Turning Point Alcohol & Drug Centre

TREATMENT FOR DEPRESSION: A QUALITATIVE EXPLORATION OF THE EXPERIENCES OF ALCOHOL AND DRUG USERS

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SUMMARY (please keep to one page only)

1. Brief description of project

In-depth, semi-structured interviews were conducted with 30 people currently receiving alcohol and drug treatment regarding their experiences of depression and depression treatment. Through the identification of barriers and supportive mechanisms, it has been possible to make recommendations for the improvement of depression treatment access and service delivery. The information collected has been of particular value as it focuses on treatment-related issues from the viewpoint of those who have accessed it.

2. Main outcomes / key findings

- Experience of depression treatment were mostly negative, compliance with medication was extremely poor.
- Of the two treatment responses counselling and pharmacotherapies, counselling was viewed more favourably, there was positive experiences of counselling, but this was very dependent on the type of counsellor.
- Despite health promotion and other messages about access to services, AOD users are still not aware of where and how to access treatment.
- While a small proportion of participants utilised other strategies to cope with depression, their use was sporadic and haphazard and not always effective.
- Participants' first depressive episode preceded problematic drug use, therefore once attending AOD treatment, depression had already manifested itself.

3. Implications for policy and practice

- Education messages about effective treatment & effective treatment engagement are needed to target this population specifically. Working with GP and other community health centres could facilitate this process.
- Further investigation into the role of therapeutic alliance in a comorbidity setting with this population is needed as well as the type of intervention that is useful and effective eg CBT
- Information needs to be user friendly and accessible to this population.
  Where do people currently access information? This is something that could further investigated, with a view to facilitating access to accurate consumer information (for example websites such as BeyondBlue, Blue Pages, etc).
- AOD workers and other health professionals can support AOD users to manage their depression by identifying it as a treatment issue and by exploring strategies that are meaningful to the client. This could be done through individual treatment plans.

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The study took place from December 2005 to July 2006.

ABBREVIATIONS

AOD	Alcohol & Drug
BDI II	Beck Depression Inventory
DHS	Department of Human Services
GPs	General Practitioners
N7	NVivo 7
SDS	Severity of Dependence Scale
SPSS	SPSS for Windows

1 BACKGROUND

There is a clear link between alcohol and other drug use and depression. It has been consistently reported that people who use alcohol and other drugs have both higher rates and more severe levels of psychological impairment than individuals who do not use drugs (Bachman & Duckworth, 2003; Brook, Brook, Zhang, Cohen, & Whiteman, 2002; Crawford, Crome, & Clancy, 2003; Lambert et al., 2005; Ortiz Fra´gola, 2006).

In the US, the Epidemiologic Catchment Area study reported that 37% of persons with an alcohol use problem and 53% of those with another drug problem had concurrently experienced a mental health disorder, most commonly depression (Reiger et al., 1990). The National Comorbidity Survey, a UK study, demonstrated that 52% of individuals with a lifetime history of alcohol abuse and 59% of those with a lifetime history of drug abuse also had a comorbid mental health disorder, most usually depression (Kessler et al., 1994). In Australia, the 1997 National Survey of Mental Health and Well-Being reported that a quarter of people with drug dependence have at least one other mental health disorder, most commonly depression (Teesson, 2000). In addition, studies have also examined the rate of substance use among people with mental health disorders. Reiger et al (1990) reported that up to a third of people with a mental health disorder in their study were also substance-dependent. In a study conducted by Virgo et al (2001), 20% of people with mental health disorders, typically depression, were also diagnosed with either substance abuse or dependence.

It is also important to note that these rates involved *diagnoses* for depression and as such, it is likely that many more users have subclinical problems, which also cause significant distress.

A number of barriers have been identified that can result in non-treatment or under-treatment of depression. Barriers can be broadly categorised as patient/client-centred, practitioner-centred, and systemic (Nutting et al., 2002; Simon, Fleck, Lucas, & Bushnell, 2004).

Patient/client-centred factors impacting on treatment access may include resistance, concerns about stigmas, medication side effects or certain demographics, such as age and gender. Practitioner-centred factors include level of training, attitudes to mental illness and clinical judgment. Systemic barriers may involve continuity of care issues, financial problems, and travel barriers (Nutting et al., 2002; Simon et al., 2004).

Barriers have also been identified in accessing substance use treatment. A qualitative study involving substance users in Victoria identified a range of treatment barriers that have some resonance with findings from research on access to mental health up (Berends & Richards, 2003). Practical and personal barriers to treatment were identified. These barriers were waiting lists, service requirements, attitudes to treatment, a lack of service information, difficulties for parents with dependents, treatment costs and beliefs about drug use and giving up (Berends & Richards, 2003).

Research into barriers to treatment has typically involved depressed individuals seeking depression- specific treatment, and substance users seeking alcohol or drug treatment. There is a lack of research that has investigated the treatment experiences of individuals who are *both* depressed and AOD users.

Mann (2003) emphasises that there is a need to identify the barriers to effective interventions in the area of comorbidity, and further, that a consumer perspective is crucial in understanding the needs of people with both AOD use and mental health problems.

Nutting et al (2002), in a practitioner-centred study on the barriers to initiating depression treatment, also identified the need to conduct patient-centred qualitative studies. Conducting research from the clients' perspective allow for insights to be gained that cannot always be measured from other perspective such as treatment providers. Such insights can assist clinicians and researchers alike to understand and develop appropriate treatment interventions and practices.

Treatment providers with knowledge and understanding of clients' experiences will be better able to engage and develop relationships with their clients.

2 AIMS OF THE STUDY

This study had 3 main aims:

1) To identify common patterns of depression treatment among a sample of people currently in treatment for their alcohol and or drug use – this could be treatment accessed as part of alcohol and drug treatment, or separately,
2) To identify the barriers to depression treatment access and utilisation as perceived by clients and
3) To investigate how people managed their depression without professional help.

Through the identification of barriers and supportive mechanisms, it is possible to make recommendations for the improvement of treatment access and service delivery. The information collected focuses on treatment-related issues from the viewpoint of those who have accessed it.

3 METHOD

3.1 DESIGN

In-depth, semi-structured interviews were conducted with 30 people currently receiving alcohol and drug treatment regarding their experiences of depression and depression treatment. The interview tool used was developed with reference to relevant research literature and previous instruments used in similar research. The tool was also reviewed by a Reference Group comprised of eight members with expertise in treatment delivery, research, and/or consumer perspectives in either the mental health or the alcohol and drug field.

Four study sites were involved. The sites were chosen to reflect four different alcohol and drug treatment types; inpatient withdrawal, residential rehabilitation, outpatient counselling and pharmacotherapy treatment.

3.2 ELIGIBILITY

There were four eligibility criteria for participation;

- Aged 18 or over
- Able to give informed consent
- Currently receiving alcohol and/or drug treatment at one of the four study sites
- Endorsement of five or more items on the depression screening instrument (see below for further information)

3.2.1 DEPRESSION SCREENING INSTRUMENT

Participation in the study was not restricted to those who had been formally diagnosed with depression. However, it was important to include only those participants who had experienced symptoms that were severe enough to suggest that the person suffered from

depression, rather than transitory feelings of sadness or loss of pleasure. A screening instrument was therefore developed based on the diagnostic criteria for depression contained within DSM-IV (see Appendix 1). Potential participants were asked to indicate the presence or absence of nine different depressive symptoms. The presence of at least five of the nine symptoms (including at least one of the first two symptoms, depressed mood and loss of interest or pleasure) for a period of at least two weeks within the last 12 months was taken to indicate the person may have had depression, and could therefore be included in the study.

