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Abstract

Little is understood about the self-care activities undertaken by drug treatment clients. Using data from a qualitative study of drug treatment and mental health we identify the self-care practices of drug treatment clients diagnosed with anxiety and depression. 77 participants were interviewed in four sites across Australia. Participants described a range of self-care practices for mental health including: self-medication, seeking social support, physical exercise, counselling-derived techniques, keeping busy and other less common strategies. These findings show that drug treatment clients undertake similar self-care practices to the general population and illicit drug users and that these activities echo beneficial practices identified in the research literature. The results suggest opportunities for service providers to work with clients on self-care activities that may improve mental health. Tensions between consumer and professional views of self-care, and the limits to encouraging self-care as a substitute for treatment, are discussed.

Introduction

People commonly undertake activities to promote, maintain or restore their health, or to limit the effects of illness. Activities undertaken by individuals without professional assistance aimed at improving or maintaining health or ameliorating the effects of illness can be referred to as self-care strategies (Levin, 1976; Levin & Idler, 1983). Commonly reported self-care strategies include physical exercise, seeking social support, relaxation and engaging in pleasurable activities (Hansson, Hillerås & Forsell, 2005).

Self-care gained prominence as part of the consumer health movement and the development of patient-centred medicine during the mid- to late-twentieth century (DeFriese, Woolmert, Guild, Steckler & Konrad, 1989). Consumer groups advocated self-care in response to the perceived medicalisation of everyday life, arguing that people should play a greater part in maintaining their own health and decisions about medical treatment (Illich, 2003; Levin, 1976; Levin & Idler, 1983). Self-care was also enthusiastically supported by public health advocates, with the World Health Organization recognising self-care as a significant component of the 'lay health care system' (Kickbusch, 1989).

Self-care strategies continue to be encouraged within patient education programs designed to make the management of chronic diseases more effective (Bodenheimer, Lorig, Holman & Grumbach, 2002; Funnell & Anderson, 2003; Holman & Lorig, 2000). When patients are trained to manage chronic illness, this tends to be referred to as 'self-management' rather than self-care (Creer & Holroyd, 2006). It is recognised that lay self-care priorities may not always align with professional priorities for self-management

(DeFriese *et al.*, 1989). Patients may see self-care as a broad set of activities that help them adapt to illness or cope with treatment rather a discrete set of strategies concerned with, for example, symptom identification or treatment compliance (Kralik, Koch, Price & Howard, 2004).

Continuing interest in self-care is focused on people living with chronic diseases, where the responsibility for the day-to-day management of conditions (like asthma, depression or diabetes) largely falls on patients (Bayliss, Steiner, Fernald, Crane & Main, 2003; Bodenheimer *et al.*, 2002; Hunt, Pugh & Valenzuela, 1998; Kralik *et al.*, 2004; Vidler, 2005). Although problems with illicit drug dependence can be protracted and drug treatment clients commonly report high levels of comorbid physical and mental health conditions (Anglin & Hser, 1990; Callaly, Trauer, Munro & Whelan, 2001; Hser, Anglin, Grella, Longshore & Prendergast, 1997; Teesson, Hall, Lynskey & Degenhardt, 2000), there is little or no research on what drug treatment clients do to promote or maintain their health outside of clinical settings. This means that "there is little research identifying specific health-promoting strategies among drug users that treatment specialists may use to improve overall intervention plans" (p. 610, Drumm, McBride, Metsch, Neufeld & Sawatsky, 2005).

Some research exists on self-care in relation to illicit drug use, largely focused on what people do to manage drug use and reduce drug-related harm. For example, a recent study analysed the ways in which drug users tried to manage their heroin or methamphetamine use (Boeri, Sterk & Elifson, 2006). Successful strategies included paid work, caring for children, limiting levels of drug use, and changing routes of administration. Similar strategies were found in research in San Francisco, which found illicit drug users reported

other health-promoting strategies such as sleeping and eating regularly, taking vitamins, exercising and practicing safe sex (Duterte, O'Neil, McKearin, Sales & Murphy *et al.*, 2001). The authors concluded that "the health practices of the study participants closely mirrored those of the general population" (p. 181).

