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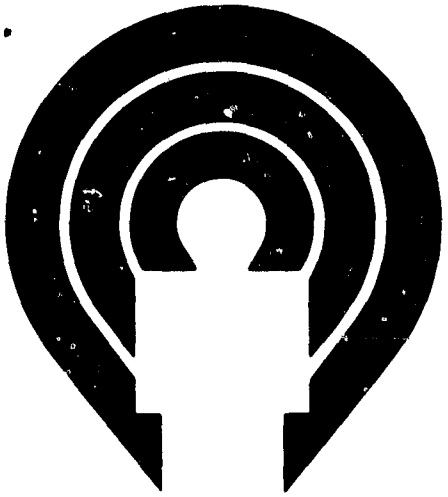

A Comparison of Mental Health Treatment Center and Drug Abuse Treatment Center Approaches to Nonopiate Drug Abuse

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
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The Services Research Reports and Monograph Series are issued by the Services Research Branch, Division of Resource Development, National Institute on Drug Abuse (NIDA). Their primary purpose is to provide reports to the drug abuse treatment community on the service delivery and policy-oriented findings from Branch-sponsored studies. These will include state-of-the-art studies, innovative service delivery models for different client populations, innovative treatment management and financing techniques, and treatment outcome studies.

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FOREWORD

This study is part of an effort by the National Institute on Drug Abuse (NIDA) to assess treatment resources available to the nonopiate drug abuser. Drs. Safer and Sands have summarized the report submitted by Research Triangle Institute into the format herein.

The purpose of the study is to obtain information about the types of treatment available to persons who abuse drugs other than opiates (e.g., amphetamines and barbiturates), to describe the treatment programs and the clients in these programs, and to identify critical needs in nonopiate drug abuse treatment. It is hoped that the information from this study will be useful in both national and local efforts to provide effective treatment for nonopiate drug abuse problems.

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CONTENTS

Summary

This report presents the findings of a study on the treatment of nonopiate drug abusers in drug abuse treatment centers and mental health treatment centers. This exploratory investigation provides a description and comparison of incidence rates, demographic variables, and treatment of the nonopiate abuser population in three types of settings:

- Type I--four freestanding drug abuse clinics
- Type II--four drug abuse units in community mental health centers (CMHCs)
- Type III--four community mental health centers without separate facilities for drug abusers.

Findings are based on a sample of 1,113 clients from the overall population of the 12 clinics--including 281 nonopiate abusers.

Client records and staff interviews were the sources of data.

The emphasis of this report is placed on the exploratory, descriptive nature of the project, the principal findings of which follow.

DEMOGRAPHIC CHARACTERISTICS

In the sample as a whole (N=1,113), the majority of clients were male (56 percent), white (65 percent), unmarried (at least 72 percent), young (mean age 26.4), and unemployed (63 percent). Typically, Type I programs had young male opiate addicts with limited education and low-status jobs, who were frequently referred by the criminal justice system. Type II clients were more often diagnosed as having personal or emotional difficulties than were Type I clients. Type III clients were more likely to be older and female; many of these clients had been diagnosed as psychotic and were on daycare status.

DIFFERENCES IN DRUG PROBLEM INCIDENCE BY CLINIC TYPE

In Type I programs, 73 percent of clients received diagnoses of drug addiction, while only 26 percent in Type II and less than 1 percent in Type III were so diagnosed. Drug problems of any type, including alcohol abuse, were reported in case records of 97 percent of the Type I sample, and 44 percent and 15 percent, respectively, of the Type II and III samples. It should be noted that programs of Types I and II have a specific mandate to identify and treat drug abusers and therefore are likely to apply different diagnostic criteria from those applied in mental health centers (Type III).

CHARACTERISTICS OF THE NONOPIATE ABUSERS SAMPLE

A subsample of those persons with primary problems of nonopiate drug abuse (N=281) was selected and the data gathered were analyzed in greater detail. Comparative data thus obtained must be interpreted with caution since the extent to which each sample represents the clinic population of nonopiate abusers is unknown. It also should be made clear that there is an unspecified overlap of the nonopiate sample with the general clinic sample.

