Reflections on Lost Opportunities at the Haight Ashbury Free Clinic: Lessons for Progressive Non-Profit Organizations

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Abstract

Discussions about healthcare policy frequently include the contention that, "Healthcare is a right not a privilege." However, relatively few people know that phrase was made popular by the Free Clinic movement during the late 1960's and early 1970's. The Haight Ashbury Free Clinic (HAFC) in San Francisco was the flagship of the Free Clinic movement and has provided medical, addiction, and housing services to low income individuals for over 35 years. Rapidly after its inception in 1967, the clinic achieved notoriety for its innovative services to the community, particularly to those most in need. However, during the last decade the agency has suffered from severe financial problems, disorganization, and plummeting staff morale. News media reports during the past two years have described charges of embezzlement, lawsuits, counter lawsuits, and a flood of dedicated, skilled, and committed staff leaving in disgust. This paper presents an analysis of the decline of the HAFC, including key issues that were never adequately addressed and lost opportunities for promoting progressive healthcare. The paper closes with suggestions for other progressive non-profit organizations, which include increased efforts to garner public support for progressive healthcare and strategies for adapting to changing organizational and environmental circumstances.

Keywords: Free Clinic, Haight Ashbury, Drug treatment, Non-Profit

Introduction

Contemporary progressive non-profit organizations must balance what sometime seem to be incompatible objectives. On one hand, they pursue progressive objectives that respond to community needs, such as facilitating empowerment of underserved groups, mobilizing community involvement, and confronting oppressive bureaucracies. The priority is the welfare of the client and financial rewords are deemphasized. The commitment to the mission is the driving force in these organizations. On the other hand, non-profits exist in an environment that increasingly demands that they account for their use of public funds. Accountability demands a level of organizational sophistication, including procedures for quality control, measuring efficiency and effectiveness, inter-departmental communication and coordination, and assurance that staff workers have adequate professional qualifications for their positions. Further, as organizations increase in size and complexity, they must adapt their style of managing and operational procedures. Informal mechanisms of communication and coordination that may have worked in small programs may not suffice in large, multi-service organizations.

This paper addressed the challenge of how progressive non-profits can keep their progressive values, advocate for progressive healthcare policy, and maintain the administrative infrastructure necessary to exist in today's political and economic environment. The progression of events at the Haight Ashbury Free Clinic (HAFC) over the past 35 years is offered as an illustration of what can go wrong.

For a variety reasons, the HAFC thrived after it opened in the late 1960's. Among other things, it enjoyed widespread support and popularity because it succeeded in addressing the medical, addiction, and related needs of those who were not receiving services from traditional providers. The clinic provided an informal, supportive service delivery process that was well matched to the needs of its clients, community and funding sources. However, problems began to emerge as the political and economic environment changed and as the clinic grew in size and scope. While the HAFC attempted to keep its focus on free, non-judgmental service delivery within an informal organizational environment, tasks that were essential to agency operations were neglected.

Problems that developed included difficulty coordinating various services, non-compliance with funding requirements and regulators, and serious financial debt. While attempts were made to modify operations to meet the changing need, they were never sufficient. Worse, many of the responses to the problems created larger problems. The progression of events led to serious charges of embezzlement by the chief financial officer, a flood of staff resignations, plummeting morale, the termination of many services, and the eventual resignation of key individuals, such as the medical director who founded the clinic over 35 years ago (Delfin, 2006 March 6; Thompson & Woodward, 2006). To the horror of community activists, a corporate executive was brought in to mandate the business discipline that the board of directors deemed necessary for the clinic to survive.

The events illustrate the importance of progressive non-profit organizations to monitor and promote public support for their services, but also to be sufficiently flexible to change in response to internal and external pressures. However, while doing so, they

must also maintain fidelity to the values and principles of their mission. This paper addresses these issues by first reviewing the history, philosophy and mission of the HAFC in the late 60's and 70's. The emergence of problems the agency faced as it expanded and as the political and economic environment changed is then addressed. Emphasis is placed on functional versus dysfunctional administrative responses to the problems; particularly how many of the agency's response to its challenges created new problems. It is suggested that the HAFC lost major opportunities to address cutting edge problems in the human services field, such as bridging research and treatment in addiction, expanding novel addiction treatment approaches that it had conceived, and providing large-scale medical care to the huge numbers of uninsured individuals in its community. The paper ends with suggestions for how progressive non-profit organizations can maintain loyalty to their mission, promote progressive healthcare policy, and make necessary adjustments to organizational, political and economic pressures.

