Barriers to Psychological Treatment for Mental Illness Among People Who Use Illicit Drugs

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Statement

I declare that this research report is my own work and that, to the best of my knowledge and belief, does not contain material from published sources without proper acknowledgment, nor does it contain material which has been accepted for the award of any other higher degree or graduate diploma in any university.

Rachael Beckley – Author

Date: 4 August 2021

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Abstract

The connection between illicit drug use and mental health is well understood, however, individuals who use illicit drugs seek professional help for their mental health at a lower rate than the general population. The aims of this study were to identify if people who use illicit drugs seek psychological help and subsequently explore the barriers experienced. The outcomes of the study were then used to provide recommendations to psychological services to improve access and satisfaction. Australians (n=140) aged 18 or above, all who had used an illicit drug in the past 12 months and reported concerns about their mental health completed an online survey addressing their experiences with psychological services and the aspects of psychological services that they were satisfied with or dissatisfied with. Participants responded to a series of statements addressing barriers to seeking and accessing psychological services and recommendations to assist in improving them. Survey results were analysed using descriptive statistics. Respondents identified that structural barriers of cost and availability were the most problematic. This was followed by personal barriers including mental health preventing attendance, previous poor experiences and perceived judgements of psychologists. In addition, participants reported feeling stigmatised due to their illicit drug use. Findings indicate the need for increasing education of psychologists regarding illicit drugs and the interaction with mental health problems or symptoms. Further, findings suggest recommendations for increasing education for people who use illicit drugs about psychology and psychotherapy, specifically informed consent, confidentiality, and the differences between mental health providers.

Keywords: illicit drugs, barriers, psychology, mental health, treatment

Barriers to Psychological Treatment for Mental Illness Among People Who Use Illicit Drugs

In 2019, the Australian Institute of Health and Welfare (AIHW) (AIHW, 2020b) reported that 9 million Australians 14 years or older had used an illicit drug in their lifetime and 3.4 million had used illicit drugs in the preceding 12 months. Among those who use illicit drugs, there is greater rates of psychological distress and mental illness, specifically mood disorders and generalised anxiety, compared with the general Australian population (Kingston et al., 2017). Individuals who use illicit drugs may seek help for illicit drug use, symptoms related to illicit drug use, or psychological distress. However, individuals who use illicit drugs are less likely to seek psychological help than the general population (Kingston et al., 2017).

Unfortunately, with the specific demographic population being studied, we do not fully understand the barriers preventing mental health treatment. People who seek drug treatment experience personal barriers including negative attitudes towards treatment and beliefs that they do not need help with their illicit drug use, as well as barriers associated with gender, age, alternative support structures and structural barriers including transport availability, location of services and service proximity to police (Holt et al., 2007). No currently available research has focused on barriers specific to seeking or accessing psychological services. Consequently, further research in this field aims to assist in increasing accessibility and desire to access suitable services.

For all individuals, motivational factors to seeking help differ. Understanding this will help to address barriers and make effective recommendations. This study also interested in identifying negative experiences that people have had when attending a psychologist and the drivers of negative experiences. Knowledge of these

factors would allow us to understand barriers that exist not only in seeking and accessing psychological treatments among people who use illicit drugs, but to also identify barriers to continued treatment, and those factors that would increase attendance and positive experiences. This gap is critical to address to reduce the distress faced by individuals and assist in decreasing the daily burden of disease resulting from mental illness and illicit drug use.

Mental Health

Mental illness or mental disorder are terms used to describe a spectrum of mental health and behavioural disorders, the most prevalent in Australia being depression, anxiety and substance use disorders (AIHW, 2019a). In 2020, AIHW reported that 46% of adult Australians have a lifetime prevalence of mental illness considered severe, moderate or mild and 20% have experienced a mental illness in the preceding 12-month period (AIHW, 2020b). This means that over 3.7 million Australians are impacted by mental health concerns, and when we consider stigma associated with reporting of mental illness, these numbers may be underreported, meaning estimates could be higher (Slade et al., 2009).

Mental illness is a significant contributor to the burden of disease in Australia, highlighted by its ranking of fourth in the total burden of disease following cancer, cardiovascular diseases and musculoskeletal conditions and second in the number of healthy years lost due to non-fatal disease (AIHW, 2019a). Reports indicate a budget of $736.6AU million aimed at mental health services in Australia for 2019 (AIHW, 2020b). However, with increasing rates of mental illness in Australia, research should consider if this money is being utilised wisely.

Mental health services in Australia include General Practitioners, Psychiatrists, Psychologists, Social Workers and Drug and Alcohol Counsellors (Slade et al., 2009). Whilst there is an array of mental health services available to Australians, one of the primary services comprises psychological services, which are the focus of this thesis. Psychological services are defined as assessment, diagnosis and interventions provided by a registered Psychologist according to the Australian Health Practitioners Regulation Agency (AHPRA). Psychologists provide support to individuals and the individual's family or friends to assist individuals in achieving a state of mental wellness.

Given high rates of mental health problems and lifestyle problems that predispose and perpetuate illicit drug use, people who use illicit drugs may be in need of psychological services Treatment objectives generally include reduction in the frequency and quantity of illicit drug use or complete abstinence, and the improvement of social and personal functioning linked to mental health or illicit drug use (AIHW, 2020a), as well as treatment of mental health conditions and education of skills and strategies to manage thoughts, feelings and behaviours associated with illicit drug use and poor mental health. Whilst research has been conducted in other areas of drug treatment (Andrade et al., 2014), this paper aims to address specific use of psychological services.

Illicit Drug Use

An illicit drug is any drug deemed illegal under the international drug control treaties (Degenhardt et al., 2013), such as methamphetamines, cocaine, heroin and cannabis. This also includes the use of prescription medications for non-medical purposes. Non-medical use of prescription medication includes the use of

medications not prescribed by a doctor, or using more or less of the drug than has been prescribed (AIHW, 2020). Nine million Australians 14 years and older have illicitly used a drug in their lifetime and in 2019 16% of adult Australians reported using an illicit drug in the past 12 months (AIHW, 2020). Much like mental illness, associated stigma and criminalisation of illicit drugs may drive underreporting of total illicit drug use within Australia.

People who use illicit drugs report the use of them for a range of reasons and indicate that illicit drugs serve diverse functions for an individual. Drug use may be recreational or functional aiming to decrease symptoms of distress or increase positive affect. Psychologists should be aware that all individuals have a different reason for using illicit drugs and must assess this on an individual basis with every client.

Illicit Drug Use and Mental Health

It is noted that while not all illicit drug use can lead to problematic outcomes or mental illness (Fraser, 2008), there is a complex interplay between illicit drug use and mental health. Kingston et al. (2017) reported that greater than 47% of individuals presenting for substance use treatment at any mental health service have a comorbid mental health condition. Most commonly reported mental health comorbidities include depression and anxiety (Hunt et al., 2020).

A mental illness may make a person more likely to use drugs to provide relief for their symptoms, while in others use of illicit drugs may trigger symptoms of mental illness (Kingston et al., 2017). It is often difficult to determine the bidirectional nature of ones' illicit drug use, and importantly, which preceded the other. For some, mental illness may be unrelated to illicit drug use and vice versa.

According to the 2016 National Drug Strategy Household Survey (AIHW, 2017), there was an increase in levels of psychological distress experienced by people who use illicit drugs compared to previous years. Additionally, the 2019 Ecstasy and Related Drugs Reporting System (EDRS) (Peacock et al., 2018) indicated that among people who regularly use ecstasy there were primary concerns regarding anxiety and depression. It should be noted that this is not significantly different to the general population who also report depression and anxiety as the most prevalent mental health concerns.

Barriers to Psychological Treatment

As recognised previously, there is a large subset of individuals who have a mental health problem, not seeking or who are unable to access, available treatments. Further, of interest to service providers, research has identified that individuals who are seeking help for mental health problems often do not disclose their illicit drug use and people who seek help for illicit drug use often do not disclose mental health problems (Holt et al., 2007). As a result, the interplay between illicit drug use and poor mental health cannot be resolved accurately by psychologists or other treating professionals and subsequently treatment may not be as efficacious. It is important to acknowledge these limitations within service delivery and assess the reasons that individuals do not feel comfortable or are unwilling to disclose illicit drug use to health professionals. One possible explanation relates to stigma, discussed further below.

When assessing barriers to mental health treatment, it is noted that these can be barriers to seeking treatment, accessing the available services, or maintaining a positive treatment experience. Previous research (Mojtabai et al., 2011) has

identified three subsets of barriers (1) structural barriers, (2) personal barriers, and (3) stigma. We discuss each form of barrier below and note that at present barriers are based on general population statistics and access to all treatment services (not only psychological services) and hypothesise that the below barriers may be apparent among people who use illicit drugs, however additional research is required to address specific barriers to psychological services among people who use illicit drugs.

Structural Barriers

Structural barriers include physical obstacles that reduce an individual's opportunity to seek treatment (Mojtabai et al., 2011). These may include living in regional or remote areas and not having access to available services. Structural barriers may also include reduced internet connections limiting available telehealth services, lack of transport to and from available services, and absence of time or available finances to pay for services (Andrade et al., 2014). In addition, whilst many people lack the available finances, this is further exacerbated by limited, or an absence of, health insurance cover (Van Spijker et al., 2019). Finally, the concept of police stations being in close proximity to a psychological service can induce fear or anxiety and lead to a reluctance to physically attend services in case one is arrested. This is especially relevant among people who use illicit drugs (Priester et al., 2016).

Personal Barriers

Personal barriers are generally cognitive or affective factors within an individual that prevent them believing that they need or are suitable to receive mental health services (Priester et al., 2016). Among these include an individual's belief that they can manage alone, that they do not have a problem or that a

psychologist would not be able to help them. Further, any individual who has previously had a negative experience with mental health services, or the criminal justice system because of their illicit drug use, may be less willing to seek help a second time due to fear or a lack of confidence in the psychological profession (Bayer & Peay, 1997).

In addition, personal barriers can relate to the demographical or cultural identity of the individual. This can include an individual's gender, education level; with lower levels of education linked to higher levels of risk, and employment status or income; with unemployment or low income being linked to higher levels of risk and lower levels of help seeking behaviours (Priester et al., 2016). However, it is unclear the impact of these demographical barriers.

Stigma Barriers

Stigma is the discrimination and devaluation of another individual, or the self, based on specific attributes such as gender, race, religion or behaviours (Livingston & Boyd, 2010). Illicit drug use has often been stigmatised by both the general population and, more specifically, by those involved in the criminal justice system. Reports indicate more than 59% of people who inject drugs report an experience of stigma and discrimination (Cama et al., 2018). As a result, many people who use illicit drugs fear persecution or discrimination as a result of their drug use and are subsequently unwilling to disclose any drug use (Van Boekel et al., 2013). Further, people with mental health problems often experience discrimination, particularly if they do not have health cover, are unemployed or have a lower socio-economic status (Bastos et al., 2018). As a result, individuals who use illicit drugs

and have concerns about their mental health are further reluctant to disclose their drug use in case of judgement or discrimination (Mojtabai et al., 2011).

Current research indicates that perceived judgement from self, therapists, peers or police are all barriers to an individual being willing to seek available treatments (Holt et al., 2007). Due to this, people who use drugs are often unwilling to seek psychological help or disclose their illicit drug use; in anticipation of discrimination, poor treatment or being reported to the police (Gutierrez et al., 2020). In addition, the internalisation of experienced public stigma from illicit drug use can lead to stigmatisation of one's self (Akbiyik et al., 2016), which is associated with low self-esteem and self-efficacy, poor recovery and therapeutic engagement, hopelessness, guilt, anxiety, and depression (Gutierrez et al., 2020); all contributing to additional mental health difficulties.

There are a number of people who, due to perceived stigma, are willing to seek help for mental health treatment, however do not disclose their illicit drug use. The reasons for this may include fear of confidentiality being broken and being reported to police or the hospital. As a result, therapists may not be able to implement accurate or effective therapeutic modalities. This information has not been adequately studied and therefore research is required to determine if this hypothesis is accurate or if there are other reasons individuals who seek psychological help do not disclose their illicit drug use.

Summary

For those people who both use illicit drugs and attended mental health services, research has identified that positive experiences were linked to the establishment of a trusting, non-judgemental and genuine therapeutic relationship.

Whereas, negative experiences were related to judgmental attitudes, difficulties establishing regular access, and a perceived lack of therapist experience and knowledge (Andrade et al., 2014). However, research cited on structural, stigma and personal barriers to help seeking are based on studies of the general population only. Further research is required to determine more specific barriers faced by people who use illicit drugs to disclosing their drug use, factors that influence non-attendance at follow up sessions and how this applies to psychological treatment services. This research asks participants who have seen a psychologist about their experiences and any aspects they liked, disliked or barriers that they faced in seeking, accessing or continuing treatment.

Research Questions

This study aimed to develop an understanding of barriers to seeking or accessing psychological support among Australian people who use illicit drugs. The Australian Government has provided $736.6 AU million in 2020 to improve mental health and harm reduction services (AIHW, 2020a), however, if the available services are not applicable to, or have barriers that prevent people attending, then available funding may not achieve the desired outcomes.

Specific research questions comprise:

1. Do people who use illicit drugs seek psychological help and do they disclose their substance use when seeking psychological?
2. If individuals who use illicit drugs are seeking psychological help, what is their experience and level of satisfaction with the psychological service?

3. What are the barriers experienced by individuals who use illicit drugs seeking and accessing psychological services? And;
4. What do individuals who use illicit drugs believe would help them to feel comfortable seeking this help in the future?

Method

Participants and Procedure

Participants were Australian residents 18 years and older who had consumed an illicit drug (defined as any drug made illegal by the Australian Government or the non-medical use of a prescription drug) in the last 12 months. Additionally, participants must have had concerns about their mental health or had seen, or thought about seeing, a psychologist in their lifetime. Participants must have had access to a phone or computer on which they could complete the online survey. Ethics approval for this study was obtained from the University of Tasmania Human Research Ethics Committee (see Appendix A for approval confirmation).

Participants were recruited via online advertising and group posts on social media platforms ‘Facebook’ and ‘Instagram’ and through research associates of the University of Tasmania (UTAS) researchers. Recruitment was passive, in that advertisements were made available, and individuals clicked on the advertisement if they wished to participate. Participants were directed to an information sheet and consent form (Appendix B) hosted on the survey platform Limesurvey, managed by UTAS. Participants were then required to denote their consent and were given the opportunity to withdraw consent at any stage of the study by ending the survey without completion.

The main survey (Appendix B- The complete survey) comprised of five sections that took approximately 15 minutes for participants to complete. No personally identifying information was collected except for an email address for the prize draw which was not linked to participant responses. The prize draw was drawn on 14th April 2021.

In addition, all participants were directed to information and links to the National Alcohol and Other Drug Hotline and Counsellingonline.org.au if they had any concerns about their personal drug use of mental health after completion of the survey.

Survey Design and Content

Section A: Drug Use Module

The drug module was a combination of questions adapted from existing surveys such as the Illicit Drug Reporting System (IDRS) (Peacock et al., 2018). The questionnaire comprised four questions asking participants about their use of illicit drugs in the previous 12 months. Questions included "*How often did you use illicit drugs (e.g. cannabis, MDMA, heroin and NON-MEDICAL or personal use of prescription drugs like benzodiazepines and opioids) in the last 12 months?", "What is your drug of choice (excluding tobacco)?", "Mark ALL drugs that you have used in the last 12 months", "Which of these drugs did you use the most in the past 12 months?".* Participants also identified their primary drug of concern and completed the 5-item Severity of Dependence Scale (SDS) for this drug. The SDS demonstrated validity in identifying cases of DSM (Diagnostic Statistics Manual) cannabis, amphetamine, cocaine, ecstasy and benzodiazepine dependence (Bruno et al., 2011).

Section B: Mental Health Module

The mental health module comprised four questions adapted from existing questionnaires including the IDRS (Peacock et al., 2018), asking participants about their experience of mental health problems. Questions were designed to assess mental health status and desire or need for psychological treatments. Questions

included *"Have you had any mental health problems in the last 12 months? This includes any issues that you haven't spoken to a mental health professional about"*. Participants who answered 'yes' were directed to answer the following questions *"Specify the mental health problem, Mark ALL that are true", "Have you ever received help for your mental health problem?"* and*, "Have you seen any of the following providers for help with mental health problems?"*. For each question, participants were provided a choice of options as well as the option to provide 'other' answers or skip the question. Following this, all participants completed the Kessler Psychological Distress Scale (K10) to measure psychological distress in the last four weeks (Andrews & Slade, 2001). The K10 comprises 10 questions about how a participant has felt in the month prior to completion on a 5-point Likert scale, 'None of the time', 'A little of the time' 'Some of the time'. 'Most of the time' or 'All of the time'. Scores range between 0-50, with scores between 20-24 indicate a likely mild mental disorder, scores between 25-29 indicate a likely moderate mental disorder and scores of 30 and over indicate a likely severe mental disorder (Andrews & Slade, 2001).

