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...EDICAL DIRECTOR

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TELEPHONE 458-8282

BRENTWOOD HEALTH CENTER
750 - 3RD STREET
BRENTWOOD, CALIF. 94513
TELEPHONE 634-2168

PLEASE DIRECT REPLY TO

February 2, 1973

61;754

Mr. Jerry Martinez
California Council on
Criminal Justice
1927 - 13th Street
Sacramento, California 95814

Dear Mr. Martinez:

As per our telephone conversation on February 2, 1973 I am enclosing a copy of our Annual Methadone Maintenance Report and ~~a copy of our~~ Annual Data Evaluation Report, NOVEMBER 1, 1971 - NOVEMBER 30, 1972.

If there is anything more I can do for you please do not hesitate to call me.

Sincerely yours,

CONTRA COSTA COUNTY (CA)
DRUG ABUSE PROGRAM

Frank Scalercio, Jr.
Executive Director

FS:ks

Enclosures

15602

January 31, 1973

ANNUAL REPORT

Part B. Methadone Maintenance Project (Project 0580)
Leonti H. Thompson, M.D., Program Chief (Project Director)
Mental Health Services, County Medical Services
Roy E. Buehler, Ph.D., Project Coordinator

This report covers the period November 1, 1971, through November 30, 1972, or 13 months of project operations rather than the usual 12-month annual report. This is to coincide with the 3-month periods used in previous quarterly reports.

The project proposal specified two months' lead time from the date of contract to the beginning of treatment operations. Authorization to begin work on the contracted funds was given as of November 1, 1971. Treatment began (at the Pittsburg Clinic) in February, 1972. This intervening period thus was approximately 3-1/2 rather than the scheduled 2 months. The lag was due largely to the delay on the part of the Bureau of Narcotics and Dangerous Drugs, Washington, D.C. office, in giving written approval based upon the recommended approval of the San Francisco BNDD office after the site visit in November, 1971. Since methadone purchases must be approved by BNDD, it was impossible to accept and treat patients until BNDD responded.

Previous reports reflect the patient and staff build-up over time. In retrospect, it appears that had we placed a staff person in the communities for direct contact with the heroin addicted population, our intake process may have been faster. This was done in the Pittsburg-Antioch area after intake appeared to stop around 10 persons. When one counselor (Dr. Ed Haupt) was assigned to spend afternoons, 5 days each week "on the street", persons in need of treatment appeared to be less apprehensive about volunteering to participate in this public treatment program. Patient build-up in the larger population of Richmond was faster, numerically.

Other lags in mounting the full scope of authorized treatment under the contract were related to problems in personnel recruitment and selection, as reported previously.

Program operations were handicapped until late November due to the unanticipated crowded space situation in both the County Medical Services Outpatient Clinics. The major problem was the lack of office space available for counselors, with resulting instability and unavoidable interruptions in program schedules other than scheduled methadone dispensing. These problems were resolved very satisfactorily when the clinics were moved to separate facilities, as reported in our last quarterly report. Patient response to the new sites has been excellent, e.g. more regular attendance, trends toward a lower rate of dirty urines, marked increase in inter-patient and patient-staff cooperative behavior in the clinical situations. Apparently this has

been the experience, too, in programming elsewhere, because the new FDA regulations (par. 130.44, 12/15/72) states, "To obtain program approval, the applicant shall demonstrate that he will have access to adequate physical facilities to provide all necessary services. The physical facilities should be sufficiently spacious ... to provide appropriate conditions for conducting individual and/or group counseling." We now have such facilities.

1. Patient Demographic Data

The patient demographic data, summarized previously in quarterly reports, remains essentially unchanged as of November 30, 1972.

Age: Over 75% of the patients are from age 25 through 35, with only one who is over 45. Moreover, over half of all inquiries from potential patients are under 25 years. These data suggest that with additional funding to enable us to drop the age criteria to 21, the intake rate would accelerate rapidly.

Race: Mexican-American persons are most highly represented in terms of population ratio, with Black persons second and Caucasians third. This indicates that the program is reaching the ethnic minority population in the county. What these data represent in terms of ratio of addicted persons in each total ethnic group is unknown at this time.

