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

STANDARDS FOR CERTIFICATION OF NARCOTIC AND DRUG ABUSE TREATMENT CENTERS

CRITERIA FOR CENTER CERTIFICATION

The certification process, as outlined in Section "C", "Procedures For Certification As A Narcotic and Drug Abuse Treatment Center", will include a thorough evaluation of the center's conformity with it's stated programs and objectives and it's compliance with the standards as outlined in this manual.

The State, in it's evaluation, will consider:

a. Applicability of Standards relating to the Center's programs, services, facilities and general administrative and treatment activities.

b. The degree to which each applicable standard, chapter or section thereof, is met.

c. When there is a deficiency in meeting minimum standards:

(1) whether the deficiency is one concerning the statutory requirements which must be met by all centers;

(2) whether the deficiency creates a hazard to health and safety;

(3) whether the center has the financial and administrative ability to correct the deficiency.

Questions relating to these standards or the administration of the certification process, including the inspection procedures, should be directed to the Division.

CHAPTER I - PHILOSOPHY AND DEFINITIONS

A. Philosophy

Narcotic addiction and drug abuse is a controversial field, wrought with conflicting views as to the extent of the problem, its etiology, treatment requirements, and almost any other aspect one might wish to isolate and discuss. There is, however, almost universal agreement that increased addiction to and abuse of narcotics and drugs requires the development and expansion of a full complement of treatment programs and services.

How such programs and services are to be individually realized and effectively administered to assure quality referral, treatment and re-entry processes, while safeguarding the health and emotional well-being of the patient, is the subject of this standards manual.

The newness of New Jersey's drug abuse treatment centers, and the continuing quest for effectiveness in treatment appear sufficient in themselves, however, to warrant standards which reject rigidity, and utopian concepts of patient care. Rather, such standards should, as are herein presented, serve as a reliable guide to and yardstick of those current accomplishments which warrant sanction as models or rules of thumb in the future development of, or current administration of, treatment programs.

B. Definitions

1. Narcotic and Drug Abuse Treatment Center

Any establishment, facility or institution, public or private, whether operated for profit or not, which primarily offers, or purports to offer, maintain, or operate facilities for the residential or outpatient diagnosis, care, treatment, or rehabilitation of two or more non-related individuals, who are clients as defined herein, excluding, however, any hospital or mental hospital otherwise licensed by Title 30 of the Revised Statutes.

2. Client

A patient or recipient of services of the center who is addicted to or otherwise suffering physically or mentally from the use, or abuse of narcotic and dangerous drugs and who requires continuing care of a Drug Abuse Treatment Center.

3. Residential Facility

Any drug abuse treatment center which includes as part of its treatment requirement, and/or process, that a patient physically reside on the premises.

4. The Division

The words "the division" shall indicate the Division of Narcotic and Drug Abuse Control.

5. Applicant

An applicant is any individual, partnership, corporation, or other entity, whether for profit or non-profit, who applies to the Division of Narcotic and Drug Abuse Control on prescribed application forms for the purpose of requesting Certification to operate a Narcotic and Drug Abuse Center.

6. Explanation of Words "Shall" and "Should"

a. Where the word "Shall" is used, it means compliance is mandatory.

b. Where the word "Should" is used, it means a suggestion or recommendation.

CHAPTER II - PHYSICAL FACILITIES

A. Building Structure and Inspection Requirements

1. General Requirements

A suitable structure is essential to safe and efficient operation of a drug treatment center. Care should be exercised in selecting a structure which is adaptable to the standards as outlined in this manual, including such considerations as follows:

a. The adequacy of space for program, administrative, medical, educational, and/or other center activities.

b. Suitability of electrical, plumbing, heating, and hot water accommodations; in consideration of the number of

sidents, and the intended provision of washing, cooking, undering and sanitary equipment.

c. Cleanliness and suitability of facilities for food eparation and storage, when applicable.

d. The extent of renovations necessary to provide lequate facilities which meet local ordinances, and andards as set forth in this manual.

Local Approvals

The center shall meet all local ordinances including ıilding, zoning, health and fire, and other regulations as ıtlined in this manual. Evidence of such compliance shall : kept on file, and may be established by letter (see sample tter under appendix E), certificate, or other written ɔcument.

In the absence of a Health Officer, Local Health epartment inspections and approvals shall be secured ırough the District State Health Officer or the State epartment of Health.