Section C: Mental Health Treatment Module

The treatment module provided the main portion of the survey assessing barriers to seeking and accessing available treatments. Questions in this section were taken from previous research in the field (Andrade et al., 2014; Gulliver et al., 2010; Holt et al., 2007; Mojtabai et al., 2011; Peacock et al., 2018) as well as additional questions developed for the purpose of this questionnaire. Questions taken from previous research have been adapted to specifically relate to psychological treatment. This section comprised two subsections based on participant responses to having

seen a psychologist in their lifetime*;* participants who answered 'yes', were directed to answer all 25 questions based on their experience of seeing a psychologist and barriers they experienced. Questions included *"When was the last time you saw a Psychologist?", "How did you decide to see a psychologist last time?"*, *"What helped you decide to see a psychologist last time?", "The last time you saw a psychologist, did you discuss your mental health?", "The last time you saw a psychologist, did your psychologist ask you about illicit drug use?", "The last time you saw a psychologist did you disclose your illicit drug use without being asked?", "The last time you saw a psychologist, did you discuss how your illicit drug use was related to mental health?".* If participants reported a history of speaking to a psychologist about illicit drug use, they were asked an array of questions about their experience. Response options were provided on a 7-point Likert scale of Strongly Agree to Strongly Disagree and participants were asked to select one or more options that best associated to them. Example statements included *"I felt supported when speaking about my illicit drug use"* and *"My psychologist had knowledge about illicit drug use".* Following this, participants were asked about their overall experience of seeing a psychologist and speaking about their mental health. Examples of statements included *"My psychologist was experienced and knew what they were talking about", "I felt that I could trust my psychologist"* and *"My psychologist was genuine and honest".* Participants were then asked *"Did you stop seeing your psychologist before they wanted you to stop?"*; if they answered 'Yes' they were asked to provide further details about why they stopped seeing them.

All participants were then asked the following questions about times that they wanted to, or believed they should have seen a psychologist, but did not. Participants were given statements in an array from which they identified a response on a 7-point

Likert scale (Strongly agree to Strongly disagree). Participants were asked if they believed each statement was a barrier to their seeking or accessing psychological treatment. Example statements included *'My health insurance would not cover this type of treatment', 'I was unsure who to see'* and *'I was scared about being put into hospital against my will'.* Finally, participants were asked if they believed identified factors would have made the process of seeking or accessing a psychologist easier. Participants were provided with an array of statements which they rated on a 7-point Likert scale from Strongly Agree to Strongly Disagree. Example statements included *'Move them away from Police stations', 'Knowing my psychologist had information and knowledge on illicit drugs and alcohol'* and *'The psychologist asking about illicit drug use routinely'.*

Section D: Demographics Module

Participants were asked general demographic questions. Demographic data collected about participants included age, gender identity, location, highest education completed, employment status and current accommodation.

Data Analysis

Participants who did not meet eligibility criteria or who missed data on key variables including barriers to treatment and ways to improve psychological services, were excluded from the final sample. Data for the SDS and K10 were scored to determine substance dependence and psychological distress. Frequencies and means for categorical and continuous demographic data, respectively were calculated for all variables of interest using SPSS Statistics Version 24 (IBM, Somers, NY).

Results

Sample characteristics

Of the 263 participants who started the survey, 44 were excluded because they did not meet eligibility and a further 55 did not complete all compulsory questions or finish the survey. The final sample forming the focus of following analyses was 164 people with an age range from 18 to 63 (M= 30.6, SD=8.85); 88 (53.7%) were male, 62 (37.8%) were female and 14 (8.5%) participants reported identifying with a non-binary gender. Table 1 describes the distribution of demographics including age, gender, accommodation status, employment and education for participants who reported seeing a psychologist and across all participants who completed the survey.

Table 1.

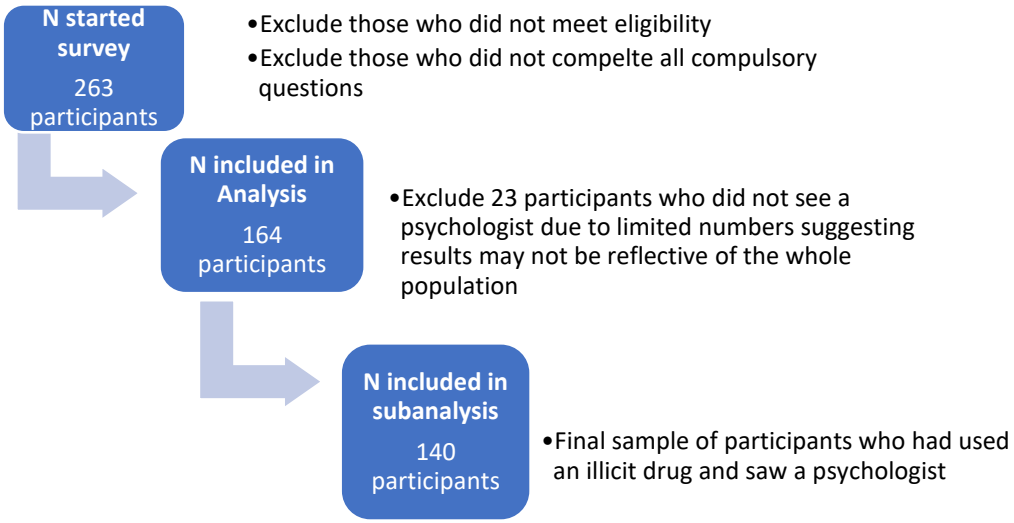
Sociodemographic characteristics of the total sample (n=164), and those who had seen a psychologist (n=140).

Demographic characteristic	Seen a psychologist N=140 %	Total Sample N=164 %
State/Territory		
NSW	20.7% (29)	17.7% (29)
ACT	1.4% (2)	4.3% (7)
VIC	17.9% (25)	20.7% (34)
TAS	12.9% (18)	11.6% (19)
SA	6.4% (9)	7.3% (12)
WA	20.7% (29)	19.5 % (32)
NT	0.7% (1)	1.2% (2)
QLD	19.3% (27)	17.7% (29)
Location		
Capital City	63.6% (89)	64.6% (106)
Regional	25.7% (36)	26.2% (43)
Rural or Remote	8.6% (12)	7.3% (12)
Type of Accommodation		
Own/Renting	71.4% (100)	71.4% (117)
Public housing	5.7% (8)	6.1% (10)

Demographic characteristic	**Seen a psychologist N=140 %**	**Total Sample N=164 %**
Boarding house/refuge	1.4% (2)	1.8% (3)
Drug treatment residence	0.7% (1)	0.6% (1)
Rough sleeping or squatting	1.4% (2)	1.2% (2)
Other accommodation (company housing, tent/caravan, university accommodation)	2.1% (3)	1.8% (3)
Gender		
Male	52.8% (74)	53.7% (88)
Female	37.9% (53)	37.8% (62)
Different Identity	7.9% (11)	7.3% (12)
Highest level of education		
High School or earlier	42.1% (59)	45.7% (75)
Trade or Technical	26.4% (37)	25.6% (42)
University	28.6% (40)	26.2% (43)
Currently Completing education		
No	66.4% (93)	67.7% (111)
Yes	32.8% (46)	31.7% (52)
Current Employment Status		
Not employed	37.1% (52)	34.8 (57)
Full Time	25.7% (36)	27.4 (45)
Part Time/Casual	20.7% (29)	22 (36)
Home Duties	3.6% (5)	3.6 (6)
Self-employed	6.4% (9)	6.7 (11)
Other (Disability/pension, seeking work, student)	5% (7)	4.3 (7)
Chose not to answer	1.4% (2)	1.2 (2)
Age		
18-25 years	35% (49)	34.8% (57)
26-35 years	37.1% (52)	38.4% (63)
36-45years	24.3% (34)	22.6% (37)
46+years	3.6% (5)	4.3% (7)
Mental Health Disorder		
Depression	85.7% (120)	78 (128)
Generalised Anxiety	73.6% (103)	67.1% (110)
Social Anxiety	55% (77)	48.8 (80)
Panic Attack	45.7% (64)	40.9 (67)
OCD	14.3% (20)	13.4 (22)
ADHD	26.4% (37)	22.6 (37)
Eating Disorder	21.4% (30)	18.9 (30)
Personality Disorder	22.1% (31)	18.9 (28)
Schizophrenia	5.7% (8)	5.5 (9)
PTSD	42.9% (60)	39.6 (65)
Autism	2.8% (4)	2.4 (4)
Other	2.8% (4)	3.1 (9)

Figure 1.

Flow diagram depicting the steps taken to finalise participant sample.



Of the total sample, 85.4% reported having seen a psychologist, 92.1% reported wanting to see a psychologist and 95.7% reported concerns about their mental health. Table 2 describes the type of drug used by each participant and their most used drug. 70.7% participants reported substance dependence for their drug of choice based on their responses to the SDS, 64.5% of participants reported cannabis as their preferred drug and 8% reporting methamphetamines. Further, according to results from the K-10, 143 participants scored moderate or higher for mental health concerns. The highest reported mental health concerns were depression, generalised anxiety, social anxiety, panic attacks and post-traumatic stress disorder as detailed in Table 1. The overall breakdown of participants based on SDS and emotional wellbeing (K10) can be viewed in Appendix C.

Table 2.

Past 12 month illicit Drug Use and most frequently used drug (n-164).

Drug	Any use in last 12 months % (n)	Most frequently used % (n)
Non-medical use of benzodiazepines (e.g., Xanax)	33.5% (55)	3.7% (6)
Cannabis	86.7% (142)	64.6% (106)
Cocaine	31.7% (52)	6.7% (11)
GHB/GBL/1,4-BD	3.7% (6)	0.6% (1)
Heroin	4.9% (8)	1.8% (3)
LSD	31.7% (52)	0.6% (1)
Ketamine	17.7% (29)	0.6% (1)
MDMA/ecstasy	36% (59)	2.4% (4)
Meth/amphetamine	26.9% (44)	8.5% (14)
Non-medical use of pharmaceutical opioids (e.g., morphine, codeine), including methadone and buprenorphine	25% (41)	1.8% (3)
Other drug	34.8% (57)	7.3% (12)
Don't know	0.6% (1)	0% (0)
Skip question	0.6% (1)	1.2% (2)

Attended a psychologist

Of the participants who reported seeing a psychologist, 77.1% participants were self-referred and 37.9% were referred by a medical practitioner; other referral sources are detailed in Figure 2. Participants reported the following were the top five referral reasons for attending a psychologist, '*My Problem is/was Serious'* (85.9%), '*Psychologists can help with Mental Health Problems*' (74.3%), *'Psychologists are Confidential'* (80.5%), '*My Doctor recommended a Psychologist*' (66.4%) and '*I was encouraged by family or friends'* (62.8%) as detailed in Figure 3.

Figure 2.

Referral sources among participants who reported seeing a psychologist (n=140). Participants could identify with more than one referral source.

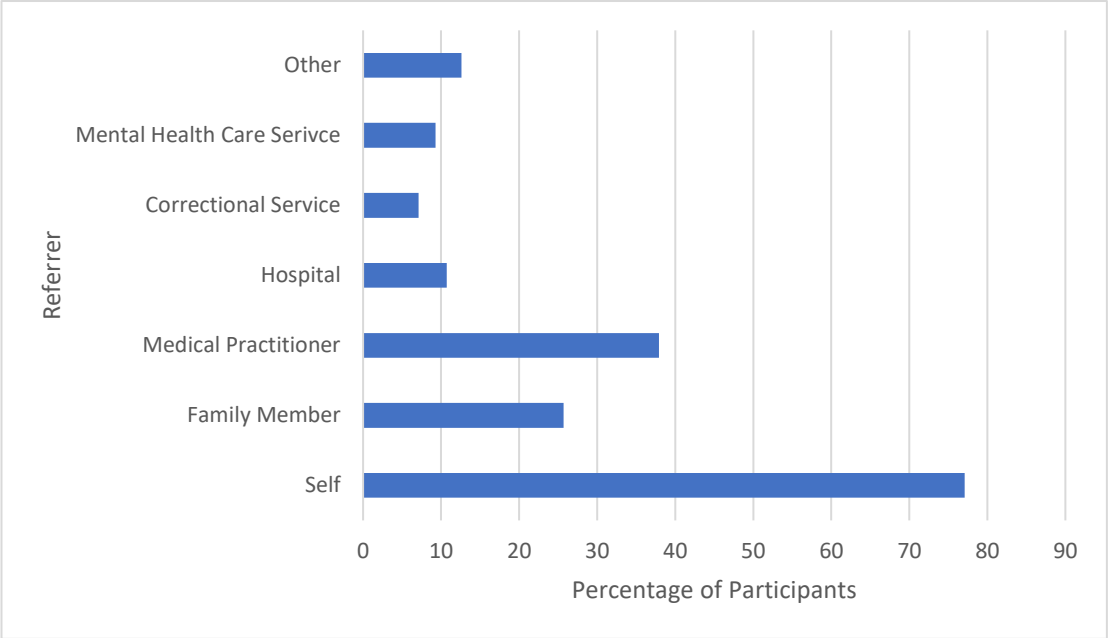
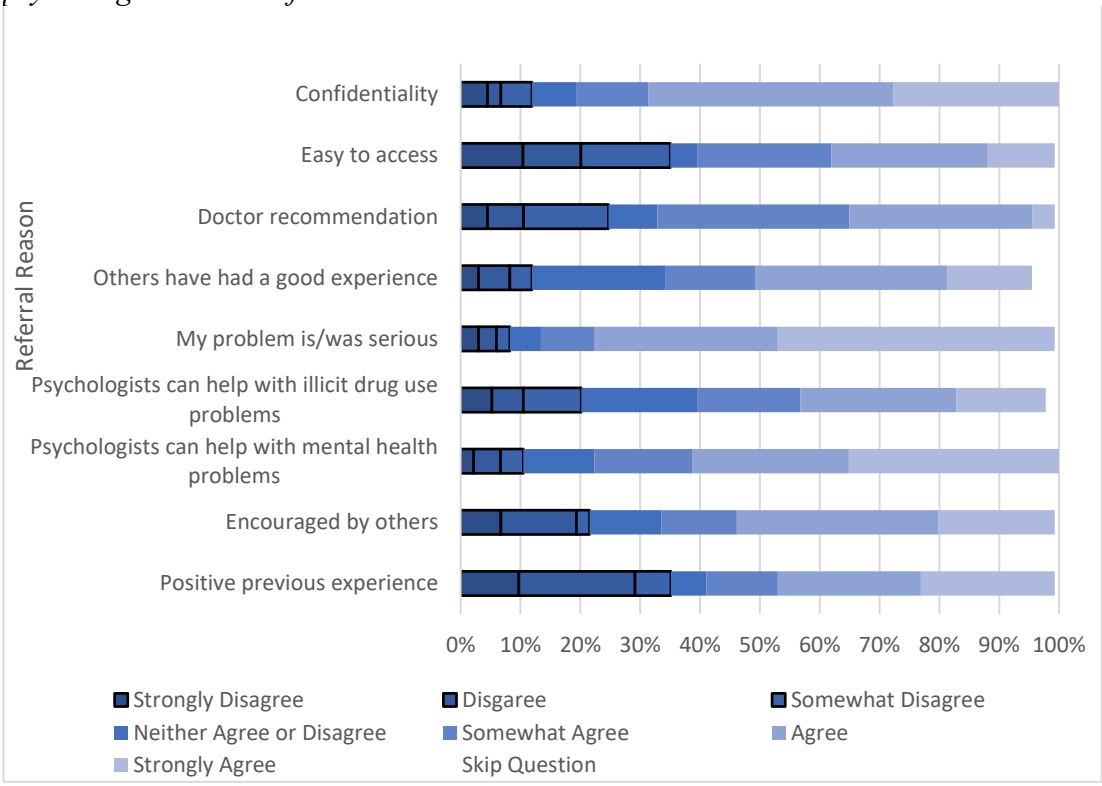


Figure 3.

Reasons for referral among the 140 participants who reported seeing a psychologist in their lifetime.



Disclosure of illicit drug use

Of the 140 participants who attended a psychologist, 89.3% stated that they spoke to their psychologist about their mental health, 64.3% reported that their psychologist asked about any illicit drug use and 12.1% disclosed their illicit drug use without being asked by their psychologist. Further, of those who spoke about their illicit drug use (n=125), 52.1% participants reported that their psychologist discussed the link between their illicit drug use and their mental health, finally, 15% reported that their psychologist changed their treatment plan to adapt for their use of illicit drugs.

Satisfaction with psychological services

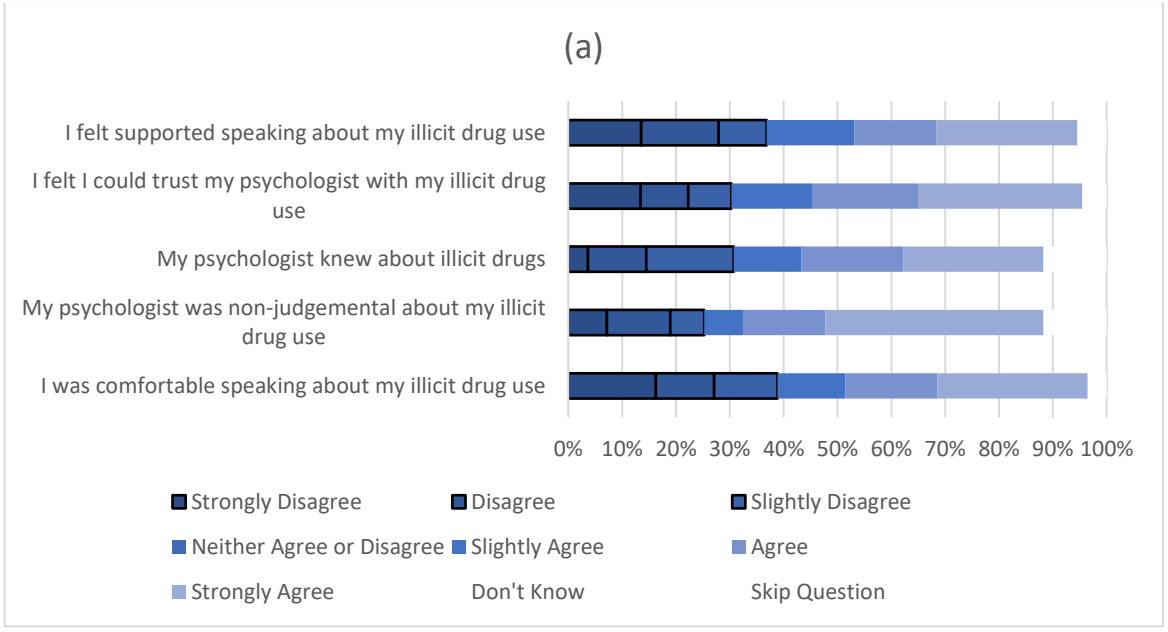
Of the 140 participants who reported attending a psychologist, 22.9% were very satisfied and 19.3% were satisfied. A further 18.6% stated their experience was neutral, 14.3% were dissatisfied and 15% were very dissatisfied. 5.7% of the participants who had seen a psychologist stated that it was too early to say regarding their level of satisfaction with their psychologist.