Marital Status: Only 7 patients (10%) have never been married, although 17% of the "married" have "common marriage" status. Separation and divorce are highly represented among the patients. Number of children to couples range up to 6, although only 7% exceed 3 children. Our informal conclusion based upon interviews suggests that the small-size families are mainly a function of the brevity of marriage among these patients.

Half of the patients live with a spouse (legal or common-law), and the other half live alone, with friends or with relatives. Thirty percent live with an addicted person. Only two couples, both spouses addicted, have been admitted. Half of the patients have less than 12 years of education. Some have some college work.

The age at which patients started daily use of heroin (a major criteria of addiction) is low, i.e. 15 to 19 years for 29% of the patients and 20-24 years for 44%. Additionally, the preponderance of the patients were heavy users of psychoactive drugs in addition to heroin. How much of this was through illegal procurement is unknown.

In terms of financial support, 84% reported sole dependence upon illegal acts, 33% reported partial support by welfare and only 26% reported wages or salaries. (See change data, discussed below.) In terms of criminal behavior, whether reflected in criminal statistics or otherwise, the high percentage of illegal acts is a critical statistic.

2. Intake and Turnover Data

A total of 81 patients were admitted to the project during this report period and 18 separated. This is depicted below.

	Pittsburg Clinic (2/72)	Richmond Clinic (3/72)	Total	Percent
Total admitted to program	30	51	81	
On rolls as of 11/30/72	26	37	63	
Total separation	4	14	18	
Separation Breakdown:				
Voluntary termination	1	5	6	7.4%
Jail	2	4	6	7.4%
Death	1	0	1	3.7%
Transferred	0	2	2	
Terminated by staff	0	3	3	3.7%
TOTAL	4	14	18	
% OF LOSS	13%	27%	22%	

These data indicate that 7.4% separations have been voluntary (ceased reporting for treatment), and an equal number were jailed, de-toxified and have not reapplied for admission. Another 3.7% loss was due to death and transfer, and 3.7% terminated by staff for excessive missing of appointments, persistent dirty urines, lack of minimal participation in program except for appearing, irregularly, at the clinic for dosing.

3. Change Data

The critical question in all treatment programs is change - i.e. what changes in critical variables related to the problem occur during treatment. Change, in any program, may occur because of other variables besides those under treatment control. However, in a small sample such as we have now, it appears impossible to tease out such influential variables, if any are there. The following data depict patient change in those variables upon which this project has focused. Due to the small total sample in treatment as of November 30, 1972, and the fact that some patients had been in treatment less than one month, these data must be seen as only temporary trends. Firm data on change awaits further treatment and the stability of change awaits follow-up for at least one year after the conclusion of treatment.

a. Change in Rate of Dirty Urines

A summary of urinalyses by treatment experience-month (that is, a patient's first, second, third, etc., month after reaching maintenance dosage level) indicates an apparently random fluctuation, as follows:

Treatment-Month	Percent Urinalyses Morphine-Positive	Number of Patients
1	31.8	75
2	39.7	66
3	31.0	57
4	41.2	46
5	38.3	33
6	42.8	27
7	39.5	19
8	42.5	18

An analysis of the pooled data indicates that 37.2% of all urinalyses were dirty (morphine present) over the 8-month treatment period, or, to put it another way, 62.8% of all urinalyses were "clean". The number of patients in each treatment experience month varied from 75 for one month down to 18 who have been treated for 8 months.

An inspection of individual cases suggests that after maintenance dosage was achieved, some patients remained clean over periods from several weeks to several months, and no patient in treatment 7 months or more was dirty all the time. Thus, the daily habit of heroin injection which characterized all patients upon admission has been broken, to a varying extent, among all patients.

b. Change in Employment Status

Of 61 patients in treatment, only 10 were employed at entry to the program. A total of 26 obtained jobs after starting on methadone (3 subsequently lost their jobs), and 25 have never been employed since entering the program.

c. Relation Between Employment and Urinalyses

A question which was built into the research design was the differential effects of employment status versus unemployed status. Using rate of heroin use as measured by urinalysis as a dependent variable, a tentative finding shows that to date, the 10 patients who have been employed throughout treatment have had 70% of all urinalyses clean, while the 51 patients who were unemployed at intake have had 47% of all urinalyses clean.

