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Experiences of telehealth among people receiving alcohol and other drug treatment during the COVID-19 pandemic: Implications for future telehealth delivery

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Abstract

Introduction: The novel coronavirus (COVID-19) pandemic necessitated the rapid uptake of telehealth to deliver treatment for alcohol and other drug (AOD) concerns. However, little is known about how the move from in-person to telehealth delivery impacted clients' experience of care. This qualitative study aimed to explore experiences of telehealth among people receiving alcohol and other drug treatment during the COVID-19 pandemic, and their preferences regarding future telehealth care.

Methods: Participants were aged 34–66 years ($M = 44$ years, 60% male) and were recruited from Victorian AOD treatment services and consumer networks. A total of 20 semi-structured interviews were analysed using thematic analysis.

Results: Three themes were identified: (i) experiences of the practical impacts of telehealth; (ii) experiences of telehealth interactions; and (iii) preferences for future telehealth. Contextual factors, including location and socioeconomic status, were found to impact clients' ability to access reliable telehealth with sufficient privacy. While telehealth was generally associated with increased treatment engagement (for a typically stigmatised population), participants noted varying effects on the therapeutic alliance. Although in-person treatment was generally favoured, participants often valued telehealth as a modality to provide empathic care during the pandemic. Participants expressed a preference for a hybrid treatment model in the future, in which they could choose a combination of telehealth and in-person services.

Conclusion: Client and clinician information and training are vital to improve the future delivery of telehealth for AOD treatment.

KEYWORDS
addiction, COVID-19 pandemic, health service, telehealth, treatment

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1 | INTRODUCTION

The novel coronavirus (COVID-19) pandemic led to a need for physical distancing and other lockdown measures, which necessitated changes in the way alcohol and other drug (AOD) treatment services were delivered. The Australian state of Victoria endured the longest period in lockdown globally, with its capital city, Melbourne, spending a cumulative 262 days under stay-at-home orders [1]. As in other parts of the world in 2020, Victorian AOD treatment services transformed rapidly from in-person care, to care delivered via telehealth [2]. Telehealth — *the provision of healthcare services* via *telephone or videoconferencing* — promises to broaden treatment availability by enabling the economical and accessible provision of healthcare [3]. There is a long-established literature supporting the benefits of telehealth in other medical and mental healthcare settings [3–5]. Commonly recognised benefits include the enhancement of treatment accessibility, convenience and cost-effectiveness [3]. Despite this, how clients receiving AOD treatment experienced the rapid transition to telehealth during the COVID-19 pandemic remains unclear. Furthermore, during the pandemic, a large proportion of AOD clinicians were practicing via telehealth for the first time [6, 7]. The hurried, sector-wide, implementation of telehealth at the start of the pandemic meant that there was little time to train the broader AOD workforce, the implications of which are also uncertain [7].

Recent qualitative research has explored the affordances of telehealth in AOD treatment, finding that contextual factors such as access to technology, and a private setting to engage in telehealth, influence clients' experiences of telehealth and care [8, 9]. On the one hand, telehealth difficulties, including privacy concerns and lack of access to reliable technology, may be exacerbated within AOD treatment populations, who may experience economic and social disadvantage [10–12]. On the other hand, given the high rates of treatment attrition and non-attendance in in-person AOD treatment, telehealth may provide a solution by allowing ready access to treatment remotely [13].

Telehealth may also impact clinical aspects of AOD treatment. Telehealth may potentially disrupt continuity of care and lead to a less engaging treatment experience, which may undermine the formation of a strong *therapeutic alliance*: the working relationship between a client and clinician [14, 15]. Telehealth may remove the capacity for clinicians to identify and respond to non-verbal communication and assess a client's physical appearance and symptoms, particularly in audio-only formats [14]. However, there may also be clinical and financial benefits of telehealth treatment, such as reducing the burden of accessing care, travel costs associated with treatment, and experiences of stigma for what are often highly judged and moralised health conditions [8, 16].

The potential benefits of telehealth may be constrained by a lack of clinician confidence to deliver telehealth [17]. In part, low clinician confidence may be related to a lack of appropriate training. While some self-directed telehealth training resources were available for clinicians (e.g., Australian Psychological Society resources), they tended to have low uptake before the COVID-19 pandemic [18, 19].