Fire Procedures, Protection Measures and Storage of lammables

In addition to compliance with local fire ordinance, the :nter shall meet the following minimum standards as set y the department:

a. *Fire Procedures*

A fire procedure shall be established indicating the :nter's fire detection system, fire alarm procedures, and /acuation routes. The fire procedure shall, furthermore, be nplemented through the conduct of fire drills, at least one :r month. A record of all fire drills shall be maintained for ıspection by the Division.

b. *Fire Protection Measures and Equipment*

The center shall, in addition to the establishment of a fire rocedure, maintain operable fire extinguishers, evacuation ɔute signs, fire escapes and other such detection, /acuation and fire fighting equipment as required under ıcal ordinances.

c. *Storage of Flammables*

Paints, varnishes, lacquers, thinners, cleaning fluids, and ther flammable materials and liquids should preferably be ored outside of the building, or otherwise within closed ıetal cabinets or other fire resistant facilities. The storage f combustible materials shall not be permitted within eater rooms or within twenty feet of any heater or open ame.

Space, Facilities, and Accommodations

a. *Administration*

The applicant shall provide space for administrative ctivities, including provisions for the storage and safe-uarding of personnel, administrative and client records nd materials.

b. *Medical Facilities*

Centers providing for examination and/or other medical rocedures shall designate a specific area for this purpose, nd shall follow standard medical procedure, as followed y approved hospital facilities.

c. *Sanitary Facilities*

Bath and toilet facilities shall be kept clean, ventilated nd in operating condition. Toilet and bath facilities shall ırthermore be available in the following minimum ratios r in accordance with local ordinances whichever is more :ringent: Toilets, wash basins, bath-tubs or showers — one ach to fifteen persons.

d. *Kitchen Facilities and Dining Area*

(See Chapter III, Sections B1 and 2 for Food Preparation, Handling and Nutrition)

(1) Cooking, and/or preparation of hot meals, shall be restricted to kitchen areas, which shall furthermore, be adequately cleaned and maintained in strictest sanitary condition.

(2) Precautions shall be taken to assure safe operating condition of all kitchen equipment. Installation of exhaust ducts, exhaust fans electrical, gas, or other accommodations or equipment shall be in accordance with local ordinances.

(3) It is recommended that dining areas be appropriately furnished and maintained separate from kitchen facilities.

e. *Communal Facilities*

(1) All space provided for recreation, visiting, educational, and group therapeutic or other activities, shall be well lighted and ventilated, and suitable for intended usage. Considering the diverse age and interests of clients of both residential and out-patient or day centers, it is recommended that two or more rooms be available for simultaneous use in group activities.

(2) All facilities used for vocational, educational, or other training or therapeutic purposes, shall meet the requirements of the appropriate state or local regulating agency.

f. *Sleeping Accommodations*

The following standards apply to residential centers and others providing over-night accommodations. Such facilities shall provide:

(1) Adequate and clean sleeping accommodations.

(2) Adequate storage for personal belongings and clothing.

(3) Centers shall assure that consideration of usable bed space includes provisions for adequate and safe passage between beds, and appropriate ventilation. A minimum of 50 square feet of floor space per bed is recommended.

g. *Laundry Facilities*

(1) Residential centers shall make provisions for the laundering and regular maintenance and repair of resident's clothing.

(2) Any center which installs laundering, dry-cleaning, or clothes drying equipment, shall assure appropriate inspection and compliance with local ordinances. Furthermore, appropriate measures shall be taken to insure proper ventilation and protection against misuse.

h. *Basements*

(1) Basement space shall not be utilized as living space, except by approval of the Division.

(2) Basements shall be kept dry and free of clutter, and shall further be periodically inspected for fire hazards and freedom from insects and rodents.

i. *Study Area*

All centers providing education and/or work study programs shall provide well-lighted ventilated space for study purposes, including table space and chairs.

j. *Grounds*

Yard space and/or grounds surrounding the property shall be maintained free of debris and other hazards.

k. *Stairways, Halls and Exits*

Easy access must be maintained throughout the building. Stairways, hallways, and exits shall be kept free and clear

of obstructions at all times. A fire escape, when required by ordinances, shall be constructed in conformity with local fire standards.

l. *Laboratory Facilities*

Laboratory facilities shall be operated only under professional supervision, as required by law.

m. *Other Facilities*

The applicant shall keep the Division informed of the utilization of all sections and space identified as being owned, operated, or under the direction, control or supervision of the center. No section or space so identified may be used for the purpose of an illegal act, or for the sale, or manufacture of any item, without the written approval of the Division.

