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Field Experiences in Counseling at a Methadone Treatment Program and a Rural Drug Abuse Program

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FIELD EXPERIENCES IN COUNSELING AT A METHADONE TREATMENT PROGRAM AND A RURAL DRUG ABUSE PROGRAM

by

Thomas E. Lucking

A Project Report
Submitted to the
Faculty of The Graduate College
in partial fulfillment
of the
Specialist in Education Degree

Western Michigan University
Kalamazoo, Michigan
August 1975
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Thomas Edward Lucking
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# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>INTRODUCTION .......................... 1</td>
</tr>
<tr>
<td></td>
<td>Drug Use ................................ 1</td>
</tr>
<tr>
<td></td>
<td>My Role in Drug Abuse Treatment ........ 2</td>
</tr>
<tr>
<td></td>
<td>Rationale For Internships ............ 2</td>
</tr>
<tr>
<td>II</td>
<td>REVIEW OF SELECTED LITERATURE ON METHADONE TREATMENT ................................. 3</td>
</tr>
<tr>
<td></td>
<td>History of Methadone Treatment ........ 3</td>
</tr>
<tr>
<td></td>
<td>Methadone Treatment Programs .......... 4</td>
</tr>
<tr>
<td></td>
<td>Evaluations of Methadone Treatment Programs ... 6</td>
</tr>
<tr>
<td>III</td>
<td>THE POTTER PROGRAM EXPERIENCE ........ 8</td>
</tr>
<tr>
<td></td>
<td>The Potter Program .................... 8</td>
</tr>
<tr>
<td></td>
<td>The Placement Activities ............. 9</td>
</tr>
<tr>
<td></td>
<td>Log of Experiences .................... 9</td>
</tr>
<tr>
<td></td>
<td>Summary of the Potter Experiences .... 19</td>
</tr>
<tr>
<td></td>
<td>Discussion and Recommendations ...... 20</td>
</tr>
<tr>
<td>IV</td>
<td>REVIEW OF RELATED LITERATURE .......... 21</td>
</tr>
<tr>
<td></td>
<td>The Programs .......................... 21</td>
</tr>
<tr>
<td></td>
<td>Drug Education ....................... 22</td>
</tr>
<tr>
<td></td>
<td>Drug Abuse Counseling ............... 24</td>
</tr>
</tbody>
</table>
# TABLE OF CONTENTS, CONTINUED

<table>
<thead>
<tr>
<th>CHAPTER</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>V · THE VAN BUREN COUNTY DRUG ABUSE PROGRAM</td>
<td></td>
</tr>
<tr>
<td>EXPERIENCE</td>
<td>27</td>
</tr>
<tr>
<td>The Program</td>
<td>27</td>
</tr>
<tr>
<td>The Field Experience</td>
<td>28</td>
</tr>
<tr>
<td>Log of Experience</td>
<td>29</td>
</tr>
<tr>
<td>Summary of the Van Buren Experience</td>
<td>34</td>
</tr>
<tr>
<td>Recommendations</td>
<td>36</td>
</tr>
<tr>
<td>REFERENCES</td>
<td>37</td>
</tr>
</tbody>
</table>
CHAPTER I.
INTRODUCTION

Drug Use

Throughout history, drugs have been used for medicinal and recreational purposes. Opium was used in China as far back as 5000 BC., and Egyptian, Greek, and Roman writers refer to its use in recreation and medicine (Willis, 1973). Alcohol has been known to almost every culture, making its first appearance in Mesopotamia about 5,000 years ago (Ullman and Krasner, 1969). The medical use of marijuana was described in a Chinese treatise dating back to 2737 BC. (Brecher, 1972).

In many cultures, some forms of drug use have been defined as problems and have been subject to various types of treatment and prevention. In 14th century India, Sheikhoui attempted to end marijuana use by the peasants by imprisoning users and destroying plants; however, use of marijuana increased (Willis, 1973). In the United States, morphine was prescribed for alcoholism (Brecher, 1972), and heroin was used to treat morphine addiction because it was thought that heroin was not addicting (Willis, 1973). In New York, Florida, and Kentucky, clinics administered opiates, including heroin, to addicts, from 1912 through 1924 (Brecher, 1972).

During the 1960's, use of heroin and other illegal drugs proliferated throughout the United States. As drug abuse became defined as a serious national problem, a wide variety of treatment and preventative approaches were employed. This was reflected in the
federal bureaucracy; by 1972, at least 25 federal agencies were involved in some form of drug abuse treatment and prevention (Ran-

gel, 1972).

My Role in Drug Abuse Treatment

In 1974, I began studies in the Specialty Program in Alcohol and Drug Addiction (SPADA) at Western Michigan University while enrolled in the Specialist Program in Counseling and Personnel. My career objective is to work as a counselor in a drug abuse or alcohol program. It is likely that a counselor in many settings works with some alcohol and drug related problems. As a consequence, this experience could be of benefit regardless of subsequent decisions.