The limited research that does exist exploring telehealth for AOD concerns occurred prior to the COVID-19 pandemic and was conducted mainly outside of Australia [20]. How the heightened stress and loss of control over the modality of treatment delivery, as a result of the COVID-19 pandemic, impacted the experiences of clients attending AOD treatment requires further research [6, 8]. Moreover, the rapid move to telehealth at the beginning of the pandemic, and ongoing adoption of telehealth within AOD treatment systems as restrictions have eased, means that contemporary research to inform future telehealth delivery and practice is vital.

1.1 | Research aims and questions

This study aimed to explore the experiences of clients attending AOD treatment via telehealth during the COVID-19 pandemic. The study focused on three research questions:

1. What are the contexts in which clients access telehealth for AOD treatment?
2. What are the impacts of telehealth on their experiences of care?
3. What are their preferences for how future telehealth services are delivered during and beyond the COVID-19 pandemic?

2 | METHODS

This qualitative study was part of a wider mixed-methods project that explored people's experiences of telehealth for AOD treatment during the COVID-19 pandemic. The study received ethical approval from Monash University Human Research Ethics Committee (Project ID: 26975).

2.1 | Participants and setting

In 2021–2022 in the state of Victoria, Australia, publicly funded AOD treatment agencies provided treatment to

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36,375 people [21]. The main treatment types delivered to clients included: assessment; counselling; support and case management; withdrawal treatment; and rehabilitation. Furthermore, approximately 15,000 clients were receiving opioid agonist pharmacotherapy in Victoria in 2022 [22].

As with other jurisdictions, the Victorian government implemented a range of measures to respond to COVID-19. These included 6 lockdowns (31 March 2020 to 12 May 2020; 9 July 2020 to 27 October 2020; 13 February 2021 to 17 February 2021; 28 May 2021 to 10 June 2021; 16 July 2021 to 27 July 2021; and 5 August 2021 to 21 October 2021) affecting the Melbourne metropolitan area (and often also affecting other parts of Victoria), as well as in-person activity restrictions and face mask requirements [17]. Given these restrictions, most treatment for AOD concerns during the pandemic was conducted via telehealth from the beginning of April 2020, although exceptions included residential (inpatient) rehabilitation and withdrawal services [23].

Participants ($n = 20$) were recruited via two methods: advertising through various Victorian AOD treatment services; and by contacting consumers through the *Association of Participating Service Users* email list. The *Association of Participating Service Users* is a Victorian consumer representative body that has a mailing list of consumers from a wide variety of backgrounds who have accessed AOD treatment and may wish to participate in future research. Participants were included if they: (i) were aged >18 years; (ii) lived in Victoria; (iii) experienced AOD concerns; and (iv) received AOD treatment via telehealth during the COVID-19 pandemic. Participants were excluded if they reported psychological distress during an initial wellbeing check conducted by the interviewer, comprising questions about their current wellbeing and readiness to be interviewed.

The sampling approach involved convenience sampling, given we advertised via an email list; however, we also sought to purposively recruit certain types of clients from specific backgrounds via a number of AOD treatment services based in metropolitan Melbourne. Specifically, we aimed to recruit participants with varying demographic characteristics (e.g., age; gender; location); AOD use histories (e.g., alcohol, opioids); and treatment types (e.g., counselling; pharmacotherapy). Twenty-eight individuals expressed interest in participating, of whom three were excluded due to not meeting inclusion criteria and five could not be contacted. The final sample consisted of 20 participants (see Table 1).

Fourteen AOD types were identified as being drugs of concern. Prescription opioids ($n = 8$), alcohol ($n = 7$) and heroin ($n = 7$) were the most common (note that participants could nominate more than one drug of concern). The mean number of telehealth appointments that participants reported attending between March 2020 and May 2021 was 27 (range 3–150). Appointments specifically targeting AOD concerns were not delineated from those targeting a combination of mental health and AOD concerns, hence, the high upper range value may reflect some appointments which largely addressed other mental health concerns. The most frequently utilised form of AOD telehealth care was individual counselling ($n = 18$). A large majority of participants had also accessed other telehealth services (e.g., general practitioner; psychiatry) for comorbid mental health concerns ($n = 17$) or physical health concerns ($n = 18$).