CHAPTER III - PHYSICAL AND MEDICAL WELL-BEING

A. Sanitary, Health and Special Medical Requirements

1. General Requirements

For purposes of this Act, this Section shall include but not be limited to all aspects of accident prevention, housekeeping, sanitation and the general physical and mental well-being of the client as defined under law. It is expected that a common sense attitude will be taken by the applicant in matters pertaining to the clients general well-being and appropriate precautionary measures instituted.

2. General Housekeeping and Sanitation

The applicant shall assure that all sections and passageways within the facility are kept in a clean and orderly condition, and free from obstructions.

a. An adequate and continuous supply of hot water shall be available for bathing, dishwashing, laundering and general cleaning, etc.

b. Provision shall be taken to guard against infestation by insects and vermin including periodic inspection and extermination. Screening should also be utilized during summer months, to assure maximum heat reduction and ventilation.

c. The center shall provide for trash and garbage disposal, including provisions for storage in enclosed containers until removal.

3. Personal Care Services

a. Residential centers shall provide each resident, or make available to him, such articles of personal hygiene as soap, toothbrush and toothpaste, comb and/or hairbrush, shaving equipment, and towels and washcloths. Female patients shall be provided sanitary napkins, and/or other items of personal hygiene as required.

b. Residential centers shall arrange for or provide all necessary articles of clothing and bedding, including provisions for their cleaning, repair, and/or replacement.

4. Health Supervision

Centers shall place responsibility for the provision of health services under the supervision of a licensed physician, who, in addition to the establishment and supervision of the center's medical policies shall:

a. Institute procedures for the control and treatment of communicable diseases, including, but not limited to hepatitis, tuberculosis, and venereal disease.

b. Encourage personal hygiene

c. Assure maintenance of personal health records, and inventories of all medical equipment, supplies, medicines, and medical paraphenalia.

5. Special Requirements

a. *Evaluation and Control of Regression to Drug Use*

The center shall establish and implement policies for the evaluation of clients or staff suspected of regression to drug usage which may include periodic urinalysis. These policies shall also include follow-up procedures for dealing with persons found to be using narcotics or other dangerous substances.

b. *Methadone Detoxification, Induction and Maintenance*

As an experimental drug, the use of methadone in the treatment of addicts is subject to federal rules and regulations as issued, and, standards and guidelines as established by the Division. (See Appendices A through C). Applicant operating or desiring to operate a methadone program shall notify the Division's Medical Director and shall conform to the standards of methadone detoxification, induction and maintenance as established by the Division.

c. *Control and Storage of Drugs and Other Medical Paraphenalia*

(1) The center shall abide by all state and federal laws and regulations pertaining to the storage, maintenance, or inventories of drugs or other medical paraphenalia. Furthermore, individual prescriptions must be kept locked in appropriate storage facilities and dispensed only under the supervision of a licensed physician.

(2) The center shall, furthermore, provide for the control and supervision of Controlled Dangerous Substances (CDS) entering the center through either illicit or legitimate means.

6. Medical or Psychiatric Procedural Changes

The Division may require any changes, alterations, additions or deletions of medical or psychiatric procedures which do not conform to generally accepted medical practice.

B. Food Preparation and Handling

1. Food Preparation

Since good food served in pleasant surroundings contribute substantially to both health and welfare of patients, when provided by the center, a sound plan of food service should be established and followed in accordance with the following standards:

a. Menus should be planned and written at least one week in advance to assure well-balanced appetizing and varied diet sufficient to meet nutritional needs.

b. Special diets shall be provided on physicians order, otherwise, in accordance with approved standard of food and nutrition as herein outlined. (See Appendix F)

c. Only pasteurized milk and U.S. government inspected meats shall be served.

d. There shall be adequate provision for proper refrigeration of food items. Furthermore, all spoiled, molded, or contaminated foods will be immediately removed.

e. Residential centers shall assure residents of three well-balanced meals per day served on a regular schedule. One of the three meals shall consist of at least one hot dish item.

f. A record of specific meals, as served, will be kept for a period of not less than 30 days.

g. Adequate dishes, utensils and condiments shall be provided.

h. Food preparation equipment, such as canopeners,

slicers, grinders, mixing machines, and similar equipment, shall be maintained in a sanitary condition.

2. Food Handling

A person shall be clearly designated to supervise and be responsible for all food handling. Contact shall further be made with the local and/or State Health Department to determine the availability of food handling courses and to determine proper food handling practices.