Rationale For Internships

It seemed to me that specializing in alcohol and drug addiction was enough specialization; consequently, my internships were chosen so as to get as broad an exposure to the field as possible. Through a field placement and part time job, I had previous experience in an alcohol treatment setting. The Potter Program offered an opportunity to work in rehabilitation of narcotics addicts at a methadone treatment program and the Van Buren County Drug Abuse Program offered an opportunity to become familiar with public relations, prevention, and counseling individuals with a variety of drug related problems. Both internships were carried out under the auspices of SPADA.
CHAPTER II

REVIEW OF SELECTED LITERATURE ON METHADONE TREATMENT

History of Methadone Treatment

Methadone is a synthetic narcotic developed in Germany during World War II in response to a shortage of natural morphine. It was found to be pharmacologically similar to morphine and, after the War, it was used in the United States as a pain killer and to assist in narcotics withdrawal (Brecher, 1972).

In 1964, Dole and Nyswander (1965) studied the behavior and metabolism of two heroin addicts. The two subjects were allowed as much morphine as they desired during the experiment. They took large amounts, a considerable tolerance developed, and they chose to spend most of their time watching television on the hospital ward. After the metabolism studies were completed, the investigators followed normal medical procedure by switching the morphine dependence to methadone and began gradual detoxification. Marked changes in behavior were observed while the subjects were on methadone: they became much more active and asked to be able to attend classes during the day. A subsequent experiment with 750 heroin yielded similar results (Dole, Nyswander, & Warner, 1968).

Prior to this time, supplying addicts with heroin had been tried in the United States and in England (Brecher, 1972). Methadone demonstrated a number of important advantages over heroin or morphine as a maintenance drug. First, methadone could be taken orally, elimi-
nating the infections and other problems of intravenous administration. Second, unlike heroin or morphine, methadone was effective for over 24 hours, eliminating the need for several doses per day. Third, methadone had a mechanism of action much slower than heroin or morphine; so, patients did not rapidly change in psychological or subjective states. After developing a tolerance to methadone—usually in about two weeks—sensitive physiological and behavioral tests were unable to distinguish methadone patients from drug free persons (Brecher, 1973).

At the time of the original Dole-Nyswander studies, existing treatment modalities were ineffective in the treatment of narcotics addicts. While effective for those who stayed, therapeutic communities—such as Synnanon, Daytop Village, and Phoenix House—were highly selective and had low retention rates. Only 3% to 5% of addicts treated in hospitals remained drug free and out of prison after in-patient treatment (Brecher, 1972). In view of the spread of heroin addiction and the need for effective widespread treatment, the rapid proliferation of methadone treatment was not surprising. In 1973, 85,000 patients were in methadone treatment in the United States (Campos, 1973) and methadone treatment had spread to Canada, England, Sweden, and the Virgin Islands (Brill, 1973).

Methadone Treatment Programs

With the Drug Enforcement Agency (DEA) and the state authorities, the Food and Drug Administration (FDA) regulated the use of methadone. The 1973 FDA regulations (FDA, 1973) specified a number of program
guidelines involving setting up new programs, staffing centers, and
the mechanics of running a program—including admissions, urinalysis,
dosage limits, confidentiality, and record keeping. Programs could
use detoxification, substituting methadone in decreasing amounts for
21 days, and/or maintenance, continuous administration of methadone.
Only persons addicted for two years or more were eligible for mainte­
nance and the regulations discouraged maintenance for more than two
years. Programs were required to provide counseling, rehabilitation,
and social services.

Considerable variation existed among methadone treatment programs
within the framework of federal guidelines. There were inpatient pro­
grams, outpatient programs, methadone therapeutic communities, private
clinics, several kinds of detoxification, and many variations of an­
cillary services in terms of modalities offered (Senay, Jaffee, Chap­

Many practitioners have emphasized the need for ancillary ser­
\vices. Dole and Nyswander stressed that the change of pharamacologi­
cal dependence was only the beginning, and that effective treatment
also includes a change in the patients' life style (1973b). They also
stated that the label methadone treatment "...puts the emphasis on
what is merely the medicinal aspects of the treatment. More impor­
tantly, the clinics should be rehabilitation programs, not simply dis­
conducted a study that suggested methadone alone was not sufficient
for addicts to change their life styles. While drug seeking behavior
and criminal activity decreased, problems of moodiness, poor self-image,
and conflict in sexual identification continued.

Two other studies suggested the importance of ancillary services. Creel, Berkson, and Patch (1973) found a positive correlation between increased counseling activity and methadone dose reduction. They concluded that those reducing dosages were in a state of change and sought counseling in order to deal with withdrawal and emerging psychological difficulties. Fish (1973) found a positive correlation between depression and the clients who dropped out of the clinic. He concluded that more supportive services were needed.

