Moving Clinical Deliberations on Administrative Discharge in Drug Addiction Treatment Beyond Moral Rhetoric to Empirical Ethics

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ABSTRACT

Patients' admission to modern substance use disorder treatment comes with the attendant risk of being discharged from treatment—a widespread practice. This article describes the three mainstream theories of addiction that operate as a reference point for clinicians in reasoning about a decision to discharge a patient from treatment. The extant literature is reviewed to highlight the pathways that patients follow after administrative discharge. Little scientific research has been done to investigate claims and hypotheses about the therapeutic function of AD, which points to the need for empirical ethics to inform clinical addictions practice.

The latest data from the Substance Abuse and Mental Health Services Administration, for 2011, conservatively reports that 126,718 clients admitted to drug addiction treatment—7.3 percent of admissions—were expelled from treatment.[1] The existing literature has not thoroughly examined the multiple and varied pathways that patients follow after they are ejected from treatment. Additionally, across drug categories, no study has longitudinally tracked this empirically.

Different theoretical orientations follow different lines of reasoning in conceptualizing patients' outcomes after administrative discharge (AD). The reasoning can be dogmatic, and may either exaggerate or understate the ramifications of AD. Each stance makes political and emotional appeals according to a particular model of addiction and associated ideologies. The *choice philosophy*, for example, views addiction as a matter of weakness or as a lack of willpower among "addicts," and underlies the theory of "hitting rock bottom." The assumption is that progressive rehabilitation of the will requires strong doses of punishment (that is, AD) with the right mixture of consequences for the "addict" to stop abusing drugs.

The *moral theory of addiction* implies that free choice is present in addiction, but the fundamental culprits in drug addiction are characterological deficits—a sociopsychodynamic that maintains problem drug use. The idea that addiction is a choice implies a lack of willpower, and the language of the moral theory sees moral failing as an outgrowth of a degenerative personality structure. Thus, AD is part of a therapeutic process for a discharged patient that induces introspection, catalyzes motivation for change, and fosters character development, all of which are dimensions of the choice model and the moral theory of addiction.

In marked contrast, the *disease model* views addiction as a chronic condition that is mostly determined by neurobiology, and, as White notes, thus "posit[s] addiction as a disease of the will marked by a progressive loss of volitional control over [alcohol or drug use] and related decision-making."[2] In this model, AD is inconsistent with the chronic, relapsing nature of addiction of many patients. Wil-

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son Compton notes that AD can prematurely arrest the continuation of care, and, in turn, assails the goal of figuring out what treatment approach, modality, and intervention method will be most therapeutically useful to a patient.[3]

Given this, studies exploring the long-term consequences of AD and the perspectives of those who have been discharged are needed (see table 1 on the models of choice, moral, and disease in the AD debate, and the clash between the arguments and ideological priors that bias thinking when it comes to AD). In essence, the choice and moral theories of addiction affect the threshold of tolerance for safety violations and rule infractions (for example, drug use). A medically critical question left unanswered in the literature is whether AD might be beneficial for patients or categorically counter-therapeutic. This article surveys the extant literature and presents an evidence base that captures the posttreatment trajectories of patients who are administratively discharged, and follows this with a discussion on future directions.

LITERATURE ON POST-TREATMENT AD

Svensson and Andersson at the University of Malmö assessed the outcomes of 35 people with a long history of heroin addiction who were undergoing medication-assisted therapy (MAT) with methadone or buprenorphine following involuntary discharge (that is, AD) and a three-month exclusion from MAT.[4] Based on the reported experiences of 25 males with an average age of 43.2 years and 10 females with an average age of 46.0 years, the authors observed a general trend in the respondents' lives after AD. These former patients first experienced difficulty phasing out the methadone or buprenorphine medication, and those who were unable to properly taper off the medication in small doses were abruptly forced into withdrawal. Simultaneously with, or subsequent to, their discharge, the former patients often became homeless, as their housing was a condition of participating in treatment, before reaching a state of physical and mental deterioration. To maintain their heroin and illicit methadone or buprenorphine use, four patients returned to prostitution, and 13 of the 35 patients engaged in criminal activity, although most received welfare payments and pensions on which they could live.

