WISCONSIN DEPARTMENT OF SAFETY AND PROFESSIONAL SERVICES

Wisconsin Department of Safety and Professional Services
Access to the Public Records of the Reports of Decisions

This Reports of Decisions document was retrieved from the Wisconsin Department of Department of Safety and Professional Services website. These records are open to public view under Wisconsin's Open Records law, sections 19.31-19.39 Wisconsin Statutes.

Please read this agreement prior to viewing the Decision:

- The Reports of Decisions is designed to contain copies of all orders issued by credentialing authorities within the Department of Safety and Professional Services from November, 1998 to the present. In addition, many but not all orders for the time period between 1977 and November, 1998 are posted. Not all orders issued by a credentialing authority constitute a formal disciplinary action.
- Reports of Decisions contains information as it exists at a specific point in time in the Department of Safety and Professional Services data base. Because this data base changes constantly, the Department is not responsible for subsequent entries that update, correct or delete data. The Department is not responsible for notifying prior requesters of updates, modifications, corrections or deletions. All users have the responsibility to determine whether information obtained from this site is still accurate, current and complete.
- There may be discrepancies between the online copies and the original document. Original documents should be consulted as the definitive representation of the order's content. Copies of original orders may be obtained by mailing requests to the Department of Safety and Professional Services, PO Box 8935, Madison, WI 53708-8935. The Department charges copying fees. *All requests must cite the case number, the date of the order, and respondent's name* as it appears on the order.
- Reported decisions may have an appeal pending, and discipline may be stayed during the appeal. Information about the current status of a credential issued by the Department of Safety and Professional Services is shown on the Department's Web Site under "License Lookup."
  The status of an appeal may be found on court access websites at: http://ccap.courts.state.wi.us/InternetCourtAccess and http://www.courts.state.wi.us/wscca .
- Records not open to public inspection by statute are not contained on this website.

By viewing this document, you have read the above and agree to the use of the Reports of Decisions subject to the above terms, and that you understand the limitations of this on-line database.

Correcting information on the DSPS website: An individual who believes that information on the website is inaccurate may contact the webmaster at web@drl.state.wi.gov

FILE COPY

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST

BARBARA J. BONSALL, R.N.,
RESPONDENT.

FINAL DECISION AND ORDER

ORDER0001736

The parties to this proceeding for the purposes of Wis. Stats. sec. 227.16 are:

Barbara J. Bonsall
2425 North Oakland Avenue
Milwaukee, WI 53202

Board of Nursing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708

Department of Regulation & Licensing
Division of Enforcement
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708

A party aggrieved by this decision may petition the board for rehearing within twenty (20) days after service of this decision pursuant to Wis. Stats. sec. 227.12. The party to be named as respondent in the petition is Barbara J. Bonsall, R.N.

A party aggrieved by this decision who is a resident of this state may also petition for judicial review by filing the petition in the office of the clerk of the circuit court for the county where the party aggrieved resides within thirty (30) days after service of this decision. A party aggrieved by this decision who is not a resident of this state must file the petition for judicial review in the office of the clerk of circuit court for Dane County. A party aggrieved must also serve the board and other parties with a copy of the petition for judicial review within thirty (30) days after service of this decision pursuant to Wis. Stats. sec. 227.16. The party to be named as respondent in the petition is the Board of Nursing.

FINDINGS OF FACT

1. Barbara J. Bonsall, R.N., 2425 North Oakland Avenue, Milwaukee, Wisconsin 53202, was and is duly licensed in the State of Wisconsin as a registered nurse (License #60614).

2. On or about March 24, 1984, Ms. Bonsall was working as a registered nurse supervisor on the P.M. shift at Sacred Heart Rehabilitation Hospital in Milwaukee, Wisconsin.

3. On that date Ms. Bonsall diverted eighty-four (84) tablets of Tylenol with codeine (Tylenol #3) from the hospital pharmacy. Ms. Bonsall also illicitly had in her possession tablets of Darvon (propoxyhene napsylate), Darvocet (propoxyphene napsylate and acetaminophen), and Lomotil (diphenoxylate hydrochloride with atropine sulfate). Tylenol with codeine, Darvon, Darvocet, and Lomotil are all controlled substances.

4. On September 6, 1984, Ms. Bonsall was convicted on a plea of no contest for the theft of Tylenol with codeine, as described above in paragraph 3.

5. Ms. Bonsall has a history of drug abuse commencing approximately in 1975 and continuing, with several periods of remission, to the present. This history includes the following treatment:

a. In 1977, Ms. Bonsall was treated at Hazelden Foundation in Center City, Minnesota, for narcotic and stimulant drug abuse.

b. On or about August 19, 1981, Ms. Bonsall was admitted to Elmbrook Memorial Hospital in Brookfield, Wisconsin, with a diagnosis of "chemical dependency."

c. On or about January 29, 1982, Ms. Bonsall went to DePaul Rehabilitation Hospital in Milwaukee, Wisconsin, for the purpose of an assessment. The diagnosis made as a result of this assessment included a finding of "opioid dependence." On or about February 21, 1982, Ms. Bonsall was admitted to Mt. Sinai Medical Center in Milwaukee, Wisconsin.

d. On or about October 11, 1982, Ms. Bonsall was admitted to Elmbrook Memorial Hospital in Brookfield, Wisconsin, for a possible drug overdose. On or about October 12, 1982, Ms. Bonsall was admitted to Winnebago Mental Health Institute in Winnebago, Wisconsin, pursuant to a 72-hour detention order from Waukesha County, for diagnosis and observation. The diagnosis for Ms. Bonsall subsequent to her admission to the Winnebago Mental Health Institute was "Axis I: drug addiction, multiple; Axis II: reactive depression, depressive neurosis with suicide attempt."

e. The day following her drug diversion set forth in paragraph 3 above, Ms. Bonsall was admitted as an inpatient of the DePaul Rehabilitation Program in Milwaukee, Wisconsin, with a provisional diagnosis of opiod dependence. She remained in the DePaul inpatient program for approximately two months. Thereafter she was placed in a halfway house for approximately three months, and subsequently underwent outpatient treatment until December, 1984.

6. In December, 1984, Ms. Bonsall enrolled in the Milwaukee County Methadone Program. The program is an outpatient drug abuse and treatment program which uses methadone and other chemotherapy in conjunction with psychotherapy and individual and group counseling. The program is designed for a minimum participation of three years with most individuals being required to participate for from three to five years. Attached hereto, and incorporated herein, is a written copy of the full treatment program

(Respondent's Exhibit 2). Ms. Bonsall is in compliance with the requirements of the program and progressing satisfactorily.