Evaluations of Methadone Treatment Programs

There were many studies supporting the effectiveness of methadone treatment, usually in the form of program evaluation. Three are included here. In Chicago, (Senay et al., 1973) patients were given the choice of four treatment modalities; methadone outpatient, methadone residential, abstinent outpatient, and abstinent residential. The outpatient methadone modality had the highest retention rate and the lowest rate of narcotics use. In Washington D.C., (Brown, 1972) patients were given the choice of methadone maintenance, methadone detoxification, and abstinence. All were given the same ancillary services. Those on methadone maintenance demonstrated significantly higher retention rates and significantly lower arrest rates. Comparisons of employment and drug seeking behavior were impossible because only 6 of the original 98 abstinent patients were still in treatment after one year. (Arrest data was gathered from non-program sources.) In a New York study of addicts entering treatment from 1964 to 1968, Gearing
(1973) found that in 1972, 58% were still in treatment, arrest rates for those in treatment fell to less than 1% of the clients arrested per year, and 75% of those in treatment were employed. While no baseline data was given, Gearing indicated that these were "hard core" criminal addicts at admission.

While studies of methadone treatment have yielded impressive results, Maddox and Bowden (1972) suggested that reports of success with methadone appeared to be ambiguous and exaggerated. They pointed out that programs have not been consistent in their criteria for success, with some relying only on retention in the programs, and that insufficient comparison groups have been used. Furthermore, data have usually been analyzed on the basis of patients still in treatment, with drop outs excluded.

Methadone treatment has been highly controversial. Brill (1973) listed a number of sources of criticism: some medical societies and law enforcement agencies, drug free therapeutic communities, the Puritan ethic, and some black militants who consider methadone a form of white control over the black community. Brecher (1972) suggested that some criticism and anti-methadone rumors originated from pushers who feared losing customers.
The Potter Program, a methadone treatment program located on the grounds of the Kalamazoo State Hospital, began operations in 1972. During the fall of 1974, it was in the process of changing its administration from the County Mental Health Services Board to the Kalamazoo County Health Department. The treatment staff consisted of a director, two counselors, a registered nurse, and a physician sponsor. The service areas consisted of narcotic rehabilitation service, about 95% of service delivery, and counseling for non-narcotic drug problems, about 5% of service delivery. The program was licensed to serve a maximum of 50 clients.

The narcotic rehabilitation service included methadone maintenance and methadone detoxification. Methadone detoxification, 21 days of declining doses of methadone with ancillary services, was available only to those who demonstrated an addiction of at least two years. Weekly counseling was mandatory and could have been group, individual, and family counseling. Other ancillary services were medical services, referrals to other agencies, and consultations with other agencies.

Program objectives included helping individuals to become drug free and to learn behaviors to help maintain a drug free state, employment, education, improvement in family relationships, elimination of criminal behavior, and community acceptance of the program and clients.
The Placement Activities

My specific goals in doing a field placement at the Potter Program during the fall of 1974 were as follows:

1. To experience working in a methadone treatment program.
2. To experience working with individuals with narcotic related problems.
3. To gain more experience in individual and group counseling.
4. To become familiar with day to day program operations, including record keeping, staff meetings, and administrative concerns.

My field placement supervisor was Ms. Carolyn Chingo, the Program's Senior Counselor. During the placement, I was at the program approximately twelve hours per week, on Monday, Wednesday, and Friday mornings.

The most significant learning experience for me was co-leading two counseling groups with Ms. Chingo and Ms. Jerry Woods, another of the Program's counselors. These ongoing, open ended groups began in September and were mandatory for the clients, most of whom were quite resistant to being in the group during the earlier stages.

Other activities included attending staff meetings, attending meetings of the Program Committee (a body of clients elected by program participants that had input into program operations), attending board meetings, assisting in the methadone dispensing clinic, assisting a client in preparation for the High School Equivalency Examination, and doing some brief individual counseling.

Log of Experiences

9-12-74

After an initial phone conversation, I met today with Carolyn Chingo,
one of the counselors at the Potter Program. After a tour of the facili-
ties, we met and discussed the program in general, the clients, coun-
seling in a methadone treatment setting, and some of my possible activ-
ities at the Program. I was informed that I was the first student
to inquire about a placement at the Potter Program and that I would
have to be interviewed by the entire staff before being accepted for
field work.

9-16-74

I had my interview with the staff and was accepted to do the placement.
The interview was conducted by Mr. Walter Reynolds, program director,
Ms. Carolyn Chingo, and Ms. Jerry Woods, a counselor. The interview
was much like a job interview and gave us a chance to learn some
things about each other. A number of generalities emerged regarding
program clients:

1. Most do not want counseling initially but are required by
   program policy and state regulations to engage in counseling
   on a weekly basis.
2. Most of the clients are excellent con artists and this has
   become a significant part of their survival.
3. Work at the program can be very difficult and frustrating.

The staff was open and flexible in terms of my needs and expectations.

9-18-74

I attended a staff meeting in which routine program matters were dis-
cussed and stayed on after the meeting to discuss group counseling with
Carolyn and Jerry and to plan for group counseling that the three of
us would lead. The clients who were told that they would be part of
the group were quite upset at the prospect. We finished the morning
by attending a Committee Meeting—a self governing body of clients who make suggestions for improved program functioning and plan activities for the clients. Elections were held for positions on the Committee.