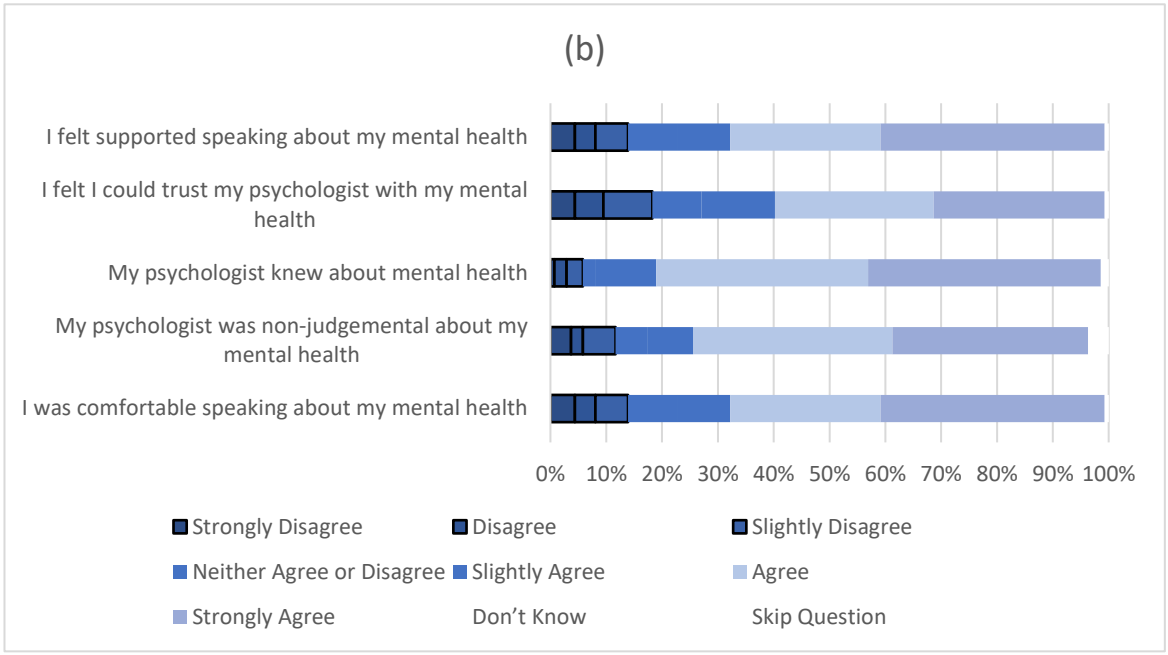
Participants indicated reasons that they liked a psychologist these are detailed in Figure 4. The reasons with the higher percentage agreeing included psychologist's knowledge of mental health (88.9%), psychologists being genuine and honest (83.2%), psychologists being experienced (78.1%), and psychologists being non-judgemental about mental health (77.2%). As can be seen in Figure 4 participants felt less supported (45.7%) and less comfortable (45.7%) when speaking about their illicit drug use compared to speaking about their mental health (75% respectively). They reported that they could trust their psychologist less (52.1%) and that their

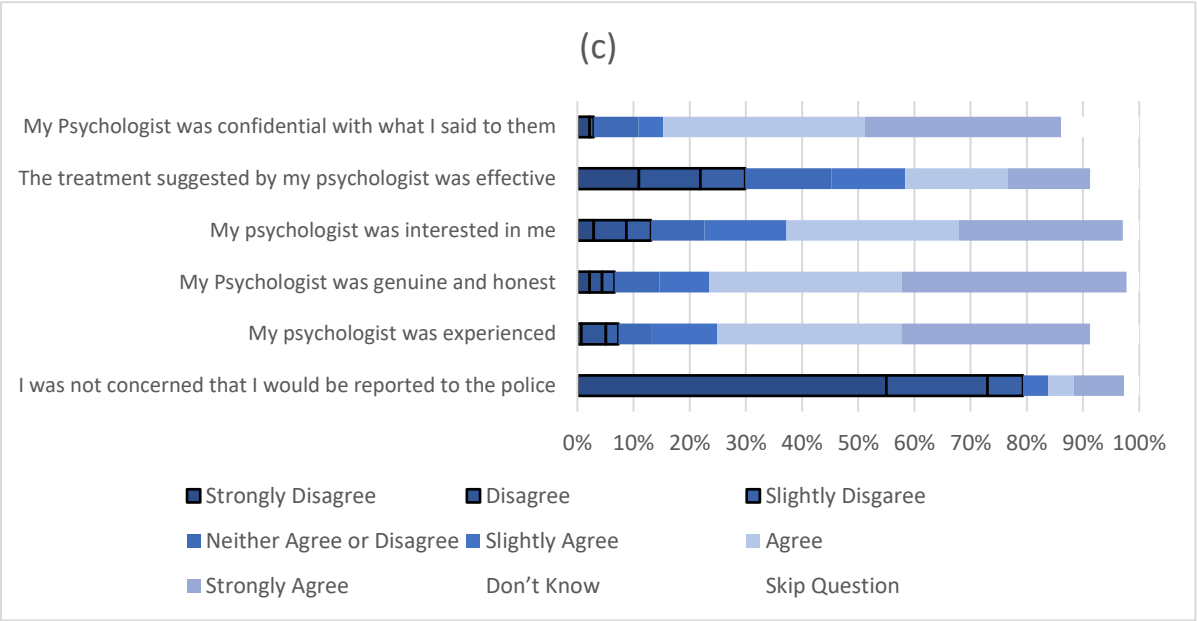
psychologist knew less (45.7%) about illicit drugs than about mental health (70.8% and 88.5%).

Figure 4.

Percentage of participants who agree or disagree with statements regarding their experiences of seeing a psychologist, comparing experiences of discussing (a) illicit drug use (b) mental health and (c) general experiences.







Participants provided optional comments regarding positive experiences with a psychologist, all additional comments are documented in Appendix D. Participant 93 (F, 20 years old) stated:

"A psychologist is neutral and impartial/non-judgemental towards your behaviour. They act as a third party outside observer to tell you the truth with your health in mind non-inclusive of other factors such as your relationship to them."

Characteristics that participants reported liking included their psychologist being understanding, encouraging, authentic and non-coercive. Further, comments in support of psychological treatment reported that psychologists helped them to feel positive about themselves, remain accountable for their own actions and helped them to see alternative perspectives to difficult situations.

Figure 4 also outlines the reasons that participants did not like their psychologist. The top identified reasons included fear of being reported to police

(79.3%), ineffective treatments (29.8%) and psychologists lacking knowledge of illicit drugs (24.4%).

Participants provided optional comments regarding negative experiences with a psychologist, all additional comments are documented in Appendix D. Participants highlighted that cost and availability were the primary problems experienced when seeking and regularly attending a psychologist. There was also a high level of confusion identified between psychologists and psychiatrists, with participants reporting dissatisfaction when they were treated predominantly with medication over alternative therapies.

Additional comments included:

"I felt that the only options provided to me were very run of the mill, a very one size fits all approach. It was also difficult financially…" (Participant 39, M, 25 years old)

"..Found they had no idea on drug use and had lived a totally different lifestyle. They couldn't relate…" (Participant 48, F, 34 years old)

"The cost, the lack of access. Most psych's don't have much availability workable to someone working a full time job…" (Participant 107, M, 27 years old)

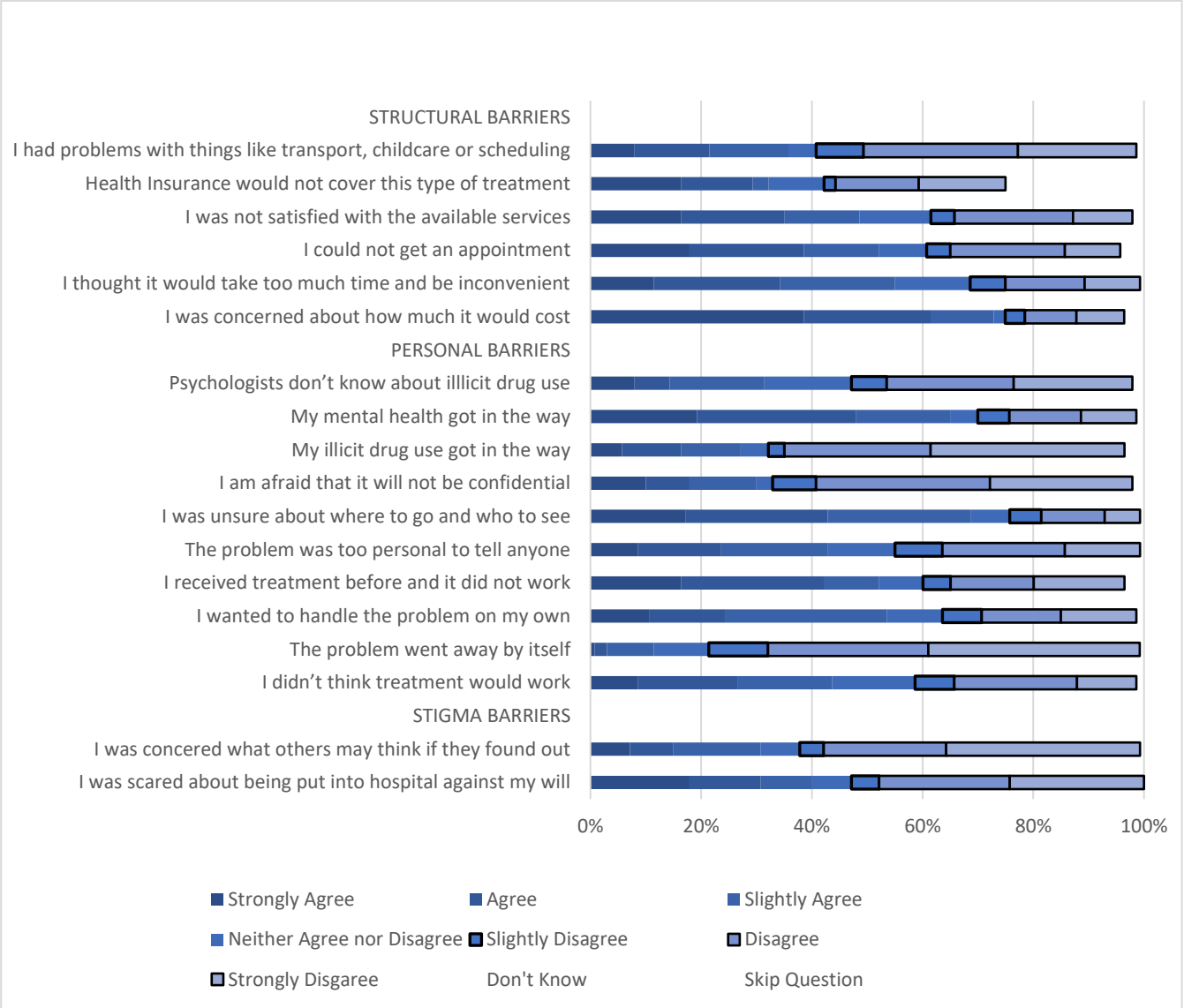
"At times the psychologist can come across as patronising. Understanding the plan for my recovery at the beginning of treatment would've been nice…" (Participant 145, F, 30 years old)

Barriers to treatment

Figure 5 outlines the barriers to treatment identified by all participants who had accessed psychological help. Barriers were broken into structural, personal and stigma barriers as per recommendation from Andrade et al. (2014).

Figure 5.

Barriers to seeking and accessing psychological treatment, by participants who had seen a psychologist. (n-140)



In addition, when assessing barriers to treatment, 41.4% participants who saw a psychologist reported ceasing attendance prior to their psychologist wishing them to stop. They identified ongoing access barriers including '*Lack of Time'*, *'Treatment was too Expensive', 'I wanted to handle the problem on my own'*, *'My mental health affected my ability to attend'* and *'I had a bad experience'*.

Participant 155 (non-binary, 36 years old) provided a comment reflective of structural, personal and stigma barriers. They stated

"Money. Fear of losing my kids. No transport. Disabilities"

Structural Barriers The most commonly identified structural barrier was concern about the cost of treatment, with over 72.9% of individuals agreeing that this was a barrier to seeking and continuing to access available services. The top three barriers after cost of treatments were believing that it would take too much time or be inconvenient (55%), not being able to get an appointment (52.2%) and not being satisfied with the services available (48.6%).

Participants provided optional comments regarding structural barriers to seeking and accessing a psychologist. Additional comments are documented in Appendix D.

"The GP's have no idea about specific psychologists and what they're specialising in." (Participant 10, F, 30 years old)

"Availability. By the time I really needed a psychologist, it was a 3 month waiting time to see one." (Participant 102, M, 30 years old)

Further participants indicated that COVID-19 had been a barrier in 2021 to receiving psychological treatments.

Personal Barriers The main identified personal barriers included participants feeling unsure of who to see (68.5%), mental health getting in the way (65%), wanting to handle the problem on their own (53.6%) and prior experience of unsuccessful treatment (52.1%).

Participants provided optional comments regarding personal barriers, all additional comments are documented in Appendix G.

"Past experiences with judgemental psych's" (Participant 2, F, 31 years old)

"Confidentiality has been broken in the past leading me to never be fully honest again" (Participant 47, trans-gender, 26 years old)

Stigma Barriers The main identified stigma barrier was concern of being sent to hospital against one's own will, with 40.1% of participants agreeing that this was a concern when deciding to see a psychologist. Other stigma barriers included concern of what other's would think if they found out, with 30.7% of individuals agreeing that this served as a barrier to their accessing available psychological services.

Participants provided optional comments regarding stigma barriers to seeking and accessing a psychologist, all additional comments are documented in Appendix D.

"Fear that a psychologist may blow the issue out of proportion"

(Participant 66, M, 20 years old)

"Last time I spent time seeing a counsellor all they could focus on was my drug use…instead of focusing on my trauma… mental health workers need to realise that drug use is a symptom of underlying mental health issues, not the problem itself." (Participant 129, M, 30 years old)

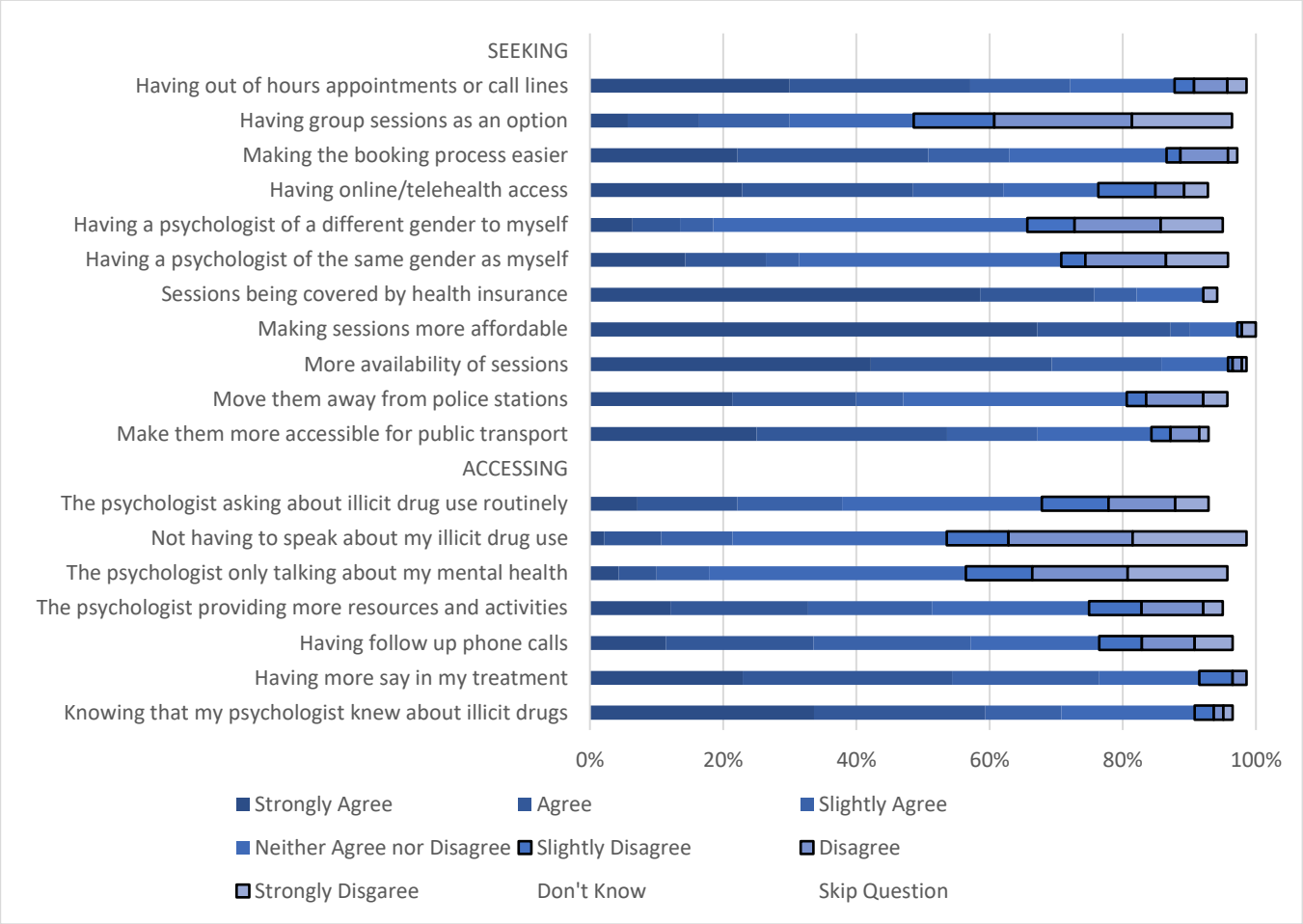
Additionally, participants reported fear of police involvement or child support services taking custody of their children as a result of their mental health and illicit drug use.

