The Experience of Alcohol Use in Young People with Severe Mental Illness: An Interpretive Phenomenological Analysis

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Declarations

Statement of Originality

This thesis contains no material which has been accepted for the award of any other degree or diploma in any university or other tertiary institution and, to the best of my knowledge and belief, contains no material previously published or written by another person, except where due reference has been made in the text. I give consent to this copy of my thesis, when deposited in the University Library**, being made available for loan and photocopying subject to the provisions of the Copyright Act 1968.

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I hereby certify that the work embodied in this thesis contains a published paper/s/scholarly work of which I am a joint author. I have included as part of the thesis a written statement, endorsed by my supervisor, attesting to my contribution to the joint publication/s/scholarly work.

Acknowledgement of Collaboration

I hereby certify that the work embodied in this thesis has been done in collaboration with other researchers. I have included as part of the thesis a written statement, endorsed by my supervisor, clearly outlining the extent of collaboration, with whom and under what auspices.

I, Caroline Anderson, attest that I was responsible for the review of literature and writing of the manuscript contained within this thesis. I conducted the recruitment of

participants, the semi-structured interviews, transcribing of data, and analysis of data. Professor Amanda Baker and Sonja Pohlman designed the study, and Sonja Pohlman also independently analysed the data. Both Sonja Pohlman and myself contributed to the interpretation of the data and implications of the findings. Drafts of the manuscript were forwarded to Professor Amanda Baker, Associate Professor Sean Halpin, Dr Kristen McCarter, and Sonja Pohlman for review, and amendments were made based on their feedback.

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The Experience of Alcohol Use in Young People with Severe Mental Illness: An Interpretive Phenomenological Analysis

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Abstract

Poorer health for Australians living with a mental illness is a public health concern. There is a high prevalence of comorbid substance misuse in people living with severe mental illness (SMI), and alcohol misuse is a key factor in cardiovascular disease, cancer and obesity. Research suggests a better understanding of how people with SMI use substances such as alcohol is needed. The present study aimed to explore the experience of young people with SMI who use alcohol. Participants (*n*=8, aged 18-25) were residents of a medium term mental health treatment facility, and completed interviews and self-report questionnaires. Data was analysed using an interpretive phenomenological analysis approach, with five superordinate themes emerging: mental health and wellbeing; alcohol as a means to navigate the social world; alcohol to control internal states; alcohol to feel normal; and ambivalence about alcohol use. Questionnaire data suggested alcohol was the most commonly used substance amongst participants, participants tended to understate their alcohol consumption in interview, and alcohol was most frequently used for social and enhancement reasons. Alcohol use was seen as an important social tool, a way to control aspects of life that SMI had impacted, and a way to feel normal around peers. The results aid understanding of how and why young people in Australia with a SMI use alcohol and may assist with future interventions to reduce alcohol related harm. Interventions for young people with a SMI who misuse alcohol should take a holistic approach and explore the function of alcohol in the young person's life.

Keywords: alcohol, motivation, severe mental illness, youth

Introduction

Worldwide, mortality rates are significantly higher for those living with a mental illness, and approximately 14% of deaths each year may be attributable to mental illness (Walker, McGee & Druss, 2015). Consistent with worldwide data, Australians living with a mental illness have poorer general health outcomes in comparison to those who do not (Roberts, 2016), and they are more likely to die prematurely from non-communicable diseases such as cardiovascular disease (CVD) and cancers (Harris et al., 2018). The risk of poor health outcomes increases for people with a severe mental illness (SMI). People with a SMI are more vulnerable to experiencing a range of other health problems, including obesity, CVD, poor nutrition, and lower levels of physical activity (Morgan et al., 2010). Life expectancy for those with a SMI is also significantly lower than the general population, with estimates between 14 to 23 years lower age at death (Roberts, 2016). The economic cost associated with the additional physical illness associated with SMI is also great, at around $15 billion annually, equating to nearly 1% of Australia's Gross Domestic Product (Roberts, 2016).

There is a high prevalence of comorbid substance misuse in people living with a SMI (Moore et al., 2012) and subsequent negative health outcomes, with alcohol misuse being a key factor in CVD (Rehm & Roerecke, 2017), cancer (Baan et al., 2007; Cao & Giovannucci, 2016) and obesity (Traversy & Chaput, 2015). In 1997-1998 the first Australian National Low Prevalence (Psychotic) Disorders Study, surveying people with psychoses, found 28% of survey participants reported lifetime alcohol abuse or dependence (Jablensky et al., 2000; Kavanagh et al., 2004). The more recent Survey of High Impact Psychosis (SHIP), conducted as a follow-up to the 1997–1998 study in 2010, found this figure had increased to 51% (Moore et al., 2012). The samples in both studies were heterogenous, and research suggests a better understanding of how people with SMI use substances such as alcohol is needed. In

particular, there is limited knowledge of how and why young people (aged 16-25) diagnosed with a SMI consume alcohol, and whether or not their alcohol use is different to other substance use and to that of older people living with SMI. The present study investigated alcohol use amongst young people residing in a medium term treatment facility for people with a SMI, such as schizophrenia, bipolar disorder, or depression with psychotic features.

Risk of Alcohol Misuse and Psychosis

In a review of self-reported reasons for substance use in people with psychosis, Gregg and colleagues (2007) suggested there are a number of factors involved in substance use and psychosis, including demographic and contextual factors. Alcohol misuse does not necessarily precede schizophrenia, is more common in those with psychosis, and may worsen symptoms of psychosis (Gregg et al., 2007). A more recent longitudinal study in the United Kingdom suggested that alcohol has a negative effect on mood in people with psychosis, but has less effect on psychotic symptoms (Barrowclough et al., 2014). The negative impact on affect is reversible with reduction in alcohol use (Barrowclough et al., 2014).

A large prospective American study (Buchy et al., 2015) of youth at high risk of psychosis found that although participants endorsed higher rates of cannabis and tobacco use, they reported lower severity of alcohol use over a one year period, compared to controls. However, Australian youth at risk of psychosis have been found to consume alcohol differently. A recent Australian study reported that young people at risk of psychosis used alcohol more than other young people seeking help at a youth mental health service (Carney et al., 2017). Strong associations between substances suggested that polysubstance use was likely in both at risk and other young people seeking help. A limitation of the study was the lack of consideration of the social factors that may have contributed to both issues. A comparision of the younger legal drinking age in Australia than the United States of America

(18 compared to 21 years of age) and how this impacts on alcohol use in young people was not considered by either study, but may be an interesting area of further research.

Reasons for Alcohol Consumption

In Australian university students, personality features, including sensation seeking and impulsivity, were found to be associated with higher drinking during university orientation, and six months later (Loxton et al., 2015). A 2006 review by Kuntsche and colleagues on drinking motives in young people found personality factors such as sensation seeking and extraversion were associated with drinking for enhancement, while anxiety and neuroticism were associated with drinking for coping reasons. They found that those who drank for enhancement drank more heavily, and those who drank for coping reasons experienced more alcohol related problems. They found that there were similarities between drinking motives across cultures in young people, with most drinking for enjoyment and social reasons. They noted, however, that the majority of the studies available were from North America and greater diversity in studies would be informative. Limitations in the review included differences in definitions of problematic use of substances and use of different measures to assess these.

An Australian study using both qualitative and quantitative data examined reasons for substance use in those with psychotic disorders (Thornton, Baker, Johnson, Kay-Lambkin, & Lewin, 2012a). An interpretive phenomenological analysis found that people with psychotic disorders used substances for various reasons including pleasure, coping, and social reasons, with alcohol primarily used for pleasure and social reasons. There was variability in age amongst participants and a focus on adults, with a mean age of 43 years. Furthermore, the participants were drawn from a research bank and they may have been higher functioning than residents of an intermediate stay mental health unit undergoing mental health treatment,

who were the focus of the present study. Using data from five randomised controlled trials examining reasons for substance use in Australian adults with mental disorders, Thornton and colleagues (2012b) found that both tobacco and alcohol were used foremost for coping, with alcohol specifically used to cope and escape from feelings of loneliness, boredom and negative affect. Alcohol was also found to be used for social reasons, in line with Thornton and colleagues (2012a).

Interpretive Phenomenological Analysis

Pietkiewicz and Smith (2012) encourage the use of qualitative research in psychological studies. They propose the use of interpretive phenomenological analysis (IPA) to allow exploration of lived experiences and an understanding of how individuals make sense and meaning of their experiences. The IPA method utilises a double hermeneutic approach whereby the researcher attempts to make sense of the participant's sense making. The focus is on the experience of individuals, treating them as experts on their own lives and experiences. The 2012 Australian study by Thornton and colleagues used IPA for the qualitative analysis component of their study with adult Australian participants with SMI using various substances. The present study similarly used IPA, but focussed specifically on Australian young people with SMI and their alcohol use. The IPA method was chosen over quantitative methods to allow an in-depth exploration of the lived experiences of Australian youth with SMI, without presumptions. Also, the IPA method allowed scope for commentary on aspects of alcohol use not captured by psychometric data such as social influences, cultural influences, and ambivalence towards alcohol. Participants in the present study were asked questions using a semi-structured interview and were asked to complete self-report measures.

The Present Study

The aim of the present study was to explore the knowledge and understanding gained through lived experiences of young Australians with SMI who consume alcohol, and to gain an understanding of their motives and use of alcohol, and experiences and expectations of mental health treatment and therapy. The purpose of the study was to understand the experiences and motivations around alcohol use in these individuals, rather than define them as a group. Based on a previous similar study with adults with SMI using various substances (Thornton et al., 2012a), it was predicted that the themes identified may include using alcohol for intoxication, using alcohol to cope, using alcohol for social reasons, and positive and negative effects of alcohol use. Given the younger age of participants in the current study, other themes more relevant to young people were also expected to emerge. The study aimed to address gaps left by the predominance of quantitative research on reasons for substance use (Chorlton & Smith, 2016) – specifically limited depth of understanding on contextual factors involved in substance use. Understanding contextual nuances of motivations for alcohol consumption was expected to provide treatment-relevant information.

Method

Participants

Participants were inpatients of the Intermediate Stay Mental Health Unit (ISMHU) in Newcastle, NSW, Australia. Participants were drawn from those who identified as consumers of alcohol. Unit staff assisted with recruitment of participants by identifying potential participants. The interviewer (CA, a Master of Clinical Psychology student with previous experience as a generally registered psychologist) attended ISMHU morning meetings on three occasions during December 2018, and screened interested potential participants for eligibility in person. Participants were a homogenous group who were purposively sampled

using criteria relevant to research questions, rather than being representative of the population of young people living with SMI as a whole. Additional eligibility criteria for participants included having consumed alcohol within the past six months, not currently in the acute stage of mental illness, not currently experiencing substance withdrawal, and aged between 16 and 25 years. In line with Pietkiewicz and Smith's (2012) recommendations for balancing depth and opportunity to examine similarities and differences between individual participants, eight participants were interviewed. Table 1 shows the demographic information for the eight participants (who have been given aliases for confidentiality). Participants were recruited regardless of gender, which was not a major consideration of the present study. The higher number of male participants was reflective of the population of residents at ISMHU at the time of data collection.