9-23-74
In the morning, there was a lengthy staff meeting regarding a disruptive incident on the previous Thursday. Later, the Committee sat in and offered suggestions. The members involved in the incident came in to tell their side and later in the day some difficult decisions were made.

9-26-74
The counselors and I met to plan for the group counseling sessions to begin next Monday. We did not specify any long term objectives, but we decided to begin by focusing on communication. We decided that I would take responsibility for conducting the first few sessions because the members do not know me and this would give me a chance to establish myself with the groups.

9-27-74
I attended the Albert Ellis workshop at Nazareth along with the rest of the counseling staff.

9-30-74
The first group counseling session was held today. Only four of the eight participants showed. The clients expressed a considerable amount of resentment about being in the group. They also expressed
doubt that a non-addict could understand them— I spent much of the
time doing active listening. Later, we met with the Committee and
they offered some valuable suggestions concerning work in the group.

10-2-74
I attended the usual 9:00 to 10:00 Wednesday staff meeting, and led
the first Wednesday group counseling session. The group was coopera­tive and the getting acquainted exercise went well. Some self dis­closure, humor, and anxiety were expressed.

10-4-74
The Friday staff meeting included a discussion of medical concerns by
the program medical supervisor, Dr. Joseph Sabota. The staff discuss­ed some of the problems of operating a methadone program. We sat in
on a Committee meeting as members discussed managing client behaviors.

10-7-74
Carolyn, Jerry, and I met early to plan for the group. The group
was difficult in that it was a struggle to avoid the chaos of many
people talking and few people listening. We spent the rest of the
morning discussing some of the problems of counseling in this
setting and how to deal with detractors in the group.

10-9-74
I attended the Wednesday morning staff meeting. The Wednesday group
went well again. The members handled a listening exercise well and
used it to explore some significant matters in their lives. I was
at the Substance Abuse Board meeting at the Whistle Stop from
12:00 to 3:00. This was a particularly interesting meeting in that it dealt with the change of sponsorship and administration from the Mental Health Board to the Health Department. Several board members expressed some apprehension about the move.

10-11-74
I attended the Friday morning staff meeting with the medical personnel, helped the nurse record the methadone dispensed to the clients in the morning, and had an opportunity to meet most of the participants I had not yet met. Later, I met with the Committee as they discussed their reactions to some proposed policy changes.

10-14-74
We met early to plan for group. This was once more a very difficult group to lead and centered on the clients' resentments about being in the group. The communication was better in that people began to listen.

10-16-74
I met early with co-leaders to discuss group. The Wednesday staff meeting met to discuss policy changes regarding criteria to become a member of good standing and to be allowed "take-home" privileges. Take homes are important to members in that they are allowed to take methadone home on the week ends and avoid extra trips to the clinic. They also provide contingencies for appropriate behavior in the clinic. The Wednesday group went well in terms of the participants doing communication and listening exercises. We worked with the Committee members in a group counseling session that lasted into
the afternoon.

10-18-74
I sat in on the medical staff meeting from 9:00 to 10:30, helped the nurse in the clinic from 10:30 to 11:30, and assisted a client in preparation for the GED test from 11:30 to 12:30. This GED preparation is rather enjoyable. I have taught this area for several years, and the client I am working with has an excellent chance of passing.

10-21-74
Once more the Monday group was difficult to lead. Some of the frustrations of counseling in a methadone treatment setting are becoming clearer to me. I spent the rest of the morning informally rapping with a number of the clients.

10-23-74
I attended the regular Wednesday morning staff meeting. The theme that emerged in group counseling had to do with the "stuff" the clients felt they had to get together in order to lead relatively independent lives. In a private session, a member from the Monday group gave his perceptions of how the group could be improved.

10-25-74
The regular Friday morning medical staff meeting was particularly interesting in that the procedures for analysis of urine sample to detect morphine was described. Later in the morning, I assisted the nurse in the methadone clinic for one hour and spent another half our helping a student prepare for the GED test.
10-30-74

We met early to discuss the group, and then met with entire staff later over the implementation of some new program policies. These seem to be very good in that they specify appropriate clinic behavior, provide contingencies for these behaviors, and provide a clear set of categories so that members know where they stand in the clinic. In the Wednesday group we used "choice" as a theme, and a number of valuable things happened. I attended a general meeting of clients in which the new regulations were introduced to the member. On the whole, the response was positive.

11-1-74

I attended the medical staff meeting for one hour, began individual counseling with a client on 21 day detoxification, worked briefly with a GED student, and attended the committee meeting.

11-4-74

I planned group with the co-leader from 9:00 to 10:00. We introduced an exercise on getting, giving, and accepting positive strokes. In terms of participation and increasing group cohesiveness, this approach worked very well.

11-6-74

This was a routine Wednesday with general staff meeting and Wednesday group session. To my surprise, some members participated less than usual.

11-8-74

The medical staff meeting provided more insight into some of the
medical and health problems associated with heroin use. I had the second individual session with the detoxification client and attended a Committee meeting in the afternoon as they discussed the possibility of having a Christmas party.

11-11-74

The whole atmosphere of the group has changed in that there is much more cooperation and positive feeling about the group. Anger emerged as a theme and we did some role playing of individual situations.

