Patient Termination as the Ultimate Failure of Addiction Treatment: Reframing Administrative Discharge as Clinical Abandonment

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Abstract

The proverbial elephant in the addiction treatment industry is the accepted disciplinary intervention of administrative discharge; the forced termination of patients from addiction treatment services. Despite its usage, this practice is not anchored in consensus about best practices or sanctioned by national guidelines. As a result, administrative discharges are based on rationale ranging from violations of clinic rules regarding safety to merely failing to conform to staff expectations. Patients may be administratively discharged with little nexus to addiction recovery resources and while continuing to exhibit symptoms that demonstrate continued need for treatment. Unchecked use of this administrative tool creates a risk of clinical abandonment and may mask prolonged and repeated program failures. Thus, the practice of administrative discharge may simultaneously increase the risk of relapse while precluding quality assurance and improvement initiatives.

Keywords: discharge, addiction treatment, forced termination, administrative discharge, clinical abandonment

Introduction

Inpatient (residential) and outpatient addiction treatment services are governed by a matrix of rules, regulations, and staff expectations meant to ensure a safe and supportive therapeutic environment for patients (Williams, 2015a). This system is enforced by administrative discharge, which is exercised, often reactively, in response to program rule violations (Condon et al., 2011; Deck & Carlson, 2005; Woody, Kane, Lewis, & Thompson, 2007), noncompliance with treatment protocols (Forman, Bovasso, & Woody, 2001), violation of safety regulations (Chang, Chiu, Gruber, & Sorensen, 2017), and perceived misbehavior or lack of cooperation with staff expectations on successful clinical engagement (Carr, 2010; Lee & O'Malley, 2018).

The practice of administrative discharge has been recognized within the United States (Reisinger et al., 2009), Canada (Spithoff et al., 2019), and Sweden (Svensson & Andersson, 2012). In 2017 (the latest available reporting year), 6.0 percent (or 99,319 cases) of forced service termination from addiction services within the United States were recorded at the national level (SAMHSA, 2018). Additionally, data indicates that the rate of administrative discharge is not uniform among

individual state systems in the U.S. For example, in Hawaii there were 3,754 discharged cases recorded during 2014 (Kim, Sabino, Zhang, & Okano, 2015). Among these discharges, the proportion of those who had treatment services terminated by program staff for non-compliance with program rules was 15.9 percent (Kim et al., 2015). Additionally, in Oregon and Washington State, the administrative discharge rate in methadone maintenance treatment reached 22% and 45%, respectively (Deck & Carlson, 2005).

Patient termination is the ostensible course of action only in extreme circumstances (e.g., physical assault causing severe bodily injury). In most cases, however, the decision whether to administratively discharge a patient from addiction services is not as clear-cut, and its complexities make for one of the most morally vexing and ethically complicated experiences practitioners face (e.g., see Williams & Taleff, 2015a). This is in large part because, despite the known repercussions of termination (which include premature death), the decision to terminate patient care is largely unregulated administrative practice (White, Scott, Dennis, & Boyle, 2005; Williams & Taleff, 2015b). Administrative discharges can be carried out in a manner inconsistent with:

a) The practitioner's professional code of ethics (Reamer, 2000). Here, the ethical standards set by the National Association of Social Workers (NASW) code, including but not limited to the addiction professionals' code of ethics (National Association for Alcoholism and Drug Abuse Counselors [NAADAC], 2016);
b) The tenets of the disease model of addiction contraindicating termination of medication or medical service delivery (e.g., methadone) (Koob & Volkow, 2016; Volkow & Boyle, 2018; Volkow, Koob, & McLellan, 2016);
c) DSM-5 criteria for substance use disorders indicating continued need for treatment (American Psychiatric Association, 2013);
d) The actual category of discharge classifying a client's discharge status (Williams & Mee-Lee, 2017).
e) Patient bill of rights and clinic policies, procedures, and procedures meant to promote and safeguard due process (Chang et al., 2017; Klingemann, 2017).
f) The National Association of Social Workers Standards for Social Work Practice with Clients with Substance Use Disorder (NASW, 2013).