A study of injecting drug users focused exclusively on the self-care strategies employed by participants to maintain or promote wellbeing (Drumm *et al.*, 2005). These included maintaining a healthy diet and fluid intake, exercise, using over-the-counter medications, home remedies, practicing safe sex, and using harm reduction strategies to moderate the effects of alcohol and other drugs. While it was unclear whether these activities were always beneficial or unproblematic for participants, the authors concluded that drug users "were actively involved in managing and improving their health and that they attempted to take self-protective actions, even while continuing to engage in active drug use" (p. 624).

Because there is no research that we are aware of that describes the self-care strategies employed by people participating in drug treatment, the results we report below address an omission within the literature. What is also important about our analysis is that it focuses on the self-care strategies used by drug treatment clients to maintain mental wellbeing when they report a current or recent experience of anxiety or depression. Given the high prevalence of mood and anxiety disorders among drug treatment populations (Ross, Teesson, Darke, Lynskey & Ali *et al.*, 2005; Teesson, Havard, Fairbairn, Ross & Lysnkey *et al.*, 2005), and the difficulty many drug treatment services face in supporting clients with these high prevalence conditions (Greig, Baker, Lewin, Webster & Carr, 2006; Kavanagh, 2001; Siegfried, 1998), our findings will be useful for service providers

in providing an outline of the activities undertaken by clients to promote or maintain mental health. This may encourage service providers to support helpful self-care activities among clients, identify problematic practices, and better integrate formal treatment plans with the self-care practices undertaken by clients.

Method

The interview material presented here was collected as part of an Australian qualitative study of barriers and incentives to drug treatment for people with both illicit drug and mental health problems. The method for this study has been described in detail elsewhere (Holt, 2007). Approval for the conduct of the study was granted by the relevant ethics committees in each recruitment site.

Recruitment

Participants were recruited from Brisbane (Queensland), Perth (Western Australia) and Sydney and Bathurst (New South Wales). Purposive sampling was undertaken using peer recruitment (employing local drug treatment clients to find eligible people through social networks), word-of-mouth, and advertising in local drug treatment centres and user organisations. All potential participants had the project explained to them and were screened for eligibility by a peer recruiter. To be deemed eligible, participants had to be able to give or withhold consent, be aged 18 or over, report a history of illicit opiate or stimulant use, have current or recent experience of formal drug treatment (within the previous two years), and report a clinical diagnosis of (or treatment for) a common mood or affective disorder, such as depression or anxiety, during the previous two years.

Interviews were semi-structured, focusing on drug use history, experiences of drug treatment and experiences of mental health problems. As part of the interview, participants were asked whether they had found ways to manage their drug and mental health problems, other than through formal treatment. Interviews lasted up to one hour and were tape-recorded. Participants received AU$20 expenses.

Analysis

After being transcribed verbatim, checked for accuracy and de-identified, interviews were coded by the authors and entered into NVivo qualitative analysis software. The coding framework included pre-existing areas of interest (e.g. experiences of substitution treatment, mental health treatment) as well as areas that were identified through reading the material (e.g. self-care practices). Differences in coding between the authors were discussed and resolved by either changing or removing coding or adding additional codes. Analysis proceeded by looking for patterns of consistency in each area of coding, drawing on the core procedures of textual and discourse analysis (Potter & Wetherell, 1987; Willig, 2001). Here we focus on the ways that participants described managing their mental health problems or trying to maintain their wellbeing. All quoted participant names are pseudonyms.