The pathways that patients follow after AD, and the consequences that ensue, are consistent with past research on opioid addiction and AD from MAT. According to research by Coviello and colleagues, narcotic "addicts" generally want, and are in dire

TABLE 1. Reasoning regarding AD using the choice model, the moral model, and the disease model of addiction

Elements of the choice model and the moral model of addiction:
- Baseline volitional control over the connection between intent and behavior is higher in congruence
- Drug user is viewed in moral terms as "bad" and addiction is less a matter of chronic disease management or a behavioral health problem
- Addiction has genetic implications; however, its etiology is psychodynamically rooted in unresolved trauma, unprocessed parent–child relationship dynamics, etc.
- Repeated rule infractions (whether "minor" or otherwise) constitute a litmus test or proxy for a client's motivation and choice for initiating recovery, motivation for treatment, readiness for treatment, receptivity to engagement, and expected trajectory
- Drug use is a function of the psychological, social, and emotional drivers for coping with stressors, masking pain, facilitating social adjustment, etc.

Elements of the chronic disease model of addiction:
- Baseline volitional control over the connection between intent and behavior is lower in congruence[1]
- Use/non-use behavior is more of a manifestation of addiction or a residual effect of past drug use
- Substance use disorders are a primary health problem, and the standard for patient care is analogous to other chronic diseases (e.g., diabetes or cancer)
- Rule breaking is generated by irresistible impulses and neurobiological determinants; addiction is a chronic, severe, and progressive medical condition
- Drug use is a function of a "hijacked" dopamine reward system: disordered motivational priorities, impaired inhibitory control, erosion of executive function[2]

NOTES

1. W.L. White, C. Scott, M. Dennis, and M. Boyle, "It's Time to Stop Kicking People Out of Addiction Treatment," Counselor 6, no. 2 (2005): 2-13.
2. W.L. White, "Toward a Philosophy of Choice: A New Era of Addiction Treatment," *Counselor* 9, no. 1 (2008): 38-43.

need of, such treatment.[5] Not accessing MAT puts them at risk for grave health consequences, including HIV and other blood-borne diseases, seroconversion, death by overdose, and criminal behavior.[6] Svensson and Andersson report that "patients with opiate addiction who were involuntarily discharged face a significantly impaired life situation and significantly increased mortality."[7]

Mitchell and colleagues interviewed six individuals with a mean age of 37 years, a mean history of 15.8 years of drug use (heroin and/or cocaine), and a mean of four prior treatment episodes that ended prematurely due to AD from a methadone-assistance program as a result of a partner's discharge, conflict with staff or other patients, lodging threats, absence for more than a week, social welfare's refusal to pay for treatment, or "side abuse" (using alcohol/illegal drugs or psychopharmacological drugs obtained outside of the program).[8] This study found that when most participants had their treatment terminated within 12 months, they "showed no indication of giving up at that point, and often fought to continue their treatment at their original program . . . [and drew] . . . informational and emotional support from family members, peers, pastors, and even needle exchanges to help them find and gain entry into a new program after administrative discharge."[9] The authors noted the resourcefulness and resilience of the program participants and concluded, "Even among patients who are prematurely terminated, one may still see a dramatic reduction in drug use and a greater willingness and likelihood of returning to treatment. Reduction in drug use over time, as well as other changes that may not be apparent in a single treatment program experience, might be identified when a longer-term perspective is taken."[10]