Administratively discharging patients is particularly problematic when such incidences take place in the context of prolonged and repeated program shortcomings. Critical analysis of the processes used to evaluate the appropriateness of administrative discharges is essential in such settings. The task at hand is to discern whether discharges have been appropriate or if they amount to a form of clinical abandonment. Failure to engage in this type of evaluative process may lead to obfuscation of systemic failures and thereby prohibit remediation.

Administrative Discharge: A Byproduct of Systemic Program Failure

In this section, addiction treatment is approached from a systems perspective. This approach elucidates program-level factors—couched in treatment philosophies and embedded in the treating agency's policies, procedures, and protocols (or lack thereof)—that lead to a diminished quality of care in service delivery, culminating in patient termination. These program-level factors manifest in: a) screening neglect, b) transfer neglect, c) referral discrimination, and d) (re)admission recycling of former patients (see figure 1).

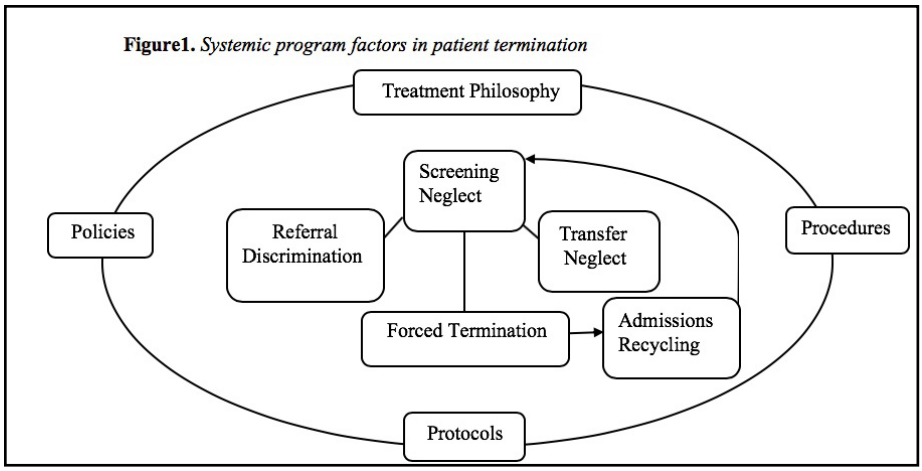

Figure1. *Systemic program factors in patient termination*

Screening Neglect

For the purposes of this paper, screening entails two dimensions. The first involves ruling out treatment candidates who are deemed inappropriate for program placement. The second involves treating staff maintaining continuity of the screening process in order to ensure the treating agency is (re)assessing adequately to meet its patients' changing needs and clinical status.

Screen for appropriate treatment placement

Part of the admissions process entails screening candidates in order to select persons entering into addiction treatment, match them to the appropriate mental health service delivery, and assign adequate therapeutic care in light of their presenting needs (Flynn & Brown, 2008).

McGovern, Xie, Segal, Siembab, and Drake (2006) surveyed addiction treatment agency directors, clinical supervisors, and clinicians in a single state system about co-occurring disorders among their patient population. They found overall estimates of 40–42% mood disorders, 24–27% anxiety disorders, 24–27% posttraumatic stress disorder, 16–21% severe mental illness, 18–20% antisocial personality disorder, and 17–18% borderline personality disorder (p. 272). Watkins et al. (2004) screened patients (n= 415) at intake at three outpatient addiction treatment facilities and found 210 patients (about 50%) had probable co-occurring mental health disorders, and of those more than a third had two or more probable disorders (pp. 754–755). Despite this biopsychosocial complexity, treatment programs tend to deliver only brief and low-intensity services to those with severe, complex, or chronic problems (White, 2008). Such treatment placements put patients at high risk of being designated "inappropriate for services" or "noncompliant" by staff members and subsequently being administratively discharged.