3.3 INTERVIEW TOOL

The semi-structured interview tool included three sections; demographic profile, alcohol and drug use (history and treatment), and depression (history and treatment). A copy of the interview tool is in Appendix 2. Those questions intended to describe the sample (for example, demographic items) were highly structured and quantitative in nature. In contrast, those items that were intended to explore more fully the aims of the study were deliberately constructed as open questions, to encourage participant narratives. A timeline was included to assist participant recall of substance use, depression, treatment and other significant events. Two previously validated instruments were also embedded within the interview tool, the Severity of Dependence Scale (SDS) and the Beck Depression Inventory II (BDI-II).

The SDS was designed to measure severity of dependence and has been validated for use with a range of drugs. It consists of five items relating to the psychological, rather than physiological, signs of dependence. Each item is scored from 0-3, and the overall score is obtained by adding the item scores together (0-15). Different drugs have different cut-off points for dependence, but in general, higher scores reflect greater levels of dependence. For this study each person was asked to identify the *main drug* for which they were currently in treatment, and then to answer the SDS in relation to that substance.

The BDI-II is used to measure the severity of depressive symptomatology. It is comprised of 21 items that relate to DSM-IV criteria for depression, each of which are scored from 0-3. Item scores are added together to give a total score; 0–13 indicates minimal depression, 14–19 mild depression, 20–28 moderate depression and 29–63 severe depression. The BDI-II has been validated in a range of populations including substance-using populations (Dawe, Loxton, Hides, Kavanagh, & Mattick, 2002).

3.4 RECRUITMENT

The researcher visited each site prior to data collection to provide staff and, in the case of the residential sites, potential participants, with information regarding the study. Posters were used where applicable to increase awareness of the study. In some instances staff members also assisted in promoting the study. At all sites except the outpatient counselling site, people who were interested in taking part were asked to refer themselves to the researcher to be screened for eligibility. Due to time and space constraints it was necessary for participants at the outpatient-counselling site to be screened for eligibility by their counsellor prior to booking a research interview appointment.

Potential participants were given a copy of the Participant Information and Consent Form which was also verbally summarised by the researcher. Participation was completely voluntary and signed consent was sought before proceeding to interview.

All interviews were conducted at the study sites between December 2005 and March 2006. Eleven (36%) participants were recruited from a residential rehabilitation service, nine (30%) from inpatient withdrawal, five (17%) from pharmacotherapy treatment and five (17%) from an outpatient-counselling agency.

The average interview time was 80 minutes (range 48 – 123). Participants were reimbursed $50 cash or voucher for their time at the completion of the interview.

3.5 DATA MANAGEMENT

Interviews were digitally recorded and later transcribed verbatim. Text data were analysed using the qualitative analysis package NVivo 7 (QSR International Pty Ltd, 2006). Two conventional qualitative procedures were used: thematic and grounded-theory analyses. For thematic analysis, data were coded according to predesignated themes, such as the age of onset for substance use and depression, treatment barriers, and effectiveness of treatment. Grounded-theory analysis was used to capture unanticipated themes emerging from the data. Frequencies for the quantitative elements of the data such as demographic variables, current alcohol/drug dependence, and severity of depression were calculated using SPSS.

All data were stored securely in accordance standard data protection protocols.

3.6 ETHICS

The Human Research Ethics Committees of the Department of Human Services and St Vincent's Hospital Melbourne approved this study.

3.7 A NOTE ON QUALITATIVE ANALYSIS

Inductive qualitative research seeks to understand all facets of a particular issue. In this case, the responses of drug and alcohol clients currently in AOD treatment and their experience of depression. In order to achieve this, we used a qualitative method and asked many open-ended questions that elicited a lot of rich data. The main benefits of this approach are that all issues raised by respondents can be explored, even if the researchers did not anticipate them.

The qualitative themes listed in this report represent comments volunteered by a proportion of clients or indeed just one client. Where appropriate, numbers have been used to further reflect quantifiable issues e.g. numbers of clients who have been prescribed antidepressants but when talking about issues around this, it is not always suitable to calculate the number of participants giving a particular type of response. Direct participant quotes have been used to illustrate the themes under discussion.

4 FINDINGS

The results presented here are divided into a number of sections. The first section briefly characterises the study participants, including demographic information, alcohol and drug use and treatment history (including SDS data), and depression history (including BDI-II data). The remaining sections address the three study aims; identification of common patterns of depression treatment, barriers to depression treatment access and utilisation, and finally, self-management of depression.

4.1 PARTICIPANT CHARACTERISTICS

4.1.1 DEMOGRAPHIC INFORMATION

4.1.1.1 AGE AND SEX

The mean age of participants was 36 years (range 24-53), and 50% were female.

4.1.1.2 LIVING CIRCUMSTANCES

Participants were asked who they lived with (or in the case of those currently in residential treatments, who they normally lived with). As can be seen from Table 1 (overleaf), most participants usually lived with family members, most commonly their own parents.

Table 1 – People Participant Currently Lives With

	N (30)	%
Parents	10	33
Friends/housemates	5	17
Children (not partner)	5	17
Partner and children	3	10
Partner	3	10
Alone	3	10
Other relative	1	3

Most participants reported stable accommodation; with almost half the sample in owner occupied accommodation (14/47%). Another third (10/33%) were in rental accommodation, 3 participants (10%) were in public housing, 2 (7%) were in transitional housing, and one participant was staying with a friend.

4.1.1.3 EDUCATION AND EMPLOYMENT

About half the sample (14/47%) had completed year 12, a third had completed year 10 or 11 (9/30%), and the remainder had a year 9 or less education (7/23%). Of the 19 (63%) participants who had completed further education, 3 (16%) participants had completed a short course, 7 (37%) participants had completed a trade/technical course and 9 (47%) participants had completed or were currently at college/university.

Almost half the sample was unemployed (Table 2). A further third were in full or part time employment.

Table 2 – Employment Status

	N (30)	%
Unemployed	14	47
Employed – part time	5	17
Employed – full time	5	17
Home duties	3	10
Sex worker	1	3
Pensioner	1	3
Student	1	3

4.1.1.4 CULTURAL/ETHNIC IDENTITY

The majority of the sample identified themselves as Australian (27/90%), two (7%) were Greek and one (3%) was Serbian. No participants identified they spoke another language and all but one participant stated they were Australian Citizens.

4.1.2 ALCOHOL AND DRUG HISTORY (USE AND TREATMENT)

4.1.2.1 MAIN DRUG USED

Table 3 (overleaf) provides a breakdown of the *main drug* that people identified they were currently in treatment for at the time of the interview.

Table 3 – Main Drug for Which in Treatment

	N (30)	%
Alcohol	15	50
Heroin	11	37
Cannabis	3	10
Benzodiazepines	1	3

4.1.2.2 SEVERITY OF DEPENDENCE

The SDS is a five-item questionnaire designed to measure dependence. There are different cut of scores for each drug type. We asked participants to complete the SDS based on their main drug used at the time of the interview. Of our sample of participants, alcohol users had SDS score between 9 – 15, suggesting a continuum of dependence, of the heroin users all (11/37%) had a score of >5 which is indicative of dependence, all three cannabis users had a score > 3 which is indicative of dependence, the single benzodiazepine user had a score of 13, a score >6 is indicative of dependence. The SDS scores reflect that most, if not all participants were dependent on their main drug (Dawe et al., 2002; Gossop et al., 1995; Gossop, Marsden, & Stewart, 2002).

4.1.2.3 AGE OF FIRST DRUG USE, REGULAR USE, AND PROBLEMATIC USE OF MAIN DRUG

Using the timeline and recording age ranges in a table, we asked participants the age they were when they first used their *main drug*, first used that drug regularly, and first experienced problematic use of their main drug. The results are detailed below in Table 4 (overleaf).