Ways to improve access to Psychological Treatment

Participants selected ways that they believed psychological treatment could be improved. These have been broken into seeking services and accessing services (Figure 6). The main improvements to seeking services include *'sessions being covered by health insurance'* (82.1%), *'sessions being made more affordable'* (90%) '*having out of hours appointments'* (72.1%), *'more availability of sessions'* (85.6%) and *'making them more accessible by public transport'* (67.2%), *'making the booking process easier'* (62.8%), and *'having online or telehealth services available'* (62.2%). The main improvements to accessing and continuing to access services include *'having more say in one's own treatment'* (76.4%), *'knowing that the psychologist has knowledge of illicit drugs'* (70.7%) and *'having follow up phone calls'* (57.1%). Figure 6 details the percentage of participants who agree with each statement.

Figure 6.

Breakdown of participant beliefs on improving the experience of seeking and accessing a psychologist. (n=140)



Participants provided optional comments regarding their views on what would improve the process of seeking and accessing psychological services, additional comments are documented in Appendix D.

"[The] referral process needs to be made more efficient and accurate according to drug abuse and mental health" (Participant 10, F, 30 years old)

"Honestly, making it more affordable, more strict standards on breaching confidentiality…no one is going to seek help if they fear going to jail, hospital or other punishments.." (Participant 47, trans-gender, 26 years old)

"It would be a lot better if the psychologist didn't immediately equate illicit drug use with having a 'drug problem' and instead took a more open approach to it." (Participant 92, M, 24 years old)

Additional qualitative comments to improve access include the availability of face-to-face sessions during the COVID-19 pandemic, subsidisation of complex mental health treatments and acknowledging clients' knowledge of their own illicit drug use and mental health. Several participants reported that psychological services need to be made easier to access and affordable for all Australians.

Participants who did not see a psychologist

24 participants reported that they have not seen a psychologist. As a result of the low numbers of participants who did not attend a psychologist responding to this survey, there was insufficient power to statistically analyse this data.

Preliminary visual analysis of this data indicated that the majority of participants who did not see a psychologist believed that they should have at some point. The reported reasons for not seeing a psychologist included their *drug use not being a problem and not impacting their mental health*, being *unsure of who to see*, believing it would be *too time consuming* and being *concerned about what others would think*. However, additional research is required in this field to report data reflective of the specific population.

Discussion

The current research identified that people who use illicit drugs and seek psychological help are more dissatisfied with their experience of psychological services relating to illicit drug use than non-illicit drug users who seek help for mental health. Findings indicate structural barriers including cost and availability of services which were reported at a higher rate than the general population. In addition, they also indicated personal and stigma barriers which appeared to reduce willingness to continue attendance with a psychologist. Findings identified recommendations for psychologists to communicate limits of confidentiality clearly and to increase knowledge of illicit drug use. The following discuses each research question in detail.

Research Question One: Do people who use illicit drugs seek psychological help and do they disclose their substance use when seeking psychological treatment?

According to survey results, 85.4% of participants reported attending a psychologist in their lifetime. This suggested that within the given sample, people who use illicit drugs and have concerns about their mental health, generally do seek psychological help. Among those individuals who saw a psychologist more than half were asked about any use of illicit drugs and, of those not asked close to half disclosed their illicit drug use anyway. These findings are contraindicative of that discussed by Holt et al. (2007) who reported that individuals who are seeking help for mental health problems do not disclose their illicit drug use to mental health providers. Findings of the current study are focused on psychological services only and may indicate that individuals are more willing to disclose illicit drug use to a psychologist than other mental health providers. The reason for this is unclear and

further research should address these differences. Possible explanation of the difference in findings include a possible sample bias in which people who are more likely to complete an online survey as linking mental health concerns and illicit drug use may be predisposed to having a higher likelihood of disclosing their illicit drug use with a psychologist.

As such psychologists need to be adequately trained and have knowledge about illicit drug use and the interaction between illicit drugs and mental health, including the possibility that they may not be related. Psychologists should also feel comfortable in discussing this with clients, following the code of ethics which indicates doing no harm to clients. This would aim to result in decreased perceptions of stigma. If a psychologist did not feel comfortable discussing illicit drug use with clients, they should refer clients to another psychologist to ensure participants are satisfied with available services. Additionally, it is suggested by current researchers that as a result of specific training, psychologists are more likely to ask clients about illicit drug use than other mental health service providers.

Further, results indicate that in general psychologists do elicit information regarding illicit drug use. However, 35% of respondents indicated that their psychologists did not ask about illicit drug use as a part of an intake session. Due to the increasing number of Australians having reported use of an illicit drug in their lifetime (AIHW, 2017) and the increasing link between illicit drug use and mental health concerns including anxiety and depression (Forsythe & Gaffney, 2012), it is considered that this must be a routine question for all clients during an initial session with a psychologist.

The current study does not stipulate the referral reason for seeing a psychologist. Whilst this may reduce the likelihood of participants not being asked about illicit drug use, all clients should be asked as any substance use can impact symptoms of mental health. If client's presenting problems are linked to their illicit drug use and they are not asked about it, this may indicate reasons for negative experiences with psychological services and may lead to decreased willingness to seek help from alternative psychological services.

In the current study only half of the participants who disclosed their illicit drug use, discussed the link between illicit drug use and mental health. There may be a number of reasons for this including a lack of connection between the participants mental health and their illicit drug use, a lack of knowledge of illicit drug use among psychologists or co-occurring problems may be of higher priority to treatment. Given the identified correlation between illicit drug use and mental health disorders (Kingston et al., 2017), particularly depression and anxiety, this suggests that psychologists should always consider possible links between illicit drug use and mental health concerns to assist in treatment. As previous studies have identified similar barriers among drug treatment settings (Holt et al., 2007), this indicated a need to adequately resource and train psychologists in co-occurring drug and mental health problems.

Research Question Two: If people who use illicit drugs seek psychological help, what is their experience and level of satisfaction with the psychological service?

The therapeutic working alliance, the working bond between psychologist and client (Castonguay et al., 2006), is one of the strongest predictors of treatment gains in psychological services (Murphy et al., 2020). The therapeutic alliance can

be visualised through treatment satisfaction of clients and their continued attendance to psychological treatment. As a result, this study aimed to assess the satisfaction level of people who use illicit drugs with the psychological services that they attended.

Among the individuals who reported attending a psychologist, less than half reported being satisfied with the service provided by their psychologist and almost one third of participants were dissatisfied with the services provided. Three key reasons for dissatisfaction with psychological services include perceived stigma and negative judgement, psychologists lack of knowledge regarding illicit drug use and concern of lack of confidentiality, specifically regarding an individuals' illicit drug use.

Participants reported dissatisfaction with their psychologist as a result of perceived stigma and negative judgement from psychologists regarding illicit drug use. Van Boekel et al. (2013) indicated that the perception of negative attitudes towards illicit drug use contributed to suboptimal health care of clients, and as a result reduced satisfaction with services and reduced treatment gains were noted among clients seeking mental health treatment. Dissatisfaction with psychological services is likely linked to high dropout rates during treatment and ongoing mental health and illicit drug use concerns (Schulte et al., 2011). This may lead to exacerbation of the impact of illicit drug use on the individual. Further, negative experiences are linked to reluctance of participants to seeking assistance in future, even if mental health concerns or lifestyle problems are exacerbated. As such, it is of importance that psychologists work to destigmatise illicit drug use. If psychologists feel that they cannot separate clients from this stigma, they should be encouraged to

develop personal understanding of their own limitations when working with illicit drug use and have knowledge of alternative drug treatment services to whom they can refer clients to.

One-third of participants indicated that psychologists lacked knowledge of illicit drugs. When compared to 6% of participants who indicated that their psychologist lacked knowledge of mental health, this raised concerns that psychologists may be ill informed about illicit drugs or are unable to effectively communicate this with clients. The current study does not address psychologist training or knowledge of illicit drug use however may indicate a need for additional training and research in this field. Current findings may align with lower levels of perceived support and comfort when disclosing illicit drug use compared to mental health. Results are congruent with previous research which indicated that service users identified that mental health practitioners lacked interest in, knowledge of, or experience in drug related issues (Holt et al., 2007). Lack of knowledge regarding illicit drug use may lead to psychologists focusing on mental health or lifestyle concerns that are secondary to illicit drug use or introducing treatment methods that are not best fit for clients. Alternatively, psychologists may focus on aspects of drug use that are not problematic for their client or are unrelated to presenting problems. As such, treatment may be ineffective and result in poor experiences and a reluctance for clients to attend ongoing or future psychological services. Further, participants in the current study indicated that their psychologists lack of knowledge in the field was related to higher rates of treatment drop out, indicating that poor understanding of illicit drug use can impact the ability to build effective rapport.

Additional concerns reported by participants leading to dissatisfaction with services included the assumption of proximity of psychological services to police stations and the fear of lack of confidentiality. This is associated with the perceived stigma of illicit drug use and concern among clients that their information will be passed on to police or hospitals. This concern among participants suggests that confidentiality and informed consent regarding the release of information, specifically focused on illicit drug use and associated behaviours, is not appropriately communicated to clients in an understandable format. Previous research has indicated that fear of a breach in confidentiality has discouraged people who use illicit drugs from accessing medical care until absolutely necessary, if at all (Ellis et al., 2020). Psychologists need to understand and communicate information regarding confidentiality and its limitations in a person-centred manner and in such a way that clients feel comfortable and understand when information would need to be reported. This should be discussed immediately on intake and re-iterated when discussing illicit drug use and associated behaviours. Any time a psychologist asks a client about illicit drug use, they should remind clients about confidentiality and the limits imposed around criminal behaviour and harm to self or others. However, it is considered possible that clients may fear breaches in confidentiality prior to attending a psychologist, and as a result may be more inclined to distrust a psychologist before commencing therapy and this being explained. To assist in helping clients feel comfortable with this, information given to clients prior to their attending an initial session should include information regarding informed consent.

By contrast, participants who reported satisfaction with psychological services linked this to psychologists' knowledge of mental health and psychologists' personal characteristics such as genuineness, honesty and being non-judgmental.

These characteristics are associated with clients feeling supported and validated. These results align with previous research regarding therapeutic relationships (Murphy et al., 2020) and treatment barriers to mental health treatment (Holt et al., 2007) that indicated the need for counselling skills including reflective listening, non-judgemental attitudes and validating a clients thoughts and feelings to increase client satisfaction with mental health services. As such psychologists should focus on counselling skills and in-action reflective practice to build a secure therapeutic basis for treatment.

As a result of the current study, it is proposed that psychologists should engage in regular professional development and training regarding counselling skills and specifically illicit drug use and the therapeutic treatments for clients who have co-occurring difficulties with mental health and illicit drug use. In addition, promoting understanding of psychological services as confidential and safe places for clients is essential to promote treatment gains for clients and subsequent client satisfaction with psychological services.

Research Question Three: What are the barriers experienced by individuals who use illicit drugs to seeking and accessing psychological services?

The third aim of the present study was to investigate the barriers to seeking and accessing psychological services experienced by people who use illicit drugs. Results are largely congruent with structural, personal and stigma barriers to initiation and continuation of mental health treatment among individuals of the general population who attend mental health services (Andrade et al., 2014), with the exception that people who use illicit drugs experience additional barriers relating to their illicit drug use. Whilst previous research indicated personal and attitude barriers

(not believing that they need help or wanting to handle the problem on their own) were the most reported barriers to mental health treatment (Andrade et al., 2014), results from the current study indicated structural barriers (cost and availability) as the most reported barriers among people who use illicit drugs. Personal barriers were the second most reported barriers followed by stigma barriers. Regarding non-continuation with a psychologist however, personal, and attitudinal barriers were the most reported reasons, including not needing further help, wanting to handle the problem alone and mental health being a barrier to motivation.

Structural Barriers

According to results, key structural barriers are cost and availability of psychological services. Although in Australia individuals with public health insurance are entitled to ten (currently twenty during the period of COVID-19 pandemic) rebated sessions (Marshall et al., 2020), participants indicated that the remaining cost was often still too expensive for many to afford. According to the Australian Psychological Society the cost of psychological services continues to rise and this cost is passed on to clients, who often are unable to afford the sessions (Australian Institute of Health and Welfare, 2019b; Kisely & Looi, 2020). There is evidence to suggest that more people who use illicit drugs are within a low socioeconomic status (Chan et al., 2018; Quine et al., 2003), further limiting their access to subsidised mental health care plans and their ability to pay the remining gap fees for psychological services. This research indicates a need for the Australian Government to assess mental health care plans and individuals' access to these plans in all areas of Australia.

Almost 10% of participants indicated that their General Practitioner, who would be creating a mental health care plan to enable to healthcare rebated sessions, were often unaware of available services, or did not effectively communicate the availability of psychological services. Research conducted by Banfield et al. (2019) identified that care plans for mental disorders were not comparable to care plans developed for chronic physical illnesses and the care plans did not improve the quality of care received by clients. Their findings suggested that mental health care plans are underutilised for mental disorders and do not result in ongoing care. Further research should investigate General Practitioner awareness of psychological services and the communication of this information to all patients to assess differences for people who use illicit drugs.

As in previous surveys of the general population (Andrade et al., 2014), lack of time and transport were reported barriers to psychological treatment among people who use illicit drugs. This is often associated with cost and socioeconomic status as those of lower socioeconomic status report working longer hours leading to limited available time outside of working hours, when many psychologists are not available (Tsuno et al., 2019). As suggested by survey participants, after-hours treatment sessions are preferred by many clients to enable them to continue to work without penalisation from their employment. In addition, we recognise that there is a higher density of psychological services in areas of higher affluence, further limiting access to services among individuals who do not have access to personal transport or who live in more rural and remote locations. This would include close to 10% of the current study participants.

Finally, in terms of structural barriers, a number of participants made comment about psychologists prescribing medication or suggesting medical alternatives to psychotherapy. This indicates confusion and a lack of awareness of the difference between different types of mental health service providers and may indicate a need for psychologists to provide psychoeducation into the role of psychologists. This could be assisted by the Australian Health Practitioners Regulation Agency in differentiating mental health services.

Personal Barriers

Personal barriers such as mental health literacy, previous poor experiences of psychologists judgement, low perceived need and the perceived ineffectiveness of psychological services were reported. This aligns with previous research which suggested that, in more severe cases, individuals are likely to recognise the need and would seek help in the absence of personal barriers (Andrade et al., 2014). In addition, the presence of mental health difficulties further reduced motivation to access a psychologist. It is noted that participants did not perceive illicit drug use as presenting any additional motivational or personal barriers to seeking or continuing to access psychological services. These results are consistent with personal barriers from previous studies (Andrade et al., 2014), indicating that personal barriers do not appear to differ between people who use illicit drugs and the general population, or between individuals who seek psychological help and individuals who seek help from any mental health service provider. As a result of these findings it is recommended that general education of mental illness, illicit drug use and psychological services would be beneficial for the community.

Stigma Barriers

For many individuals the stigma of mental health often presents as a barrier to open communication about difficulties experienced (Smith, 2011). However, for people who use illicit drugs, this is compounded by the societal stigma of illicit drug use. This perceived stigma was identified among survey participants who reported concern about the beliefs of their family and friends as well as the psychologist. They reported experiencing judgement and dislike from psychologists after disclosing their illicit drug use. Participants reported a fear that the psychologist would blame them for their mental health concerns as a result of their illicit drug use and feared disclosing illegal activities due to perceived repercussion of confidentiality being breached to police.

Stigmatising attitudes of health professionals towards people who use illicit drugs may negatively affect healthcare delivery and can result in treatment avoidance (Van Boekel et al., 2013). Results from the current study are congruent with this. Participants reported ending treatment prior to their psychologist wished due to perceived judgement because of their illicit drug use. Further, participants reported concerns regarding confidentiality of substance use, believing that they would be reported to police or hospitalised as a result of their illicit drug use. As a result of this perceived stigma, individuals fear disclosing their illicit drug use and therefore do not always receive appropriate or adequate treatments, or do not seek, access or continue to attend psychological services.