Moreover, use of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5; American Psychiatric Association, 2013), is not mandated by state authorities or standardized nationally across treatment programs to diagnose and screen for substance use disorder (SUD) severity. The DSM-5 distinguishes between mild, moderate, and severe SUD based on the number of criteria an individual meets out of the 11 listed in the manual (American Psychiatric Association, 2013). Those with severe SUD, or whose moderate SUD meets some of the five disorder criteria (i.e., desire/unsuccessful effort to cut down; craving/strong desire or compulsion to use; failure to fulfill role obligations; sacrificing social/occupational/recreational activities; and withdrawal), dubbed the 'Big Five', appear to be related to a more chronic condition that results in loss of control (Hoffmann & Kopak, 2015, p. 698), and highly likely to require total abstinence in order to achieve SUD remission (Dawson, Goldstein, & Grant, 2007; Office of the Surgeon General, 2016; Vaillant, 2003). Patients whose SUD rates are either mild or moderate, however, may benefit from an approach that permits moderation (Office of the Surgeon General, 2016; Vaillant, 2003). Despite this, addiction treatment programs have a well-established reputation for relying on abstinence-only approaches as a one-size fits all policy, regardless of the severity of the individual's disorder (Williams and Mee-Lee, 2019). It is not uncommon for treating agencies to have simply cobbled single questions for the DSM-5 criteria onto intake/assessment forms or a preexisting

clinical instrument in an attempt to claim that it can cover diagnoses. This is disingenuous in that typically one has to ask several questions within context of a biopsychosocial clinical interview for each criterion so as to be sure that that criterion is either negative or positive (Hoffmann, 2019).

By the most recent account of data from the 2016 National Survey of Substance Use Treatment Services (N-SSATS), the Substance Abuse and Mental Health Services Administration reported that of 14,399 treatment facilities, 73% claimed to use 12-step facilitation (SAMHSA, 2017). Treatment facilities may nonetheless show low fidelity to 12-step facilitation model and the notion that addiction is a disease (Williams and Mee-Lee, 2019), and, consequently, continued drug use may be viewed as a behavioral problem rather than a symptom of the substance use disorder. In such a way patient engagement and patient choice are compromised by an abstinence-only ethos that limits treatment options (Subbaraman & Witbrodt, 2014).

Conceptualizing abstinence as pre-requisite to any other goals is problematic not only because it limits patient choice, but it may also lead to treatment failures. The belief that abstinence is requisite to all other goals prohibits clinicians from genuinely supporting clients who are focused on other areas of life. Many such clients may become disenfranchised with treatment services, especially if they achieve their goals and without complete abstinence. More importantly, absent the benefit of genuine clinician support, many other of these clients may not achieve these other goals thereby increasing their risk of recurrence of substance misuse.

In prioritizing abstinence as the main recovery goal for all patients, as opposed to adhering simultaneously to a moderation approach or harm-reduction model for lower severity substance use disorders, patients who cannot abstain or are uninterested in becoming totally abstinent can be refused continued treatment by way of administrative discharge (Condon et al., 2011). In essence, the prevalence of programs that hold to a blanket policy rather than tailor their treatment based on where the patient lies on the SUD spectrum implies that addiction practices are out of line with the DSM-5 (Williams & Mee-Lee, 2019).

The DSM-5, furthermore, defines SUD remission as having no positive diagnostic criteria other than cravings in a three-month period for initial (early) remission or a 12-month period for sustained remission (American Psychiatric Association, 2013). Substance use per se is not part of the remission definition. The DSM-5 recognizes that not every patient needs to become abstinent to achieve remission even though the majority of program philosophies do not. This structural mismatch between the treating agency's goals, rules, and expectations and the needs or preferences of the patients sets the stage for diminished treatment effects, or program staff to pressure patients to adopt the goal of abstinence and discharge those who do not meet the provider's expectation of treatment compliance (Forman et al., 2001). Consequently, patients who disagree with the program's treatment philosophy are denied service. Alternatively, patients may have access to services but only if they are disingenuous about their goals. Lee and Malley (2018), for example, found patients at high risk of service termination when: a) honest about their drug use and true orientation toward recovery, b) viewed as incompetent and lacking self-determination (i.e., "you can no longer know what's best for you") because of drug use despite punitive responses and threats of being kicked out of services, and c) perceived not to comport in manner of thought, behavior and feeling accepted by treating staff to be regarded as: motivated to change, serious about recovery, compliant, and not in denial or resistant to "doing treatment."