CONCLUSIONS OF LAW

1. The Board of Nursing has jurisdiction in this matter pursuant to Wis. Stats. sec. 441.07.

2. Respondent, by the conduct set forth in paragraphs 3 and 4 of the Findings of Fact, is subject to disciplinary action against her license pursuant to Wis. Stats. secs. 441.07(1)(c) and (d), and Secs. N 11.03(3)(a) and (b) and N 11.04(1), Wis. Adm. Code (1980).

ORDER

NOW, THEREFORE, IT IS ORDERED that the license of Barbara J. Bonsall, R.N., be, and hereby is, revoked.

EXPLANATION OF VARIANCE

The Board of Nursing has accepted the Hearing Examiner's Findings of Fact and Conclusions of Law. The board has not, however, accepted the examiner's recommended order granting to Ms. Bonsall a limited license. Rather, the board considers Ms. Bonsall to be an inappropriate candidate for a limited license at this time. The Findings of Fact in this matter reflect a pattern of repeated drug dependency and relapse after treatment. While at the time of hearing in this matter in February, 1985, it appears that Ms. Bonsall was successfully participating in Milwaukee County Mental Health Complex Drug Treatment Program, that program uses methadone and other chemotherapy as a part of its treatment modality. Methadone is itself a Schedule II controlled substance having a high potential for abuse as defined by Wis. Stats. sec. 161.15.

Pursuant to Wis. Stats. sec. 441.07(2), Ms. Bonsall may apply for reinstatement of her license after one year. If she makes application at that time, and if it appears at that time that she has continued to progress satisfactorily in a rehabilitation program, the board will be in a position to determine whether granting of a limited license is appropriate and, if so, what limitations, if any, should be imposed. The board concludes, however, that granting of such a license at this time is not appropriate.

Dated at Madison, Wisconsin, this 19th day of June, 1986.

STATE OF WISCONSIN
BOARD OF NURSING

by Suzanne A. Schuler
A Member of the Board

WRA:rjt
262-612

BEFORE THE STATE OF WISCONSIN
BOARD OF NURSING

IN THE MATTER OF DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	NOTICE OF FILING
BARBARA J. BONSALL, R.N., RESPONDENT.	:	PROPOSED DECISION

To: Steven J. Lownik
Schober & Radtke, S.C.
15525 West National Avenue
P. O. Box 65
New Berlin, Wisconsin 53151

Steven M. Gloe
Attorney at Law
Department of Regulation and Licensing
Division of Enforcement
P. O. Box 8935
Madison, Wisconsin 53708

PLEASE TAKE NOTICE that a Proposed Decision in the above-captioned matter has been filed with the Board of Nursing by the Hearing Examiner, Donald R. Rittel. A copy of the Proposed Decision is attached hereto.

If you are adversely affected by, and have objections to, the Proposed Decision, you may file your objections, briefly stating the reasons and authorities for each objection, and argue with respect to those objections in writing. Your objections and argument must be submitted and received at the office of the Board of Nursing, Room 174, Department of Regulation and Licensing, 1400 East Washington Avenue, P. O. Box 8935, Madison, Wisconsin 53708, on or before May 12, 1986.

The attached Proposed Decision is the Examiner's recommendation in this case and the Order included in the Proposed Decision is not binding upon you. After reviewing the Proposed Decision together with any objections and arguments filed, the Board of Nursing will issue a binding Final Decision and Order.

Dated at Madison, Wisconsin this 25th day of April, 1986.

Donald R. Rittel
Hearing Examiner

STATE OF WISCONSIN
BEFORE THE BOARD OF NURSING

IN THE MATTER OF THE DISCIPLINARY PROCEEDINGS AGAINST	:	
	:	PROPOSED DECISION
BARBARA J. BONSALL, R.N., RESPONDENT.	:	

The parties to this proceeding for the purposes of Wis. Stats. sec. 227.16 are:

Barbara J. Bonsall
2425 North Oakland Avenue
Milwaukee, WI 53202

Board of Nursing
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708

Department of Regulation & Licensing
Division of Enforcement
1400 East Washington Avenue
P.O. Box 8935
Madison, WI 53708

A hearing was held in the above-captioned matter. Steven M. Gloe, attorney, appeared for the Department of Regulation and Licensing, Division of Enforcement, P.O. Box 8935, Madison, Wisconsin. The respondent appeared in person and by her attorney, Steven J. Lownik, SCHOBER & RADTKE, S.C., 15525 West National Avenue, P.O. Box 65, New Berlin, Wisconsin 53151.

Based upon the record in this case, the hearing examiner recommends that the Board of Nursing adopt as its final decision in this matter the following Findings of Fact, Conclusions of Law, and Order.

FINDINGS OF FACT

1. Barbara J. Bonsall, R.N., 2425 North Oakland Avenue, Milwaukee, Wisconsin 53202, was and is duly licensed in the State of Wisconsin as a registered nurse (License #60614).

2. On or about March 24, 1984, Ms. Bonsall was working as a registered nurse supervisor on the P.M. shift at Sacred Heart Rehabilitation Hospital in Milwaukee, Wisconsin.

3. On that date Ms. Bonsall diverted eighty-four (84) tablets of Tylenol with codeine (Tylenol #3) from the hospital pharmacy. Ms. Bonsall also illicitly had in her possession tablets of Darvon (propoxyhene napsylate), Darvocet (propoxyphene napsylate and acetaminophen), and Lomotil (diphenoxylate hydrochloride with atropine sulfate). Tylenol with codeine, Darvon, Darvocet, and Lomotil are all controlled substances.

4. On September 6, 1984, Ms. Bonsall as convicted on a plea of no contest for the theft of Tylenol with codeine, as described above in paragraph 3.

5. Ms. Bonsall has a history of drug abuse commencing approximately in 1975 and continuing, with several periods of remission, to the present. This history includes the following treatment:

a. In 1977, Ms. Bonsall was treated at Hazelden Foundation in Center City, Minnesota, for narcotic and stimulant drug abuse.

b. On or about August 19, 1981, Ms. Bonsall was admitted to Elmbrook Memorial Hospital in Brookfield, Wisconsin, with a diagnosis of "chemical dependency."

c. On or about January 29, 1982, Ms. Bonsall went to DePaul Rehabilitation Hospital in Milwaukee, Wisconsin, for the purpose of an assessment. The diagnosis made as a result of this assessment included a finding of "opioid dependence." On or about February 21, 1982, Ms. Bonsall was admitted to Mt. Sinai Medical Center in Milwaukee, Wisconsin.

d. On or about October 11, 1982, Ms. Bonsall was admitted to Elmbrook Memorial Hospital in Brookfield, Wisconsin, for a possible drug overdose. On or about October 12, 1982, Ms. Bonsall was admitted to Winnebago Mental Health Institute in Winnebago, Wisconsin, pursuant to a 72-hour detention order from Waukesha County, for diagnosis and observation. The diagnosis for Ms. Bonsall subsequent to her admission to the Winnebago Mental Health Institute was "Axis I: drug addiction, multiple; Axis II: reactive depression, depressive neurosis with suicide attempt."

e. The day following her drug diversion set forth in paragraph 3 above, Ms. Bonsall was admitted as an inpatient of the DePaul Rehabilitation Program in Milwaukee, Wisconsin, with a provisional diagnosis of opiod dependence. She remained in the DePaul inpatient program for approximately two months. Thereafter she was placed in a halfway house for approximately three months, and subsequently underwent outpatient treatment until December, 1984.

