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## American Indians with Substance Use Disorders: Treatment Needs and Comorbid Conditions

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### Abstract

**Background**—American Indians and Alaska Natives (AI/ANs) experience significant disparities in health status and access to care. Furthermore, only limited data are available on substance use, mental health disorders, and treatment needs for this population. Addressing such disparities and developing culturally relevant, effective interventions for AI/AN communities require participatory research.

**Objectives and Methods**—The Western States Node of the National Institute on Drug Abuse Clinical Trials Network partnered with two American Indian substance abuse treatment programs: an urban health center and a reservation-based program to assess client characteristics, drug use patterns, and treatment needs. Data collected by staff members at the respective programs from urban (n = 74) and reservation (n = 121) clients were compared. Additional sub-analysis examined patients reporting regular opioid use and mood disorders.

**Results**—Findings indicate that urban clients were more likely to report employment problems, polysubstance use, and a history of abuse. Reservation-based clients reported having more severe medical problems and a greater prevalence of psychiatric problems. Clients who were regular opioid users were more likely to report having a chronic medical condition, suicidal thoughts, suicide attempts, polysubstance abuse, and IV drug use. Clients who reported a history of depression had twice as many lifetime hospitalizations and more than five times as many days with medical problems.

**Conclusions**—Findings from this project provide information about the patterns of substance abuse and the importance of comprehensive assessments of trauma and comorbid conditions. Results point to the need for integrative coordinated care and auxiliary services for AI/AN clients seeking treatment for substance use disorders.

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Declaration of Interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of this article.

## Keywords

Indians; North American; substance abuse treatment

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## INTRODUCTION

American Indians and Alaska Natives (AI/ANs) experience significant disparities in health status, including elevated rates of suicide (1), accidental deaths (2), liver disease (3), diabetes (4), and comorbid conditions (5) as compared with nonnative groups. Alcohol and drug use, moreover, disproportionately contribute to and are, in turn, influenced by mental health problems (6–8), early trauma and childhood abuse (9), cultural displacement, unemployment, and poverty (10) within AI/AN communities. A history of trauma significantly increases the odds of developing alcohol use disorders (9,11) and is especially troubling for AI/ANs given the prevailing rates of posttraumatic stress disorder (4,12) and the trauma associated with domestic violence, loss, violence, and racism. Overall, AI/ANs appear to be at increased risk for physical, mental health, and social complications related to alcohol and drug use.

AI/ANs have endured both limited and differential access to resources, creating disparities in health status and exposure to quality health care for over 500 years (13). In fact, although some services in specific locations are available through Indian Health Service, over one in three AI/ANs lack health insurance, a rate more than double that for Caucasians (4). Research also acknowledges that disparities in care among AI/ANs can be traced to historical patterns of legalized segregation and discrimination (14). Such isolation contributes to difficulties in obtaining accurate behavioral health and census data resulting in underreporting of substance use, abuse, and dependence (15,16).

Because AI/AN reservations are sovereign nations and can in part determine what resources are used for data collection, and because tribal communities are often located in rural areas, it can be difficult to access comprehensive epidemiological data that are consistent for comparison across communities. There are few reliable descriptions of trends, utilization patterns, comorbidities, treatment needs, or the overall impact of drug use in AI/AN communities. Data on drug and alcohol use from the National Survey on Drug Use and Health (17) provide some preliminary prevalence data of use within AI/AN communities. Compared with other ethnic groups in the United States, greater proportions of individuals identified as AI/AN meet the criteria for past year drug (5.0% vs. 2.9%) and alcohol (10.7% vs. 7.6%) disorders (18). AI/ANs are also more likely to report use of illicit drugs in the past year: marijuana (13.5% vs. 10.6%), opiate pain medications (5.4% vs. 4.8%), cocaine (3.5% vs. 2.4%), hallucinogens (2.7% vs. 1.7%), and stimulants (2.0% vs. 1.2%) (18). The survey data, however, fail to capture the multidimensional consequences of drug and alcohol disorders in AI/AN communities.

To address this research gap, the Western States Node of the National Drug Abuse Treatment Clinical Trials Network (CTN) partnered with a tribal community of the south central plains and their reservation-based treatment program and an urban treatment program in the Northwest to prepare descriptive analyses of their patient populations. Although the programs differ on many characteristics, data are presented and compared from each program to illustrate the range of drug abuse problems and problem impacts within AI/AN communities.