2.2 | Data collection

Twenty in-depth, semi-structured interviews were conducted by JW, AB, and RP between March and May 2021 — as such, most interviews were conducted when there was no lockdown in effect, but there were still significant restrictions that required most outpatient treatment to be conducted via telehealth. All interviews were conducted over the phone or online via Zoom. The interview schedule was developed and agreed upon by the authors and explored participants': (i) life context; (ii) AOD consumption; (iii) experiences of telehealth; and (iv) perspectives about improving telehealth. Interviews were audio-recorded and had a mean duration of 38 min (range 14–51 min). Participants were reimbursed with a $50 AUD supermarket voucher.

2.3 | Data analysis

Audio files were transcribed verbatim and de-identified. The files were imported into the NVivo qualitative database management program (Version 12). Braun and Clarke's [24] thematic analysis guided the development of themes and sub-themes, through both deductive and inductive processes. After reading two transcripts each and discussing initial codes and themes, JW, AB, and RP developed a preliminary coding framework. At a high level, the framework was organised into topics of interest relevant to the project that answered the research questions. Then, the formation of sub-themes within each topic of interest was inductively generated from the data analysis (taking a 'bottom up' approach). JW and AB coded the entire corpus of transcripts ($N = 20$) guided by the preliminary framework. The preliminary framework was updated as new themes were found, and JW and AB held regular meetings to further refine the coding framework.

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TABLE 1 Characteristics of sample.

Variable	*n* (total = 20)	Proportion (%)
Age, years		
30–39	6	30
40–49	10	50
50–59	2	10
60–69	2	10
Gender		
Female	12	60
Male	8	40
Sexual orientation		
Heterosexual	11	55
Homosexual, bisexual or asexual	7	35
Did not select a category	2	10
Location		
Metropolitan	15	75
Regional	3	15
Rural	2	10
Place of birth		
Australia	18	90
Overseas	2	10
Aboriginal and Torres Strait Islander		
No	20	100
Alcohol and other drug type[a]		
Prescription opioids (e.g., codeine, morphine, oxycodone)	8	40
Alcohol	7	35
Heroin	7	35
Methamphetamine	5	25
Cannabis	4	20
Cocaine	3	15
Benzodiazepine	2	10
Hallucinogens	1	5
Number of drugs of concern		
Single drug of concern	13	65
Multiple drugs of concern	7	35
Type of AOD-related telehealth care[a]		
Individual counselling	18	90
Group counselling/peer support groups	4	20
Pharmacotherapy	4	20
General practitioner	2	10
Case management	2	10
Rehabilitation day program	1	5

[a]Participants were able to select multiple alcohol and other drug and telehealth care type.

3 | RESULTS

We identified three themes, including: (i) experiences of the practical aspects of telehealth; (ii) experiences of telehealth interactions; and (iii) preferences for future telehealth. Themes and sub-themes are described in Figure 1. When presenting interview excerpts, we adopt pseudonyms to protect participant anonymity.

3.1 | Experiences of the practical aspects of telehealth

In this theme, we consider how participants experienced the practical aspects of telehealth, within their individual contexts, including the technology they used to access telehealth, the environment in which they engaged with telehealth appointments, and its accessibility and convenience.

3.1.1 | Technology

Participants' interactions with, and experiences of, the technical aspects of telehealth led to various challenges when attempting to engage in treatment. For some participants who were particularly marginalised, financial concerns acted as a barrier to accessing telehealth technology. For example, Amanda (female, 30–39) recalled her difficulty accessing telehealth when stating: 'I got offered [videoconferencing] but I hardly ever had internet credit so I couldn't'. While videoconferencing was often preferred as it fostered a more personal experience, participants experiencing financial difficulties often had to settle for a phone call to speak to a clinician in the absence of data credit. For example, Stephen (male, 40–49) reflected on not being able to access video conferencing due to data credit difficulties, despite it being his preferred option: 'there's certainly a difference between being in-person, and being on video, and being on the phone [...] the video was better in that regard because you could see each other'.