It would be misrepresentative of the aforementioned findings on opiate users to characterize the consequences of AD similarly for all other drug use categories. Indeed, a false equivalency is achieved when no distinction is made between the variety of drug use profiles found in addiction treatment programs—ranging in severity from mild, moderate, to severe—compatible with the *Diagnostic and Statistical Manual of Mental Disorders, 5th Edition* (*DSM 5*). Thus, the consequences of AD and posttreatment pathways for a patient with marijuana addiction will generally not be the same for a patient with opiate addiction. For example, Svensson and Andersson note, "patients who begin MAT often come from harsh backgrounds, with a history of mental problems, suicide attempts, poor physical health, crashed personal relations and experiences of incarceration,"[11] while Hoffmann relates, along the continuum of drug addiction severity, "the vast majority of those in treatment with a mild diagnosis likely can moderate use and achieve remission,"[12] which is coherent, to some degree, with the choice or moral model of addiction. Hoffmann notes that "the vast majority of those who meet the *DSM 5* criteria for a severe diagnosis will require abstinence to achieve remission,"[13] a therapeutic paradigm that is seemingly in line, to some extent, with the disease hypothesis of addiction.

Since mild, moderate, and severe addiction cases are integrated within the general treatment population, it is necessary to contextualize any discussion about AD in terms of the threshold of tolerance for safety violations and rule infractions (for example, a nonfraternization policy[14]) by distinguishing patients with addiction profiles that are indicative of a loss of control similar to the disease theory of addiction, and requiring abstinence, from those patients who might benefit from some moderation or a behavioral adjustment approach regarding drug use, which is more compatible with the choice or moral theory of addiction.

To further an understanding of how AD can impact patients, critical biopsychosocial questions about the consequences of this clinical practice must be raised. For example: How many administratively discharged patients achieve successful long-term recovery, experience a remission of symptoms, or report improvement in behavior while in treatment in the weeks and months following AD from the previous treatment program? What factors are predictive of post-discharge consequences, and what variables moderate or mediate such consequences? These questions may elucidate the relationships between specific clinical profiles and post-AD pathways. However, since no known longitudinal study exists in the literature, the effects of AD are not entirely understood, including whether the experience can be converted into a source of resiliency, behavioral modification, and motivation that will improve patients' recovery outcomes.

CONCLUSION

Data indicate that multiple drug addiction treatment episodes are the norm for a sizable portion of the overall treatment population, and that they have "facilitative effects" on the initiation, stabilization, and maintenance of recovery.[15] Multiple treatment episodes are also associated with greater retention in methadone treatment, and, according to Williams and White, "may serve as a proxy for problem se-

verity, complexity (co-occurring psychiatric illness), and chronicity."[16] Interestingly, the rates of discharge for those who have undergone several instances of treatment due to AD remain an undefined population parameter in the literature. Speculation abounds as to the possible reasons. One possible reason is that members of the substance use disorder population are generally difficult to locate, as they are represented among higher incidences of family estrangement, residential mobility, spontaneous relocation, disconnected phones, unreliable contact information, limited education, homelessness, and criminal offense that often compel them to conceal their identity and location.[17] Additionally, those who are discharged may be a worse-off group to the extent that continued drug use or the socioeconomic factors related to, and accompanying, biopsychosocial aspects of addiction, are severe or persistent enough to precipitate AD; instability adds further difficulty to efforts to locate them. Moreover, the how, when, and why of AD likely make a significant difference in whether patients desire to stay in contact with a treatment program or make themselves unavailable after leaving.

Field historian William L. White suspects that a study examining AD "would reveal the underbelly of addiction treatment by exposing the untherapeutic consequences of this practice."[18] Moreover, while it is hard to predict if, and when, AD will become obsolete, it may be that as the treatment and prevention field evolves into a medical practice, and evidenced-based care becomes the norm in addiction treatment, and is followed with fidelity, AD will become an outmoded practice.

