

# Responding to rural adversity: a qualitative study of alcohol and other drug service users’ experiences of service response to COVID-19 in Western Australia’s Southwest

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## Abstract

**Objective:** This study reports on the impact of the COVID-19 pandemic on the lived experiences of people with substance use problems in accessing services in the Southwest region of Western Australia, and its implications for preparedness in a context of rural adversity.

**Method:** This was a qualitative study informed by the principles of phenomenology. Data were collected through semi-structured interviews and subjected to thematic analysis.

**Results:** Twenty-two participants were interviewed. Two main themes were identified: disruption to supportive connections; and bridging the connection gap: local service response to the COVID-19 pandemic.

**Conclusions:** The COVID-19 pandemic restrictions exacerbated social isolation and mental health issues, and disrupted services and treatment in the Southwest. Our results demonstrate that local alcohol and other drug services in rural areas can successfully respond to crises by assertively and flexibly adapting their service provision.

**Keywords:** substances, alcohol and other drugs, COVID-19, lived experience, rural adversity

Rural adversity is the cycle of adverse events impacting the rural physical environment, placing pressure on social and economic capital, potentially leading to poor health and wellbeing, and reducing the capacity of communities to respond to continuing or future adverse events.<sup>1,2</sup> Adopting an ‘ecosystem’ perspective, the COVID-19 pandemic can be seen as an example of universal adversity impacting community-level adversities, further exacerbating individual experiences of adversity within a rural context.<sup>2</sup>

Alcohol and other drug (AOD) users face barriers to accessing services, including stigma, poor coordination between services, associated costs, poor accessibility, and lack of timeliness and tailoring of interventions.<sup>3,4</sup> These access barriers are exacerbated in rural Australia, with confidentiality concerns, longer travel distances, AOD

workforce issues, and limited availability of services resulting in longer waiting lists.<sup>4–7</sup> Ensuring adequacy of engagement and treatment for people with substance use problems during the COVID-19 pandemic presented an immediate test to the capacity of AOD services.<sup>8</sup>

National reported patterns of AOD use changed with COVID-19 pandemic restrictions, with cannabis and alcohol use experiencing the largest increase, and

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methamphetamine the largest decrease.<sup>9</sup> In Western Australia (WA), strict lockdown measures were in place from late March through April 2020, leading to disruptions in AOD availability. Similarly to other Australian jurisdictions,<sup>10</sup> restrictions on alcohol sales in bottle shops came into force, combined with a relaxation of alcohol licensing restrictions, allowing licensed businesses to sell alcohol for off-premise consumption.<sup>11</sup> Further, illicit drug availability reportedly decreased,<sup>12</sup> which is likely to have been greater in rural areas given WA's intraregional travel restrictions.<sup>13</sup>

The impact of the pandemic and COVID-19 related restrictions on the lived experiences of WA rural substance users accessing local AOD services has not, to our knowledge, been described in the literature. Furthermore, the implications of the local AOD service response in the broader context of addressing rural adversity have not been explored. This paper describes results on the impact of the COVID-19 pandemic on people with AOD use problems from a broader study exploring the experiences of AOD service users in WA's South West (SW) region, and discusses the implications for community resilience and response to continuing rural adversity.

## Methods

This qualitative study of lived experience was informed by the principles of phenomenology. Participants were aged 18 years and over, resident in the SW at the time of recruitment and identifying as having an AOD use problem. Participants were recruited through advertisements in local media and flyers in local health and AOD services. In addition, a snowballing sampling technique was used as the AOD using population is a hidden population from a research perspective within the community. Recruitment ceased after data saturation was achieved.<sup>14</sup>

Data were collected through semi-structured telephone interviews conducted by two trained interviewers. The interview schedule consisted of open-ended questions and prompts designed to explore participants' lived experience of the impact of the COVID-19 pandemic on their mental health, substance use and access to AOD services. Issues of power imbalance and participant vulnerability during the interview encounter were discussed with the interviewers as part of the scheduled project meetings during the data collection phase. The interviews had an average duration of 30 minutes.

De-identified transcripts of the audio recordings were imported into NVivo software<sup>15</sup> and subjected to triangulation and thematic analysis by the research team.<sup>16</sup> The study obtained Human Research Ethics approval through the University of Western Australia (RA/4/20/5656).

## Results

A total of 22 participants were interviewed between June and September 2020. No deviant cases were identified within the sample. See Table 1.