Results

77 consumers of drug treatment services were recruited across the four sites, with a mean age of 37 years (SD=7.60, range 20-53). Participant characteristics are shown in Table 1. The characteristics of participants are similar to those found in drug treatment (particularly substitution treatment) populations in Australia, although we deliberately

recruited equal numbers of men and women, and men are typically over-represented in drug treatment populations (Callaly *et al*., 2001; Treloar *et al*., 2004). All participants had sought drug treatment after problems with illicit opiate or stimulant drugs, particularly heroin and amphetamines. The most commonly reported treatment was methadone maintenance treatment. Diagnosis of or treatment for depression was more common than for anxiety, and nearly all those diagnosed with anxiety also reported experiences of depression (18 of 22).

[insert Table 1 here]

The majority of participants (n=61) described at least one self-care strategy for mental health. Of the whole sample, participants typically described at least one activity they used to maintain mental wellbeing (n=77, mean no. of strategies=1.2, SD=1.0, range 0-4). These strategies were a mixture of informal and practical activities, as well as techniques inspired by counselling, therapy or self-help approaches. The following is a summary of the main strategies described by participants. Additional examples and the number of participants reporting each strategy are shown in Table 2.

[insert Table 2 here]

Self-medication

It was common for participants to describe having used alcohol or illicit drugs to lift or stabilise mood and cope with the symptoms of anxiety or depression. Participants often referred to this practice as ‘self-medication’. Self-medication was seen as a temporary escape from the debilitating symptoms of anxiety and depression such as feeling stressed, anxious or depressed:

> ‘Yeah I deal with it [depression] my own way yeah, pretty much… Go and get a shot.’ (Mark, 26 yrs old)

> ‘I’ve always turned to drugs and stuff like that when I’m depressed ‘cause it’s all I know, it’s pretty, it’s very easy to get and, yeah. Too easy.’ (Ruth, 28 yrs old)

While for participants like Ruth self-medication was seen as the most available or easiest way to deal with their problems, many were aware that relying on alcohol or drugs to manage mental health problems was problematic (although that did not necessarily mean that they had stopped self-medicating). Recognising that self-medication was unlikely to provide a long-term solution to their mental health issues, many participants developed alternative ways to cope with and manage their mental health problems:

> ‘Makes me feel a lot better knowing that I can deal with it [depression] in other ways so I can, instead of going out and having a shot. I’d rather talk about it than have a shot to hide it’ (Mike, 35 yrs old)

Social support

As Mike indicates above, talking to someone who was trusted and could be relied upon was seen as a useful self-care strategy for mental health. Participants described turning to friends, family members, or trusted acquaintances to talk over problems, get support, or share their experiences:

> ‘…y’know if I’ve got a problem and I’ve got a good mate that I know that [I can] go air raiding about shit, y’know what I mean. I’ll try and talk to the person about it. Y’know, because it does help’ (Geoff, 37 yrs old)

Participants also described the value of spending time with friends or family members who could distract them from their mental health problems through everyday and enjoyable activities:

> '…when I get depressed I sort of, I just go over to a mate's place, y'know what I mean, and just don't tell him that I'm depressed but just go over there and just end up having a good time and just, gets it out of my mind and I forget about it.' (Toby, 20 yrs old)

Exercise

Physical exercise, such as swimming, cycling, going to the gym or going for a walk, was reported as a useful mental health self-care strategy. Exercise was variously seen as a way to lift mood, relax, improve self-esteem and provide a distraction from negative experiences or the temptation of using illicit drugs. Those suffering from depression said that it was sometimes hard to find the motivation to undertake exercise, even though they found it useful for alleviating symptoms:

> 'I know going down the beach and swimming getting any sort of exercise makes me feel better but... yeah motivating myself to do those things can be quite difficult... yeah it's a matter of actually forcing yourself to do it. Which is easier said than done' (Phillip, 38 yrs old)

> 'I go for walks and that or try playing a sport of some sort. I try not to turn to the bad things if I'm feeling real down.' (Lisa, 35 yrs old)