The selected nonopiate sample is 62 percent male, 83 percent white, and 80 percent neither married nor living together. In Type I clients (N=138), less than half mention drugs in presenting complaints, and only 4 percent complain specifically of nonopiate use. This suggests that these clients do not consider or choose to acknowledge drug abuse as the sole, or even primary, problem for them. Diagnoses given Type I clients, in addition to that of drug abuse, tend to be transient situational disturbances and personality disorders.

Nonopiate abusers in Type II clinics (N=98) tend to be older than the Type I clients, and also better educated, with higher status of employment. They are more often self-referred. Two-thirds mention drugs in presenting complaints, and 12 percent specifically seek treatment for their nonopiate drug use.

The Type III nonopiate addicts (N=45) tend to be the oldest, best educated clients with the highest unemployment rates. They are most often referred by professionals or institutions. Half mention no presenting complaint at all, and those who do usually describe emotional difficulties. Psychosis is the most common diagnosis, followed by personality disorder or neurosis.

When the nonopiate abuser sample is compared with the general sample--the nonopiate sample has a greater proportion of unmarried, young, white male types.

TREATMENT OF THE NONOPIATE SAMPLE

Data were collected on treatment modality, medication, and supportive services for the nonopiate sample, but are extremely sparse. Clinics of Types I and II provided clients with drug-free treatment (their only available service), and Type III provided daycare. Individual therapy was the most common technique in all clinics. Some differences in treatment depending on drug of primary abuse were noted, however. Amphetamine users were in group therapy more frequently than depressant abusers, and also received more psychological testing and detoxification, perhaps because their symptoms were more overt. Type III clients received more medications, probably for control of psychotic symptoms. Few clients in any program received supportive services such as medical care, transportation, child care, or housing assistance from the clinic, probably because of limited funding and availability. Type I clients received somewhat more of such services (e.g., transportation).

The records on treatment outcome were extremely limited, demonstrating the need for developing a standardized and informative data bank in CMHCs if useful comparative data is to be obtained in the future. Average overall stay is 40 weeks, Type III having the longest average stay. Type I clients more often completed treatment, and those who completed their treatment in this modality stayed a shorter time than Type II or III completers. Clients in Types II and III were longer term, and more were still in treatment at the time of the study. This may reflect the more serious emotional problems of these clients, or differences in treatment philosophy.

This survey further fails to detect any specific treatment for nonopiate abusers, whose services tend to be similar regardless of the drug used or the type of facility attended (individual therapy in 86 percent of cases, group therapy in more than a third).

Only one of the 12 clinics provided staff training in the management and treatment of nonopiate abusers. It therefore appears that CMHC staffs (at least those studied here) are not presently trained or experienced in treating nonopiate abusers and may experience difficulty in recognizing and/or undertaking this task.

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[1]It should be noted that this study might not detect more subtle differences in approach to treatment for different populations.

Introduction

Drug abuse treatment programs have traditionally focused on providing services to the opiate abuser. Recent data, however, suggest that there is a substantial and currently underserved population of abusers of nonopiate drugs such as barbiturates, tranquilizers, and amphetamines. Therefore, the Domestic Council's Drug Abuse Task Force in its White Paper on Drug Abuse (1975) recommended more extensive use of the federally funded community mental health center (CMHC) network to meet the treatment needs of this population. Public Law 92-255, the Drug Abuse Office and Treatment Act of 1972, and Public Law 74-63, the Special Health Revenue Sharing Act of 1975, also stipulate that CMHCs treat and rehabilitate drug abusers in their catchment areas. Given this mandate, a survey of the kind and quality of drug treatment services currently available in these facilities focusing on the ways in which programing in mental health centers and drug abuse programs differ, appears relevant for policy planning and needs assessment.

Data were gathered on demographic and diagnostic characteristics of both the general clinic clientele and selected nonopiate abusers, and on treatment process and outcome in order to obtain a descriptive comparison of the populations served and the treatment given in CMHCs and in clinics specifically designed for drug abusers. Principal results and conclusions are presented here, as well as methodological comments and implications of the study.

