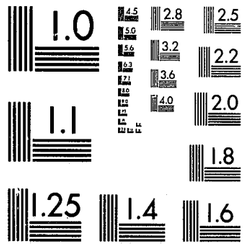

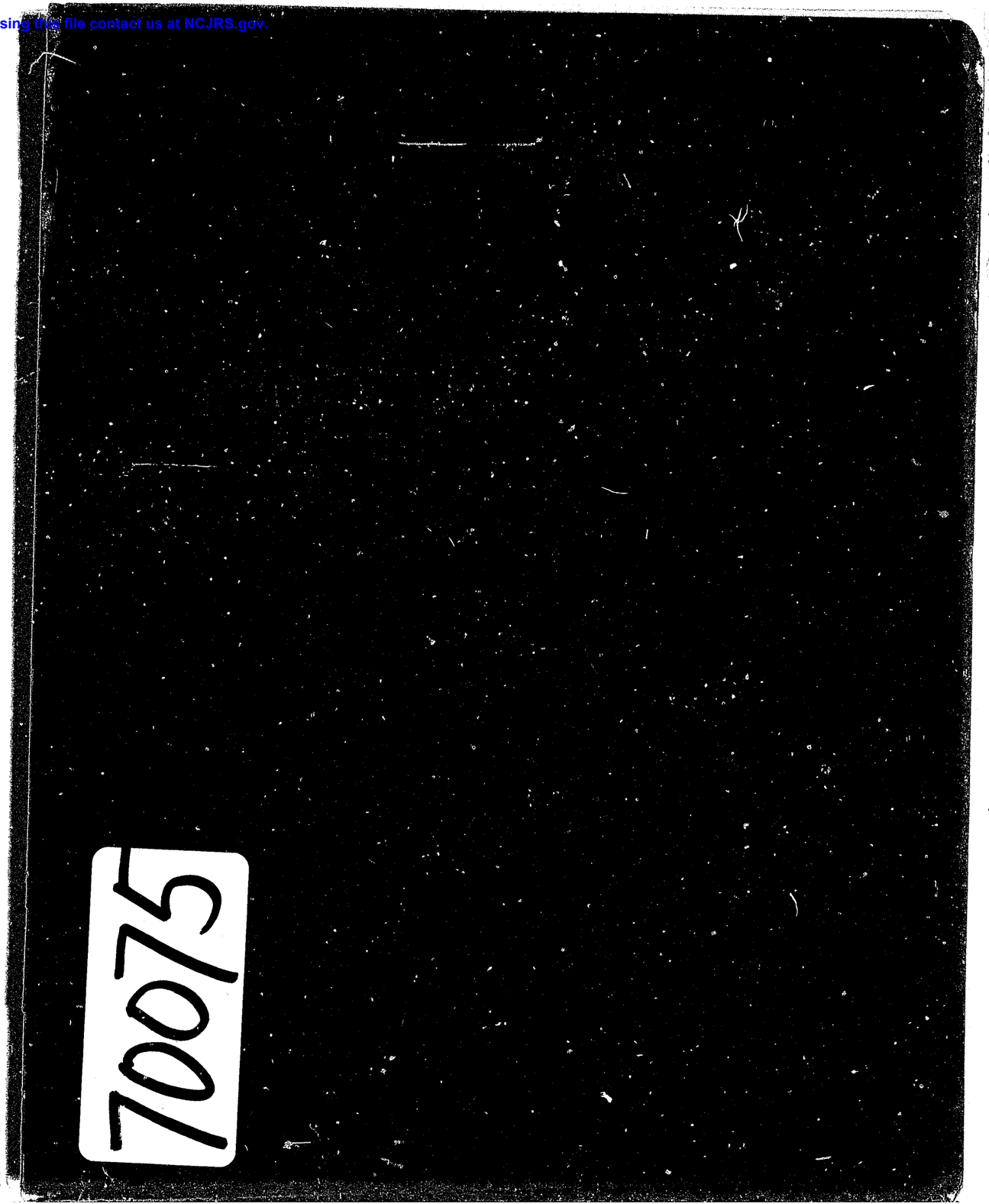

NEW JERSEY STATE DEPARTMENT OF HEALTH

TO Mr. Court Fisher, Community Service Offic. II

FROM Hans W. Freymuth, M.D., Program Director DATE Feb. 10, 1972

SUBJECT Report for Fiscal Year July 1, 1970 to June 30, 1971

The questionnaire provided for this purpose was completed as much as possible, but some questions could not be answered because pertinent data are not available for the grant year ending June 30, 1971. This applies to the information requested on pages four, five and six. Inauguration of a central registry will hopefully allow for more complete data to be available for the next grant year.

The fact that our Program consists of a network of Clinics rather than a single Clinic also limits the applicability of the report.

On June 30, 1971, the Methadone Maintenance Program of this State included 16 Clinics as listed on Attachment "A" of this report. In addition to this, the Drug Addiction Treatment Center of the New Jersey Neuro-Psychiatric Institute served as induction center for the entire system on an in-patient basis until March 1971. At that date there was a total of 327 patients on Methadone Maintenance throughout the State and increasing demand and the limited size of the induction facility at the New Jersey Neuro-Psychiatric Institute caused us to introduce semi-ambulatory induction as a Clinic function, first in some of the major Clinics. Guidelines for ambulatory induction (Attachment "C") include creation of day care facilities for induction, which must be attended by the patients on induction from the opening hour of the Clinic, generally 8 a.m., to closing time, generally from 4 to 5 p.m. Other precautions pertaining to ambulatory induction are identified and described in the Guidelines.

