

PROFILES OF CLUB DRUG USERS IN TREATMENT

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In looking at what has been going on with our club drug use, we now have some very good protocols for detoxification, particularly for the very complicated substances like GHB. And for methamphetamine we have evaluated, highly tested protocols for substance abuse treatment. The matrix model that Robert Ali in South Australia, Dr Walter Ling and Richard Rawson at UCLA have put out has been tested and is very good. But for the other drugs, when I look at the literature I really find nothing about how a person who is dependent on a substance should be treated.

We have been collecting data on clients in Texas treatment programs since 1988 and I looked at the dataset and pulled 38,000 records of people with a primary, secondary or tertiary problem with a club drug – these are unduplicated admissions. In addition, there were another 350,000 admission records on people who came to treatment with a problem other than a club drug (primarily alcohol or crack cocaine, heroin, marijuana or powder cocaine).

We have been collecting methamphetamine and hallucinogen data since 1988, ecstasy since 1989, GHB since 1997 and ketamine since 2001. So this is the largest dataset that exists on clients in treatment and as you can see, it is very much dominated by methamphetamine. Hallucinogen use has dropped, as has ecstasy (and I am going to call it ecstasy because no lab tests were used to see if the drug the patients reported was actually MDMA or not). A little bit of GHB - about 45 unduplicated cases. Basically this is looking at club drug versus non-club drug users. The people coming in with a problem with club drugs are younger, more likely to be male, more likely to be white, less likely to be homeless and slightly less likely to have a job.

We collect the Addiction Severity Index (ASI) on everybody, and the ASI asks: “In the thirty day prior to coming into treatment have you had a physical health problem not related to alcohol or drugs use?” “Have you had problems with a job or school?” The club drug users are more likely to report more days of job or school problems. Problems with family or spouse are again more likely for club drug users, as are problems with peers or social settings, psychological or emotional problems, and then problems with alcohol and drug use (wanting to quit and unable to quit, blackouts, shakes or tremors and going into withdrawal).

This chart is confusing to look at, but it is a fascinating one (referring to screen). This is the data for every client with a primary, secondary or tertiary problem with ecstasy and then I looked at that pool of people to see what was their primary drug problem. For 20% the primary drug was ecstasy, 30% had a primary problem with marijuana and alcohol, but what is interesting is that for about 30% it was stimulants, either powder cocaine, crack cocaine or methamphetamines. So the primary problem for 30% of these individuals was a harder drug. In comparison about 20% had a primary of hallucinogens, but for the majority the primary drug problem was marijuana or alcohol. GHB really surprised me because not only have you only got some with a primary problem of heroin, but about 26% had a primary problem with amphetamines or methamphetamine and 26% with GHB. And what this did was show the

relationship of either using GHB to come down from a speed run or taking GHB, wanting to enjoy the benefits of GHB, and so using methamphetamine to stay awake, but there is a real relationship there.

Ketamine only had seven unduplicated records, but it has a very different picture that we need to look at. Of the ketamine patients, a couple had a primary problem with ketamine, heroin, one with methamphetamine and one with powder cocaine, so what that says is that even though it is not enough to draw any conclusions, for that group clearly they are using hard drugs. It is not the typical alcohol and marijuana group. For methamphetamines, for 66% their primary drug was methamphetamine, for a few the primary was crack or powder cocaine, and a little bit of alcohol or marijuana but this is clearly a methamphetamine population.

Looking at race and ethnicity, we tend to think of party drug users as all being white, but they are not the – the methamphetamine users clearly are white, but for the other drugs we see some Hispanic and African Americans. And what is interesting about this is, we have heard it mentioned elsewhere during the conference, that ecstasy is moving out the club population and that it is on the streets. Back in 1989, 100% of ecstasy patients were white, but there has now been a drop in white and an increase in Hispanic and Black. So this to me is the first data that confirms the anecdotal ethnographic sorts of information about the increase in people of colour coming in with a problem of Ecstasy.

Looking at the differences in characteristics - for methamphetamine users, only about 55% are male and this has traditionally been a drug that has been split about half and half between males and females. GHB and methamphetamine users are more likely to report a history of ever having injected a drug. There is not a lot of difference in employment. The ecstasy and hallucinogen users are more likely to be in treatment because of problems with the criminal justice or legal system, which got them into treatment. And this is an impoverished population, as these government-funded programs only serve lower income clients.