Methodology

PROCEDURE AND SAMPLE

Data were collected on a random sample of clients treated during 1975 in 12 clinics from 4 communities (New Orleans; San Francisco; Raleigh/Durham, N.C.; and Boston). Four settings of each of the following three types comprised the sample: freestanding drug clinics (referred to as Type I), drug units in community mental health centers (CMHCs) (Type II), and CMHCs without separate facilities for drug abusers (Type III). The sample consisted of 1,113 clients from the overall population of the 12 clinics including 281 nonopiate abusers from 10 of the 12; 2 of the Type III clinics could not identify an adequate sample. Data from a Type III program in Dumont, N.J., was later added for descriptive purposes. The larger sample and the nonopiate sample were compared on demographic characteristics, problems, drug involvement, length of treatment, and discharge data.

FACILITIES

The Type I drug clinics used in this study are free standing, licensed, and supported at least partly by the National Institute on Drug Abuse (NIDA). Two of the four predominantly treat heroin abusers with methadone maintenance or detoxification and drug-free outpatient counseling. The other two drug clinics did not accept heroin addicts and were oriented toward the adolescent multiple-drug abuser, one through affiliation with a public health department, the other through outreach programs for runaways.

The relation of the four Type II programs to the CMHCs with which they are associated, varies from a primarily administrative affiliation to a full integration with the services offered by the parent clinic. Some have entirely separate facilities, some have a broad mental health orientation, and some focus completely on drug abuse treatment.

None of the four Type III programs offer specialized drug abuse services nor have accurate estimates of the extent of such problems in their full client population. The samples that were obtained came in one case from a separately housed combination daycare and outpatient facility that provides aftercare to a deinstitutionalized population viewed as seriously ill.

SITE SELECTION AND DATA COLLECTION

Site selection for this study proved difficult. Very few drug treatment programs visited appeared to provide services to primary nonopiate abusers. Nonopiates, according to staff reports, tended to be used in combination with or as substitutes for opiates rather than as drugs of choice, and multiple abusers tended to be classified as primary heroin abusers for funding purposes. Staffs in

CMHCs visited tend to refer abusers to drug clinics, because they feel they themselves lack the expertise to treat such patients and that services are available elsewhere.

When CMHCs agreed to participate in the study, it was found that requisite information was often not available in client records. Whereas federally funded drug abuse facilities are required to maintain CODAP records with detailed drug information, in CMHCs, where the focus is not on drug abuse treatment, there is neither detailed nor standardized reporting of drug use. In addition, concerns with confidentiality made patient data more difficult to obtain in the CMHCs. Finally, none of the clinics of any type had standardized, precise records of treatment process.

MEASURES

Sources of data were patient records and staff interviews. Interview topics included treatment model, extent of the problem, and counselor's knowledge about drug abuse. Patient records provided demographic characteristics, drug use and history, diagnosis, presenting complaints, and data on duration and type of treatment and case disposition. Chi-square tests of distribution were used to test significances of differences where applicable.

Even after appropriate sites had been selected, the investigators had difficulty in obtaining a sample. The original criterion for sample selection was 6 months in treatment, which was of necessity subsequently shortened to 4 weeks. There was considerable intraprogram as well as interprogram variability in duration of treatment, and the result is some admixture of long- and short-term patients within cells.

The comparison of CMHC clients to the drug clinic sample was complicated by the different diagnostic criteria used by these two types of facilities and the lack of systematic data on drug abuse in the CMHC records, requiring investigators to rely on progress notes and counselor reports of varying degrees of thoroughness.

Results

Interviews indicated that staff of Type I and II clinics were more knowledgeable and better experienced in drug abuse treatment, as expected, and that Type III staffs had no training and minimal experience in this area. Only 1 of the 12 clinics studied provided organized staff training in identification, treatment, or management of drug abusers.

At no clinic investigated (insofar as this study could detect) did nonopiate abusers receive a specialized treatment regimen; individual counseling was usually employed. Drug-related concerns were the focus of attention in sessions with Type I clients, while Type II and III sessions emphasized emotional problems.

