

Treatment Access Program (TAP)
Community Substance Abuse Services (CSAS)
Division of Population Health and Prevention

Department of Public Health
San Francisco

QUARTERLY REPORT

January 1, 2001 to March 31, 2001

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EXECUTIVE SUMMARY

Over the past six months, Community Substance Abuse Services (CSAS) has undertaken a refocusing and redesign of the Treatment Access Program (TAP). The purpose is to strengthen the Program's fundamental mission to assist San Francisco residents, with the most urgent needs and serious access barriers, to enter treatment. TAP has also begun to take a more active role in concretely addressing ways to better integrate the publicly funded system of substance abuse treatment services. An important part of this effort is to improve TAP's accountability to the community, and make its day-to-day operations transparent. This inaugurates the beginning of routine quarterly reports to community service providers and the community at large.

In brief, TAP screened 379 clients during the first quarter of 2001. Of these, comprehensive assessments were conducted with 59%, or 222 of the clients. By and large, these were clients with serious access barriers and/or an urgent need for treatment. Of the 222, TAP was able to successfully place 36%, or 81 clients, however an additional 18% (40) were still engaged and waiting to be placed at the end of the quarter. Of the 81 clients who entered treatment, 80% (65) remained in treatment for 30 days or longer.

The major unmet service need, by far, is for Dual Diagnosis Residential Treatment Services. Of the 141 clients who disengaged from TAP in this period, 72% were facing long waits to get into a Dual Diagnosis program. In contrast, while the average wait for a non-dual diagnosis residential program was 12 days, for a dual diagnosis program the average wait was 32 days.

INTRODUCTION

The Treatment Access Program (TAP) is the assessment / referral and placement unit of Community Substance Abuse Services. TAP directly assesses clients who self refer or are referred by various providers throughout the City. In addition, TAP works closely with assessors at S.F. General Hospital and the DPH community clinics, as well as the assessors at Drug Court and other parts of the Criminal Justice system in order to assist in the appropriate placement of clients into the City's publicly funded treatment system.

Over the past six months, TAP has been in the process of being redesigned and refocused in order to increase its overall effectiveness to clients, as well as its accountability to the network of community providers. This report will be the first of a series of routine reports that will be released quarterly. The reports will highlight different features of TAP's work, as well as a statistical profile of the clients served and services provided during the previous quarter. In addition, the report will highlight urgent service gaps and challenges that face us in terms of increasing access to substance abuse treatment in the City and County of San Francisco.

REFOCUSING PRIORITIES

In an attempt to more efficiently allocate scarce resources consistent with public health practice, TAP has explicitly refocused the priorities for assisting and placing clients into available substance abuse treatment services. The prioritization is based upon the recognition that some people face more severe barriers to entering treatment, or present with an urgent need in light of their overall medical and mental health condition. These access considerations cannot be easily reduced to a formula, and must be triaged on a case-by-case basis. Nonetheless, the key triage priorities have been determined and are listed below:

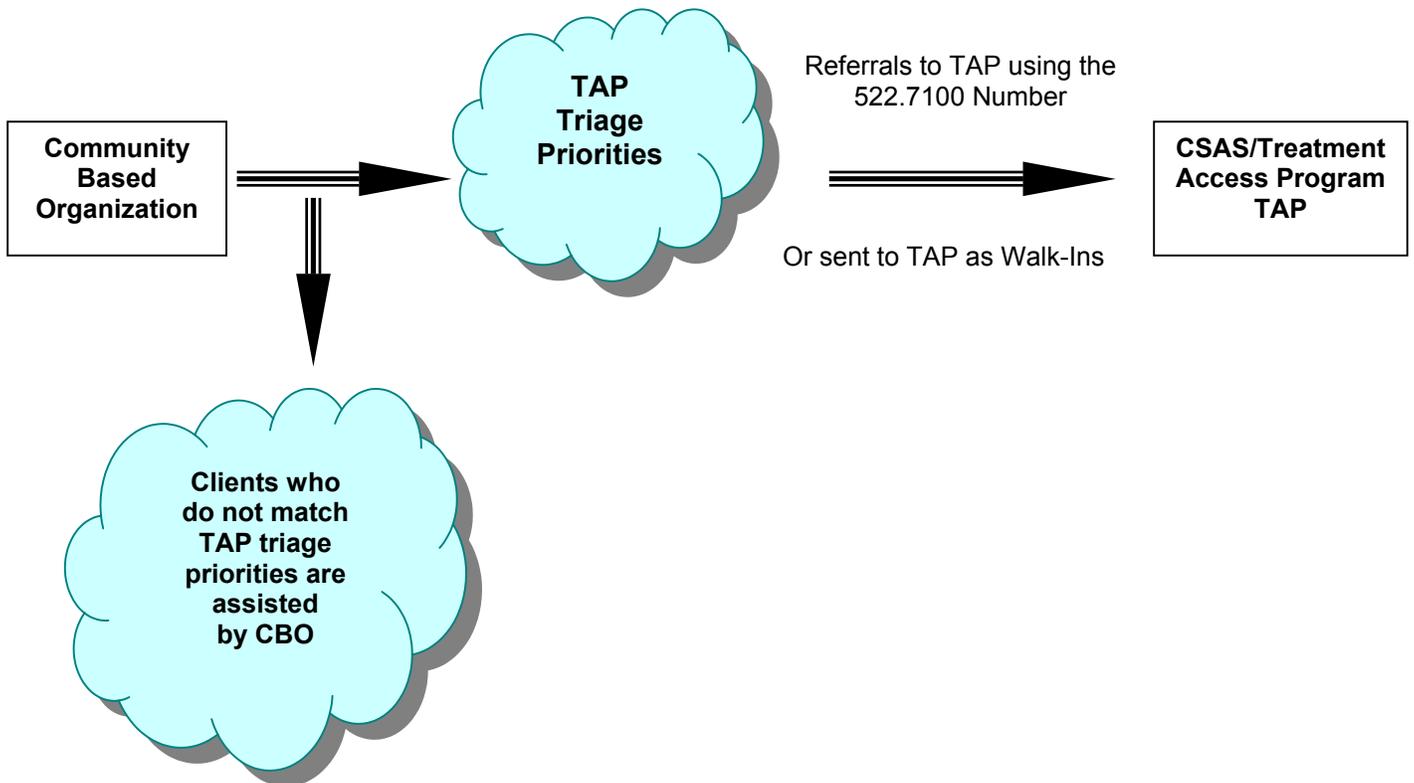
- Clients who never have had a "treatment experience" (regardless of age)
- Young adults with relatively serious drug / alcohol problems
(Between the ages of 18 and 23)
- Individuals with medical "barriers" or conditions that make attempts to stabilize their alcohol and/or drug use a relatively urgent public health priority and/or constitute a serious obstacle to them being able to access treatment.
 Non-ambulatory / frail secondary to a medical condition (i.e., recent gun shot wounds, endocarditis, necrotizing fasciitis, late stage AIDS related conditions, acute hepatitis C, etc.).
- Pregnant women
- People with mental health "barriers" or psychiatric conditions that make attempts to stabilize their alcohol and/or drug use a relatively urgent public health priority and/or constitute a serious obstacle to them being able to access treatment.
 This would be clients with a relatively serious range of mental health problems (currently treated or untreated). It would not apply to those with a range of mental health symptoms routinely associated with late stage drug / alcohol dependency (i.e., moderate depression, moderate anxiety disorders, etc.)