Table 4 – Age Drug Use (Main Drug)

Age (n=30)	Mean	Median	Range
First use	15.8	15.0	11 - 33
Regular use	20.7	20.0	13 - 33
Problem use	26.1	25.0	14 -38

4.1.2.4 TREATMENT

As indicated in the recruitment section, two thirds of participants were in residential treatment at the time of interview (rehabilitation or withdrawal), and the remainder in community based treatment (counselling or pharmacotherapy).

Participants were asked to identify all the treatment episodes they had engaged in for each of the drugs they had identified as being a problem for them. However, owing to the complexity of their history, some participants were unable to distinguish between different drugs and different treatment episodes. It was therefore difficult to record the data in a consistent manner across participants. It was possible, however, to calculate the number of times that participants received treatment for the main drug they identified, as well as the age at first and last treatment attendance for the main drug identified. The details are in Table 5 below. There was a substantial gap between age at onset of drug use (15.8) and first treatment intervention (28.8). There was a two-year gap between identified problematic drug use (26.1) and first treatment intervention (28.8). The mean number of treatment episodes was 10.2 (range 1 – 56, median 7.0).

We asked participants to identify the type of treatment they had attended. It was difficult for participants to recall precisely, treatment type and number of attendances but the most

common treatment types were inpatient / outpatient withdrawal, unassisted withdrawal, outpatient AOD counselling, medication (pharmacotherapies for AOD), rehabilitation and to a lesser degree alternative therapies and self help groups.

Table 5 – Main Drug Treatment

Main Drug Treatment (n=30)	Mean	Median	Range
Age at first treatment	28.8	25.5	17 - 52
Age at last treatment	36.1	35.0	23 - 53
Number of treatment episodes	10.2	7.0	1 - 56

4.1.3 DEPRESSION HISTORY

4.1.3.1 BDI-II Scores

Table 6 illustrate the BDI-II results of participants. Most participants were moderately or severely depressed. The mean BDI-II of participants was 28.4, mode 18, and range 11-48.

Table 6 – BDI-II Scores

	N (30)	%
Minimal	4	13
Mild	6	20
Moderate	11	37
Severe	9	30

Participants were asked if they felt their BDI-II score was consistent to how they were feeling. For the majority this was indicative of how they were feeling but for a small proportion of

participants (n = 4), there had been a recent change and improvement in how they has been feeling, as the quotes below illustrate.

4.1.3.2 AGE AT FIRST EPISODE OF DEPRESSION

Participants were asked to identify the age they were when they thought they had their first episode of depression. The mean age for the first episode of depression was 17.8 (median 14.5, range 5-38).

Approximately a third of the participants (n = 11) first experienced depression in early to late childhood (5 – 11 years). Another third (n=9) spoke about experiencing their first episode of depression from early to late teenage years (13-18 years). The remaining participants (n=10) talked about episodes occurring from their early twenties into later adulthood.

> *The first time? I feel like it lasted throughout my whole childhood. You know, when I think about good memories about my childhood, I think about Christmas. Or when I was able to get away from my father and my stepmother and go to my friend's house, I felt better. I was always anxious about going home; I was always scared (#001, Female, Age 40).*

> *I was a really sad child. Looking back and remembering what depression to me, feels like, I really do feel like I had that quite young. Certainly, by 11 or 12, I was really depressed. I wouldn't speak to anyone or socialise at all (#007, Female Age 30).*

> *Well frankly I think I've been depressed since I was a baby and I know by the age of five, maybe a little younger, I was definitely depressed because I was running away from home, I hated it so much (#025, Female, Age 47).*

4.1.3.3 DURATION OF FIRST AND SUBSEQUENT EPISODES OF DEPRESSION

Participants found it difficult to identify the length of the first episode and subsequent episodes of depression. For some it was ongoing, for others episodes would vary according to variables such as AOD use and other events in their lives. A summary of these comments is illustrated in below.

> *Yeah, it lasted straight through, until I was about 23 (#011, Male, Age 25).*

> *I remember it being like maybe a fog I was going through. Something that you carry around, but you still keep trying to function (#024, Female, Age 52).*

> *There were times when it months. There were times when I couldn't be happier, but there were also times when I felt that I was breathing air that I shouldn't be breathing (#018, Male, Age 46).*

4.1.3.4 MEANING OF DEPRESSION

Three main themes emerged, when participants were asked to describe what behind depressed meant to them. For some it was a feeling of being 'heavy' and 'weighed down'. For other participants it was about a loss of something for example 'loss of meaning', 'hopelessness', 'and pointlessness'. For others it was about their actions such as not eating, sleeping, or functioning. The quotes below reflect this meaning as participants described it.

> *It feels heavy. Like anything that you think should be enjoyable, or you imagine that to be fun or exciting or nice is weighed down by something and isn't anywhere near as enjoyable as it could be. And then I'm feeling severely depressed. It's debilitating, I can't find the desire or the energy to do anything, to get up (# 007, Female, Age 30).*

Loss of meaning. Everything loses meaning. It becomes all encompassing. If it's like that now and it's lost all it's meaning, then it's going to be like that forever. And I really can't see a way around that (# 005, Male, Age 50).

Debilitating. No motivation whatsoever. Even slightly paranoid. No confidence. No energy. Didn't eat. Would go days without food. Excess of whatever I could get to take the feeling away. Tears nearly every day or more (#008, Male, Age 45).

4.1.3.5 EFFECT OF DEPRESSION

Participants were also asked to reflect on how being depressed affected them. Two themes dominated the responses; a general lack of motivation to do anything and a sense of isolation or withdrawing from the world.

WHAT HAPPENS TO YOU?
With the depression? I lose my confidence. I feel guilty. I feel helpless.
AND WHAT CHANGES DO YOU NOTICE IN YOURSELF?
I'm not doing anything. I'm not participating in what I'd normally be participating in. I'm spending a lot of time in bed. I'm not eating. I'm not answering the phone or the door. I'm checking who's there. I'm letting it go to answering machine. I'm hiding (#001, Female, Age 39).

It does change me. I withdraw, I isolate myself, don't talk to anyone, just stop believing and loose faith in myself, very critical of myself and become angry and volatile (#002, Male, Age 23).

4.1.3.6 FIRST DIAGNOSIS OF DEPRESSION

A total of 24 out of the 30 (80%) participants stated that a professional had diagnosed them with depression; four participants stated they had never been diagnosed as depressed by a professional.

4.1.3.7 OTHER MENTAL HEALTH DIAGNOSIS

In Table 8 below you can see that more participants self-identified other mental health conditions than were diagnosed professionally. While only 27% of participants had been professionally diagnosed with anxiety disorder, half the sample self identified themselves as having an anxiety disorder. Similarly, only 7% of the sample had been professionally diagnosed as having a sleep disorder, however 40% self identified as such. The mean number of self-diagnosed conditions for the sample was 1.6 and the mean number of professionally diagnosed conditions for the sample was .9.

Table 8 – Other Mental Health Conditions

Condition	Self identified		Diagnosed	
	N (30)	%	N (30)	%
Sleep disorder	12	40	2	7
Anxiety disorder	15	50	8	27
Anorexia	3	10	1	3
ADHD	2	7	3	10
Schizophrenia	1	3	3	10
Personality disorder	0	0	1	3

4.2 DEPRESSION TREATMENT

This section examines the experiences of participants who had ever received treatment for depression, including how many had been treated, expectations upon entering treatment, motivations for seeking treatment, and types of treatment.