Introduction of ambulatory induction has led to a rapid increase of patient numbers and at the end of the grant year, a total of 767 patients were on Methadone Maintenance. A further, rapid increase of patient numbers is expected, as ambulatory induction has decreased or abolished waiting times and in many instances has made it easier and more acceptable for patients to join the Program.

It is the goal of the Program to achieve the optimal socio-economic re-intigration possible for each patient successfully established on Methadone Maintenance. For this purpose full-time social workers are attached to all Clinics and their individual caseload is held to 20 patients per worker as closely as possible. It is the social worker's duty to be helpful to addicts in all phases of their rehabilitation needs which may range from job training to job finding or relate to such problems as reconciliation with their families or dealing with law enforcement officers or agencies who are unaware of the patient's maintenance program or ignorant about its implications.

70075

M3892

Patients requiring temporary welfare subsistence will be aided. Furthermore, the social worker will work closely with his patients assessing their life adjustments and attempting to change their life style. The social workers must also discern unacceptable adjustment patterns which might force us to eliminate a patient from the Program. This might include alcoholism, continuing heavy drug use or continuing anti-social behavior or drug pushing.

Our approach to maintenance has remained conservative. By far the majority of our patients start on high dose level maintenance (80 mgm. daily or more) and have to appear daily for their medication on a seven days a week basis. Medication has to be taken in the presence of the registered nurse in charge of medication. A urine specimen is demanded of patients at each Clinic visit and on the average two of these specimens are processed for monitoring every week.

So-called take-home doses are given only as exceptions and relatively rarely during the first year of maintenance. Patients who show good adjustments might later on opt for low dose level maintenance (30 mgm. to 40 mgm. daily), which can be successful only if the patient can resist the temptation of using Heroin. This drugs regains its effectiveness as a euphorizing agent with low dose level maintenance.

Patients who show their ability to handle low dose level maintenance might then be placed on weekly supplies, reducing their Clinic visits to one a week, at which time they are to give a urine specimen and see their social worker.

A small number of patients have expressed their desire to be detoxified from Methadone after having been successfully on maintenance for some time. We are supportive of such decisions and detoxify these patients on a slow detoxification schedule ranging from three to four weeks. We advise them that they should return to the Program if they should feel unable to handle their problem on a drug free basis.

Results with patients detoxified from maintenance have so far not been overly encouraging, and of the small number who have availed themselves of this step, approximately 65 percent rejoined the Program after a varying lapse of time.

Of the 35 percent who did not rejoin, approximately half have remained drug free, the others have returned to street use of opiates. However, experience in this area is still too limited to allow for final conclusions. Every effort will be made in the future to terminate Methadone Maintenance successfully so as to enable these patients eventually to remain drug free.

HWF:jmb
Attachment

Special Conditions

to be attached to all

3.2.1 Grants

(Rehabilitation of Narcotics

and

Dangerous Drug Offenders)

NOTE:

Completion of this Report is required as a special condition for receipt of funds from the New Jersey State Law Enforcement Planning Agency (SLEPA) under Program 3.2.1 (Rehabilitation of Narcotics and Dangerous Drug Offenders).

If a currently funded 3.2.1 project wishes to apply for continuation of its Grant, it must submit this Report at the time application is made for continued funds from SLEPA, normally one-two months before the end of a project year. Requests for Grant continuation will not be considered until this Report is received by SLEPA.

If a current 3.2.1 project does not request continued SLEPA funds, it must submit this Report no later than one month after the end of its funding period.

1. Name of Program

   New Jersey State Methadone Maintenance Program

2. Name of Operating Agency

   Div. of Narcotic & Drug Abuse Control, State Dept. of Health

3. Address (for each location if more than one)

   A. See Attached List (Attachment "A")

   B. _____

   C. _____

4. Program Directorship (If one person acts in a dual capacity enter the name in both spaces).

   A. Project Administrator Mr. Richard J. Russo, Deputy Director

   B. Project Director Hans W. Freymuth, M.D.

5. Phone Number

   609-292-5760

6. Year and Month Program Began

   July 1970

7. Financing (If joint financing enter dollar amount and percentage).

   A. Federal-SLEPA $184,000 58%

   B. Federal-HEW _____

   C. Federal-HUD _____

   D. Federal-OEO _____

   E. Federal-Other, Specify _____

   F. State $84,300 26%

   G. Municipal _____

   H. County $50,300 16%

   I. Patient Fees _____

   J. Private-Foundation _____

   K. Private-Community Chest _____

   L. Private-Other _____

8. Type of Facility and Client Capacity (Check appropriate type) By End of Program Year

Type	Check	Capacity
A. Hospital and/or Clinic		
Residential	X	64
Outpatient	X	767
B. Rehabilitation and/or Treatment		
Residential		
Outpatient	X	N.A.
C. Coordination and/or Referral		N.A.
D. Halfway House (residential)		N.A.
E. Information and Education		N.A.
F. Other, specify		

9. Total and Average Caseload

Facility Type	Total Caseload Past 12 months	Average Active Caseload Past 12 months
A. Hospital and/or Clinic		
Residential	590	49
Outpatient	767	95
B. Rehabilitation and/or Treatment		
Residential	590	49
Outpatient	767	95
C. Coordination and/or Referral		N.A.
D. Halfway House (residential)		N.A.
E. Information and Education		N.A.
F. Other, specify		N.A.

10. Characteristics of Drug Users Accepted for Treatment

To complete this section it is required that the project establish and maintain files on all drug users accepted for treatment during the reporting period.

The statistical averages required in this section can be derived from the "Treatment Facility Report of Controlled Dangerous Substance (CDS) Abuser" which a treatment facility must file with the New Jersey Department of Health on each client accepted for treatment. It is understood that data requested in this section are statistical averages only, and that individual clients' names or personal histories are not required for SLEPA evaluation.