- People with social “barriers” that constitute a serious obstacle to them being able to access treatment.
 - > 55 years old
 - Non-English monolingual or Limited English Speaking
 - Clients with active and sole parenting responsibilities for children
 - People with transgender and gay and lesbian treatment issues

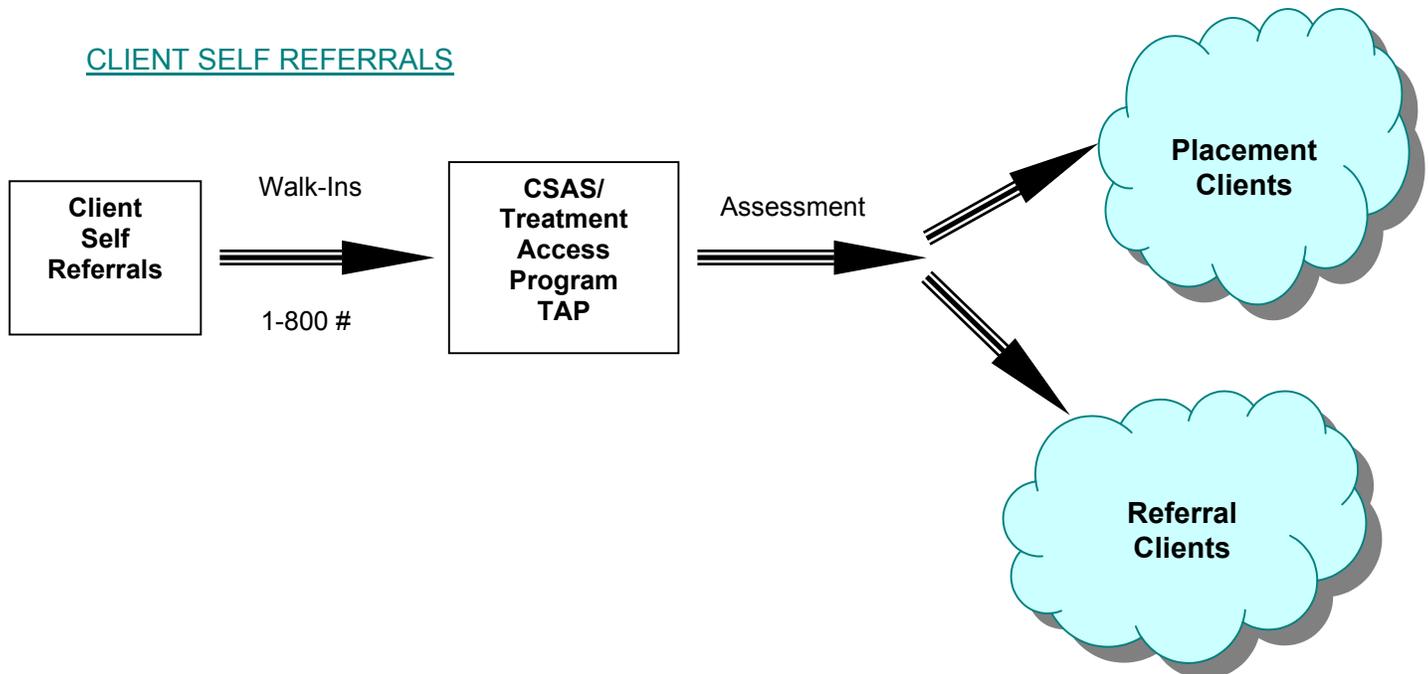
The hope is that these triage priorities will assist service providers in determining which clients to refer to TAP. To make a referral, contact (415) 522-7100 (M-F, 8:00 a.m. until 5:00 p.m.). The client will be given an appointment date for an assessment within three working days of the referral. From the time of the assessment, TAP will make every effort to assist and closely follow the client until s/he has been successfully placed into a treatment program. If the referring provider has an existing, long-term relationship to the client, TAP will coordinate case management efforts accordingly. TAP will refer to these clients as “placement clients”.