Of the 51 unemployed at intake, the 23 who have become employed have varied so much in the length of new employment that no correlation between employment and change in urinalyses can be teased out for statistical reference at this time. As overall length of new employment increases, statistical analyses will be done.

Intensive effort to assist unemployed patients in obtaining jobs became possible only after Mr. Clay was employed on August 2, 1972. This effort is continuing.

d. Change in Rate of Heroin Use

Urinalysis, done on an average of 5 days, is, of course, only one of the indices of heroin use, particularly since laboratories report only the presence of morphine, not the quantity used.

Using patient self reports obtained by the Behavioral Analyst as data, the number of "fixes" one month after maintenance dosage was established had dropped from a mean of 15 down to 1.10 per week (significant at the <.001 level). This reduced rate appears as a relative constant in both the three-month and the six-month repeat Behavioral Analyses. This drop in the number of fixes is associated with a drop from 23.1 to 1.48 "bags" of heroin used each week, or 21.6 bags. At a reported street price of $10.00 per bag, for 60 patients this is a total of $674,000.00 reduction per year in street retail purchases. (See "Impact on Crime", below.) Again, these are self reports. We attach considerable significance to these, however, because self reported heroin use is confidential information given to the Behavior Analyst and only the laboratory, attendance, and legal or illegal behavior are used as criteria for patient privileges or the revocation of privileges. Self plus lab reports become the basis for planning counseling objectives and procedures.

e. Other Changes

A number of other changes in patients' style of life may be noted. There has been a marked increase in job seeking behavior among the unemployed or partially employed. The total amount of time, on a weekly basis, spent among addicts has dropped very significantly; patients tend to spend much more time with families, non drug using friends, practicing job related skills such as repairing their own or friends' cars, repairing their homes, baby sitting if their spouses are employed, etc. Following is a summary of behavior changes as reflected by the repeated Behavior Analyses on the 7 variables which, from a functional perspective, are seen as most critical measures of change. Items 1, 2 and 3 show improvement when scores decrease, as all have. Items 4, 5, 6 and 7+ show improvement when scores increase.

		PRE		1 MO.		3 MOS.		6 MOS.		
		N	Mean	N	Mean	N	Mean	N	Mean	
1.	Number of fixes per week	60	15.0	60	2.0	41	1.25	19	1.10	
2.	Number of $10 bags used/week	50	23.1	50	3.4	41	1.85	19	1.48	
3.	Illegal activities engaged in/week	60	2.7	60	.20	41	.23	19	.37	(Only one person)
4.	Practicing job related technical and social skills, hours/week	60	1.7	60	4.0	41	6.12	19	2.32	
5.	Seeking work, incidents/week	60	0.5	60	0.9	41	.54	19	.24	
6.	Holding job, days/week	60	0.6	60	1.2	41	1.76	19	1.84	
7.	Time spent with addicts (- score) and non-addicts (+ score), net incidents/ week	60	-3.7	60	2.10	41	2.11	19	3.66	

Research Developments

Research is continuing, with data accumulating which will allow comparative analysis over an increasing number of variables as patients are in treatment for longer periods of time. A treatment cohort of at least 60, all in treatment for one full year, plus the persons separated will yield much more information for analysis than is possible at this juncture. At the recent FDA Regional meeting in San Francisco, an FDA speaker advised against de-toxification from methadone under two years of treatment. He gave no empirical data in support of this opinion. During the second year of treatment (beginning in Feb. 1973), we propose to do some experimental research on this issue, on a few patients whom we see as making excellent progress in only 5 to 8 months of treatment.

The small sample of 10 patients, holding jobs on admission, plus the 26 who accepted and have held jobs since being in the program (less 3 who lost jobs) have done better on most measures than have the 25 unemployed patients. Separating these 25 from the total group leaves a hard core group for whom an outpatient treatment facility does not appear appropriate for initial treatment. One factor, however, which partially negates this assumption is the fact that all the losses in the Richmond Clinic occurred before the Clinic obtained adequate space for regular counseling. However, even under the previous space limitations,

most of the patients except the hard core loss group did adapt to the program. Consequently the recommendation has been made to local administration that in any projected expansion of the program, a short term residential facility should be included for this hard core population. Such a residential program would focus upon taking new patients off the streets, putting them in a situation requiring and strongly rewarding the development of socially appropriate behaviors before they graduate to outpatient treatment.