For convenience in preparing data in this section, the following key shows the information category of this SLEPA report and the corresponding question number on the Department of Health report for each client.

This report Item #10	Dept. of Health CDS Abuser Report Item #
A. Age Range and Average	5. Date of Birth
B. Total by Sex	8. Sex
C. Ethnicity	9. Race
D. Drug of Principal Abuse	11. Drug or CDS of Principal Abuse
E. Length of Drug Use	13A. Date of First Abuse
F. Employment Status	12. Employment
G. Education	12A. Education
H. Religion	14. Religion
I. Previous Treatment	15. Treatment (Prior)
J. Domicile at Intake	17. Living With
K. Current Legal Involvement	18. Current Legal Involvement
L. Prior Legal Involvement	19. Prior Legal Involvement

Where percentage breakdowns are required, percentage should total 100%.

Please indicate here the period of time on which data in this section is based:

Reporting period from 1 (month) / 1 (day) / 71 (year) to 6 (month) / 30 (day) / 71 (year)

A. Age Range and Average

Youngest Client	18
Oldest Client	45 +
Average Age	28

B. Total by Sex

Male 673 ; Female 94

C. Ethnicity, percent of total

White	55%
Black	40%
Puerto Rican (Not cuban or other Spanish surname)	3%
Other	2%

D. Drug of Principal Abuse, percent of total

Opiates	100%
Amphetamines	N.A. for this Program
Barbiturates	N.A.
Hallucinogens	N.A.
Hydrocarbon vapors	N.A.
Marijuana or Hashish	N.A.
Alcohol	N.A.
Other	N.A.
No Principal Drug	N.A.
Unknown	N.A.

E. Length of Drug Use

Average length of drug use (in years) 4 YEARS

Percent of total using drugs 3 years or longer 84%

F. Employment Status (at intake), percent of total

Permanent, full-time	_____
Permanent, part-time	_____
Temporary	_____
Unemployed	_____
Enrolled student, full-time	_____
Enrolled student, part-time	_____
Unknown	_____

G. Education percent of total

Completed 0 - 8 grades	_____
Completed 9 - 11 grades	_____
Completed 12th grade	_____
Completed 1 - 3 years college	_____
Completed 4 years college	_____
More than 4 years college	_____
Unknown	_____

H. Religion, percent of total

Catholic	_____
Protestant	_____
Jewish	_____
Other	_____
None	_____
Unknown	_____

I. Previous Treatment

	Average Number of Previous Treatments	% of Total Having More Than One Such Previous Treatment
Psychiatric inpatient	_____	_____
Psychiatric outpatient	_____	_____
Chemo-therapy inpatient	_____	_____
Chemo-therapy outpatient	_____	_____
Therapeutic community inpatient	_____	_____
Therapeutic community outpatient	_____	_____
Other inpatient	_____	_____
Other outpatient	_____	_____
No previous treatment	_____	_____
Unknown	_____	_____

J. Residence - Living with, percent of total

Parents or other relatives	____
Spouse	____
Parents or relatives and spouse	____
Friends	____
Alone	____
Unknown	____

K. Current Legal Involvement (at intake), percent of total

Non-punitive custody (civil commitment, mental health, etc.)	____
Punitive custody (jail, reformatory, etc.)	____
No legal involvement	____
** Charges pending	____
Parole	____
Probation	____

L. Prior Legal Involvement, percent of total

Previously arrested for drug offense	99.6%
Previously arrested for other offense	____
No prior legal involvement	____
Unknown	____

** A patient may not have any charges pending to be eligible for Methadone Maintenance.

11. Services Provided

Services	All or Most	Some	None
A. Group Psychotherapy	____	X	____
B. Individual Psychotherapy	____	____	____
C. Family Therapy	____	X	____
D. Medical Treatment-Detoxification	X	____	____
E. Medical Treatment-Withdrawal	____	____	N.A.
F. Medical Treatment-Drug Maintenance	X	____	____
G. Other Chemotherapy	____	X	____
H. Medical Treatment-Other	____	X	____
I. Detoxification Nonmedical (cold turkey)	____	____	X
J. Social Casework-Group	X	____	____
K. Social Casework-Individual	X	____	____
L. Pastoral Counseling	____	X	____
M. Vocational Training	____	X	____
N. Work Experience	____	X	____
O. Job Placement	____	X	____
P. Education	____	____	____
Q. Recreation	X	____	____
R. Financial Assistance	____	X	____
S. Legal Aid	____	____	____
T. Other Services (specify service)			
General counselling and advice	X	____	____
____	____	____	____
____	____	____	____
Referral to Other Agencies (specify service)			
State Vocational Rehabilitation Commission	____	X	____
Welfare	____	X	____
Employment Services	____	X	____

12. Criteria for Acceptance	Yes	No
A. Commitment by Court		X
B. Commitment by Civil Authority		X
C. Motivation and Ability to Profit from Treatment	X	
D. Residence Requirement (geographic area)	X	
E. Sex Requirement		X
F. Age Requirement	X	
G. Voluntary	X	
H. Type of Drug Used	X	
I. Referral, Other Agency		X
J. Presence of Primary Medical or Psychiatric Problem		X
K. Ability to Pay		X
L. Other, Specify		
_____		
_____		
_____		

13. Criteria for Termination		
A. Voluntary	X	
B. End of Court Sentence		X
C. End of Civil Commitment		X
D. Lack of Motivation and Ability to Profit from Treatment	X	
E. Moved from Program Area	X	
F. Relapse to Drug Use	X	
G. Referral to Other Agency	X	
H. Arrest for Drug Offense		X
I. Development of Primary Medical or Psychiatric Problem	X	
J. Other, Specify		
_____		
_____		