Psychologists need to be aware of concerns that clients may have around disclosure of illicit drug use and work to alleviate these concerns. Possible avenues to assist with this may include education programs, campaigns or flyers that describe

the process of attending a psychological service. These should aim to explain the role of a psychologist, informed consent and limits to confidentiality and address any barriers to seeking psychological help. Further recommendations are discussed in the following sections. Psychologists should also be aware of general counselling skills to reduce judgment and stigmatisation of people who use illicit drugs.

Additional comments from participants identified that non-binary gender added additional stigma. They reported finding it difficult to find a psychologist who identified as LGBTQI. Although this was not a specific focus of this study, Brown et al. (2016) have completed a systematic review regarding this in the general population and it is recommended that future research address the role of non-binary gender among people who use illicit drugs and the impact of this on barriers to seeking and accessing psychological services.

Research Question Four: What do individuals who use illicit drugs believe would help them to feel comfortable seeking this help in future?

Finally, participants were asked to detail what they believed would be helpful to make them feel more comfortable when seeking psychological help in the future. These suggestions were congruent with identified barriers, with participants indicating the need for increased availability of services, including out of normal working hours appointments, and sessions being made more affordable or covered in full by health insurance. In addition, participants reported the need for psychologists to have a more comprehensive understanding of illicit drug use and be better able to explain the limits of confidentiality and informed consent regarding illicit drug use.

These recommendations should be taken into account by all practicing psychologists and the Australian Psychology Society (APS) when releasing

information regarding illicit drug use and psychological services and when engaging in treatment with people who use illicit drugs. The APS regularly update resources for practicing psychologists and this research should be made available to clients where possible. Psychologists should engage in regular up to date professional development on illicit drugs within Australia and should always conduct in-action and post-session reflection to ensure best practice for their clients.

Practical Recommendations

Based on the responses provided by participants throughout the survey the investigation has made a series of recommendations.

Education for Psychologists

Almost one third of participants reported that many psychologists do not have adequate knowledge of illicit drug use, the culture of illicit drug use or the link between illicit drug use and mental health. Based on this, psychologist should understand a) illicit drugs, drug culture, b) the function of illicit drug use for individuals, c) the association between mental health, illicit drug use and a client's presenting problem, and d) knowledge of psychotherapies that are effective in treating substance related problems or symptoms related to interacting illicit drug use and mental health concerns. It is recommended that psychologists receive in depth and up to date information. One proposed way would be to increase professional development opportunities including regular webinar's, presentations and training programs regarding illicit drug use and treatment. These should be conducted by professionals in the industry or by individuals with lived experience. These can be incorporated into training to be a psychologist, such as during undergraduate and postgraduate studies.

Training programs for psychologists should detail the following in order to reduce barriers to clients seeking and continuing to access treatments with a psychologist:

- Information on illicit and non-prescribed drugs and the current trends, including correct terminology;
- The link between illicit drug use and mental health concerns;
- The differing functions of illicit drug use for individuals;
- Treatment options for people who use illicit drugs; including psychotherapy and psychopharmacology;
- Treatment for mental health concerns exacerbated by illicit drug use; and
- Barriers experienced by people who use illicit drugs.

In addition, when addressing continued access to psychological services 38.7% of participants reported feeling uncomfortable disclosing illicit drug use due to experiences of judgement and stigma. One participant reported that their psychologist had a "*poor poker face*" and the psychologists' opinion of illicit drug use was obvious to them. Psychologists should engage with practical counselling skills (Woolfe et al., 2003) to reduce stigma and model comfortability when discussing illicit drug use. Specific practical counselling skills recommended to assist with this include:

- Empathic and reflective listening and summarising;
- Non-judgemental reflections;

- Non-verbal skills including maintaining eye contact, having an open posture and using minimal encouragers to demonstrate interest in the client;
- Use language preferred by people who use illicit drugs, such as:
    - Emphasise the person first, do not define people by their drug use;
    - Choose strengths based language;
    - Avoid terms such as drug habit, junkie;
    - Use terms such as ‘people/person who use’s drugs; and
    - Use terms such as drug dependence over drug addiction or substance use.
- Use of open questions to encourage appropriate client disclosure;
- Maintenance with the code of ethics, including referring the client to another psychologist if they are uncomfortable or have personal barriers to working with clients who use illicit drugs;
- Sitting with silence and emotions to model such experiences for clients and encourage the space for a client to disclose their experience;
- Rapport building exercises to engage the therapeutic rapport and encourage clients to continue attending treatment;
- Using immediacy to discuss barriers to continued attendance in treatment; and,
- Be collaborative with the client, remember that the client is the subject matter expert on their own experience and allow them a say in their treatment.

It can be helpful for psychologists to consult guides developed by people who use illicit drugs on how they would like to be treated, for example *'Words Matter'* by Madden and Henderson (2020).

Education for clients

The current survey identified a gap in knowledge for people who use illicit drugs about psychology and psychological treatments. There are two proposed ways to increase client education. Firstly, there needs to be a general increase in community knowledge of psychology, psychotherapy and where to access psychological treatments. It is proposed that this could be implemented through AHPRA and psychology businesses in advertising and education campaigns (Arango et al., 2018). These campaigns should include what a psychologist is, the difference between a psychologist and other mental health service providers; specifically psychiatrists, where to find a psychologist and what psychotherapy involves. Secondly, when a client attends a psychology service, a psychologist should engage a client through psychoeducation about the course of treatment (Beck, 2011). This psychoeducation should include possible treatment options, referral options for other courses of treatment, the expected number of sessions and expectations of both the psychologist and the client.

Communication of informed consent, confidentiality and the limits to confidentiality

Two thirds of survey participants raised concerns regarding confidentiality of their information and fears of their illicit drug use being reported to medical or legal professionals including hospitals, police and child protection services. Prior to any form of disclosure in psychological treatments, the client should give informed

consent. In order to give this informed consent, psychologists must explain confidentiality and the limits of confidentiality (APS, 2007). This should include disclosure of mandatory reporting obligations regarding harm to ones-self or others. Psychologists should review the mandatory reporting guidelines for their state and seek legal advice where they are uncertain.

Fisher and Oransky (2008) identified that clearly communicated informed consent increases a clients perception of respect from their psychologist and can initiate increased levels of disclosure. Whilst this research is not specific to illicit drug use, it is hypothesised that results would be transferrable to disclosure of illicit drug use.

Three possible reasons for insecurity regarding client confidentiality proposed include;

a) A lack of communication from one's psychologist about confidentiality. To ensure clients are aware of confidentiality guidelines, services can provide flyers and pamphlets to clients. This pamphlet should include what confidentiality is, situations of limited confidentiality and how/to whom information is disclosed in situations of mandatory reporting;

b) Lack of follow up throughout service access when disclosing illicit drug use. Any time psychologists discuss issues of mandatory reporting with clients, they should actively remind clients of limits to confidentiality; and,

c) Lack of psychologists' understanding of confidentiality and informed consent regarding illicit drug use. As each state in Australia has different requirements, this information should be updated regularly and made readily

available with the aim of decreasing fear and concern about being reported to police, hospitals or child protection agencies.

The current study did not assess if clients had been informed about confidentiality and its limitations. Future research should assess both client knowledge of informed consent and psychologists' comfort in explaining this.

Limitations and Future Directions

Results discussed should be considered in light of population and design limitations. Firstly, due to a small sample of people the sample size may not accurately reflect the overall population of people who use illicit drugs. In addition, due to COVID-19 pandemic restrictions the current study was conducted as an online survey only. As a result, the participant pool was restricted to online and may not reflect the associated difficulties with people who have limited access to technology. Further, COVID-19 has resulted in a reduction in access to psychological services (Rahman et al., 2020) and survey participants commented that this impacted their perception of psychology and their treatment as they could not access services and believed telehealth did not provide the same level efficacy in treatment.

As a consequence of being restricted to an online study, respondents may be unwilling to complete online questions relating to illicit drug use or detail the extent of engagement in illicit activities. This is supported by current research regarding the stigma associated with illicit drug use and individuals lack of willingness to disclose their use due to fear of limited confidentiality and legal repercussion. However, research does indicate that when disclosed, reports of illicit drug use are reliable (Darke, 1998). Therefore, although people who use illicit drugs may raise concerns

of confidentiality, we can be confident in reports of illicit drug use from current study participants, thus validating current findings.

The current survey demographics are reflective of proposed difficulties regarding access to individuals who have used illicit drugs and have not seen a psychologist. This subset of individuals proposes difficulties with targeted advertising and may not be aware of the full benefits of their participation in such research. As a result of this, the current study was unable to utilise results from participants who had not seen a psychologist preventing us from capturing the complexity of representation in the sequence of help-seeking. Further research should consider additional studies focused on people who use illicit drugs, but do not seek help from psychological services and the barriers experienced. In addition, it would be beneficial to compare current results with this population and against the general population to consider differences in structural, personal and stigma barriers so as to inform services and strategies targeted at people who use illicit drugs compared to the general population.

Finally, the current study is subject to response bias in sampling. This may suggest that people who respond to such surveys are more likely to be extremely satisfied or extremely dissatisfied with psychological services. As a result this survey may not fully reflect the experiences of people who use illicit drugs.

Conclusion

In conclusion, the current study aimed to expand on previous research regarding barriers experienced in seeking and accessing mental health treatment among people who use illicit drugs with specific focus on accessing psychological services.

Differences can be between participant experiences in disclosure of illicit drug use and disclosure of mental health concerns. Participants reported feeling less comfortable and perceived more judgment when disclosing illicit drug use compared to mental health concerns. Based on the present research, it appears that there is increased stigma, both personal and perceived stigma when addressing concerns related to illicit drug use which subsequently impacts an individual's satisfaction with psychological services. Participants reported extremes of satisfaction from very satisfied to very dissatisfied. While this may be a result of response bias in participant sampling, it appears that when participants disclose their illicit drug use, and feel supported, they experience positive results from the psychological services. However, if participants feel uncomfortable, and perceive that their psychologist is not genuine or honest, they experience lower levels of satisfaction with the service.

Overall, it appears that people who use illicit drugs are willing to seek help from psychological services, however they experience a number of barriers to seeking and accessing psychological services that impede satisfaction. Barriers are congruent with previous research of barriers to seeking and accessing mental health services among the general population, with the exception that there is a higher level of structural barriers such as transport, location, cost and availability. Based on previous research, we are aware that people who use illicit drugs are more likely to be of a lower socioeconomic status and have lower incomes, as well as increased difficulty accessing personal transport. Further, psychological services tend to be located in more affluent locations, this is likely contributing to the identified barriers and should be considered when psychological services are being established.

Finally, it was identified that there is a perception that psychologists lack detailed knowledge of illicit drug use and the correlation with mental health concerns. As such a general positive regard for clients and an understanding that illicit drug use can fulfil functions such as coping, joy and relaxation in important. These findings identify a need for further analysis or psychologist drug knowledge to verify this, and if confirmed, that psychologists be encouraged to engage in regular professional development related to illicit drugs trends in Australia. However, if the finding is that psychologists have sufficient depth of knowledge, then further analysis on their ability to communicate with clients at an acceptable level and or further education to the client population about psychologists' capabilities to remove this perception. Further, psychological services should increase their communication with the public regarding confidentiality and consent regarding illicit drug use to support client comfortability when seeking help from psychological services.

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Appendix A: HREC approval

04/09/2020

Dear Associate Prof Bruno

Ethics project Id: 22971

Project title: Barriers to Psychological Treatment for Mental Illness Among People Who Use Illicit Drugs

We are pleased to advise that the above named project submission and associated documentation has been approved by the Tasmania Social Sciences Human Research Ethics Committee.

The decision and authority to commence the associated research may be dependent on factors beyond the remit of the ethics review process. For example, your research may need ethics clearance from other organisations or review by your research governance coordinator or Head of Department. It is your responsibility to find out if the approvals of other bodies or authorities are required. It is recommended that the proposed research should not commence until you have satisfied these requirements.

All committees operating under the Human Research Ethics Committee (Tasmania) Network are registered and required to comply with the National Statement on Ethical Conduct in Human Research 2007 (updated 2018).

Therefore, the Chief Investigator's responsibility is to ensure that:

(1) All investigators are aware of the terms of approval, and that the research is conducted in compliance with the HREC approved protocol or project description.

(2) Modifications to the protocol do not proceed until **approval** is obtained from the HREC. This includes, but is not limited to, amendments that:

(i) are proposed or undertaken in order to eliminate immediate risks to participants;
(ii) may increase the risks to participants;
(iii) significantly affect the conduct of the research; or
(iv) involve changes to investigator involvement with the project.

(3) Safety reporting for Clinical Trials must follow the 2016 NHMRC Guidance: Safety Monitoring and Reporting in Clinical Trials Involving Therapeutic Goods.

(4) The HREC is informed as soon as possible of any new safety information, from other published or unpublished research, that may have an impact on the continued ethical acceptability of the research or that may indicate the need for modification of the project.

(5) All research participants must be provided with the current Participant Information Sheet and Consent Form (if applicable), unless otherwise approved by the Committee.

(6) This study has approval for four years contingent upon annual review. A *Progress Report* is to be provided each year on the anniversary date of your approval, and you will be sent a courtesy reminder closer to this due date. Ethical approval for this project will lapse if a Progress Report is not submitted in the time frame provided.
*Generally ethics approval is granted for a maximum of 6 years for applications; this includes the initial approval and up to two 1-year extension requests. However applications will be reviewed on a case by case basis as to whether additional extensions will be granted. It is up to the discretion of the Tasmania Social Sciences Human Research Ethics Committee , whether additional 1 year extensions will be granted, or if a new revised application is to be submitted to the HREC, or a final report is required.
(7) A *Final Report* and a copy of the published material, either in full or abstract, must be provided for HREC review and approval at the end of the project.
(8) The HREC is advised of any complaints received or ethical issues that arise during the course of the project.

(9) The HREC is advised promptly of the emergence of circumstances where a court, law enforcement agency or regulator seeks to compel the release of findings or results. Researchers must develop a strategy for addressing this and seek advice from the HREC.

In accordance with the National Statement on Ethical Conduct in Human Research, it is the responsibility of institutions/organisations and researchers to be aware of both general and specific legal requirements, wherever relevant. If researchers are uncertain they should seek legal advice to confirm that their proposed research is in compliant with the relevant laws. University of Tasmania researchers may seek legal advice from Legal Services at the University.

Additional Information:

For all Clinical trials approved by the Tasmania Health and Medical HREC

Please note that all clinical trials are to be registered on a clinical trial registry. In Australia, registration must occur prospectively, that is before enrollment of the first participant. For more information please refer to NHMRC: Clinical Trial registries

IF YOUR PROJECT IS AN EXTERNALLY SPONSORED CLINICAL TRIAL (commercial or collaborative not-for-profit) YOU ARE REQUIRED TO PROVIDE (if you have not already done so):

1. Where the University of Tasmania is not the sponsor or a site: provide 3 copies of the Medicines Australia HREC Review Only Indemnity Forms, signed by the sponsor

2. Where the University of Tasmania is a site only: provide 3 copies of the Standard Medicines Australia Indemnity Forms, signed by the sponsor

Kind regards

Ethics Executive Officer

CRICOS 00586B

Appendix B: Information and Consent Form and Survey

PARTICIPANT INFORMATION SHEET

Below is information about the survey, the survey starts on the next page

Research team

Chief Investigator: Associate Professor Raimondo Bruno, University of Tasmania

Investigator: Dr Amy Peacock, University of Tasmania

Student Investigator: Rachael Beckley, Masters Student, University of Tasmania

Email: treatmentbarriers@utas.edu.au

Invitation

You are invited to participate in a study of barriers to psychological treatment for people who use illicit drugs. We hope to learn about the experience of people who use illicit drugs with psychological services so that we can identify if these services are adequate and how they might be improved.

What is the purpose of this study?

This study aims to investigate if people who use illicit drugs seek psychological treatment and any barriers to accessing effective psychological treatment.

How is the study being funded?

This study is funded by the University of Tasmania School of Psychological Sciences.

Why have I been invited to participate?

You were selected as a possible participant in this study because you are an Australian resident, over the age of 18, speak English, have experience of illicit drug use in the last 12 months and have concerns about your mental health, have wanted to see a psychologist or have seen a psychologist.

Your participation is voluntary, and your choice to take part or not take part will not affect your relationship with the University of Tasmania or future drug and alcohol research.

Participation in this study is confidential; no personal or identifying details will be obtained. Personal email address for entry into the prize draw is recorded separately and cannot be linked to your responses in the survey.

What will I be asked to do?

If you decide to participate, you will be asked to complete the following survey. The survey contains questions asking about your experience of alcohol and illicit drug use, mental health and any experience with psychological services as well as demographic information.

This survey will take approximately 20 minutes to complete. When you provide consent below, you are indicating that you have read the information about the study, and that you agree with each of the points listed here. We remind you that all participation is voluntary.

A2.

Section A: Eligibility Criteria

To start off with, we're going to ask you some questions to check you're eligible to take part in the study.

B1. Are you an Australian resident?

Yes ☐

No ☐

B2. What is your current age in years?

☐☐☐☐☐☐☐☐☐☐

B3. In the past 12 months, have you used any illicit drugs?

An illicit drug is any drug made illegal by the Australian Government or the non-medical use of a prescription drug. Examples of illegal drugs include cannabis, methamphetamines, MDMA, LSD, ketamine and heroin. Non-medical use refers to the use of pharmaceutical drugs (e.g., opioids, benzodiazepines) which are not prescribed to you or which are prescribed but not taken in accordance with prescription directions (e.g. taking more or less than the prescribed dose).

Yes ☐

No ☐

B4. Have you ever had concerns about your mental health?

Yes ☐

No ☐

B5. Have you ever considered seeing a psychologist?