Table 1: Participant Demographic Data

Gender	Male	5
	Female	2
	Other	1
Age	18-19	2
	20-21	3
	22-23	2
	24-25	1
Employment Status	Employed	0
	Not employed	8
Educational Background	High School	5
(Highest level attempted)	Tertiary	3
	Vocational trade	1
Relationship Status	Partnered	3
	Not partnered	5

Procedure

Ethics approval was obtained from relevant Hunter New England Health and University of Newcastle Human Research Ethics Committees. Interviews were conducted in person at ISMHU during December 2018, and January and April 2019. A semi-structured interview format was used, with interview duration between approximately 30 to 60 minutes per participant. Interview questions on five broad areas were included and were open ended in nature. These areas were: current and past experiences and patterns of alcohol consumption; alcohol expectancies; reasons for consuming alcohol; self-efficacy with regards to alcohol consumption; and previous experiences with therapy. Participants often

spontaneously offered information outside of these broad areas, and flexibility to explore these potential tangents was maintained. When interviews moved entirely off topic, however, attempts were made to guide the discussion back to alcohol use. Audio recordings of interviews were made using a small, unobtrusive digital voice recording device.

Following the interview, participants completed several brief self-report measures including the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) (WHO, 2002), the Alcohol Use Disorder Identification Test (AUDIT) (Saunders et al., 1993), two versions of the Patient Health Questionnaire (PHQ-9) for current and lifetime depression (Kroenke & Spitzer, 2002), an adapted version of the Drinking Motives Questionnaire Revised – Short Form (DMQ-SF-R2) (Kuntsche & Kuntsche, 2009), the Positive Alcohol Metacognitions Scale (PAMS), and the Negative Alcohol Metacognitions Scale (NAMS) (Spada & Wells, 2008). The time taken for participants to complete these instruments with the researcher assisting completion was approximately 45 minutes, therefore total time for each participant was approximately 90 minutes.

Data Analysis and Interpretation

The first step in analysis involved listening to the audio recordings of eight interviews, and a verbatim transcript was then created for each interview by the interviewer. In accordance with Pietkiewicz & Smith (2012), the transcripts were read several times by two researchers (CA and SP). Descriptive comments, summaries, and preliminary interpretations were made for each interview and emerging themes were documented. The NVivo computer program (NVivo 12 for Mac) was used to code and organise interview themes. A cyclical process of re-reading, analysing and comparing themes was used to identify superordinate and subordinate themes. Interpretation of themes was compared by two researchers, with disagreements or inconsistencies resolved through discussion between

the researchers. Themes from the group as a whole were used to create a narrative interpretation of the lived experiences of the group.

Several principles were followed in order to ensure rigour in the qualitative research process. Reflexivity was maintained through self-reflection, discussions between the research team about preconceptions and findings and summarising, reflecting, and checking understanding during the interview process (Malterud, 2001). While impossible to remove the researchers' expectations entirely, awareness of pre-existing assumptions, presuppositions and own biases shaped by historical, cultural and personal history allowed these to be suspended with an open mind and attendance to participants' experiences maintained (Tufford & Newman, 2012). Method triangulation was adopted and the results of the self-report questionnaires were used as an additional data source to develop a more comprehensive understanding of the phenomenon of alcohol consumption in young people with a SMI (Mays & Pope, 2000). Results from the questionnaires were used to describe rather than compare participants. Transparency was maintained through frequent discussions with the research team at all stages of the study, and detailed recording of the data collection and analysis process.

Results

Following analysis of the eight interviews, five superordinate themes and ten subordinate themes were identified. Themes identified were: (1) mental health and wellbeing (with subordinate themes of impacts of mental illness, the role of alcohol amid mental illness, coping, interests and goals, and thoughts on mental health treatment); (2) alcohol as a means to navigate the social world (with subordinate themes of social aspects of alcohol use and cultural influences on alcohol use); (3) alcohol to control internal states (with subordinate themes alcohol to control mood and sensation and intoxication); (4) alcohol to feel normal; and (5) ambivalence about alcohol use (with subordinate themes of positives and negatives of

alcohol use). These themes, including participant quotes and interpretation, are presented below.

Mental Health and Wellbeing

This theme described participants' experiences living with SMI, the impacts SMI had on their lives, and the role alcohol played amid their symptoms. For all participants, alcohol related problems had not been the presenting problem leading to their admissions, but all had experienced varying positive and negative interactions between alcohol and their symptoms. Mixed emotions were evident towards both alcohol and their SMI symptoms. Participants were open with sharing their thoughts on treatment, and identified a number of helpful and not-so-helpful aspects of their experience with treatment to date.

Impacts of mental illness. The participants were at various stages of admission onto the inpatient unit, with all having been admitted for at least several days and considered past the acute stage of their admission. As such, most participants had reflected upon the impact mental illness had upon their lives, encouraged through group therapy sessions offered at the unit. Most were pragmatic, positive, and open when discussing their mental illness. However, sadness was apparent on occasion, such as Rory's reflections on a difficult period:

> Ah, pretty severe depression and I had just been diagnosed … um, not long after I turned 18 and I was already drinking, when I got that diagnosis and ah, I just didn't know what I was doing with my life. And I didn't know how to deal with all of these emotions that were popping up.

For some, mental illness had steered their lives in a different direction than what they had planned. Taylor's experience with mental illness had involved taking time away from studies, and most friends had moved out of town:

> I am taking a break from Uni, um, I kind of have like other friends now that I spend time with. Yeah.

When recalling an incident that had led to a previous inpatient admission, Kim recalled:

> I felt so ashamed of myself, felt low.

The role of alcohol amid mental illness. For some participants, alcohol served as a substitute for other substances. Alcohol was seen as having less of a negative impact on mental illness symptoms than other substances. For example, Austin commented:

> Well at the moment I am trying to give up marijuana so it's like um, it is just a substitute sort of thing at the moment. I use it as a substitute.

Brooklyn similarly felt alcohol was a 'safer' option than illicit substances:

> Because it really didn't have much of an effect on like bringing out any like, psychosis or like manic symptoms or anything like that, so.

Cameron, however, had found that using alcohol as a substitute for cannabis had its own negative consequences:

> So ah, once I started getting off that, ah, I started drinking a bit. Um. But then I was like, yeah that's not a good idea. I was drinking most nights, um. But then I moved back to pot, and then I came in here to get off pot.

For others, alcohol was used as a coping mechanism in the context of their mental health symptoms, with varying degrees of success. For example, Taylor described using alcohol to cope with distressing thoughts and to temporarily forget about the mental illness:

> I would drink to a certain point where my brain kind of forgets that um, I have an illness… I think thoughts, like all the bad ones just go away… Um. I think maybe it just helps me forget that I have, like all these anxieties or um, yeah problems in general I guess.

Similarly, Cameron had found that drinking alcohol reduced distressing thoughts in a way cannabis has not been able to:

> All the negative thoughts that I'll have with the, you know, smoking pot or the drinking will just dissipate. Which is, like, as opposed to when I'm not drinking, there's all these negative thoughts coming in.

For Brooklyn, alcohol was seen as an easily available, temporary 'fix' for mental illness related concerns, including medication side effects:

> [Medication] it gave me, it made me quite restless and I found that if I had drank some alcohol like, or like, like a fair bit of alcohol, and then like, on a night out or whatever and then go the next day. The next day that restlessness wouldn't like, be there. Like I could actually sit still. When, like, normally I would be like rocking and I don't know, things like that, like pacing up and down. I did find that it, kind of um, it was like a temporary fix.

Coping, interests and goals. Despite the challenging aspects of living with SMI, a sense of hope, optimism and future orientation was evident amongst participants. Most of the participants described future goals, and alternative coping mechanisms that they had developed over the course of their treatment. Taylor was looking forward to finishing a six-week stay at the unit:

> Um yeah, like sometimes when I do something fun with other people, um, just like telling stupid jokes or going camping or something. It is nice. And does a similar thing without the alcohol.

For some participants, being at the unit and not being able to consume any non-prescribed substances had meant they had been confronted with finding other ways to cope, such as Austin's use of distraction:

> I just play the computers. Go on Facebook, um, and talk to your friends on Facebook, sort of things like that. Yeah.

Some participants, like Sage, were optimistic about their ability to 'stay on track' once they left the relative safety of the unit by using meaningful engagement in enjoyed activities:

> Yeah, like sports, just hanging out with mates, um yeah just keeping busy with work and stuff like that, that all helps.

A sense of need to find meaning and new ways of living their life was evident for most participants, such as Cameron who was looking forward to starting a job on discharge and commented:

> Yeah, and also the fact that I've never been not high, so I've never had something to fill up my day. I guess like, if you feel that anxiety, and you've got nothing else to do. So you just turn to that. Rather than sort of, having a job and focussing on that to get through I guess.

A determination to capitalise on the recovery gains they had made while an inpatient was often felt throughout the interviews, with some feeling that substances did not have a place in their post-discharge world. Participants acknowledged both the potential difficulties they could face moving from the protected environment of an inpatient facility to their regular environments, with most commenting on the importance of developing and maintaining new skills, and filling their lives with meaningful activities such as work or focus on family.

Mental health treatment. Participants were generally positive in their comments about their treatment experience, which was consistent with their context at the time of interviews

(voluntary admission to an open unit). There was unanimity in the belief that treatment had helped them, and even a sense of pride in some participants that they had the courage to seek assistance. Kim, for example, commented:

> Um, I was a bit shocked that I got in because it's been two years that – no been a year since I've tried to get in. And then now I finally got in, and I want to start my recovery journey again. Re-start, put everything to the past. And then um, start my new life again.

Positive elements of treatment including knowing that "there were, like, other people who were a similar age" (Taylor), treatment tailored "specifically to do with my mental illness" (Taylor), and people "showing their experiences" (Austin). Sage appreciated knowing:

> Like if, if I had a problem, like, I'd know that there is help out there and to like, seek help… Um, you're in like a good environment here where people are very open about like, situations they're going through. And it's um, they have specific programs for addiction and stuff.

Several participants were interested in hearing others' lived experiences of substance problems and mental illness, and felt that would enable them to engage more readily in treatment. Brooklyn, for example, stated:

> Um, probably by hearing someone's first-hand account as to how it helped them.

There were mixed opinions on methods of treatment. Some participants preferred one-on-one treatment, some wanted substances to be addressed during treatment for their primary mental illness whereas others wanted dedicated alcohol and other drug treatment, and some liked the idea of phone or internet interventions for the privacy and convenience they offered.

Brooklyn was positive about alternative methods of intervention:

> I could just actually like get into, as, like sooner, than have to go like, somewhere, like, on a set date. You know, um, um like not having to like, physically be somewhere, where I can be like in the just privacy of my own home. Not like, maybe, if it were to be like something like AA, where like I met, what if I saw someone I knew? Or something like that. Yeah.