**Table 1. Sample characteristics**

<i>Characteristic</i>	<i>Count (n)</i>	<i>Proportion (%)</i>
<b>Gender</b>		
Female	15	68.2
Male	7	31.8
<b>Age Group</b>		
18–20	1	4.5
20–29	5	22.7
30–39	7	31.8
40–49	6	27.3
50–59	2	9.1
60+	1	4.5
<b>AOD of Concern*</b>		
Alcohol	4	–
Cannabis, marijuana, THC	5	–
Cocaine	1	–
Heroin	1	–
LSD	1	–
MDMA	2	–
Methamphetamine, Ice	14	–
Prescription Medication	2	–

\*Multiple answers possible.

∞ Nicotine/Tobacco use was not included in the study.

Two main themes arose: disruption to supportive connections; and bridging the connection gap: local AOD service response to the COVID-19 pandemic. Themes, subthemes, and supporting quotations are presented in Table 2.

### Disruption to supportive connections

**Isolation from people and services.** Most participants reported feelings of social isolation and dislocation from family, friends and services. Being 'stuck' at home was broadly reported as a negative experience, and this was exacerbated for those who reported spending the lockdown in households with unhealthy dynamics, and for those waiting to be admitted to a residential rehabilitation facility.

Those living in communal settings during the lockdown – residential withdrawal and rehabilitation facilities or prison – reported experiencing increased isolation as visits and physical contact were restricted, and programs involving external facilitators were cancelled.

**Impact on mental health and AOD use.** The majority of participants ( $n = 15$ ) reported that the COVID-19 pandemic had adversely impacted their mental health, with many reporting increased anxiety and/or depression. Whilst some reported being 'stressed' or 'nervous' about becoming infected with the virus, in most cases the

**Table 2. Participants' quotations illustrating the themes and subthemes**

<b>Theme</b>	<b>Subtheme</b>	<b>Supporting verbatim quotations</b>
Disruption to supportive connections	Isolation from people and services	<p><i>'When everything was shut off, the world just shut off [...] Just couldn't go see my mates, couldn't get the kids out of the house, couldn't go to the park.'</i> (P02; female; 30s; cannabis &amp; meth)</p> <p><i>'You know, the hardest part, I think, for myself and others, was when we weren't allowed to actually meet up at a park.'</i> (P01; female; 40s; meth)</p> <p><i>'I was restricted to visits and phone calls and all that sort of stuff, and that hit hard. That was really hard to deal with, not being able to see people on the outside.'</i> (P06; female; 40s; meth)</p> <p><i>I felt like you were isolated. Very difficult. A lot of people in the unit that I was in and there's only like two phones between like 70 or 80 people. [...] So it was hectic. And then not seeing your family and stuff like that; it all takes its toll.'</i> (P11; male; 30s; meth &amp; cannabis)</p>
	Impact on mental health & AOD use	<p><i>'I think in hindsight now I realise I watch too much news all the time, so you always had that dark depressing sort of thing if you watched it every day, plus drinking on top, so my mental health did go down a little bit.'</i> (P10; male; 40s; meth &amp; alcohol)</p> <p><i>'I was pretty stressed out during that time, just with the uncertainty and not knowing what was really going on.'</i> (P14; male, 20s; cannabis &amp; meth)</p> <p><i>'Because I was home all the time I just used more and didn't do anything else [...] All the emotions: depression, anger, regret. I went through a lot of stages of different emotions.'</i> (P13; male; under 20; meth, cannabis &amp; alcohol)</p> <p><i>'I was stuck at home, obviously, during the waiting period for rehab as well. So it was like, I couldn't really start work or anything else, just in case I got called, to day I have to go. So I was stuck at home at mum's all the time, so it was hard, which made me use more drugs.'</i> (P19; female; 20s; MDMA &amp; meth)</p> <p><i>'There were no drugs on the street at all, none at all, because everyone was in lockdown, you know what I mean? And I can name dozens of people that have cleaned up because of COVID-19.'</i> (P17; male; 40s; meth)</p> <p><i>'As far as COVID's concerned and the isolation – I mean, we – us drug addicts we self-isolate anyway, so that didn't bother me whatsoever. As far as drug taking and getting off it is concerned, the COVID thing has been really healthy for a lot of people.'</i> (P09; female; 50s; meth)</p>
Bridging the connection gap: Local AOD service response to COVID-19	Impact on access and availability	<p><i>'I was not quite a phone person. I prefer to talk about things face-to-face, so it made it a bit hard for me, but I had to do what you had to do.'</i> (P05; female; 20s; meth)</p> <p><i>'I think you get a lot more out of it when you're actually there in person. You know everybody has got their own little story and have been through their own struggles. But yeah, I guess you always hear someone with a similar story or a similar struggles which sort of makes you feel that you're not on your own, sort of thing.'</i> (P12; male; 30s; cannabis, meth, LSD, MDMA, cocaine)</p> <p><i>'It was hard to get into the detox because they weren't taking as many people at the time because of COVID. So they didn't. They had two in each in each room, and they weren't letting people share a room so that dropped their numbers. Their numbers were a lot lower, so that's why it took a while to get in.'</i> (P15; female; 60s; alcohol)</p> <p><i>'In the lead-up to coming here [rehab], I got told 'yes, you're going to be going soon', then I got told 'no, we're not letting anyone in and we don't know any more', and then it was weeks and weeks and weeks and weeks, and it kept going back and forth.'</i> (P18; female; 20s, meth).</p> <p><i>'I'd been told there'd be a longer time than what I actually waited [...] Well, because they had the COVID and all that was on, they were still trying to figure out how they were going to operate the rehab with the COVID and all that.'</i> (P12; male; 30s; cannabis, meth, LSD, MDMA, cocaine)</p>
	Flexibility and assertive engagement	<p><i>'And then COVID-19 came, and they were still making contact with us. They've been really good there. I can't fault them, to be honest. They're really nice people. And they've patted me on the back when I needed a pat on the back.'</i> (P17; male; 40s; meth)</p> <p><i>'They [the chemists] bent the rules for me and they did a home delivery, a witnessed delivery, so I could have my witnessed dose. [...] I just wasn't allowed to travel. I had to stay at home.'</i> (P08; female; 50s; heroin)</p> <p><i>'I was really scared because I'm like: 'These people aren't getting back to me. These people aren't getting back to me. Am I ever going to get in there?' But just as I started to get that real terrible feeling in my stomach, the phone would call, just to reassure me that they hadn't forgotten about me. Don't worry. And just to check up on me.'</i> (P05; Female; 20s; meth)</p> <p><i>'She was just calling me every week, pretty much, to see how I was going and everything else, so it's been good. Good experience.'</i> (P19; female; 20s; MDMA &amp; meth)</p> <p><i>'You know, they had nothing to go off, so they just responded the best they could at the time as things were happening, and I don't think there's anything more than anyone could have done at the time [...] Everyone was just doing their best.'</i> (P18; female; 20s; meth)</p>