C. Control of Deviant and/or Criminal Behavior

1. General Requirement

The center shall make every endeavor to assure that no client is exposed to, or instigates such behavior as might be physically, emotionally or morally injurous to himself or to another person directly or indirectly related to the program.

Any incident resulting in serious injury or death shall be investigated by the director of the center, appropriately reported to local authorities, and immediately reported to the division. A written report of the incident shall be made and kept on file at the center and made available for review by authorized personnel.

CHAPTER IV-PERSONNEL PRACTICES

A. Staff Development and Personnel Policies

1. All staff positions shall be identified as to Title, function, authority and responsibility, minimal educational and/or experience requirements, and salary ranges. Such identification shall be in writing, and made available to the staff person employed within the position.

2. All full and part-time staff shall be apprised of all personnel policies, standards, and procedures, including hours of work, fringe benefits such as holidays, accrual of sick leave, promotional opportunities, etc., and center's grievance procedures.

3. Rules should be established covering staff-to-clients, staff-to-staff, and staff-to-community relationships.

4. There shall be no barrier to the hiring or up-grading of ex-addict, or other para-professional staff, provided such persons remain drug free, and are, by nature of their rehabilitation process and/or training, suitable for the position assigned.

5. The center shall provide structrued in-service training programs on a regularly scheduled basis. A record of all such training sessions shall be kept, including notation of date held, topic presented or discussed, number and position of persons in attendance, and the position or credentials or the persons leading the session.

6. When feasible, the center shall also encourage staff members attendance at seminars, institutes and other outside educational programs.

B. Use of Vendor Services

To insure quality services, and that fees are commensurate with responsibilities, centers contracting for outside lay, para-professional, or professional consulting or vendor services, including services of part-time physicians, social workers, educators, therapists, etc., must have on file a written agreement. It should include the number of hours per week of consultation, the agreed rate for services rendered including transportation expenses and all other miscellaneous expenditures and a description of consultation or vendor services to be rendered. The center should verify credentials, and/or other qualifications to assure that they are as stated. This is not intended to restrict the employment or use of ex-addicts or other community personnel.

C. Volunteers

The donation of services by lay or professionally trained persons, while encouraged, should be undertaken with care. The following minimal requirements have been established:

1. An application form must be on file including evidence of verifications of credentials, educational background, and/or work experience.

2. Volunteers, including ex-addicts and other lay and professional persons, should be included in regularly scheduled in-service training programs and career development programs, as feasible.

CHAPTER V - PROGRAMS AND SERVICES

A. General Requirement

All individual programs and services of the center shall be individually identified in writing, including a description of the program, admission requirements, statement of objectives, methodology of delivery, personnel requirements, and procedure for evaluation of program effectiveness.

On-going programs are expected to demonstrate the treatment philosophy of the center. It should be anticipated by the applicant that assumptions may be drawn about the center's effectiveness in relationship to one or more of the following areas:

1. The provision of a positive experience leading to the development of positive client attitudes.

2. The curbing of drug abuse on criminality as reflected by client participation in productive activities.

3. Provision by the center of ancilliary services including family counseling, prevention programs, etc.

4. The utilization by the center of all existing professional and community services.

5. The center's maintenance of a positive community relationship.

6. The center's on-going relationship with recipients of services including graduates and splitees.

B. Client Participation in Program Planning

1. The center shall provide clients the opportunity to express opinions regarding programs, staff and the methodology by which individual programs are offered.

2. In addition, the schedule of on-going programs shall reflect the center's concern for client's needs for educational, work, recreational activities, rest periods, meal-time, and socialization periods, and therapeutic experiences.

3. Clients shall be free to register grievances, make general comment, or offer suggestions about existing programs, with representatives of the Department of Health and other officials, without fear of reprisal, punishment, and/or dismissal from the center.

4. A center desiring to utilize any client for purposes of experimentation, demonstration or example or for the use of any drug, device, or procedure outside of those described in these standards, shall submit a written proposal for review by the Division prior to implementation. Such

written proposal shall include the voluntary written consent of the client or clients to be utilized.

C. Client Evaluation

The center shall make specific provisions for the evaluation of individual client's ability to relate to and utilize the regimen, programs and services. In addition, the following shall be made common knowledge:

1. How decisions are made by the center with respect to the individual client's progress, assignment to work and/or other activities, or his involvement within any specific program and/or service.

2. The center's rules or guidelines in determination of the client's relationship with the outside community, and/or family, including telephone, letter, and visiting privileges.