The Origin and Growth of the HAFC

In his acceptance speech at the 2004 Democratic National Convention, presidential candidate John Kerry described why he believed the U.S. was in a healthcare crisis. He pointed out that 4 million Americans lost their health insurance over the past 4 years. He called for affordable and accessible healthcare "not as a privilege for the wealthy and connected and elected, it is a right for all Americans" (FDCH Media Inc, 2004, July 29). "Healthcare is a right, not a privilege," is a common contemporary rallying cry among progressives interested in healthcare reform. However, many who use this phrase are not aware of its roots as a guiding principle in the Free Clinic movement of the late 1960's and 1970's. The first and best known was the Haight Ashbury Free Clinic (HAFC) in San Francisco. Founded in 1967 by Dr. David Smith, the clinic originally served thousands of young people arriving in the Haight Ashbury district to take part in the "summer of love" (Seymour & Smith, 1986). However, when the summer was over and the young people left, it became apparent that there remained a serious need for medical and drug treatment services to the local community. Therefore, the HAFC continued to operate, and it appeared to effectively meet gaping needs in the community. Its popularity and reputation rapidly expanded and soon it became a model for other clinics.

During the early years the clinic was small and informal. Guiding principles for HAFC included an emphasis on non-judgmental, decentralized care, often delivered by volunteers in consultation with professionals. During that time, many young people in the Haight Ashbury community and elsewhere distrusted traditional healthcare institutions as part of "the system."

Seymour and Smith (1986) pointed out that frequently the young people in the Haight Ashbury district had good reason to distrust traditional healthcare. Patients with substance abuse problems in particular were often greeted with judgmental attitudes that were alienating and shaming. The HAFC and the Free Clinic movement in general served as an alternative type of healthcare that was more respectful and responsive to patient needs. While healthcare professionals were central to delivery of services, there

was also an emphasis on peer helping and volunteerism. Self-help groups such as the Alcoholics and Narcotics Anonymous were central to addiction treatment. The practice of medicine and recovery from addiction were demystified and made understandable of consumers of services.

As the HAFC's reputation expanded, it attracted more volunteers as well as skilled professionals. Because some of the key individuals who founded the clinic were trained or had been employed at the University of California, San Francisco (UCSF) Medical School, there had always been an informal affiliation with it. That relationship grew as the clinic expanded. A number of HAFC staff acquired UCSF academic appointments and the clinic served as a training site for medical, nursing, and pharmacy students. The clinic also became an important training site for local counseling and psychology training programs.

From the early 1970's on the HAFC had acquired a variety of treatment grants to fund its services (Seymour & Smith, 1986). During the 80's and 90's the clinic broadened its grant applications to include research as well as treatment. Grants were acquired to study the epidemiology of addiction in the community as well as the effectiveness of treatment interventions delivered at the clinic.

By the late 1990's and early 2000's the HAFC in some ways was perfectly situated to lead the way for community based medical care, addiction treatment, and research. Its reputation in the local community for delivering high quality of services was excellent and it was particularly recognized for its work with underserved populations. Other achievements included: 1) its notoriety had become national in scope, 2) it had developed a number of cutting edge intervention programs for addiction treatment, and 3) it had attracted skilled and motivated professionals who could conduct treatment as well as research. Innovative programs served specific needs for women with children, Asian Americans, African Americans, dual diagnosis and homeless clients. Although it started as a small, informal program partly staffed by volunteers, by 2006 it was treating about 65,000 clients per year and had a budget of about $14 million (Thompson, 2006, April 5).

The HAFC was perfectly situated to address the perpetual complaint in the field that there was too large a gap between community-based treatment and research. The National Institute on Drug Abuse (NIDA) was emphasizing that more research needed to be conducted in "real world" clinical settings (Carroll et al, 2002) and established a program of research called the Clinical Trials Network (CTN) designed to bridge treatment and research in the addiction field. The HAFC was invited to participate.

