Telementoring Counseling Skills for Deaddiction Counselors in Punjab During the COVID-19 Pandemic

To the Editor,

The COVID-19 pandemic has caused unprecedented restrictions on mobility and activity. Health care services have been disrupted[1]: Many services have been labeled as nonessential and resources diverted. Persons with substance use disorders (SUDs) have experienced many challenges in continuing their recovery journeys.[2,3] They are also at an increased risk of contracting COVID-19.[4,5]

An important aspect of addiction care services has been providing brief, evidence-based psychosocial interventions.[6] In resource-limited settings like that of India, these tasks have been shifted to paraprofessionals, such as nurses and counselors.[7] In north Indian states, community-level surveys show that Punjab, with a population of three crores,[8] is most affected by SUDs.[9,10] Two-thirds of households in Punjab have at least "one drug addict."[11]

The government of Punjab launched Outpatient Opioid Assisted Therapy (OOAT) Centers[12] to provide agonist therapy for those with opioid use disorders. Deaddiction counselors (DCs) are a paraprofessional cadre recruited to address the psychosocial care needs of persons with SUDs. Counselors are inducted after completing their postgraduate or master's level education in the streams of sociology, social work, or psychology. Their roles are to screen patients, assess drug use history, assist the psychiatrist, educate treatment seekers, engage families, and provide brief psychosocial interventions. Varying backgrounds and disparate training in counseling pose challenges to service parity.

During the pandemic, as in-person health care services were disrupted or suspended, changes were made to the provision of addiction care services across the country.[13,14] The frequency of visits to OOAT centers was reduced from once daily to once fortnightly.[15] Counseling services for persons with SUDs and their families became inaccessible.[13,16]

As yet, there have been no reports of engaging DCs to aid in providing substance-related counseling services. We report here an introductory telemental health training for the DCs in Punjab.

Methods

National Institute of Mental Health and Neurosciences (NIMHANS), Bengaluru, conducted a short-term synchronous training from February to March 2021 on Zoom videoconferencing.

A mandatory pretraining survey on attitudes and practices and a posttraining survey (one month after completion of training) were conducted to identify attributable changes. All participants were provided with the option of engaging in another self-assessment survey. This was conducted before and six weeks after completion of training to assess knowledge with regard to diagnosing and managing mental health conditions. This survey contained case-based questions highlighting common practice issues.

After each session that lasted 90 min to 120 min (Table 1), feedback for improvement was sought. Trainers adopted adult learning principles.[17] Case-based learning was done in which clinical and management problems were discussed and possible solutions were identified. The topics included groundings in their clinical and practical experiences and managing mental health conditions, especially in busy OOAT centers. Discussions were participatory and inclusive, in a supportive atmosphere. Video and document resources complementing the discussion themes were provided, and mentorship by the resource persons continued.

This manuscript reports the results of surveys and how they inform on proceeding forward with the capacity building during the pandemic. All survey data were anonymized during collection and stored in password-protected files. No prior ethical permissions were deemed necessary, keeping in mind the Indian Council of Medical Research guidelines.[18]

Results

A total of 229 DCs, with a mean (±SD) age of 31 (±5.6) years and a mean experience of 3 (±2.2) years, enrolled for the training. A total of 75% of the respondents worked in OOAT centers. Over 50% of these DCs had no prior clinical exposure. The majority reported having received cumulative training of fewer than three months postinduction. A total of 95% (n = 217) expressed the need for further training. Most reported facing challenging counseling situations and dissatisfaction with their current knowledge and practices. The average pretraining score was 5.6 (±2), and the average posttraining score was 5.9 (±3). Pre- and posttraining surveys using case-based scenarios demonstrated a change in knowledge scores (3%). Participants' feedback on a visual analog scale ranging from one to ten for each session are presented in Table 1. These demonstrate high participant engagement and satisfaction. The most common expected benefits of training were being able to identify mental health issues in patients (28%), identifying when to refer patients to a psychiatrist or a mental health professional (4%), conducting individual psychotherapy for all patients (4.5%), and identifying mental health issues in the carers of patients (7%).

Discussion

These results show that mental health training as part of capacity building for DCs is feasible. Posttraining assessments showed modest improvement. A shorter duration of engagement may have limited the change in scores.