Research on the Behavioral Analysis Technique for assessing pre-treatment behavior and change in life style during treatment is approaching publication stage. A scientific paper is being readied for submission and only awaits data covering 12 months of treatment. The advantage of this assessment technique is that it yields more precise data on social adaptation than do personality tests, questionnaires, or clinical judgment.

Development of Drug Abuse counseling techniques using data from the Behavioral Analyses as baseline information for counseling goal setting is continuing. Staff training materials are being developed and used as work on this progresses. If time permits, the training materials will be organized in manual format and made available for use in Training Workshop situations.

Impact on Crime

Our tentative assumption is that the best available criteria for assessing the impact of a methadone program on crime are the urine tests for morphine, the patients' self reports (Behavioral Analysis interviews and counseling sessions) and shifts from unemployment to employment.

Law enforcement rap sheets which are in all our patient files are extremely lacking in precise data on patient's illegal economic behavior. A few patients have no records of convictions, some have had convictions before becoming addicted, became addicted while in prison, and have no arrests or convictions since, albeit using illegally procured heroin everyday until they entered treatment. Among those arrested and convicted for purchasing, possession, or selling of heroin, the fact is that before the incident of arrest, the person was practicing these illegal acts daily.

Since entering treatment, 6 of our 61 patients cohort have been convicted of drug related crime (7.4%). Other jailings have been for "holding on suspicion" and unpaid traffic citations. The latter have not interrupted treatment. One man was imprisoned in San Quentin for parole violation (a dirty-urine sample taken by the Parole Dept.). Upon release he returned for treatment and was assisted in getting a job as a welder, and has been clean since.

Urinalysis data indicate a drop from 100% dirty labs on admission to 37.2%, and patients' self reports indicate a reduction in bags of heroin used each week, which amounts to approximately $674,000 annually in less illegal retail business on the streets. A conservative estimate would indicate that the 10 employed-at-intake patients used earned income to purchase heroin and that the 51 unemployed patients had to steal or deal in stolen goods. Thus, the savin;

to the community probably approaches millions of dollars. Much of this represents police-undetected crime which is nevertheless of tremendous importance to the businesses and households of the community. In our considered opinion, official criminal statistics have little relationship to the economic and social impact of heroin addiction on the business community or to tax paying citizens in general. In short, the question is not how many fewer notations on a person's rap sheets, but rather how much less cost is there to business, homeowners, car owners, taxpayers.

The above analysis is well illustrated in Richmond, California. In areas of Richmond where heroin addicted persons congregate, business evacuates, real estate property declines, buildings become empty and are vandalized, police hours are greatly increased, and the Richmond Redevelopment Agency has to move in to aid in reconstructing a "burned out" urban area. Meanwhile, the Richmond Police Department seeks desperately to find treatment resources other than prisons to which it can refer the addict whose daily habit can only be fed by economically and sociably destructive behavior.

ANNUAL REPORT

Part A. Discovery Project (Project 0580)
Leonti H. Thompson, M.D., Program Chief
Frank Scalercio, Jr., Project Director
Report Period: November 1, 1971 through November 30, 1972

1. General Program Progress

The Discovery Program's developments during this report period are enumerated in considerable detail in the Program Narrative which is being submitted as separate document.

This report summarizes the treatment events, for the Discovery House and Centers.

2. Discovery Houses

a. Martinez Discovery House

Approximately 630 persons entered the drug service program on M Ward, County Hospital. Of these, approximately 567 were addmitted for drug detoxification. Of this number of admissions, approximately 110 expressed an interest in participating in the Drug Family program in the Martinez Discovery House. During the candidacy period of one month, all but 46 left for various reasons. These 46 were admitted to Discovery House.

Of the 46 patients who were admitted during this report period, 15 remain in the House and 31 have separated. Separation breakdown is as follows:

Completed full treatment program	= 11
Left at end of 6 months	= 12
Left for reasons unknown	= 2
Jailed for offenses, all of which occurred before treatment started	= 3
Discharged for infraction of rules	= 3

Among the eleven who successfully completed the full treatment program, eight have full time employment, one has a part time job and is seeking full time employment, one is in college full time, and one is unemployed but actively job seeking.