## METHODS

Clinicians at a reservation-based substance abuse treatment program and an urban multisite treatment center completed Addiction Severity Index (ASI) interviews (19) with their patients and provided the data for the analyses. The ASI provides general information, including demographics, for each client. The main sections of the ASI include questions about the respondent's problems in seven dimensions: medical, employment, legal, family, psychiatric, drug, and alcohol. Data collection varied by site.

### South Central Plains Tribal Program

The rural treatment program, located in a plains state, is referred to as the South Central Plains Tribal Program. The center offers a 28-day residential program including individual counseling, group counseling, and marriage and family counseling. At the time of this project, medications to treat substance use disorders were not being prescribed. The South Central Plains Tribal Program is a spiritually based treatment facility for persons aged 18 years or older who are enrolled in the tribe and have a primary problem with alcohol or other drugs. The rural center is located on tribal lands and owned by the tribal community.

The study sample included patients (n = 121) admitted between December 2007 and December 2008. At admission, a trained staff member interviewed clients using a modified version of the ASI 5th Edition (19). The ASI is used on a routine basis as part of admission. Because the treatment program modified the ASI, composite scores were not available for comparison with the Urban Center sample. The program was unable to collect new data for our project and limited their participation to providing access to previously collected ASI interviews.

### Urban Treatment Center

The urban facility offers a continuum of mental health and substance abuse treatment services: residential family treatment, outpatient services, transitional housing for Native women and children, and a primary health care clinic. At the time of this study, medications to treat substance use disorders were not being prescribed. Services were available to American Indians, Alaska Natives, and other vulnerable populations and were not restricted by race or ethnicity. AI/AN clients self-identify when they enter treatment services. Length of stay in residential treatment can last up to 6 months. Parents were able to bring their children, up to the age of 5 years, with them to treatment. The program is Indian-owned and Indian-operated within a major metropolitan area.

Participants included AI/AN patients in residential treatment during calendar year 2009. Because of the prevalence of methamphetamine use and concern about patient needs, the program limited study participation to individuals with a self-reported history of methamphetamine use. A trained staff member interviewed the clients using the Native ASI (20). The Native ASI includes questions about tribal affiliation, including cultural and ceremonial practices as well as demographic information and the seven core ASI dimensions (19).

### Addiction Severity Index

ASI data collected from the two samples were compared by matching identical items and selecting variables of interest. Some items were re-coded into binary variables. Drug and alcohol use items included questions about alcohol, amphetamine (including methamphetamine), opioid (heroin, methadone, other opioids), cannabis, cocaine, sedatives, barbiturates, inhalants, hallucinogens, and polysubstance use (more than one drug per day). For each substance, clients reported past-30-day use, lifetime years of use, route of

administration, major substance problem, periods of voluntary abstinence, and a history of alcohol and/or drug treatment. Because of varying data collection time points between the two samples (at admission versus within 36 days of admission), it was not practical to compare past-30-day use in the two samples. Lifetime years of use was selected as the measure of regular use. Lifetime years of use questions inquire about the extended periods of regular use, which generally means three or more times per week, but also refers to frequent binges. Data regarding “lifetime years of use” were re-coded as a binary variable, regular use for at least 1 year.

Medical status items include questions about a lifetime history of hospitalization, chronic medical conditions, and a recent history of medical problems. Employment status items inquire about employability (having a profession, trade, or skill), transportation, and self-sufficiency (having a valid driver’s license and automobile available). For analysis, categorical responses to “usual employment pattern” were re-coded into a binary variable, unemployed (in general past 3 years). Family relationship items assess marital status, living situation, and a lifetime history of abuse. Categorical responses to “marital status” were recoded into a binary variable, married. Psychiatric status items include a lifetime history of psychological issues, including depression, anxiety, suicidal thoughts, and suicide attempts. A lifetime psychiatric history included problems experienced for any significant period of time, and that did not directly result from drug or alcohol use.

### Data Analysis

Data were analyzed with SPSS version 18. Analysis included a description of each client sample, with comparisons between the two samples. The two samples were compared to examine patient subgroups who reported regular opioid use and depression/anxiety. Frequencies and percentages were examined and compared using  $\chi^2$  tests for categorical variables, whereas means were compared using independent sample t-tests. More sophisticated analyses were not conducted because of the exploratory nature of the analysis and the limited nature of the data collection.