The Development of Problems

Managing Research Grants

Although the HAFC was ripe with opportunity to be at the forefront of bridging treatment and research, it suffered from serious limitations. First, it simply did not have sufficient infrastructure to organize and implement research protocols. For example,

communication forums for coordinating the activities of clinical and research staff did not exist. Procedures for ensuring that research funds were spent according to the approved budget were lacking. Other shortcomings included administrators' lack of quality assurance procedures necessary to oversee implementation of research protocols and lack of knowledge about Institutional Review Board (IRB) regulations.

Other problems included a lack of staff support for these joint research and treatment projects. While some staff appeared to favor research in the clinic's programs, others seemed decidedly skeptical. They viewed research as somewhat elite; not relevant to what happened in front line community treatment. No formal mechanisms were in place to educate staff about research or negotiate different points of view about research in the agency. Thus, no consensus was reached about types of research that staff could support. The NIDA CTN studies that were begun at the HAFC encountered problems recruiting clients into studies, following research protocols, and complying with IRB requirements. The studies were never successfully completed.

Managing Treatment Services

Management of treatment programs fared no better. The clinic simply did not have the organizational knowledge or skills to manage its expansion. A major shortcoming was the absence of infrastructure adjustments to accommodate new programs and assist them in their development. Implementation of new programs was often disorganized and lacked clear plans. While the goals of new programs were frequently clear, operational procedures for how services would be delivered and coordinated were lacking. Thus, program coordinators and staff tying to begin new services were often left feeling frustrated and unprepared. For some staff, their commitment to the philosophy and values of the HAFC kept them in jobs. However, many staff left and turnover was a growing problem. By the 1990's even those most committed were showing signs of low morale.

The lack of infrastructure and meager oversight of operations led to other serious problems. For example, there were problems complying with the requirements of funding sources. The primary funding source, the City and County of San Francisco, required agencies to track units of service. While some HAFC programs developed systems for compliance within individual programs, others did not. There was no efficient, centralized process for developing reports on units of service or ensuring they were delivered to funding sources according to contract.

Financial Problems

With the exception of several time points in the 1970's, the clinic has consistently suffered from financial problems. However, residing in the progressive San Francisco Bay Area and capitalizing on good will toward the clinic, the HAFC managed to get by; when its viability became a question someone always came through and provided financial help. Frequently the city found money for the clinic. By the 1990's the political and economic landscape had changed. Now the city wanted to see documented units of service. When the clinic could not produce this for a number of programs, the city demanded funds be returned. Media reports indicated that the HAFC had to return $1.6

million to the City and County of San Francisco because it could not produce documents showing units of services delivered by programs (Thompson & Woodward, 2006).

The financial problems meant limited improvement in staff salaries. While staff pay at the clinic was always limited, resentment grew when poor compensation was perceived to be a function of poor management. While staffers were extraordinarily committed to the HAFC mission, they were also increasingly resentful. Criticism was leveled at managers and staff questioned their training and competence.

Staff Qualifications and Supervision

During the clinic's early years, many staff workers were volunteers. There was a philosophy that everyone could contribute to the clinic; a commitment to the clinic's values was more important than formal qualifications. As the clinic grew in size, staff members who had been employed in this type of informal environment were promoted into administrative positions. Frequently their only training or qualifications in management was their experience at the clinic. Most had degrees in fields largely unrelated to management. Their informal manner of handling issues was problematic for a larger, decentralized agency.

By the 1990's programs were spread throughout the San Francisco Bay Area and ensuring consistent and competent treatment in these programs became difficult. Administrators did not have the oversight procedures in place to have a good sense of what happened on a day-to-day basis and programs felt isolated and cut off from the larger agency. In addition, new services required new expertise that was at times lacking. For example, it was assumed that staff who had experience in outpatient addiction treatment could also work in residential programs. However, that was not necessarily the case. Because clients live in residential programs, it raises a host of issues not encountered in outpatient settings.

During the clinic's early years, hiring and supervision was informal. The ethos of the early clinic deemphasized bureaucracy. Thus, formal training was deemphasized in the hiring process and mechanisms for monitoring staff performance were limited. During the early years, the clinic was small enough to address concerns and problems informally as they arose, but this became problematic in an increasingly large and complex organization. Often, staff did not feel that they were sufficiently trained or supervised for their jobs. In addition, they often worked somewhat independently, resulting in problems providing consist and competent care.