4.2.1 NUMBER OF PARTICIPANTS RECEIVING TREATMENT

When asked about treatment for depression 24 (80%) participants stated they had received depression treatment and six (20%) of participants said they had never had treatment for depression. It is noteworthy that of the six people that stated they had never received treatment for depression, three of these participants disclosed being prescribed antidepressants. These few participants did not appear to view the prescribing of antidepressants as a form of treatment for depression.

4.2.2 MOTIVATION FOR TREATMENT

Eleven participants *specifically* commented on their motivation to seek depression treatment themselves. Others spoke about accessing treatment as a result of other routes, for example prison, or via their GP. A few had simply wanted help, for example describing how they were 'sick of being sick'. Some participants were subject to outside influences and pressures, which included AOD relapse, family pressure, prison and losing custody of children. For others, accessing treatment was not driven by internal motivations or outside pressures. They had simply presented themselves to a GP, described their feelings, and were given treatment advice and support, usually in the form of antidepressants.

> *I think I was sick of feeling the way I was. Sick of not being happy, sick of it generally (#26, Female, Age 37).*

> *The Department took custody of my son again so that would have been a motivation and I knew that, I suppose I came to terms with that there's no way that I'm going to be able to do this away from here (#001, Female, Age 39).*

> *Just probably myself. I ended up getting sick of trying to close myself off from the world. It got a bit too much (#011, male, Aged 25).*

4.2.3 EXPECTATIONS OF TREATMENT

Of those participants that spoke about their expectations of treatment, two main themes emerged. Mostly participants just did not have any expectation, this was a whole 'new world' and they just didn't know what to expect. There were a few participants, however, who did not want to have any expectations, therefore protecting themselves from potential disappointment.

I didn't know what to expect, I didn't care at that time, sort of. I just wanted to get out of where I was at (#011, Male, Age 25).

> *No I had no idea. I'd never heard about depression before. Just shit happens you know, you've gotta deal with it (# 20, Male, Age 47).*

> *No, not really I just, I never try to expect anything out of anything, I just go and see how it unfolds and if it works, good, if it doesn't, it doesn't. I don't like to have expectations because it's not what you want it to be then. You feel even more sad and depressed, whatever comes comes, whatever doesn't doesn't (#26, Female, Age 37).*

4.2.4 TYPE OF TREATMENT

Twenty participants had been treated using antidepressants; 17 participants had attended counselling for depression treatment. Issues in relation to each of these interventions are explored in more detail below.

4.2.4.1 ANTIDEPRESSANTS

A number of key themes emerged in relation to antidepressants. The strongest theme was in relation to side effects (leading to non compliance). A number of other sub themes also emerged including a fear that antidepressants were addictive, a general disbelief that they could work (especially if there was no noticeable effect), and positive experiences of

antidepressants. In this section each of these major themes & sub themes explored in more detail.

In relation to side effects, eleven participants spoke negatively about the side effects of the antidepressants they had taken.

> *I think I just got over the side effects. Feeling lethargic and tired all the time adds to my lack of motivation (003, Female, Age 32).*
>
> *I didn't like the butterflies in the stomach, it made me feel anxious. Even a bit confused. It was confusing (008, Male, Age 45).*
>
> *He (GP) got me a few different types of anti-depressants 'cause a lot of them weren't sitting right with me (011, Male, Age 25).*
>
> *Because they seem to numb everything and then I don't know what is going on, I lose track of it (012, Male, Age49).*
>
> *One of them made me couldn't sleep, like my heart beat fast, it was like being on speed a little bit. Um, another one made me nauseous, I think the other one made me sleepy (023, Male, Age 27).*

As a result of the side effects, a few participants simply would stop taking them.

> *I've tried a couple of them over the years, since about 2002ish. But they all had ill side effects and I didn't like the way they made me feel, so I had to stop taking them (023, Male, Age 27).*

Another theme to emerge was a general disbelief that antidepressants could work. Six participants spoke about this theme. One participant below describes her most recent

experience of discontinuing antidepressants because she didn't feel any benefit from taking them.

I did, but I didn't stay on them for very long at all.

BECAUSE...? I couldn't feel any benefits and also the last time that I had a go I started drinking again and obviously just stopped taking them...

She goes on to talk about her other experiences.

First time because it wasn't working and I couldn't see the need but as I said, I'd been on them 10 days. Second time was because of drinking and the third one was because of side effects (025, Female, Age 47).

Other participants just didn't believe in or didn't think that antidepressants could help them.

Um, I haven't really found any of those type of medications effective, you know, I honestly steer clear of them, unless I really have to (012, Male, Age 49).

The major impact was just my total disbelief that it would work. So I'd be prescribed medication, I would leave the chemist and I'd just throw them in the corner. I might take one or two or three and just leave the rest. I just didn't believe they worked (005, Male, Age 50).

Generally, participants seemed not to have a clear understanding of how antidepressants worked. For example, if they didn't notice immediate changes in their mood they would just stop taking them.

Only two participants spoke about the positive impact of antidepressants and felt they had benefited from taking them. One of these participants went on to describe how it was combination of no AOD use, counselling and being on the correct medication that had made an impact on her depression, as she had in the past had negative experience with antidepressants.

As for overall depression, probably in the last two months, I've noticed a significant shift to where I used to be and this is probably the first time I've felt a bit more positive since I was fifteen. So it's probably a combination of not drinking, the sort of counselling I've been doing, and the medication having a chance to work (#004, Female, Aged 30).

4.2.4.2 COUNSELLING

A wide range of experiences of counselling was reported. In many cases it was difficult for participants to differentiate between counselling for alcohol and drug use and counselling for depression, as both issues may have been addressed. Many participants also had difficulty in recalling exactly when and where they had received counselling. Participants reported seeing a wide range of professions including psychiatrists, psychologists, AOD workers and social workers. As a consequence, it was difficult in some cases to accurately complete the depression treatment timeline for counselling. There were three main themes that emerged in relation the experience of counselling for depression treatment; positive and negative experience of counselling itself, the issue of having to 're-tell' your story over and over again, and the need to 'find the right counsellor'. Each of these themes is further explored below.

Participants reported a range of positive and negative experiences of the counselling process itself. The following is an extract where one participant was talking about a positive experience of counselling in contrast to previous negative experiences.

WHAT WAS GOOD ABOUT HER? WHAT WAS DIFFERENT?

Just her approach and everything, the way, like, the issues that were real bad for me … we got to them, she wouldn't just sit there and listen 'til I finished. As soon as she'd seen that something really troubled me, as I was about to start saying it, she would pause me and say 'let's work around what you said just then'. And we would sit down and draw out a plan. Just work on it and see why, make up a few different things, just why and that. Just everything. She is a good listener, very positive comments and feedback.

AND THAT WAS DIFFERENT TO YOUR PREVIOUS?

Yes, a lot of the others would just listen and say "why, why, why?" They would want me to… we used to go pretty deep, pretty hard, pretty quick. Used to get pretty frustrated with it because they never made you feel like you were … There were never ways that they would work on to try and calm yourself down. It was just like, 'tell me more, tell me more'. By the time you were finished, you would just want to run out of there and either hurt yourself or do drugs or something (011, Male, Age 25).

And I've just found it a lot of those people … ok, one woman I thought she had a condescending attitude and she was as dry as anything. She had nothing going for her for me. The other guy was light hearted and I thought he was a bit of a dill. He was a nice enough person but you've got to be on the same level. That's what it is about. You've got to have someone who understands where you are coming from at the same level. That's what it is. That's one way I can put it (024, Female, Age 24).

The strongest theme to emerge from participants was that they had to 'find the right counsellor' in order for the counselling to be a success. They indicated that the counsellor needed to have empathy and a complete understanding of AOD issues as well as depression.