14. Applications and Terminations (past 12 months)

A. Number of Drug Users Applying	4,132
B. Number of Drug Users Accepted	827
C. Number of Drug Users Not Accepted	
D. Number of Drug Users Who Did Not Return After Initial Inquiry	
E. Number of Drug Users Voluntarily Terminated	25
F. Number of Drug Users Involuntarily Terminated	35
G. Number of Drug Users Currently Enrolled	767

15. Individual Case Evaluations (type of procedures utilized

	All or Most	Some	None
A. Medical	X		
B. Psychiatric		X	
C. Psychological Tests		X	
D. Vocational Tests		X	
E. Social Histories	X		
F. Educational Tests		X	
G. Other Types, Specify			
EEG		X	
EKG		X	
Laboratory Work-up	X		

16. Follow-up Evaluations

The following questions refer to follow-up evaluations of persons who were discharged or voluntarily left the program during this program year; i.e., those clients referred to in question 14.E and 14.F above.

	Yes	No
A. Were follow-up evaluations made on clients after program termination?	X	
B. How many and what percentage of ex-clients were contacted? Number _____ Percentage (of 14.E and 14.F)		
N.A.		
C. How many ex-clients were unavailable or could		

D. Average number of attempts to reach each ex-client before giving up trying to contact? ___ ___

E. What method(s) of follow-up were used?

	By Staff	By Other Patients	By Other Agencies
1. Mail questionnaire	X		
2. Personal interview	X		
3. Phone call	X		
4. Other (describe) information through others			

F. How long after termination were follow-up evaluations conducted?

1. 0 - 3 months	X
2. 4 - 6 months	X
3. 7 - 12 months	X
4. 13 - 24 months *	
5. 25 months or more *	
6. No standard time period	

* As a matter of policy or for those ex-clients terminated before this program year.

G. What were the results of the follow-up evaluation? (Data reported here should be based on number of contacted ex-clients in question B above)

	Not Available
1. Number drug free	
2. Number using drugs	
3. Number using alcohol to excess	
4. Number arrested for drug offense	
5. Number arrested for non-drug offense	
6. Number employed	
7. Number in school or training	

H. Because different programs serving different client groups may use other criteria for follow-up evaluation, you may include your own evaluation on an attached sheet. Note here whether separate evaluation is attached or not attached ___.

17. Staff Training and Selection

	Yes	No
1. Is preservice training provided?		X
2. Is preservice knowledge of drug abuse required?	X	
3. Is previous treatment experience with drug abusers required?	X	
4. Is previous experience with specific treatment modalities required?		X
5. Is inservice training provided?		X

6. Describe here the content of the training provided

7. Who provides the training? Members of the Division of Narcotic & Drug Abuse Control

8. Who receives the training? Staff members of the Clinics

18. Staff

1. List the professional staff

	Job Title	Age	Sex	Profession	Degree	Years of Experience with Drug Abusers
a.	20 full-time Registered Nurses					
b.	1 full-time Practical Nurse					
c.	24 part-time Registered Nurses					
d.	2 full-time Physicians					
e.	20 part-time Physicians					
f.	39 full-time Social Workers					
g.	8 part-time Social Workers					
	15 full-time Clinic Supervisors					

2. List the nonprofessional staff (excluding clerical).

	Job Title	Age	Sex	Profession	Degree	Years of Experience With Drug Abusers
a.	See under #20 on page 13.					
b.						
c.						
d.						
e.						
f.						
g.						

19. Agency Cooperation

1. If you have received case referrals from other agencies list the agencies here.

a. Other treatment agencies to include therapeutic communities

b. Law enforcement agencies and officials

c. Private physicians

d. Community out-reach centers and storefront operations

e. Others

2. If you have referred cases to other agencies, list the agencies here.

	Agency	Reason for Referral
a.	State Vocational-rehabiliation Agencies	Self-explanatory
b.	Welfare agencies	"
c.	Employment agencies	"
d.	Schools and colleges	"
e.	Civil Service	"

3. If other agencies provide concurrent services to your client list the agencies here.

	Agency	Service Provided
a.		
b.		
c.		
d.		
e.		

20. If you have additional information or comments pertaining to the above items enter these here.

ATTACHMENT "A"

Methadone Maintenance Clinics

Bergen Co. After-Care Clinic
Bergen Pines County Hospital
East Ridgewood Avenue
Paramus, New Jersey 07652

Burlington Co. After-Care Clinic
42 Grant Street
Mt. Holly, New Jersey 08060

Camden Co. After-Care Clinic
212 South Broadway
Camden, New Jersey 08103

Cumberland Co. After-Care Clinic
821 Church Street
Millville, New Jersey 08332

Essex Co. After-Care Clinic (DANA)
222 Morris Avenue
Newark, New Jersey

Hunterdon Co. After-Care Clinic
Hunterdon Medical Center
Flemington, New Jersey 08822

Kearny Methadone Maintenance Clinic
645 Kearny Avenue
Kearny, New Jersey 07032

Mercer Co. After-Care Clinic
132 Perry Street
Trenton, New Jersey 08625

Middlesex Co. After-Care Clinic
Roosevelt Hospital
P.O. Box 151
Metuchen, New Jersey 08840

Morris Co. After-Care Clinic
Thebaud Building
95 Mt. Kemble Avenue
Morristown, New Jersey 07960

N.A.R.C.O., Inc.
2006 Baltic Avenue
Atlantic City, New Jersey 08401

Passaic Co. After-Care Clinic
323 Main Street
Paterson, New Jersey 07505

Patrick House
287 Clerk Street
Jersey City, New Jersey 07304

Somerset Co. After-Care Clinic
74 East High Street
Somerville, New Jersey 08876

Union Co. After-Care Clinics
Plainfield Area Clinic
519 North Avenue
Plainfield, New Jersey

Elizabeth Area Clinic
45 Rahway Avenue
Elizabeth, New Jersey

Attachment "B"

MM-4
May 71

New Jersey State Department of Health
DIVISION OF NARCOTIC AND DRUG ABUSE CONTROL
P.O. Box 1540
Trenton, New Jersey 08625

MONTHLY
METHADONE MAINTENANCE
REPORT

M7871

Please send report to Program Director at above address
not later than five work days after the end of each month

Clinic

Patient's name (last, first, middle)	Sex ☐ M ☐ F	Age	Methadone dosage mgms. per day
Address	Other medication, if any:		
City State			

Was patient engaged in any of the following activities this month?