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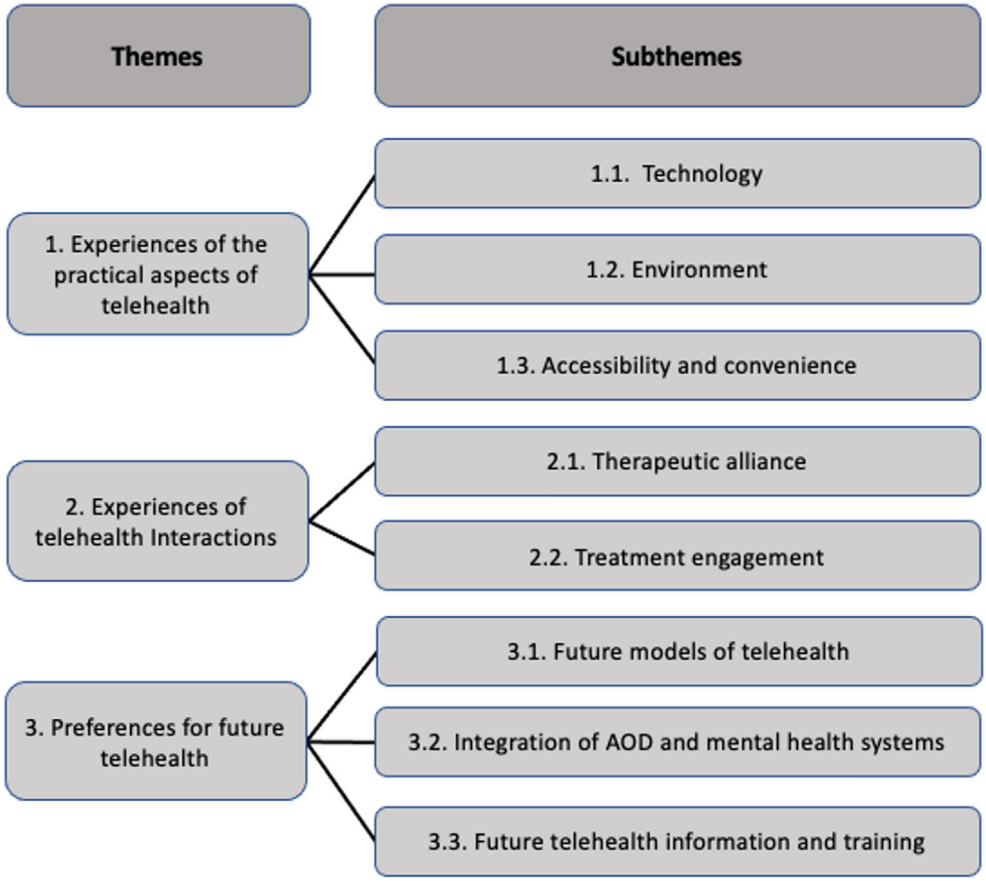

FIGURE 1 Overview of themes and subthemes.

Several participants experienced technical issues, including those who lived in rural or regional locations. For example, Jenny (female, 40–49) lived in a rural area and explained that her poor internet quality made communication challenging: 'it was just very difficult to try and hold a conversation with [your clinician] when you're missing part of the sentences'. These disruptions led to frustration among many participants. For example, Jane (female, 30–39) stated, 'it was a nightmare, they couldn't see me and then they couldn't hear me, and I felt really frustrated'. Hence, negative experiences and frustration often flowed from technical issues that undermined the quality of the telehealth call or videoconference.

3.1.2 | Environment

Telehealth afforded participants access to treatment from a broad range of private and public settings, often chosen based on availability and the level of privacy they could provide. Several participants lived in high-density areas and had concerns about being overheard. At times, this led some participants to proactively take telehealth calls in private locations. For example, Colin (male, 60–69) stated: 'I've got my son and his mother staying with me at the moment so usually to get some privacy I'd just come out and sit in my car and just do a phone [telehealth session] from there'. In another account, Sue (female, 40–49) raised the concern of not being able to find a private place to engage in telehealth: 'if I was inside, I was scared my kids would hear but if I was outside [...] my neighbours are going to hear'. Privacy concerns had the potential to impact treatment by constraining the depth of discussion during a telehealth call. With telehealth intersecting with everyday life, for some participants, engaging in telehealth care took place during banal, everyday activities that limited engagement: 'I remember the last time I was in the park down at the local shops. Oh, I probably just wanted to get off the phone quickly because you know, you don't want people listening in' (Linda, female, 50–59).