ANY client can self-refer to TAP by calling (1-800) 750-2727 regardless of whether or not they meet any of the triage priorities listed above. Clients who have previous treatment experience but do not meet TAP’s triage priorities will still receive counseling assistance in determining appropriate treatment referrals, assistance in making calls to treatment programs to set up in-take appointments, and transportation assistance (when needed) to get to their in-take appointment. TAP will refer to these clients as “referral clients”.

PROVIDER REFERRALS



CLIENT SELF REFERRALS



ENGAGEMENT SERVICES

Even in ideal situations where there is an adequate supply and efficient use of treatment resources, many clients may have to wait for some period before actual placement or entry into a program. Consequently, “engagement services” are essential to the notion of “treatment on demand”: ways to actively assist and support clients in order to increase their chances of “surviving” the wait period and successfully entering treatment.

TAP has been conducting basic engagement services for a number of years. These priorities primarily consist of daily “treatment readiness” groups and acupuncture sessions. Over the past six months TAP has begun to transform these services in a number of important ways:

- The drop-in group and acupuncture formerly conducted at 1663 Mission (TAP’s administrative office) is now being facilitated by staff at the McMillan Drop-In Center.
- TAP is coordinating a two-year plan to establish a network of engagement services in various community-based venues in different parts of the City.
- “Treatment readiness” support groups and acupuncture services in a number of sites will be open to all clients waiting to get into a treatment program.
- All engagement services will continue to apply harm reduction methods in working with clients who may still be using, but are prepared to show up and still want to get into a treatment program.

For placement clients who meet the triage priorities, TAP will provide (in addition to the basic engagement groups and acupuncture) short-term case management services. This includes crisis assistance, brokered shelter services, one-on-one supportive counseling, etc.

SERVICE BURDEN (Quarter ending March 31, 2001)

BASIC SERVICE

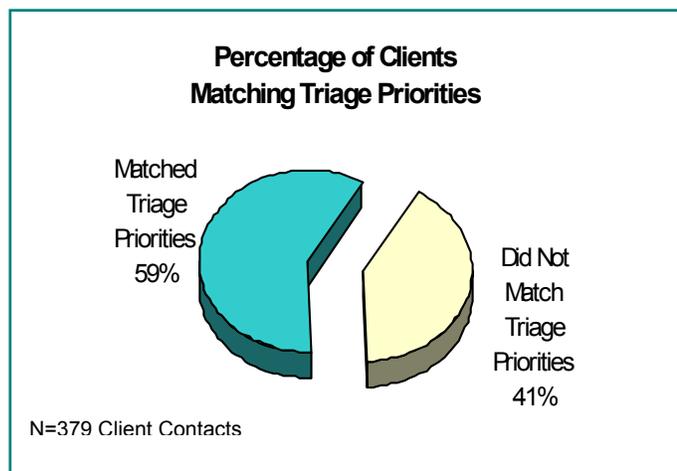
Currently, TAP focuses its primary attention on stabilizing, assisting and placing clients who meet the triage priority criteria listed above. For these clients, a thorough assessment is conducted utilizing the Addiction Severity Index. TAP then actively brokers admission for these clients into the existing system of CSAS funded treatment programs. Previously, TAP tended to restrict its placements to a relatively small set of treatment slots across a few programs that it had been assigned to manage. This will change, however, as TAP begins to broker admission into the full range of CSAS funded treatment services.

The client and TAP assessor work collaboratively to determine the type of program that best suits the client's needs. TAP arranges for an in-take appointment and keeps track of the tentative admission date. During the wait period, TAP actively attempts to keep the client engaged by using a variety of strategies, including daily groups, acupuncture, phone calls, individual counseling, etc. In addition, crisis intervention and detoxification services are provided whenever necessary in the course of the wait period. For clients who are "on the streets", TAP attempts to broker shelter as well. Each morning TAP staff reviews all new clients who were assessed the day before, as well as the admissions, progress and crises of the clients actively waiting to get into treatment.

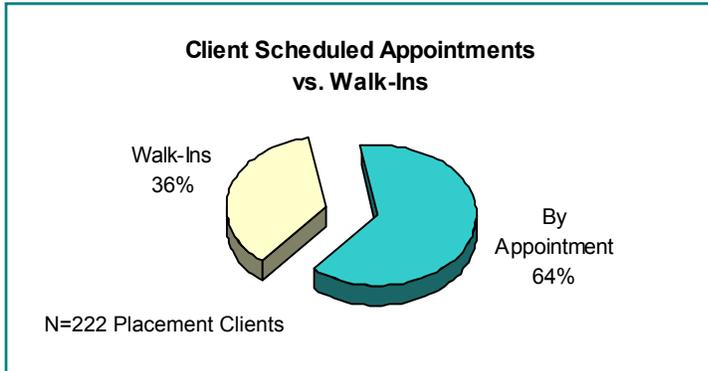
During the period under review, TAP's line staff consisted of four (4) Assessment / Placement Specialists. In addition, in the early part of the quarter, TAP was still in the midst of redesign and start-up efforts that resulted in a less than optimal performance in some aspects of service delivery and data collection.

In spite of this, TAP had a total of approximately 379 client contacts in the first quarter of 2001. This amounts to an average of 6.3 individual client assessments / screenings per workday.

59% of the clients assessed (222 out of 379) matched the triage priorities. These "placement clients" are tracked daily and assisted until they have been successfully placed in a treatment program or they disengage from the process, at which point TAP closes the case after about two or three weeks of no client contact).