☐ Working ☐ Attending School ☐ Other socially acceptable activity (specify) _____

If not, explain _____

Did patient have medical problems this month?

☐ No ☐ Yes (explain) _____

Did patient have legal problems this month?

☐ No ☐ Yes (explain) _____

Was patient terminated during this month? ☐ Yes ☐ No

If yes: ☐ By clinic (explain) ☐ On his own request (explain)

Remarks (use reverse side if necessary)

Date	Completed by (name & title)	Signature

Attachment "C"

Guidelines for a Methadone Maintenance Program to Include Ambulatory Induction

Ambulatory induction as an alternative to In-Patient induction has been gaining increasing acceptance in maintenance programs conducted elsewhere.

Other investigators, such as Jaffe and Goldstein,[1] feel that intermediate and long-term results with ambulatory induction fully equal those obtainable with In-Patient induction, although the initial attrition factor seems to be somewhat higher.

The main advantage of In-Patient induction consists of the fact that the patient remains under full-time supervision in a protective environment. This prevents him from using drugs other than those prescribed by the physician and enables physician and staff to react promptly and constructively to any side reactions or difficulties which may appear during induction. In-Patient induction also protects the patient against the possible consequences of a certain degree of emotional instability and judgmental impairment, frequently observed during the build-up phase of Methadone Maintenance.

On the other hand, In-Patient induction is expensive and time consuming. Following induction, the patient has to leave the induction center to join a maintenance clinic, which presents frequently an adjustmental problem at a critical moment. He is confronted with new faces and has to deal with a new environment.

By contrast, ambulatory induction can be and should be conducted at the same clinic and by the same staff which later on takes care of the maintenance phase of the individual. Other advantages of ambulatory induction are its relative inexpensiveness, short duration, and more spontaneous initiation of maintenance. Waiting times for admission to an In-Patient induction center can present a serious problem and lead to losing patients who otherwise could be helped. In our State, this problem is accentuated by the fact that only one In-Patient facility is available for induction. Because of its limited bed space, waiting times at the Drug Addiction Treatment Center have been constantly increasing, sometimes to four to five weeks. This is highly undesirable from a therapeutic standpoint.

---

1 As communicated at the Third National Conference on Methadone Treatment (November 14-16, 1970).

A disadvantage of ambulatory induction consists of the limited control of the patients environment and the possible difficulties or dangers connected with this. These may be listed as follows:

1. The patient may engage in the use of other drugs during induction, making proper induction difficult or impossible. Specifically, there is a certain danger that the patient might use Methadone as a "pump primer" and booster for his Heroin habit. This is particularly true during the earlier phases of induction before Heroin blockade has been achieved.

2. Temporary instability of mood, which might express itself in irritability, mild depression, or episodes of euphoria, might lead to difficulties. Drowsiness and decreased alertness is another, potential problem.

3. A number of physical side reactions which may develop during induction, to include constipation, nausea, skin reactions, and excessive perspiration, are less subject to close observation and treatment in an ambulatory situation.

To minimize these disadvantages of ambulatory induction, a number of precautions must be taken:

1. Ambulatory induction must be conducted only in a Day Care Center type of setting, allowing for the patient's entry in the morning to spend his day at the Clinic until closing time.

2. During induction certain activities where good judgment and full alertness are essential, must be prohibited. This will include driving of motor vehicles or any type of work involving potential physical danger to self or other, such as construction work or work with power tools or potentially dangerous machines.

3. To minimize possible difficulties which may result from a temporary emotional instability and irritability, a voluntary curfew must be made a condition for ambulatory induction patients after they have left the Clinic in the afternoon.

An ambulatory induction schedule must represent the best possible compromise between the desirable goal of rapid induction on one hand and sufficient time to minimize side reactions on the other. Side reactions tend to increase in proportion with build-up speed, making slow induction desirable. On the other hand, slow induction increases the danger of use of other drugs,

as indicated before.

Selection of patients for Methadone Maintenance has to consider the following:

1. The patient must be at least 18 years old and identifiable as a hard-core Heroin addict beyond reasonable doubt. He must have a well-documented and established regular Heroin habit of at least one year's duration.

2. If the addict requesting maintenance is under 21 years of age, the parent's or guardian's agreement must be obtained. For details, see attached forms MM-1 and MM-2.

3. The addict requesting maintenance must be sincerely and maturely motivated for this form of treatment and must be aware of the limitations and obligations it will impose upon him. Young addicts who see Methadone as a magic solution or who simply want an easy way out, do not do well on Methadone Maintenance.

4. Great care has to be taken in including patients with multiple addiction patterns into maintenance programs. This is particularly true for those Heroin addicts whose history indicates that they are also alcoholics. These patients generally do not do well on Methadone Maintenance, and if placed on this form of treatment, show very frequently an increase in their alcoholism. They tend to get in considerable trouble in the community and Methadone Maintenance is often erroneously accused as the causing factor.

