treatment has been mixed. Fiacco et al., (2021) found that telehealth offered the opportunity for virtual group work with high consumer satisfaction, although in this study, in-person groups were previously not available in the service under examination before the COVID-19 pandemic. Similar studies in the United States have shown improved engagement under the telehealth model, although often with the caveat of an initial loss of consumer engagement during the transition to telehealth services (Langabeer et al., 2021).

Our findings of clinician preference for face-to-face service delivery correspond with a wider survey of the overall non-governmental alcohol and other drug treatment sector in Australia (van de Ven et al., 2021), where it has been reported that nearly all consumers of alcohol and other drug services had returned to face-to-face healthcare services once COVID-19-related restrictions had been lifted. These findings indicate a strong preference for face-to-face service expressed by consumers. The study also described utility in the ongoing use of telehealth for consumers who were isolated or younger, reflecting responses obtained during our interview process, and also reflected several of the barriers and impediments to the transition to technology-based telehealth services that participants in our study experienced.

Although telehealth might be acceptable for many healthcare consumers in other settings or isolated locations (O'Cathail et al., 2020), there is a need to explore the telehealth satisfaction of healthcare consumers who use alcohol and other drugs. A recent study conducted by Krawczyk et al. (2021) examined posts made by users of a Reddit opioid forum, finding disclosures of distress concerning the closure of services, the ability of telehealth to provide opiate substitution treatments (such as methadone and suboxone), and an overall concern with ongoing treatment engagement and motivation.

The rapid 'scaling up' of telehealth was not without its problems. Our findings are supported by Murphy et al.'s (2021) qualitative analysis of an electronic study of behavioural health service providers conducted in New York ($n = 259$), which found several issues around ongoing engagement of service users (including refusal of the use of telehealth), limited access or issues with technology. Our research also shows that there is mixed satisfaction with telehealth, and several problems inherent in commencing telehealth. Further, our participants described developing rapport and maintaining engagement as challenging when using telehealth methodologies, both key to keeping consumers in AOD treatment and essential for ongoing linkage with services (Wolfe et al., 2013).

5.1 | Limitations

To our knowledge, this is the first study exploring the use of telehealth among alcohol and other drug nurses from Australia and New Zealand. Despite this being a strength of our study, there are limitations that need to be considered in its interpretation. The sampling approach used in this study resulted in a high number of participants from the Australian state of New South Wales, with no representation from the Australian states and territories of South Australia, Tasmania, Victoria or the Northern Territory. Although workforce data indicate that most Australian nurses who work in alcohol and other drug settings are located in New South Wales (Searby & Burr, 2020), the lack of representation and subjective nature of the experiences described by participants in this study means the findings may not be representative of all alcohol and other drug nurses across Australia. Similarly, only one participant was in New Zealand despite

efforts to increase recruitment from New Zealand alcohol and other drug nurses; factors contributing to the lack of New Zealand participants may be poor engagement with the professional organization (DANA) or ongoing COVID-related lockdowns.

6 | CONCLUSION

The COVID-19 pandemic has caused several changes to the operation of healthcare services, including a rapid transition to the delivery of clinical services via telehealth. Although consumer satisfaction with telehealth in several areas is said to be high, the use of telehealth to provide service to marginalized consumers, such as those who use alcohol and other drugs, needs further investigation. Clinicians noted several elements of risk that they felt could not be addressed through telehealth, leading to the perception that they were not completing their roles adequately. Although telehealth shows utility in scenarios such as isolated consumers in rural areas, its use as a mainstay for the delivery of specialist clinical services, particularly to marginalized consumers, needs further investigation.

ACKNOWLEDGEMENTS

The authors acknowledge the Drug and Alcohol Nurses of Australasia (DANA) for their financial support to conduct this study. We would also like to thank the AOD nurses who volunteered their time to take part in this study.

CONFLICT OF INTEREST

No conflict of interest has been declared by the authors.

AUTHOR CONTRIBUTIONS

All authors have agreed on the final version and meet at least one of the following criteria (recommended by the ICMJE): (a) substantial contributions to conception and design, acquisition of data, or analysis and interpretation of data and (b) drafting the article or revising it critically for important intellectual content.

PEER REVIEW

The peer review history for this article is available at <https://publons.com/publon/10.1111/jan.14939>.

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How to cite this article: Searby, A., & Burr, D. (2021).

Telehealth during COVID-19: The perspective of alcohol and other drug nurses. *Journal of Advanced Nursing*, 77, 3829–

3841. <https://doi.org/10.1111/jan.14939>

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