CHAPTER VI - RECORDKEEPING AND ACCOUNTABILITY

A. General Requirement

The maintenance of appropriate patient, fiscal, statistical, medical, and other records as required by this standards manual is viewed as a vital function of the Center. To meet this general requirement the center shall designate responsibility for all record keeping and reporting activities, to a responsible person.

B. Registry Reports

All persons that the center determines to be drug abusers shall be reported to the Controlled Dangerous Substance Registry on the confidential form entitled "Treatment Facility Report of Controlled Dangerous Substance (CDS) Abusers" (see appendix "D") and on such other forms as may be required by the Division.

C. Client Records

Client records and such other forms as required by the Division shall be kept on all clients enrolled in one or more of the center's programs, since the inception of these standards and maintained for five years, regardless of current status of the client. Such records shall contain the following:

1. Admission Records

(1) Application materials; (2) completed face sheet, including name, address, date of birth, name and address of nearest relative; (3) medical examination forms and laboratory and TB reports; (4) social and family history, including history of drug abuse and/or drugs used; (5) any reports of prior medical, psychological, or psychiatric treatment; (6) other information the center requires to make appropriate determination of suitability for admission.

2. On-going Client Activity Reports

Results of urine monitoring; reports of medical treatment and services; report of client's level of activity, and progress with appropriate recommendations for future treatment; training; medical; dental and other follow-ups.

3. Discharge and/or Follow-up

Terms of discharge; to whom discharged (self or other agency, service, etc.); reference to educational and/or work status; and recommendations for follow-up and/or future contacts should client have left program against advice shall be recorded.

It should be possible to determine from a review of the client's records what the person got from the program and over what period of time, and how well he did.

4. Unusual Incident Reports

Reports should be maintained of all unusual incidents such as accidents, injuries, attempted suicides, etc., including the date(s), witnesses to the incident, and as full a statement as possible relating specific information as to how the incident occurred and what specifically happened; and follow-up.

5. Transference of Records

The center shall have an established policy regarding the transference of treatment records or the sharing of treatment information should any client transfer or become a future client transfer or become a future client of another center, institution and/or treatment facility. Such policy shall include necessary provisions to assure the confidential nature of client records.

6. All records, reports, or other documents relating to any client shall be handled in strictest confidence. This standard shall not, however, exclude the sharing of vital treatment information, or other materials, records, etc., which may through withholding, jeopardize the client's health or well-being.

D. Center Activity Reports and Schedule of Events

The center shall maintain an on-going record of activities and events including speaking engagements, meetings, and daily activities. A daily schedule of events shall be posted in a conspicuous place.

E. Evaluation Procedures

In conjunction with the Division, the center shall implement a system of evaluating its programs and services, and to make such facts, statistics, and results of such evaluation available to the Division.

F. Financial Accountability

The center shall develop, and shall assign a person to administer the following fiscal policies and procedures:

(1) The recording, handling, and disposition of all incoming monies, donations, etc., including the granting of receipts. (2) The budgeting and allocation of funds, including maintenance of appropriate ledgers and securement of receipted bills for cash payments or expenditures. (3) The annual reporting of all assets liabilities, accounts receivable, payable, etc.

The division shall have the right to review and examine the fiscal records of any center, and may require, as a matter of routine, that annual reporting be submitted on State forms.

G. Fund Raising Procedures

The center shall maintain current records of all gifts, grants and donations of money, supplies, equipment, negotiable instruments, etc. Receipts should be issued as a matter of policy.

Furthermore, the center shall review and conform to all tax rules and regulations pertaining to fund raising activities, including applications for tax exempt status.

H. Application for Grants or Financial Assistance

A copy of each application for federal, state, county, municipal, and private funding shall be concurrently submitted to the Division for review.

JAMES R. COWAN, M.D.
STATE COMMISSIONER OF HEALTH

APPENDIX A

State of New Jersey

DEPARTMENT OF HEALTH

JOHN FITCH PLAZA, P.O. BOX 1540, TRENTON, N. J. 08625

November, 1970

TO: All Physicians

SUBJECT: Methadone

A serious increase in trafficking in methadone has prompted this Department to submit the following comments and recommendations for your consideration. We believe they will be of assistance to practitioners and aid in averting diversion of the drug into illicit channels.

It is urged, with no intention of restricting the practice of medicine, that practitioners avoid over-prescribing. Methadone is a narcotic. As such, its prescription for analgesia or as an antitussive agent should be strictly limited in keeping with good medical practice. When possible, non-narcotic drugs should be prescribed.

