

CHAPTER 63

CERTIFICATION AS A NARCOTIC AND DRUG
ABUSE TREATMENT CENTER

Authority

Unless otherwise expressly noted, all provisions of this Chapter 63 were adopted by the Division of Narcotics and Drug Abuse Control pursuant to authority delegated at N.J.S.A. 26:2G-25 and were filed and became effective November 15, 1971, as R.1971 d.205. See: 3 N.J.R. 202(a), 3 N.J.R. 256(c).

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SUBCHAPTER 1. PHILOSOPHY AND
DEFINITIONS

8:63-1.1 Philosophy

(a) 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.

(b) How such programs and services are to be individually realized and effectively administered to assure quality referral, treatment and re-entry processes, while safe-guarding the health and emotional well-being of the patient, is the subject of this Chapter.

(c) 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.

8:63-1.2 Definitions

The following words and terms, when used in this Chapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Applicant" means any individual, partnership, corporation, or other entity, whether for profit or nonprofit, 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.

"Client" means 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.

"Division" means the Division of Narcotic and Drug Abuse Control.

"Narcotic and drug abuse treatment center" means 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 nonrelated individuals, who are clients as defined herein, excluding, however, any hospital or mental hospital otherwise licensed by Title 30 of the Revised Statutes.

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

"Shall" means compliance is mandatory.

"Should" means compliance is suggested or recommended.

SUBCHAPTER 2. BUILDING STRUCTURE AND INSPECTION REQUIREMENTS

8:63-2.1 General requirements

(a) A suitable structure is essential to safe and efficient operation of a drug treatment center.

(b) Care should be exercised in selecting a structure which is adaptable to the standards as outlined in this Chapter, including such considerations as follows:

1. The adequacy of space for program, administrative, medical, educational and/or other center activities.
2. Suitability of electrical, plumbing, heating and hot water accommodations; in consideration of the number of residents, and the intended provision of washing, cooking, laundering and sanitary equipment.
3. Cleanliness and suitability of facilities for food preparation and storage, when applicable.
4. The extent of renovations necessary to provide adequate facilities which meet local ordinances, and standards as set forth in this Chapter.

8:63-2.2 Local approvals

(a) The center shall meet all local ordinances including building, zoning, health and fire, and other regulations as outlined in this Chapter. Evidence of such compliance shall be kept on file, and may be established by letter (see sample letter under Appendix E), certificate, or other written document.

(b) In the absence of a health officer, Local Health Department inspections and approvals shall be secured through the District State Health Officer or the State Department of Health.

8:63-2.3 Fire procedures, protection measures and storage of flammables

(a) In addition to compliance with local fire ordinance, the center shall meet the following minimum standards as set by the Department:

1. A fire procedure shall be established indicating the center's fire detection system, fire alarm procedures, and evacuation routes. The fire procedure shall, furthermore, be implemented through the conduct of fire drills, at least one per month. A record of all fire drills shall be maintained for inspection by the Division.
2. The center shall, in addition to the establishment of a fire procedure, maintain operable fire extinguishers, evacuation route signs, fire escapes and other such detection, evacuation and fire fighting equipment as required under local ordinances.
3. Paints, varnishes, lacquers, thinners, cleaning fluids and other flammable materials and liquids should preferably be stored outside of the building, or otherwise within closed metal cabinets or other fire resistant facilities. The storage of combustible materials shall not be permitted within heater rooms or within twenty feet of any heater or open flame.

8:63-2.4 Space, facilities and accommodations

(a) The applicant shall provide space for administrative activities, including provisions for the storage and safeguarding of personnel, administrative and client records and materials.

(b) Centers providing for examination and/or other medical procedures shall designate a specific area for this purpose, and shall follow standard medical procedure, as followed by approved hospital facilities.

(c) Bath and toilet facilities shall be:

1. Kept clean, ventilated and in operating condition;
2. Available in accordance with whichever is more stringent of the following:
 - i. Local ordinances;
 - ii. Minimum ratios of one each per 15 persons for toilets, wash basins and bathtubs or showers.