A substantial number of the clients assessed are “walk-ins” with no scheduled appointments. However, the majority of them do have prearranged appointments. These are either client self-referrals or provider referrals. In the previous period there were 343 scheduled appointments. Of these, 202 (59%) were “no shows”. In other words, about one out of every two scheduled appointments are “no shows”, with an even higher ratio at the beginning and middle of the month when disability and General Assistance checks are issued.



Of the 222 “placement” clients case managed during the first quarter of 2001, 64% had scheduled appointments and 36% were “walk-ins”.

Discussion:

1. The high “no show” rate is worrisome. The rate is now being tracked on a monthly basis in order to gradually accumulate reliable trend data.
2. Certainly, part of the “no show” rate is an expression of the ambivalence characteristic of people with substance abuse disorders – the tendency to want help yet simultaneously have a difficult time showing up to get it.
3. However, the challenge before us is to examine the ways in which the “no show” rate is a function of barriers that can be identified and lowered over time. For example:
The number and type of venues where people can go to be assessed and assisted could be increased.
 - a) The motivational style, orientation and encouragement provided in setting up the appointments could be improved.
 - b) The barrier closest to the principle of “treatment on demand” – the time between when a person asks for help and how soon he/she gets assessed and concretely assisted could be shortened.
4. “72 Hour Protocol” – beginning in December 2000, TAP instituted a protocol that all appointments are set within three working days of the initial phone request or referral. In the main, we have been successful in enforcing the protocol. Given current staffing levels, this policy has been made possible by scheduling appointments at both the 1663 Mission Street TAP office and the McMillan Drop-in Center, as well as routinely double-booking appointment times in light of the current “no show” rate.

REFERRAL SOURCES

In the majority of instances, the source of client referrals is logged, especially for placement clients. Following is a general proportional breakdown of the sources of TAP referrals for the first quarter of 2001:

24% Client Self Referral

24% Detoxification Units

16% Shelters / Drop-in Centers

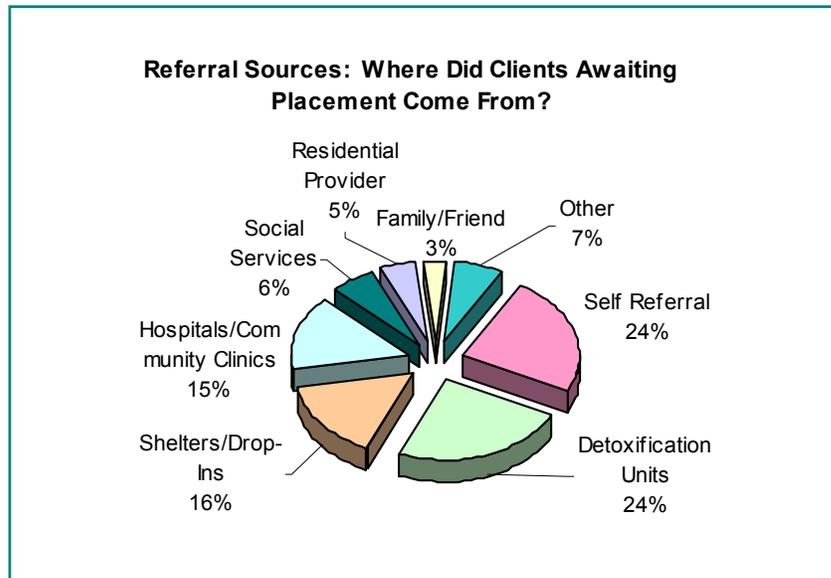
15% Hospitals /
Community Health Centers

6% Social Service Agencies

5% Residential Providers

3% Family/Friend

7% Other (Methadone clinics,
Needle Exchange, Acute Diversion Units, Criminal Justice System)



DETOXIFICATION SCREENINGS AND PLACEMENTS

In addition, TAP handles brief screenings for detoxification services, concretely methadone 21-day detox programs, as well as “social model”, non-medical detox placements.

During the first quarter of 2001, 89 referrals were made to Methadone 21-day Detox. Of these referrals, 93% were to Westside Methadone, the remainder to Bayview Hunters Point Foundation.

Beginning February 2001, in close cooperation with the Haight Ashbury Free Clinics (HAFCI), TAP assumed management of referrals into Smith House Women’s Detoxification Services (Monday through Friday, 8:00 a.m. until 5:00 p.m.). During February and March 2001, TAP handled 63 referrals and/or screenings for Smith House, resulting in 43 placements (68%).

TREATMENT READINESS GROUPS AND ACUPUNCTURE

The core of TAP’s “engagement services” is to provide the opportunity to participate in daily support groups and acupuncture for clients awaiting placement into a treatment program. In November 2000, in cooperation with Community Awareness and Treatment Services (CATS), TAP established a jointly facilitated, daily group at McMillan Drop-in Center. In February 2001 a similar agreement was initiated with Saint Vincent DePaul Society. A daily group was begun at Multi-Service Center South. During the first quarter of 2001, a total of 247 clients participated in these support groups during the first quarter of 2001.

Table 1: TAP Engagement Services

	Total Number of Clients Attending
Treatment Readiness Groups	247
Acupuncture Groups	149

Acupuncture services are subcontracted through Pacific Acupuncture Associates. In the fall of 2000, TAP transferred the acupuncture formerly offered at its 1663 Mission Street office over to the McMillan Center. Currently, acupuncture is offered there three days a week in conjunction with the support groups. In the first three months of 2001, 149 clients attended acupuncture at McMillan Center.