11-13-74

I attended staff meeting and worked with the Wednesday group. This group remains accepting of each other.

11-15-74

I completed individual counseling with 21 day detoxification client, helped tutor a student for the GED test, and attended the Committee meeting.

11-18-74

The Monday group is still functioning very well in that some significant things are happening and the clients are much more accepting about being in the group. I stayed on later to gather data on the program and to study the federal regulations governing the operations of the program.

11-20-74

This was a usual Wednesday, with staff meeting followed by group.
11-21-74

I had a very productive meeting with the program director, Mr. Walter Reynolds. The meeting was concerned with being the director of a methadone treatment center. A new perspective for me regarding problems and rewards of working in this setting was provided.

11-22-74

Regular Friday of attending medical staff meeting, helping out in the clinic, and helping the client prepare for the GED test.

11-25-74

We followed the regular Monday morning schedule: planned group, conducted group, and discussed the group. Jerry introduced psychodrama and it went well. The clients seemed to be comfortable with this modality.

11-27-74

We followed the regular Wednesday schedule of staff meeting followed by group.

12-2-74

Once more we used psychodrama in the Monday group—we probably will remain with this modality in that we have had our best results with it.

12-4-74

This was a normal Wednesday with staff meeting, group, and Committee meeting. The Wednesday group seems to go best with theme centered interaction.
12-6-74
I attended the regular meeting with the medical staff, did some individual counseling with one of the group members over something that came out in group. I worked with the GED student—she is now ready for the test and it is just a matter of her taking it. In the Committee meeting that I attended, members planned the Christmas party.

12-13-74
I was out sick for Monday and Wednesday of this week. I had another individual session with the client from the group and my last session with the GED student.

12-16-74
I had my final session with the Monday group. This was a particularly gratifying session in that two new clients were introduced to the group, and the members assured them that, although difficult at first, the group "grows on you" and is worthwhile.

12-18-74
Today's session was my last with the Wednesday group. I feel good about what has happened in these groups and glad that they will continue with Carolyn and Jerry.

12-20-74
My wife and I attended the pot-luck Christmas party. This seemed to be an ideal situation for my last day at the clinic. It was a good time, and I found out that the GED student passed the test.
Summary of the Potter Experience

My goals in working at Potter were to experience working in a methadone program, to experience working with individuals with narcotics related problems, to gain counseling experience, and to become familiar with the day to day operations of a methadone treatment program. The placement at Potter gave me an opportunity to fulfill these goals through group and individual counseling, attending staff conferences, and participating in a variety of program activities. The staff was cooperative with regards to my needs and expectations, and the placement was an important learning experience.

Beyond my original learning objectives, the staff provided some important lessons. They demonstrated a high level of dedication, skill, and professionalism. In one of the SPADA classes during the time I was at Potter, several administrators of substance abuse agencies described some of the difficulties that led them to terminate the methadone maintenance components of their service delivery. The problems they described were similar to those that sometimes arose at the Potter Program. These administrators responded to the problems by concluding that it was not possible to have a therapeutic atmosphere at methadone treatment programs. The staff at Potter responded in such a way that these problems were resolved and that their resolution became part of effective treatment.

The two counseling groups provided experiences that were in sharp contrast to much that was written and said about work with addicts. At first, most clients resented participating in the groups. However,
both groups began to function well by November. It seems as though persons with narcotics-related problems are frequently stereotyped as being in a category separate from the rest of humanity. As a consequence, much of what is described as treatment appears to more resemble hazing, and it is not surprising that some programs are unable to function. The group experience demonstrated to me that the same approaches to counseling that were effective in other settings were effective here. The only difference seemed to be the length of time needed to develop rapport; this probably had more to do with the involuntary nature of the group than it did with the client population.

Discussion and Recommendations

The placement at the Potter Program provided an opportunity for a great deal of professional growth. Considering its close proximity to SPADA, it is unfortunate that the Potter Program has had no prior, and as of this writing, no subsequent field placements. Many persons in alcohol and drug related work encounter some narcotics-related problems. A placement at Potter provides an opportunity to reexamine much that is said and written about addicts, to obtain some insight into problems associated with dependence on narcotics, and to gain experience in working with individuals who are changing from a drug centered way of life to more rewarding ways of living. I highly recommend this experience to people entering the field of alcohol and substance abuse treatment.
CHAPTER IV.
REVIEW OF RELATED LITERATURE

The Programs

In the sixties, there was a rapid growth of a group labeled the "street people" -- wandering, unemployed young persons often involved with drugs. Because of their appearance and frequent migratory status, social and health agencies were reluctant to serve them. This group also had a mistrust for traditional services. Hospital emergency rooms frequently reported drug reactions to law enforcement agencies. Many traditional agencies viewed the varied problems of this group, including health and pregnancy problems, as being primarily drug problems. Some agencies required written parental approval prior to treatment. As a result, various kinds of free clinics, drop-in centers, and crisis centers developed within the counter-culture to meet the needs of this group (Brecher, 1972). These new agencies were staffed by persons who identified with the counter-culture, and they had credibility within their target population (Meyer, 1972).