It is significant in terms of planning that of the 65 staff members interviewed, only 1 mentioned community mental health centers or traditional drug abuse clinics as likely treatment choices of nonopiate drug abusers. Staff members felt that nonopiate drug abusers rarely consider their drug use a problem requiring treatment partially because of the stigma attached to admitting drug dependence, and partially because of a laissez-faire or even subtly encouraging attitude by society, family, and physicians. There is no consensus on treatment of choice for these clients.

REPRESENTATIVE CLIENT DATA

Demographic characteristics. Table 1 presents the demographic characteristics of the general clinic sample. Significant differences occur among programs in percentage of males and females, with most males in Type I programs (70 percent) and fewest (44 percent) in Type III. Type II has equivalent numbers of both sexes. Sex distributions also vary by location. Most clients in all programs are young; nearly three-fifths in Type I clinics are 24 years old or younger, and one-fifth overall are 19 or younger. Types II and III have substantial populations 15 or younger. That drug clinics tend to serve a more homogeneous group of late adolescents while the CMHC clients vary more in age reflects the broader mental health concerns of the latter facilities, as well as the findings in the literature that there are either fewer older addicts or fewer older addicts seeking treatment.

The majority of clients are white. A large number (48 percent) of the total sample were never married, which may be related to the relative youth of the population. Educational status of clients in all programs is relatively high with 68 percent of the whole sample high school graduates, and 13 percent in Types II and III college graduates. Only 3 percent of Type I clients were college graduates but since many clients had attended college this low figure may reflect the youth of this sample.

TABLE 1.—Demographic characteristics of total sample of clients by program type (percentages)

	Program type			All clients
	I (N=407)	II (N=410)	III (N=296)	(N=1,113)
Sex				
Male	70	51	44	56
Female	30	49	56	44
Age at admission				
<15	2	11	13	8
15-19	21	9	10	14
20-24	35	24	21	27
25-29	27	23	21	24
30-39	12	20	17	16
40+	3	12	18	11
Mean	24.1	27.3	28.6	26.4
Range	13-54	4-78	4-84	4-84
Race/ethnicity				
White	65	61	71	65
Marital status for those age 18+				
Never married	48	51	44	48
Married or living together	38	19	27	27
Dissolved	14	31	29	24
Education for those 18+				
<High school graduate	33	32	29	32
High school graduate	44	29	31	35
Some college	19	25	25	23
College and some graduate	3	13	13	9
Vocational, business, technical	<1	1	3	1
Usual occupation				
None	[1]19	13	19	16
Bus., prop., prof.	5	16	18	14
Clerical and skilled	17	26	16	21
Semiskilled and unskilled	26	16	14	18
Student	26	22	25	24
Homemaker, retired, disabled	7	7	7	7
Employment status for those 18+				
Full time	25	24	23	24
Part time	8	11	6	9
Unemployed: not sought in 30 days	43	53	66	52
Unemployed: has sought in 30 days	24	12	5	15
Percent not in labor force	15	26	28	23
Unemployment rate for labor force	64	59	67	63

[1]Information on usual occupation was available for only 59 percent of the sample of Type I clients.

Occupational data were limited for the entire sample, but students appear to comprise approximately 25 percent of the population in each program. Statistically significant differences are found in the overrepresentation in Type I of semiskilled and unskilled workers and the larger proportion of skilled jobholders in Types II and III, but since data were available for only 59 percent of Type I clients, they should be interpreted cautiously. Approximately one-third of the clients in each program type were employed. However, employment rates are low considering the high occupational and educational level reported for the sample.

Problem characteristics and diagnosis. Data from all patient records on problem areas, motivation, referral source, and drug involvement at intake were collected to see why patients choose a particular type of treatment facility. The vast majority of the sample mentioned no referral source. Of those who did mention a source, Type I clients were sent by the criminal justice system significantly more often and by professionals significantly less often than other clients. Type III programs include significantly more persons referred for aftercare and significantly fewer sent by family or friends (one of the Type III programs was a day center for deinstitutionalized clients).