Counselling-derived techniques

Some of the self-care practices described by participants suggested the adoption or reworking of formal therapeutic techniques (such as cognitive-behavioural therapy or relaxation training) for use outside clinical or counselling settings. Participants described monitoring their thoughts, feelings and behaviours in order to identify, modify or divert mental health problems before or as they arose (particularly for depression), or applying the relaxation techniques they had learnt in therapy (or through a self-help guide) to control anger, stress, panic or anxiety. Acquiring a different perspective on one's mental health problem, as well as techniques that could lessen the severity of a depressive or anxious episode, was highly valued by these participants:

> 'I think it was the combination of family support and drawing on the skills that I've developed through the process of going through the therapeutic community process and learning about myself and cognitive-behavioural therapy type techniques, to try and change the negative thoughts and patterns I experienced' (Travis, 34 yrs old)

> 'Yeah, if I feel like I'm having an anxiety attack or a panic attack, I do try and just breathe more calmly and just try to talk myself very calmly, just um as if… how you talk to somebody else. "It's okay… you know what this is, it's fine. It will be okay, you're just having a panic attack, it will pass. There's no real reason for it. You know you've had it before. It always goes away…" y'know, all those sort of stuff and trying to breathe – I guess it's almost meditational.' (Melanie, 37 yrs old)

Keeping busy

Participants described staying active or keeping busy as a practice to improve mental wellbeing. Activities mentioned included shopping, reading, cooking, housework, decorating, and paid or voluntary work (where available). This strategy seems to reinforce the idea (as indicated in the Social Support and Exercise sections above) that for our participants, self-care strategies for mental health problems often involved distraction from negative mood states, particularly depression, and that concentrating on everyday tasks and achieving small goals increased feelings of self-worth.

> 'I eat well, I mean I enjoy cooking um, ahh I enjoy eating well, you know preparing my own food um… yeah shopping for it, etc etc. Um, I'm a voracious reader, you know I mean this is all in an attempt really to sort of um keep the black dog [depression] at bay or whatever, um, you know I do try and keep myself as active as I can.' (Tom, 48 yrs old)

Other self-care strategies

A number of other self-care strategies were described by participants, although these were not as common as the practices outlined above. Some participants (n=5) said they found that providing support to their families (by caring for children, supporting partners or relatives) improved their mental wellbeing. A few participants mentioned taking herbal remedies (n=2), having a pet (n=2), listening to music (n=2) or sleeping (n=2) as useful self-care practices.

> '…when I first went off the antidepressants, I, I threw myself into the kids, y'know like, doing their school work with them, going walking with them or

> whatever, just, everything revolved around my kids. Y'know, I made them the centre of my attention and that was it, y'know I just had to be a strong mum for my kids.' (Michelle, 36 yrs old)

Discussion

Our participants reported a range of self-care strategies they used to improve or maintain mental wellbeing and cope with the symptoms of depression and anxiety. The findings suggest that drug treatment clients report very similar self-care strategies to illicit drug users and general population samples (Boeri, Sterk & Elifson, 2006; Drumm *et al.*, 2005; Duterte *et al.*, 2001; Hansson, Hillerås & Forsell, 2005).

The most commonly reported strategy by participants was self-medication. The research literature and lay knowledge suggest that illicit drug users (and the general public) may use drugs to cope with negative affect and stressful life experiences (Crutchfield & Gove, 1984; Khantzian, 1985; Klee & Reid, 1998). Regardless of the veracity of the 'self-medication hypothesis' what is clear is that it is common for drug treatment clients (and the general public) to see alcohol and other drugs as temporary solutions to negative mental health states. Our participants often recognised that self-medication had caused more problems than it had solved in the broader scheme of their lives. That self-medication was the most commonly reported strategy may reflect a lack of alternative strategies for some people, including poor access to treatment (Klee & Reid, 1998; Treloar, Abelson, Cao, Brener & Kippax *et al.*, 2004).