## RESULTS

The South Central Plains Tribal Program patients ( $n = 121$ ) ranged from 19 to 57 years of age ( $M = 33$  years). The Urban Center patients ( $n = 74$ ) ranged from 18 to 64 years of age ( $M = 35$  years). There were more women in the urban sample (57%) than in the rural plains (35%). Table 1 compares the two treatment center samples.

### Alcohol and Drug Use

Alcohol was the most commonly reported substance of abuse; 74% of the total sample reported regular alcohol use for at least 1 year (urban = 82%; rural plains = 69%). Almost 7 of 10 patients (68%) reported regular methamphetamine use (urban program = 100%; rural plains = 48%; remember, the patients at the Urban Center were restricted to those who reported methamphetamine use). Sixty percent of patients reported cannabis use and proportions were similar in the two samples. About 3 of 10 patients (28%) in both settings reported at least 1 year of opioid use; the use of cocaine was similar. Hallucinogen use was more common among South Central Plains Tribal Program clients (17%) compared with the Urban Center clients (3%). Of the remaining substances, South Central Plains Tribal Program clients reported regular use of sedatives (16%), barbiturates (7%), and inhalants (7%); Urban Center clients did not report regular use of any of the three substances. Notably, almost all Urban Center clients (96%) reported regular polysubstance use (more than one drug per day), significantly more than South Central Plains Tribal Program clients

(18%). Finally, injection drug use was reported by similar proportions of South Central Plains Tribal Program (14%) and Urban Center (23%) clients.

### Medical Status

South Central Plains Tribal Program clients reported more than twice as many hospitalizations ( $M = 5.0$  versus  $M = 2.0$ ) and more days with medical problems in the past 30 days ( $M = 6.7$  days vs.  $M = 4.6$ ) than the Urban Treatment Center clients. However, significantly more Urban Treatment Center clients reported having chronic medical conditions (57% vs. 40%).

### Employment/Support Status

Compared with Urban Treatment Center clients, South Central Plains Tribal Program clients were more likely to report having a valid driver's license (43% vs. 26%) and an automobile available (50% vs. 22%). Although the protocol for question administration regarding having a valid driver's license and automobile available differs somewhat from standard for the ASI, many AI/ANs borrow and share cars and some do so without a valid driver's license. South Central Plains Tribal Program clients also were considerably less likely to be currently unemployed (3% vs. 45%), and less likely to have been generally unemployed in the prior 3 years (35% vs. 51%). South Central Plains Tribal Program clients also reported more days with employment problems in the past 30 days ( $M = 17.5$  days vs.  $M = 4.5$ ).

### Family/Social Relationships

South Central Plains Tribal Program clients were more likely to report being married (33% vs. 10%), and reservation-based clients were also more likely to report living with someone with a current alcohol problem (25% vs. 14%). The majority of the total sample reported a lifetime history of emotional abuse (72%), and nearly half reported physical abuse, and/or sexual abuse (45%). Urban Center clients were significantly more likely to have been victims of all forms of abuse when compared with their reservation-based peers, with 92% reporting emotional abuse (vs. 59%), 92% reporting physical abuse (vs. 41%), and 73% reporting sexual abuse (vs. 27%).

### Psychiatric Status

Almost two-thirds of the total sample reported a lifetime history of depression and/or anxiety (74%). Lifetime history of other psychiatric issues also was common. Almost half of the total sample (47%) reported trouble concentrating or remembering, 32% reported having a violent temper, 20% reported hallucinations or hearing voices, and 44% reported having been prescribed medication for any psychological problem. Notably, 39% of the total sample reported a lifetime history of suicidal thoughts, and 19% reported a suicide attempt. The two samples were similar for most psychological characteristics except more South Central Plains Tribal Program clients were more likely to report depression/anxiety (80% vs. 64%), trouble concentrating or remembering (54% vs. 35%), and violent temper (40% vs. 18%).

### Subsample Analysis

The South Central Plains Tribal Program and Urban Treatment Center data sets were combined to compare opioid use versus non-opioid use (Table 2), and depression and/or anxiety (Table 3). Tables list only those client characteristics significantly associated with regular use of any opioids (Table 2) and characteristics associated with a lifetime history of depression and/or anxiety (Table 3).