The presenting complaint most commonly mentioned by clients in the freestanding drug clinics was drug addiction (71 percent), with heroin or methadone mentioned in 75 percent of those instances. Only 29 percent of clients in CMHC drug units present with drug problems, which most frequently involve marijuana or unspecified drugs (15 percent) or alcohol (7 percent). Problem areas specified by clients in both kinds of CMHC facilities tend to be personal and emotional. In general, the number of clients seeking help for self-acknowledged nonopiate abuse was small; it was the presenting complaint in 29 percent of Type II cases, 12 percent of Type I cases, and less than 1 percent of Type III cases. Prevalence of use of these drugs seems to be considerably greater than their report as presenting complaint.

Diagnosis might be expected to reflect program orientation as much as it reflects actual client characteristics. Drug abuse is the most frequent primary diagnosis of Type I clients (73 percent); situational problems (30 percent), drug abuse (26 percent), and neurosis (14 percent) in Type II; and psychosis (33 percent), personality disorders (17 percent), situational problems (15 percent), and neurosis (14 percent) in Type III programs. Those clients who received an intake diagnosis of drug abuse accounted for, respectively, 73 percent, 26 percent, and less than 1 percent of each clinic type.

Notations by staff of patient drug problems were collected and, again as might be expected, the data indicate that the freestanding drug clinics serve a drug-abusing population almost exclusively, whereas the majority of clients (58 percent and 85 percent respectively) in the two other types of clinics are not seen as drug abusers. There are also differences in primary drug of abuse by clinic type; heroin is the principally abused drug of 61 percent of the Type I sample followed by marijuana (19 percent). Heroin also claims the largest number of Type II abusers (16 percent of the 44 percent about whom reports revealed any substance abuse), followed by alcohol (13 percent). In Type III programs, where 15 percent of the case records indicated a drug problem, alcohol and nonbarbiturate sedative/hypnotics were most prevalent.

The prevalence of nonopiate abuse appears much greater when all notations (primary, secondary, and tertiary) of drug use in records are considered; then, barbiturates, other sedative/hypnotics, and tranquilizers can be seen as a problem for 16, 12, and 5 percent of clients by respective clinic types, and amphetamines as affecting 8, 5, and 3 percent of the respective subsamples.

Outcome indicators. The only "outcome" data available from patient records was length of treatment and reason for termination. While such measures cannot be interpreted as indices of effectiveness, they do suggest differences in program functioning and record-keeping that need to be considered in future research and evaluation efforts. Variations in reporting criteria of the various clinics probably account for some differences which at first appear to be significant.

The largest apparent difference is between clients who come for intake only versus those who remain for 6 months or more. Type I clinics reported that only 2 percent of clients leave after intake. The mental health clinics lose a far greater number of prospective clients after intake--24 percent in Type II and 16 percent in Type III. Two of the four freestanding clinics in the study, however, do not consider a case officially open until the third patient contact. When this factor is taken into account in data analysis and the number of clients who stay in treatment less than a month is compared over facilities, the differences disappear, and the percentages of terminees at 1 month are 31, 41, and 32 percent, respectively.

Treatment lasts 1 to 5 months for approximately half of Type I and III patients and for 35 percent of Type II patients. Long-term treatment of 12 months or more is more common in the mental health clinics, accounting for approximately a quarter of the Type II and III samples of clients still in treatment, and for 11 percent and 15 percent of Types II and III, respectively, compared to 1 percent in Type I, when considering only patients who have left treatment. These differences may be explained by a variety of factors, including the stricter discharge criteria of Type I programs, a view that clients who come to CMHCs have more serious problems, differing time orientations of programs, and differing client personality traits. Varying discharge policies within the programs studied make it difficult to factor out specific causes.

NONOPIATE CLIENT DATA

Demographic characteristics. The subsample of 281 clients identified as being in treatment primarily for nonopiate abuse either through CODAP reports or clinic files was analyzed separately, and was also compared with the large client sample from the various programs. Data on Type III nonopiate abusers is limited to half the original Type III sample, since two of the four facilities did not have a sufficient population of this type of client.