The Management Response

It must be acknowledge that management did try to make improvements and even hired an outside consulting firm to help with some of the problems. However, some staff considered this a way to deflect criticism. By the 1990's management's strategy of using the clinic's good name to elicit political support had worn thin and had limited value. Many management responses to the agency's problems created new problems. For example, the clinic was tenacious in its efforts to maintain services, even if they were losing money. The aversion to closing programs that were not financially viable

created financial drains on other services, which in turn became financially unfeasible as well.

As financial problems increased, management of the clinic became increasingly frustrated. They viewed themselves as protecting the welfare of the clients and they resented some of the criticism coming from staff. Loyalty to the leadership and organization became an important issue. Increasingly, issues were decided by top managers and the board of directors with limited input from staff.

Despite the fact that the HAFC was a private non-profit, few people in the organization had access to financial records that existed. Budgeting decisions were experienced by staff as occurring in a black hole. However, everyone knew finances were a huge problem. Rumors spread that hundreds of thousand of dollars were unaccounted and deposited in some type of account. Finally, the San Francisco Bay Guardian reported that the Chief Financial Officer at the HAFC had been arrested and charged with embezzling approximately $773,000 (Thompson & Woodward, 2006). Apparently, the lack of oversight of staff extended beyond frontline staff and included individuals at the highest levels.

Out of what many believed to be sheer desperation, the board of directors hired corporate business leaders to put its house in financial order. The new Chief Executive Officer (CEO) was a corporate executive with little experience in human services work. Some HAFC staff accused the new CEO of bringing a corporate style to the clinic that was antithetical to the history and philosophy of HAFC. Conflicts arose between corporate and community-oriented staff. Some of the community-oriented staff were laid off due to their “non-revenue generating status.” These included some individuals who helped found the clinic and promoted it over its 35-year tenure. Although some were well known in the addiction treatment field, no attempt was made to use their status for revenue generating purposes.

The clinic then leveled charges against the founder and medical director of the clinic, saying he had misused clinic money for his own purposes (Thompson, 2006, April 5). Lawsuits and counter lawsuits ensued. While the specifics of the allegations are not entirely clear, nor resolved, several matters are clear. First, the issue was obviously not resolved through negotiation. It is unclear what types of attempts were made or what forums for resolution were even available. Second, the charges addressed behaviors that occurred over a number of years. In an interview with the San Francisco Bay Guardian the medical director alleged that no concerns were raised by the HAFC board of directors and the clinic was aware of his financial dealings (Smith, 2006, April 18). Third, the clinic did not have in place the necessary procedures to address these concerns as they arose. Thus, they presented themselves as crises many years later. Fourth, some individuals who had left were viewed as the historical foundation of the HAFC. Some staff feared that core HAFC values had been lost. The new leaders were viewed as limited in terms of their knowledge about addiction or community based service delivery. Finally, as a result of these and other controversial issues, the clinic has lost a great deal in terms of its local and national reputation.

Recommendations for Progressive Non-profits

Examination of the decline of the HAFC could yield important insights for other progressive nonprofit organizations. Offered here are specific suggestions gleaned from our experience.

1. As new services are created or existing services expanded, there must be a corresponding adjustment in the infrastructure. Consideration should be given to financing, organizing, implementing and monitoring new or expanded services.

2. As new services are created or existing services expanded there may also need to be adjustments in the clinical approach, management philosophy or both. When the HAFC was a small, organization, an informal philosophy of management was sufficient. As it grew and expanded, more formal management mechanisms were necessary but never implemented.

3. Recognize, monitor, and respond to changes in the political and funding climate. Specific strategies should include efforts toward garnering public support for services. Strategies toward this goal are described elsewhere in greater detail (i.e., Polcin, 2000) but include supporting and disseminating research that validates the positive impact of services and lobbying private and governmental agencies that oversee healthcare financing. However, progressive nonprofits also need to be proactive in assessing and responding to untoward changes in their organizational environments. The HAFC was often in the position of reacting to environmental demands (e.g., funding requirements) rather than implementing changes proactively. As the political and social environment changes, the agency must adapt.

4. When making organizational changes, involve input from all affected parties as much as possible. Decisions made quietly and in secret may result in quicker temporary resolution of issues, but they can be deadly in the long term. Forums for open discussion of issues need to be created. It is critical that the facilitators of these forums have skills in managing group dynamic, particularly knowing when to provide structure and when to elicit open discussion of issues. Providing a forum for input into decisions does not mean everybody will be pleased or get what they want. However, an honest rationale for why decisions were made will result in less resistance and resentment from staff even if they disagree with it. Leaders should formally document meetings so staff can read about them if they cannot attend.