Reflecting that self-medication is probably an uncertain strategy at best, participants described a range of other self-care practices that did not rely on alcohol or other drugs.

Drug treatment clients turned to friends and family for support and to be distracted from problems and negative mood states. Distracting oneself from mental health problems (particularly depression) was a common feature of a number of participants' self-care practices, including exercise, keeping busy and paid or voluntary work. Clinical research suggests that distraction from affective states and personal circumstances is effective in alleviating depressive episodes (Just & Alloy, 1997; Nolen-Hoeksema & Morrow, 1993; Nolen-Hoeksema, Morrow & Fredrickson, 1993).

Physical exercise was another self-care strategy described by participants that has been investigated in clinical research. A review of literature on physical exercise and mental health concluded that the symptoms of depression and anxiety are significantly alleviated by regular exercise (Paluska & Schwenk, 2000). The combination of exercise, relaxation, stress management and cognitive techniques is an effective overall strategy to lift negative moods (Thayer, Newman & McClain, 1994).

It would appear that the self-care strategies described here often mirrored therapeutic techniques used in clinical settings. This probably reflects the fuzzy boundaries between expert and lay knowledge, where therapeutic techniques take their inspiration from 'common sense' practices and where lay beliefs are influenced by the diffusion of expert knowledge in popular culture (Kangas, 2002). The overlap between therapeutic and self-care techniques was perhaps most obvious in the counselling-derived strategies described by participants. Techniques learnt during treatment were adopted by participants to self-manage mental health problems in everyday life. The self-monitoring techniques taught in cognitive-behavioural therapy were drawn upon to manage depression in particular, and participants described using relaxation techniques and meditation to manage stress

and panic attacks. Relaxation techniques, meditation and cognitive-behavioural therapy have all been shown to help patients control anxiety disorders (Borkovec & Costello, 1993; Delmonte, 1985; Öst & Breitholtz, 2000).

Our results indicate that drug treatment clients typically report a range of self-care strategies for mental health, many of which have been shown to be effective in research studies. We suspect that the practices reported here underestimate the full range of self-care strategies undertaken by drug treatment clients, as people may not recognise the activities they employ to cope with mental health difficulties. While our qualitative design could not produce a statistically representative account of self-care practices within drug treatment populations, we believe our description of self-care activities addresses an omission within the research literature, and demonstrates the investments that drug treatment clients make in their own wellbeing. This counters the common assumption that drug treatment clients lack skills or the capacity to care for themselves (Treloar & Holt, 2006), and suggests that treatment providers could explore their clients' self-care practices in order to strengthen treatment interventions for drug dependence and mental health problems.

As researchers have noted, there is a tension between consumer and professional views of self-care; self-care can be seen as lay strategies towards health, independent of or resistant to institutional medicine. Alternatively, self-care practices can be seen as resources to be harnessed by health professionals with the aim of improving treatment effectiveness, disease management, and reducing the burden on clinical services (Levin & Idler, 193; DeFriese *et al.*, 1989; Kralik *et al.*, 2004). We do not see self-care as a substitution for formal drug or mental health treatment where clients need and have

sought professional assistance. Nor do we see self-care as merely a set of practices that health professionals can harness to improve treatment outcomes. From our perspective, self-care is a normal, routine set of practices which may become more important for people when they are suffering ill health or participating in challenging or long-term treatment. Clearly, some self-care practices can be encouraged in formal treatment settings (as evidenced by the counselling-derived strategies outlined above). However, in other cases self-care practices may reflect attempts by clients to compensate for difficulties experienced within treatment or a lack of support for mental health problems. Encouraging self-care among drug treatment clients is likely to work best when formal treatment issues (if any) have been addressed first.