Continue screening and reassessing patient placement

McGovern, Lambert-Harris, Gotham, Claus, and Xie (2014) sampled 256 programs across the US and found that approximately 18% (n= 180) of addiction treatment and 9% (n = 76) of mental health programs were co-occurring diagnosis capable (p. 208). Together, "this suggests that patients and families seeking care in these programs have a 1 in 10 to 2 in 10 chance of having both disorders addressed adequately" (p. 209). Hence

"reassessing changes in status during treatment can reveal particular points of vulnerability in the early recovery process, including mismatches between service interventions and emerging stages of recovery that can spark a breakdown in the service relationship and the clinical deterioration that often follows" (White et al., 2005, p. 13).

The initial biopsychosocial interview conducted during patient admission marks the beginning of a screening process, but its duration should last the patient's treatment term (Hoffmann, 2019). This ongoing process ensures and maintains the treating agency is appropriate for the patient. Continuous screening entails monitoring patient progress (via urinary drug testing; medication adherence; and demonstrated changes in attitudes, thinking, and behavior rather than compliance with program rules, phases, and lengths of stay), adjusting to better meet the patient's current situation (e.g., negotiating a new treatment plan), and helping patients understand their condition and what they can do about it (Hoffmann, 2019). With continuous screening (beyond the focus of what clients are not doing right), the treating agency can proactively respond to the patient's needs and determine whether more of the same treatment is contra-indicated and, if so, immediately refer or transfer them to a treatment whose level of care, intensity and regimen better meet their clinical needs. Neglecting to continuously screen the patient at reasonable intervals, on the other hand, likely results in mismatches leading to "emergency service termination" and reactive administrative discharges (or threats of termination that get the patient to sign out against medical advice [AMA]; Calsyn et al., 1995).

The manner in which urine drug screen(s) (UDS) are used within the substance abuse treatment industry highlights how program philosophy can lead to clinical neglect. In order to ensure proper placement of clients and to help establish that medical necessity criteria for reimbursement of treatment, treatment providers utilize UDSs. During the admission phase of a treatment episode, a positive (+) UDS helps establish the medical necessity for admission to all levels of treatment. During the active treatment phase, a +UDS may indicate persistence of symptoms and used to establish continued medical necessity during utilization reviews. Alternatively, however, a +UDS during treatment may indicate 'non-compliance' and used to discharge clients administratively (e.g., Caplehorn, Lumley, & Irwig, 1998). The determination of whether a +UDS during treatment indicates non-compliance and warrants termination of services versus persistent symptomology and increasing treatment support depends on the philosophy of the treatment program and the opinion of the primary clinician (e.g., Gjersing, Waal, Caplehorn, Gossop, & Clausen, 2010). For example, in one study, only 35.91% of clients across 106 treatment programs representing 11,533 treatment episodes, reported abstinence at successful discharge (e.g., Frimpong, Guerrero, Kong, & Kim, 2016).

In treatment settings that view complete abstinence as a necessary criterion to determine a client's commitment to recovery, a +UDS indicates non-compliance. Whereas in settings that do not exclusively view abstinence, attendance, or compliance as a benchmark of success, and concerned with progress related to actual recovery, the client's engagement in services as commitment to recovery, a +UDS indicates persistence and/or exacerbation of symptoms. In facilities that equate commitment to complete abstinence with commitment to recovery, a +UDS indicates non-compliance only if the clinician does not believe the client is truly committed. If the clinician is somehow convinced that the client is truly committed to abstinence, a +UDS indicates symptom exacerbation and/or persistence.

Programs that base the determination of treatment appropriateness on the client's commitment are at risk of inappropriately discharging clients. This is particularly true if the program lacks validated methods for evaluating clinical symptomatology, client commitment, treatment progress and outcomes.