5. Utilize political connections in service of the organization, but using them to compensate for organizational weaknesses will fail. In San Francisco, whenever a new drug hit the street many in the media came to the HAFC to get information. However, the clinic never really used those connections to promote itself. We gave out invaluable information and expected little in return.

6. Remember your mission, history and values. Ask yourself how you can implement changes and maintain fidelity to your identity. When the HAFC rejected key individuals who helped found it, it also rejected much of its history, its commitment

to progressive values, and healthcare as a right rather than a privilege. The new corporate leadership may espouse a commitment to the historic values of the clinic, but their professional careers suggest something different. It can be argued that the HAFC felt a need to reject much of its history in order to survive. The challenge for contemporary progressive non-profits is how to be true to their missions in changing organizational environments.

7. Find an acceptable change agent. The person implementing change must be acceptable to the clients and staff who will be affected. Bringing in a corporate CEO to implement change in a community based nonprofit organization is a risky proposition.

8. Commitment to the agency's mission is important in hiring personnel, but professional competence is equally important. Knowing and liking people are not sufficient reasons for hiring them. When the clinic was small it operated informally, so staff were often chosen from clinic volunteers that were known personally by managers. Formal qualifications were often minimized in favor of familiarity and personal relationships. Thus, some staff in key positions at HAFCI were not well qualified. Worse, because supervisory standards were not explicit, they were rarely held accountable. Excellence and accountability should be progressive values.

9. Enjoy the sunshine. In the spirit of the 1960's free-love mentality, do it in the open where everybody can see. When decisions are made in public forums, stakeholders are less likely to be taken by surprise.

10. Count Everything. Quantifying helps progressive non-profits. Non-profits should document information about clients, staff, program operations, money at each program, money spent by each program, budgets, and funding. Most important, programs need not be afraid of documenting the quantity or results of their services. If programs are not meeting targets for number of services delivered or effectiveness, the data can be used to guide necessary changes.

11. Communicate. It is surprising that nonprofits are in the business of communicating but often do not do it in their own organizations. Non-profits often do not create the necessary forums to elicit staff input to address problems. At the HAFC, staff and management often loathed "more meetings" because they were not conducted with the skill necessary to build consensus or publicly acknowledge legitimate differences.

12. Organize. The HAFC was born in the 1960's. The characteristics and values of that time period and the clients who were served by the clinic deemphasized bureaucracy in favor of the individual. Thus, slogans such as, "let it all hang out" and "do your own thing" became popular. While their needs to be room for individual creativity, survival of progressive non-profits depends on organized procedures for monitoring operations and quality assurance. Individuality and formal organization are not necessarily incompatible and finding a proper balance between the two is essential.

13. Toot your own horn. Why do few people know that taxpayers save obscene amounts of money from drug treatment? The National Institute on Drug Abuse has documented that taxpayers save an average of $15 for every $1 spent on drug treatment services (National Institute on Drug Abuse, 1999, October), primarily from reduced criminal justice and healthcare costs.

14. Bottom lines: Fiscal accountability is a bottom line. However, for progressive nonprofits, the bottom line needs to include other things, such as our impact on clients, staff, and community residents. It needs to include an assessment of whether we have implemented progressive values, such as the values inherent in "healthcare is a right not a privilege." That is why a corporate approach to management at HAFCI does not bode well.

Conclusion

Few organizations in our history have better exemplified a progressive commitment to community-based services than the HAFC. A remarkable confluence emerged after the "summer of love" in 1967 that brought together novel, community based treatment approaches; broad-based delivery of different types of services; academics who were committed to community based care and research; and empowerment of clients in their receipt of services. Where the HAFC failed was in its inability to adapt organizationally to changing circumstances while maintaining its integrity and commitment to its mission.

A variety of considerations for progressive nonprofits have been presented here that were gleaned from the HAFC experience. Programs need to challenge the destructive effects of political forces that are inconsistent with their missions and goals. However, they also must monitor changing social environments and adapt to external pressures when necessary. If progressive nonprofits are to avoid becoming victims of their own success, they must also adapt to the changing needs their organizations present as they evolve.

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