Discussion:

1. Acupuncture has proven to be an important complement to daily support groups in keeping clients engaged while they wait for admission to a treatment program. Efforts are underway to find the ways and means to provide similar acupuncture services at Multi-Service Center South.
2. Recognizing that the environmental pressures and stressors to use drugs and/or alcohol are tremendous for the vast majority of clients attempting to get into treatment, a harm reduction approach is taken in all TAP's engagement services. Clients are encouraged to attend (or return) to group even if they've "used". Their place on the wait list is not jeopardized if they are able to keep in touch with us. This includes instances where clients may need to access detox services in the course of waiting to get into a program.
3. TAP's principle efforts in the past period have been focused on establishing the foundation of a network of engagement services. However, there is room for improvement, both in finding ways to encourage higher attendance at groups, as well as determining an effective focus for the groups

CLINICAL STAFFING / GROUP SUPERVISION / COLLATERAL SERVICES

A significant portion of the service effort of the TAP clinical team cannot be easily tracked or measured as an "individual client service".

For instance, approximately 1.5 hours per workday is spent collectively in clinical rounds and group supervision / case conference. This amounts to about 7.5 hours per week for each assessor.

In addition, a little less than one (1) hour per day is spent by each TAP assessor in conducting collateral services. This amounts to about 16.5 hours per week total, or roughly 4 hours per week for each assessor.

**Table 2: Collateral Services in 15 minute intervals
For the week of April 23rd, through April 27th, 2001**

3.9 hours	Calls to Providers
3.6 hours	Calls from Providers
0.9 hours	Calls to Clients
2.2 hours	Calls from Clients
3.6 hours	Brief encounters with Clients
2.15 hours	Brief consultations with fellow staff regarding client dispositions

16.35 Total Hours of Collateral Services

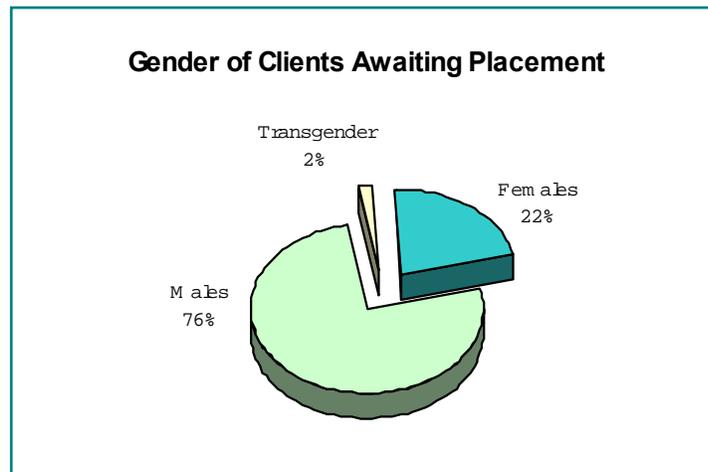
A Time Study was conducted over a period of a week during the quarter under review. TAP clinical line staff collected data on their activities, recording their data into 15 minute increments in order to arrive at a formula for collateral services. Similar time studies will be conducted twice a year to maintain the validity of the formula.

DEMOGRAPHIC PROFILE OF PLACEMENT CLIENTS

Of the 222 Placement Clients in the first quarter of 2001, complete demographic data was collected on the vast majority – following is the demographic profile that emerged.

Gender

76% Males
22% Female
2% Transgender

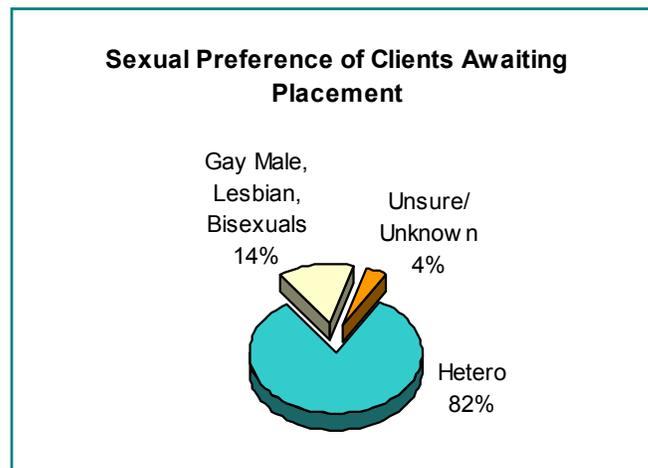


Discussion:

Clearly, females are under-represented in terms of TAP services, indicating a need for specialized outreach and stronger referral bridges to community based, women-focused service agencies.

Sexual Preference

83% Heterosexual
14% Gay, Lesbian, Bisexual
3% Unsure / Unknown



Age

The average age for all the placement clients was 40 years old – male average was slightly older (41) and females and transgender people a bit younger (37).

Table 3: Mean (Median) Age

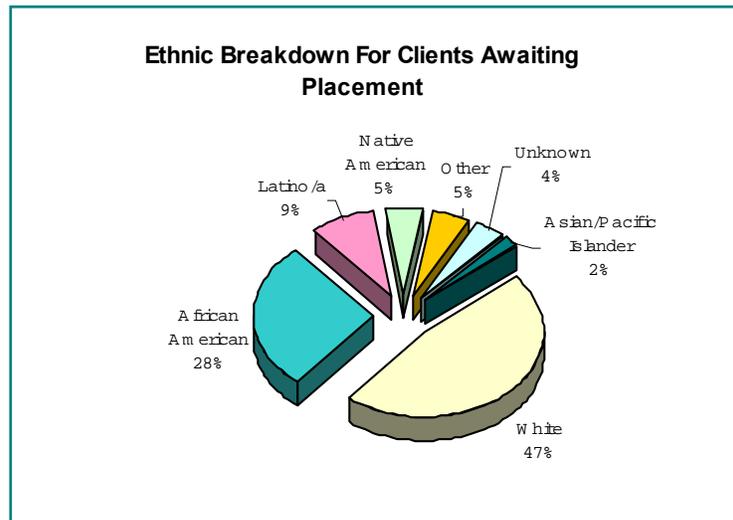
	Male	Female	Transgender
Mean (Median) Age	40 (41)	37 (38)	37 (35)

Discussion:

The mean age of 40 indicates the need for more outreach to younger people with serious drug problems. Given the multiple and severe character of the issues facing TAP clients, it is understandable that they would tend to be older. The average client has a late stage addiction, with heavy use patterns over one or two decades, and chronic, medical co-morbidities characteristic of middle age.