6. In December, 1984, Ms. Bonsall enrolled in the Milwaukee County Methadone Program. The program is an outpatient drug abuse and treatment program which uses methadone and other chemotherapy in conjunction with psychotherapy and individual and group counseling. The program is designed for a minimum participation of three years with most individuals being required to participate for from three to five years. Attached hereto, and incorporated herein, is a written copy of the full treatment program (Respondent's Exhibit 2). Ms. Bonsall is in compliance with the requirements of the program and progressing satisfactorily.

CONCLUSIONS OF LAW

1. The Board of Nursing has jurisdiction in this matter pursuant to Wis. Stats. sec. 441.07.

2. Respondent, by the conduct set forth in paragraphs 3 and 4 of the Findings of Fact, is subject to disciplinary action against her license pursuant to Wis. Stats. secs. 441.07(1)(c) and (d), and Secs. N 11.03(3)(a) and (b) and N 11.04(1), Wis. Adm. Code (1980).

ORDER

NOW, THEREFORE, IT IS ORDERED:

(a) The license of Ms. Bonsall is SUSPENDED FOR A PERIOD OF NOT LESS THAN TWO (2) YEARS. This suspension shall be in STAYED for a period of three (3) months, conditioned upon compliance with the conditions AND LIMITATIONS outlined in Paragraph (b), below.

i. Ms. Bonsall may apply for consecutive three-month extensions of the stay of suspension, which shall be granted upon Ms. Bonsall's acceptable demonstration of compliance with the conditions and limitations imposed on her practice during the prior three-month period.

ii. If the Board denies a petition by Ms. Bonsall for an extension, the Board shall afford Ms. Bonsall an opportunity for a hearing in accordance with current regulations governing denial proceedings, upon timely receipt of a hearing request.

iii. Upon successful compliance for a period of two years with the terms of Paragraph (b) below, the Board may grant a petition by Ms. Bonsall for a return of full licensure.

(b) CONDITIONS OF STAY

i. Ms. Bonsall must remain in a program acceptable to the Board for the treatment of chemical dependency. As a part of this treatment, Ms. Bonsall must attend therapy on a schedule that is recommended by her therapist; attendance, however, shall be required at least one time per week. In addition, Ms. Bonsall must attend Alcoholics Anonymous or Narcotics Anonymous at least one time per week.

ii. Upon request of the Board, Ms. Bonsall must provide the Board with current releases complying with state and federal laws authorizing release of her counseling, treatment and monitoring records.

iii. Ms. Bonsall must remain free of alcohol and contolled substances not prescribed for a valid medical purpose during the period of limitation.

iv. Ms. Bonsall must participate in the program of random, witnessed monitoring for controlled substances and alcohol in her blood and/or urine. Drug screens are required at least four times monthly. If the therapist supervising Ms. Bonsall's plan of care or her employer deems that additional blood or urine screens are warranted, Ms. Bonsall must submit to those screens.

Ms. Bonsall shall be responsible for obtaining a monitoring facility and reporting system acceptable to the Board as well as all costs incurred in conjunction with the monitoring and reporting required.

To be an acceptable program, the monitoring facility must agree to provide random and witnessed gatherings of specimens for evaluation. It must further agree to file an immediate report with the Board of Nursing upon such failures to participate as: if Ms. Bonsall fails to appear upon request; or if a drug or alcohol screen proves positive; or if Ms. Bonsall refuses to give a specimen for analysis upon a request authorized under the terms of this order.

v. Ms. Bonsall shall arrange for written quarterly reports to the Board of Nursing from her employer evaluating her work performance, from her monitoring facility providing the dates and results of screenings performed; and from her counselor evaluating her attendance and progress in therapy as well as evaluating her level of participation at AA/NA meetings.

vi. Ms. Bonsall shall report to the Board within five (5) days of any changein her employment status.

(c) Ms. Bonsall may petition the Board in conjunction with any application for an additional stay to revise or eliminate any of the above conditions.

(d) This order shall become effective ten (10) days following the date of the Final Decision and Order of the Board of Nursing.

OPINION

Barbara J. Bonsall was convicted in September, 1984, upon a plea of no contest, of the theft of Tylenol with codeine (Tylenol #3). This conviction was based upon her diversion of eighty-four tablets of Tylenol #3 on March 24, 1984, from the pharmacy at Sacred Heart Rehabilitation Hospital in Milwaukee, Wisconsin. At that time, Ms. Bonsall also was discovered to have several other controlled substances in her possession, as set forth in paragraph 3 of the Findings of Fact. The primary issue in this case is the appropriate discipline to be imposed, if any, given the nature of Ms. Bonsall's misconduct as well as the surrounding facts and circumstances concerning her history of drug abuse.

Complainant's attorney recommends that Ms. Bonsall's license be revoked in light of two basic factors. First, Ms. Bonsall, as set forth in the Findings of Fact, has a lengthy history of drug abuse. Secondly, that history is also replete with instances of unsuccessful attempts at treatment, and relapse. In addition, Ms. Bonsall's most recent treatment modality involves the use of a methadone program which in the past has not been accepted by the Board as a basis for continued practice under limited licensure.

Respondent's attorney argues that Ms. Bonsall should be permitted to practice under a limited license in light of the Board of Nursing's commitment to the rehabilitation of impaired practitioners, as well as in light of testimony from both Ms. Bonsall's past and present employers concerning her competent nursing performance.

In order to assist the Board in exercising its discretion regarding discipline in this case, attached is a copy of the methadone treatment program in which Ms. Bonsall is engaged. This attachment is provided in order to facilitate the Board's review of that particular program in order to determine whether or not it substantially meets the requirements of those programs previously approved by the Board in granting impaired licensees the right to practice nursing under limited conditions.

In my opinion, after a review of the methadone program as set forth in the attachment, there appear to be sufficient safeguards to assure the Board that the program is capable of providing the nature of assistance to impaired professionals which will permit the Board to monitor the progress of Ms. Bonsall under similar terms and conditions as ordered in recent disciplinary decisions. Although the use of methadone as a portion of the treatment program is unlike programs previously approved by the Board, I believe that the Board should approve of its use in this case in order to assess its viability to meet the rehabilitative function of discipline and to promote Ms. Bonsall's rehabilitation.