However, in contrast to experiences of in-person care such as sitting in a waiting room or a private room with a clinician, this intersection between telehealth and everyday life settings afforded some participants the opportunity to multitask and engage in other activities during appointments. Some viewed this as valuable: 'I'd often sketch just because that's calming' (Lauren, female, 40–49). However,

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some found that other activities could lead to distraction: 'pottering around in my bedroom did lead me to [...] not take in as much as I would have otherwise' (Sarah, female, 30–39).

Telehealth also afforded possibilities for AOD consumption during participants' interactions with clinicians compared with in-person sessions. Some participants discussed episodes where they had consumed substances whilst receiving treatment via telephone (where they could not be seen): 'I'd make some joints and smoke them and talk to him [clinician] about [quitting] bud while I was stoned' (Sue, female, 40–49). These situations had the potential to afford positive experiences, such as being more open to discussing difficult topics: 'I can [...] talk and go deep and stuff [when consuming cannabis]' (Sue, female, 40–49). In another account, Michael (male, 40–49) discussed how telehealth afforded engagement with treatment, regardless of whether he had consumed alcohol on the day of his appointment: 'even the fact if you are seeking treatment for addiction, you often might be not able to drive. Because you've drunk a six pack of beer or something and there'll be times, I've had a couple of drinks before, speaking to my counsellor [via telehealth] and I couldn't have driven there if that's the case'.

3.1.3 | Accessibility and convenience

Several participants highlighted how telehealth promoted access to treatment. For many, reduced need to travel to appointments improved accessibility. For example, John (male, 40–49), who lived in a rural area, travelled extensively for in-person care before telehealth: 'the round trip was about four hours'. Telehealth reduced travel time and was especially convenient for those living in rural and regional areas with fewer in-person treatment options.

Participants with busy schedules (e.g., full-time workers; primary caregivers) found telehealth convenient as they could schedule their appointment around their other obligations. For example, Michael (male, 40–49) stated: 'Monday to Friday going into a clinic or an office, that would eat into the workday [...] you can schedule [telehealth] toward the end of your day'. Michael discussed how this convenience promoted treatment engagement and retention: 'if I had to go to a clinic or an office [...] I probably would have given up'.

3.2 | Experiences of telehealth interactions

In this theme, we consider participants' experience of within-session telehealth interactions, exploring therapeutic alliances, and treatment and recovery trajectories.

3.2.1 | Therapeutic alliance

A primary concern about telehealth was the potential impact on the therapeutic alliance. Many participants were able to maintain good rapport with their clinician, despite the modality change: 'it's no different to sitting in [their] office' (Jenny, female, 40–49). Nearly all participants who reported this had established a relationship with their clinician before the pandemic. For example, Paul (male, 60–69) stated 'if you've been involved with the person before [...] and you've got a good rapport with them, it's great, but if you don't know them, you're a bit tentative'. Elaborating further, during the pandemic Paul recounted how he had to start working with a new clinician, and described that lacking a prior therapeutic relationship made his treatment seem impersonal: '[there was] no emotion [...] you're talking to a piece of plastic'. Participants were also less likely to prioritise appointments when this prior in-person bond was not well-developed: 'with my AOD counsellor I don't feel in any way obligated or committed to taking or continuing with the appointments, whereas with my [psychologist], I have that established relationship with him and I feel more committed' (Jenny, female, 40–49).

Participants also reflected on how telehealth and being physically separated from a clinician influenced their experiences of care. Some participants believed that the physical separation from their clinician helped them be more forthcoming: 'it's often easier to be open' (Michael, male, 40–49). However, several participants, particularly those accessing audio-only telehealth formats, noted that the nonverbal aspect of communication was missing: 'when you're on a telephone call, you don't have any of that body language' (Michael, male, 40–49). Some participants viewed telehealth as reducing clinicians' capacity to assess their physical wellbeing, which Andrew (male, 40–49) believed led his doctor to underestimate his symptom severity: 'over the phone [...] doctors can dismiss and not really take it seriously'.

3.2.2 | Treatment engagement

Participants sometimes discussed how daunting it can be to seek AOD treatment and that this can deter people from initially engaging or actively participating in treatment. Consequently, Lauren (female, 40–49) believed that being able to access preliminary information via telehealth, may encourage more people to seek help: '[telehealth could help] people that aren't quite ready to see someone face-to-face'.