Moreover, all took up residence in what are, for them, new communities to avoid interpersonal contacts with former friends in the drug subculture. All those who were married returned to their spouses and families. All, to our knowledge, are living drug-free lives.

Of the twelve who separated before completion of the full term treatment program, all were making satisfactory progress at the time of separation. All gave as the reason for leaving their desire to obtain employment. Follow-up data on these twelve indicates that few have obtained employment, and their present drug status, and often their whereabouts too, are unknown.

All patient residents participate in educational programs two evenings each week, working toward G.E.D. qualification.

b. Pittsburg Discovery House

The Pittsburg Discovery House re-opened on July 15, 1972. A total of fifteen patients have been referred from the parent candidacy program from M Ward, County Hospital. Of these, eight remain in the program.

For want of staff and other cogent reasons, the Pittsburg patients participate daily in the Martinez Discovery House program, commuting the distance daily. In addition, they participate each morning in a group meeting in the Pittsburg House, in Synanon-type game techniques three times weekly, and in many informal group discussions with staff in evenings. Also, they all are participating in the evening educational program, working toward completion of their G.E.D. qualifications.

The Pittsburg House, located in Black Diamond House (formerly Unified Pittsburg Drug Treatment Center) could accommodate 30 patients. However, the building will be demolished in the near future, and unless space for continued treatment is assured, it appears medically inadvisable to admit 22 new patients.

It is important to note, too, that all patients in the Pittsburg House came from residences outside east County, i.e. from Martinez westward through Richmond. The Pittsburg residents in the program are in the Martinez Discovery House. This assignment system is followed in order to take a patient away from his drug culture and to help him sever his social ties with former addict friends.

3. Discovery Centers

The Discovery Center clients are unique in county service agencies, in several respects. The most singular factor is the informality of admission to a Center for service. As stated previously in the project proposal, the Centers are in the communities to reach young people who are

involved, in varying degree, in the use of drugs. To reach such youth before drug habits become firm, before the youth has shifted to narcotics, requires less detailed and formal admission procedures than are found in Juvenile Departments, Social Welfare, Medical Services, etc. The doors of the Centers are open for drop-ins. No examination for fiscal, medical, or legal eligibility can be made, else many of the youths with personal problems would quickly disappear. The Centers are, in fact, service outreaches to youth, beyond the formal service systems of the county which must erect formal eligibility and entrance requirements.

These necessary characteristics of a Discovery Center are emphasized, because much of the client data collected through formal intake and service processes in other public and private agencies simply cannot be collected. This is acutely true of the drop-ins--youth who came, without appointment, remain for some program activity, and leave--permanently or to return another week or month later for a brief contact or to become a more regular participant.

The regular participants too, may cease coming to a Center, unannounced, leaving no time for discharge procedures through which much evaluative data is normally obtained in formal agencies. For these reasons, the usual test of treatment effectiveness, i.e. pre/post measures, cannot be applied to all clients, or even to the majority of the youth served by Centers.

The fact is, too, that the Discovery Project is not designed or funded as a research project. Consequently an evaluation of its effectiveness can legitimately follow the usual evaluation procedures in public agencies where the specific impact on the client, in terms of changed social, interpersonal functioning is usually absent. Where and when possible, each Center has used pre/post measures of change and this, to date, has been possible for a small minority of the youth served.

Following is a description of programs for each Center, with an overall summary at the end.

a. Concord Discovery Center

The Concord Discovery Center is the largest Center in terms of staff and numbers of clients. Its program is described in considerable detail in the budget narrative (parallel submission). Following is a summary of client and activity data.

1. Drop-Ins
An average of 272 drop-in visits per month or a total or 3600 persons a year. This does not include parents and persons from referral agencies who came to check out services offered at the Center. Most of these drop-in youth are 14 to 18 years of age, both sexes. Some older youth and young adults, 19 to 26 years, and parents, too, occasionally participate in evening activities. These drop-ins appear to need immediate crisis counseling on some personal, often situation problem, and do not plan to come more often than once, at least for each crisis as crises arise. Crisis

problems involve hassles at home, or at school, or experiments with drugs which disturb the client; peer group problems "boy vs. girl", etc.