In addition, Ms. Bonsall's employment history, as testified to by both past and current employers, indicates that despite her significant abuse of controlled substances in the past, there has been no observation of impairment while engaged in providing professional services, nor was there diversion of patient medications. Ms. Bonsall's current supervisor at the Oakland Manor Nursing Home in Shorewood, Wisconsin, indicated that since Ms. Bonsall was hired in July of 1984, she has been closely monitored. According to the supervisor, Ms. Bonsall was hired with the knowledge of her drug problem and treatment regimen, and that Ms. Bonsall's performance has been excellent, with no indication of impairment while performing services or diversion.

Despite the fact that Ms. Bonsall has suffered numerous relapses of her drug abuse in the past, it appears that she has been successfully pursuing treatment since her conviction in September, 1984. Furthermore, her prognosis for recovery appears good, in the opinion of her current therapist. Her work performance has been excellent, according to her supervisor. Ms. Bonsall's past conduct does not appear to have resulted in any harm to patients under her care. The fact that the methadone treatment program is of a nature diverging from the traditionally accepted rehabilitation approach should not, in my opinion, prevent Ms. Bonsall from continuing to practice under the limited conditions normally ordered in similar drug impairment cases.

Dated at Madison, Wisconsin, this 25th day of April, 1986.

Respectfully submitted,

Donald R. Rittel

Donald R. Rittel
Hearing Examiner

DRR:rjt
951-060

MILWAUKEE COUNTY MENTAL HEALTH COMPLEX

DRUG TREATMENT PROGRAM WRITTEN PLAN

PROGRAM DESCRIPTION, PHILOSOPHY AND GOALS

The Milwaukee County Mental Health Complex Drug Treatment Program is an outpatient drug abuse treatment and rehabilitation program aimed primarily, but not exclusively, at the heroin user. The program uses methadone and other appropriate chemotherapy in conjunction with psychotherapy and individual and group counseling, emphasizing social and emotional readjustment. The program's multidisciplinary staff includes physicians, registered nurses, psychiatric social workers, certified drug counselors and addiction specialists.

The program's treatment philosophy emphasizes the functional and problem oriented approaches to drug abuse treatment and rehabilitation. Treatment is provided as an alternative to a continuing dysfunctional drug lifestyle. In this program clients join with medical and mental health professionals in planning and implementing problem oriented treatment plans. This involves drug dependent persons in a process which brings corrective resources to bear on dysfunctions in physical health, psychological development, social adaptation, educational performance and occupational functioning. Narcotic dependency is viewed as a chronic relapsing disease for which the establishment and maintenance of functioning is the most important treatment objective.

The goal of the program is to strive for the optimal biological and psychosocial functioning of each client. The main indicators of progress toward rehabilitation used by the program are: (1) freedom from illicit drug use, as evidenced by frequent urine testing, (2) a satisfactory vocational adjustment, that is: full employment or its equivalent, (3) the ability to cope with stress and crisis situations without resorting to drug abuse or other dysfunctional behaviors, (4) the development of personal relationships (family and peer group) that are satisfying and lasting, and (5) the establishment of leisure time activities which are not drug related.

Individual, marital, family and group treatment methods, as well as medical management, are utilized to facilitate the treatment process. A full range of mental health and psychiatric services are available on site or through other units of the Mental Health Complex. Supportive community resources are utilized where appropriate to implement individualized treatment plans.

POPULATION SERVED

Patients are primarily adult, opiate dependent, non-veteran, Milwaukee County residents with greater than a one year addiction history. The approximate age range is 26 through 44; approximately 20% are minority and 38% are women. High levels of unemployment (55.3% unemployment at the time of admission) and an increased risk of depression and other primary affective disorders (approximately 30%) are also characteristic of the patient population.

HOURS AND DAYS OF OPERATION

Monday through Friday 7:45 A.M. - 5:45 P.M.
Saturday 8:45 A.M. - 12:45 P.M.
Sunday - Closed

ROLE IN MILWAUKEE COUNTY DRUG TREATMENT CONTINUUM

Drug treatment services at the Milwaukee County Mental Health Complex are part of a 51.42 Board funded drug treatment continuum which includes a variety of other treatment components. As part of this system, private sector agencies provide detoxification, inpatient, residential, and outpatient drug free treatment. The Milwaukee County Mental Health Complex Drug Treatment Program comprises the public component of the Milwaukee County drug treatment continuum. The program is the only drug treatment facility in the community licensed to provide outpatient methadone maintenance treatment for non-veterans and serves approximately 280 patients.

SCOPE OF ENTRY

Most clients are self referred to the Drug Treatment Program after hearing of the facility through personal contact with other clients. Referrals are also received from other service providers in the Milwaukee County drug treatment continuum, other departments of the Milwaukee County Department of Health & Human Services and other areas of the Mental Health Complex. Referrals are also received from private physicians and a broad range of health and social service agencies in the Milwaukee area. Clients are also referred by concerned family members, employers, attorneys, probation and parole officers, etc. Although patients may seek to enter treatment due to pressures from employers, family members, or the criminal justice system, treatment is on a voluntary basis.

ADMISSION POLICY

It is the policy of the Milwaukee County Drug Treatment Program to accept those non-veteran, non-incarcerated persons who refuse to be treated elsewhere; who are actually physiologically dependent on abuse substances exclusive of alcohol; who are likely to benefit from the treatment offered; who meet all FDA admission criteria where applicable; and who are at low risk of potential violent behavior. Preference is given to Milwaukee County residents. Out of county residents may be accepted for treatment on a space available basis, provided the cost of their care is either (1) completely paid through 1st or 3rd party sources or (2) authorized by the 51.42 board of the client's residence and completely paid by a combination of 1st and 3rd party sources and/or the authorizing 51.42 board.

It is the policy of the Milwaukee County Drug Treatment Program to establish a waiting list of prospective patients who might meet the acceptance criteria and who will be called for evaluation examinations as treatment capacity permits. Persons are not refused admission solely on the number of previous admissions to treatment in this program or other programs.

It is policy to collect sufficient information during the intake process so that a tentative treatment plan can be developed. The information shall be gathered in a manner consistent with procedures developed by the Chemical Dependency Coordinating Committee and shall be recorded on standardized forms. The completed forms shall become part of the applicant's case record.

It is policy that applicants are required to provide, as a condition of admission, information necessary to the treatment process and/or to essential program operations,

such as patient registration and financial determination. The applicant shall retain the right to withhold any information that is not demonstrably necessary to the treatment process or to essential program operations. When an applicant refuses to divulge information, the refusal shall be noted in the patient case record.