This polarized analysis of AD and the disease paradigm of addiction have wide acceptance in the shifting addiction landscape and highlight the recovery care management of addiction as a chronic disease. These tenets have been aided by the mainstream guidance of the Affordable Care Act and the Mental Health Parity and Addiction Equity Act. Research that methodologically explores the long-term consequences of AD on patients' lives might not only produce controversial findings, but run counter to the service priorities and research imperatives of institutes and agencies (for example, the National Institute on Drug Abuse, the Center for Substance Abuse Treatment, and so on) that are vested in a presupposition of chronic disease. Field historian William L. White offers the following thoughts:

> The majority of research dollars are now focused on unraveling the neurobiology of addiction in the hopes of medication, vaccines and related interventions that will enhance recovery outcomes and provide new avenues of prevention. There is far less long-term performance research on the treatment system itself, but I have not seen a study that focused specifically on what happens to people after being essentially kicked out of treatment. . . . That is unconscionable at this stage in the development of addiction treatment in the United States.[19]

In the case of AD, empiric research that is informed by the perspectives of patients would add an evidence-based response regarding the immediate and long-term costs of AD on addiction and recovery,[20] which would offer guidance on program policy, procedures, and practices. Rigorous study focused on understanding the diverse pathways to recovery that are experienced by patient groups would better grasp the trajectories of AD as a distinguishing feature in AD outcomes, and the possibility that AD would be demonstrated as a promising practice.

With more clearly defined patient subgroups and treatment program components (for example, graduation ceremonies[21]), modality, philosophy, staff background and experience, and clinical and demographic profiles of clinical subpopulations, a greater distinction can be made to clarify what factors contribute to discharge,[22] the subsequent outcomes for patients, and ways to lower the potential for AD in the development of national guidelines that establish best practices. In this way, programs could be ethically guided in setting appropriate limits on what constitutes the practical grounds for AD and how to engage therapeutically in the process of making determinations regarding AD. In so doing, the clinical examination of AD can move beyond the realm of moral rhetoric to a basis in empirical ethics.[23]

NOTES

1. *Treatment Episode Data Set (TEDS): 2011. Discharges from Substance Abuse Treatment Services* (Rockville, Md: Substance Abuse and Mental Health Services Administration, 2014), BHSIS Series S-70, HHS Publication No. (SMA) 14-4846.

2. W.L. White, "Toward a Philosophy of Choice: A New Era of Addiction Treatment," *Counselor* 9, no. 1 (2008): 38-43.

3. Wilson Compton, e-mail message to the author, 27 April 2015. Wilson Compton, MD, MPE, is deputy director of the National Institute on Drug Abuse (NIDA) at the U.S. National Institutes of Health;

4. B. Svensson and M. Andersson, "Involuntary Discharge from Medication-Assisted Treatment for People with Heroin Addiction—Patients' Experiences and Inter-

pretations," *Nordic Studies on Alcohol and Drugs* 29, no. 2 (2012): 173-93, 176.

5. D.M. Coviello, D.A. Zanis, S.A. Wesnoski, and A.I. Alterman, "The Effectiveness of Outreach Case Management in Re-enrolling Discharged Methadone Patients," *Drug and Alcohol Dependence* 85, no. 1 (2006): 56-65; H. S. Reisinger et al., "Premature Discharge from Methadone Treatment: Patient Perspectives," *Journal of Psychoactive Drugs* 41, no. 3 (2009): 285-96.