Table 2 summarizes the characteristics of clients who reported regular use of any opioids (28%) as compared with those who did not (72%). Clients who reported regular opioid use were significantly more likely to report having a chronic medical condition (59% vs. 42%) and co-occurring use of amphetamines (82% vs. 62%), cannabis (76% vs. 49%), cocaine (43% vs. 22%), hallucinogens (26% vs. 6%), and sedatives (20% vs. 6%). Regular opioid users also were more likely than nonusers to report injection drug use (35% vs. 11%). Finally, psychiatric status varied significantly. Regular opioid users were significantly more likely to report a lifetime history of serious depression and/or anxiety (84% vs. 70%), use of psychiatric medication (60% vs. 37%), suicidal thoughts (54% vs. 34%), and suicide attempts (32% vs. 14%).

Table 3 examines the characteristics of clients who reported a lifetime history of depression and/or anxiety (73%) in comparison to those who did not (26%). Women were significantly more likely to report a history of depression/ anxiety (50% vs. 26%). Clients who reported a history of depression/anxiety were more likely to report a chronic medical condition (53% vs. 30%), more lifetime hospitalizations ( $M = 4.4$  vs.  $M = 1.8$ ), and about six times as many days with medical problems in the past month ( $M = 7.7$  days vs.  $M = 1.3$ ). Clients with a history of depression/ anxiety also reported approximately twice as many days with employment problems in the past month ( $M = 14.5$  days vs.  $M = 7.4$ ) as well as co-occurring use of opioids (32% vs. 18%), cocaine (32% vs. 16%), and sedatives (12% vs. 2%). Clients with a history of depression/anxiety were significantly more likely to report hallucinations or hearing voices (25% vs. 4%), trouble concentrating or remembering (61% vs. 8%), violent temper (39% vs. 10%), psychiatric medication (57% vs. 6%), suicidal thoughts (52% vs. 4%), and suicide attempts (26% vs. 0%).

## DISCUSSION

This successful partnership with a South Central Plains Tribal Program and an Urban Treatment Center documents the feasibility of assessing alcohol and drug use patterns among AI/ANs admitted to culturally based programs. Results described life situations, client characteristics, drug use patterns, and treatment needs for AI/AN clients in two unique treatment settings. Differences in how patients were selected for study participation and idiosyncrasies in data collection mean the analysis and interpretation of data must be conservative and that the absolute differences between the sites are not the primary interest. What is more important is the recognition that both patient populations displayed complex patterns of alcohol, drug, and psychiatric disorders that would challenge every therapist.

Similar to other studies and consistent national surveys, clients at both the Urban Treatment Center and the South Central Plains Tribal Program reported that alcohol was their primary drug of choice with nearly three-fourths of all study participants reporting regular use of alcohol (17,18). As a group, opioids represented the fourth most common substance with nearly a third of study participants reporting regular use. Differences were also noted between the two patient populations. Whereas South Central Plains Tribal Program clients were more likely to report the use of hallucinogens, sedatives, barbiturates, and inhalants, Urban Treatment Center clients were much more likely to report using more than one drug per day. When designing and implementing the most effective treatment strategies, knowledge of such trends and patterns in use may inform treatment planning and the continued development and integration of culturally relevant interventions.

The prevalence of co-occurring mental health disorders including depression and anxiety plays a significant role in the treatment experience and the overall health status for clients with SUDs (21–23). Of significant concern in this study is the elevated rate of depression (73% combined samples) as compared with approximately one-third of nonnative clients

reporting comorbid depression (23). Findings from this study were also consistent with research, which indicates that AI/AN clients with a history of depression/anxiety were significantly more likely to hear voices, have trouble concentrating, experience suicidal thoughts, have a violent temper, and report higher rates of suicide attempts. Participants who reported symptoms of depression and/or anxiety were also more likely to report having a chronic medical condition, greater number of hospitalizations, more employment problems, and increased use of opioids, cocaine, and sedatives. These findings indicate the complexities each individual AI/AN client is facing as they enter the treatment, confirming the urgent need to find the best methods for addressing both SUD and mental health concerns of this population.

The results of this study confirm the need for comprehensive intake procedures that capture the full range of client characteristics including abuse history, family dynamics, cultural experiences, family history and dynamics, and mental health symptoms and treatment history. As noted in previous research with AI/ANs, failure to assess such individual, family, and social risk factors may impact the development of effective treatment plans and thus limits successful outcomes across a range of treatment settings (24). Finally, given the comorbid psychiatric and chronic medical conditions found in this study, the need for integrative coordinated care and auxiliary services for AI/AN clients is paramount.