Transfer Neglect

Transfer neglect occurs when the provider fails to refer a patient to a facility, professional, or

program level that could provide the patient with a more appropriate form of treatment or within other levels of care to better help improve the likelihood of positive clinical outcomes. Program staff might, for instance, ignore, dismiss, or overlook key indicators that signal the current level of care is unsuitable. The standards for terminating treatment of a patient with substance use disorder in a particular level of care should be similar to the standards applied to the treatment of other medical disorders (White, 2008).

When there are signs of clinical deterioration indicating that a patient can no longer be effectively treated in a level of care, for instance, that patient should be transferred to a level of care capable of responding to the greater severity and complexity of their condition with the objective of stabilization, rather than terminating the service relationship. The other condition warranting transfer is when a patient's continued treatment in a particular level of care poses a threat to their own safety (e.g., suicide risk in a setting with unsafe levels of supervision).

In situations involving fighting and interpersonal conflict between patients or threat to the safety of other patients, even under these conditions, however, termination of services is not always necessary. Where possible, staff-patient mediation, patient-patient conflict resolution, and other approaches involving sound clinical judgment may be acceptable and even preferred by patients (Svensson & Andersson, 2012). And when done properly, such interventions can actually help in terms of creating valuable opportunities for learning, education, personal growth and development, both for patients and treatment staff. The decision to terminate services should prudently consider the increased risk of morbidity and mortality among terminated patients discharged for continuing drug use or behavioral problems (Woody et al., 2007), which research further indicates can be reduced by retaining the patient in treatment while maintaining the safety and security of the treatment milieu or until the patient can be transferred to another provider to accommodate an appropriate level of care (Woody et al., 2007).

Providers anticipating the possibility of patient termination can show due diligence by establishing corroborative care coordination relationships with other providers well in advance of any incident warranting "emergency" termination. Providers who neglect to collaborate with other providers are more likely to be inclined toward administratively discharging patients when they are unable to immediately transfer them to a more appropriate level of care on short notice.

Referral Discrimination

Addiction treatment facilities treat people with all kinds of character foibles—some driven by residual effects of addiction and some completely unrelated to addiction (Littlefield & Sher, 2016). These patients can face administrative discharge due to obnoxious or confrontational behaviors (Chang et al., 2017). The conflicts that arise from this type of conduct are problems of countertransference or from staff frustration with the patient's irritating behavior, incorrigible attitude, or seemingly intractable self-defeating style of "doing treatment" in which these patterns exist (Fletcher, 2013; White et al., 2005). Terminating service delivery of addiction treatment on these grounds or when harboring a degree of dislike for the patient (Linn-Walton & Pardasani, 2014), instead of attempting to assertively link the patient to support services and actively find immediate placement availability with another care provider, is an act of referral discrimination.

The NASW Code like The NAADAC code of ethics (2016) requires referral when the "Provider is unable to remain objective" (p. 4). Treating agencies may nonetheless prematurely terminate care (especially when other people are waitlisted for services) or retain the patient (to financially benefit the provider or "keep the beds full") under the justification that such a course of action constitutes clinically appropriate care or is in response to noncompliance and violation of program rules. To illustrate, when a patient poses too great a risk to the rest of the population to remain in treatment due to entrenched patterns of patient predation, discharge constitutes an appropriate treatment intervention. In

such cases, the basis for extrusion may serve as an indication that the provider is committed to providing a safe, supportive environment to those able to comply with the behavioral requirements necessary for the provision of a therapeutic environment conducive to recovery initiation and maintenance. Consequently, failure to administratively discharge patients could serve as an indication of a lack of commitment, competence, or both on the part of the provider, especially if it results in vulnerable service recipients in the early stages of their treatment recovery being unnecessarily exposed to physical injury, destabilizing affects, and hazardous behaviors. When moralizing judgments impede professional detachment or clinical objectivity, staff may not proactively offer the patient a necessary and needed referral or assertively link the patient to ancillary support. When treatment is terminated, the patient may simply be given a passive provider referral (i.e., handed a slip of paper listing three treatment providers with verbal instruction to call and make an appointment) instead of a more active and helpful linkage to care.