In 1972, a survey of 72 innovative drug programs that were developed during the late sixties was conducted (Dwarshuis, Kolton, & Gorodezky). It was found that for the most part, these programs were initiated by persons who identified with the counter-culture, they made extensive use of volunteers, they had the support of clients,
and the clients had input into program management. They offered many services to meet many needs. The following services were offered by 50% or more of the programs: referrals, hot-line, job placement, encounter groups, legal intervention, and group, family, and individual counseling. Many offered alternatives to drug use, such as recreation.

A number of the programs were in a state of change and controversy. They began to define client dependency and limited target populations as interfering with maximum effectiveness. Some programs were moving away from recreational and drop-in services and moving towards increased therapeutic, educational, and preventive services.

Drug Education

As the experimentation, use, and abuse of drugs spread, it became clear to many that law enforcement was not sufficient for prevention. A new approach was tried: prevention through drug education in the schools. In a review of the drug education literature, Braucht, Follinstad, Brakarsh, and Berry (1973) offered some observations. They noted that most of these programs lacked clear philosophies and explicit goals, and that most were subject to community pressures. Despite the enormous amount of money spent in this area, most of the programs were based on unsupported opinions and much of the research contained serious methodological flaws.

Swisher, Crawford, Goldstern, and Yura (1971) classified drug

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education according to seven categories, including scare tactics, presentations by authorities, and integrating drug education into the curriculum. The assumption of most of these approaches was that given factual information, students will be less likely to use drugs. Publications by the Council on Mental Health, commercial companies, and the Department of Health, Education, and Welfare were quoted to show that these organizations agreed with the factual approach.

A number of studies suggested that the assumptions of the factual approach were false. In a Department of Health, Education, and Welfare sponsored study (Macro Systems, Inc., 1972), awareness of legal and medical drug hazards did not deter drug use. Swisher et al. (1971) found a positive correlation between liberal attitudes towards drug use and factual knowledge. Mason (1972) found a positive correlation between drug education being presented and an increase of curiosity about drugs, favorable attitudes towards reducing drug penalties, and a tendency to deal with psychological discomfort with drugs. In a survey of high school students, Swisher and Hoffman (1971) found a positive correlation between drug use and drug knowledge.

Since drug abuse has been associated with other social problems, a number of global strategies emerged as alternatives. Gordon (1970), for example, recommended making education "turned-on" in the non-drug sense, humanization of social institutions with emphasis on school and family, and making education relevant.

Horan and Swisher (1972) reported success through induced cognitive dissonance. They deliberately set out to change student drug
attitudes in a conservative direction by identifying those who pre-
ferred direct experience to mediated experience and pointing out to
them that drugs are mediators.

Perhaps the unrealistic general goal of abstinence in a drug
oriented society was a factor in the discouraging results of drug ed-
ucation for prevention. The studies did not differentiate between use
and abuse; it may be that the factual approach encouraged more dis-
criminative forms of drug taking. The following recommendation in the
Department of Health, Education, and Welfare sponsored study seems
realistic (Macro Systems, Inc., 1972, p. 7):

In place of prevention as a reasonable goal, drug use on the
part of youth could be accepted — especially marijuana use. DHEW
could abandon drug education as a single concept and de-
velop programs more in keeping with current youth development
areas involving broader decision-making and problem solving
capabilities.

Drug Abuse Counseling

Much drug counseling literature originated in the innovative
drug programs. The philosophy of treatment of many of these programs
developed relatively independent of knowledge of the theories of
counseling and psychotherapy (Kolton, 1973). As a consequence, much of
it may appear to be either extreme or redundant to those familiar with
counseling theories. For example, Kolton noted that some programs in-
dicated that anyone who can express love and relate honestly is a
good counselor. Also, the treatment philosophies of many programs
included a lack of sharp distinction between counselors and clients
and a lack of counseling techniques. Einstein and Quinnes (1971) suggested "action therapies" instead of "verbal therapies" on the ground that drug abusers were action oriented instead of word oriented. In search of more effective ways of counseling drug abusers, Demos (1969) suggested listening and attending to clients, helping clients explore themselves and their motives, and helping clients discover their strengths.

In the treatment of drug related problems, the use of various modalities has been reported. Bratter (1972) described success using Reality Therapy with groups of adolescent drug abusers. In hot-line crisis counseling, Rogerian approaches have been used (Schmitz & Mickelson, 1972). Spevack, Pihl, and Rowan (1973) used aversion conditioning to treat amphetamine abuse and systematic desensitization to treat the after effects of bad LSD trips.

On an outpatient basis, Fort (1972) suggested that a variety of approaches should be made available, including vocational counseling, psychodrama, hypnosis, behavior therapy, encounter groups, Gestalt, and others. He also advocated non-professional approaches such as Synonan, Daytop Village, and Alcoholics Anonymous.