There is not much difference in homelessness, but the ecstasy and hallucinogen users are more likely to never have been in treatment previously. Looking at the ASI, these are health problems again, higher rates with the methamphetamine users. Job problems were most likely for GHB and methamphetamine, and also with family and marital problems, social problems, psychological problems, and drug and alcohol problems. Clearly the GHB and methamphetamine users are the most impaired at admission, which is not a surprise.

This is completion of treatment. The GHB users, even though they have a lot of problems on the ASI, did better in treatment than the others. For ecstasy users, 39% completed treatment. And looking at the non-club drug users, users of hallucinogens, methamphetamines and other drugs really do not do well in treatment - only about a quarter complete treatment.

Drawing it all together, the users of ecstasy reported they used ecstasy on about eight days in the month prior to treatment, which again matches what we have heard over and over during this conference, that it is weekend use. And clearly the ones coming into treatment may be using other drugs but their ecstasy is a weekend use pattern,

and the primary drug was something else. But I think that cocaine and methamphetamine have a different implication for treatment in terms of relapse. We do not have programmes that are equipped to do a good job treating Ecstasy, but clearly we need to be providing culturally relevant services to populations that are not just white club druggers anymore.

Not many of the Texas programmes ran the DSM on clients, but when they did the clients were depressed, and the literature talks very clearly about depression as an after effect of ecstasy. I did not find in the Texas Programmes much use of anti-depressants, and after people have been in treatment for three or four weeks, after the drugs have cleared from their systems, a clinician needs to consider the use of anti-depressants with this population for a while, but it is not happening. Also the literature talks about impaired concentration, so maybe initially in treatment it is counter productive to put them in lectures where you are lecturing them about substance abuse? I do not know if it works - if you cannot concentrate, do you benefit from being in a group setting? Another thing that needs to be considered in dealing with the script, is perhaps encouraging better outcomes.

Hallucinogens, primarily cannabis and some alcohol, had low ASI scores at admission and follow up. They were in treatment long than any other group. They were more likely to be in residential programmes. But in that last month in treatment they were less likely to be abstinent, less likely to attend twelve step meeting or to complete treatment, so something is going on. They are not that impaired at admission but they are not completing treatment and they are not doing that well. One of the keys might be where the DSM was reported it was a conduct disorder, so maybe we have some behavioural factors that clinically we should be addressing with this population to improve their treatment outcomes.

GHB users use their drug of choice more days than any of the other party drug users use their substances - seventeen days in the previous month. And the relationship between GHB and methamphetamine - they had severe problems at admission but yet they did well in treatment, they had good treatment outcomes. They were older, they were self-referred to treatment, they were unmarried - only 4% were married, we did not ask sexual preference but I suspect this picks up the gay male GHB use. They were impaired before coming in for treatment, they reported more emergency room or hospital visits in the six months prior to coming to treatment, so they had a lot of other problems. The DSM was major depression but there were more likely to be abstinent and to attend twelve step meetings in the last month of treatment, and more likely to complete treatment.

Methamphetamine users were the oldest, had a history of injecting drug use, and about half were females. Clearly their favourite drug was methamphetamine, and they reported using this drug twelve days in the month prior to treatment. Unlike the other clients, a third of them entered detox, which would indicate that they were fairly toxic at the time they came to treatment, and 23% received medications. They were diagnosed as depressed, they were not abstinent in the last month of treatment and had a low completion rate. And I cannot help but wonder - the Texas Programmes tend to be very abstinence orientated, and talking to people who have come off methamphetamine, even after it has left their system, their nerves are shot for a couple of months. I did not see the programmes really giving out Valium or anti-anxiety

medications to make them more comfortable during treatment and clearly they are not doing well at treatment. At both admission and ninety day follow up, they were using drugs one, two and three on more days, they had higher ASI scores and are not doing well in treatment.

So basically, this is the first look at any data I have seen on clients in treatment and based on the things we have heard here, we clearly need to be moving to clinical trials and trying to find out what is good treatment for these very different populations, because clinicians tend to think all club drug users are alike in terms of the drugs they use and the characteristics of the users.

Thank you.