Critics have suggested that an overly narrow focus on self-care eclipses social inequities and barriers to treatment, and reinforces the idea of health-seeking as a solely individual responsibility (Anderson, 1996; Crawford, 1980). The socioeconomically disadvantaged, among whom drug treatment clients are typically overrepresented, may be poorly placed to enact self-care without encouragement and support (Cockerham, Lueschen, Kunz & Spaeth, 1986; Evert, Harvey, Trauer & Herman, 2003). It is notable that most of the self-care practices our participants described were free or low-cost activities. For a group of people largely reliant on welfare payments for income, additional investment in self-care (such as paying for gym attendance) is unlikely. Other than financial constraints, barriers to self-care include physical limitations, symptom severity, additional comorbid conditions, medication problems, and lack of access to resources (Bayliss *et al.*, 2003). Drug users often report these kinds of problems (Treloar *et al.*, 2004), so in some cases

successful self-care practices may be achieved despite rather than because of participation in drug treatment (Holt, 2007).

It is important to note that although most participants identified self-care strategies, there was a significant minority that did not. This may reflect under-reporting, but it may also reflect drug treatment clients who do not know how to cope with their mental health difficulties other than through formal treatment. As noted above, it may require a change in perspective for service providers to recognise the capacity and motivation of people in drug treatment to practice self-care. However, positive recognition of self-care should not generate an expectation that drug treatment clients should rely on their own resources to augment or replace formal mental health treatment.

The research described here identified a range of self-care practices undertaken by drug treatment clients to maintain or improve mental health. While self-care practices are unlikely to substitute for effective formal treatment, they provide evidence of drug treatment clients' investments in their own wellbeing. Our findings suggest opportunities for service providers to work with clients on everyday activities that may help clients cope with common mental health problems like anxiety and depression.

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Table 1: Participant characteristics

	n (% of sample)
Male	39 (51%)
Female	38 (49%)
Born in Australia	63 (82%)
Born outside Australia	14 (18%)
Aboriginal or Torres Strait Islander heritage	12 (16%)
Any experience of substitution pharmacotherapy treatment	70 (91%)
Diagnosis of or treatment for depression (lifetime rate)	73 (95%)
Diagnosis of or treatment for anxiety (lifetime rate)	22 (29%)
Welfare/social security benefits as main source of income	68 (88%)

Table 2: Additional examples of self-care strategies

Self-care strategy	Quotation
Self-medication (n=21)	'And I was using these drugs to medicate, self-medicate the feelings that I was having. Anything, if I was feeling anything that I could feel the energy coming up and I was sitting around… I knew I was gonna snap. So I would quickly run off, I had to try to keep it in as much as possible til I could get to something, smoke a bong or have a shot and medicate it.' (Helen, 24 yrs old)
Social support (n=14)	'…just recently I've found someone else that's in a similar situation and I've been able to like unload with them and they'll be going "oh fuck, that's amazing, that exact same thing happened," y'know, and it's been really good to talk to that person, but before that, it was just something that I had to deal with.' (Peter, 38 yrs old) 'Um, because I am living with mum and dad again um, when I am sort of feeling a bit down I sort of say to mum, "oh I am feeling a bit down" and you know she sort of does her best to try and cheer me up a bit' (Alicia, 27 yrs old)
Physical exercise (n=12)	'I have been on, joined the gym again recently, which is what I used to do when I got clean before and that also helps with the depression, it gets my blood flowing, it helps me with my self-

	esteem and that sort of getting fit.' (Matt, 42 yrs old)
Counselling-derived techniques (n=14)	'I got sent to the Salvation Army um, anger and stress classes and I did a full 8 weeks course and it did help me to get into my space and with music or even at home and meditate and all that stuff. And I found it helped me, for a while' (Catherine, 40 yrs old)
Keeping busy (n=11)	'Yes, I really try to keep busy because I find it's usually when I'm home on my own that I get like that [depressed]. So I really am trying to keep my life fuller which at times is hard to do. But busy is better than being bored. Definitely better than bored. Boredom is very dangerous.' (Calvin, 43 yrs old)