Yeah, some kind of understanding. I hate it when a counsellor turns around to you and says, 'look, I don't understand, what do you mean?' They are constantly saying it. It feels like you are getting nowhere and you have been talking to them for so long and it just snaps you eventually, just gets to you. It doesn't have to be someone who has done drugs or anything, but someone who understands where you are coming from, it makes it a lot easier (011, Male, Age 25).

With (name of counsellor), I think it's worked because I'm on the antidepressants. I've resigned myself to the fact that I'm a depressant alcoholic. But with (name of counsellor) in general I think it's just her nature. Just her approach as I said before to her clients, her genuineness to her clients. It's not like, oh well, you're here, tell me, get out. You can see it in her face. She doesn't judge, she guides you. She looks at you as if to say well, you're my priority, right here, right now, you're my number one (026, Female, Age 37).

He (counsellor) has had a little bit of experience, his brother has been involved in drugs and he has had it touch his life personally. So without having a habit he has got a pretty good understanding of … you know, he's on our side.
IS THAT IMPORTANT?
Totally. You don't want to be sitting across from some old, 60 year old man who has just read about marijuana in a book once and now he is judging you on a list of holier than thou. I mean he is right on your level (023, Male, Age 27).

In comparing the two treatment options for depression, pharmacotherapies and counselling, a greater proportion of participants spoke positively about the impact counselling had made on them as compared to antidepressants. The most important factor in this process was getting the 'right counsellor'.

4.2.5 RELATIONSHIP BETWEEN DEPRESSION AND AOD USE

The impact of alcohol and drug use on depression was described by one participant as a "chicken and the egg" scenario, at times it was difficult to know what came first the alcohol and drug use or the depression. However, if the first episode of depression (mean, 18 years) is compared with first AOD use (mean, 16 years) (Figure 1 overleaf) in the most of cases the AOD preceded the first episode of depression. However, the mean age of *regula*r alcohol and drug use (21 years) and *problematic* use (26 years) both occur after the first depressive episode (an age comparison for first depression treatment is not included as there too much missing data from the timeline).

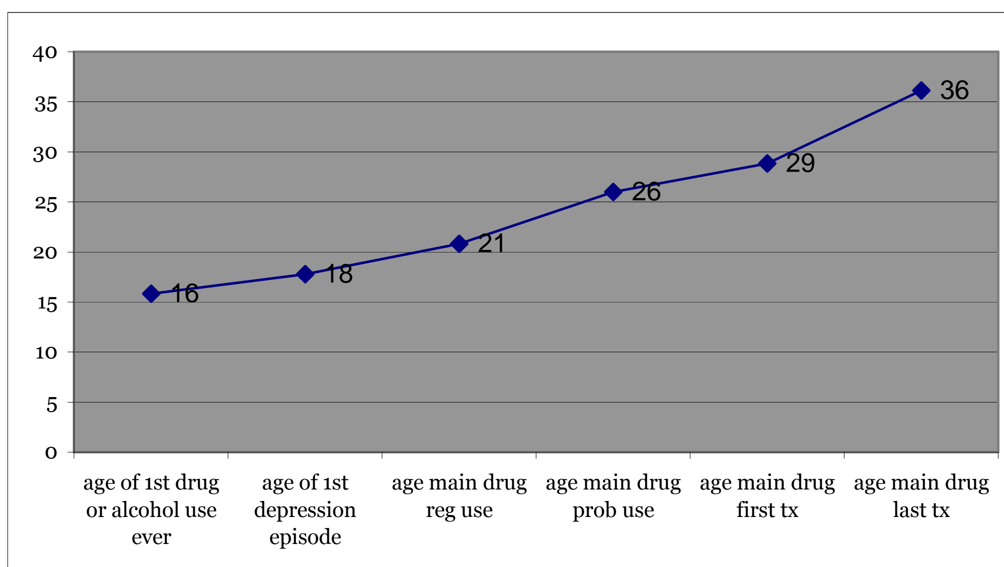

Figure 1 – Development over time of AOD use and 1st Depressive Episode

The qualitative data illustrates how, as a result of continued alcohol and drug use, some respondents overlooked their depression.

> *And I guess the other significant barriers are that it's been covered over by something that is a lot more black and white, drinking and taking drugs and you can easily be more focussed on that, and the rest gets ignored. That would be what happened (#005, Male, Age 50).*

4.3 BARRIERS TO DEPRESSION TREATMENT

This section examines barriers to treatment experienced by those participants who had actually sought treatment for their depression, and then the barriers identified by participants who had never received depression treatment.

4.3.1 BARRIERS AMONG PARTICIPANTS WHO HAD PREVIOUSLY SOUGHT DEPRESSION TREATMENT

Barriers identified as an obstacle to depression treatment included continued alcohol and drug use, a lack of knowledge of where to access help, waiting lists, and reluctance to acknowledge that depression might be a problem.

4.3.1.1 CONTINUED ALCOHOL AND DRUG USE

A few participants talked about how continued alcohol and drug use would use would allow them to avoid dealing with depression, this collusion allowed them to not recognise that underneath their continued AOD was a depression problem.

> *SO YOU KNEW THAT THE DEPRESSION WAS THERE, YOU KNEW THE ALCOHOL WAS PART OF THE COVER UP?*
>
> *Yes. Which became a problem in itself.*
>
> *AND YOU DIDN'T RECOGNISE THAT STRAIGHT AWAY?*
>
> *No. And I don't think I wanted to recognise that it was a problem either.*
>
> *DO YOU THINK YOU KNEW THAT THE DEPRESSION WAS THE UNDERLYING THING?*
>
> *Yeah, because I've had it for most of my life. I think I originally started drinking to try and block out emotions and that sort of thing. And it became more of a dependence and abuse problem.*

4.3.1.2 LACK OF KNOWLEDGE

A few participants talked about how they had no idea where or how to access depression treatment. This lack of knowledge of treatment interventions, where to access help, and the role of antidepressants in treatment suggests that current health promotion strategies and other messages are not reaching this more vulnerable group.

4.3.1.3 WAITING LISTS AND ACCESSIBILITY

Another difficulty with access to treatment was waiting times and waiting lists and not being able to contact counsellors or other professionals when they were most needed.

> *I suppose I have been lucky that I have had, over the years, a couple of good counsellors. But the problem with counsellors, because nine times out of ten I just end up using my GP or pharmacist because it is really hard to get them (counsellors), and find them and you ring up and you want to see them, and it is, oh, three months down the line and it's too late then (012, Male, Age 49).*

4.3.1.4 DENIAL OF PROBLEM

A few participants found that they were not willing to acknowledge that they might have a problem with depression.

> *Once again, probably a bit of denial. And other things got in the way, laziness possibly (#008, Male, Aged 45).*

4.3.2 BARRIERS AMONG PARTICIPANTS WHO HAD NEVER SOUGHT DEPRESSION TREATMENT

Among the six participants who had never received depression treatment, there were three themes identified as barriers to treatment access: lack of awareness that depression was a problem, fear of taking antidepressants, and being too depressed to attend for treatment.

4.3.2.1 LACK OF AWARENESS

For some participants, while they knew there was something amiss, they were not aware that they were experiencing symptoms of depression.

> *CAN YOU DESCRIBE WHAT THOSE BARRIERS MIGHT BE IN YOUR HEAD?*
>
> *I don't believe it was something that I was aware of. I always had inklings or feelings that I could tell other people relaxed more around each other than I did, and interacted more freely and enjoyed, stopped to enjoy things that they were sort of doing but, yeah, I just felt*

uncomfortable to sit in the one spot for five seconds so I couldn't grasp how that was done. And I certainly couldn't achieve doing it myself (#10, Female, Aged 27).

4.3.2.2 FEAR OF TAKING ANTIDEPRESSANTS

A few participants spoke about a fear that antidepressants would be addictive and therefore they weren't prepared to risk taking them.