While telehealth may help people engage with treatment, some participants were concerned about its potential to reduce the quality and quantity of social connection. For

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people in AOD treatment in the initial stages of recovery, attending in-person treatment services may give rise to their only social interaction in a day (e.g., with clinicians, other people in treatment): 'going to the doctors could be your only outing for the day, when you're in early recovery' (Jane, female, 30–39). For this reason, Claudia (female, 30–39) worried that telehealth would lead her to feel isolated: 'I was worried [...] because at a certain point when you become really unwell your only connections unfortunately, or mine are, [...] health professionals'. This sense of disconnection led some participants to terminate treatment: 'I couldn't do it because I couldn't actually get that bond' (Gabe, male, 40–49).

Nonetheless, telehealth was considered useful during the pandemic by most participants, as it provided access to AOD treatment when it was otherwise unavailable: 'it's a good tool because it's better than nothing' (Sue, female, 40–49).

3.3 | Preferences for future telehealth

The following theme outlines participants' preferences for the future of telehealth delivered care, including after the end of COVID-19 restrictions (many of which were still in place at the time of data collection).

3.3.1 | Future models of telehealth

Most participants indicated a preference for a future treatment model comprising a combination of telehealth and in-person services (referred to herein as a hybrid model): 'having both options would be the ideal' (Lauren, female, 40–49). Many emphasised the value of a hybrid model due to the perceived importance of choice when it comes to an individual's treatment options.

Participants often identified instances in which telehealth would be most appropriate, such as for simple appointments, which were considered time-consuming or inconvenient: 'getting scripts updated, things that aren't physical' (Kate, female, 30–39). Another suggestion was that telehealth could be utilised for aftercare, following in-person treatment, to reduce the risk of relapse: 'once the hard yards are done with, telehealth is definitely something that could be ongoing [...] so that there's still that personal check-in [...] on how you're travelling [...] That lack of follow-up [...] is where it fails' (Jenny, female, 40–49).

Many participants believed that initial appointments should be in-person, regardless of their long-term preferences. Participants with this view often had not met their clinician before telehealth, which reportedly compromised their experience. For instance, Jenny (female, 40–49) stated, 'I would prefer to maybe have three or four face to face sessions to begin with and then switch over to telehealth appointments. I think that would be a much smoother transition and also something that would solidify that connection and engage people with the service'. This account is consistent with the notion that the participants with a pre-existing relationship with their clinician had a superior telehealth treatment experience during the COVID-19 pandemic.

3.3.2 | Integration of alcohol and other drug and mental health systems

The complexity of telehealth was seemingly heightened among those receiving treatment for comorbid concerns. Participants receiving many forms of care were required to navigate several booking systems and telehealth platforms, while undertaking a more complex schedule of appointments. Claudia (female, 30–39) saw her AOD counsellor and general practitioner weekly, and her psychologist fortnightly. This resulted in over 100 telehealth appointments over a 14-month period, with each clinician utilising different systems and modalities, which she stated 'can be unmanageable'. Participants generally believed that Victoria's current AOD treatment system, including telehealth, could be simplified and better integrated with mental healthcare: 'the lack of integration for comorbidities in the system means that people slip through the cracks' (Claudia, female, 30–39).

3.3.3 | Future telehealth information and training

Participants frequently discussed the need for improved telehealth information and training for both clients and clinicians. Many recalled that during the rushed implementation of telehealth in March/April 2020, little time was taken to teach clients how to use it: 'I don't know where I go or how I access these things [...] they just took that as me being lazy' (Amanda, female, 30–39). Thus, many participants emphasised the need for client information or training on accessing telehealth, which could be achieved by 'having really specific instructions on how to access telehealth' (Lauren, female, 40–49), along with managing clients' expectations by 'explaining the challenges that are faced within [telehealth]' (John, male, 40–49).

Suggestions for clinician training were also discussed, particularly by participants who encountered therapeutic alliance difficulties. Suggestions for clinician training

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were often related to rapport-building and overcoming the absence of nonverbal cues: '[training clinicians] around how to connect [...] over the phone' (Jane, female, 30–39).