Brill and Chambers (1972) related treatment to the substances abused. In treating barbiturate abusers, they advocated inpatient detoxification for two or three weeks, frequent counseling during initial abstinence, and regular group sessions during extended abstinence. For amphetamine abusers, they warned against depression and psychosis during detoxification and initial abstinence and
they advised frequent supportive sessions. Because of the danger of recidivism, long term counseling was suggested.

A great deal has been written about the special approaches, techniques, and sensitivities needed to treat drug abusers. Renault and Schuster (1972) provided another perspective from a behavioristic framework. They saw drug abuse as a behavior that like other behaviors is governed by consequences. They added that this behavior stops when the aversive contingencies are stronger than the reinforcing properties of the drug abuse behavior.
CHAPTER V.

THE VAN BUREN COUNTY DRUG ABUSE PROGRAM EXPERIENCE

The Program

The Van Buren County Drug Abuse program began in 1972 as the
Manchester House, a program for the youth of the Paw Paw area located three miles north of Paw Paw in an old farm house. The Manchester House offered recreation, learning workshops in arts and crafts, referrals, and counseling by the staff and student volunteers. After an unfortunate incident in mid 1974 that adversely affected public relations, the program hired a new director, moved to Paw Paw, and changed the emphasis of service delivery from a youth recreational and drop-in center to more counseling and education. In February of 1975, the program changed sponsors from the County Mental Health Board to the Public Health Department.

At the time of the placement, the staff consisted of a director, a counselor, and an administrative assistant. The Program goal was to provide comprehensive drug abuse services to all residents of Van Buren County. The service areas were drug abuse counseling, crisis calls, drug education and information, drug analysis, and referrals.

The drug abuse counseling services included crisis intervention and ongoing counseling. The counseling services were offered at offices in Paw Paw and South Haven on specified days and in other communities by arrangement.
The Program provided drug education through supplying speakers to community groups and classrooms and through courses for area educators taught by the counselor. The approach was to offer some factual information with values clarification and decision making related to the use of drugs.

The drug analysis service provided analysis of street drugs with the anonymity of the person requesting service insured through the use of a code.

The Field Experience

My stated goals in doing the field placement were as follows:

1. To experience persons with situational and long term drug problems, and to develop skills in assisting individuals in resolving drug and drug related problems.
2. To assist in community relations activities, such as panel presentations, speaking gigs, and community drug consciousness.
3. To assist in special educational presentations to professional personnel.
4. To keep and maintain case and program records as they relate to above activities.

The activities included individual counseling, several crisis intervention situations, speaking to several junior high classes, public relations with agency personnel, and records keeping. When no activities were scheduled, there was an opportunity to review the Program's ample supply of drug information pamphlets and literature on drug education and values clarification.

My field supervisor was the program director, Mr. John Deren. He frequently interrupted his busy schedule to provide valuable consultation, discussion, and advice. After a brief initial period,
my placement was scheduled for Monday afternoons and all day on Thursdays.

Log of Experience at the Van Buren County Drug Abuse Program

1-7-75
I met with John Deren, the director and field placement supervisor. We discussed the Program, the service areas, and some of my possible activities during the placement. Later, we met several persons from other agencies and a board member. The rest of the day was spent examining the rather elaborate filing and records keeping system.

1-10-75
Met John Deren in Paw Paw at 6:45 A.M. We went to South Haven to be on the radio for the "Breakfast Club Show". Mr. Joseph Foster, a county alcoholism counselor, was also on the program. The discussion centered on alcohol and drug related problems. A call-in question and answer period followed. Later in the morning, we met with a lady who was conducting rap sessions in her home for young persons with actual and potential drug related problems. We shared our perceptions and made tentative plans for follow-up. The rest of the day was spent visiting the Mental Health Program in Bangor and studying the local referral sources at the Paw Paw office.

1-13-75
I read the proposal for the next fiscal year. We were contacted
by a Friend of the Court worker and discussed the possibility of conducting group counseling for young offenders. I followed up on a referral by a public health nurse by contacting a county person who reported drug related problems. We made arrangements for an interview in Hartford.

1-16-75
I had an initial session with the client in Hartford in the morning. In the afternoon, I had a lengthy discussion with John regarding the Program's philosophy of drug education and prevention. This area seems to be very difficult.

1-23-75
I arrived at the Paw Paw office early in the morning and reviewed the records keeping procedure and the state regulations regarding confidentiality. I went to Hartford to counsel a new client. The afternoon was spent with John at the Hartford Junior High School doing drug education sessions. We met with four classes--a total of over 250 students. The approach we took was to discuss certain limited factual information about drugs and to explore the decision making process regarding drug use.

1-29-75
During this week, I was attending the Midwest Institute of Alcohol Studies. There was time this afternoon to conduct a counseling session with a Hartford client.
2-3-75

The first two hours were spent at the Paw Paw office reviewing some of the drug information pamphlets. They seem to vary tremendously in accuracy and quality. The rest of the afternoon was spent with John in Covert with the purpose of meeting with a rap group organized by a teacher. The group did not show.

2-6-75

I was at the Paw Paw office early to review the procedures for making a referral and releasing client information. Later, I drove to Hartford and had a session with a client. The afternoon was spent discussing drug prevention with John and reading some of the literature on drug prevention and education.