Admissions Recycling

Over 50% of those admitted to addiction treatment have one prior treatment episode, and approximately 1 in 5 have three or more prior admissions (SAMHSA, 2014). These statistics indicate that a revolving door of patients who are administratively discharged likely return to the same program or recycle through a state's treatment system within the same year or over a longer period of time. It is not always inappropriate to place a patient in the same program more than once. For instance, if a patient is discharged for smuggling and selling drugs in the treatment facility, they may be readmitted after staff members implement better security procedures aimed at curbing this type of violation. Or staff training in de-escalation and crisis intervention might make a program adequate for a potentially volatile patient who was previously discharged for "uncontrollable" aggressive outbursts. Unfortunately, when patients are readmitted to a program, the provider often has made little if any change in treatment quality that could translate to better odds of a successful outcome for the returning patient and for new patients by mitigating risk of unnecessary termination.

Admissions recycling, then, is a problem when programs terminate the treatment services of a patient, only to subsequently readmit that patient despite a high likelihood that they will reexperience the very same systemic program shortcomings and treatment approach that set the stage for their administrative discharge in the first place. This is especially so when the level of care provided by the treating agency is not equipped to meet the needs of the patient and a more appropriate placement via referral or level of care transfer within the program or to another agency in the community could meet these needs.

Implications for Clinical Abandonment

Clinical abandonment is framed by NAADAC's code of ethics (2016) according to the following formulation: "Addiction Professionals shall not abandon any client in treatment. Providers who anticipate termination or interruption of services to clients shall notify each client promptly and seek transfer, referral, or continuation of services in relation to each client's needs and preferences" (p. 4). While the code prohibits treatment professionals from abandoning patients, NAADAC (2016) does not define abandonment. It does, however, provides some indication of what a proper discharge entails:

> Addiction Professionals shall terminate services with clients when services are no longer required, no longer serve the client's needs, or the Provider is unable to remain objective. Counselors provide pre-termination counseling and offer appropriate referrals as needed. Providers may refer a client, with supervision or consultation, when in danger of harm by the client or by another person with whom the client has a relationship (p. 11).

Extrapolating from this, permits understanding of abandonment as the wrongful, premature, or inappropriate termination of treatment services, often as a result of provider neglect or dereliction of fiduciary duty.

Administrative discharge as abandonment often takes the form of passing the blame. When the patient's symptoms continue or worsen, providers may be reluctant to admit that their program is not adequately treating the patient. Instead, the patient is blamed for the ineffectual outcome and often punished by being removed from the program. The patient is framed as having "blown their chance" at a better outcome (White et al., 2005).

Abandonment, moreover, is not the only relevant variable for premature administrative discharge. Clinical punishment can also play a role, either as the core motivator of an administrative discharge or as a punitive measure "to teach a lesson" in response to unwanted patient behavior or repeated rule violations (Condon et al., 2011). The disparity in the application of termination by payment method (cash paying vs. welfare) is another dimension of the administrative discharge phenomenon that may serve as a proxy measure for a client's level of psychosocial functioning (Proctor, Herschman, Lee, & Kopak, 2018). While the punitive dimension is not explicitly stated as the rationale for a discharge, payment method may also confer protective status in the sense that program staff are known for working to "dump" a troublesome patient, especially when insurance funds are exhausted or preauthorization requests by the provider for continued services are denied by the insurance carrier.

It is true that there may be some patients who are simply too recalcitrant to benefit from addiction treatment services. If giving those burdened with the disease of addiction a better chance at recovery is desired, however, the primary responsibility for successful outcomes must rely primarily not on those afflicted, but rather on those desiring to ameliorate their suffering. Patients have a complex set of emotional, psychological, physical, and social needs, and treatment programs must be equipped to meet these when such patients are acceptingly enrolled in services. To the extent that they fall short, they should make every effort to improve their treatment philosophy, policies, procedures and protocols rather than simply terminate treatment and hold the patient solely responsible for their failure to "complete" or "graduate" from the program. As it stands, the bar for an ethical discharge is low. Providers are simply advised by some state authorities (one example being the Alcohol and Drug Abuse Division in Hawai'i) to provide a semblance of notice with instruction for the patient to seek an alternative provider following service termination.