INITIAL SCREENING

Intake phone calls and/or referral letters are initially screened by the program's intake worker to determine eligibility. Veterans are normally referred to the Veterans Administration Drug Treatment Program at Woods, Wisconsin, while out of county residents are referred to the Combined Community Services Board in their county of residence. Individuals with a presenting problem other than narcotic dependency are referred to other programs in the Milwaukee County drug treatment continuum. Applicants who have previously been treated by the Milwaukee County Mental Health Complex Drug Treatment Program and have had less than successful treatment episodes may be asked to come in for a pre-admission interview to determine the appropriateness of the current request for treatment. As a condition of readmission the patient may be requested to consent to a "Treatment Agreement" which outlines the expectations of the patient upon readmission and the consequences for noncompliance. The purpose of a "Treatment Agreement" is to identify those problems that led to the previous unsuccessful treatment episode so that these difficulties can be avoided in the patient's new episode of care. After completing the pre-admission screening, new and returning patients are scheduled by the intake worker for an intake appointment.

INTAKE PROCEDURES

It is the policy of the Milwaukee County Mental Health Drug Treatment Program to comply with all necessary documents and required examinations as specified in Federal, State and local regulations and standards. The first step in the intake process is an interview with the program's intake worker. At this interview the patient will be informed of the intake process, given a written copy of the patient handbook, notified of an orientation meeting, and informed of assessment procedures he or she must complete as part of the intake process. The intake worker will obtain the patient's written consent for a Nalaxone challenge. A "Consent to Methadone Treatment", and any necessary "Consent for Disclosure of Confidential Information" to coordinate treatment with needed community resources will also be obtained. The Drug Treatment Program utilizes the initial intake form developed by the National Institute on Drug Abuse as presented in the Clinical Records System for Drug Abuse Treatment Programs. This form includes a drug use and drug treatment history, alcoholism use and treatment history, legal history (brief), employment history, military history, source of referral, and initial assessment. The second step in the intake process is an interview with a registered nurse who completes the medical history and schedules the patient for laboratory work and an identification card picture. Also as part of this interview the nurse will weigh and measure the patient and record vital signs. The third step in the intake procedure is for the applicant to see a staff physician for a physical examination. After completing the physical, the patient is given a Nalaxone test to confirm his or her opiate dependency and establish the appropriate initial dosage of methadone. The above admission services are completed on the first clinic visit and form the basis for the physician's decision whether the patient is physically dependent on opiates and could benefit from methadone treatment. Prior to leaving the clinic on the first day, the patient will leave a urine specimen.

Additional intake requirements include: (1) obtaining three verifications of the duration of addiction to narcotics; (2) obtaining blood work and urinalysis; (3) obtaining I.D. card; (4) attending a patient orientation conference (scheduled each Tuesday at 3:30 P.M.); (5) meeting with a Mental Health Complex fiscal worker to obtain billing information and determine the patient's ability to pay as mandated by State law (the financial interview may take place in person or via telephone and must be completed within fifteen days of admission); (6) completing and returning the patient's self assessment sheet; (7) meeting with a program psychiatric social worker to provide information for the social history and initial social work profile; (8) meeting with the psychiatric social worker to develop an individualized treatment plan; (9) attending an initial treatment plan conference with a staff physician, psychiatric social worker, and assigned primary counselor to review and adopt a master treatment plan.

All of the above intake and assessment procedures must be completed prior to the end of the fourth week of treatment. Patients who do not cooperate in the formulation and implementation of an individualized treatment plan may be discharged for non compliance with the program's policy and procedures.

ASSESSMENT PROCEDURES

It is the policy of the Milwaukee County Mental Health Complex Drug Treatment Program to conduct a complete assessment of each patient. This shall include, but not necessarily be limited to, the physical, emotional, behavioral, social, recreational and - where appropriate - legal, vocational, and nutritional needs. Clinical consideration of each patient's needs shall include the determination of the type and extent of special clinical examinations, tests and evaluations necessary for a complete assessment.

In addition to the intake procedures already stated, an "Initial Social Work Profile" is completed by a psychiatric social worker. The psychiatric social worker collects and examines the facts and circumstances of the individual's drug abuse and associated environmental and psychosocial problems, including any interpersonal emotional or behavioral, legal, vocational, leisure time, housing and financial, or lifestyle problems. It also requires the identification and review of environmental or psychosocial factors sustaining or reinforcing dysfunctional behavior or patterns of substance abuse, and the formulation of a "dysfunctional substance abuse statement" which specifies any behavioral/psychosocial problems precipitated or reinforced by the patient's alcohol or drug use.

The 'Initial Social Work Profile" is divided into two major sections; these are the "social history", which includes the data base information, and the "assessment", which presents the social worker's assessment of the data and appraisal of the nature of the drug abuse and associated problems in relation to the patient's, internal and external functioning. Patient's strengths and limitations are also identified. The assessment integrates and analyzes the information contained in the social work data base in order to form a basis for understanding the patient's strengths, weaknesses and clinical needs. The above information should be documented and entered in the patient's clinical record within four weeks of admission. In cases where the diagnostic evaluation and initial social work profile cannot be completed within the designated time frame, the reasons for non compliance and a plan of correction are entered in the client's clinical record.

Assessment Procedures for the Early Detection of Mental Health Problems

The following assessment procedures are available for the early detection of mental health problems that are life threatening, indicative of severe personality disorganization or deterioration, or that may seriously affect the treatment or rehabilitation process.

1. Psychosocial assessment - Service Provider: psychiatric social worker. A psychosocial assessment as obtained within four weeks of admission on all new clients of the Drug Treatment Program. Psychosocial assessments are obtained on ongoing clients when the patient's primary counselor or another member of his treatment team believe that a psychosocial re-assessment is diagnostically indicated.

2. Mental status evaluation - Service Provider: physician, psychiatric social worker or registered nurse. Performed when the patient's affect, behaviors, cognitive processes or psychological history suggests a possible psychiatric or emotional problem.

3. Depression Screening/Affect Evaluation Scale - Service Provider: physician, registered nurse or psychiatric social worker. The Depression Evaluation Scale is administered as part of the intake process when a psychosocial assessment indicates the possibility of depression. The Scale is also obtained on ongoing clients of the Drug Treatment Program when a patient's primary counselor or another member of his treatment team suspects the presence of depression.

4. Psychological testing - Service Provider: Mental Health Complex Psychology Department. Drug abuse clients may be referred to the Mental Health Complex Psychology Department for comprehensive psychological testing and evaluation upon the recommendation of a drug program staff physician. Psychological testing may be conducted for either diagnostic and/or treatment planning purposes.