## Limitations

The study is a secondary analysis of data collected during treatment in two disparate programs that treat AI/ANs with alcohol and drug use disorders. The convenience sample and idiosyncratic adaptation of the ASI in one center limit the generalizability of the data. Interrater reliability was not possible for this study as staff administering the ASI were trained in different locations at different times. Moreover, data from the rural setting were collected as part of the routine admission processes and investigators did not influence data collection. The consistency of findings across the two addiction treatment programs that differed in location (plains vs. northwest), setting (rural vs. urban), and heterogeneity (limited to enrolled tribal members vs. open to everyone reporting an American Indian heritage) suggest that the data are robust. The results of this study begin to illuminate the complex nature of alcohol and drug use disorders within AI/AN communities. Nonetheless, our study also illustrates the challenges of working in AI/AN communities and gaining access to patients and data.

## Research Needs

In addition to more details about the epidemiology of alcohol and drug use disorders among AI/ANs, there is also the need for more information about the treatment system. Individuals living on reservations in the United State may seek treatment at local tribal treatment programs, or nearby IHS clinics, and at times they may commute or relocate to obtain services at an urban treatment program. Finally, some AI/AN clients may seek treatment at programs serving primarily the Caucasian or the nonnative clients. In terms of actual interventions or treatment services, some argue that possibilities for culturally appropriate options have decreased due to the current emphasis on evidence-based practices (25) and the lack of randomized clinical trials examining traditional, culturally relevant interventions. Healing and perceptions of wellness in AI/AN communities are driven by a long history of traditional practices, such as sweat lodges, talking circles, and drumming; yet little scientific evidence exists about their efficacy due to their sacred nature (26,27). Research on these culturally specific interventions will inform the quality care AI/AN clients receive and may result in greater access to culturally relevant services that address the unique and complex needs of AI/AN clients seeking treatment for addiction.

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TABLE 1

Addiction Severity Index characteristics: comparison by treatment center sample.

Characteristics	South Central Tribal Program (N = 121) n (%) or mean (SD)	Urban Treatment Center (N = 74) n (%) or mean (SD)	p-Value	Total (N = 195) n (%) or mean (SD)
Demographics				
Age	35 (11.5)	33 (9.5)	.13	34 (10.5)
Female	42 (34.7%)	42 (56.8%)	.01	84 (43.1%)
Drug and alcohol use				
Regular use for at least 1 year				
Alcohol	84 (69.4%)	61 (82.4%)	.06	145 (74.4%)
Amphetamines	58 (47.9%)	74 (100%)	<.01	132 (67.7%)
Cannabis	66 (54.5%)	45 (60.8%)	.46	111 (59.6%)
Cocaine	40 (33.1%)	15 (20.3%)	.07	55 (28.2%)
Any opioids	35 (28.9%)	20 (27.0%)	.87	55 (28.2%)
Sedatives	19 (15.7%)	0	<.01	19 (9.7%)
Barbiturates	8 (6.6%)	0	.03	8 (4.1%)
Inhalants	8 (6.6%)	0	.03	8 (4.1%)
Hallucinogens	20 (16.5%)	2 (2.7%)	<.01	22 (11.3%)
Polysubstance (more than one drug per day)	21 (17.4%)	71 (95.9%)	<.01	92 (47.2%)
Intravenous drug use	17 (14.0%)	17 (23.0%)	.12	34 (17.4%)
Alcohol treatment (number of times)	1.1 (3.0)	1.8 (2.5)	.50	1.3 (2.4)>
Drug treatment (number of times)	1.1 (2.9)	1.5 (1.5)	.35	1.2 (2.5)
Voluntary abstinence (most recent; months)	10.0 (17.0)	20.0 (21.2)	.03	13.4 (20.9)
Medical status				
Hospitalizations (lifetime total)	5.0 (8.8)	2.0 (2.9)	<.01	3.8 (7.3)
Days with medical problems (past 30 days)	6.7 (10.9)	4.6 (8.8)	<.01	5.9 (10.2)
Chronic medical condition	47 (40.2%)	43 (56.8%)	.03	89 (45.6%)
Employment/support status				
Days with employment problems (past 30 days)	17.5 (13.9)	4.8 (10.2)	<.01	12.6 (14.0)
Unemployed (in general past 3 years)	42 (35.0%)	38 (51.4%)	.04	80 (41.0%)
Valid driver's license	52 (43.3%)	19 (25.7%)	.01	71 (36.4%)
Auto available	59 (49.6%)	16 (21.6%)	<.01	75 (38.5%)
Profession, trade, or skill	82 (73.9%)	47 (63.5%)	.14	129 (69.7%)
Family/social relationships				
Married	39 (32.8%)	7 (9.5%)	<.01	46 (23.6%)
Live with anyone with current alcohol problem	29 (24.4%)	10 (13.5%)	.10	39 (20.0%)
Live with anyone who uses nonprescribed drugs	17 (14.4%)	12 (16.2%)	.83	29 (14.9%)
Lifetime history of Emotional abuse	70 (58.8%)	68 (91.9%)	<.01	138 (71.5%)
Physical abuse	49 (41.2%)	68 (91.9%)	<.01	117 (60.6%)
Sexual abuse	32 (26.9%)	54 (73.0%)	<.01	86 (44.6%)
Psychiatric status				
Lifetime history of Depression and/or anxiety	95 (79.8%)	47 (63.5%)	.02	142 (73.6%)