Yes ☐

No ☐

B6. Have you ever seen a psychologist?

Yes ☐

No ☐

B7.

The following questions ask you about your drug use in the last 12 months. Remember you may skip any questions that you do not feel comfortable answering.

C1. How often did you use illicit drugs (e.g. cannabis, MDMA, heroin and NON-MEDICAL use of prescription drugs like benzodiazepines and opioids) in the last 12 months?

- ☐ Less than monthly
- ☐ Monthly
- ☐ 2-3 days a month
- ☐ 1-2 days a week
- ☐ 3-4 days a week
- ☐ 5-6 days a week
- ☐ Daily
- ☐ Don’t know
- ☐ Skip Question

C2. What illicit or non-medical drugs have you used in the past 12 months?

- ☐ Cannabis (Weed, Pot)
- ☐ Cocaine (Coke, Crack)
- ☐ MDMA/Ecstasy (E, Molly, Pingers)
- ☐ GHB/GBL/1,4-BD (liquid E)
- ☐ Heroin (Homebake, Smack)
- ☐ LSD (Acid)
- ☐ Ketamine (Special K, Tranquilizers)
- ☐ Methamphetamine crystal (Ice)
- ☐ Morphine
- ☐ Benzodiazepines (e.g., Xanax, Benzo's, Valium, Serapax)
- ☐ Other pharmaceutical opioids (Methadone, Buprenorphine, Codeine, Fentanyl, Tramadol)
- ☐ Oxycodone (Oxy's)
- ☐ Pharmaceutical Stimulants (Dexamphetamine, Modafinil, Methylphenidate, Ritalin)
- ☐ Don't Know

Skip Question ☐

Other ☐

Other

C3. Now we want to ask about problems some people may have related to their drug use.

To start off with, which of these drugs did you use the most in the past 12 months?

For this question, do not include alcohol, tobacco or e-cigarettes

Cannabis (Weed, Pot) ☐

Cocaine (Coke, Crack) ☐

MDMA/Ecstasy (E, Molly, Pingers) ☐

GHB/GBL/1,4-BD (liquid E) ☐

Heroin (Homebake, Smack) ☐

LSD (Acid) ☐

Ketamine (Special K, Tranquilizers) ☐

Methamphetamine crystal (Ice) ☐

Morphine ☐

Benzodiazepines (e.g., Xanax, Benzo's, Valium, Serapax) ☐

Other pharmaceutical opioids (Methadone, Buprenorphine, Codeine, Fentanyl, Tramadol) ☐

Oxycodone (Oxy's) ☐

Pharmaceutical Stimulants (Dexamphetamine, Modafinil, Methylphenidate, Ritalin) ☐

Don't Know ☐

Skip Question ☐

Other ☐

Other

C4. **Now we want to ask about problems some people may have related to their drug use.**

To start off with, which of these drugs did you use the most in the past 12 months?

For this question, do not include alcohol, tobacco or e-cigarettes

- ☐ Cannabis
- ☐ Cocaine
- ☐ MDMA/Ecstasy
- ☐ GHB/GBL/1,4-BD (liquid E)
- ☐ Heroin
- ☐ LSD
- ☐ Ketamine
- ☐ Methamphetamine crystal
- ☐ Morphine
- ☐ Benzodiazepines (e.g., Xanax)
- ☐ Other pharmaceutical opioids
- ☐ Oxycodone
- ☐ Pharmaceutical Stimulants
- ☐ Don't Know
- ☐ Skip question
- ☐ Other

Other

C5. How often did you use THAT illicit drug in the last 12 months?

- Less than monthly ☐
- Monthly ☐
- 2-3 days a month ☐
- 1-2 days a week ☐
- 3-4 days a week ☐
- 5-6 days a week ☐
- Daily ☐
- Don't Know ☐
- Skip Question ☐

C6. Thinking about your use of that drug in the past 12 months, did you think your use was out of control?

- Never/almost never ☐
- Sometimes ☐
- Often ☐
- Always/nearly always ☐
- Don’t know ☐
- Skip Question ☐

C7. Thinking about your use of that drug in the past 12 months, did the prospect of missing out on using the drug make you anxious or worried?

- Never/almost never ☐
- Sometimes ☐
- Often ☐
- Always/nearly always ☐
- Don’t know ☐
- Skip Question ☐

C8. Thinking about your use of that drug in the past 12 months, did you worry about your use of it?

- ☐ Never/almost never
- ☐ Sometimes
- ☐ Often
- ☐ Always/nearly always
- ☐ Don't know
- ☐ Skip question

C9. Thinking about your use of that drug in the past 12 months, did you wish you could stop?

- ☐ Never/almost never
- ☐ Sometimes
- ☐ Often
- ☐ Always/nearly always
- ☐ Don't know
- ☐ Skip question

C10. Thinking about your use of that drug in the past 12 months, how difficult would you find it to stop or go without?

- ☐ Not difficult
- ☐ Quite difficult
- ☐ Very difficult
- ☐ Impossible
- ☐ Don't know
- ☐ Skip question

The following questions ask you about your mental health. Remember you may skip any questions that you do not feel comfortable answering.

D1.

Have you ever had any mental health problems?This includes any issues that you haven't spoken to a health professional about.

- [ ] No
- [ ] Yes in the last 12 months
- [ ] Yes more than 12 months ago
- [ ] Yes, both in the last 12 months and previous
- [ ] Don't know
- [ ] Skip question

D2. **Please specify the mental health problem/s you experienced. Mark ALL that apply.**

- [ ] Depression
- [ ] Generalised Anxiety
- [ ] Social Anxiety
- [ ] Panic Attack
- [ ] Obsessive Compulsive Disorder (OCD)
- [ ] Bipolar
- [ ] ADHD
- [ ] Eating Disorder
- [ ] Personality Disorder
- [ ] Schizophrenia
- [ ] PTSD
- [ ] Don’t Know
- [ ] Skip Question

Other ☐

Other

D3. Have you ever received professional help for your mental health problem(s)?

No ☐

Yes ☐

Don't know ☐

Skip question ☐

D4. Who did you see for professional help for your mental health problem? Mark ALL that apply.

Psychologist ☐

Social Worker ☐

Drug and Alcohol Counsellor ☐

Doctor or GP ☐

Psychiatrist ☐

Don’t Know ☐

Skip Question ☐

Other ☐

Other

E1. The following questions ask about how you have been feeling in the last MONTH.

	None of the time	A little of the time	Some of the time	Most of the time	All of the time	Don't Know	Skip Question
How often did you feel tired for no good reason?	☐	☐	☐	☐	☐	☐	☐
How often did you feel nervous?	☐	☐	☐	☐	☐	☐	☐
How often did you feel so nervous that nothing could calm you down?	☐	☐	☐	☐	☐	☐	☐
How often did you feel hopeless?	☐	☐	☐	☐	☐	☐	☐
How often did you feel restless or fidgety?	☐	☐	☐	☐	☐	☐	☐
How often did you feel so restless you could not sit still?	☐	☐	☐	☐	☐	☐	☐
How often did you feel depressed?	☐	☐	☐	☐	☐	☐	☐
How often did you feel that everything was an effort?	☐	☐	☐	☐	☐	☐	☐
How often did you feel so sad that nothing could cheer you up?	☐	☐	☐	☐	☐	☐	☐
How often did you feel worthless?	☐	☐	☐	☐	☐	☐	☐

What is psychology?

Psychology is the study of the mind and behaviour, including all aspects of the human experience from how the brain works to an individual's actions, thoughts and feelings. A person with a problem that is affecting their mental health may benefit from assessment and treatment with a psychologist. A psychologist may offer treatment that focuses on behavioural or thought changes. A psychologist is like a doctor for the brain likely to focus on management of mental health issues, problem solving and support. Psychology is a registered profession through Australian Health Practitioner Regulation Agency (AHPRA), and has strict education and professional requirements.

F1. Have you ever attended a psychologist?

- [ ] Yes
- [ ] No

The following questions ask about your experience having seen a psychologist. Remember you can skip any questions that you do not feel comfortable answering.

G1. When was the last time you saw a psychologist?

- [ ] In the last month
- [ ] In the last 12 months but not in the past month
- [ ] In the past 12 months
- [ ] 2 years ago
- [ ] Between 3-5 years ago
- [ ] Between 6-10 years ago
- [ ] More than 10 years ago
- [ ] Don't Know
- [ ] Skip Question

G2. How did you decide to see a psychologist last time? Mark ALL that apply

- [ ] Self
- [ ] Family Member/ Friend
- [ ] Medical Practitioner
- [ ] Hospital
- [ ] Mental Health Care Service
- [ ] Alcohol and other drug treatment centre
- [ ] Other community/ health care centre
- [ ] Correctional Service

Police or Court diversion ☐

Don't Know ☐

Skip Question ☐

Other ☐

Other

G3. For each of the following statements, please rate how much you agree that this helped you decide to see a psychologist the LAST TIME.

	Strongly Disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Strongly Agree	Dont Know	Skip Question
I have had a positive experience with a psychologist in the past	☐	☐	☐	☐	☐	☐	☐	☐	☐
I was encouraged to see a psychologist by friends or family	☐	☐	☐	☐	☐	☐	☐	☐	☐
I know that a psychologist can help with mental health problems	☐	☐	☐	☐	☐	☐	☐	☐	☐
I know that a psychologist can help with illicit drug use problems	☐	☐	☐	☐	☐	☐	☐	☐	☐
My problem was/is serious, and I needed help	☐	☐	☐	☐	☐	☐	☐	☐	☐
People I know have had a good experience with a psychologist	☐	☐	☐	☐	☐	☐	☐	☐	☐

	Strongly Disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Strongly Agree	Dont Know	Skip Question
My doctor recommended that I see a psychologist	☐	☐	☐	☐	☐	☐	☐	☐	☐
The psychologist was easy to access	☐	☐	☐	☐	☐	☐	☐	☐	☐
I know that what I say to a psychologist is confidential	☐	☐	☐	☐	☐	☐	☐	☐	☐

G4. Please state any other reasons that helped you to decide to see a psychologist.

G5. The last time you saw a psychologist, did you discuss your mental health?

- ☐ No
- ☐ Yes
- ☐ Don't Know
- ☐ Skip Question

G6. The last time you saw a psychologist, did your psychologist ask you about illicit drug use?

- ☐ No
- ☐ Yes
- ☐ Don't Know
- ☐ Skip Question

G7. The last time you saw a psychologist, did you disclose your illicit drug use without being asked?

- ☐ No
- ☐ Yes
- ☐ Don't Know
- ☐ Skip Question

G8. The last time you saw a psychologist, did you discuss how your illicit drug use was related to mental health?

- ☐ No
- ☐ Yes
- ☐ Don't Know
- ☐ Skip Question

G9. Please rate the following statements about your experience after speaking to your psychologist about your illicit drug use.

	Not at all	Very little	A little bit	Somewhat	Mostly	Very much so	Don't Know	Skip Question
I felt supported speaking about my illicit drug use	☐	☐	☐	☐	☐	☐	☐	☐
My psychologist knew about illicit drugs	☐	☐	☐	☐	☐	☐	☐	☐
I felt I could trust my psychologist with my illicit drug use	☐	☐	☐	☐	☐	☐	☐	☐
My psychologist was non-judgemental of my illicit drug use	☐	☐	☐	☐	☐	☐	☐	☐
I was comfortable talking about my illicit drug use	☐	☐	☐	☐	☐	☐	☐	☐
I was concerned my illicit drug use would be reported to the police	☐	☐	☐	☐	☐	☐	☐	☐

G10. After speaking about your illicit drug use with your psychologist, did your psychologist change your treatment to address your illicit drug use?

- ☐ No
- ☐ Yes
- ☐ Don't Know
- ☐ Skip Question

G11. Overall, how satisfied are you with the last psychologist you saw?

- ☐ Too early to say
- ☐ Very satisfied
- ☐ Satisfied
- ☐ Neutral
- ☐ Dissatisfied
- ☐ Very dissatisfied
- ☐ Don't know
- ☐ Skip question

G12. Using the below scale, please rate the following statements about your experience the LAST time you saw a psychologist

	Strongly Disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Strongly Agree	Don't Know	Skip Question
I felt supported by my psychologist to speak about my mental health	☐	☐	☐	☐	☐	☐	☐	☐	☐
My Psychologist knew about mental health	☐	☐	☐	☐	☐	☐	☐	☐	☐
I felt that I could trust my psychologist with my mental health	☐	☐	☐	☐	☐	☐	☐	☐	☐
My psychologist was non-judgemental about my mental health	☐	☐	☐	☐	☐	☐	☐	☐	☐
I was comfortable speaking about my mental health	☐	☐	☐	☐	☐	☐	☐	☐	☐
My psychologist was experienced	☐	☐	☐	☐	☐	☐	☐	☐	☐

	Strongly Disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Strongly Agree	Don't Know	Skip Question
My psychologist was genuine and honest	☐	☐	☐	☐	☐	☐	☐	☐	☐
My psychologist was interested in me	☐	☐	☐	☐	☐	☐	☐	☐	☐
The treatment suggested by my psychologist was effective	☐	☐	☐	☐	☐	☐	☐	☐	☐
My psychologist was confidential with what I said to them	☐	☐	☐	☐	☐	☐	☐	☐	☐

G13. Please provide any other reasons you liked seeing a psychologist.

G14. Please provide other reasons you did not like seeing a psychologist.

G15. Did you stop seeing your psychologist before they would have liked you to stop?

- ☐ No
- ☐ Yes
- ☐ Don’t know
- ☐ Skip Question

G16. Based on the below scale, please rate the following statements on why you stopped seeing your psychologist before they would have liked.

	Strongly Disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Strongly Agree	Don't Know	Skip Question
I didn't need help anymore	☐	☐	☐	☐	☐	☐	☐	☐	☐
The psychologist moved away	☐	☐	☐	☐	☐	☐	☐	☐	☐
The police were a hassle	☐	☐	☐	☐	☐	☐	☐	☐	☐
The problems were with lack of time, schedule change or lack of transportation	☐	☐	☐	☐	☐	☐	☐	☐	☐
Treatment was too expensive	☐	☐	☐	☐	☐	☐	☐	☐	☐
My health insurance would not pay for more treatment	☐	☐	☐	☐	☐	☐	☐	☐	☐
I got better	☐	☐	☐	☐	☐	☐	☐	☐	☐
I wanted to handle the problem on my own	☐	☐	☐	☐	☐	☐	☐	☐	☐
I had bad experiences with the psychologist	☐	☐	☐	☐	☐	☐	☐	☐	☐
I was concerned about what people would think if they found out I was seeing a psychologist	☐	☐	☐	☐	☐	☐	☐	☐	☐

	Strongly Disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Strongly Agree	Don't Know	Skip Question
My family wanted me to stop	☐	☐	☐	☐	☐	☐	☐	☐	☐
My illicit drug use affected my ability to attend	☐	☐	☐	☐	☐	☐	☐	☐	☐
My mental health affected my ability to attend	☐	☐	☐	☐	☐	☐	☐	☐	☐

G17. Please report any other reason you stopped seeing your psychologist.

The following questions ask about reasons you have not seen a psychologist. Remember that you may skip any questions you do not feel comfortable answering.

H1. Was there a time where you wanted to or believed you should have seen a psychologist but didn't?

- ☐ No
- ☐ Yes
- ☐ Don't know
- ☐ Skip question

H2. Based on the below scale, please rate the following statements on why you did not need to, or did not, see a psychologist.

	Strongly Disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Strongly Agree	Don't Know	Skip Question
My illicit drug use is not a problem	☐	☐	☐	☐	☐	☐	☐	☐	☐
My illicit drug use does not impact my mental health	☐	☐	☐	☐	☐	☐	☐	☐	☐
My mental health does not impact my illicit drug use	☐	☐	☐	☐	☐	☐	☐	☐	☐

	Strongly Disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Strongly Agree	Don't Know	Skip Question
I can handle the problem by myself	☐	☐	☐	☐	☐	☐	☐	☐	☐
A psychologist cannot help with my problem	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychologists would tell the police my information	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychologists would tell my family my personal information	☐	☐	☐	☐	☐	☐	☐	☐	☐
A psychologist would send me to the hospital	☐	☐	☐	☐	☐	☐	☐	☐	☐
I can get help from family or friends	☐	☐	☐	☐	☐	☐	☐	☐	☐
I can get help from a different service (e.g. rehab, social worker)	☐	☐	☐	☐	☐	☐	☐	☐	☐

H3. Please provide any other reason that you do not need to see a psychologist.

H4. Based on the below scale, please rate the following statements on the barriers that you experienced when seeing, seeking or accessing a psychologist.