5. Psychiatric evaluation - Service Providers: (A) Mental Health Complex liaison psychiatry service, or (B) Mental Health Complex outpatient psychiatry service. Drug treatment clients may be referred for psychiatric evaluation upon the recommendation of a drug program physician or psychiatric social worker. Patients may be referred for psychiatric evaluation for either diagnostic or treatment planning purposes.

TREATMENT PLANNING PROCESS

It is the policy of the Milwaukee County Mental Health Complex Drug Treatment Program that each patient shall have a written individualized treatment plan that is based on assessments of his or her clinical needs. The treatment plan shall be developed as soon as possible after the patient's admission. Appropriate therapeutic efforts may begin before a fully developed treatment plan is finalized. The treatment plan shall reflect the program's philosophy of treatment and the participation of staff of appropriate disciplines. Treatment plans should be developed in partnership with the patient, reviewed regularly with the patient and revised as often as necessary. Master treatment plans should be reviewed at least every ninety days. Master treatment plans

shall adhere to the problem oriented format and should clearly identify specific patient needs or problems, treatment goals and objectives (along with time frames for their attainment) and treatment methodologies.

Upon admission, a preliminary treatment plan based on the intake assessment is formulated by a staff physician and recorded in the "recommendations" section of the "physical examination" form. The preliminary treatment plan is completed on the first day. During the intake and assessment period, a psychiatric social worker or other designated social service staff person is assigned to coordinate the overall development and implementation of the treatment plan. Prior to the end of the fourth week of treatment, an Initial Treatment Plan Conference is conducted to review and adopt a Master Treatment Plan. The Initial Treatment Plan Conference is attended by the patient and those staff members responsible for his or her assessment or treatment. The Initial Treatment Plan Conference and the Master Treatment Plan shall be recorded and documented in the patient's record.

An appropriate member of the professional staff shall be designated as the patient's primary counselor. He or she shall have case management responsibility and will coordinate the overall implementation and review of the treatment plan. The Master Treatment Plan shall be reviewed and updated every ninety days by the treatment team. The patient and all staff members involved in the patient's treatment should sign the updated Master Treatment Plan. Reviews of and changes in the plan shall be recorded in the patient's case record.

A treatment plan review summary shall be prepared at least every ninety days during the first year of treatment and then at least twice a year after the first year of continuous treatment. The treatment plan review summary documents the patient's progress in attaining the specific goals and objectives outlined in the master treatment plan. All staff members involved in the patient's treatment should sign the patient's treatment plan review summary which shall be dated and recorded in the patient's case record.

It is the policy of the Milwaukee County Mental Health Complex Drug Treatment Program that multi-disciplinary treatment plan review conferences shall be regularly conducted to review and evaluate each patient's treatment plan and his or her progress in attaining the stated treatment goals and objectives. The conference will include the patient. Treatment plan review conferences are held on a regular basis to review problems in treatment and determine whether there should be a change in the patient's status, i.e., promotion, demotion, etc., as well as annual reviews of treatment progress. Treatment plan review conferences are conducted at least annually. The results of the review and evaluation are documented in the patient's record and signed by the members of the patient's treatment team.

In addition to the comprehensive reviews which occur during treatment planning conferences, problem specific case conferences are held as needed when the program director or a member of the patient's treatment team notes any of the following conditions: A. an infraction of the program's regulations such as a lost or stolen take home bottle, failure to return empty take home bottles, failure to keep counseling appointments, etc.; B. temporary situations affecting treatment; and C. limited treatment plan problems not warranting a full treatment plan review conference. Patients are required to attend problem specific case conferences. Each time a patient is staffed at a problem specific case conference, the reasons for the conference and the results of the staffing are documented in the patient's case record.

THERAPEUTIC MODALITIES

Medical Management and Chemotherapy

All patients of the Drug Treatment Program receive medical management. In methadone maintenance treatment, methadone (a synthetic narcotic) is administered daily to drug abuse patients. The use of this drug prevents the development of a withdrawal condition, satisfies the addict's craving for narcotic drugs, and permits the narcotic addict to stabilize his life situation and focus his energy on obtaining corrective and rehabilitative treatment for dysfunctions in physical health, psychological development, social adaptation, and vocational and academic performance. The medical stabilization of patients on methadone provides an opportunity for narcotic addicts to remove themselves from the addiction lifestyle and the constant 24 hour a day struggle to maintain their habit. It further permits them to avoid the physical dysfunctions associated with addiction, avoid the postwithdrawal syndrome of depression, anxiety, and craving for narcotics and allows them to marshall their existing resources to improve functioning in other areas of adjustment. Methadone maintenance provides an opportunity for addicts to progressively deal with their problems in that while stabilizing medically on an oral dose of methadone they can take one problem at a time, making use of the social service and counseling services provided by the program. Using the counseling services provided by the program, patients can develop skills in interpersonal relationships, become resocialized members of society, and work through the psychological components of their narcotic dependence. Because of the chronic relapsing nature of narcotic dependency, many patients will continue to need medical management and chemotherapy with methadone after their psychosocial problems are largely stabilized.

The program also provides medical management for psychiatric problems, particularly depression and other affective disorders. Antianxiety, antidepressant and antipsychotic medication are administered as diagnostically appropriate to increase the patient's level of functioning and ability to respond to counseling and social services. Approximately 30% of the patient population can benefit from medical management of psychiatric problems.

The program also provides medical management and chemotherapy for those patients dually addicted to opiates and alcohol. Antabuse is prescribed and administered as necessary and patients may supplement their treatment at the methadone clinic with group counseling from the Mental Health Complex Antabuse Program.

Individual Counseling/Therapy

Each patient of the Drug Treatment Program is assigned a primary counselor. The primary counselor may be a physican, registered nurse, psychiatric social worker, certified drug counselor, or addiction specialist. The primary counselor is the patient's case manager as well as the primary provider of individual counseling and/or psychotherapy. All patients receive individual counseling to facilitate their optimal psychosocial adjustment. Each client receives a minimum of one hour a month of counseling. The amount and frequency of counseling is determined by the patient's clinical needs as reflected in his or her treatment plan. Individual counseling/psychotherapy sessions focus on the problems identified in the patient's treatment plan. Special problems, such as unsatisfactory urinalysis, behavior problems, or lack of progress in treatment, are also addressed through individual counseling.

Family Therapy

Family therapy is available to a patient through the program's psychiatric social workers. The purpose of family therapy is to enable family members, family segments and the total family to mobilize their resources through the interactional process to deal with problem areas. Family therapy is provided in those cases where this service is diagnostically appropriate and the patient and family agaree to participate.