When one session crisis intervention does not appear sufficient to resolve the problem, the counselor encourages the youth to participate in short term treatment. Many do.

2. Short term treatment - 3 to 6 months
Approximately 140 persons were seen in short term individual and group counseling during the report period. All were on schedules ranging from one to four sessions per week, plus participating in extra-mural activities sponsored by the Center, e.g. The above figure includes adults, most of whom were parents or relatives of the youth participants. A sample of the characteristics of this group is presented in the chart below.

3. Long term treatment
Approximately 74 clients were seen for periods over 6 months. The usual pattern is for attendance to diminish in frequency after 6 months and continue at infrequent intervals, without breaking ties with the Center.

Services rendered to youth by the Center extend far beyond direct counseling. The Center has referral functions; individual youths and families, much telephone counseling for youth and adults who are in crisis and ask for immediate help, over 50 talks given to school classes, PTA's, church groups, service clubs, women's organizations. These indirect services are an essential feature of any prevention program.

b. Tri-Cities Discovery Center

This Center has functioned under CCCJ funds since February, 1972. A summary of its activities is as follows:

1. Characteristics of Clients. (See Sample Descriptions, chart below).

a. Drop-in
This group is comprised of young people of the Pinole, Rodeo, and Crockett areas and also from the adjoining county area, i.e. Tara Hills. They range in age from 14 to 19 years old, and are predominantly white of lower middle class parents. Of the youth from the Crockett and Rodeo areas, there is a substantial degree of one-parent families or families in conflict, i.e. excessive drinking, etc. Average of 20 per week or an annual rate of approximately 1,000.

b. Short Term
This group includes those youths who prematurely terminate treatment, youths involved in one-to-one short term sessions and those with one specific problem, i.e. VD information. This group is basically the same demographically as the first group, the major difference being that this group has the higher percentage of Black and Chicano members. Specific parent counseling appointments are also included in this group. The youth are contacted primarily by our Counsellor Aides at John Swett High School in Crockett and at Willow Continuation School in Rodeo.

c. Long Term
This group is made up of those youth who have elected to continue their involvement at the Center and are participating in the ongoing groups. This group ages from 16 to 20 years old, is predominantly white of lower middle to middle class parents with one member at present self-supporting.

Total attendance rate for this Center averages 168 per month.

2. Outcomes (for each group)

a. Drop-in
The measurement of the outcome for this group is extremely difficult in that most are contacts for only one to a few times. Information about drug effects is the most frequent inquiry for this group.

b. Short Term
Of those involved in one-to-one counseling sessions with specific problems and defined goals, the outcome is good. Whether this entails referrals out to other agencies, i.e. Planned Parenthood or resolving crises in home or at school, e.g. communication or interpersonal problems, the outcomes generally tend to be satisfactory. We attempt to measure and depict these changes in grids, but the major problem is that many of these short term cases last for only one month and cease participating without any "exit interview".

c. Long Term
The problem with evaluating this group is that only two people have successfully completed this stage of the program to date. For both these individuals, a final evaluation shows a positive change in behavior in previous problem areas. A new group was formed in November, 1972, and we have gathered intake data and grids for these people. We will be following these people through the program with additional grids and hope to again show positive changes in both attitudes and behavior.

3. Increased Demands for Services

There are basically two major areas in which the demand for our services in the Tri-Cities area will increase in the coming year. The first relates to the community at large. We have seen in recent months an upswing in the requests for speakers from our staff for various drug information nights at PTA's, service organizations, and civic groups. A number of service clubs have approached us and asked us to become involved in their community outreach programs to further the spread of drug abuse information throughout the area. Most notably, the Pinole Jaycees are planning a number of events with us to make the entire area more aware of the scope of the problem, the existing services available, and also to help us become more financially stable. The next large area where I can see the need for increased services is in the Richmond Unified School District. Although there has been substantial trouble in working in this area in the past (see Ms. Gibbs' reports), we hope to resolve this situation in the next few months. At this time (when the situation is resolved), we will be called on for additional staff hours in drug abuse education and information along with back-up counseling services to those students referred through the school system. We also have been contacted by the Dean of Instruction of Contra Costa College in relation to providing the above-mentioned services either at the school or by referral to the Center. We also met with representatives of the Youth Authority and expect a large number of referrals out of their Parole Department. The approach here is to deal with the problem of re-entry from Youth Authority facilities into the local community.

c. Richmond Discovery Center

The Richmond Center opened in September, 1972. Consequently, only 2½ months of this report period applies.