> *Well because I've heard that they can become addictive, and I thought I don't need them, I'll fight it and I'll do it myself. I talked to my Mrs about it and she said no, don't take them, so we both agreed (#013, Male, Age 35).*

4.3.2.3 TOO DEPRESSED

One participant described herself as being so depressed that she just wasn't able to access treatment, despite efforts by her family to get help.

> WHY DID YOU THINK YOU NEEDED HELP AT THAT POINT?
>
> *Because I knew how depressed I was, I just knew that I wasn't living, that's not living, just existing.*
>
> *WHY DIDN'T YOU TAKE THAT FURTHER AND DO SOMETHING?*
>
> *Because I was just so depressed. My Mum booked for me to see counsellors but I never went. And I just never did anything about it.*
>
> *WHAT GOT IN THE WAY DO YOU THINK? WHAT STOPPED YOU FROM SEEING THE COUNSELLORS?*
>
> *The depression. That's me. I didn't even go to my Grandma's funeral; I was just so selfishly depressed.*
>
> *DO YOU THINK THERE WAS SOMETHING THAT COULD HAVE HELPED YOU TAKE THE STEP?*
>
> *If I was getting the … I need the professional help, I need the tools, to be given the tools to know what to do. Because I don't, you know, I don't know how to…and, obviously, coming to rehab is going to force me to interact with other people, and I love other people, and work a bit and just get things done (#019, Female, age 27).*

4.4 SELF-MANAGEMENT OF DEPRESSION

4.4.1 NEGATIVE SELF MANAGEMENT STRATEGIES

4.4.1.1 SELF- MEDICATING

There were a small number of participants (n = 5) that talked about 'self-medicating' to cope with their feelings of depression. There was also an acknowledgement that this would in fact make their depression worse.

> *I suppose I used it in some ways as self-medicating (#004, Female, Age 30).*
>
> *SO IS YOUR GOAL WHEN YOU'RE DRINKING TO SELF-MEDICATE?*
>
> *Yes, the goal when I drink is to self medicate myself and to forget about things and to sleep and because of pure boredom. Boredom is my biggest enemy (#022, Male, Age 25).*

Other participants talked about using AOD to cope with feelings of depression but not articulate the action of self-medicating. Although this could be considered essentially the same thing, those that defined as 'self medicating' were very much aware on a conscious level that this is what they were doing in lieu of treatment, whereas those participants who just used AOD when they had bad feelings were perhaps not aware of this process on such a conscious level. The actual use of the language, as 'self- medicating', distinguished the two groups.

> *What motivation I do have, I lose. In the past, I'd drink more. Don't want to be around people. More teary. And I look it as well. Look depressed. Not excited about anything, not happy. I think I used alcohol to try and not feel how I was feeling (#004, Female, Age 29).*

One participant who had been prescribed antidepressants for many years, had developed his own coping mechanism, he would recognise when feelings were developing he would simply

remove himself from, access professional support if possible and if that didn't work he would simply 'knock himself out'.

> *WHAT IS IT THAT WORKS? WHAT ARE THE STRATEGIES THERE THAT WORK FOR YOU?*
>
> *Umm, the strategies are by usually going to see someone, a professional, and talking about it. And removing myself from the situation. Those are the two things that do the best.*
>
> *SO SHUT YOURSELF AWAY?*
>
> *Yeah.*
>
> *AND WHEN YOU SAY KNOCK YOURSELF OUT, DO YOU TAKE SOMETHING TO DO THAT OR JUST LOCKING YOURSELF AWAY IN A PHYSICAL SENSE FROM THE WORLD? WHAT DO YOU MEAN BY THAT?*
>
> *Yes, in a physical sense, but also with the help of sleeping tablets as well (#012, Male, Age 49).*

Of those participants that had never attended for depression treatment, self-management techniques were similar but not always as successful as detailed by one participant below.

> *YOU SAID BEFORE YOU HAD TALKED TO FRIENDS AND FAMILY AND TRIED MASSAGE, ETC? IN TERMS OF MANAGING THE DEPRESSION, OF ALL THESE THINGS, WHAT WAS USEFUL?*
>
> *None of them. A lot of stuff, a lot of feedback I got on an intellectual, logical level but I was never open to the shift within me and didn't know how to be. And the big one for me growing up was I hated to say 'I don't know', so I would always rationalise it one way or the other and put up barrier after barrier and could never throw my hands up in the air and say 'I need help'. (#10, Female, Age 27).*

4.4.2 POSITIVE SELF MANAGEMENT STRATEGIES

A few participants had managed to cope with their feelings of depression as a result of either developing their own copings skills, or as a result of counselling or other supports and had

developed a range a positive strategies that included self talk, doing something new, keeping busy and linking in with family, as illustrated by the quotes below.

> *I talk to my family. They don't really understand because they don't... I talk to myself. I read books; I research it (depression) (#13, Male, Aged 35).*

> *There was one brief technique I used to try and get to sleep, breathing technique for stress, a grounding technique to try and sit still even though I was feeling really uptight and stressed and uncomfortable, to try and ride it through. Nutrition, exercise, talking about that, strategies to get yourself out of the house, all sorts of strategies (#25, Female, Age 47).*

> *DID YOU TALK (TO AOD WORKER) ABOUT WAYS TO COPE WITH THAT OR STRATEGIES?*
> *Yep and I guess that's why I went out and got my coaching position and started doing things for myself.*
> *HOW HAS THAT HELPED YOUR DEPRESSION?*
> *It's helped a lot. It's started to give me confidence again in myself (#030, Male, Age 24).*

> *My Mrs said try these things. Try and see how you go, go for a walk, if you're starting to feel down, play with the little one or go outside, do something, clean the car, clean the house. And it's been working, it's been good...Well basically keep yourself occupied, if you're in a position where you can do something and you start to feel down or something I'll go and see what my son is doing, play with him, go outside, do some gardening, do something, change my mood, totally (013, Male, Age 35).*

> *With me, my little nurturing things, the only things I've got left (Female, Age 52).*

5 SUMMARY & CONCLUSIONS

People with serious AOD use can find it difficult to access mainstream services. This can present a major barrier to them receiving primary health and other care. Thirty people currently accessing AOD treatment provided insights into their experience of depression, including treatment, barriers to treatment and self-management.

The sample was mainly substance dependent with a history of repeated AOD treatment episodes. Most had first experienced depression in their late teens and were at least moderately depressed at the time of interview. Participants found depression to be debilitating by decreasing their level of motivation and by increasing their isolation.

There was an average gap of approximately 8 years between first regular drug use and first AOD treatment, and 11 years between first depressive episode and first attending for AOD treatment. As a result depressive symptoms had the potential to manifest themselves in a far more serious presentation by the time people sought treatment for AOD issues.

The majority of the sample had previously been treated for depression with antidepressant medication and/or counselling. Experiences of antidepressant medication were mainly negative, particularly due to side effects. However, perceptions about the efficacy of antidepressant medications may also have been influenced by not taking the medications correctly. Mixed reports were forthcoming about the experience of counselling, with the key factor in positive treatment experiences appearing to be finding the 'right' counsellor. It therefore appears that positive engagement with the service provider is crucial to this group of clients. While this was noted in relation to counselling, it is possible that an improved therapeutic alliance may also be useful in pharmacological treatment by allowing some of the concerns raised regarding antidepressant medications to be better addressed. Consideration

needs to be given to how this might be achieved in the context of different service provider/client relationships (for example, GPs prescribing medication generally have shorter appointment times available than counsellors).