As noted in table 2, 60 percent of the nonopiate sample in each type of facility was male. Age distribution differed significantly by facility type, with 55 percent of Type I clients and only about 15 percent of CMHC clients under age 20. Eighty-three percent overall were white, with Type I programs serving the lowest number (12 percent) of nonwhites. These figures vary by geographic sites with San Francisco clinics of all three types serving the largest number of nonwhites. The majority of clients in all types of programs, two-thirds in Types I and III and 56 percent in Type II, were never married. Type I clients tended to have the lowest educational levels, and Type III the highest. Programs also differ in the occupational level of clientele, with Type I clients more likely to hold unskilled jobs, Type II overrepresented in more skilled jobs, and over two-thirds of Type III, despite higher educational attainment, neither working nor seeking employment. This rate may reflect the large proportion of daycare psychotics in Type III facilities. High unemployment rates of clients currently in the labor force (excluding those not seeking work) characterized the nonopiate sample generally, with rates of 61 (Type I), 60 (Type II), and 83 (Type III) percent.

Problem characteristics and diagnosis. Half the sample mentioned referral sources, and these differed significantly by clinic type; approximately a quarter of Type I clients were sent by the criminal justice system, almost one-half of Type II clients were self-referred, and most of the small number of Type III clients who mentioned a source were self-referred. That nonopiate drug use is not seen by the user as a basis for entering treatment is suggested by the fact that over one-half of these clients did not mention their drug use as a presenting complaint. Breakdown by clinic type indicates that over two-thirds of Type II clients, as opposed to 43 percent of Type I, and only 11 percent of Type III clients identified in their records as nonopiate drug abusers, mention drug abuse when they come for treatment. Such differences in rate of drug mentions may reflect differences in recording of presenting complaints by various kinds of facilities, and are of unknown reliability since methods are not standardized either across or within clinic types.

When presenting complaints are considered, clients in Type III clinics are least specific about their problem areas, but in all clinic types emotional difficulties predominate, followed by a combination of interpersonal and behavioral dysfunction. Rarely is nonopiate addiction reported as a major problem by these patients.

Programs differ significantly in diagnosis of the nonopiate sample in ways consistent with the literature; psychoses, neuroses, and personality disorders are most frequent in Type III, and transient situational disturbances in Type I. That the Type I clinics in this sample, which are oriented to adolescents, use the drug abuse diagnosis less frequently (44 percent so diagnosed versus 65 percent in Type II) may be another instance of differences in the application of criteria rather than clientele.

Drug use. Table 3 presents patterns of abuse by program type. Barbiturates were by far the most commonly used primary nonopiate for the sample (44 percent), and account for 63, 44, and 24 percent, respectively, of all drug use among the three types of clients when secondary and tertiary substance choices are included. Other sedatives and hypnotics tend to be more commonly used as secondary drugs.

The drugs chosen as primary nonopiates most frequently by Type I clients are barbiturates and amphetamines, and these clients secondarily abuse a variety of other drugs. Type III clients tend to be quite diverse in both

TABLE 2.—Demographic characteristics of selected sample of nonopiate clients by program type (percentages)

	Program type			All clients
	I (N=138)	II (N=98)	III (N=45)	(N=281)
Sex				
Male	62	63	60	62
Female	38	37	40	38
Age at admission				
<15	6	-	-	3
15-19	49	13	16	31
20-24	30	38	31	33
25-29	10	31	20	19
30-39	5	14	22	11
40+	<1	4	11	4
Race/ethnicity				
White	88	77	82	83
Marital status for those 18+				
Never married	65	56	67	62
Married or living together	17	25	17	20
Dissolved	17	19	17	18
Education for those 18+				
< High school graduate	50	29	24	37
High school graduate	33	36	24	33
Some college	12	26	39	22
College and some graduate	4	7	10	6
Vocational, business, technical	1	2	2	2
Usual occupation[1]				
None	7	10	39	13
Bus., prop., prof.	9	13	9	10
Clerical and skilled	12	25	12	17
Semiskilled and unskilled	39	33	24	35
Student	29	13	6	20
Homemaker, retired, disabled	4	6	9	6
Employment status for those 18+				
Full time	23	25	14	22
Part time	9	12	2	9
Unemployed: not sought in 30 days	44	55	67	52
Unemployed: has sought in 30 days	23	9	16	16
Percent not in labor force	16	11	6	13
Unemployment rate for labor force	61	60	83	64

[1]Information on usual occupation was not available for 24 percent of the clients in the sample.