Methadone is often over-prescribed in the detoxification of opiate addicts. While it is recognized that dosage must be patient related, the serious dangers of methadone overdosage cannot be too strongly stressed. For that reason, the following detoxification schedule, which has proven highly effective in detoxifying over 90 percent of all opiate addicts treated, is strongly recommended.

Urine monitoring is required to indicate possible concomitant use of other drugs which can lead to dangerous cumulation. Consequently, the practitioner should have available clinical laboratory services to provide urine monitoring. Medication should be limited to the use of oral dosage forms, and should be administered in the presence of the practitioner, as follows:

FIRST DAY:	25 milligrams of methadone are given in divided doses, the first consisting of 15 mgms. The second dose of 10 mgms. is given 8 to 12 hours later.
SECOND DAY:	The same dosage is given as on the first day.
THIRD DAY:	Two doses of 10 mgms. each are given. The first is given in the morning, the second 8 to 12 hours later. Urine monitoring should be conducted on this and following days.
FOURTH DAY:	A single dose of 10 mgms. is administered.
FIFTH DAY:	A single dose of 5 mgms. is administered.
SUBSEQUENT DAYS:	If additional daily doses are required, 5 mgms. may be given in the practitioner's presence. The detoxification period should not exceed 10 days of therapy nor a total dosage of 110 mgms. in that period.

Methadone is still classed as an experimental drug when it is used in the maintenance of narcotic addicts. It may be used legally only by investigators who have an effective Investigational New Drug Application granted by the Federal Food and Drug Administration. Its use in this area is subject to federal rules and regulations as issued, and guidelines or rules which may be established by the State of New Jersey. Only hard core addicts who have been addicted for at least one year should be considered eligible for maintenance.

In order to avoid iatrogenic addiction, it is imperative before selecting a patient for treatment to determine unequivocally that he is indeed a helpless addict. For the youngster who merely experiments with drugs or may be only acutely intoxicated, other forms of treatment are required.

All addicts do not respond adequately to methadone maintenance. The rate of failure is lowest among those addicts who show sincere motivation to free themselves from their addiction, and those who believe that methadone represents a real solution to their problems.

Phase I (induction or buildup stage) preparatory to methadone maintenance, which takes approximately three to six weeks, should be indivdualized and it is strongly emphasized that induction should be conducted only in an inpatient facility. After the patient is balanced and a maintenance dosage is established, the schedule should never be altered without difinite medical indications.

After the patient has completed Phase I and before he leaves the treatment center, he should be given a tamperproof identification card to be kept on his person at all times in case of accidents or emergencies.

The patient may be returned to the referring physician who should require the addict to appear daily at a fixed time and place, seven days a week. On his arrival, the patient should present his identification card, which should be checked because identification cards are being loaned to friends or sold. The patient should provide a urine sample, each day, and at least two of those should be analyzed each week. The patient should not be apprised of which and how many urine samples are being analyzed. The drug may then be given, but it must be given by a professional person allowed by law to administer narcotic drugs, i.e., a physician, pharmacist, or registered nurse.

When an addict moves to a distant community or another state, he should be provided with the address of an authorized agency or physician who is prepared to continue his treatment. Under no circumstances should an addict be given a supply of methadone. Too frequently, supplies are abused or sold.

A complete record of each visit must be made and kept on file for at least two years. Records and supplies of the drug must be safeguarded and ready for examination by authorized agents.

The physician in charge of the patient's maintenance should make every effort to recover the identification card of any addict who discontinues maintenance therapy. The names of patients whose maintenance is discontinued should be forwarded to the State Department of Health.

The help of the medical profession is required to prevent abuse of methadone, a potentially dangerous drug. The State Department of Health, Division of Narcotic and Drug Abuse Control (609-292-3395 or 609-292-5760) will be glad to extend medical and legal consultation to interested physicians.

Sincerely,

James R. Cowan

James R. Cowan, M.D.
State Commissioner of Health

Information Copies:
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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.

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[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.

HWF:jmb
2/19/71

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-4
May 71

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

APPENDIX C

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

FOOD AND FOOD SERVICE

I. DIET AND MENU

The resident center should provide a nutritionally adequate diet that is of good quality food, correctly prepared, attractively served, in sufficient quantity, and in a form and texture that will meet the minimum nutritional needs of the residents.