Other important factors in treatment included developing coping mechanisms, and being understood and heard. Cameron, for example, commented:

> Just like, coping mechanisms to deal with like, anxiety and stuff like that. Um, not like any therapy that I've tried, it just, when I feel like they don't quite understand what I'm laying forth, it makes me a bit frustrated… So, say if I say something, and they just try to rephrase it but it's just completely not what you were trying to get at.

Caelan summarised a concern that was voiced by other participants:

> I think it would make sense um, for there to be like minimal pressure on the attendees, um, I, I've heard about AA sort of expecting maybe a little too much from people, that's just what I've heard… Um, something that's a bit more impartial would make more sense I think.

Despite their help-seeking behaviour and the perceived acceptability of treatment, participants felt stigma still existed around seeking help for the 'invisible' illnesses of addiction and mental illness. Rory was hopeful in the future, there would be less stigma and more information available to the public about mental illness in young people:

> …I think adolescent mental health, it needs to be on the radio and on the TV as much as the, I think the um, they need to be advertising every aspect of mental health. Um, whether that's age, diagnosis, things like that. I think they need to be doing that so much more than they currently are so that it's more normalised. Ah, even putting up stats of how young people are in some kind of therapy, because it's not talked about between younger kids very often… I think it wouldn't be seen as, you wouldn't be so ashamed. And you would be happier to talk about with, you know even close friends. Um. You wouldn't try and hide that you were going to therapy. And I, yeah, I guess I know that from a personal. I was missing a fair bit of school and was telling even very, very close friends that I was just going to the doctor's. And they, you know, I always had sleeping issues and I just kind of blamed it on that. But you just kind of pick and choose… You say you're on a medication because you're not sleeping well and people can accept that easier than they can accept a medication for mental health… And um, yeah, it's, it's a lot easier to lie because a lot of people don't understand.

Alcohol as a Means to Navigate the Social World

For all participants, alcohol was used either presently or in the past as a social tool, either to make socialising more enjoyable, or to facilitate social contact. For some, alcohol was seen as an expected, even unavoidable, part of the cultural experience of Australian youth. Most participants (six) had been introduced to alcohol in a social setting, and while they did not describe feeling coerced into consuming alcohol, an element of 'drinking to fit in' resonated throughout the interviews.

Social aspects of alcohol use. All participants had primarily used alcohol in social settings, although some had also used alcohol at home or alone. For example, Taylor commented:

> Um, mostly as a social thing, so either if I'm going out with friends or having a night in with my housemates.

Similarly, for Sage alcohol consumption was a way to 'bond' with co-workers when working for the first time:

> Um. My experience with alcohol is um mainly just social um, and why I use it is kind of like, at the end of the work week, like just go out with mates and stuff and kind of relax and have a few beers, that's the main reason for my use of it.

Alcohol was seen as a way to enhance social experiences, and experience simple pleasure, as was the case for Kim:

> Yeah, with friends… Just have a good time, listen to music. Have a few drinks.

Alcohol was also seen as a way to make it easier for participants to engage socially. It was expected that alcohol, to a point, would increase interpersonal effectiveness and make participants more enjoyable to be around. Brooklyn commented:

> I guess just that kind of typical drunkenness. Drunkenness feeling. Um, ah, I'll be just like expect to be, I, it's expected for me to kind of be more um, talkative and like, social. Um, I don't know. I do expect to, I don't know, have a good time I guess.

There was a sense of feeling that in order to live up to friends' expectations and maintain a 'fun' persona despite living with SMI, alcohol ultimately took some of the pressure off, as was the case with Cameron:

> Cameron: … if I just chilled with them without drinking, I just get a bit shitty, you know?
> Researcher: Yeah, it would be difficult?
> Cameron: Yeah, because it would be difficult even not with them, you know what I mean?

There was often a sense that if participants chose not to consume alcohol, they would be left behind or left out of things, such as in Caelan's case:

> I have found it to really allowed myself to um, go on more social events than I would have otherwise, so um, were I to withdraw myself, which I have in the past, from um alcohol use it's almost um in a colloquial sense social suicide um,

> because you're just reducing the amount of opportunities that you have to interact with others in your you know, sort of general community and age bracket, yeah.

Caelan was also concerned that refraining from alcohol use entirely would make self-expression difficult:

> I'm more likely to express myself and I often get comments from people saying you're much more yourself when you partake. Because you're willing to you know, actually express, I'm willing to express myself more, and I, I don't really allow the barriers that I place on myself socially when I'm sober to really be there.

Cultural influences on alcohol use. Alcohol use was ubiquitously seen as a normal part of Australian culture for young people, summarised by Sage's comment:

> I just feel like something that pretty everyone does, like especially in Australia.

There was a sense that alcohol use was socially acceptable, as opposed to illicit substances which were associated with risks and shame. Most participants did not feel their alcohol consumption was problematic, and indeed, some felt that abstaining would be problematic and leave them as an outsider. According to Caelan:

> So um I guess it's also um just the ah, the standard in young people particularly in the way that they interact… Oh well, just because so many um, events, surround

> or involve alcohol usage and if you don't participate um, I guess you'll be at a level that's above what everyone else will be.

Given the perceived pervasiveness of alcohol use in young Australians, it was seen as embarrassing and shameful to admit there was a problem with one's alcohol consumption. A sense that if friends without SMI could consume alcohol seemingly without problems, it made one different and defective to not have the same experience. Rory, for example, had found that alcohol had become problematic at various times, but felt glad to be able to control alcohol use presently:

> I've now got a bit more of a hold on it and this year that's what I've said- if I want to have a drink I'm not going to actively stop myself. Um, because I've shown that I can stop myself um, and yeah I guess it's such a big culture thing as well. That you go out and you have a drink.

Rory's comments about peers' alcohol consumption typify the struggle between 'being like everyone else' and 'doing what will benefit own recovery':

> At that age everybody's drinking and they're usually drinking a bit too much and nobody's calling it a drinking problem. It's just you know, people going to uni and they're making new friends, there's more birthdays, there's more people that are adults so they can be drinking. Um, and that's why, I think that's why it took so long for me to realise that it was a problem but I'm very glad that I picked it up while I was still young.

There was a sense amongst participants that binging alcohol consumption amongst young people, often with limited insight into the potentially hazardous nature of this consumption, was normal. There was an acknowledgement that within the wider group of Australian young people some consume alcohol more problematically, or with a greater purpose. This included consuming alcohol as a means to control internal states.

Alcohol to Take Control of Internal States

Alcohol was often described as a means to control the way participants were feeling. Several participants used alcohol to reduce anxiety and some used alcohol as a solution when they were feeling distressed:

> I was probably looking for something to use as a crutch (Caelan).

Some participants enjoyed the bodily sensations associated with alcohol, including feeling relaxed, whereas others drank with the intention of becoming intoxicated. For all participants, alcohol served some purpose as a tool for coping, often associated with the complications their SMI diagnosis brought.

Alcohol to control mood. For some participants, alcohol was associated with happiness, including enjoyable times with friends and family:

> Just I'm sort of like happier when I drink yeah (Austin).
>
> Um just the feeling that it gives you, like when you, you've had a few, it just feels good so you just want to keep going (Sage).

For some, their mood when consuming alcohol was not always positive:

> I'll be like more self-loathing at times. Like, I will just like, hate myself, I'll think I'm just pathetic and stuff. But other times it's like, um like I feel like I have a heightened um self-esteem. So yeah it just depends on where my mood is at, I think (Brooklyn).

And:

> I'm more funny and happy and I laugh about anything… I'm a happy drunk. Sometimes. But if someone crosses, like bees a smart-ass I just, I'm not in the mood for smart-asses. I hate smart-asses (Kim).

In some cases, the unpredictability in the impact alcohol would have on mood was attributed to the stability or otherwise of their mental illness symptoms:

> So it can go yeah either way, like if I'm feeling more, if it is like got to the point where I have missed all this, like, sleep and I have just been doing like just being just manic basically, um, and yeah being drunk yeah, I will just get more irritable. But earlier, um, like in that, during that like phase of mania, where I am feeling very like up, kind of stimulated I guess, um, it um, just will kind of chill me out a bit I think (Brooklyn).

Reduction in anxiety when consuming alcohol was noted on a number of occasions:

> Like I, it would de-stress me a lot. You wake up, feeling a little bit shit. And also, you can't really think through the night if you've been drinking for like, six or seven hours (Brooklyn).

And:

> I'd say generally, um, it makes me a lot happier. It um, it reduces any anxieties or apprehensions that I might have (Caelan).

And:

> Ah, it helped numb the anxiety (Rory).

Sensation and intoxication. A common enjoyable aspect of alcohol use described by participants was the sensation or 'buzz' they received. Although participants had different ideas about the ideal level of intoxication, they all had an idea of what they were trying to achieve upon commencing a session of consuming alcohol:

> I do like to drink to a point where like you get a little bit of that buzz and it just feels like how I used to feel with my friends, just like hanging out (Taylor).

For some participants, the aim of the alcohol consumption was simply to become intoxicated:

> Nah, I still drink to get drunk. I don't drink just to enjoy it (Austin).

Whereas for others, their aim was to become 'tipsy':

> Ah, yeah I just like the feeling you get when you have a couple. Like, I guess (Sage).

And:

> It was just to get that tingly feeling. And just, your senses aren't as heightened… (Rory).

Alcohol to Feel Normal

Despite remarkable optimism in participants, there was a predominant sense of being different to others because of their mental illness. While being in an inpatient facility at the time of interviews was perceived by some as safe and protective at best, and boring and frustrating at worse, most participants had found time to reflect on their lives and what their mental illness meant. There was a sense that their mental illness had stripped part of their identity, and robbed them of opportunities. Some found that alcohol was a means to regain their lost identity and feel like everyone else:

> But that was mostly just like because I liked how it felt. Like it feels like I am not sick or have something… I kind of just missed that feeling of like, being normal, and yeah (Taylor).

For Sage, alcohol acted as an escape:

> Yeah maybe just like kind of like, lets you escape from the problem for a little bit.

Whereas Cameron felt that alcohol helped with self-acceptance and ability to concentrate:

> Ah, I guess I'm more like, comfortable with myself… Yeah, just sort of zoned in and able to concentrate.

Caelan felt comforted, and a sense of returning to normal when able to see friends and share some alcoholic beverages:

> It had been a while since I'd really felt like I'd done normal, sort of, you know, night with friends or whatever. Um, because it had been quite some time for me. It had been like, three or four months. Um, and it's, it's not necessarily like a return to form, that's probably giving it too much credit but um just yeah, like a comfort in that you, you know, you're back to doing normal things um, yeah, yeah.

For some, feeling in control of their mental illness symptoms enough to warrant returning to alcohol consumption was interpreted as a victory in their recovery journey:

> It's only really on occasions or if I've just kind of gone oh I could, you know, a glass of wine tonight would be nice. So, I might do that now (Rory).

Ambivalence About Alcohol

Most participants described some reservations about alcohol consumption, and some described negative impacts consuming alcohol had in their lives. Overall, there was a sense of ambivalence with regards to alcohol, especially in the context of participants' mental health recoveries.