Ethnicity

47% White
28% African American
9% Latino
2% Asian Pacific Islander
5% Native American
5% Other
3% Unknown



Discussion:

The Latino and API communities are under-served in terms of the ethnic profile of TAP placement clients. Over the past six months, TAP has qualitatively strengthened its capabilities to provide assessment and placement services in Spanish. Efforts are also underway to improve and increase the referral bridges between TAP and agencies that focus services to the Latino community. The next priority will be to make similar progress and arrangements vis-à-vis the Asian and Pacific Islander communities.

Housing Status

80% are listed as “homeless”
7% lived by themselves (usually in an SRO hotel)
9% lived with family (for almost one fourth of those, “family” included dependent children)
3% lived with roommates (half with “shared expenses”)
1% unknown

Discussion:

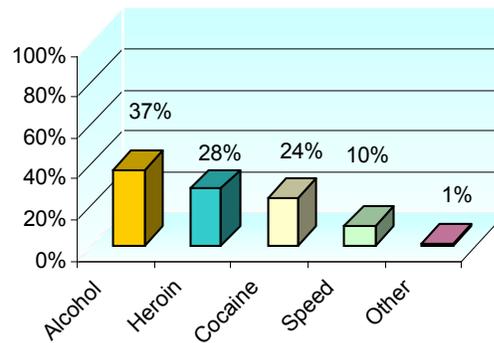
We are not satisfied with the strength of the housing data. Generally, TAP assessors do not distinguish between living “on the streets” and the variety of “marginally housed” situations in which people find themselves. Steps will be taken to collect demographic data in a more precise manner during the next period under review.

CLINICAL PROFILE OF 222 PLACEMENT CLIENTS

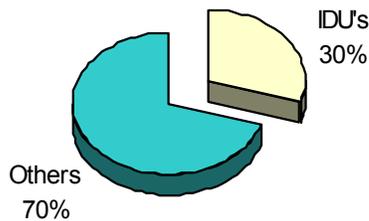
Primary Drug of Choice

37% Alcohol
28% Heroin (89% IDU)
24% Cocaine
(88% Crack, 4% IDU)
10% Speed (72% IDU)
1% Other
(Marijuana, Benzodiazapines)

Primary Drug(s) of Choice of Placement Clients



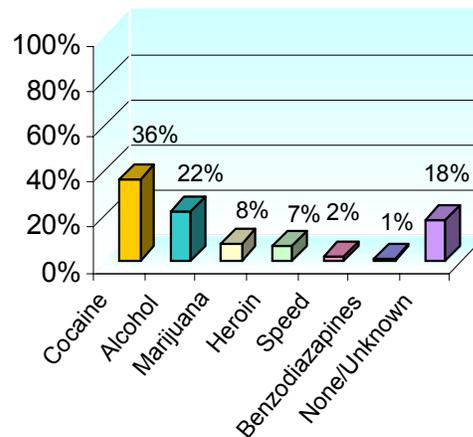
Percentage of Clients Injecting Primary Drug



Secondary Drug of Choice

36% Cocaine (100% Crack)
22% Alcohol
8% Marijuana
7% Heroin (83% IDU)
2% Speed
1% Benzodiazapines
18% None or Unknown

Second Drug(s) of Choice of Placement Clients



Discussion:

1. The ranking of alcohol as a primary drug of choice is not surprising. As a legal drug it is easier to obtain, and for many it may be the first drug that signals the pathway into addiction. However, the categories of primary and secondary drug of choice do not inform us about the cycle of use, nor does it tell us which drug may initiate such a cycle. For instance, when we examined the data more closely we discovered that 35% of the clients who reported alcohol as a primary drug of choice listed crack cocaine as their secondary drug of choice. Thus, this ranking may mask a deeper relationship in which crack cocaine may be the primary drug of choice whenever the client reaches a sufficient money threshold to make an actual choice practical. TAP will begin to take more care in the assessment in order to more precisely tease out this subtlety.
2. Crack cocaine remains a substantial problem with little evidence that it is receding in any significant manner.
3. More than one out of every three TAP placement clients are IDUs (mostly heroin addicts) – indicating the need to strengthen the education work regarding the importance of “clean works” and detailed information about Needle Exchange.

HIV AND HEPATITIS STATUS

The data collected in the first quarter of 2001 regarding HIV status was considered qualitatively unreliable and therefore disqualified for this report. (See discussion below)

In terms of Hepatitis, 37% of placement clients reported having Hepatitis C. When we cross-tabbed the finding with active IDU status, we discovered that 59% of the IDU clients reported being Hepatitis C +.

In contrast, only 3% of the clients reported known positive status for Hepatitis B.

Discussion:

We are dissatisfied with this data in a number of ways.