A. The daily diet for each resident should include the minimum servings from each of the following food groups:

("Food for Fitness - A Daily Food Guide," U. S. Department of Agriculture, Leaflet No. 424, available from Superintendent of Documents, U. S. Government Printing Office, Washington, D. C., is recommended as an additional guide in meal planning.)

Milk

Teenagers - 16-18 years - 4 or more cups or equivalent daily;

Adults - 22-35 years - 2 or more cups or equivalent daily.

Milk may be fresh fluid-whole or skim; evaporated, dry, or buttermilk and may be used as a beverage or in cooking.

One ounce of hard cheese is equivalent in calcium to 2/3 cup of milk.

Meat, Poultry, Fish and Eggs

5-6 ounces or its equivalent daily at two or more servings.

Vegetables and Fruit

Four or more servings daily.

One serving of a citrus fruit or juice daily or a satisfactory Vitamin C substitute in proper quantities.

Three or more servings in proper quantities of other vegetables and fruits, including potatoes. This shall include some raw fruit and vegetables.

A serving of a dark green or deep yellow vegetable or a satisfactory Vitamin A substitute in proper quantities shall be served at least every other day.

Bread and Cereals

Four or more servings daily.

Count as one serving: 1 slice bread, 1 ounce of ready to eat cereal; 1/2 - 3/4 cup cooked cereal, corn meal grits, macaroni, noodles, rice or spaghetti.

Other Foods

As needed to complete meals and to provide additional food energy and other food values shall be served, including some butter or fortified margarine at each meal.

B. All modifications of the diet shall be in writing by the attending physician.

DSR-3
MAR-71

NEW JERSEY STATE DEPARTMENT OF HEALTH
DIVISION OF NARCOTIC AND DRUG ABUSE CONTROL

TREATMENT FACILITY REPORT OF CONTROLLED DANGEROUS SUBSTANCE (CDS) ABUSER

For Registry Use

PLEASE PRINT OR TYPE — SEE REVERSE SIDE FOR INSTRUCTIONS

APPENDIX D

1. LAST NAME | 2. FIRST | 3. MIDDLE

4. PRESENT ADDRESS — STREET | CITY | COUNTY | STATE

5. DATE OF BIRTH — MO ☐☐ DAY ☐☐ YR. ☐☐

6. PLACE OF BIRTH

7. SOCIAL SECURITY NO ☐☐☐ ☐☐ ☐☐☐☐ NONE ☐

8. SEX — 1 ☐ MALE 2 ☐ FEMALE

9. RACE — 1 ☐ WHITE 2 ☐ BLACK 3 ☐ PUERTO RICAN 4 ☐ OTHER

10. MAIDEN NAME

11. DRUG OR CDS OF PRINCIPAL ABUSE — NO PRINCIPAL DRUG OR CDS ☐ — UNKNOWN ☐ — DATE STARTED USING MO. ☐☐ YR. ☐☐

12. EMPLOYMENT

	TIME FULL	TIME PART
1 ☐ PERMANENT	☐	☐
1 ☐ TEMPORARY	☐	☐
2 ☐ UNEMPLOYED	☐	☐
3 ☐ ENROLLED STUDENT	☐	☐
4 ☐ UNKNOWN	☐	☐

12A. EDUCATION - HIGHEST GRADE COMPLETED ☐☐

13. CDS OF 1ST ABUSE

13A. DATE OF 1ST ABUSE — MO. ☐☐ YR. ☐☐

14. RELIGION
- 1 ☐ CATHOLIC
- 2 ☐ PROTESTANT
- 3 ☐ JEWISH
- 4 ☐ OTHER
- 5 ☐ NONE
- 6 ☐ UNKNOWN

15. TREATMENT

	PRIOR NO. OF TIMES IN PATIENT	PRIOR NO. OF TIMES OUT PATIENT
PHYCHIATRIC	____	____
CHEMO-THERAPY	____	____
THERAPEUTIC COMMUNITY	____	____
DETOXICATION ONLY	____	____
OTHER (SPECIFY ____)	____	____
NONE	☐	
UNKNOWN	☐	

15A. PLANNED AT THIS FACILITY.