	Strongly Disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Strongly Agree	Don't Know	Skip Question
The problem went away by itself, and I did not really need help	☐	☐	☐	☐	☐	☐	☐	☐	☐
My health insurance would not cover this type of treatment	☐	☐	☐	☐	☐	☐	☐	☐	☐
I was concerned about how much money it would cost	☐	☐	☐	☐	☐	☐	☐	☐	☐
I was unsure about where to go or who to see	☐	☐	☐	☐	☐	☐	☐	☐	☐
I thought it would take too much time and be inconvenient	☐	☐	☐	☐	☐	☐	☐	☐	☐
I could not get an appointment	☐	☐	☐	☐	☐	☐	☐	☐	☐
I had problems with things like transport, childcare or scheduling that would have made it hard to get to treatment	☐	☐	☐	☐	☐	☐	☐	☐	☐
I didn’t think treatment would work	☐	☐	☐	☐	☐	☐	☐	☐	☐

	Strongly Disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Strongly Agree	Don't Know	Skip Question
I was concerned about what others may think if they found out	☐	☐	☐	☐	☐	☐	☐	☐	☐
I wanted to handle the problem on my own	☐	☐	☐	☐	☐	☐	☐	☐	☐
I was scared about being put into a hospital against my will	☐	☐	☐	☐	☐	☐	☐	☐	☐
I was not satisfied with available services	☐	☐	☐	☐	☐	☐	☐	☐	☐
I received treatment before and it did not work	☐	☐	☐	☐	☐	☐	☐	☐	☐
The problem was too personal to tell anyone	☐	☐	☐	☐	☐	☐	☐	☐	☐
I am afraid that it will not be confidential	☐	☐	☐	☐	☐	☐	☐	☐	☐
Psychologists don't know about illicit drug use	☐	☐	☐	☐	☐	☐	☐	☐	☐
My illicit drug use got in the way	☐	☐	☐	☐	☐	☐	☐	☐	☐
My mental health got in the way	☐	☐	☐	☐	☐	☐	☐	☐	☐

H5. Please report other barriers that stopped you from seeking help.

H6. Based on the below scale, rate the following statements on what you believe would make the experience of seeking and accessing a psychologist easier.

	Strongly Disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Strongly Agree	Don't Know	Skip Question
Make them more accessible for public transport	☐	☐	☐	☐	☐	☐	☐	☐	☐
Move them away from police stations	☐	☐	☐	☐	☐	☐	☐	☐	☐
Knowing that my psychologist had information and knowledge on illicit drugs and alcohol	☐	☐	☐	☐	☐	☐	☐	☐	☐
Having more say in my treatment	☐	☐	☐	☐	☐	☐	☐	☐	☐
More availability of sessions	☐	☐	☐	☐	☐	☐	☐	☐	☐
Not having to speak about my illicit drug use	☐	☐	☐	☐	☐	☐	☐	☐	☐
Making sessions more affordable	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sessions being covered by health insurance	☐	☐	☐	☐	☐	☐	☐	☐	☐
Having a psychologist of the same gender as myself	☐	☐	☐	☐	☐	☐	☐	☐	☐
Having a psychologist of a different gender as myself	☐	☐	☐	☐	☐	☐	☐	☐	☐
Having online/telehealth access	☐	☐	☐	☐	☐	☐	☐	☐	☐

	Strongly Disagree	Disagree	Slightly disagree	Neither agree nor disagree	Slightly agree	Agree	Strongly Agree	Don't Know	Skip Question
Making the booking process easier	☐	☐	☐	☐	☐	☐	☐	☐	☐
The psychologist only talking about my mental health and not my illicit drug use	☐	☐	☐	☐	☐	☐	☐	☐	☐
The psychologist asking about illicit drug use routinely	☐	☐	☐	☐	☐	☐	☐	☐	☐
The psychologist providing more resources and activities (e.g. reading or videos)	☐	☐	☐	☐	☐	☐	☐	☐	☐
Having group sessions as an option	☐	☐	☐	☐	☐	☐	☐	☐	☐
Having follow up phone calls	☐	☐	☐	☐	☐	☐	☐	☐	☐
Having out of hours appointments or call lines	☐	☐	☐	☐	☐	☐	☐	☐	☐

H7. Please provide any other suggestions that may have made your experience better.

H8. Do you have any other comments about seeking or accessing a psychologist?

Now for the last few questions to help us broadly describe the people completing this survey. Remember, you can skip any questions you don't want to answer.

I1. What state/territory do you currently live in?

- NSW ☐
- ACT ☐
- VIC ☐
- TAS ☐
- SA ☐
- WA ☐
- NT ☐
- QLD ☐
- Don't know ☐
- Skip Question ☐

I2. How would you describe the area in which you currently live?

- Capital City, inner suburban ☐
- Capital City, outer suburban ☐
- Regional city or town ☐
- Rural ☐
- Remote ☐
- Don't Know ☐
- Skip question ☐

I3. What type of accomodation do you CURRENTLY live in?

- [ ] Own house/flat
- [ ] Rented house/flat
- [ ] Public housing
- [ ] Parents/family house
- [ ] Boarding house/hostel
- [ ] Shelter/refuge
- [ ] Drug treatment residence
- [ ] Couch surfing (home of friends or family)
- [ ] Rough sleeping or squatting
- [ ] Share housing
- [ ] Don't Know
- [ ] Skip Question
- [ ] Other

Other

I4. Which of the following best describes your current gender identity?

- [ ] Male
- [ ] Female
- [ ] Non-binary/gender fluid
- [ ] Don't know
- [ ] Skip question
- [ ] Other

Other

I5. What is the highest level of education that you have completed?

- [ ] Grade 9 or earlier
- [ ] Grade 10
- [ ] Grade 11
- [ ] Grade 12
- [ ] Trade/technical qualification (e.g. TAFE)
- [ ] University qualification
- [ ] Don't Know
- [ ] Skip Question

I6. Are you currently studying for any qualifications?

- [ ] No
- [ ] Yes, Trade/Technical
- [ ] Yes, University
- [ ] Yes, High school certificate
- [ ] Don't Know
- [ ] Skip Question

I7. How are you currently employed?

- [ ] Not employed
- [ ] Full time
- [ ] Part time/casual
- [ ] Home duties
- [ ] Self employed
- [ ] Don't know
- [ ] Skip question
- [ ] Other

Other

Thank you for taking the time to complete this survey. Please confirm your consent to us using your responses to this survey in our study.

J1. **I confirm that my responses may be used in this study.**

Yes ☐

No ☐

K1. **Thank you for taking part in this study. If you would like to enter the prize draw to win an Apple iPad™ please click the link below to enter your email address into a separate survey. Please note, we will only use your email address to notify you of the prize draw outcome. Your email address will not be linked to your responses to this survey in any way. If you would prefer not to provide your email address you can simply exit the survey now.**

The Prize Draw will be drawn randomly by University of Tasmania staff on the 31st January 2021.

Link to prize draw.

K2. **Unfortunately you are not eligible to participate in this survey. We thank you for your time.**

K3. **Thank you for taking the time to work through this survey. We understand you have withdrawn your consent and you will not be asked any further questions. Your responses will not be used in this study.**

To thank you for your time, you can to enter the prize draw to win an Apple iPad™ please click the link below to enter your email address into a separate survey. Please note, we will only use your email address to notify you of the prize draw outcome. Your email address will not be linked to your responses to this survey in any way. If you would prefer not to provide your email address you can simply exit the survey now.

The Prize Draw will be drawn randomly by University of Tasmania staff on the 31st January 2021.

Link to prize draw.

{if(confirmconsent == "Y", endTextCompleted.question , if(ecAll,endTextNonConsent.question ,endTextIneligible.question))}

If you have any concerns about your drug use or mental health please contact your GP, a psychologist or one of the following services

National Alcohol and Other Drug Hotline

1800 250 015

Lifeline Australia

13 11 14

Online Counselling

www.counsellingonline.org.au

Harm Reduction Advice

www.globaldrugsurvey.com/brand/the-highway-code

Appendix C: Overall Demographics

Demographic	Seen a psychologist	Total Sample	Substance Dependence	Moderate or above Distress
State/Territory n=164				
NSW	29	29	20	29
ACT	2	7	4	3
VIC	25	34	27	27
TAS	18	19	15	16
SA	9	12	8	11
WA	29	32	17	28
NT	1	2	2	2
QLD	27	29	23	27
Location n=161				
Capital City	89	106	74	93
Regional	36	43	35	40
Rural or Remote	12	12	7	9
Type of Accommodation n=160				
Own/Renting	100	117	86	105
Public housing	8	10	5	8
Living with parents or friends	23	27	19	22
Boarding house/refuge	2	3	2	2
Drug treatment residence	1	1	1	1
Rough sleeping or squatting	2	2	1	2
Other accommodation (company housing, tent/caravan, university accommodation)	3	3	2	2
Gender n=163				
Male	74	88	67	75
Female	53	62	41	55
Different Identity	11	12	6	11
Highest level of education n=160				
High School or earlier	59	75	52	64
Trade or Technical	37	42	31	36
University	40	43	30	40
Demographic	**Seen a psychologist**	**Total Sample**	**Substance Dependence**	**Moderate or above Distress**
Currently Completing education n=163				
No	93	111	81	95
Yes	46	52	34	47
Current Employment Status				

Not employed	52	57	44	55
Full Time	36	45	30	37
Part Time/Casual	29	36	25	30
Home Duties	5	6	3	6
Self-employed	9	11	9	8
Other (Disability/pension, seeking work, student)	7	7	3	6
Chose not to answer	2	2	2	1
Age				
18-25	49	57	35	47
26-35	52	63	48	57
36-45	34	37	28	35
46+	5	7	5	4
Mental Health Disorder				
Depression	120	128	98	121
Generalised Anxiety	104	112	83	107
Social Anxiety	77	80	61	77
Panic Attack	64	67	53	66
OCD	20	22	17	21
ADHD	37	37	29	37
Eating Disorder	30	31	23	29
Personality Disorder	31	31	24	28
Schizophrenia	8	9	9	9
PTSD	60	65	54	63
Autism	4	4	1	3
Other	4	5	3	5
Don’t know	1	9	3	3
Chose no to answer	4	1	1	1
No Mental Health Condition	3	5	3	2

Appendix D: Qualitative Comments

Reasons to see a psychologist

- Addressing shame and esteem issues. Not illicit drugs as I only used weed once at a party.
- Panic attack at work so put on forced leave until I saw a psychologist.
- My kids
- Severity of my symptoms I have a psychology degree
- Help with PTSD triggers and grief over my child being kidnapped.
- I needed to be diagnosed and treated for post trauma of my brothers suicide.
- Have found it useful in the past, not only for assistance with problem solving, but also providing practical skills and strategies for managing anxiety.
- Hope
- I was at uni, so I had access to uni counsellors. it's not so easy otherwise.
- Recognised signs of deep lows of depression from previous bad hard times
- Recommended by a doctor. It was trusted advice
- My Son and being the best version of myself to be then able to be the best father figure possible!
- Suicide attempt, involuntary hold
- Psychological services are not confidential if they psych thinks you are at risk, then it's everybody's business. Horrible service for those who need it most.
- I felt it was that or killing myself
- Impact on daily life and relationships
- Was depressed/suicidal, had to do something!
- Felt I had to to stop my family worrying and to improve my relationship with my GP.
- I smoked pot for over 30 years, serotonin receptors were basically useless because my cannabinoid receptors gave me the the pleasure and relaxation I needed, sleep was not possible without pot. I looked for help but they gave me no, except to try to put me on various drugs that were far worse that the pot I was using. I needed help to legally obtain what my mind required. I just smash Valium now, which is far worse than what I had. I am a high functioning stoner that needed the drug that my mind had got use to, to bring my seratonin receptors back online without me losing my mind was impossible by that stage.
- Head wasnt feeling right, needed to feel better to stop drug use
- self awareness of the deterioration of my own mental health (especially during covid isolation)
- I abused a lot of psychedelics over the last 2 years because I believed that I was able to change something in my brain. Maybe create a new pathway or something, but ended up distorting my thoughts to the point were I'd be really stressed or anxious almost all the time.
- I was in total mental down when I went, 7 years ago. My life was falling apart and I cried all the time
- Previous positive counselling experience

- I was putting myself in a constant state of hypomania/mania as a result of regular stimulant abuse (I consider that a much larger problem than cannabis). It was having huge consequences on my life and it had to stop.
- Last resort what else am I to do ?
- Mental health ward doctors/nurses and partner at the time.
- Asked my doctor about it said it was too expensive for me, that there was no point seeing them until I had stopped smoking as there would be no point. Felt very judged and hopeless. My educational provider had a free service which encouraged me to go or otherwise I would not be able to afford
- Past trauma n trying to heal
- I knew that I couldn't figure it all out on my own, was dissociative and deeply depressed so I needed advice from someone I could trust. At the time, I couldn't trust anyone around me so I began fighting to get an appointment. DMT (Dimethyl Tryptamine) opened my mind up and derailed my addictions somehow, it was what showed me that I was strong enough to defeat depression, I just needed guidance from a professional.
- When I need help and notice that I do and also have people telling me to them I go feeling like i wasn't capable of helping myself and that nothing would change without it
- I wanted to see a psychologist for ongoing support with my mental health/illness, particularly for support in developing strategies for managing anxiety.
- I was referred
- my boss encouraged me
- was affecting my work
- Trauma
- I wanted to try and help myself.
- Referral for neurofeedback therapy, learn skills to manage anxiety
- I was released from hospital after a suicide attempt and my husband called the psychologist who told me to give him a chance I had nothing to loose
- It was at my doctors recommendation an my mothers that i go due to ongoing an long term problems
- Was single parent of a primary school age child at the time. I needed to make sure I was ok to be able to be a parent.
- Suicide attempts
- I have had an extensive experience with mental health departments over 20 years and it wasn’t until I hit rock bottom the last time and finally got help from a caring case manager did I see one At 42 I was finally diagnosed with a.d.d
- Suicidal, memories of childhood sexual abuse.

What participants liked about their psychologist

- Helpful talking to someone about my painful past, identifying root cause of some triggers relating to shame, anger, low esteem and confidence.
- Becoming more aware of the origins of my condition and the triggers that induce anxiety.

- She's a woman (as am I) and she bulk bills.
- Cannot say I have had much luck.
- A different perspective on things you might be too close to, validation that your feelings & emotions about a situation are valid, re-framing trauma to allow you to process & therefore heal from it.
- I mean it's always good to talk to someone.
- The helped get me into detox
- They provided some good general advice, but it was nothing that couldn’t have been obtained by general internet searches
- It helps, small and basic statement but it's true
- Captive audience for an attention seeking comedian
- They helped me get valium so I could feel normal
- I liked seeing a psychologist who used subtle techniques to gently bring me to understanding something without explaining the science behind it or giving me breathing exercises.
- Neuro feed back
- I remember she said a couple things that clicked with me over the sessions.
- This psychologist was less coercive than others I had seen.
- I didn’t
- Very effective encouragement to try sobriety using talk therapy
- Keep me on track and accountable
- none
- Hated it
- When I found the right one I learnt a lot about myself and learnt how to cope with life without problematic drug use
- Good fit with me Very experienced Authentic
- He helps me get back the perspective & ability to self-reflect that my illness takes away from me. That’s hugely important to quality of life & recovery.
- I didn't it didn't help she was affordable and the only one with availability
- A psychologist is neutral and impartial/non judgemental towards your behaviour. They act as a third party outside observer to tell you the truth with your health in mind non inclusive of other factors such as your relationship to them.
- Was nice to finally talk about everything to someone that I felt like would understand.
- A space where I can say anything n not be judged
- She gave me insight into how much I've been through, that it isn't normal and that im very resilient. I feel justified and ok about who I am now. I feel strong enough to work through without medication now. Thats just one session, im very excited to build a plan with her as I feel with our different understanding and approaches, she'll be able to help me find a way through the maze and out of my head.
- Close conversation with an impartial person.
- I got a dope ass dude aye prof Zubaran an his wife are sick cunts aye fuckin life savers
- to help lead a more enriching life.
- Perspective on relationship issues

- a psychologist is supportive in a professional way, non-judgemental, and is not emotionally involved in my life. I like this. It provides me with the opportunity to work on myself with professional support.
- It was nice to be heard
- Two days after I was drugged and raped I had my first appointment with my psychologist. She confirmed for me that I was to trust my gut and she believed me that it had taken place. The day before I had gone to the hospital to request relevant tests be done and the hospital denied me said test as I didn't have any recollection of the event. They made me feel like it was all in my head so my psychologist believing me was a relief and helped build trust.
- I didn’t really like going.
- It was good to get things out of my head
- I liked releasing all my heavy emotions to someone
- She understands and makes me feel "normal". As in my mental health is not something I should be ashamed of.