Negatives of alcohol consumption. Taylor felt consuming alcohol was incongruent with certain values, such as setting a good example for younger people:

> My boyfriend's under aged siblings that made me want to like, do the right thing and you know not be a bad influence on them. Yeah.

Whereas for others, concern about worrying and disappointing family members was evident:

> They don't really like it at the moment because they know I'm 18 and I can drink, but they don't really like it at the moment because um, on my medication it says I am not allowed to drink on it (Austin).

Intense and negative emotions were occasionally experienced when consuming alcohol:

> Sometimes just like rage. A little bit of that… I just um, see the worst in everything. Um, I feel really bad about myself, like I'm angry at myself, I'm self-loathing, um just irritable, like um, yeah just thinking like everything just sucks basically (Brooklyn).

And:

> I kind of realised that I was feeling guilty for drinking. Um and I think it had a bit of an effect on the depression. I think it made it a bit worse. Sometimes I would in like a bit of the anxiety or the anger or it kind of, even positive emotions (Rory).

Other participants were concerned about risk taking behaviours and regrettable situations:

> If you take it too far like you're obviously going to regret it, because you're going to end up like vomiting or passing out or saying things you might regret, like because it's just too far… Yeah it's just like drinking too much, maybe saying some things that I wouldn't have said when I was sober to some people, and um getting in fights probably driven by alcohol. Um, yeah just making, making dumb decisions yeah (Sage).

And:

> And then I'm on, now a 12 month good behaviour bond…So now I've got a start of a criminal record (Kim).

For half the participants, family history of substance misuse and alcohol related problems led to concerns they may repeat history:

> Dad's Dad, and like he – he's good now, but like, when they were growing up you know, he'd get on the piss and be a bit abusive. So they had – that was sort of, always on the back of my mind (Cameron).

Positives of alcohol use. The benefits and positives of alcohol use meant that it was difficult for participants to imagine cutting alcohol out of their lives completely. Most participants did not see their alcohol consumption as problematic despite describing several drawbacks of alcohol consumption including those mentioned above. Taylor commented:

> It has never been, like, a huge problem for me.

And Cameron's comments echoed this sentiment:

> Drinking's never been, like a, an addictive issue.

The sense that the benefits of alcohol often outweighed the drawbacks was strongly felt. Kim recalled previous enjoyable nights consuming alcohol with laughter:

> On me 18th I was that plastered the security guard's like "Hey have some water." And I got some water, drank it, went to the toilet and then just poured my um, flask in the cup with vodka and then started drinking again. And then she clicked on and then she took it and chucked it away.

Caelan recalled mainly positive experiences with alcohol:

> I never experienced any withdrawals or anything like that, it's always been um, pretty um, positive experiences with alcohol.

Most participants felt that they now, or always had, appropriate self-efficacy to control their alcohol consumption, as exemplified by Taylor and Sage's comments:

> I think I, I have always been able to stop if I wanted to (Taylor).

And:

> I think it's just about like finding that like middle ground where you're just not like doing it to excess (Sage).

Quantitative Results

Participant ages ranged from 18 to 25. The mean age of participants was 21 years of age, and 63% of participants were male. Questionnaire results are summarized below.

Participant AUDIT total scores varied from the low risk to the high risk range (*M*=14, *SD*=7.98), with half of the participant group scoring 16 or above, placing them in the high risk or harmful range for alcohol use (alcohol use that is likely to end in harm or dependence). Two participants fell into the low-risk range on the AUDIT total scores. The average AUDIT consumption score (*M*=7.38, *SD*=4.10) is indicative of potential harm for groups more susceptible to the effects of alcohol, including people with a mental illness. The above results suggest that participants tended to understate their alcohol consumption during interviews, with most describing their alcohol use as non-problematic in interview.

Consistent with interviews, ASSIST results demonstrated alcohol was the most commonly endorsed substance of choice (*n*=8), followed by cannabis (*n*=7), tobacco (*n*=6), and amphetamines (*n*=5). All participants had used alcohol within the past three months, with all but one participant having also used at least one other substance. Alcohol was identified in the ASSIST as having caused problems for two participants, tobacco one participant, and cocaine one participant. As expected, participants who reported using alcohol as a substitute for other substances such as cannabis reported lower consumption of the other substances in the past three months.

The group endorsed most frequently using alcohol for social (*M*=7.63, *SD*=1.69) and enhancement (*M*=7.63, *SD*=1.41) reasons on the DMQ-SF-R2, which was consistent with their self-report in interviews. Participants reported using alcohol to manage mental illness symptoms least frequently (*M*=4.25, *SD*=1.40). In interviews, admissions of using alcohol to manage mental health were sometimes accompanied by embarrassment and shame, which may account for the less frequent endorsement of these reasons. Motives endorsement can be seen below in Figure 1.

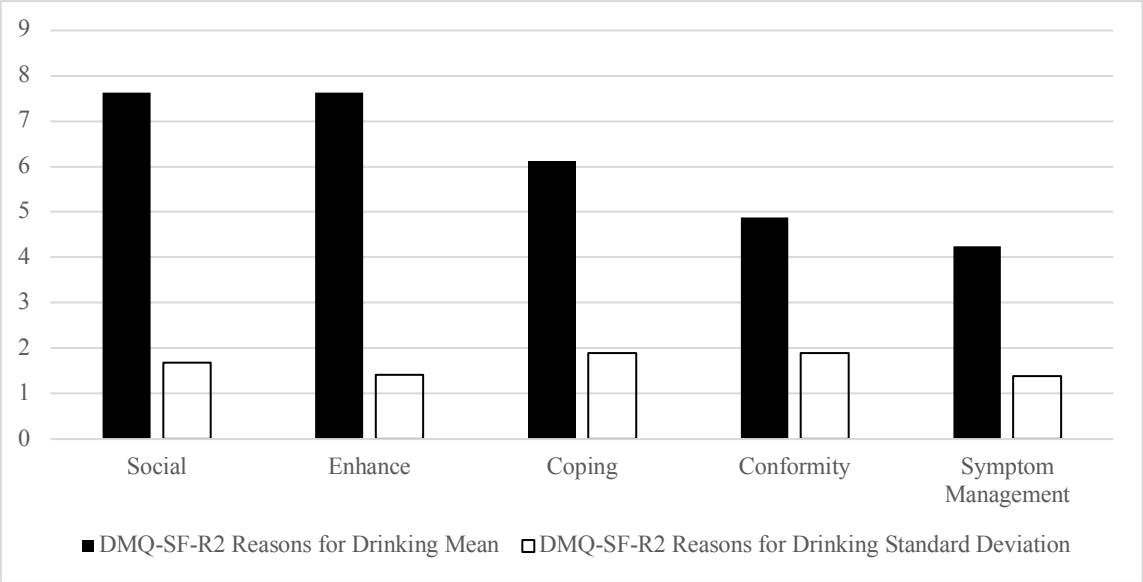

Figure 1. DMQ-SF-R2 reasons for alcohol use

The PAMS and NAMS results were congruent with comments in interviews. Participants were less likely to endorse negative alcohol metacognitions about uncontrollability of alcohol use (*M*=5.35, *SD*=3.66) than metacognitions about the potential harm associated with alcohol (*M*=6.63, *SD*=2.93). Participants agreed more strongly with positive metacognitions about alcohol, which is congruent with their endorsement of alcohol for anxiety reduction, social, and mood improvement reasons in interviews. On the PAMS, participants agreed more strongly with positive metacognitive beliefs about emotional and social impacts when drinking alcohol (*M*=23.50, *SD*=5.76) than they did with positive metacognitive beliefs about positive impacts of alcohol on cognition (*M*=8.63, *SD*=3.66).

PHQ-9 lifetime scores (depressive symptoms during their most severe two weeks in participants' lives) varied from the moderate to severe range (*M*=17.63, *SD*=4.98), but in all cases were lower for the most recent two weeks (*M*=8.25, *SD*=5.23), in the context of being within an inpatient setting. PHQ-9 results were congruent with the commonly reported belief that treatment had been helpful for participants.

Discussion

This interpretative phenomenological study examined alcohol use in young people with SMI. The qualitative results of this study provide insight into the reasons for and nature of alcohol consumption within young people with SMI, and may be useful for informing treatment for this group. The quantitative results provide descriptive information that is generally consistent with the participant interviews. Together, the results suggest that young people with SMI experience unique challenges, and alcohol use was sometimes problematic for young people with SMI. Despite this, participants did not define themselves by their mental illness or use of alcohol, and it is important to acknowledge participants as multi-faceted individuals with identities that include, but are not limited to, SMI.

The participants, young people with SMI, shared some commonalities in their alcohol consumption with young people in general. Namely, they also drink for social, coping and enhancement reasons, and they tend to have positive attitudes towards alcohol consumption. The differences lie in the nuances of these reasons – such as coping with specific mental illness symptomatology, and attempting to fit in with peers where their SMI has left them feeling different to their peers. Consuming alcohol to attempt to reclaim a partially lost identity was also unique to young people with SMI, suggesting that treatment to address thoughts on alcohol, identity and loss is needed.

Participants identified their SMI had a significant impact on their lives. Participants noted they sometimes used alcohol to cope with various impacts of their mental illness, with some using alcohol as a legal and readily available alternative to illicit substances. The importance of alternative coping mechanisms, and engagement in meaningful activities was noted as important, with alcohol taking on less importance when other activities became important. There was variability in the types of treatment participants wanted, with some preferring substance use to be addressed within their normal treatment, and others hoping for

discrete and specific treatment on substance use. There was some evidence that cognitive therapy addressing cognitions about alcohol might be helpful, for example to address the largely positive metacognitions participants associated with alcohol use. Given participants tended to strongly agree with positive metacognitions about alcohol use, but tended to only slightly agree with negative cognitions about harm and uncontrollability of alcohol use, cognitive biases towards alcohol use as advantageous appeared to be at play.

Participants had found their admission to an intermediate stay facility, where they resided but were able to leave the facility, helpful. All participants described resolve to maintain progress they had made in the inpatient setting, but several acknowledged that moving from a protected inpatient environment to their regular environments would be confronting and challenging. Results suggest empowering young people and encouraging autonomy regarding their individual treatment needs is important, rather than a 'one size fits all' approach to treatment. Secondly, multidisciplinary involvement is important to develop coping strategies and plans for engagement in future activities that will help young people with SMI less likely to see substance use as a necessary coping mechanism.

Similarly to their adult counterparts, young people with SMI identified social reasons as a major motivator for alcohol consumption (Thornton et al., 2012a). Alcohol was often described as a bridge to their social lives – young people want to feel connected to others and feel their SMI makes that harder. Early adulthood is a period in which fitting in with others is important and identities are being further developed. Alcohol is often used in social settings and for special occasions, with the 'right level of intoxication' the goal, in a similar manner to other young people without SMI (Aresi & Pedersen, 2016). Furthermore, alcohol was considered an accepted part of the culture in Australia by participants, which may mean problematic alcohol use is not readily identified. Indeed, participants tended to emphasize

their alcohol was not problematic even when they later reported drinking at hazardous levels on a screening instrument.