(continued)

**Table 2. (continued)**

<b>Theme</b>	<b>Subtheme</b>	<b>Supporting verbatim quotations</b>
Other impacts	Financial	<i>'I was earning more money on unemployment than I did when I was working' (P14; male; 20s; cannabis &amp; meth)</i> <i>'I suppose the COVID thing actually helped [...] Well, with the COVID you get extra money.'</i> (P11; male; 30s; meth & cannabis)
	Travel restrictions	<i>'... because I had to go to detox first [in Perth]. And obviously, with the COVID, they were having the traffic things [...] The blocks. And it was hard.'</i> (P19; female; 20s; MDMA & meth) <i>'... and then they closed the highway off, so I spent isolation with my parents, which was quite –'</i> (P20; female; 30s; alcohol)
	Health & wellbeing	<i>'I suffer from horrendous migraines. [...] That's how I'm getting these procedures done on my back and on my neck, and I've got a surgery coming up on my lower back – because of this COVID-19 everything's been put off. It's just a matter of when the dates become available again.'</i> (P08; female; 40s; heroin)

increase in anxiety and/or depression was linked to the prevailing uncertainty, being 'stuck' at home and boredom. Those living in a communal setting were less likely to report adverse mental health impacts.

AOD use was reported as a way to 'escape the reality of it all', deal with boredom or cope with increased anxiety. Participants' reports of the impact of the COVID-19 pandemic on AOD use varied, and were somewhat influenced by their reported drug of concern and lockdown setting. Two participants who reported using methamphetamines spoke of the beneficial impact of the lockdown, explaining their use had decreased due to the unavailability of the drug; in contrast, participants reporting an increase in AOD use tended to use alcohol. Those who reported no change in their AOD use tended to be those who described themselves as having been 'sober/clean' before the COVID-19 pandemic and those who were in rehabilitation or prison during the lockdown.

#### **Bridging the connection gap: Local AOD service response to the COVID-19 pandemic**

**Impact on access and availability.** All participants reported disruptions to AOD services during the lockdown. Whilst some services closed temporarily, most remained open with restrictions. Local AOD group programs including Alcoholics and Narcotics Anonymous were cancelled, and face-to-face counselling became unavailable. Although most participants expressed a marked preference for face-to-face interaction, all acknowledged switching to telephone or Internet-based service delivery during the lockdown was a necessity.