Similar considerations apply to addicts who habitually use barbiturates, cocaine, or other drugs together with Heroin. These patients must be distinguished from those addicts who use drugs other than Heroin only as a second choice, if and when Heroin is not available. These patients may do well on Methadone Maintenance.

5. Psychiatric evaluation is indicated to rule out individuals who show major psycho-pathology and whose condition would not enable them to conform with the requirements of a Methadone Maintenance Program or who cannot be expected to function in the community. Those patients should be first referred to a psychiatric facility on an In-Patient basis and may be placed on Methadone Maintenance after their psychiatric condition has been brought under satisfactory control. Patients with signs of major character disorders or neurotic problems requiring psychiatric Out-Patient treatment should be identified and receive such treatment in conjunction with their Methadone therapy.

6. Before a patient is placed on Methadone Maintenance, he must undergo careful physical examination, to include x-ray and laboratory studies. Special attention must be given to history or evidence of tuberculosis, venereal disease, cardiac conditions, hypertension, diabetes, liver disease, abscesses, etc. It must be left to the physician's judgment whether he wants to treat such a condition, e.g. venereal disease, together with maintenance induction, or whether correction of the physical condition should preceed induction. This, of course, would apply to any condition requiring hospitalization, such as tuberculosis. Experience has shown that stabilization of a diabetic condition ought to preceed Methadone induction, as it is extremely difficult to stabilize these patients while undergoing Methadone treatment. Acute or sub-acute liver disease with clinical symptoms ought also to be first controlled on an In-Patient basis, before the patient is placed on Methadone Maintenance.

Once a patient has been screened and selected for Methadone Maintenance, induction will be carried out as follows:

1. The patient will be requested to sign a statement on a State approved standard form, in which he pledges to cooperate fully with the conditions of induction. Specifically, he must:

a. Declare his willingness and ability to attend the Day Care Center of the Clinic during the hours from 8 a.m. to 4 p.m. for approximately 15 to 18 days needed for ambulatory induction.

b. Declare his willingness to deposit his Driver's License at the Clinic during the time of induction, and to absolutely abstain from driving during this time.

c. Promise not to use any drugs other than those prescribed and keep the Clinic informed concerning any medical treatment or drugs he may receive from other physicians during this time.

d. Promise to go directly home and stay home after Clinic hours and to spend as little time as possible away from home during his induction phase.

e. Promise not to use or work with any type of potentially dangerous machines, to include power tools during induction time.

f. Declare his willingness to give a daily urine specimen at the Clinic and that the discovery of use of drugs other than Methadone may lead to removal from the Program.

g. Declare his willingness to join an In-Patient treatment center, if and when this should become necessary in the judgment of the physician directing his ambulatory induction.

2. The following represents a recommended ambulatory induction schedule:

First Day:	10 mgm. @ 8 a.m.		5 mgm.	at closing time of Clinic*
Second Day:	10 mgm. @ 8 a.m.		10 mgm.	
Third Day:	15 mgm. @ 8 a.m.		10 mgm.	
Fourth Day:	20 mgm. @ 8 a.m.		10 mgm.	
Fifth Day:	35 mgm. @ 8 a.m.		5 mgm.	
Sixth Day:	40 mgm. @ 8 a.m.			
Seventh Day:	45 mgm. @ 8 a.m.			
Eighth Day:	50 mgm. @ 8 a.m.			
Ninth Day:	55 mgm. @ 8 a.m.			
Tenth Day:	60 mgm. @ 8 a.m.			
Eleventh Day:	65 mgm. @ 8 a.m.			
Twelfth Day:	70 mgm. @ 8 a.m.			
Thirteenth Day:	80 mgm. @ 8 a.m.	or	75 mgm. @ 8 a.m.	
Fourteenth Day:	90 mgm. @ 8 a.m.	or	80 mgm. @ 8 a.m.	
Fifteenth Day:	100 mgm. @ 8 a.m.	or	85 mgm. @ 8 a.m.	
Sixteenth Day:			90 mgm. @ 8 a.m.	
Seventeenth Day:			95 mgm. @ 8 a.m.	
Eighteenth Day:			100 mgm. @ 8 a.m.	

Further increases in steps of 5 mgm. daily may be made if:

1. The patient is not comfortable during the 24 hour interval between medication and develops definite and objectively observable withdrawal difficulties during the last part of this interval. This is not frequent, but happens in a number of patients. This is sometimes not well controlled by dose increases and might have to be handled by giving these patients medication in two divided doses.

2. Clinical observation and urine testing as well as the patient's own statements indicate insufficient Heroin blockade on that 100 mgm. dose of Methadone. One must be careful not to rely entirely on the patient's statements pertaining to this problem. Repeated Heroin positive urines are the best proof for such a condition, inasmuch as a patient with effective blockade generally does not repeat attempts to use Heroin after he has experienced its lack of effect due to Methadone blockade.

* Not to be given before 4 p.m.

One must be careful not to be persuaded to increase the daily Methadone dose because the patient expresses all types of vague complaints or misfeelings, which often represent only projections of non-related problems.

Careful observation is necessary to avoid producing a state of drowsiness or sedation caused by a dose too high for the individual and his inability to develop a corresponding tolerance. If drowsiness, sleepiness, nodding, or a state of sedation is observed and continues for more than two weeks following stabilization, a gradual decrease of Methadone by 5 mgm. steps daily is indicated. Care must be taken to leave a Methadone patient unaware of his maintenance dose and his questions to this effect should never be answered other than by generalities such as "you get the dose which is best for you." If decreases are made, the patient should not be informed and he often will not be aware of them, unless the dose gets too low and the above described signs and symptoms develop.