(d) Food preparation and handling (see also Sections 3.7 (Food preparation) and 3.8 (Food handling) of this Chapter):

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) 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 outpatient or day centers, it is recommended that two or more rooms be available for simultaneous use in group activities. 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) The following standards apply to residential centers and others providing overnight 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) Residential centers shall make provisions for the laundering and regular maintenance and repair of resident's clothing. 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) Basement space shall not be utilized as living space, except by approval of the Division. 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) All centers providing education and/or work study programs shall provide well-lighted ventilated space for study purposes, including table space and chairs.

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

(k) 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 shall be operated only under professional supervision, as required by law.

(m) 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.

SUBCHAPTER 3. PHYSICAL AND MENTAL WELL-BEING

8:63-3.1 General requirements

(a) For purposes of this Act, this Subchapter 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.

(b) 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.

8:63-3.2 General housekeeping and sanitation

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

(b) An adequate and continuous supply of hot water shall be available for bathing, dishwashing, laundering, general cleaning and so forth.

(c) 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.

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

8:63-3.3 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, towels and washcloths. Female patients

shall be provided sanitary napkins and/or 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.

8:63-3.4 Health supervision

(a) 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:

1. Institute procedures for the control and treatment of communicable diseases, including, but not limited to hepatitis, tuberculosis and venereal disease;
2. Encourage personal hygiene;
3. Assure maintenance of personal health records, and inventories of all medical equipment, supplies, medicines and medical paraphernalia.

8:63-3.5 Special requirements

(a) 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) 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) The center shall abide by all State and Federal laws and regulations pertaining to the storage, maintenance or inventories of drugs or other medical paraphernalia. Furthermore, individual prescriptions must be kept locked in appropriate storage facilities and dispensed only under the supervision of a licensed physician. The center shall, furthermore, provide for the control and supervision of Controlled Dangerous Substances (CDS) entering the center through either illicit or legitimate means.

8:63-3.6 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.

8:63-3.7 Food preparation

(a) Since good food served in pleasant surroundings contributes 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:

1. 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.
2. Special diets shall be provided on physician's order; otherwise in accordance with approved standard of food and nutrition as herein outlined.
3. Only pasteurized milk and United States government inspected meats shall be served.
4. There shall be adequate provision for proper refrigeration of food items. Furthermore, all spoiled, molded or contaminated foods will be immediately removed.
5. 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.
6. A record of specific meals, as served, will be kept for a period of not less than 30 days.
7. Adequate dishes, utensils and condiments shall be provided.
8. Food preparation equipment, such as can-openers, slicers, grinders, mixing machines and similar equipment, shall be maintained in a sanitary condition.

8:63-3.8 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.

8:63-3.9 Control of deviant and/or criminal behavior

(a) 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 injurious to himself or to another person directly or indirectly related to the program.

(b) 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.

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, and the like, which may through withholding, jeopardize the client's health or well-being.

8:63-6.4 Center activity reports and schedule of events

(a) The center shall maintain an ongoing record of activities and events including speaking engagements, meetings and daily activities.

(b) A daily schedule of events shall be posted in a conspicuous place.

8:63-6.5 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.

8:63-6.6 Financial accountability

(a) 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 moneys, donations and so forth, 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 and so forth.

(b) 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.

8:63-6.7 Fund raising procedures

(a) The center shall maintain current records of all gifts, grants and donations of money, supplies, equipment, negotiable instruments and so forth.

(b) Receipts should be issued as a matter of policy.

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

8:63-6.8 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.

APPENDIX A

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, nonnarcotic 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 over-dosage cannot be too strongly stressed. For that reason, the following detoxification schedule, which has proven highly effective in detoxifying over 90 per cent 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 milligrams. The second dose of ten milligrams is given eight to 12 hours later.
- SECOND DAY: The same dosage is given as on the first day.
- THIRD DAY: Two doses of ten milligrams each are given. The first is given in the morning, the second eight to 12 hours later. Urine monitoring should be conducted on this and following days.
- FOURTH DAY: A single dose of ten milligrams is administered.
- FIFTH DAY: A single dose of five milligrams is administered.
- SUBSEQUENT DAYS: If additional daily doses are required, five milligrams may be given in the practitioner's presence. The detoxification period should not exceed ten days of therapy nor a total dosage of 110 milligrams 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 individualized 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 definite medical indications.