6. Ibid.

7. Svensson and Andersson, "Involuntary Discharge from Medication-Assisted Treatment for People with Heroin Addiction, see note 4 above; L. Grönbladh, L.S. Öhlund, and L.M. Gunne, "Mortality in Heroin Addiction: Impact of Methadone Treatment," *Acta Psychiatrica Scandinavica* 82 (1990): 223-7; J.R.M. Caplehorn, D.R. McNeil, and D.G. Kleinbaum, "Clinic Policy and Retention in Methadone Maintenance," *International Journal of Addiction* 28 (1993): 73-89; D.A. Zanis and G.E. Woody, "One-Year Mortality Rates Following Methadone Treatment Discharge," *Drug and Alcohol Dependence* 52 (1998): 257-60; A. Fugelstad et al., "Methadone Maintenance Treatment: The Balance between Life-Saving Treatment and Fatal Poisonings," *Addiction* 102 (2007): 406-12; K.R. Knight et al., "Involuntary versus Voluntary Detoxification from Methadone Maintenance Treatment: The Importance of Choice," *Addiction Research & Theory* 3, no. 4 (1996): 351-62; T. Clausen, K. Anchersen, and H. Waal, "Mortality Prior to, during and after Opioid Maintenance Treatment (OMT): A National Prospective Cross-Registry Study," *Drug and Alcohol Dependence* 94, no. 1-3 (2008): 151-7.

8. S. G. Mitchell et al., "Redefining Retention: Recovery from the Patient's Perspective," *Journal of Psychoactive Drugs* 43, no. 2 (2011): 99-107.

9. Ibid., 106.

10. Ibid.

11. Svensson and Andersson, "Involuntary Discharge," see note 7 above, p. 175.

12. Norman G. Hoffmann, e-mail message to the author, 17 April 2014. Norman G. Hoffmann, PhD, is the lead author of *ASAM Placement Criteria for the Treatment of Psychoactive Substance Abuse Disorders* (Washington, D.C.: American Society of Addiction Medicine, 1991).

13. Ibid.

14. I.L. Williams and M.J. Taleff, "Sex, Romance, and Dating in Treatment Recovery: Ethical Reflections and Clinical Deliberations on Challenging Addiction Decision Making," *Journal of Ethics in Mental Health* no. 1 (2015): 1-7.

15. M.L. Dennis, C.K. Scott, R. Funk, and M.A. Foss, "The Duration and Correlates of Addiction and Treatment Careers," *Journal of Substance Abuse Treatment* 28, no. 2 (2005): S51-62; Y.I. Hser et al., "Drug Treatment Careers: A Conceptual Framework and Existing Research Findings," *Journal of Substance Abuse Treatment* 14, no. 6 (1997): 543-58.

16. I. Williams and W. White, "Kicking People Out of Addiction Treatment: An Update and Commentary," 11 September 2015, *http://www.williamwhitepapers.com/blog/2015/09/kicking-people-out-of-addiction-treatment-an-update-and-commentary-izaak-williams-and-william-white.html;* Reisinger et al., "Premature discharge," see note 5 above.

17. I.L. Williams and C.R. O'Donnell, "Web-Based Tracking Methods in Longitudinal Studies," *Evaluation and Program Planning* 45 (2014): 82-9.

18. William L. White, e-mail message to the author, 24 April 2015. William L. White, MA, is an emeritus senior research consultant at Chestnut Health Systems in Punta Gorda, Florida.

19. Ibid., 26 April 2015.

20. W.L. White, C. Scott, M. Dennis, and M. Boyle, "It's Time to Stop Kicking People out of Addiction Treatment," *Counselor* 6, no. 2 (2005): 2-13.

21. I.L. Williams, "Drug Treatment Graduation Ceremonies: It's Time to Put This Long-Cherished Tradition to Rest," *Alcoholism Treatment Quarterly* 32, no. 4 (2014): 445-57.

22. White, Scott, Dennis, and Boyle, "It's Time to Stop Kicking People out of Addiction Treatment," see note 20 above.

23. I.L. Williams and M.J. Taleff, "Key arguments in unilateral termination from addiction programs: A Discourse of ethical issues, clinical reasoning, and moral judgments," *Journal of Ethics in Mental Health* no. 1 (2015): 1-9; I.L. Williams, "Is administrative discharge an archaic or synchronic program practice? The empirical side of the debate," *Online Journal of Health Ethics* 11, no. 2 (2015): 1-5; doi: 10.18785/ojhe.1102.06.