Deviations from this schedule might become necessary in response to the patients reactions, but it is expected to work well for most patients. We must warn against starting with Methadone doses higher than indicated on this schedule, even if the history of the addict seems to indicate recent, heavy Heroin use. Such information can never be considered as reliable because:

1. Patients are not necessarily truthful.

2. The Heroin content of a "bag," representing the black market unit of the drug, varies considerably.

For these reasons, the opiate tolerance of a patient at the onset of induction can never be safely assessed and difficulties are best avoided by starting on a low dose.

While 100 mgm. per day provides a satisfactory Heroin blockade for most patients, some require smaller amounts to avoid development of drowsiness and signs of sedation. However, there are very few patients who will require less than 70 mgm., and anything under 70 mgm. cannot be considered as having a Heroin blocking effect. On the other hand, there are certain patients who require doses above 100 mgm. daily and in whom smaller doses will either not produce a satisfactory blockade or lead to withdrawal difficulties toward the end of their 24 hour interval between medications.

It is important to realize that patients have a tendency to be manipulative concerning their drug dose, especially as far as requests for increase are concerned. They tend to interpret any difficulties of physical as well as emotional nature as a need for more medication. The physician is well advised to use sound judgment and not to give in to subjective and poorly based requests for an increase. Once a stabilizing dose has been reached, it should be changed as little as possible and only for valid reasons.

The following is a list of side reactions most frequently found during Methadone induction:

1. Constipation
2. Diaphoresis
3. General pruritus without visible skin changes
4. Over-sedation
5. Nausea
6. Dryness of the mouth
7. Headaches
8. Weight changes - most increases
9. Mood changes - instability, euphoria

These side reactions tend to increase in severity and frequency if completion of induction is attempted in less than 15 days.

Stabilization on Methadone Maintenance can be considered as successfully completed when the following goals have been met:

1. The patient experiences no major difficulties pertaining to his mood, wakefulness, and general alertness.

2. The patient's weight has been stabilized on a short term basis, indicating that no water retention is taking place.

3. The patient's vital signs are stable and within normal limits. This pertains particularly to blood pressure.

4. Appetite and sleep are normal.

5. Observation indicates stability of mood and there are no signs of being either "high" or sedated.

6. He shows no major side reactions. However, constipation, hyper-perspiration, and interference with sexual potency are frequently more stubborn and may persist for some time. Of the three, sexual disability represents often the most serious problem to the patients. If it tends to persist for more than two to three months following stabilization, some decrease in the maintenance dose is indicated and is frequently successful.

7. The patient's urine does not indicate use of other drugs.

. . . . . .

Methadone Maintenance as a medical procedure must be understood as a beginning only, from which a total rehabilitation plan has to evolve. Failure to achieve rehabilitation will at best lead to the picture of an addict who uses Methadone on a day to day basis to satisfy his drug hunger, without change of his life style, social or cultural orientation. His adjustments will remain anti-social and not infrequently he will engage in the sale of drugs. He will remain an unreliable patient at his Clinic, be frequently not on time, use constant excuses and be in permanent difficulties, necessitating eventually his elimination from the Program.

It is of utmost importance that rehabilitation is begun together with the institution of Methadone Maintenance, to include, depending on the case, job counseling, marriage counseling, and vocational rehabilitation or training. It might require working with the family and much general advice, support, and guidance. Experience has shown that those patients whose rehabilitation is not well under way after five months of Methadone Maintenance, generally do not respond well. After one year on maintenance, the patient should have re-oriented his social life away from the addict community and earn his living or be engaged in some useful and socially acceptable activities. He should show good and reliable adjustments at the Clinic with minimal or no indications of continuing drug abuse.

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ADDENDUM A

Equipment and Personnel Needs

1. Day Care Center Facilities. Facilities must consist of a room large enough to accommodate the projected number of induction patients and will have to be equipped and furnished to allow for their spending 7 or 8 hours daily at the Center. It should contain chairs, tables, television, radio, a small library, and perhaps a ping pong and/or pool table. If possible, there should be a small kitchen equipped with the necessary utensils to allow patients to prepare their lunch.

2. Physician's Examining Room. This has to be equipped with a desk and chair, a simple examining table, a medical scale, stethoscope, blood pressure apparatus, and other medical instruments which the physician may choose to use.

3. Nursing Station. This must be equipped with desk and chair, file cabinet, a safe for storage of Methadone stock solution, a refrigerator, various glassware and cups, as well as measuring devices adequate to measure out exact amounts of stock solution of Methadone in accordance with individual prescriptions.

The nursing station must further contain a medicine cabinet, which will contain a number of medicines frequently used in connection with Methadone induction, such as cathartics, calamine lotion, mild analgesics, etc. The nursing station must be equipped with stationery consisting of doctors order sheets, progress note sheets, folders, and a card file to allow for acceptable professional record keeping on each patient.

4. A simple urine processing laboratory, enabling the nurse to prepare urine specimens for mailing, must be established in a well-ventilated room. It must contain a glass-covered table, water supply, and allow for hanging up and air drying urine specimens on ion exchange paper.

5. The physician must be thoroughly acquainted with the concepts of Methadone Maintenance and able to visit the Clinic regularly and on a daily basis. He must be willing and able to be on call for problems or emergencies at any time.

6. Nursing Coverage seven days a week, preferably on a full-time basis on weekdays and at least a part-time basis of not less than 2 hours daily during Saturdays, Sundays, and Holidays. The nurse will be responsible for professional observation and supervision of patients and medical record keeping. In the absence of the nurse, another staff member must be in charge of observation and supervision of patients at all times during Clinic hours. This might be provided through a social worker or, in some instances, a carefully trained ex-addict. It will be his role to observe patients as to their adherence to the regulations pertaining to their induction as well as to their state of health. If any medical questions should arise, he must have immediate access to either the nurse or physician.