4 | DISCUSSION

The findings of this research highlighted three major themes. First, the context in which people receiving AOD treatment attended telehealth appointments impacted their experience of care. Second, telehealth impacted how participants experienced clinical interactions. Finally, participants held similar preferences for how future telehealth for AOD care should be implemented (hybrid models) and encouraged future training for clients and clinicians to promote engagement with telehealth.

4.1 | Client contexts and telehealth experiences

A key issue concerning the delivery of healthcare in general via telehealth is access to care and what types of consumers may be disadvantaged by its implementation. Our work highlights how participants experiencing financial concerns may have difficulty accessing technology required for telehealth appointments, which has been echoed in other work exploring clinicians' views on treatment access for AOD care delivered via telehealth [25]. Further, technical issues were reported by clients living in rural and regional areas, indicating that some rural locations may not have had adequate broadband infrastructure to support telehealth delivery at the time of the pandemic (see also [4]). These issues have been widely discussed in literature from the United States, where socioeconomic disparity and geographical isolation reduce telehealth access and engagement [26].

Despite technical difficulties for some, telehealth-delivered care afforded convenience and ease of access for certain participants, such as fulltime workers or caregivers, which has been reported in other work on telehealth for alcohol interventions and in paediatric medicine [4, 8]. These findings support recent research [9] suggesting that telehealth affords different opportunities for individuals, based on their unique context. As such, the benefits of telehealth are not evenly distributed across society and care needs to be taken to ensure marginalised groups are not disadvantaged by telehealth's ongoing use, as healthcare systems move away from pandemic protocols.

Furthermore, our findings shed light on the types of settings clients have access to, and how individual environments shape telehealth access. Not having a comfortable, private space within their home environment impacted some participants' telehealth experiences. Whilst some participants could set up environments conducive to engaging in telehealth, others experienced difficulties in accessing the privacy necessary for telehealth treatment. Privacy concerns have been previously recognised as a barrier to telehealth access in other work [14]. As we observed, privacy concerns led participants to, at times resourcefully, engage in telehealth appointments in atypical locations (e.g., shopping centres, their car). The ability for participants to engage in treatment within these settings challenges the current understanding of what constitutes an efficacious care environment.

In some circumstances, telehealth afforded opportunities for client AOD consumption while receiving audio-only treatment, which presents a challenge to norms and standards of in-person treatment settings where AOD use is generally not acceptable nor tolerated. The chance of participants missing appointments due to the consumption of alcohol or other drugs or being intoxicated was reduced in some telehealth examples participants recounted, which foregrounds a possible advantage of telehealth as reducing a non-attendance barrier [27]. However, many participants viewed the ability to hide their AOD consumption as potentially problematic within the context of AOD treatment. How telehealth may afford AOD consumption practices, and implications for care provision, requires future research.

4.2 | Experiences of telehealth interactions

The therapeutic alliance is vital for the successful treatment of AOD concerns [16]. Participants who established strong therapeutic alliances viewed telehealth more positively and often cited increased treatment engagement. These participants commonly had an in-person relationship with their clinician before the COVID-19 pandemic. In contrast, difficulties forming a therapeutic alliance were prevalent among those who had never met their clinician in-person before commencing telehealth treatment. In these cases, communication difficulties had a greater adverse impact due to the lack of established rapport, leading to negative perceptions of telehealth and occasionally, treatment cessation. Previous research has not yet acknowledged the beneficial role that having a prior in-person therapeutic relationship may have on the quality of treatment delivered by telehealth.

The reduced capacity for nonverbal communication and physical assessment via telehealth (particularly audio-only), are widely established difficulties across the

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telehealth literature [14, 28]. An integrated care system, wherein general practitioners can conduct in-person physical assessments while a person also receives AOD treatment via telehealth, may present a solution.

For many clients with severe AOD concerns, or early in their treatment journey, the switch to telehealth resulted in social isolation and a disruption to valued supports. A recent study reported similar findings among people receiving opioid agonist treatment, moving from pharmacy-based daily dosing of buprenorphine, to long-acting injectable buprenorphine, raising questions around how clients who value in-person supports might be catered for [29]. A worthwhile way forward may be to co-design [30] telehealth interventions and practice, by taking into account a person's care needs and desires.