TABLE 3.—Drugs of abuse for selected nonopiate clients by program type (percent)

Drug	TYPE I (N=138)			TYPE II (N=98)			TYPE III (N=45)			ALL CASES (N=281)		
	Primary	Secondary	Tertiary	Primary	Secondary	Tertiary	Primary	Secondary	Tertiary	Primary	Secondary	Tertiary
None	-	12	47	-	13	56	-	18	44	-	14	50
Heroin	2	5	4	-	12	2	2	-	-	1	7	2
Methadone	-	-	-	-	-	-	-	-	-	-	-	-
Other opiates and synthetics	-	2	-	-	1	2	-	4	-	-	2	1
Alcohol	-	9	9	1	19	10	13	11	9	2	13	9
Barbiturates	58	3	2	38	6	-	13	11	-	44	5	1
Other sed./hyp.	4	6	2	3	8	1	13	16	1	5	8	2
Tranquilizers	4	6	4	28	5	3	11	2	11	13	5	5
Amphetamines	31	6	1	26	15	3	11	11	9	26	10	3
Cocaine	-	4	2	3	2	5	-	-	2	1	2	3
Marijuana	-	33	15	-	8	12	18	7	7	3	20	13
Hallucinogens	-	15	12	2	9	5	9	9	9	2	12	9
Other	1	-	1	-	-	-	9	11	7	2	2	2

primary and secondary drug choice. Approximately a quarter of the sample abuse amphetamines primarily, and almost 40 percent of clients have some involvement with them.

When the entire sample (N=1,113) is considered, barbiturates predominate (63 percent) among those using drugs followed by marijuana (48 percent) and amphetamines (38 percent). Type II clients also tend to be primary barbiturate and amphetamine abusers, but also more often abuse tranquilizers at all levels (36 percent) than other categories of clients.

Treatment. A major objective of this study was to compare the treatment offered to nonopiate abusers at the different types of clinics in terms of length, process, and outcome, and to determine whether there were any differences in treatment of depressant and amphetamine abusers. Of the 281 clients, 62 percent were primary depressant users, and 26 percent were primary amphetamine users.

In compiling these data, investigators had to rely on clinic records which, because they were unstandardized in length and content, were of limited value and difficult to use for comparative purposes. Information on the actual process of therapy was virtually impossible to obtain.

Modality of treatment was obviously related to type of program, with drug-free outpatient and detoxification services predominant in Type I, and drug-free outpatient in Types II and III. Daycare was exclusive to Type III clinics, where antipsychotic medications are often routinely prescribed. Most patients (86 percent) received individual therapy, and over one-third were seen in groups, regardless of the type of facility. Approximately one-third of all patients were given physical examinations--most commonly patients in Type I clinics, where such examinations are mandated by law. That Type III patients were given psychological tests most frequently reflects the orientation of these clinics.

Individual counseling/therapy was more common for depressant-abusing clients in all clinics as it was for clients in general. Family counseling/therapy was most frequently available to clients in the freestanding drug clinics. Vocational rehabilitation, job placement, and training were very limited--12 percent in Type I, 17 percent in Type II.

Amphetamine abusers were also usually treated individually, and for these patients group counseling/therapy was more often available in the Type II programs, with 70 percent so treated. The drug units of mental health centers provided vocational rehabilitation services three times more frequently than did the freestanding clinics.

In sum, few differences in treatment modality were found to be related to program type; clients tended to be seen in individual counseling sessions regardless of setting. Amphetamine users in Type II programs received group counseling/therapy more frequently. There was also a tendency for amphetamine abusers in both Type I and II programs to receive an array of services including psychological testing, rehabilitation, and detoxification, which might suggest particular types of concerns with these patients. No differences were found between depressant and amphetamine users in frequency of receiving prescribed medication.