Barriers to treatment access were experienced by both those who had accessed treatment and those who had not accessed treatment. These barriers were complex and compounded by continued AOD use. Key issues identified were lack of awareness of treatment options, negative perceptions of available treatments, problems with treatment accessibility, denying the problem, and being too ill to attend treatment. This suggests that greater information needs to be made available to AOD users who may have depression about the condition and the costs and benefits of available treatments. Given the high level of AOD treatment utilisation among this group, the most efficient way of targeting information may be via AOD treatment services. Many participants suggested that their depression and AOD issues were intertwined, a finding which is relevant to the debate about the preferability of separate versus combined treatment approaches for comorbidity.

Both positive and negative self management strategies were identified. A less helpful strategy identified by many participants was the use of AOD to self medicate and cope with feelings of depression. For some people this was a conscious process, but for others it was not. Positive strategies appeared to involve distraction from feelings of depression via self-talk, engaging in other activities and so on. In some cases these strategies had been learned with the assistance of a counsellor, although not always. These findings suggest that when working with clients with comorbid depression and AOD use, the relationship between substance use and mood regulation should be specifically explored to allow the person to more fully recognise their current coping strategies, and to experiment with alternative strategies which have less harmful consequences than problematic AOD use.

5.1 LIMITATIONS OF THE STUDY

A limitation of the study was the convenience sampling that was used. Nonetheless, the results provide a valuable insight into the experiences of depression among this sample of AOD users. Due to space constraints, the timeline tool was not used to full effect in some locations. In such circumstances the questions were answered in a more traditional 1:1 setting and the interview digitally recorded and transcribed verbatim for later analyses. While the timeline tool was successful means of engagement, those interviews conducted without it yielded ample data.

6 RECOMMENDATIONS

RECOMMENDATION 1:

Experience of depression treatment were mostly negative, compliance with medication was extremely poor.

Education messages about effective treatment & effective treatment engagement are needed to target this population specifically. Working with GP and other community health centres could facilitate this process.

RECOMMENDATION 2:

Of the two treatment responses counselling and pharmacotherapies, counselling was viewed more favourably, there was positive experiences of counselling, but this was very dependent on the type of counsellor.

Further investigation into the role of therapeutic alliance in a comorbidity setting with this population is needed as well as the type of intervention that is useful and effective eg CBT

RECOMMENDATION 3:

Despite health promotion and other messages about access to services, AOD users are still not aware of where and how to access treatment.

Information needs to be user friendly and accessible to this population.

Where do people currently access information?

This is something that could further investigated, with a view to facilitating access to accurate consumer information (for example websites such as BeyondBlue, Blue Pages, etc).

RECOMMENDATION 4:

While a small proportion of participants utilised other strategies to cope with depression, there use was sporadic and haphazard and not always effective.

AOD workers and other health professionals can support AOD users to manage their depression by identifying it as a treatment issue and by exploring strategies that are meaningful to the client. This could be done through individual treatment plans.

RECOMMENDATION 5:

Participants' first depressive episode preceded problematic drug use, therefore once attending AOD treatment, depression had already manifested itself.

AOD workers and other health professionals need to be aware of this and explore with clients. This could be done through individual treatment plans

APPENDIX

Appendix 1 – Interview Guide

Interviewer	|___|___|	Date	|___|___| / |___|___| / |___|___|___|___|
Circle one:	Counselling / Pharmacotherapy / Withdrawal / Rehabilitation		
Participant number	|___|___|___|___|	Duration interview	|___|___|___| minutes

SECTION A - DEMOGRAPHIC INFORMATION

A1 0 Female 1 Male 2 Transgender

A2 DOB ___/___/___

A3 Current suburb ______________________

A4 Who do you currently live with? (or usually live with, if in residential treatment)

1	Housemates/Friends	5	Alone
2	Parents	6	With children (not partner)
3	Spouse/partner	7	Other relative(s)
4	Spouse/partner and children	8	Other (please specify) __________

A5 What is your current accommodation? (or usual accom, if in residential treatment)

1	Owner occupied	4	No fixed abode/homeless
2	Rental property	5	Other (please specify) __________
3	Refuge/shelter/hostel		

A6 What was your highest year of school completed? Year/Form ______

A7 Have you completed any further education since school?

0 No

1 Yes, short courses only (e.g. Centrelink, hospitality courses, etc)

2 Yes, trade/technical

3 Yes, university/college

A8 What is your current employment status?

1 Unemployed

2 Pensioner (specify) __________

3 Home duties

4 Student

5 Part time/Casually employed

6 Full time employed

7 Other (please specify) __________

A9 What is the main language you speak at home?

0 English

1 Other (please specify) ________________

A10 What cultural or ethnic background you identify with? (e.g. Aboriginal or Torres Strait Islander, Vietnamese-Australian, Italian-Australian)

0 Australian

1 Other (please specify) ________________

A11 What is your citizenship status?

0 Australian citizen

1 Other (please specify, e.g. permanent resident, TPV, etc) ________________

SECTION B – SUBSTANCE USE AND TREATMENT

In this section we are going to talk about your substance use, and also what alcohol and/or drug treatment you have ever had.

B1 What would you say is the main substance you are in treatment for at the moment?

____

B2 Severity of Dependence Scale (SDS)

Thinking about the main substance you are in treatment for; in the last 12 months:

(1) Did you ever think your use of (drug) was out of control?

Never/almost never	*Sometimes*	*Often*	*Always/nearly always*
☐	☐	☐	☐

(2) In the last 12 months, did the prospect of missing a hit/dose/drink make you very anxious or worried?

Never/almost never	*Sometimes*	*Often*	*Always/nearly always*
☐	☐	☐	☐

(3) How much did you worry about your use of (drug)?

Not at all	*A little*	*Quite a lot*	*A great deal*
☐	☐	☐	☐

(4) Did you wish you could stop?

Never/almost never	*Sometimes*	*Often*	*Always/nearly always*
☐	☐	☐	☐

(5) How difficult did you find it to stop or go without (drug)?

Not difficult	*Quite difficult*	*Very Difficult*	*Impossible*
☐	☐	☐	☐

I would like you to tell me some more about your history of substance use, and substance use treatment. For the next few questions we will use a timeline to show how your story unfolded (show timeline). It doesn't matter if it gets a bit messy looking or we need more than one sheet.

B3 Thinking back as far as you have been using any alcohol or drugs, which of the following substances have you used the most over your life? Which have caused you the most problems? (i.e. we are interested in the substances that are most significant, not those you have only used very occasionally)

Drug Type	Most used	Most problems
Heroin and other opiates *(H, smack, hammer)*		
Alcohol		
Cannabis *(Grass pot, marijuana, weed)*		
Amphetamines and other stimulants *(Speed, goey, whiz)*		
Ecstasy *(E, MDMA)*		
Hallucinogens *(Acid, trips, LSD)*		
Inhalants *(Amyl nitrate glue, petrol, paint, aerosols)*		
Benzodiazepines and other tranquilisers *(Xanax, valium, serepax)*		
Other (specify)		

B4 For each of these you have selected, how old do you think you were when: *(note - start with first used drug)*

a. You first ever used that drug?

b. You first started to use it regularly?

c. You first started to think it might be a problem for you?

d. You first sought help for that drug? (if applicable)

e. You last sought help for that drug? (if applicable) MARK ON TIMELINE

B5 For each of the drugs you have selected as being a problem, I would like to know about the types of help have you sought (e.g. counselling, pharmacotherapy, self help, etc) and how many times you have ever tried that treatment. This includes any treatment you are currently having.

I am going to use both this table and the timeline to write down your answers. We can work through this section in the order that things happened, or by the drug type involved, whichever is easiest for you (add more columns as necessary).