Drop-ins average approximately 30 persons each week; 20 were in short term treatment (2 times weekly) by November 30th, and 11 were beginning their second month of treatment, i.e. approaching long term treatment status. (See Chart for sample client characteristics.)

Staff were spending between 40 and 50% of their time in community contacts, as a means for facilitating program expansion and development. It is interesting to note that the Richmond Center (Sample Chart) had a very high percentage of clients using heroin. At the present level of Methadone Maintenance funding and Center House capacity, the Center is hard pressed for suitable referral for these young narcotic users.

The program had not been in operation long enough to obtain any measures of changed client functioning.

d. Danville Discovery Center - November, 1971

Danville Discovery Center functions in a semi-rural community where the population is concentrated largely among white, middle to upper class residents. Youth that come to the Center have the lowest median age (15) from any Center. The one client who was addicted to heroin was a Vietnam veteran, 20 years of age.

During this report period, approximately the following number of clients were served.

1. Drop-ins
   Approximately 1100 clients. These included youth and adults. The latter were mainly parents seeking counsel regarding their children, or parents whose children were involved in the Center program.

2. Short Term
   Approximately 400 clients participated in Center programs for periods ranging from one to three months.

3. Long Term
   Approximately 125 clients remained in Center programs for longer than three months. In most instances the frequency of participation diminished after two to three months. This maintenance of contact with the Center is encouraged by staff, and in staff opinion, is a distinct help to the client in maintaining gains achieved during more intensive participation in the program.

   For more detailed characteristics of the youth clients, see the Sample Client Description, below.

SAMPLE CLIENT DESCRIPTION

Center	Number of Clients	Median Age	Sex M	Sex F	Ethnic Group White	Ethnic Group Black	Ethnic Group Chicano	Ethnic Group Other	Marital Status Never Married	Marital Status Married	Marital Status Sep.	Marital Status Div.
Concord	56	16	28	28	54	1	1	0	45	6	5	0
Danville	36	15	23	13	35	0	1	0	36	0	0	0
Richmond	55	20	38	17	22	19	12	1	36	8	8	2
Tri-Cities	66	16	38	28	52	7	6	0	66	0	0	0
Total	213	17	127	86	163	27	20	1	182	14	13	2
% (Base=213)			59.6	40.4	76.5	12.7	9.4	0.5	85.4	6.6	6.1	0.9

	Lives with Spouse	Lives with Parent(s)	Lives with Friend(s)	Lives with Other	Legal Status No Present Involvement	Legal Status On Probation	Legal Status Warrant Issued For Arrest	Legal Status Case Pending
Concord	5	43	4	2	45	6	0	5
Danville	0	33	2	1	31	3	1	2
Richmond	7	28	19	0	31	12	9	1
Tri-Cities	0	60	0	5	58	5	0	2
Total	12	164	25	8	165	26	10	10
% (Base=213)	5.6	77.0	11.7	3.8	77.5	12.2	4.7	4.7

Drugs Used in Past Year

	Marijuana	Amphetamines (Excl. Methedrine)	Methedrine	Barbiturates	Glue	Cocaine	Hallucinogens	Heroin	Other Opiates
Concord	41	25	2	17	2	11	27	2	0
Danville	31	21	0	10	2	7	20	1	5
Richmond	44	9	4	27	0	5	12	13	1
Tri-Cities	55	39	6	41	3	7	31	2	0
Total	171	94	12	95	7	30	90	18	6
% (Base=213)	80.3	44.1	5.6	44.6	3.3	14.1	42.3	8.5	2.8

	Number treated for addiction	Median Education (Last grade completed)
Concord	2	10
Danville	1	10
Richmond	8	11
Tri-Cities	2	10
Total	13	10
% (Base=213)	6.1	

END