Those waiting to be admitted to the public metropolitan withdrawal/detoxification unit in Perth or the local rehabilitation facilities reported significantly longer waiting lists as units initially self-quarantined and stopped admissions, operating at a lower capacity. Extended waiting times triggered heightened anxiety and stress, which in some cases resulted in increased AOD use.

**Flexibility and assertive engagement.** Participants' reports of their experiences show that local AOD services effectively overcame social distancing restrictions through flexibility and assertive engagement in service delivery. Face-to-face interaction swiftly pivoted to telephone or Internet-based delivery, with some services offering group WhatsApp chats and Zoom meetings in addition to individual telephone counselling. There was a perception among some participants that services had 'bent the rules' to accommodate their needs.

Participants commonly reported that local AOD services proactively reached out to them during the lockdown. Those waiting to be admitted to residential programs were especially appreciative of efforts made by local services, providing regular updates regarding admission to detoxification and rehabilitation units. Overall, although telephone contact was a less preferred option to face-to-face delivery, participants commented positively on the efforts made by services to maintain the connection and flow of information.

## **Discussion**

Our participants experienced disruptions to their support networks during the COVID-19 lockdown. Feelings of increased isolation were commonly reported, as were heightened levels of anxiety and/or depression, sometimes resulting in increased AOD use. Our findings on mental health issues are consistent with national self-reported data showing increased prevalence of depression and anxiety following the introduction of COVID-19 restrictions, and support the early concerns raised in the literature about the greater vulnerability to mental health issues of people living in rural areas.<sup>17</sup> Our findings on reduced illicit substance use during the lockdown, are in keeping with WA results from the Illicit Drug Reporting System<sup>12</sup> and with national data on methamphetamine availability,<sup>9</sup> and show that periods during which supply is constrained may represent an opportune time to engage with treatment services. The findings pointing to

an increase in alcohol consumption support the concerns raised following the introduction of measures relaxing liquor licensing restrictions,<sup>10</sup> and demonstrate the importance of calibrating public health against economic considerations in times of community crisis.

COVID-19 restrictions had a significant impact on AOD service provision in the SW, with restrictions on access and availability broadly reported. However, local services demonstrated flexibility and assertive engagement in bridging the connection gap with service users. Our results demonstrate that a rural AOD service 'ecosystem' can successfully respond to a global adverse event, harnessing community social capital and local resources. Service-level responses are, however, influenced by contextual factors operating at regional and broader community level, including greater geographical isolation of certain areas within the SW, and baseline limited services and resources compared with metropolitan areas. Our results on service availability and waitlist times, are consistent with existing evidence.<sup>4,5,7</sup> The lack of locally available withdrawal/detoxification services, and the limited number of general practitioners prescribing opioid substitution treatment in the region and must be addressed beyond crises or disasters. The recent Royal Commission into National Natural Disaster Arrangements recognised this in recommending that all levels of government must support localised planning and delivery of integrated primary care and mental health services following a natural disaster into the longer term, in view of the recurrent nature of rural communities experiencing adversity.<sup>8</sup>

This study is the first to our knowledge to report on the lived experiences of people with substance use problems in regional Australia accessing AOD services during COVID-19 restrictions. However, we acknowledge some limitations: participants were self-selected, and given our recruitment strategy, our sample included an overrepresentation of people already accessing services within the region. Secondly, COVID-19 restrictions in WA, as compared to other states and countries, were relatively brief. Our findings need to be understood in the context of the SW region and may have limited generalizability to other rural or remote areas, or jurisdictions, of Australia.

## Conclusions

COVID-19 restrictions impacted mental health and AOD use in our sample of people with substance use problems residing in the SW. Access to AOD services was significantly disrupted; however, local services were able to successfully respond by assertively and flexibly adapting their service delivery. Lessons can be learned on how rural AOD services can implement local strategies that harness local social capital and strengthen community resilience to prepare, respond and recover from future and continuing adverse events affecting rural communities.

## Acknowledgements

The authors thank Annie West and Cheryl Lewis for assisting in the study interviews.

## Disclosure

The authors report no conflict of interest. The authors alone are responsible for the content and writing of the paper.

## Funding

The authors disclosed receipt of the following financial support for the research, authorship and publication of this report: This work was supported by the Lishman Health Foundation Inc (grant number 01252/345/51000400).

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