1. The current questions regarding HIV status focus on vague inquiries about “chronic health conditions”. We question the validity of our data, and propose the following changes. Since TAP assessments are protected by confidentiality, inquiries about HIV and hepatitis status can be conducted in a much more explicit and direct fashion. Doing so would present an opportunity for assessors to discuss openly with clients possible risk behaviors, the importance of testing, how testing may be obtained, etc. And if a client is HIV+, the assessor could inquire about whether the client has a primary care provider, and if not, this issue could be addressed in the treatment plan.
2. There are similar concerns regarding the lack of thoroughness in the gathering data regarding Hepatitis. Even so, the high incidence of known Hepatitis C among TAP clients is startling. Currently, the TAP staff’s knowledge of Hepatitis C – transmission, consequences, available treatment, etc. – is inadequate, and must be improved in the next period.

ADDICTION SEVERITY INDEX (ASI) SCORES / PROFILE

Each client who meets TAP’s triage priority criteria is assessed utilizing the Addiction Severity Index survey. The ASI is a multi-axis instrument that examines five related areas of a client’s life in addition to alcohol and drug use (i.e., medical, employment, legal, family / social, and mental health). Each area gets scored separately and the score is a synthesis of the client’s opinion of the severity of the problem and the assessor’s impressions of the level of need for services in a related area. The range is from 0 to 9 (0 being no evident problem, 9 being critical problem requiring urgent treatment) – generally a score 5 or above indicates the need for some level of treatment and/or action.

Not surprisingly, TAP clients tend to be people with late stage addictions – heavy use patterns extending back ten or twenty years or longer; persistent and compulsive use in the face of extreme negative consequences, etc. For example, 76% of the 222 “placement” clients under review had ASI severity scores 5 or above for drugs and 57% had scores 5 or above for alcohol as well.

Table 4

Level	ASI ETOH	ASI Drug
5	6%	11%
6	32%	47%
7	19%	18%
8	0	0
9	0	0
% of TOTAL	57%	76%

In terms of co-morbid problems requiring additional, separate, and often urgent, treatment – the most intense problems are in areas of family / social problems, mental and physical health, respectively. Among the 222 “placement” clients, around 58% had serious social isolation and family adjustment issues, around 47% had mental health issues indicating the need for treatment, and roughly 32% had severe medical issues.

Table 5

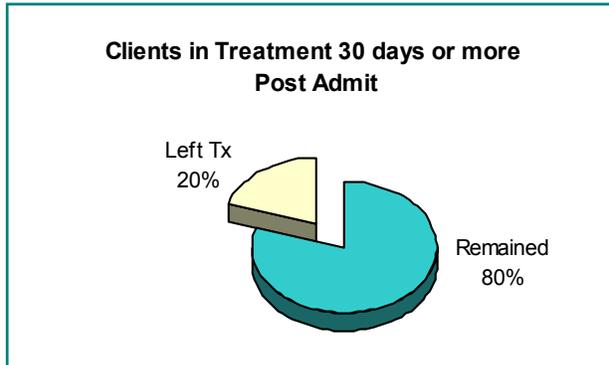
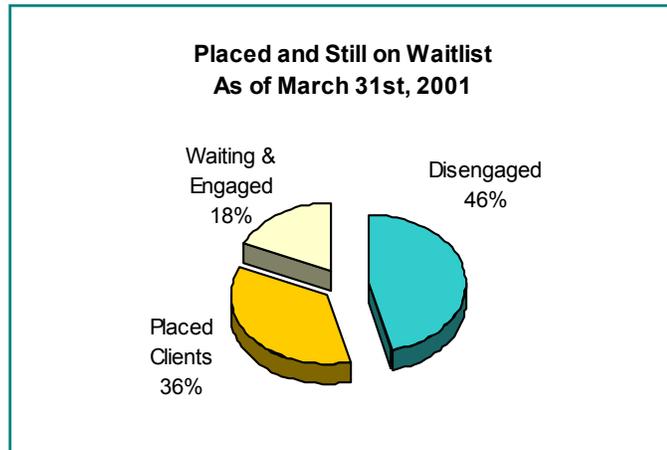
LEVEL	ASI Med	ASI Employ	ASI Legal	ASI Fam/Soc	ASI Psych
5	12%	6%	6%	14%	17%
6	15%	7%	8%	29%	20%
7	4%	2%	4%	14%	9%
8	0.5%	0	0	0.5%	0
9	0	0	0	0	0.5%
% of TOTAL	31.5%	15%	18%	57.5%	46.5%

Discussion:

Cross reliability among TAP assessors is relatively high, however there are ongoing quality assurance efforts to increase the skill and precision of assessment interviews. Generally, TAP is attempting to move away from “deficit-focused” assessments (where all the obvious “negatives” are accounted for without a comparable effort to identify the potential, positive “reserves” the client may have to assist in their rehabilitation efforts). In particular, TAP is currently focusing on improving our interviewing skills in the areas of employment and family / social situations.

CLIENT OUTCOMES

Of the 222 clients TAP attempted to place into treatment over the past period, 81 clients successfully entered (36%). In addition, as of the end of the quarter (March 31st, 2001) 40 of the 222 were still on a waitlist and still actively engaged with TAP. Since these later clients should also be considered “potentially” successful for entry into a treatment program – the range of successful placements is, more precisely, 36% to 55%.



A survey of the 81 TAP clients placed in treatment (utilizing the BIS database) indicated that fully 80% (65 out of 81) were, or remained, in treatment 30 days or longer.

URGENT UNMET NEED: DUAL DIAGNOSIS RESIDENTIAL TREATMENT

In terms of the most urgent gap in services, TAP’s experience matches that of many other service providers – Dual Diagnosis Residential Treatment.