Alcohol was often used to control the way participants felt, and to feel ‘normal’ when their SMI would otherwise mean they felt different to other young people. Despite predominantly initially denying their alcohol use was problematic, participants tended to demonstrate ambivalence towards alcohol use. For most, alcohol was not simply being used indiscriminately, with alcohol serving a purpose in participants’ lives. With treatment and time away from alcohol, however, participants had begun to see alternatives to alcohol use. This suggests understanding the motivation and challenges individual young people with SMI face is important for therapeutic engagement. Participants in the study described consciously and unconsciously weighing up the benefits of alcohol such as social facilitation and positive impacts on internal state versus the negatives such as negative impacts on mood, potential for harm, and poorer health outcomes. In order for young people to want to reduce alcohol, a holistic approach should be taken to replace alcohol with other meaningful activities and engagement. Expecting young people to view alcohol as a problem, even when being misused, is unlikely to be effective when alcohol consumption functions to serve a purpose for the young person. A focus on harm minimisation and introduction of alternatives to alcohol is likely to be less confrontational and more acceptable to young people (Midford, 2010; Jenkins, Slemon, & Haines-Saah, 2017).

There were several limitations of the study. The sample size was small. Although six to eight participants are appropriate for an IPA (Smith, Flowers & Larkin, 2009), the small sample size may mean the results are not generalizable to all young people with SMI. However, the current participants had heterogenous cultural and ethnic backgrounds, increasing generalizability. These backgrounds may have had an impact on their coping, vulnerabilities, and substance use and may be an interesting focus in future studies.

Participants were recruited from a medium stay residential unit. The findings may not be as applicable to young people with SMI who have not needed nor benefitted from such services.

Despite these limitations, the study had several strengths and improved understanding of why and how young people with SMI consume alcohol. Having participants describe and narrate their experiences with alcohol use and mental health provided richer information and more detail than psychometric tools alone. Secondly, the clinical sample of participants in the current study were all experiencing mental illness of a severity to warrant inpatient admission – providing more relevant information on SMI than a research sample drawn from the general population. The timing of the interviews at approximately midway through an intermediate stay inpatient admission meant participants' mental illness symptoms were not at their most acute, they had not used non-prescribed substances for several days, and they were actively engaged in treatment. The results of the study may be useful to inform future treatment of alcohol misuse in young people with SMI and reduce risk of alcohol related health problems in this group. Suggestions for further research include qualitative research considering the cultural impacts on alcohol consumption in those with SMI. In particular, studies including Aboriginal and Torres Strait Islander cultures, and migrants to Australia, are suggested. In addition, future research could consider young peoples' thoughts on and experiences with alcohol after receiving treatment to address their metacognitions about alcohol use.

Conclusion

Using an interpretive phenomenological analysis approach, five superordinate themes emerged from interviews with young people with SMI who consume alcohol: mental health and wellbeing; alcohol as a means to navigate the social world; alcohol to control internal states; alcohol to feel normal; and ambivalence about alcohol use. Interview findings were supported by questionnaire data that suggested alcohol was the most commonly used

substance amongst participants, participants tended to understate their alcohol consumption in interview, and alcohol was most frequently used for social and enhancement reasons. The qualitative and questionnaire results combined suggest alcohol use was seen as an important social tool, a way to control aspects of life that SMI had impacted, and a way to feel normal around peers. The results aid understanding of how and why young people in Australia with a SMI use alcohol and may assist with future interventions to reduce alcohol related harm. Interventions for young people with a SMI who misuse alcohol should take a holistic approach and explore the function of alcohol in the young person's life. Ongoing efforts to reduce stigma surrounding seeking treatment for SMI and substance misuse through information and public health campaigns will also be important to reduce alcohol related harm.

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Appendix A: The Qualitative Report Journal Author Guidelines

TQR The Qualitative Report

Policies

Contents

Philosophy of *The Qualitative Report*

For more information, please see *The Qualitative Report* Aims and Scope page.

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another journal (electronic or print) until the completion of the editorial decision process at *The Qualitative Report*. If you have concerns about the submission terms for *The Qualitative Report*, please contact the editors.

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At *The Qualitative Report* (*TQR*) we use an open peer review system to evaluate manuscripts and to nurture authors. Throughout the process the identities of the authors, peer reviewers and editors are known to all involved parties.

The editor-in-chief starts the process by conducting a preliminary review of the author's initial submission to assess the paper's editorial fit, originality, and, quality. If the editor-in-chief decides the paper is of sufficient originality, quality, and fit, then he assigns the paper to a peer reviewer, typically a member of the *TQR* Editorial Board, and a *TQR* editor. If the editor-in-chief decides the paper is lacking in fit, originality, or quality, then he notifies the authors that the paper has been rejected.

The peer reviewer conducts a full review of the manuscript by embedding comments, changes, and suggestions into the manuscript by utilizing Microsoft Word review tools; and offers a recommendation as to the paper's disposition. The editor reviews the manuscript that includes the peer reviewer's review and editorial recommendation. The editor adds comments, changes, and suggestions via the Microsoft Word reviewing tools to create a composite review and submits the review along with a recommended editorial decision to the editor-in-chief. The editor-in-chief reviews the composite review and editorial recommendations adding new comments, changes, and suggestions via the Microsoft Word reviewing tools to create a final composite review which reflects the perspectives of the peer reviewer, editor, and editor-in-chief. The editor-in-chief then renders a final editorial decision (i.e., accept, accept with minor changes, revise and resubmit, or reject) and sends the editorial decision and review to the author.

If the editorial decision is accept or accept with minor changes, the editor-in-chief will review any revised submissions returned by the author. If the editorial decision is revise and resubmit, the editor-in-chief will re-assign the manuscript to the editor who may also re-assign the paper to the peer reviewer or may decide to conduct the subsequent reviews alone. The process of editor and/or peer reviewers' reviews of revised manuscripts is the same as described above for initial review. For each review cycle the editor-in-chief makes the final editorial decision and submits the decision and review to the author.

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Formatting Requirements

Given the ways in which a style guide can shape the writing choices made by an author, we want to assist you as you prepare your submissions by letting you know that we use The Publication Manual of the American Psychological Association (APA; 6th ed.) as a guide for contributors to The Qualitative Report. This means that we ask authors to look to APA recommendations regarding the title, abstract, and headings used in the paper, as well as the format of references and citations within the text. We also request some writing practices we think improve the reporting of qualitative research methods and results, such as the use of active voice and the inclusion of the researcher's context as it relates to the topic under study.

It is ultimately the responsibility of the author to produce an electronic version of the article as a high-quality PDF (Adobe's Portable Document Format) file, or a Microsoft Word, WordPerfect or RTF file that can be converted to a PDF file.

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Appendix B: Hunter New England Human Research Ethics Committee Approval

2 August 2018

Dr Amanda Baker
Professor and Clinical Psychologist
School of Medicine and Public Health
University of Newcastle

Dear Dr Baker,

Re: Investigation of alcohol use in young people with severe mental illness (2018/ETH00286)

HNEHREC Reference No: 18/07/18/4.08
NSW REGIS Reference No: 2018/ETH00286

Thank you for submitting the above application for single ethical review. This project was first considered by the Hunter New England Human Research Ethics Committee at its meeting held on **18 July 2018.** This Human Research Ethics Committee is constituted and operates in accordance with the National Health and Medical Research Council's *National Statement on Ethical Conduct in Human Research (2007)* (National Statement) and the *CPMP/ICH Note for Guidance on Good Clinical Practice*. Further, this Committee has been accredited by the NSW Department of Health as a lead HREC under the model for single ethical and scientific review. The Committee's Terms of Reference are available from the Hunter New England Local Health District website.

I am pleased to advise, the Hunter New England Human Research Ethics Committee has determined that the above protocol meets the requirements of the *National Statement on Ethical Conduct in Human Research* and following acceptance of the requested clarifications and revised Participant Information Statements by Dr Nicole Gerrand Manager, Research Ethics & Governance, under delegated authority from the Committee, grants ethical approval of the above project.

The *National Statement on Ethical Conduct in Human Research (2007),* to which the Committee is obliged to adhere, includes the requirement that the Committee monitors the research protocols it has approved. **Ethics Approval will be ongoing subject to the following conditions:**

- A report on the progress of the above protocol is to be submitted at 12 monthly intervals. A proforma for the annual report will be sent at the beginning of the month of the anniversary of approval. Your review date is **July 2019.**
- All variations or amendments to this protocol must be forwarded to, and approved by, the Hunter New England Human Research Ethics Committee prior to their implementation.
- A final report must be submitted at the completion of the above protocol, that is, after data analysis has been completed and a final report compiled.
- Adherence to the safety reporting requirements of the with the NHMRC Safety Monitoring and Reporting Guidance for Therapeutic Goods Trials (November 2016) available at

Hunter New England Research Ethics & Governance Office
Locked Bag No 1
HRMC NSW 2310
Telephone: (02) 49214950
Email: HNELHD-HREC@hnehealth.nsw.gov.au
http://www.hnehealth.nsw.gov.au/ethics/Pages/Research-Ethics-and-Governance-Unit.aspx

https://www.nhmrc.gov.au/_files_nhmrc/file/publications/16469_nhmrc_-_ahec_position_statement-web.pdf

- Unforeseen events that might affect continued ethical acceptability of the project.

- If for some reason the above protocol does not commence (for example it does not receive funding); is suspended or discontinued, please inform Dr Nicole Gerrand as soon as possible.

The following documentation has been reviewed and approved by the Hunter New England Human Research Ethics Committee:

Document	Version	Date
HREA [Application ID: 2018/ETH000286]	Version 2	23 July 2018
Project Description		
Participant Information Statement - Interview	Version 2.0	23 July 2018
Participant Consent Form - Interview		
Participant Information Statement – Rotary Online Survey	Version 2.0	23 July 2018
Rotary Study Participant Interview Guide		
Assist Questionnaire V3		
Audit Questionnaire – Alcohol Screen		
DMQ-SF-R2		
Negative Alcohol Metacognitions Scale (NAMS)		
Positive Alcohol Metacognitions Scale (PAMS)		
Patient Health Questionnaire- 9 (PHQ-9) – Current		
Patient Health Questionnaire- 9 (PHQ-9) – Lifetime		
Rotary Online Survey Brief Advertisement		
Exit Page for Rotary Online Survey		
Facebook Rotary Online Survey Advertisement Advertising	Version 2.0	
Poster Advertisement for Rotary Online Survey		
Demographics	Version 2.0	23 July 2018

Approval has been granted for this study to take place at the following site:

- **Hunter New England Mental Health**

You are reminded that this letter constitutes ethical approval only. You must not commence this research project at a site until separate authorisation from the Chief Executive or delegate of that site has been obtained.

A copy of this letter must be forwarded to all site investigators for submission to the relevant Research Governance Officer.

Should you have any concerns or questions about your research, please contact Dr Gerrand as per the details at the bottom of the page. The Hunter New England Human Research Ethics Committee wishes you every success in your research.