After the patient has completed Phase I and before he leaves the treatment center, he should be given a tamper-proof 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, that is 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 606-292-5760) will be glad to extend medical and legal consultation to interested physicians.

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

Information Copies:
Pharmacies
Hospitals
New Jersey Institutions

APPENDIX B

Guidelines for a Methadone Maintenance Program to Include Ambulatory Induction

Ambulatory induction as an alternative to inpatient 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 inpatient induction, although the initial attrition factor seems to be somewhat higher.

The main advantage of inpatient 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. Inpatient 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, inpatient 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 inpatient 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 inpatient 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 or five weeks. This is highly undesirable from a therapeutic standpoint.

A disadvantage of ambulatory induction consists of the limited control of the patient's 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/her 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 inpatient 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 outpatient 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 and so forth. It must be left to the physician's judgment whether he wants to treat such a condition, for example venereal disease, together with maintenance induction, or whether correction of the physical condition should precede 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 precede 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 inpatient 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 8:00 A.M. to 4:00 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 inpatient 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. @ 8:00 A.M.	5 mgm.	
Second Day:	10 mgm. @ 8:00 A.M.	10 mgm.	at closing time
Third Day:	15 mgm. @ 8:00 A.M.	10 mgm.	of Clinic
Fourth Day:	20 mgm. @ 8:00 A.M.	10 mgm.	(Not to be
Fifth Day:	35 mgm. @ 8:00 A.M.	5 mgm.	given before
Sixth Day:	40 mgm. @ 8:00 A.M.		4:00 P.M.)
Seventh Day:	45 mgm. @ 8:00 A.M.		
Eighth Day:	50 mgm. @ 8:00 A.M.		
Ninth Day:	55 mgm. @ 8:00 A.M.		
Tenth Day:	60 mgm. @ 8:00 A.M.		
Eleventh Day:	65 mgm. @ 8:00 A.M.		
Twelfth Day:	70 mgm. @ 8:00 A.M.		
Thirteenth Day:	80 mgm. @ 8:00 A.M. or	75 mgm.	@ 8:00 A.M.
Fourteenth Day:	90 mgm. @ 8:00 A.M. or	80 mgm.	@ 8:00 A.M.
Fifteenth Day:	100 mgm. @ 8:00 A.M. or	85 mgm.	@ 8:00 A.M.
Sixteenth Day:		90 mgm.	@ 8:00 A.M.
Seventeenth Day:		95 mgm.	@ 8:00 A.M.
Eighteenth Day:		100 mgm.	@ 8:00 A.M.

Further increases in steps of five milligrams 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 milligram 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.

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 nonrelated 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 five milligrams 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 milligrams 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 milligrams and anything under 70 milligrams cannot be considered as having a heroin blocking effect. On the other hand, there are certain patients who require doses above 100 milligrams 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, hyperperspiration, 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 or 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.

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

APPENDIX C

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 seven or eight 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 and so forth.

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 two 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 inpatient 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 electrocardiogram 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.

APPENDIX D

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 inpatient 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 *

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

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, 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 8:00 A.M. to 4:00 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 inductions, 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 inpatient basis, I agree to enter the New Jersey Neuro-Psychiatric Institute or some inpatient 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 and so forth.

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.

APPENDIX D

Methadone Maintenance Monthly Report for
the Month of _____(month)____(year)

Clinic _____

Name of Patient _____ Sex F M

Address _____

Methadone Dosage _____

Additional Medication _____

1. Has the patient been working, going to school, or engaged in any other type of socially acceptable activity this month?

Yes No If no, please explain:

4. Remarks or comments:

2. Has the patient had any medical problems this month?

Yes No If yes, please explain:


Report completed by: _____
(signature)

3. Has the patient had any legal problems this month?

Yes No If yes, please explain:

Please send completed report to Hans W. Freymuth, M.D., Coordinator, State Methadone Maintenance Program, State of New Jersey Department of Health, P.O. Box, 1540, Trenton, New Jersey, 08625, not later than the fifth of each following month.