2-10-75

Not much was happening this afternoon so I reviewed more information on drug education and prevention. Later, I referred a client to another agency.

2-13-75

The morning was spent driving to Hartford and having two counseling sessions. In the afternoon, I met with Mr. Victor Beck, a probation officer who refers clients with drug related problems to our program.

2-20-75

In the morning, I dealt with a crisis intervention situation initiated by a concerned parent. Later, I had three sessions with Hartford clients.
2-24-75
Did some client advocacy work with a school counselor for a client. Later, I read some drug abuse information pamphlets.

2-27-75
I had two sessions in the morning at Hartford. In the afternoon, I initiated contact with a court referral.

3-10-75
Nothing was scheduled today, so I looked through some of the material on values clarification. Ms. Sandy Stuut, the counselor, has a great deal of material on this subject.

3-13-75
I went to Hartford in the morning and counseled two clients. In the afternoon in Paw Paw, we had a crisis situation involving a narcotics addict in withdrawal. The treatment alternatives were limited and not attractive to the client. We made arrangements with an inpatient facility in Berrien County; however, this involved waiting over 24 hours.

3-17-75
I did follow-up work with a client and made arrangements to meet him in his home. Because of what seemed to me to be a run-around, the crisis case we had last week was not admitted to treatment for inpatient methadone detoxification. Late in the afternoon, we saw a movie on overdose aide.
3-20-75

A client referred by the courts did not show, so I spent the morning reading. In the afternoon, I met a client in his home.

3-24-75

I had a counseling session in Hartford. Later I met with the staff to discuss treatment alternatives in Van Buren County for narcotics addicts.

3-27-75

The morning was spent counseling in Hartford. Early in the afternoon, I met with John and we discussed counseling approaches with clients with amphetamine and narcotics related problems.

3-31-75

A client canceled a scheduled appointment so I spent the afternoon reading at the Paw Paw office.

4-7-75

I had a session in Hartford during the first part of the afternoon and read during the second part. In March, we saw five clients who were addicted to heroin. John is in the process of seeking out more treatment alternatives.

4-10-75

I arrived early to review Program objectives and procedures. The scheduled client in Hartford canceled. In the afternoon, I made initial contact with a client at the Van Buren County Jail.
I spent the rest of the afternoon filling out statistical forms for the state.

4-14-75
I had a final session with a client I have seen weekly over most of the placement.

4-17-75
In the morning, I read and did follow-up work on a client. In the afternoon, I had a session with a client at the county jail.

4-21-75
Today was the final day of the placement experience. I met with John, and discussed the placement and shared recommendations.

Summary of the Van Buren Experience

My goals at the Van Buren County Drug Abuse Program were to gain experience in drug counseling, to assist in drug education and public relations, and to keep appropriate records. This placement provided an opportunity to meet these objectives by individual counseling, discussions with staff, meetings, and presentations. The staff was cooperative regarding my needs and expectations, and the placement was an important learning experience.

Beyond my original goals, the placement provided an opportunity to explore some controversial issues regarding drug programs: service delivery, education for prevention, and the nature of drug abuse counseling. Like many innovative drug programs, the Van Buren
Program started with the emphasis on drop-in and recreation for young persons with drug related problems. By the time of this placement, the Program was serving clients of many ages and backgrounds and no recreation was provided. This shift seems very reasonable to me given the lack of other drug abuse treatment alternatives in the area and the fact that drug abuse problems are not limited to youth. Also, if the lack of alternatives to drug use is a problem, it seems more beneficial to assist persons in developing more interesting lives than to pacify them temporarily with recreation.

Drug education is a subtle and difficult area. Those holding the global views that see the solution of drug related problems in the solution of other social problems may be diluting their efforts. While humanization of social institutions is a proper sphere of activity, it is reasonable to assume that severe social problems will be with us for some time. Consequently, direct efforts in the prevention of drug related problems may be in order. The strictly factual approach has had a poor record, and total emphasis on decision making and values clarification misses important factual information — such as the severity of narcotics addiction and the misrepresentation of drugs sold on the street. The Van Buren approach of limited factual information, values clarification, and decision making as it relates to drug abuse seems very reasonable to me.

The drug counseling at Van Buren is consistent with current
theories of counseling. It seems unfortunate to me that many innovative programs, in response to the lack of services provided to street people, seem to see themselves as separate from the rest of the helping professions and are now discovering things related fields discovered long ago.

Recommendations

Six months prior to this field experience, the Van Buren County Drug Abuse Program was close to closing. At the start of this placement, the Program had the respect of a broad range of the community, including the clients, the schools, law enforcement personnel, and other agencies. This change reflects the professionalism of the staff and the public relations work of the director, Mr. John Deren. I highly recommend this placement to students who plan to work in areas related to drug abuse treatment, drug education, or public relations.
REFERENCES


Horan, J., & Swisher, J.D. Effecting drug attitude change in college students via induced cognitive dissonance. Educational Resources Information Center. ED 060 808, 1972.