Currently, this level of treatment is critically scarce in the publicly funded system of substance abuse services. The resources are limited to a handful of beds at Walden House (WHITS) and Baker Places (Baker 7th Street).

On the other hand, approximately one out of every two clients assessed by TAP are considered most appropriate for this level of treatment.

No where is this problem illustrated more vividly than in comparative waitlist time:

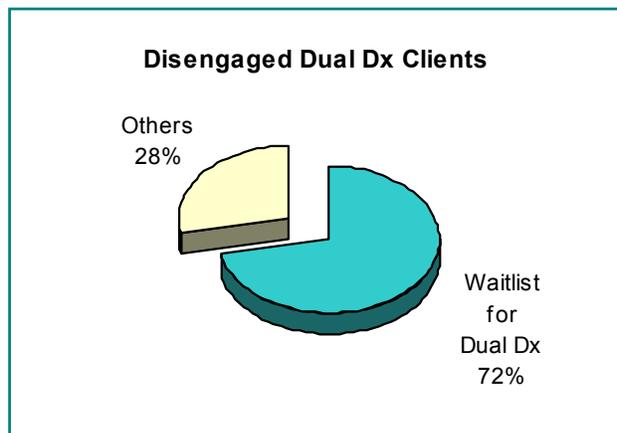
- The average wait for the 81 placed clients into “mainstream” residential treatment programs (in the first quarter of 2001) was 12 days – more significantly, the median wait was only 5 days.
- In contrast, the average wait for those clients entering dual diagnosis residential treatment programs (over the same period) was 32 days. The median wait was 23 days.

Table 6: Average and Median Wait for Tx in Days

	Mainstream Residential	Dual Diagnoses Residential
Average Wait	12	32
Median Wait	5	23

The same problem measured another way:

- Of the 222 TAP placement clients in the period under review, 141 disengaged from the process and were lost to TAP. Although this phenomenon of client disengagement cannot be viewed completely as a function of “waitlist time” – anticipated “time to wait” is probably the primary factor in clients becoming discouraged, disengaging from contact with TAP, returning to heavy use and crisis, etc.
- When we examine the treatment referrals of the 141 clients who disengaged, we discover that the vast majority of them (72%) were waiting for admission into Walden WHITS or Baker 7th Street. It is reasonable to conclude that a large part of the failure of these clients to stay engaged is having to anticipate a wait of one or two months or longer. This wait time constitutes a completely unreasonable request of clients.

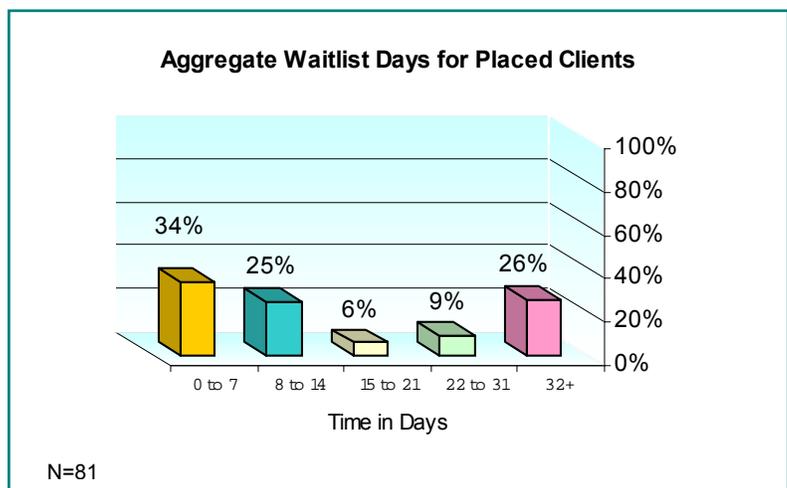


OVERALL WAIT LIST DATA

Of the 81 clients successfully placed into treatment during the first quarter of 2001:

- 34% waited 0 to 7 days until placement
- 25% waited 8 to 14 days
- 6% waited 15 to 21 days
- 9% waited 22 to 31 days
- 26% waited 32 days or more

Total wait list days = 1,785
 Average wait list days per client = 22
 Median wait = 11 days



SYSTEM INTEGRATION EFFORTS

TAP will increasingly be utilized as a vehicle to foster service integration within the CSAS funded treatment system, as well as, between the substance abuse treatment system and other related service systems supported by the City and County of San Francisco. The end-goal being increased efficiencies and optimal services for clients in need of substance abuse treatment.

In the quarter under review, TAP's closest collaborative efforts have been with the following agencies:

- McMillan Drop-In Center (CATS)
- HIV Prevention Project (Needle Exchange)
- Smith House Women's Detox Unit (HAFCl)
- Women's Place (CATS)
- Bay View Hunters Point Foundation
- DSAAM (Department of Substance Abuse and Addiction Medicine / CHN)
- Baker Places
- Multi-Service Center – South (Saint Vincent De Paul)
- Ozanam (Saint Vincent De Paul)
- Tom Waddell Clinic
- Mission Mental Health Clinic

Treatment Access Program
(Community Substance Abuse Services)
1663 Mission Street (between South Van Ness and Division)
San Francisco, California 94103

**Substance Abuse Assessment / Placement / Referral Services
And
Screenings for Detoxification Services**

Hours of Operation: Monday to Friday, 8:00 a.m. until 5:00 p.m.

Client Self Referrals: 1-800-750-2727

Service Provider Referrals: 415-522-7100

Engagement Support Services open to the public on a drop-in basis:

Pre-treatment group: McMillan Drop-In Center
Monday to Friday, 3:00 to 4:00 p.m.

Acupuncture: McMillan Drop-In Center
Monday, Tuesday and Thursday, 1:30 to 2:45 p.m.