NEW JERSEY ADMINISTRATIVE CODE

		NEW JERSEY STATE DEPARTMENT OF HEALTH DIVISION OF NARCOTIC AND DRUG ABUSE CONTROL		For Registry Use	
TREATMENT FACILITY REPORT OF CONTROLLED DANGEROUS SUBSTANCE (CDS) ABUSER					
PLEASE PRINT OR TYPE SEE REVERSE SIDE FOR INSTRUCTIONS					
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		13. CDS OF 1ST ABUSE		14. RELIGION	
1 PERMANENT 2 TEMPORARY 3 UNEMPLOYED 4 ENROLLED STUDENT 5 UNKNOWN		TIME FULL PART IN OUT PATIENT		1 CATHOLIC 2 PROTESTANT 3 JEWISH 4 OTHER 5 NONE 6 UNKNOWN	
12A. EDUCATION - HIGHEST GRADE COMPLETED		13A. DATE OF 1ST ABUSE MO YR			
15 TREATMENT		15A PLANNED AT THIS FACILITY		16. OTHER PRESENT MEDICAL CONDITIONS	
PRIORITY NO. OF TIMES IN OUT PATIENT PSYCHIATRIC CHEMO THERAPY THERAPEUTIC COMMUNITY DETOXICATION ONLY OTHER (SPECIFY) NONE UNKNOWN		IN OUT PATIENT PSYCHIATRIC CHEMO-THERAPY THERAPEUTIC COMMUNITY DETOXICATION ONLY OTHER (SPECIFY)		HEPATITIS T B V C OTHER INFECTION OBSTETRICAL PROBLEMS COMPLICATING PSYCHIATRIC NUTRITIONAL PROBLEMS UNKNOWN OTHER (SPECIFY)	
17. LIVING WITH		18. CURRENT LEGAL INVOLVEMENT		19. PRIOR LEGAL INVOLVEMENT	
1 PARENTS OR OTHER RELATIVES 2 SPOUSE 3 PARENTS OR OTHER RELATIVES AND SPOUSE 4 FRIENDS 5 ALONE 6 UNKNOWN		1 NON-PUNITIVE CUSTODY (CIVIL COMMITMENT, MENTAL HEALTH, ETC.) 2 PUNITIVE CUSTODY (JAIL, REFORMATORY, ETC.) 3 NONE 4 UNKNOWN 5 CHARGES PENDING 6 PAROLE 7 PROBATION		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			21. SOCIO-ECONOMIC STATUS OF FAMILY		
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			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 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					

New Jersey State Department of Health
 Division of Narcotic and Drug Abuse Control
 P.O. Box 1540
 Trenton, New Jersey 08625

Application For Certificate Of Approval
 For Narcotic and Drug Abuse Control Treatment Center



ASE-
 Aug-71

INSTRUCTIONS

- | | |
|--|--|
| 1. Please type or print | 3. Answer all applicable questions. |
| 2. Complete in triplicate. Submit original and one copy. | 4. Submit a separate application for each Center to be approved. |

SECTION A GENERAL

1. Name and address of applicant		3. Mailing address of applicant	
2. Name and title of person in charge of center		4. Certificate requested for (check one or more). See item 4 of instructions. See page 2 of procedure for definition of each.	
Telephone No.		<input type="checkbox"/> Residential, Drug Free <input type="checkbox"/> Residential, Chemo-Therapy <input type="checkbox"/> Non-Residential, Drug Free <input type="checkbox"/> Non-Residential, Chemo-Therapy <input type="checkbox"/> Counselling and Referral <input type="checkbox"/> Other, including Pilot and Research Programs. Specify _____	

SECTION B SPONSORSHIP

1. Name and principal address of the organization or entity responsible for the operation of the center.		2. Character of applicant organization	
		<input type="checkbox"/> Government Agency <input type="checkbox"/> Corporation <input type="checkbox"/> Partnership <input type="checkbox"/> Proprietorship <input type="checkbox"/> Other (specify) _____	
3. List names and addresses of all officers and members of the board of directors of the agency. (Attach all sheets and mark "B-3" in upper right hand corner). IF NONE, CHECK HERE <input type="checkbox"/>		4. Is organization controlled by other than your own governing board? <input type="checkbox"/> YES <input type="checkbox"/> NO If "yes", attach the name and principal address of the controlling organization and the names and addresses of all officers and members of the board of directors. (Attach all sheets and mark "B-4" in upper right hand corner).	