Please quote **2018/ETH00286** in all correspondence.

Hunter New England Research Ethics & Governance Office
Locked Bag No 1
HRMC NSW 2310
Telephone: (02) 49214950
Email: HNELHD-HREC@hnehealth.nsw.gov.au
http://www.hnehealth.nsw.gov.au/ethics/Pages/Research-Ethics-and-Governance-Unit.aspx

The Hunter New England Human Research Ethics Committee wishes you every success in your research.

Yours faithfully

For: Ms M Hunter
Chair
Hunter New England Human Research Ethics Committee

Hunter New England Research Ethics & Governance Office
Locked Bag No 1
HRMC NSW 2310
Telephone: (02) 49214950
Email: HNELHD-HREC@hnehealth.nsw.gov.au
http://www.hnehealth.nsw.gov.au/ethics/Pages/Research-Ethics-and-Governance-Unit.aspx

Appendix C: University of Newcastle Research Integrity Unit Registration of External HREC Approval

RESEARCH INTEGRITY UNIT

Registration of External HREC Approval

To Chief Investigator or Project Supervisor:	**Professor Amanda Baker**
Cc Co-investigators / Research Students:	**Caroline Anderson** **Doctor Sean Halpin** **Doctor Kristen McCarter** **Mrs Sonja Pohlman**
Re Protocol:	**Investigation of alcohol use in young people with severe mental illness**
Date:	**08-Aug-2018**
Reference No:	**H-2018-0316**
External HREC Reference No:	**18/07/18/4.08**

Thank you for your **Initial Application** submission to the Research Integrity Unit (RIU) seeking to register an External HREC Approval in relation to the above protocol.

Your submission was considered under an **Administrative Review** by the Ethics Administrator.

I am pleased to advise that the decision on your submission is **External HREC Approval Noted** effective **08-Aug-2018**.

As the approval of an External HREC has been noted, this registration is valid for the approval period determined by that HREC.

Your reference number is **H-2018-0316**.

PLEASE NOTE:
As the RIU has "noted" the approval of an External HREC, progress reports and reports of adverse events are to be submitted to the External HREC only. In the case of Variations to the approved protocol, or a Renewal of approval, you will apply to the External HREC for approval in the first instance and then Register that approval with the University's RIU, via RIMS.

Linkage of ethics approval to a new Grant

Registered External HREC approvals cannot be assigned to a new grant or award (ie those that were not identified in the initial registration submission) without confirmation from the RIU.

Best wishes for a successful project.

Mr Alan Hales
Manager, Research Compliance, Integrity and Policy

For communications and enquiries:
Human Research Ethics Administration

Research & Innovation Services
Research Integrity Unit
The University of Newcastle
Callaghan NSW 2308
T +61 2 492 17894
Human-Ethics@newcastle.edu.au

RIMS website - https://RIMS.newcastle.edu.au/login.asp

Linked University of Newcastle administered funding:

Funding body	Funding project title	First named investigator	Grant Ref
Australian Rotary Health/Mental Health Research Grant(**)	Pilot randomised controlled trial of a telephone delivered intervention for hazardous alcohol use among young people living with severe mental ill-health	Baker, Amanda	G1700922

Appendix D: Participant Information Sheet

Professor Amanda Baker
NHMRC Senior Research Fellow
Clinical Psychologist
School of Medicine and Public Health University of Newcastle
University Drive
Callaghan NSW 2308
Australia
(02) 4033 5690
Amanda.Baker@newcastle.edu.au

THE UNIVERSITY OF NEWCASTLE AUSTRALIA

3rd December 2018

Information Statement for the Research Project:
An Investigation of Alcohol Use in Young People with Severe Mental Illness (SMI)

You are invited to participate in the research project identified above which is being conducted by Caroline Anderson, Sonja Pohlman and Professor Amanda Baker, Senior Research Fellow from the School of Medicine and Public Health at the University of Newcastle. The research is part of Caroline Anderson's Master's studies at the University of Newcastle, assisted by Sonja Pohlman and supervised by Professor Amanda Baker and Dr Sean Halpin.

Why is the research being done?

The research aims to explore reasons for and patterns of alcohol use in young people with SMI. We hope through developing a better understanding of these reasons and patterns, we will be able to develop better ways to help young people with SMI who may want to change their patterns of alcohol use.

Who can participate in the research?

You are invited to participate if you:

- Are aged 16-25
- A client of ISMHU
- Have consumed any alcohol in the last six months
-

What would you be asked to do?

If you agree to participate, we will arrange a time for you to participate in a face-to-face interview with a researcher. This interview will be held at ISMHU. During this interview, you will be asked to complete some questionnaires. These questionnaires will ask about how you drink alcohol and/or use other substances, your mood, and some of your thoughts about alcohol. You will then be invited to discuss your experiences of drinking alcohol with the interviewer. You will also be asked a few questions about your experience of and thoughts about counselling preferences. We would also like your permission to access your ISMHU medical record to obtain information about your mental health symptoms and substance use. This option is voluntary.

The interview will be audio recorded so we can make sure that we accurately remember all the information you provide. At any time during the interview, you may ask for the audio recording to be stopped, edited and erased, or review the recording. An interview transcript will be produced and this transcript will be analysed by research investigators on the project. Access to the interview transcript will be limited to academic colleagues and researchers involved in this research study. All identifying information will be removed or disguised in the final transcript. At the end of the interview with the research assistant you can choose to withdraw your audio recorded discussion if you wish.

What choice do you have?

Participation in this research is entirely your choice. Only those people who give their informed consent will be included in the project. Please note, consent to audio record this interview is a requirement of study participation. Whether or not you decide to participate, your decision will not disadvantage you. If you do decide to participate, you may withdraw from the project at any time.

How much time will it take?

The questionnaires and interview should take approximately 60 minutes to complete.

What are the risks and benefits of participating?

There are no physical or social risks associated with participating in this project. The legal risks of reporting illegal activities (i.e. drug use) are minimised by maintaining confidentiality at all times, except where ethically bound to break the confidentiality agreement (described below). You will not be asked about other illegal activities apart from illicit drug use.

As part of your participation in this project you may experience some distress when answering our questions. However, most participants experience these questions as a positive experience. In case of distress, the interviews can be stopped, postponed or finished at another time. We will also connect you with support through ISMHU. Alternatively, you can also contact:

- Lifeline 13 11 14
- Beyond Blue 1300 224 636

Every effort will be made to ensure your safety and that the research interview has had no adverse impact on you.

We cannot promise any direct benefits to you in participating in this research. Sometimes discussing alcohol use in detail can help people gain increased insight into their patterns of use. We expect that the research will allow us to develop better ways to help young people with SMI who may want to change their patterns of alcohol use.

How will your privacy be protected?

We will attempt to maintain the privacy and confidentiality of your responses and any information that you give to this project. If you mention illegal activities (drug use) confidentiality will be maintained at all times except where the interviewer is ethically bound to break this confidentiality.

Exceptions to confidentiality include, a) if you disclose that you are at risk of harming yourself, b) if you disclose that you are at risk of harming others, and, c) if there is a court order for the information.

Any information obtained in connection with this project and that can identify you will remain confidential. It will only be disclosed with your permission, except as required by law. Your name will not be recorded anywhere in relation to your responses. Analysis of data will be based on all participants. In any publication, information will be provided in such a way that you cannot be identified.

Any summary interview content, or direct quotations from the interview, that are made available through academic publication or other academic outlets will be anonymized so that you cannot be identified, and care will be taken to ensure that other information in the interview that could identify yourself is not revealed.

The records will be kept securely for 20 years at the research centre after which time they will be shredded. They will be kept in a locked file cabinet that can only be accessed by the research team.

In accordance with relevant Australian and/or NSW privacy and other relevant laws you have the right to access the information collected and stored by the researchers about you. You also have the right to request that any information with which you disagree be corrected. Please contact one of the researchers named below if you would like to access your information.

How will the information collected be used?

The collected data will contribute towards Caroline Anderson's Master's thesis and may be presented in academic publications or conferences. Non-identifiable data may be also be shared with other parties to encourage scientific scrutiny and to contribute to further research and public knowledge, or as required by law.

You can access a summary of the results of the research by emailing researcher Sonja Pohlman at Sonja.Pohlman@newcastle.edu.au after June 2019.

Individual participants will not be identified in any reports arising from the project although individual anonymous responses may be quoted.

Participant reimbursement

Your participation in this study is voluntary. You will receive a gift card in return for your contribution to the research and for any inconvenience related to your involvement.

What do you need to do to participate?

Please read this Information Statement and be sure you understand its contents before you consent to participate. If there is anything you do not understand, or you have questions, please contact the researcher.

Further information

If you would like further information please contact Caroline Anderson at caroline.anderson@uon.edu.au or Professor Amanda Baker at

Amanda.Baker@newcastle.edu.au

Thank you for considering this invitation.

Professor Amanda Baker
Chief Investigator

Caroline Anderson
Student Researcher

Complaints about this research

This project has been approved by the University's Human Research Ethics Committee, Approval No. H-2018-0316 and the Hunter New England Local Health District Human Research Ethics Committee, Reference No. 2018/ETH00286
Should you have concerns about your rights as a participant in this research, or you have a complaint about the manner in which the research is conducted, you can contact one of the following people:

Professor Amanda Baker (02) 40335690 Amanda.Baker@newcastle.edu.au
Ms Caroline Anderson (02) 4033 5712 caroline.anderson@uon.edu.au

If an independent person is preferred, please contact either:

Dr Nicole Gerrand, Professional Officer (Research Ethics),
Hunter New England Human Research Ethics Committee, Hunter New England Health,
Locked Bag 1, New Lambton NSW 2305
Telephone (02) 49214950,
e-mail hnrec@hnehealth.nsw.gov.au

The Human Research Ethics Officer,
Research Office, The Chancellery,
The University of Newcastle,
University Drive, Callaghan NSW 2308
Telephone: (02) 49216333,
e-mail Human-Ethics@newcastle.edu.au.

Appendix E: Participant Consent Form

THE UNIVERSITY OF
NEWCASTLE
AUSTRALIA

CONSENT FORM

Full Project Title: An Investigation of Alcohol Use in Young People with Severe Mental Illness

I have read, and I understand the Participant Information dated 3rd December 2018.

I have had an opportunity to ask questions and I am satisfied with the answers I have received.

I freely agree to participate in this project according to the conditions in the Participant Information.

I will be given a copy of the Participant Information and Consent Form to keep.

I understand that the researcher has agreed not to reveal my identity and personal details if information about this project is published or presented in any public form.

I give permission for the researchers to access my ISMHU medical records. You are still able to participate in the study even if you choose to not allow access to these records Yes / No

I give permission for my interview with Ms Anderson to be audiotaped. I understand that this is a requirement of participation and that it is for the purpose of transcription and analysis. I understand that audiotapes will not contain any identifying information that links the audiotape to me, and I can ask for the tape to be stopped or sections edited or erased at any time during or after the interview.