7. The Clinic must make arrangements for medical back-up services in case of emergencies, allowing for immediate transfer of a patient to In-Patient care, if this should become necessary. Provisions have to be made for the initial work-up of Methadone Maintenance patients, to include a careful physical examination, laboratory studies, x-ray studies and other studies, such as electro-cardiogram and electroencephalogram, as indicated in the judgment of the Clinic physician.

8. The Clinic will be requested to use and store standard forms devised by the Department of Health, representing agreements to be signed by each prospective Methadone patient. The Clinic will have the responsibility for safe-keeping patients Driver's Licenses during the induction period.

9. The Clinic will be responsible for providing each Methadone Maintenance patient at the beginning of his induction with an identification card sealed in cellophane, to contain his photograph, full name and address, and identifying him as a member of the State Methadone Maintenance Program. The card must contain the telephone number of the maintaining Clinic and affiliated hospital for use in emergencies.

ADDENDUM B

Ambulatory induction should be attempted only with patients without major psychological, psychiatric, or physical complications. If such complications exist, induction must be anticipated to be difficult and patients should be referred for In-Patient induction to the New Jersey Neuro-Psychiatric Institute.

The same applies to patients who develop unexpected difficulties while on ambulatory induction.

New Jersey State Department of Health
Division of Narcotic and Drug Abuse Control

Name of Facility_____ Date_____

AGREEMENT*

My full name is_____
(please print). I was born on_____
(Month) (Day) (Year)
and my present age is_____.

I request to be placed on Methadone Maintenance for the treatment of my addiction to Heroin.

This type of treatment has been explained to me in detail. I understand that Methadone Maintenance does not effect a cure, that Methadone itself is a narcotic, and in order to help me, must be taken under strict medical supervision. The Clinic, under medical supervision, will take full responsibility for providing me with the necessary daily maintenance dose and help me in any possible way with my efforts to rehabilitate myself and to resume my role in society.

I furthermore understand that this Treatment Program operates under certain rules and regulations, that strict compliance with these rules will be expected of me and that failure to adhere to these rules and regulations may lead to my removal from the Program.

Specifically, I promise:

A. To submit to and cooperate with a careful screening procedure, to include physical examination, x-ray studies, laboratory studies and such other diagnostic procedures as deemed necessary by the Clinic staff. Acceptance into the Program will depend on results of this screening.

B. If accepted for maintenance, I must first undergo a build-up or "loading" phase as long as deemed necessary,

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* In the case of a minor, written consent (parent, guardian, or next of kin) must be obtained on form MM-2.

but generally expected to last from 15 to 18 days.

During this time, I promise to adhere to the following conditions:

1. During the induction phase, I must enter the Clinic from 8 a.m. to 4 p.m. daily, to include Saturdays, Sundays, and Holidays. There can be no exceptions from this rule. During my daily stay at the facility I promise to be polite, cooperative, and to obey directions given to me by members of the Clinic staff.

2. I firmly promise to abstain from driving any type of motor vehicle during my induction and I will deposit my Driver's License at the facility for safe-keeping until completion of "loading." After conclusion of my induction, my Driver's License will be returned to me and I may resume driving.

3. During induction, I pledge to abstain from working with power tools or any other type of dangerous machines, and to avoid any type of activities where full alertness and wakefulness is necessary to prevent physical danger.

4. During induction, I promise to observe a voluntary curfew, returning home immediately after Clinic hours and staying home until the next morning. I understand that the Clinic may check up on my observing this rule.

5. I agree to give a daily urine specimen to the Clinic under strictly controlled conditions to be determined by the facility.

6. During induction and thereafter, I will carry an identification card, given to me by the Clinic, at all times. The card will identify me as a Methadone Maintenance patient in the State Program, thereby affording me protection pertaining to my use of this drug. It will also be important in medical emergencies and enable a hospital or physician to get important information pertaining to my maintenance schedule.

7. If, during the induction phase, major complications

arise which, in the opinion of the Clinic staff, require that the balance of my induction phase be conducted on an In-Patient basis, I agree to enter the New Jersey Neuro-Psychiatric Institute or some other In-Patient facility as determined by the Clinic, to complete induction.

After conclusion of my induction phase, I will be expected to lead a socially and legally acceptable life and to assume responsibilities in society. I understand that I will have to continue daily visits to the Clinic at a certain time to receive my medication and give a daily urine specimen. I will be expected to inform the Clinic about any medical problems and about any medication I might be taking, such as aspirin, headache pills, sleeping pills, etc.

I will make myself available to talk with the social worker or other Clinic personnel whenever this is deemed necessary and to cooperate with them.

I have read this agreement carefully, understand its content, and promise to adhere to it.

_____
(signature)

_____
(address)

_____

_____

_____
(telephone number)

_____
(witness*)

_____
(date)

* Witness must be a professional member of the Clinic staff.

New Jersey State Department of Health
Division of Narcotic and Drug Abuse Control

Name of Facility_____ Date_____

CONSENT OF PARENT OR GUARDIAN

I, _____ (please print full name), _____ years of age, hereby declare under oath that I am the _____ (parent, guardian, next of kin) of _____, who is _____ years of age and a minor, that I have carefully read and understand the agreement that _____ (full name) has signed in order to be placed on Methadone Maintenance for the treatment of his drug addiction and I am in agreement with his request. This consent can only be revoked in writing.

_____
(signature)

_____
(address)

_____

_____

_____
(telephone number)

_____
(witness*)

_____
(date)

* Witness must be a professional member of the Clinic staff.

MM 2
May 71

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END