5. If the applicant is other than individually owned, complete the following appropriate section:

<p>A-GOVERNMENT AGENCY Identify department, division and bureau administratively responsible for the center:</p> <p>_____</p>	<p>D-CORPORATION Date incorporated _____ State where incorporated _____</p> <p>CHECK TYPE: <input type="checkbox"/> Business <input type="checkbox"/> Non-Profit</p>
<p>B-UNINCORPORATED ASSOCIATION Date Established _____</p>	<p>If other than a New Jersey Corporation, list date of qualification to operate in New Jersey _____</p> <p>List registered agent and address</p> <p>_____</p> <p>_____</p> <p>_____</p>
<p>C-PARTNERSHIP Date of Formation _____</p> <p>List names and address of partners if not listed above. (Attach all sheets and mark "B-5c" in upper right hand corner).</p>	

SECTION C - TREATMENT PROGRAM

<p>1. Submit a summary of your organization's goals and treatment philosophy. (Attach and mark all sheets "C-1" in upper right hand corner).</p> <p>2. Describe the geographic, social and economic community that the program serves. (Attach and mark all sheets "C-2" in upper right hand corner).</p> <p>3. Is this program regulated or operated in conjunction with other public or private agencies? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If "yes" identify and briefly describe the relationship with each. (Attach and mark all sheets "C-3" in upper right hand corner).</p>	<p>4.a. Give a brief narrative description of each program including the following items that apply. (Attach and mark all sheets "C-4a" in upper right hand corner):</p> <ol style="list-style-type: none"> 1. types of therapy 2. criteria for client selection 3. requirements for participation (in each program) 4. number of clients served, by age and sex 5. source of referral 6. use of other community service in the administration of the program 7. are fees charged? amounts? <p>b. Include a sample schedule of daily activities for each program. (Attach and mark all sheets "C-4b" in upper right hand corner).</p> <p>c. Are clients used for programs or activities outside of the center? <input type="checkbox"/> Yes <input type="checkbox"/> No If "yes" briefly describe the type of activities. (Attach and mark all sheets "C-4c" in upper right hand corner).</p>
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SECTION D - OTHER

<p>1. Complete enclosed "Personnel Report."</p> <p>2. Submit copy of current annual budget and most recent financial statement.</p> <p>3. Complete enclosed "Funding Report."</p>	<p>4. Specify any current or pending legal action involving applicant. (Attach and mark all sheets "D-4" in upper right hand corner)</p> <p>5. Designate approximate date when center will be ready for certification inspection:</p> <p style="text-align: center;">_____</p>
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I, _____ (Name) hereby certify that I am the _____ (Title) of _____ (Center); that I am authorized to make this application on behalf of the applicant; that I have read the foregoing application for certificate of approval and that the facts stated therein are true.

Date _____ SIGNATURE _____

FOR STATE USE ONLY					
Approved	Yes	No	Name	Title	Date

APPENDIX ESample Letter Showing that the Center Meets
Local Building Code Requirements

CITY OF OSHKOSH

September 17, 1971

Mr. Ralph Jones, Director

Second Chance Center

26 South Orange Street

Oshkosh, New Jersey

Dear Mr. Jones:

This is to certify that the Second Chance Center located at 26 South Orange Street has met the requirements, as set forth in the Building Code of the City of Oshkosh.

Yours truly,

J. Scott Smith

Building Inspector

SAMPLE

APPENDIX FProcedures for Certification as a Narcotic
and Drug Abuse Treatment Center**A. General**

These procedures have been promulgated in accordance with Chapter 334, laws of New Jersey, 1970, approved December 29, 1970. This public law provides that:

No narcotic and drug abuse treatment center shall operate within this State except pursuant to a certificate of approval obtained from the Commissioner, upon application made therefor. Such application shall be made upon forms furnished by the Commissioner, shall set forth the location of the narcotic and drug abuse treatment center, the person in charge thereof, and the facilities for caring for patients who may seek treatment therein. The applicant shall be required to furnish evidence of its ability to comply with minimum standards established hereunder and of the good moral character of the applicant and the person in charge of the narcotic and drug abuse treatment center. Any change in the facts set forth in the application shall be reported to the Commissioner within ten days after the occurrence thereof.