4.3 | The future delivery of telehealth for alcohol and other drug concerns

As telehealth-delivered services have proven effective within some contexts during the pandemic [31, 32], future provision of telehealth care is likely to continue to enhance the reach of AOD treatment. Many participants preferred a hybrid model of treatment, allowing a choice of combining telehealth and in-person services. Hybrid models have been explored among other treatment populations (e.g., patients with physical healthcare needs) and have been generally preferred by patients in these studies [33, 34]. Many of the present study's participants believed that choosing their treatment modality would enhance autonomy.

Consistent with other studies [35], participants felt that telehealth could be particularly useful for aftercare or 'simple' appointments (e.g., prescription renewal), for example for those engaging in pharmacotherapy, who may experience harms (e.g., withdrawal, relapse) if prescriptions are not renewed soon enough to maintain dosing. However, what clients might consider to be 'simple' healthcare interventions such as reissuing prescriptions for medications, may not always be as simple from a clinical perspective. Whether or not telehealth may be beneficial for a particular intervention is highly context-specific: the benefits of visiting treatment centres in-person and the provision of care via telehealth are client-specific and dependent on clients' and clinicians' goals and desires, while also constrained by relevant health legislation/policy (such as that relating to pharmacotherapy prescribing).

Increased telehealth information and training were widely desired. Participants believed that clients would benefit from being taught how to use technological devices and how to access telehealth systems. Education to increase consumer technology proficiency increases telehealth acceptance [36]. During the onset of the COVID-19 pandemic, there was little time to train AOD workers adequately in telehealth delivery [7]. Accordingly, participants suggested clinician training, particularly in communication and rapport-building strategies, would be useful.

4.4 | Limitations and future directions

This study provides valuable insights into the experiences of telehealth among those receiving AOD treatment during the COVID-19 pandemic, perspectives that have been under-researched. A limitation was that interviews were only conducted with participants who successfully accessed telehealth during the COVID-19 pandemic in Victoria, Australia. Hence, the findings may be less relevant to those in other jurisdictions, more diverse populations, as well as those who had less ability to access to telehealth due to marginalisation or a lack of technology. Future research would benefit by focusing on the experiences of other types of clients, including those from Aboriginal and Torres Strait Islander backgrounds, and for marginalised groups such as those experiencing homelessness or socio-economic disadvantage.

Additionally, future research should explore the experiences of those who could not access telehealth during the pandemic, as well as clinicians' perspectives of telehealth. Research is also needed to explore the impact of AOD consumption during telehealth treatment and how this is handled by service providers. More research on the experiences and impacts of telehealth as we move toward a 'COVID-normal' world and beyond, is also warranted.

5 | CONCLUSION

The COVID-19 pandemic has highlighted a need for accessible and effective telehealth-delivered AOD treatment. People receiving AOD treatment recognise the value of telehealth, as it allowed for the provision of care during the pandemic. However, the perceived usefulness of telehealth was contingent on a client's unique context, which generated varied practical and clinical affordances or constraints that influenced their experience. Opportunities to improve telehealth-delivered AOD treatment may include implementing a hybrid treatment model, better integrating AOD and other mental health telehealth treatment, and improving telehealth training for both clients and clinicians. Given that telehealth has become an important addition to treatment services, better training for clinicians about how to promote

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treatment engagement during telehealth care, and how to integrate telehealth within treatment settings, will have benefits for how telehealth is delivered and experienced. With continued research and policy improvements, AOD concerns may be treated more effectively via telehealth beyond the pandemic.

AUTHOR CONTRIBUTIONS

Jaimie Woolley: Conceptualisation, Methodology, Investigation, Formal analysis, Project administration, Writing – original draft, Writing – review and editing. **Michael Savic:** Conceptualisation, Methodology, Project administration, Writing – review and editing, Funding acquisition. **Joshua B. B. Garfield:** Formal analysis, Writing – review and editing. **Rachel Petukhova:** Formal analysis, Writing – review and editing. **Victoria Manning:** Formal analysis, Writing – review and editing, Funding acquisition. **Dan I. Lubman:** Formal analysis, Writing – review and editing, Funding acquisition. **Anthony Barnett:** Conceptualisation, Methodology, Investigation, Formal analysis, Project administration, Writing – review and editing.

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