Upon completion of the interview, I give permission for the audiotape of this interview to be kept for study purposes outlined above

Participant's Name (printed) ……

Signature **Date**

Name of Witness to Participant's Signature (printed) ……

Signature **Date**

Declaration by researcher: I have given a verbal explanation of the research project, its procedures and risks and I believe that the participant has understood that explanation.

Researcher's Name (printed) ……

Signature **Date**

Appenxdix F: Semi-Structured Interview Guide

ROTARY STUDY PARTICIPANT INTERVIEW

SEMI-STRUCTURED INTERVIEW GUIDE

This document serves as a guide for conducting semi-structured interviews with participants of the above named study.

Consent

Confirm that the participant has read the information sheet. Obtain verbal consent from the participant to complete the interview.

The purpose of these interviews is to gain an understanding of your experience of drinking alcohol. If you have any questions or concerns about anything I ask, please check with me and I am happy to provide further explanation.

The following questions may be used as a guide to elicit the interviewee's ideas and opinions on topics of interest. However, the interviewer is able to follow topical trajectories in the conversation that may stray from the guide when this is appropriate.

General

Can you tell me a bit about how you drink alcohol?

Can you tell me how you first started drinking alcohol?
(Possible prompts: How did you feel about it at the time? How long have you been drinking alcohol for?)

Have you changed the way you drink since you first started drinking alcohol?
(Possible prompts: Does anything make it more likely you will drink more? Does anything make it more likely you will drink less? How do you feel about the changes?

Can you tell me about a recent time when you had a drink?
(Possible prompts: What happened? How did you feel? How does this compare to other times you have a drink? Where were you?)

Alcohol expectancies

What do you expect will happen when you drink alcohol?
(Possible prompts: Can you tell me if it changes how you feel about yourself or others? Can you tell me if it changes how you think about yourself or others?)

Reasons for drinking

If you had to list three reasons for why you drink alcohol, what would these be?

Which of these would be the most important to you?

Self-Efficacy

How confident do you feel about your ability to control how much you drink once you have started drinking?

Are there any situations where you are more likely to drink more than you planned to?

Previous experience with therapy

Have you ever participated in any counselling or therapy to do with drinking alcohol?

> ***If Yes**: Can you tell me a little about your experience of that?*
>
> *Can you tell me about some of the good parts and not so good parts about the therapy/intervention you received?*
>
> ***If No**: If you were to receive therapy to help with cutting down your drinking do you have any thoughts about what would make it more likely for you to want to participate?*

Have you ever participated in any counselling or therapy using the telephone?

> ***If Yes**: Can you tell me a little about your experience of that?*
>
> *Can you tell me about some of the good parts and not so good parts about the therapy/intervention you received?*
>
> ***If No**: If you were to receive therapy to help with cutting down your drinking do you have any thoughts about what would make it more likely for you to want to participate?*

Prompts

What did you mean when you said…?

Can you give me an example of that?

Tell me more about…

What was that like?

How come?

Appendix G: Questionnaire Package

ROTARY INTERVIEWS: QUESTIONNAIRES

Participant code	
Interviewer	
Date of interview	
Verified diagnosis	

1	Demographics
2	AUDIT
3	ASSIST
4	DMQ-SF-R2
5	PAMS/NAMS
6	PHQ current
7	PHQ lifetime

DEMOGRAPHICS		
1.	**What is your age?**	1 = _____ 2 = Prefer not to say
2.	**How do you currently describe your gender identity:**	1=Female 2=Male 3 = Non-binary 4 = Prefer not to say 5 = Other _____
3.	**Would you describe yourself as transgender?**	1 = yes 2 = no 3 = Prefer not to say
4.	**Do you have a job at present?**	0=No job at present 1=Employment outside the home (full time job) 2=Employment outside the home (part time job) 3=Household 4=Studying 5 = unable to work 6 = Prefer not to say
5.	**What is the highest level of education you have completed?**	1=Primary school 2= Some high school 3 = Completed high school 4=Trade Certificate/apprenticeship 5=Some university 6=Bachelor degree 7=Masters degree/doctorate 8=Other _____ 9 = Prefer not to say
6.	**Are you currently in a romantic relationship with a partner or partners?**	1 = No 2 = Yes 3 = Yes, I have multiple partners 4 = Prefer not to say
7.	**If you answered yes, are you? (mark all that apply):**	1 = Married or in a civil union, and living together 2 = Married or in a civil union, and living apart 3 = Not married or in a civil union, and living together 4 = Not married or in a civil union, and living apart 5 = Prefer not to say
8.	**Who do you live with?**	1=Parent(s) 2=Spouse +/- children 3=Defacto partner +/- children 4=Friend(s) 5=Alone 6=Children without partner 7=Relatives 8=No fixed address 9=Supported accommodation 10=Other (specify_____) 11 = Prefer not to say
9.	**What is the postcode of your usual accommodation?**	1 = _____ 2 = Prefer not to say
10.	**I identify my ethnicity as: (select all that apply)**	1 = Aboriginal 2 = Asian 3 = Black/African 4 = Caucasian 5 = Middle Eastern 6 = Torres Strait Islander

		7 = Prefer not to say 8 = Other _____
11.	**Which of the following mental health problems have you ever been diagnosed with or received treatment for? (please select all that apply)**	1 = Schizophrenia 2 = Bipolar disorder 3 = Schizoaffective disorder 4 = Depressive psychosis 5 = Delusional; other non-organic psychoses 6 = Severe depression without psychosis 7 = Anxiety disorder 8 = Personality disorder 9= Alcohol or drug use disorder 10 = Other _____ 11 = Prefer not to say
12.	**How old were you when you were first diagnosed with any mental health problem?**	1 = _____ 2 = Prefer not to say
13.	**Have you ever been admitted to a psychiatric hospital, or the psychiatric ward of a hospital?**	1=psychiatric hospital 2=psychiatric ward in a public hospital 3=psychiatric ward in a private hospital 4=no admission 5 = Prefer not to say
14.	**How long ago was your last admission?**	
15.	**In the past month, have you been taking any medication or injection that has been prescribed by a doctor for your mental health?**	0=No 1=Yes 2 = Prefer not to say
16.	**Do you take your medication as prescribed?**	1=Yes 2=No 3=Mostly 4 = Prefer not to say
17.	**Have you ever received treatment for an alcohol or drug problem?**	1=yes 2=no 3 = Prefer not to say
18.	**What treatment have you accessed? (select all that apply**	1=inpatient detoxification 2=outpatient detoxification 3=outpatient counselling 4=Peer support group (e.g. NA/Smart Recovery) 5=residential rehabilitation 6 = phone counselling 7 = online counselling 8= other _____ 9 = N/A 10 = Prefer not to say

The following questions will ask information about yourself, your health, and drinking alcohol.

AUDIT

Please look at the response options listed under A or the Yellow set on the response card.

AUDIT - 3 month version **ALL QUESTIONS refer to the past 3 MONTHS**					
1.	**How often have you had a drink containing alcohol in the past 3 months?**				
	Never (0)	Monthly or less (1)	2-4 times a month (2)	2-3 times a week (3)	4 or more times a week (4)
2.	**How many standard drinks do you have on a typical day when you are drinking?**				
	1 or 2 (0)	3 or 4 (1)	5 or 6 (2)	7 to 9 (3)	10 or more (4)
3.	**In the past 3 months how often do you have six or more drinks on one occasion?**				
	Never (0)	Less than monthly (1)	Monthly (2)	Weekly (3)	Daily/almost daily (4)
4.	**How often during the last 3 months have you found that you were not able to stop drinking once you had started?**				
	Never (0)	Less than monthly (1)	Monthly (2)	Weekly (3)	Daily/almost daily (4)
5.	**How often during the last 3 months have you failed to do what was normally expected of you because of drinking?**				
	Never (0)	Less than monthly (1)	Monthly (2)	Weekly (3)	Daily/almost daily (4)
6.	**How often during the last 3 months have you needed a first drink in the morning to get yourself going after a heavy drinking session?**				
	Never (0)	Less than monthly (1)	Monthly (2)	Weekly (3)	Daily/almost daily (4)
7.	**How often during the last 3 months have you had a feeling of guilt or remorse after drinking?**				
	Never (0)	Less than monthly (1)	Monthly (2)	Weekly (3)	Daily/almost daily (4)
8.	**How often during the last 3 months have you been unable to remember what happened the night before because of your drinking?**				
	Never (0)	Less than monthly (1)	Monthly (2)	Weekly (3)	Daily/almost daily (4)
9.	**Have you or someone else been injured because of your drinking?**				
	No (0)		Yes, but not in the past 3 months (2)		Yes, during the past 3 months (4)
10.	**Has a relative, friend, doctor, or health care worker been concerned about your drinking or suggested that you cut down?**				
	No (0)		Yes, but not in the past 3 months (2)		Yes, during the past 3 months (4)
TOTAL AUDIT SCORE:					

WHO - ASSIST V3.0

INTRODUCTION

I am now going to ask you some questions about your experience of using alcohol, tobacco and other drugs across your lifetime and in the past three months. These substances can be smoked, swallowed, snorted, inhaled, injected or taken in the form of pills. Please look at the other side of your response card which will list the different types of substances I will ask about.

Some of the substances listed may be prescribed by a doctor (like amphetamines, sedatives, pain medications). For this interview, I will not record medications that are used as prescribed by your doctor. However, if you have taken such medications for reasons other than prescription, or taken them more frequently or at higher doses than prescribed, please let me know. While we are also interested in knowing about your use of various illicit drugs, please be assured that information on such use will be treated as strictly confidential.

The response card will also give you answer options for each of the questions I ask.

Question 1

In your life, which of the following substances have you ever used? *(NON-MEDICAL USE ONLY)*	No	Yes
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3
d. Cocaine (coke, crack, etc.)	0	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3
j. Other - specify:	0	3

Probe if all answers are negative:
"Not even when you were in school?"

If "No" to all items, stop interview.

If "Yes" to any of these items, ask Question 2 for each substance ever used.

For the next four questions, please refer to the answer options on the same page on your response sheet under the green bar (listed as Questions 2-5)

Question 2

In the past three months, how often have you used the substances you mentioned *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	2	3	4	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	2	3	4	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	2	3	4	6
d. Cocaine (coke, crack, etc.)	0	2	3	4	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	2	3	4	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	2	3	4	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	2	3	4	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	2	3	4	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	2	3	4	6
j. Other - specify:	0	2	3	4	6

If "Never" to all items in Question 2, skip to Question 6.

If any substances in Question 2 were used in the previous three months, continue with Questions 3, 4 & 5 for each substance used.