Chapter 334 defines a narcotic and drug abuse treatment center as follows:

Narcotic and drug abuse treatment center means 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 nonrelated individuals, who are patients as defined herein, excluding, however, any hospital or mental hospital otherwise licensed by Title 30 of the Revised Statutes.

B. Application Forms

All narcotics and drug abuse treatment centers, as defined under Chapter 334, shall through an authorized representative notify the Division of Narcotic and Drug Abuse Control, P.O. Box 1540, Trenton, New Jersey 08625, in writing, of their intent regarding the application for certification.

The Division, upon receipt of the letter of intent will forward application forms and material as defined above.

C. Certification Process

1. The applicant shall file application forms within 45 days of the effective date of this Chapter.
2. A Division representative will visit the center, at the discretion of the Division, to review the application materials and to make a preliminary survey of the facilities and programs.
 - a. Based on the preliminary findings, a letter of application approval and temporary certification of qualified center(s) will be issued; or
 - b. The applicant will be notified of deficiencies and the corrections to be made for the issuance of temporary certification.
3. An inspection team, consisting of representatives from the Division of Health Facilities and the Division of Narcotic and Drug Abuse, will survey such facilities. A written report of findings will be correlated by the Division of Health Facilities and forwarded to the Division of Narcotic and Drug Abuse. A final recommendation will then be sent to the Commissioner.
4. The Commissioner will:
 - a. Issue a certificate of approval; or
 - b. Notify the applicant of deficiencies to be corrected before final certification. To facilitate deficiency correction, the Commissioner may extend temporary certification; or
 - c. Notify the applicant of his intention to deny certification, stating the reason(s) for denial.

Each applicant in categories "b" or "c" of this subsection will be advised that he may within 30 days of receipt of said notification, request a hearing.

D. Categories of Certificate

Narcotic and drug abuse treatment centers shall apply for and may be issued a certificate authorizing the granting of drug abuse treatment in one or more of the following categories:

1. Residential, Drug Free—Any drug abuse treatment center which provides 24 hour-a-day care of clients, as defined, and requires detoxification and abstinence from drugs, except by medical prescription, as a condition of continued service.
2. Residential, Chemo-Therapy—Any drug abuse treatment center which provides 24 hour-a-day care of clients, as defined, and provides for the detoxification, medically supervised withdrawal, maintenance and/or induction progress.
3. Nonresidential, Drug Free—Any outpatient, or day care treatment program which provides diagnostic care, treatment or rehabilitation services to clients, as defined, exclusive of medically supervised detoxification or induction process.
4. Nonresidential, Chemo-Therapy—Any outpatient or day care narcotic and drug abuse treatment center which provides as part of its diagnosis, care, treatment or rehabilitation program a medically supervised process of detoxification or treatment of clients, as defined.
5. Counseling and referral—Any narcotic and drug abuse treatment center which provides information, counselling and/or referral services to clients, as defined.

6. Other, including Pilot and Research Programs—Any center which provides services not listed under categories "1" through "5" of this subsection: to include research pilot and demonstration projects.

E. Special Certification Provisions

1. Unless waived by the Commissioner, a separate application shall be completed, and a separate certificate issued for each location when covered activities are offered. For purposes of this Section, two or more contiguous buildings operated by an agency under common supervision shall be considered a single location, but each building must meet the standards established by the Commissioner.
2. Every certificate of approval for a residential center shall state the maximum number of patients who may be admitted as residents at one time. Every certificate of approval may state the maximum number of nonresident patients who may be treated at one time.
3. Every center that receives certificate of approval, or that is required to obtain a certificate of approval, shall be subject to inspection by the Commissioner or his representative at such times and with such frequency as the Commissioner deems necessary to assure continued compliance with the rules, regulations and standards promulgated.
4. Any change in the facts as set forth in the application shall be reported by the applicant to the Division within ten days.