What participants did not like about their psychologist

- Leaving something unresolved is hard, not knowing if I'm moving forward with strategies through the therapy provided.
- Being forced to from work when I was already seeing a psychiatrist as well.
- Hate talking
- She doesn't offer EMDR.
- I am yet to find one suitable to myself. I have tried various psychologists that have all been unsuccessful.
- Feeling as though it wasn’t helping
- Unfortunately it didn't do me any good! You can be aware of, supported in, and have a good understanding of your problems and still not be able to do anything to change them. especially where your mental health and drug use issues intersect with class - eg. my psychologist couldn't do shit all to stop me being stuck in poverty... so...
- Cost
- I take drugs to avoid feeling, so being vulnerable with some random dude was hard initially.
- Suggested that I try cocaine instead of psychedelics as apparently cocaines healthier. Psychologist was consistently late (30 mins+) and would cut the sessions short It was really hard to access as I had to do it under a MHP and it took 4 months to access a psychologist and then due to the arbitrary cool off period of 12 calender months, when covid came and I became majorly depressed and anxious and was stumbling into bad drug abuse, I was unable to access any counselling services, which lead to me being arrested.
- They were very general. They didn’t maintain a consistent dialogue and every session was a revisit to the previous as they didn’t understand their own notes. They were very black and white in advice and gave advice based on their own learnings and was not tailored to my needs as an individual
- Ineffective treatment Difficult to find alternatives and difficult to transition to a new one in so far as going through my traumas

- They never helped me
- I just dont find it particularly helpful
- I didn't like seeing a psychologist who tried to pressure me into rehab the first time I sat down in her office. Other times psychologists have been nice to talk to but overall had no impact on my mental health.
- I felt that the only options provided to me where very run of the mill, a very one size fits all approach. It was also difficult financially as I wanted to see a doctor with experience treating OCD but my mental health care plan covered less than 50% of the bill.
- I was suggested to download the headspace app which cost money, I did it anyway. I was also asked to purchase a questionnaire to fill out which would help them diagnose me. I did that too because I was feeling desperate. Looking back though just seemed like all these additional costs, like they were monetising mental health.
- I found it extremely stressful due to previous negative experiences with the psychiatry and related metal health services.
- They are of no help, a psychologist isn't what was needed.
- Mildly uncomfortable talking about self
- This is not a positive comment but in the past I said to a psychologist I felt like harming others and had no plan and they decided to revoke my weapons license and put it on record for police and Futher psychologists to see. They also noted me admitting to drug abuse. Since then I have not been open about drug use, perverted thoughts or suicidal thoughts when I see them. Preventing me from getting help with serious mental issues that will only get worse. I tottaly understand why ped0philes or people with dark thoughts will not seek help until it's too late due to fear of prosecution for thoughts and prevention of future employment or access to weapons, travel, ect.
- With previous psychologist found they had no idea on drug use and had lived a totally different lifestyle. They couldnt relate. Have found a down to earth psycologist now
- confidentiality is limited by stipulations. If I tell my psychologist that I smoked cannabis on a Sunday they have the ability to call into question my ability to care for patients on a Monday which is totally antiquated. There currently exists a paradox where health care workers are at risk of being reported to AHPRA and other regulatory bodies for their drug use even if its under control. This makes clinicians more adverse to discussing their issue under the possibility of being reported for something that doesn't impair them within their work. As a result countless people in this position are forced to lie or not reveal their issues due to fear of unjust repercussions and the ability for other parties unrelated to the management of this issue being able to read files and gain insight into confidential information.
- Because I'm still a daily stoner and doing trauma therapy is really hard because when I get home, I forgot everything we talked about because I smoke, but then the next day at work I'll be sober and all my memories and emotions will flood my brain at once and most of the time I get really quite/sad
- Felt weak
- The first time psychologist that I saw - about 3 times before I disclosed my drug use- cut the session off when I told him, I felt awful and did not go back and my life spiralled. The shame was crippling

- they didnt give me any say
- Talking about trauma is confronting and hard. This had nothing to do with my psychologist-these feelings come from within me.
- She just didn't understand the drug side of what I go through
- She wasn't really experienced in major disorders more slight disorders I was referred to psychiatrist
- They essentially didn't want to treat me as they believed it was unsafe due to my "drug habits". I resented this deeply as I felt I was being denied the help I was asking for for reasons that weren't related to the issues I genuinely had (largely relationship based)
- Expensive, hard to book appointments due to current climate (covid). Further, I felt like i was lying if i didn't tell the full truth or that I was manipulating my personal narrative somehow.
- Went through issues with TAFE. Lady high up in management asked to speak to my psychiatrist to talk about things I was saying to her. This made me not trust the process anymore. Made me feel so uncomfortable as my issues with TAFE were worsening my mental state, was so confused why she felt like my psychiatrist would have anything to say to this lady in a high up position within TAFE. This made me stop going and now have no one to speak to my problems about.
- Expensive - $205 with a Medicare rebate of $128.40. I have fortnightly appointments. Weekly is recommended but I can’t afford to.
- Slight language barrier meant alot of repeating myself but she did very well, otherwise she is great.
- Waiting time
- Just hate opening up aye
- the cost, the lack of access. Most psychs don't have much availability workable to someone working a full time job. Even with the medicare rebates, $100 a session out of pocket is a lot of money when you're living on fine margins.
- covid came at a bad time where i had to video chat most of my appointments, and then laurell house had a massive wait list, by then i was too far gone.
- Cognitive Behavioural Therapy felt like a band-aid solution
- She told me my hallucinations where real and that there’s a spirit Eelam and I’m close to it
- Because they blamed drug use as the cause of every health and mental health problem
- sessions never connect. you go in weekly at the same time and they ask you "well what do you wanna talk about"?. and my response is always "well ive told you my whole life story and all my issues. and you wonder what i want to talk about"? they sit there taking "notes" for what reason??? they never remember whats going on with you. then they offer some B.S. remedy like"imagine your problems are a leaf. put that leaf on a stream and watch it float away....". forgive my language but what the fuck is that? it tells me to just ignore my issues and that again no-one gives a shit and this is worse because youre paying them to give a shit. the mental health program for men is a joke.
- Expensive (even with a mental health care plan and medicare rebate).
- Being told things I already know but obviously already don't help

- useless prick had me locked up because his lithium didn't help my autism
- At times the psychologist can come across as patronising. Understanding the plan for my recovery at the beginning of treatment would've been nice as it began to feel like the sessions were pointless.
- Some have been very condescending when talking on drug use and remove themselves from any rational train of thought.
- Fundamental training seems flawed.
- The psychologist I saw also works for pharmacotherapy who provide my opioid replacement treatment :/
- Only interested in medications
- I was worried because of how she would view me an i have kids so i was scared docs would get involved
- Suggested treatment was not at all practical and did not take in to account my responibilities as a single father, working 6 days a week and raising a mentally unwell daughter.
- I didn't open up 💯 about everything as I'm always worried in the back of my mind they will report me or lock me away in a mental home
- It is so difficult to find one with enough time to get real help. They're just too busy.
- I felt that I was not being heard and definitely wasn't prescribed the correct medication

Barriers experienced by participants in seeking and accessing a psychologist

- My doctor went on sabbatical
- Past experiences with judgemental psychs
- Trust issues
- MONEY. Only having access to 10 sessions a year.
- The GP's have no idea about specific psychologist and what their specialising in. It is so bad that you either have to go to the referred Psych by the GP or if you know one you can try to find an appointment which is extremely painful and on a waiting list. Also GP's have no emathy or understanding when presenting with drug abuse as well as mental health issues it is ridiculous their nature when I mentioned drug abuse.
- I wanted a quick fix and not have to work for it.
- too much uni work, too few hours in the day
- Trans friendly psychs are hard to find
- Arbitrary cooling off periods on Medicare, disinterested psychologist, lazy psychology, the same treatment methods being used even though my mental illness is resistant to CBT due to it not being behavioural, not actually listening to what I had to say.
- They didn't help in the initial instance
- Covid 19 and social anexity are the main top 2
- Attachment abandonment issues and having complex mental health issues limits which practitioners are capable of assisting me

- I just didnt feel like going into my shit with a person I feel cant relate to my problems. I feel very disillusioned most mental health services. I prefer to handle my own problems and use avalible free services if I really feel the need to reach out professionally.
- Don’t want to think or talk about my problems at the time of the appointment.
- Psychologists, understandably, aren't great at dealing with issues that have arisen from negative experiences with the mental healthcare system itself.
- There were no barriers
- Costs, very complex trauma
- It takes a very long time to get an appt
- Confidentiality has been broken in the past leading me to never be fully honest again.
- When i was younger money was defiently a issue. I found now it can be hard to get appointment when its needed
- confidentiality is a flawed concept in its current form that allow stipulations for disclosure. If I want to go to a new psychologist, they can request file notes from the old one and my usage is disclosed against my will. These same notes can be used against me to enforce random drug testing at work despite zero evidence that my ability to work is impaired. What confidentiality is there in that?
- I am out of free visits and cannot afford it otherwise.
- I have very bad trust issues also I hate being vulnerable, and I believed that I could change the problem myself, by experimenting with psychedelics.
- Fear that a psychologist may blow the issue out of proportion
- Finding the process and options/ choices to be overwhelming
- Doctor said it would be pointless until I stopped smoking weed. There is no point sending the money on a psychiatrist until you stop smoking as there will be no improvement because you smoke weed.
- Availability. By the time I really needed a psychologist, it was a 3 month waiting time to see one.
- Massive anxiety
- Work Financial stress
- Last time I spent time seeing a counsellor all they could focus on was my drug use, which at the time was a very small amount if cannabis daily. Instead of focusing on my trauma that I needed to work on we would spend half the session talking about drug use, which was not a problem for me. Mental health workers need to realise that drug use is a symptom of underlying mental health issues, not the problem itself.
- i moved away
- psychologists dont care. please see previous entry.
- trust never met a shrink worthy of trust.
- I shift from wanting help, to not wanting help. Feeling hopeful, to feeling hopeless. Ofelten think about suicide being the best option
- Money Fear of loosing my kids No transport Disabilities
- I felt that sedating me would be a higher priority than solving problems
- My own brain
- Financial

- I was placed on a waiting list to see a psychologist and one year later am still waiting
- Finding help
- After 20 odd years of reaching out and being pushed away you soon learn that you are the only one who can honestly change your life for the better Yes plenty of up and down times of relapse but learning to not be so hard on yourself is another major factor that contributes to your mental state so there is so much more to this than just barriers that the system has

Recommendation by participants

- Zoom chats and the mental health care plan extension. Also I asked my GP to put me on the chronic disease management plan for 5 Medicare subsidised psychology sessions which provided additional affordable sessions after my first 10 sessions from my mental health care plan ended.
- More accessibility to psychologists and all bulk billed sessions so poor people can access regular help.
- Referral process needs to be made more effecient and accurate according to drug abuse and mental health.
- she definitely needed more info. she was very lovely and experienced in other ways but wasn't prepared to talk about drug use which I thought was an oversight for a uni counsellor considering the demographic.
- Just make it more accessible, pretty much any australian with mental health problems can't access the services and will say the same, because the way it's setup is it's easiest to access when you either only have a very mild problem or are of good sound mental health, it doesn't take the abstract nature of the brain and how it functions into account, including the persecutory nature of illicit drug use, alcohol is more likely to cause depression than most hard drugs, nicotine is more addictive than heroin etc. Psychologists need to stop being ignorant to facts and more open to discuss the nuance between dependencies, addiction, habitual use and occasional use and the hallmarks of each, as a large problem is the drug user knows more than the psychologist about the drug they're taking.
- More time each session The thing about seeing a psychologist is that there isn't enough time per session I was getting one hour a week that was the best and I like that but wanted more but couldn't because of too many clients
- Drs and psychs recommend healthy eating and exercise, these programs should exist or if they do the information should be easier to find, how can a depressed female get a boob job but I can't have help trying to loose weight and learn how to better take care of myself Not enough info on available services that these professionals can link in with to support recovery
- honestly don’t know. Mental health is such a unique experience for everyone. Maybe if it wasn’t so clinical and professional it would be less mentally exhausting.
- I dislike telehealth
- A great understanding of how “illicit” drugs can help with mental health (cbd, thc), not treating it as a dependency or a negative option when needed
- I felt like if they were more interested it would’ve been better, not that it’s their fault they weren’t interested. They tried to seem like they were but I didn’t feel it. Also needing to pay extra for a diagnostic book felt off to me.

- Don’t treat me like a fool. I know what and who I am, I know how my mind works, I want a prescribed dose of the drug that I have used for decades, so I can have some control. I don’t want to be dependent on the prescriptions and advice of those that are less knowledgeable than I am on my situation. I am fully aware of me and how my mind works. I just don’t have the power to prescribe myself what I know that I need.
- Cheaper 20 MHCP sessions a year A stronger sense of confidentiality
- Telehealth is better than nothing but worse than in person sessions
- Honestly making it more affordable, more strict standards on breeching confidentiality even more so when it comes to s3xaul thoughts, voilant thoughts or dr*g use sure these things are taboo but no one is going to seek help if they fear going to jail, hosptial or other punishments for SEEKING advice and help.
- - 100% subsidized sessions from medicare. - In person sessions - evaluation of patient affect is a standard part of the mental health evaluation - it needs to be done in person - covid is not an excuse, we signed up to help people, you knew you would be front line in the event of a pandemic. Thats the trade off we made for job security. - Priority given to psychologists with former experience with drug and alcohol work for patients requiring that assistance / therapy.
- Make it anonymous
- Sessions shouldnt be covered under health insurance as they should be publicly funded
- It would be a lot better if the psychologist I saw didn't immediately equate illicit drug use with having a "drug problem" and instead took a more open approach to it - people routinely use substances like coffee and alcohol to change their brain chemistry and this is not stigmatised. How is the use of cannabis significantly different? She tried to refer me to drug diversion programs immediately, which created a resentment that made it hard to receive effective counselling.
- Not feeling ashamed about using drugs by health care professionals.
- Obviously in this day and age it’s hard to get appointments let alone keep them. More availability is a must
- completely covered by medicare.
- caring
- correct diagnosis autism is not bipolar
- Understanding treatment. More honesty from the psychologist or one with a better Poker face. As someone who can 'read' people with scary accuracy I know when I see skepticism, underlying amusement and lack of self believe in their knowledge. I ask questions to which the answer was often, 'i can't tell you that,' which began to make the sessions seem pointless.
- Give more free sessions to people that are on welfare and make all gps do mental health plans
- This is such a hard topic for ant professional Me personally I find it hard to relate and take text book theory seriously This is a major factor of patients feeling misunderstood simply because of the professional opinion actually being not so correct in the way of understanding why people use and not understanding or ever have used illicit substances them selves so there is a big gap in the thoughts and feelings of both parties involved

Additional comments

- If you can't find anyone through your GP don't forget to try EAP if your employer provides them, or any free counselling services now available partially due to COVID-19. Also people can try self therapy through studying DBT on audio books, or psychology coaching podcasts like "UNf**k your brain"; or free apps. So much of therapy is what you do outside of hours.
- Mainly the costs are too high and the waiting lists are too long
- It has taken over a year to access a psychologist for my husband, because most psychologists books are closed. And the others just choose who they want to take on. The GPs don't know who's books are closed so my husband needs a gp appointment for the referral, then a phone call to psychologist, then back to GP for new referral....this has been a 12 month cycle. Why don't GPs have a list of this information, and on what the psychologists sub-specialty is? He also can't access the medication needed for his adhd because of his occasional cannabis use. That is medically illogical. Yet my best friend with adhd accessed medications immediately without having to do a urine test. Why different rules in the same state??? Additionally, most people can't afford private health insurance or full fees. Why is mental health support only accessible to the wealthy?
- It's more than hard to access help because when you're brother has hung himself, the last thing you want to do is be on the phone or make phone calls or attend sessions with a psychologist who isn't interested and makes you feel like it's a total waste of time. People who are psychologists are to have an interest in people and at least pretend they do or they should refer them to another psych who is more suitable.
- I'd like to see shrinks who operate more on radical class based analysis and less neocapitalist individual responsibility claptrap.
- The biggest barrier is cost
- Over 6 month waiting lists
- Just make it easier
- General practitioners should refer people to qualified and reputable psychologists for their individual needs instead of the general referral networks.
- Need a proper register of treating practitioners and which forms of treatment they offer and which issues they're capable of or interested in treating, when I'm ready to seek support it should be simple not having to Google this info, I need to be responsible for me but if I become overwhelmed and it all becomes too hard it's too easy for me to put it off
- Doctors should redirect to social worker to fill in 1 month+ wait time where critical
- I fear that most crimes will stem from people wishing they could get advice, help, thoughts, connections but can't because fear of punishment or lack of money. That's how it is a reality in Australia right now and I will d1e at age 26 because of this unless things will change.
- there is not enough information available about where to get help
- Yes. Private Health Insurance is one thing, but a significant portion of our population (especially people with substance and mental health issues) can’t afford it. An increase in public funding through Medicare would substantially contribute to the accessibility of psychological services.

- It feels very elitist now. Only wealthy people who are working on their mental health and bettering themselves can afford mental health services. All services around me are so expensive and fully booked due to this. I do believe that everyone should be using mental health services but when its basically gentrification and I end up not being able to afford help due to this.
- Having anxiety, Telehealth has made a big difference in ease of access for me. Cost and time off work remains a barrier
- Why are you not trying to train many more to help with the mental health issues of a whole generation
- I currently have a great psychologist who I have regular appointments with for free because I am on a disability pension. Some of the other psychologists that I have seen over the years, through public, have not been great. In the past, through the public system, you didn't get a choice in who you see. I don't know if this is the case at the moment because I have been very lucky to be paired with someone that I am happy with. But I do believe that the public system, and its limitations, could be a barrier for people.
- they saved my life
- telehealth experience was so helpful
- company provided was the best experience and allowed me to open up about my drug use
- mens mental health is treated like it shouldnt exist.
- never again.
- I want to understand how a psychologist can help and what tactics or treatments they plan to use at the beginning of treatment.
- Not really. Took like 3 & a half months to see one after going to hospital on a mental welfare check :(
- It is hard for me to approach gps for a mental health plan, as they are judgemental and not trained properly to deal with mental health issues let alone drug issues. You are met with a brick wall when both of these are mentioned. I went to two different gps and asked for a mental health plan so I could see a psychologist for 10 sessions free, as I am on a disability pension and can't afford to pay for one, and was told by both that sorry we don't do mental health plans, so what do I do? And even if I got a mental health plan and went to see the psychologist I'd only get 10 sessions a year which isn't enough. I'd really to see a psychologist once a week, which means I'd need probably 50 sessions a year. I think that I'd need a weekly session to make progress and work towards managing my drug and mental health issues. I'd prefer to see a psychologist because I would like to undertake a medication free option as I have enough drug problems without taking medications. It would be good if there was more information about treatment, and what yo expect so I could make an informed choice as to whether I want to see a psychologist of not. A national register if psychologists and their contact details should be put online so people can search for a psychologist in their area, and also maybe reviews by people so you can see if they are a good psychologist or not. Also, more information about specialising in drug addiction and mental health disorders could be included online as well
- Often don't know who you re getting and a bad first appointment will discourage from further appointmrnts.