Couple Therapy

Couple therapy is available to patients through the program's psychiatric social workers. The purpose of couple therapy is to assist two persons in developing their abilities to deal, to a workable degree, with the problems that trouble them in their interpersonal relationships. Couple therapy is provided when this service is diagnostically indicated and the patient and significant other agree to participate.

Group Treatment

Group work services are available for patients of the Drug Treatment Program. The purpose of group treatment is to serve individuals within and through small face to face groups in order to bring about desired changes among client participants. Traditional group psychotherapy is a method of treatment in which two or more clients participate simultaneously in the presence of one or more psychotherapists. Generally, psychotherapy groups in the drug treatment program are led by two staff members who function as co-therapists for the treatment group. Group therapists may be psychiatric social workers, certified drug counselors, addiction specialists, or nurses. Groups may be open ended or time limited. As is the case with individual, family, and couple therapy, the focus of group treatment must relate to the patient's treatment plan.

Didactic Educational Groups

Time limited didactic educational groups are periodically offered in the Drug Treatment Program. These groups include such topics as: drug abuse, coping with stress/anxiety/frustration in daily life, parenting skills, communication skills, nutrition, or other topics which may benefit the drug abuser or his family. Didactic educational groups do not necessarily relate to the patient's treatment plan and may be viewed as an educational service rather than a part of treatment. Didactic educational groups may be led by any member of the clinic staff.

Summary

Any combination of the above therapeutic services may be used to meet the identified clinical needs of patients served. The choice and frequency of treatment methodologies utilized is based on the individualized treatment plan developed for each client. Treatment plans, including the choice of treatment methodologies, are developed in partnership with the patient and reviewed regularly with the patient and revised as often as necessary.

STRUCTURE OF TREATMENT

Urine Testing

The Drug Treatment Program utilizes a regular program of urine testing to determine patient progress in avoiding illicit drug use. The frequency at which patients are requested to leave supervised urine specimens is determined by their stage in treatment. The achievement and retention of take home privileges, including promotion to higher stages of treatment depend in part on the results of urine testing. Urine is tested for the presence of methadone, other opiate drugs such as morphine, codeine, dilaudid, etc., for cocaine and amphetamines, and for such other drugs as may be indicated by behavioral history. Patients are counseled regarding any unsatisfactory urinalysis.

Phases of Treatment

It is the policy of the Milwaukee County Mental Health Complex Drug Treatment Program to organize treatment into phases, each with its own goals, objectives, requirements and expectations. The phases of the program are as follows:

1. Admission phase - Sunday take home dose only until the completion of intake procedures.

2. Phase I - Following completion of the program's intake requirements and formulation and adoption of the patient's treatment plan at the "Initial Treatment Plan Conference", the patient enters Phase I. Patients in Phase I also receive a Sunday take home dose only.

3. Phase II - Phase II patients receive three take home doses per week but not more than two at any one time during any week. Patients may be promoted to Phase II after they have been on Phase I for a minimum of three months; obtain and/or maintain employment or socially acceptable alternatives, such as school, training, disability, full time child care, etc. for thirty or more days prior to the intended day of promotion; satisfy appointment schedules prescribed in the patient's treatment plan; make satisfactory progress towards achieving the goals and objectives outlined in the patient's treatment plan; and pay such amounts billed to the patient for his or her care in a timely manner. Patients are expected to maintain these behaviors in order to retain Phase II.

4. Phase III - Phase III patients receive five take home doses per week, but not more than three at any one time during any week. In order to qualify for Phase III, a patient must have been on the program for a minimum of two years of continuous treatment and have been employed or its equivalent for at least one month prior to promotion; have a satisfactory attendance in keeping appointments as prescribed in the treatment plan for at least six months; have urine reports which are negative for illicit drugs and positive for methadone for at least 180 days prior to the desired date of promotion; satisfy fiscal obligations to the program; and make satisfactory progress towards achieving the goals and objectives outlined in his or her treatment plan. Patients are expected to maintain these behaviors in order to retain Phase III.

5. Phase IV - Phase IV patients receive six take home doses per week. In order to achieve Phase IV, a patient must have been on the program for a minimum of three years of continuous treatment and have been employed or its equivalent for at least three months; have satisfactory attendance in keeping appointments as prescribed in the treatment plan for at least a year; have reports of urine specimens which are negative for illicit drugs and positive for methadone for 365 or more days before the desired date of promotion; comply with fiscal obligations to the program; and make satisfactory progress towards achieving the goals and objectives outlined in his or her treatment plan. Phase IV is the highest level of privileging which a patient can achieve. The requirements for promotion to this phase are very strict. Patients are not eligible for Phase IV status until treatment plan problems are largely resolved and they have achieved a high level of functioning. Patients are expected to maintain this high level of functioning in order to retain Phase IV.

6. Abstinence - Abstinence patients receive no methadone but may receive all other services. Due to the chronic relapsing nature of narcotic addiction and the high rate of relapse, patients must achieve Phase IV prior to having program permission for entering the abstinence phase of treatment. Clients who wish to withdraw from methadone prior to earning Phase IV do so against medical advice. Patients are encouraged to remain in the abstinence phase of treatment for at least two years following withdrawal from methadone. Patients may remain in the abstinence phase of treatment as long as the patient and staff feel that continued treatment is indicated. If total abstinence without methadone cannot be maintained, abstinence patients may return to Phase IV without prejudice.

ROLES AND RESPONSIBILITY OF STAFF

The Drug Treatment Program's multidisciplinary staff includes physicians, registered nurses, psychiatric social workers, and AODA counselors.

Treatment Team

The patient's treatment team includes his primary counselor, a physician, and those representatives of other disciplines, i.e. psychiatric social service, AODA counselors, nursing, etc., deemed necessary to meet the treatment objectives identified in the master treatment plan. Treatment services are orchestrated by the patient's Treatment Plan and may call for several staff members to be working with any given patient at a particular time, i.e. a depressed patient may be receiving medical management and chemotherapy for his depression from a staff physician, psychotherapy from a psychiatric social worker, monitoring for medication compliance by a registered nurse, and group therapy focusing on interpersonal relations from a certified counselor and addiction specialist. The patient's primary counselor is responsible for coordinating treatment with the other members of the treatment team. Multidisciplinary treatment plan conferences are held as necessary with the patient and the members of the treatment team to review and evaluate the patient's treatment plan and his or her progress in attaining the stated treatment goals and objectives.

Medical Staff:

The program's medical staff includes a full time physician IV (program director) and 1.5 FTE physician III's. The program director and staff physicians have the ultimate medical legal responsibility for patient care.

Staff physicians perform a physical examination on all new admissions and administer the Naloxone test. The physician is responsible for determining whether an applicant is physically dependent on opiates and could benefit from methadone treatment. Physicians are responsible for the prescribing of methadone and other medication and for the medical management of patients. They are also responsible for determining whether a patient can receive take home doses of methadone, including whether a patient should be promoted to any of the higher phases of treatment.