When comparison was made for availability of supportive services other than vocational rehabilitation at the various clinics, data indicated that the Type I programs provided these more often; over one-third of Type I clients were aided, principally with transportation or medical examinations, as opposed to 9 percent of Type II, and 13 percent of Type III clients.

Outcome indicators. Treatment "outcome" data for the nonopiate sample were limited, because of inadequate records, to length of treatment and reason for discharge.

When discharges were examined, 37 percent of the Type I nonopiate sample were found to have completed treatment, a larger number than in either of the mental health clinic settings, where the figures were 24 percent and 9 percent, respectively. Type I completers tended to be in treatment 3 to 11 months while Type II completers stayed 6 to 11 months. These statistics again probably reflect differences in criteria for completion of treatment by freestanding drug units and mental health centers.

Forty percent of Type I clients left or were expelled from their program of treatment, as compared with 65 percent in Type II and 61 percent in Type III who similarly left programs. Different programmatic recordkeeping, rather than actual rates, may again be reflected in these figures. When mean treatment rates of completers, terminees, and those still in treatment were computed, it was discovered that terminees in Type I programs remained on the average 2 months longer than those who completed therapy. Explanations may be hypothesized based on the characteristics of the clients or the nature of the treatment program.

Conclusions

The exploratory, descriptive, and hypothesis-generating nature of this study has been emphasized. The extent to which this sample reflects the general population of nonopiate drug users in treatment can be determined only by obtaining a representative sample from a variety of clinical facilities, a task beyond the scope of this project and problematic in any event in view of the degree of reliability, completeness, and accuracy of clinic records.

Despite limitations, a number of observations and implications can be made from the study.

1. There appeared to be a lack of familiarity of treatment personnel in the clinics studied with the issues involved in nonopiate drug use. Only 1 of the 12 clinics provided staff training in the management and treatment of nonopiate abusers. It is possible that individuals working in Type I and II programs--that is, explicitly drug abuse treatment programs--may have substantial knowledge in these areas. However, the CMHC staffs studied do not appear to be presently trained or experienced in treating nonopiate abusers and may be reluctant to recognize and/or undertake this task. This is particularly significant in view of the fact that in this study drug problems (including alcohol) were reported in case histories of 15 percent of the Type III sample. Since records are generally scanty, we might expect the actual incidence of substance abuse in this population to be higher. If the lack of knowledge and experience in CMHCs regarding nonopiate drug use were to hold true nationally, then this would seem noteworthy since CMHCs by law are mandated to provide assurances of the availability and adequacy of drug abuse treatment services in their service areas.

2. Prognosis and perhaps treatment appear to be to a large degree related to the type of program an individual enters. Type II clients were more often diagnosed as having personal or emotional difficulties than were Type I clients. Also, although drug problems were reported in case records of 97 percent of the Type I sample, they were reported in only 44 percent of the Type II sample. Although it certainly cannot be proved by this study, there is the suggestion that the drug abuse client receives a primary diagnosis in the area of program expertise. How much difference this might make to treatment regimen and outcome is unknown.

3. Despite the small samples in the studies, there is some indication of the difference in overall populations served in a drug abuse treatment program versus a community mental health program. Typically, Type I programs saw young male opiate addicts with limited education and low-status jobs, who were frequently referred by the criminal justice system. This is clearly a socially disadvantaged population. Type III clients were more likely to be older and female; many of these clients were diagnosed as psychotic and were in daycare status.

4. At the present time, research and evaluation into the effectiveness of present therapeutic efforts is difficult because of unstandardized recordkeeping, particularly on drug use in the mental health centers and on treatment progress in all types of clients.

5. The study could not isolate any clear-cut detectable differences in the kind and quality of therapy for nonopiate addicts provided by mental health and freestanding clinics. It must be noted, however, that the study examined gross treatment categories only, e.g., individual counseling/therapy, without exploring either degree or specific nature.

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