<b>Characteristics</b>	<b>South Central Tribal Program (N = 121) n (%) or mean (SD)</b>	<b>Urban Treatment Center (N = 74) n (%) or mean (SD)</b>	<b>p-Value</b>	<b>Total (N = 195) n (%) or mean (SD)</b>
Trouble concentrating or remembering	64 (53.8%)	26 (35.1%)	.01	90 (46.6%)
Violent temper	48 (40.3%)	13 (17.6%)	<.01	61 (31.6%)
Hallucinations/hearing voices	26 (22.0%)	12 (16.2%)	.36	38 (19.8%)
Suicidal thoughts	49 (41.9%)	26 (35.1%)	.37	75 (39.3%)
Suicide attempt	25 (21.6%)	11 (14.9%)	.34	36 (18.9%)
Psychiatric medication	46 (39.0%)	38 (51.4%)	.10	84 (43.8%)

**TABLE 2**

Client characteristics significantly associated with regular use of any opioids.

<b>Characteristic</b>	<b>Regular use of any opioid (n = 55; 28.2%), n (%)</b>	<b>No regular opioid use (n = 140; 71.8%), n (%)</b>	<b>p-Value</b>
Chronic medical condition	32 (59.3%)	57 (41.6%)	.04
At least 1 year of regular use			
Amphetamines	45 (81.8%)	87 (62.1%)	.01
Cannabis	42 (76.4%)	69 (49.3%)	<.01
Cocaine	24 (43.6%)	31 (22.1%)	<.01
Hallucinogens	14 (25.5%)	8 (5.7%)	<.01
Sedatives	11 (20.0%)	8 (5.7%)	<.01
Barbiturates	6 (10.9%)	2 (1.4%)	.01
Intravenous drug use	19 (34.5%)	15 (10.7%)	<.01
Serious depression/anxiety (lifetime)	46 (83.6%)	96 (69.9%)	.05
Psychiatric medication (lifetime)	33 (60.0%)	51 (37.2%)	.01
Suicidal thoughts (lifetime)	29 (53.7%)	46 (33.6%)	.01
Suicide attempt (lifetime)	17 (31.5%)	19 (14.0%)	.01

**TABLE 3**

Client characteristics significantly associated with depression and/or anxiety.

Characteristic	Depression and/or anxiety (n = 142; 72.8%), n (%)	Neither depression nor anxiety (n = 51; 26.2%), n (%)	p-Value
Female	71 (50.0%)	13 (25.5%)	.03
Chronic medical condition	73 (52.5%)	15 (30.0%)	.01
Hospitalizations (lifetime)	4.4 (8.3)	1.8 (2.3)	.03
Days with medical problems (past 30 days)	7.7 (11.1)	1.3 (4.4)	<.01
Days with employment problems (past 30 days)	14.5 (14.3)	7.4 (12.0)	<.01
At least 1 year of regular drug use			
Any opioids	46 (32.4%)	9 (17.6%)	.05
Cocaine	46 (32.4%)	8 (15.7%)	.03
Sedatives	17 (12.0%)	1 (2.0%)	.05
Voices or hallucinations (lifetime)	36 (25.5%)	2 (3.9%)	<.01
Trouble concentrating or remembering (lifetime)	86 (60.6%)	4 (7.8%)	<.01
Violent temper (lifetime)	56 (39.4%)	5 (9.8%)	<.01
Psychological medication (lifetime)	81 (57.0%)	3 (6.0%)	<.01
Suicidal thoughts (lifetime)	73 (52.1%)	2 (3.9%)	<.01
Suicide attempt (lifetime)	36 (25.9%)	0	<.01