We note that DCs perceived their short-term training to be inadequate. They reported facing challenging situations. The majority of them worked in OOAT centers, and they expected certain benefits and competencies to be developed via mental health training. Competency in identifying mental health concerns was most frequently reported.

Skills, such as counseling and motivational interviewing, may be better inculcated during professional training.

TABLE 1.

Details of Training Program and Feedback

Topic	How Would you Rate the Content of the Session?	The Session was Interactive and Engaging	The Session Highlighted Issues I Face in my Practice
Overview of substance use disorders	9.3	4.6	4.1
Basics of counseling in addiction disorders	9.5	4.5	4.2
Brief interventions in addiction disorders	7.8	4.2	3.9

Postinduction training may be less effective in imparting these skills as there is reduced scope for supervised or peer learning. However, these short-term training programs attempt to bridge this gap while adopting adult learning principles and emphasizing case-based learning, discussions, and demonstrative role-plays.

The training provided and the results obtained are unique and support the initiation of remote mental health training for DCs, even during the COVID-19 pandemic. Remote mental health training has proven just as effective as in-person training.[19,20] The reported need for training has increased.[21] Digitally delivered training has gained acceptance.

These capacity-building initiatives are incremental steps toward realizing the Punjab pyramid model of care.[11] They address demand and harm reduction aspects while also broadening the community base for identification and interventions in SUDs.

Strengths

This is the first report of successful tele-mental health training for DCs and capacity-building initiatives for SUD care in India during the COVID-19 pandemic. Participatory, interactive, inclusive, and experience-based sessions provided the bedrock for this initiative's success. Regular feedback surveys demonstrated positive change and outcome.

Conclusion

Digital delivery of mental health training may allow better progress toward capacity building even during the pandemic. Health administrators can ensure better mental health care delivery by initiating such training programs toward realizing various health policy objectives.

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Satisfaction with Psychiatric Teleconsultation Services During COVID-19 Pandemic: Perspective of Service Users

To the Editor,

Since the onset of the COVID-19 pandemic, telemedicine is being used at a massive scale but without assessing the satisfaction and feedback of patients and their caregivers, i.e., the service users. Studies in the West have mostly reported positive feedback and acceptability toward telemedicine/teleconsultation services.[1] However, positive feedback is not universal.[1] The primary aim of this cross-sectional study was to assess satisfaction with psychiatric teleconsultation services and the ease/comfort of using teleconsultation among patients or their caregivers during the COVID-19 pandemic. The secondary aim was to assess savings in terms of cost and time while seeking teleconsultation.

Subjects and Methods

This cross-sectional study was carried out from July 20, 2020, to August 24, 2020, by approaching the participants through telephone calls, after approval from the Institutional Ethics Committee. Two hundred and fifty-one participants (patients or caregivers) were randomly selected from those who had availed teleconsultation in the psychiatry department (at the author's institute) between 2 April and mid-June, 2020, who had received a prescription over teleconsultation, were aged ≥18 years, and were willing to participate in the study. Potential participants whose phone number recorded in the register was incorrect/nonfunctional or who did not respond to the call were excluded. The assessment was done using modified Hick's questionnaire, comprising nine questions rated on a six-point Likert scale.[2]

Results

Among the 251 participants, 54.6% were patients and the rest were caregivers. The majority of the participants were males (71.9%). Their mean age was 35.25 years (SD = 12.28), and the mean duration of formal education was 8.24 years (SD = 2.51). Most belonged to an urban area (61.9%). The majority were unskilled/semiskilled workers (43.5%), followed by homemakers (28.1%). Among the diagnostic profile, the highest proportion was of anxiety disorders (32%), followed by depression (25%), schizophrenia and related disorders (22%), and bipolar disorder (17%), and a small proportion was that of substance use disorders, dementia, and other disorders.

There was a high rate of satisfaction (~90%) with psychiatric teleconsultation (**Table 1**). The majority (>75%) found it easy and comfortable and were willing to continue with teleconsultation. The responses of patients and caregivers had no statistically significant difference.

Further, it was found that, approximately, on average, the patients/caregivers had to travel 130 km (SD = 10.46) and spend ₹1,125 (SD = 372.45) and 10 hours (SD = 3.78) for each in-person consultation. The expenditure included the cost of transportation and boarding/lodging of the patient and escort and did not include the cost of medicines. The time spent included the time taken to travel to and from the hospital and the time spent in registration and waiting for consultation.