Nursing Staff:

The nursing staff consists of a .5 FTE clinical nursing supervisor, a .5 FTE RN II (head nurse), and 4.5 FTE RN I's. Nursing staff is responsible for completing the medical history on new patients, assisting the physician in administering the physical examination and Naloxone test, and assisting in annual physical rechecks. Nurses also administer methadone and other drugs as prescribed and are responsible for the narcotic count. They may also serve as primary counselors for assigned patients and/or secondary counselors for those patients who demonstrate medical, psychiatric and/or medication compliance problems. Nurses are generally assigned to monitor pregnant patients and coordinate their treatment with the patient's primary health care provider.

Psychiatric Social Service:

The psychiatric social service staff consists of a .5 FTE psychiatric social service supervisor and two full time psychiatric social workers. Psychiatric social workers serve as the case managers for patients in the intake and assessment phase. They are responsible for obtaining a social history on all new clients and preparing an Initial Social Work Profile. They also serve as primary counselors and carry a caseload of approximately 25 individuals. Cases assigned to the psychiatric social workers are generally more difficult than those given to the drug counselors and include those patients needing more intensive services due to psychiatric, martial, and/or family problems. The social worker may also be assigned secondary counseling responsibility for patients in need of psychiatric, marital, and/or family therapy. In those cases where a psychiatric social worker is assigned as a secondary counselor, the psychiatric social worker coordinates treatment with the AODA counselor, nurse or physician who is assigned as the patient's primary counselor.

AODA Counselors:

The AODA counseling staff consists of an AODA counselor supervisor, three certified counselors, and three addiction specialists. One of the addiction specialists serves as the program's intake worker; this individual is responsible for conducting preadmission screenings, scheduling patients for intake, conducting the admission interview and coordinating treatment with the psychiatric social workers, nurses and physician during the intake phase. In addition to serving as intake worker, this individual is assigned to manage the collection of a $25.00 minimum treatment fee from all patients. He also

serves as a primary counselor and carries a half-time caseload of approximately 17 individuals. The addiction specialists and certified counselors carry the primary counseling responsibility for a majority of the patients in treatment. The addiction specialists and certified counselors carry an average caseload of 35 individuals. As primary counselors, they are the case manager for those individuals assigned to them. AODA counselors provide individual counseling, group counseling, and to a lesser degree marital and family counseling.

Lines of Authority and Supervisory Relationships

Staff physicians are responsible to and supervised by the Program Director. Nursing personnel are responsible to and supervised by the Clinical Nursing Supervisor. The Clinical Nursing Supervisor is, in turn, responsible to both the Program Director and the Mental Health Complex Director of Nursing. Psychiatric Social Workers are responsible to and supervised by the Psychiatric Social Service Supervisor. The Psychiatric Social Service Supervisor is responsible to the Program Director and the Mental Health Complex Director of Psychiatric Social Services. Addiction Specialists and Certified Counselors are responsible to and supervised by the AODA Counselor Supervisor. The AODA Counselor Supervisor is responsible to the Program Director. The Program Director, Chemical Dependency Administrator, and each of the discipline supervisors (Clinical Nursing Supervisor, Psychiatric Social Service Supervisor and AODA Counselor Supervisor) serve on the Mental Health Complex Chemical Dependency Division's Clinical Coordinating Committee.

DISCHARGE PLANNING PROCESS

As with most types of medical treatment that require long term daily administration of medication, patients in methadone treatment should be evaluated periodically regarding the risks and benefits of continuing on medication. For some, eventual withdrawal from methadone is a realistic goal. However, years of experience demonstrate that for others this goal is not yet realistic, even though those patients show vocational, educational, and psychosocial improvement, and are productive members of society. Research and clinical experience have not, as yet, identified all the critical variables of determining when a patient can be successfully withdrawn from methadone and remain drug free. Thus, the determination to withdraw voluntarily from methadone maintenance is empirical and is left to the patient and the reasonable clinical judgment of the physician. Upon reaching a drug free state, the patient should be encouraged to remain in the program for as long as the program considers it necessary to insure stability in a drug free state. The frequency of required program visits for patients for drug free state may be adjusted at the discretion of the medical director.

The reasonable clinical judgment of the physician in determining whether a patient is ready to withdraw voluntarily from methadone is guided by the following criteria:

1. the non abuse of chemical substances as verified by urine reports, patient self reports and staff observations;

2. a treatment duration of three years or greater;

3. a satisfactory vocational adjustment, that is full employment or its equivalent;

4. a stable life adjustment as reflected in (a) the ability to cope with stress and crisis situations without resorting to substance abuse or other self-defeating behaviors, (b) the absence of criminal activity, (c) the development of personal relationships (family and friends that are satisfying and lasting), (d) the establishment of leisure time activities which are not drug related.

When a patient meets the above criteria (generally after achieving phase IV), they may participate in discharge and post therapy planning. The patient's primary counselor is responsible for discharge and aftercare planning. Prior to discharge, a written aftercare plan is developed in cooperation with the patient.

In those cases where a patient requests withdrawal from methadone and discharge without meeting the program's criteria, the patient is provided with detoxification services "Against Medical Advice". Patients who discontinue treatment prematurely are also offered aftercare planning through their primary counselor. Aftercare planning through the primary counselor is also available for those individuals who are involuntarily discharged for violations of their treatment agreement and/or violation of clinic policies and procedures. Following discharge, a discharge summary is prepared by the patient's primary counselor and entered in the clinical record.

SERVICES AVAILABLE, BUT NOT PROVIDED BY THE PROGRAM

As the Drug Treatment Program is part of the Milwaukee County Mental Health Complex, appropriate support services are available. The Drug Treatment Program is a Combined Community Services Board operated facility. The Combined Community Services Board provides contractual affiliations with a wide variety of agencies comprising the drug treatment continuum. A specific contractual agreement exists with the Division of Vocational Rehabilitation.

Types of Available Services Not Provided by the Drug Treatment Program but Available Upon Referral Include:

1. Alcohol and/or drug abuse detoxification;
2. Alcohol and/or drug abuse inpatient treatment;
3. Alcohol and/or drug abuse residential treatment;
4. Alcohol and/or drug outpatient drug free counseling;
5. Outpatient antabuse treatment which may be provided by the antabuse component of the Chemical Dependency Division;
6. Inpatient, outpatient, and day treatment psychiatric treatment is available from other units of the Mental Health Complex;
7. Vocational rehabilitation services are available through the Division of Vocational Rehabilitation;
8. Job development services are available through the Division of Vocational Rehabilitation and Wisconsin Correctional Service.