Treatment			
(fill in drug type for each column)			
Methadone maintenance			
Naltrexone maintenance treatment			
Other maintenance treatment (eg. Buprenorphine, *specify*)			
Outpatient detox (e.g. with GP, A&D agency, home based, *specify*)			
Inpatient detox			
Rapid opiate detox using Naltrexone			
Unassisted withdrawal/cold turkey (with or without medication)			
Outpatient counselling (not as part of other listed treatment)			
Residential rehabilitation (e.g. TC)			
Medication (e.g. Antabuse, Campral, *specify*)			
Self-help (e.g. A.A., N.A., *specify*)			
Outreach			
Supported accommodation			
Day programs			
Alternative medicines/treatments (e.g. herbal, acupuncture, hypnosis)			
Other (*specify*)			

SECTION C – DEPRESSION

In this section we are going to talk about thoughts and feelings of depression.

C1 Beck Depression Inventory-II

In answering these questions please:

- Read each group of statements
- Think about the way you have been feeling the last two weeks, including today
- Pick out the statement that best describes how you have been feeling

Complete BDI-II form and calculate score	
0-13	minimal
14-19	mild
20-28	moderate
29-63	severe
Check consistent with BDI-FastScreen rating	

C2 Your score is consistent with someone who is currently showing symptoms of mild/moderate/severe depression (If < mild - ? eligibility). Does that sound about right to you? Explore why/why not.

As we did for your substance use, I am going to ask you a bit more about feeling depressed, and any treatment you might have had for depression. Again, we will use the timeline to help organise your story into order. MARK RELEVANT ANSWERS ON TIMELINE

C3 Thinking back as far as you can remember:

a. About how old were you the first time you ever had a period of feeling sad, empty, or depressed that lasted for at least two weeks?

b. How long did those feelings last for?

c. Have you had other periods since then when you have felt sad, empty, or depressed that lasted for at least two weeks? When were they? How long did they last for?

d. Can you describe what feeling depressed means to you? What changes do you notice? How do these affect you?

e. Has a professional (such as a doctor or counsellor) ever told you that you have depression? When did that happen? Who told you?

f. I am going to show you/read out a list of conditions. Please tell me if you think you have ever had any of them (let me know if you want me to explain any of them). Also, has a professional such as a doctor or counsellor ever told you have any of these conditions?

Condition	I think I have/had this condition	A professional has told me I have/had this condition	Type of professional (e.g. GP, psychiatrist, counsellor)
Bipolar disorder			
Dysthymia			
Post natal depression			
Panic Disorder			
Posttraumatic stress disorder			
Generalised anxiety disorder			
Phobia (specify whether social, specific, agoraphobia)			
Generalised anxiety disorder			
Schizophrenia or psychosis (if psychosis, substance induced?)			
Sleep disorder			
Anorexia nervosa			
Bulimia nervosa			
Attention deficit/hyperactivity disorder			
Learning disorder			
Personality disorder (specify type)			

g. Thinking about depression again; have you ever-sought treatment, support, or help from a professional for depression? This could include things like talking to your doctor about it, taking antidepressant medication, or seeing a counsellor (If yes, go to C4. If no, go to C5)

C4 If you have sought treatment, support or help for depression: MARK RELEVANT ANSWERS ON TIMELINE

a. When did you first seek treatment, support or help for depression?

b. What/who motivated you to seek treatment, support or help at that time? How did you find out about it?

c. What were your expectations of the treatment, support or help that you sought?

d. Can you tell me some more about the treatment you had at that time? *(Prompts: type [e.g. medication, counselling, etc], benefits, costs, side effects, how useful, why finished treatment)*

e. Since that first time, what other depression treatments have you tried? *(Prompts: type [e.g. medication, counselling, etc], benefits, costs, side effects, how useful, why finished treatment)*

f. Of all the depression treatments you have had, which was the most helpful? The least helpful? Explore.

g. Have you ever had trouble accessing depression treatment when you have wanted it, or avoided seeking treatment when you think you may have needed it? What kinds of things got in the way? *(Prompts: personal, interpersonal, organisational, social and other barriers)*

h. *(If not already clear from above information)* Has your alcohol and drug treatment ever addressed your feelings of depression? Has your alcohol and drug treatment ever helped improve your feelings of depression? Made them worse? (And vice versa, has depression treatment ever helped you with your alcohol and drug use? Made it worse?)

i. As a person with depression who also uses alcohol/drugs, do you think people in your situation face any special issues in getting help for depression? Explore.

j. What impact does your alcohol and drug use have on feeling sad, empty or depressed? (And vice versa, does feeling sad, empty and depressed influence your alcohol and drug use? If so, how?)

k. Aside from formal treatment, what other types of things (if any) have you ever tried to help manage your depression? *(Prompts: talk to friends/family, other types of activity/alternative treatments not already covered [e.g. yoga, herbal remedies], self talk, exercise, etc)*

l. Of all these other things you have tried, which was the most helpful? The least helpful? Explore.

m. Ideally, what do you think would be a good treatment response for people who have both depression and alcohol and drug problems? *(Prompts: delivered in same setting/different setting, concurrent/sequential)*

C5 If you have NOT sought treatment, support or help for depression:

a. Have you ever thought about seeking treatment, support or help because you have felt sad, empty or depressed? Explore.

b. If so, what motivated you to think about getting help?

c. Have you ever had trouble getting help to deal with feelings of depression when you have wanted it, or avoided seeking treatment when you think you may have needed it? What kinds of things got in the way? *(Prompts: personal, interpersonal, organisational, social and other barriers)*

d. Do you think there might be any benefit to you in having depression treatment? What factors would make you decide to get help? *(Prompts: personal, interpersonal, organisational, social and other factors)*

e. Has your alcohol and drug treatment ever addressed your feelings of depression? Has your alcohol and drug treatment ever helped improve your feelings of depression? Made them worse? Explore.

f. As a person who has feelings of depression and who also uses alcohol/drugs, do you think people in your situation face any special issues in getting help for depression? Explore.

g. What impact does your alcohol and drug use have on feeling sad, empty or depressed? (And vice versa, does feeling sad, empty and depressed influence your alcohol and drug use? If so, how?)

h. What types of things (if any) have you ever tried to do to manage your feelings of depression? *(Prompts: talk to friends/family, other types of activity/alternative treatments not already covered [e.g. yoga, herbal remedies], self talk, exercise, etc)*

i. Of all these things you have tried, which was the most helpful? The least helpful? Explore.

j. Ideally, what do you think would be a good treatment response for people who have both depression and alcohol and drug problems? *(Prompts: delivered in same setting/different setting, concurrent/sequential)*

Timeline	Current age □□
Alcohol and drug use	
Alcohol and drug treatment	
Depression	
Depression treatment	
Other milestones (e.g. finished school, travel, relationships)	

Appendix 2 – Contract Report

1 A comparison between the achieved outcomes of the project against the objectives;

The objectives of the proposed study were to:

- *Identify common patterns of depression treatment among sample of alcohol/illicit drug users.*
- *To examine attempts at self-management of depression by a sample of alcohol or illicit drug users.*
- *To identify the major barriers to treatment service access and utilisation by this group.*

2 Recommendations on how any objectives that were not achieved could be achieved in the future;

All objectives were achieved.

3 Any statistics collected in the course of the project;

Only a small number of demographic statistical and some clinical measure were collected and have been fully described in the report.

4 A complete copy of the register of all assets.

Not applicable

5 A **statement of compliance** by the participant, certified as correct by the participant's liaison officer certifying whether the participant has applied the funds strictly in accordance with this agreement; and

See Attached

6 A **financial statement** specifying the manner in which, and the purposes for which, any funds paid by beyondblue under this agreement have been expended and accompanied by supporting documentation.

See Attached

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