Question 3

During the past three months, how often have you had a strong desire or urge to use *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	3	4	5	6
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	3	4	5	6
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	3	4	5	6
d. Cocaine (coke, crack, etc.)	0	3	4	5	6
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	3	4	5	6
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	3	4	5	6
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	3	4	5	6
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	3	4	5	6
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	3	4	5	6
j. Other - specify:	0	3	4	5	6

Question 4

During the past three months, how often has your use of *(FIRST DRUG, SECOND DRUG, ETC)* led to health, social, legal or financial problems?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	4	5	6	7
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	4	5	6	7
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	4	5	6	7
d. Cocaine (coke, crack, etc.)	0	4	5	6	7
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	4	5	6	7
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	4	5	6	7
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	4	5	6	7
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	4	5	6	7
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	4	5	6	7
j. Other - specify:	0	4	5	6	7

Question 5

During the past three months, how often have you failed to do what was normally expected of you because of your use of *(FIRST DRUG, SECOND DRUG, ETC)*?	Never	Once or Twice	Monthly	Weekly	Daily or Almost Daily
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	5	6	7	8
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	5	6	7	8
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	5	6	7	8
d. Cocaine (coke, crack, etc.)	0	5	6	7	8
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	5	6	7	8
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	5	6	7	8
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	5	6	7	8
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	5	6	7	8
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	5	6	7	8
j. Other - specify:	0	5	6	7	8

For the next three questions, please refer to the answer options on the same page of your response sheet under the blue bar (listed as Questions 6-8)

Ask Questions 6 and 7 for all substances ever used (i.e. those endorsed in Question 1)

Question 6

Has a friend or relative or anyone else ever expressed concern about your use of *(FIRST DRUG, SECON D DRUG, ETC.)?*	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3

Question 7

Have you ever tried and failed to control, cut down or stop using *(FIRST DRUG, SECON D DRUG, ETC.)?*	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)	0	6	3
b. Alcoholic beverages (beer, wine, spirits, etc.)	0	6	3
c. Cannabis (marijuana, pot, grass, hash, etc.)	0	6	3
d. Cocaine (coke, crack, etc.)	0	6	3
e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.)	0	6	3
f. Inhalants (nitrous, glue, petrol, paint thinner, etc.)	0	6	3
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.)	0	6	3
h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.)	0	6	3
i. Opioids (heroin, morphine, methadone, codeine, etc.)	0	6	3
j. Other – specify:	0	6	3

Question 8

	No, Never	Yes, in the past 3 months	Yes, but not in the past 3 months
Have you ever used any drug by injection? *(NON-MEDICAL USE ONLY)*	0	2	1

DMQ-SF-R2

The next set of questions ask about how you drink alcohol. I'm going to read a list of reasons people might choose to drink alcoholic drinks. Please look at the Purple/C responses on your response card and use them to answer how frequently your own drinking is motivated by each of the reasons I mention.

	I DRINK…	Never/ Almost Never	Sometimes	Almost always/Always
1.	Because you like the feeling?	1	2	3
2.	To get high?	1	2	3
3.	Because it's fun?	1	2	3
4.	Because it helps you enjoy a party?	1	2	3
5.	Because it makes social gatherings more fun?	1	2	3
6.	Because it improves parties and celebrations?	1	2	3
7.	To fit in with a group you like?	1	2	3
8.	To be liked?	1	2	3
9.	So you won't feel left out?	1	2	3
10.	Because it helps when you feel depressed or nervous?	1	2	3
11.	To cheer up when you are in a bad mood?	1	2	3
12.	To forget about your problems?	1	2	3
13.	Because it helps reduce the side effects of your medication?	1	2	3
14.	Because it helps reduce the symptoms associated with your mental illness?	1	2	3
15.	To help get away from voices or feeling paranoid?	1	2	3

The next questions are about some of your thoughts about drinking alcohol. People use alcohol for recreational and other purposes. I'm going to read a number of beliefs about using alcohol given by people.

Thinking about your own usage of alcohol, please listen to each statement and use the teal green/D responses on your response card to indicate how much you agree with each one. There are no right or wrong answers. Please try to be as honest as possible in your response.

Positive and Negative Alcohol Metacognitions Scale (PAMS/NAMS)

PLEASE INDICATE HOW MUCH YOU AGREE WITH EACH OF THE FOLLOWING STATEMENTS WHEN YOU BEGIN DRINKING:

		Do not agree	Agree slightly	Agree moderately	Agree very much	Emo/Soc	Cog
1	Drinking makes me more affectionate	1	2	3	4		
2	Drinking makes me more confident	1	2	3	4		
3	Drinking makes me think more clearly	1	2	3	4		
4	Drinking makes me feel more relaxed	1	2	3	4		
5	Drinking helps me to control my thoughts	1	2	3	4		
6	Drinking makes my negative thoughts more bearable	1	2	3	4		
7	Drinking reduces my anxious feelings	1	2	3	4		
8	Drinking makes me more sociable	1	2	3	4		
9	Drinking reduces my self-consciousness	1	2	3	4		
10	Drinking makes me feel happy	1	2	3	4		
11	Drinking helps focus my mind	1	2	3	4		
12	Drinking helps me fit in socially	1	2	3	4		
					TOTAL		

PLEASE INDICATE HOW MUCH YOU AGREE WITH EACH OF THE FOLLOWING STATEMENTS AFTER YOU HAVE STOPPED A SESSION OF DRINKING:

		Do not agree	Agree slightly	Agree moderately	Agree very much	Uncontrol	Harm
1	I have no control over my drinking	1	2	3	4		
2	If I cannot control my drinking, I will cease to function	1	2	3	4		
3	Drinking will damage my mind	1	2	3	4		
4	My drinking persists no matter how I try to control it	1	2	3	4		
5	Drinking will make me lose control	1	2	3	4		
6	Drinking controls my life	1	2	3	4		
					TOTAL		

*The next questions ask about how you have been feeling during the past **two weeks**. For each question, please pick the description that best describes how much you have been bothered by the following problems. Please look at the pink/F responses on your response card.*

PHQ-9 current

		Not at all sure	Several days	Over half the days	Nearly every day	Score
1	Feeling down, depressed, irritable or hopeless?	0	1	2	3	
2	Little interest or pleasure in doing things?	0	1	2	3	
3	Trouble falling asleep, staying asleep, or sleeping too much?	0	1	2	3	
4	Poor appetite, weight loss, or overeating?	0	1	2	3	
5	Feeling tired, or having little energy?	0	1	2	3	
6	Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	0	1	2	3	
7	Trouble concentrating on things like school work, reading, or watching TV?	0	1	2	3	`
8	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?	0	1	2	3	
9	Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3	
					Total	

*I'm going to ask the same questions again, but this time think about the **two weeks in your life that you were most blue, sad, or depressed**. For each question, please pick the description that best describes how much you have been bothered by the following problems. Please look at the pink/F responses on your response card.*

PHQ-9 Lifetime

		Not at all sure	Several days	Over half the days	Nearly every day	Score
1	Feeling down, depressed, irritable or hopeless?	0	1	2	3	
2	Little interest or pleasure in doing things?	0	1	2	3	
3	Trouble falling asleep, staying asleep, or sleeping too much?	0	1	2	3	
4	Poor appetite, weight loss, or overeating?	0	1	2	3	
5	Feeling tired, or having little energy?	0	1	2	3	
6	Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?	0	1	2	3	
7	Trouble concentrating on things like school work, reading, or watching TV?	0	1	2	3	`
8	Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?	0	1	2	3	
9	Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3	
					Total	

That's the end of the surveys, thank you for participating today. Do you have any questions for me?

(Provide participant with gift card)

Appendix H: Participant Response Card

A

Never	Less than monthly	Monthly	Weekly	Daily/almost daily

No	Yes, but not in the last year	Yes, during the last year

B

Strongly disagree	Disagree	Agree	Strongly Agree

C

Never/almost never	Sometimes	Almost always/always

D

Do not agree	Agree slightly	Agree moderately	Agree very much

E

None of the time	A little of the time	Some of the time	Most of the time	All of the time

F

Not at all sure	Several days	Over half the days	Nearly every day

G

Very poor	Poor	Neither poor nor good	Good	Very good
Very dissatisfied	Dissatisfied	Neither satisfied nor dissatisfied	Satisfied	Very satisfied
Not at all	A little	Moderately	Mostly	Completely

WHO ASSIST V3.0 RESPONSE CARD

SUBSTANCES

a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.)
b. Alcoholic beverages (beer, wine, spirits, etc.)
c. Cannabis (marijuana, dope, pot, grass, hash, etc.)
d. Cocaine (coke, crack, etc.)
e. Amphetamine-type stimulants (speed, ecstasy, meth, ice, paste, crystal, base, diet pills, etc.)
f. Inhalants (nitrous, NOS, glue, petrol, sprays, paint thinner, amyl, etc.)
g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, Normison, diazepam, temazepam, etc.)
h. Hallucinogens (LSD, acid, mushrooms, trips, Ketamine, etc.)
i. Opioids (heroin, opium, morphine, methadone, codeine, etc.)
j. Other - specify:

Response Card (ASSIST Questions 2-5)

Never	Not used in the last 3 months
Once or twice	1 to 2 times in the last 3 months
Monthly	Average of 1 to 3 times per month over the last 3 months.
Weekly	1 to 4 times per week.
Daily or almost daily	5 to 7 days per week.

Response Card (ASSIST Questions 6-8)

No, never

Yes, but not in the past 3 months

Yes, in the past 3 months

Appendix I: Questionnaire Descriptive Results Tables

Table 2: AUDIT and DMQ-SF-R2 descriptive statistics

	AUDIT Total	**AUDIT Consumption**	**DMQ Social**	**DMQ Coping**	**DMQ Symptom Management**	**DMQ Conformity**	**DMQ Enhancement**
Mean	14.00	7.38	7.63	6.13	4.25	4.88	7.63
SD	7.98	4.10	1.69	1.89	1.39	1.89	1.41
Minimum	3.00	1.00	5.00	4.00	3.00	3.00	6.00
Maximum	25.00	11.00	9.00	9.00	7.00	9.0	9.00

Table 3: PAMS, NAMS, PHQ Current and PHQ Lifetime descriptive statistics

	PAMS Emotional	**PAMS Cognitive**	**NAMS Uncontrollable**	**NAMS Harm**	**PHQ Current Total**	**PHQ Lifetime Total**
Mean	23.50	8.63	5.25	6.63	8.25	17.63
Std. Deviation	5.76	3.67	3.66	2.93	5.23	4.99
Minimum	16.00	4.00	3.00	3.00	2.00	12.00
Maximum	31.00	13.00	12.00	12.00	15.00	27.00

Table 4: ASSIST substance endorsements

Substance	**Participant Use**	**Participants**
Alcohol	Used ever	8
	Used in the past 3 months	8
	Problems	2
Tobacco	Used ever	6
	Used in the past 3 months	5
	Problems	1
Cannabis	Used ever	4
	Used in the past 3 months	3
	Problems	3
Cocaine	Used ever	2
	Used in the past 3 months	2
	Problems	1
Amphetamines	Used ever	5
	Used in the past 3 months	1
	Problems	0
Inhalants	Used ever	5
	Used in the past 3 months	1
	Problems	0
Sedatives	Used ever	4
	Used in the past 3 months	1
	Problems	0
Hallucinogens	Used ever	4
	Used in the past 3 months	2

	Problems	0
Opioids	Used ever	4
	Used in the past 3 months	1
	Problems	0
Other	Used ever	1
	Used in the past 3 months	0
	Problems	0