	IN PATIENT	OUT PATIENT
PHYCHIATRIC	1 ☐	2 ☐
CHEMO-THERAPY	1 ☐	2 ☐
THERAPEUTIC COMMUNITY	1 ☐	2 ☐
DETOXICATION ONLY	1 ☐	2 ☐
OTHER (SPECIFY ____)	1 ☐	2 ☐

16. OTHER PRESENT MEDICAL CONDITIONS.
- ☐ HEPATITIS
- ☐ T B
- ☐ V D
- ☐ OTHER INFECTION
- ☐ OBSTETRICAL PROBLEMS
- ☐ COMPLICATING PSYCHIATRIC
- ☐ NUTRITIONAL PROBLEMS
- ☐ UNKNOWN
- ☐ OTHER (SPECIFY)

17. LIVING WITH
- 1 ☐ PARENTS OR OTHER RELATIVES
- 2 ☐ SPOUSE
- 3 ☐ PARENTS OR OTHER RELATIVES AND SPOUSE
- 4 ☐ FRIENDS
- 5 ☐ ALONE
- 6 ☐ UNKNOWN

18. CURRENT LEGAL INVOLVEMENT
- 1 ☐ NON-PUNITIVE CUSTODY (CIVIL COMMITMENT, MENTAL HEALTH, ETC.)
- 2 ☐ PUNITIVE CUSTODY (JAIL, REFORMATORY, ETC.)
- 3 ☐ NONE
- 4 ☐ UNKNOWN
- ☐ CHARGES PENDING
- ☐ PAROLE
- ☐ PROBATION

19. PRIOR LEGAL INVOLVEMENT

ARRESTED FOR CDS OFFENSE

1. ☐ YES 2. ☐ NO 3. ☐ UNKNOWN

19A.

ARRESTED FOR OTHER OFFENSE

1. ☐ YES 2. ☐ NO 3. ☐ UNKNOWN

20. FOR HOSPITAL EMERGENCY ROOM ONLY

REASON	RESULTS
☐ OVERDOSE	1 ☐ DIED
☐ BAD TRIP	2 ☐ RELEASED
☐ ACCIDENT	3 ☐ DISCHARGED AGAINST ADVICE
☐ OTHER MEDICAL	4 ☐ ADMITTED TO HOSPITAL
☐ WITHDRAWAL	5 ☐ REFERRED TO DRUG TREATMENT FACILITY
☐ UNKNOWN	6 ☐ REFERRED TO PRIVATE PHYSICIAN

21. SOCIO-ECONOMIC STATUS OF FAMILY

A. AREA RAISED	B. ECONOMIC LEVEL OF FAMILY	C. HIGHEST EDUCATIONAL LEVEL OF FAMILY (PARENT FIGURE)
1 ☐ RURAL	1 ☐ POOR	1 ☐ GRAMMAR
2 ☐ SUBURBAN	2 ☐ BELOW AVERAGE	2 ☐ HIGH SCHOOL
3 ☐ URBAN	3 ☐ AVERAGE	3 ☐ COLLEGE
4 ☐ UNKNOWN	4 ☐ ABOVE AVERAGE	4 ☐ GRADUATE
	5 ☐ UNKNOWN	5 ☐ UNKNOWN

REPORTED BY: NAME AND TITLE (IN HOSPITALS AND INSTITUTIONS ONLY PHYSICIANS REPORT)

22. DATE OF REPORT

ADDRESS OF PRACTITIONER OR NAME OF INSTITUTION:

SIGNATURE

FOR REGISTRY USE ONLY ☐ Y ☐ N

M7414

INSTRUCTIONS:

1. Print or type all entries.
2. "CDS" means "Controlled Dangerous Substance".
3. Complete all boxes: if unknown, none, or not applicable, check or write appropriate term in box and mail to CDS Registry, P.O. Box 180, Trenton, N.J. 08608.
4. Item 4. Use principal address, or address at which individual can be reached.
5. Item 5. Date of Birth: Give numerical designation of month, day and year; i.e., June 14, 1969 is 06-14-69.
6. Item 12A. Do not include GED Tests.
7. Items 15, 16, and 18. Check all applicable boxes.
8. Item 20. To be completed by hospital emergency rooms only.
9. Signature block - For Hospitals and Institutions: Doctor or physician should sign and submit report.
10. Additional forms can be obtained from CDS Registry, P.O. Box 180, Trenton, New Jersey 08608.

Chapter 227, P.L. 1970 (N.J.S.A. 26:2G 17 et seq) requires the collection of appropriate data from various practitioners and others with respect to the use and abuse of controlled dangerous substances for the purpose of establishing and maintaining a <u>confidential</u> Controlled Dangerous Substance Registry. Report, when completed, will be <u>confidential</u> and will not be admissible in any criminal proceedings.