Conclusion

The national rate of administrative discharge represents a conservative annual percentage that does not reflect the actual prevalence of this practice due to systemic underreporting (Williams, 2018). Nonetheless, the personal and social costs of ineffective substance use disorder treatment are significant (White, 2008). When patients experience multiple and repeated program failures within a single treatment episode, which culminated in AD, it raises the question of whether these terminations amount to a form of clinical abandonment. This is particularly important to examine when treatment settings terminate services for the most neurologically compromised patients who need more, not less, treatment engagement effort (Rupp et al., 2016).

Despite its acceptance and usage in treatment clinics, AD is not a practice anchored in consensus about best practices or sanctioned by national guidelines (Williams, 2016). Our analysis then is meant to interrogate and problematize the practice of administrative discharge by bringing attention to the ways that components of a treatment model (policies, procedures, protocols, overall treatment philosophy) are interlinked and conspire to create conditions conducive to clinical abandonment. The proverbial elephant in the addiction clinic that the authors hope to highlight is the indeterminable number of treating agencies that employ

administrative discharge as an administrative tool, yet sidestep systemic program limitations and failures to mask a negligence in taking appropriate steps for treating a patient.

As a clinical instrument or program-level intervention, rather than blaming patients for failing to progress through the program, administrative discharges should be met with initiatives aimed at preventing future uses of this administrative tool (Williams & Taleff, 2015b), such as crafting clinical decision-making protocols (Walton, 2018), bolstering staff training and equipping them with proper education (White et al., 2005), imbuing treatment philosophy with evidence-based practice (Williams, 2015b), minimizing rules, and making improvements to policies and procedures to change the treatment milieu to obviate patient termination (White et al., 2005). Otherwise, the treating agency continues to operate with its limitations despite perpetually failing and clinically abandoning patients and labeling it administrative discharge.

References

American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (5th ed.). Arlington, VA: American Psychiatric Publishing.

Association for Addiction Professionals. (2016). *NAADAC/NCC AP code of ethics*. Retrieved from http://www.naadac.org/code-of-ethics

Calsyn, D. A., Wells, E. A., Saxon, A. J., Jackson, T. R., Wrede, A. F., Stanton, V., & Fleming, C. (1995). Contingency management of urinalysis results and intensity of counseling services have an interactive impact on methadone maintenance treatment outcome. *Journal of Addictive Diseases*, *13*, 47–63. https://doi.org/10.1300/J069v13n03_05

Caplehorn, J. R., Lumley, T. S., & Irwig, L. (1998). Staff attitudes and retention of patients in methadone maintenance programs. *Drug and Alcohol Dependence*, *52*(1), 57–61. https://doi.org/10.1016/S0376-8716(98)00047-7

Carr, E. S. (2010). *Scripting addiction: The politics of therapeutic talk and American sobriety*. Princeton, NJ: Princeton University Press.

Chang, J. S., Chiu, J. D., Gruber, V. A., & Sorensen, J. L. (2017). Fair hearing outcomes of patients recommended discharge from methadone maintenance. *Journal of Substance Abuse Treatment*, *83*, 68–72. https://doi.org/10.1016/j.jsat.2017.07.011

Condon, T. P., Jacobs, P., Tai, B., Pintello, D., Miner, L., & Elcano, J. C. (2011). Patient relapse in the context of drug abuse treatment. *Journal of Addiction Medicine*, *5*, 157–162. https://doi.org/10.1097/ADM.0b013e31820497ae

Dawson, D. A., Goldstein, R. B., & Grant, B. F. (2007). Rates and correlates of relapse among individuals in remission from DSM-IV alcohol dependence: A 3-year follow-up. *Alcoholism: Clinical and Experimental Research*, *31*, 2036–2045. https://doi.org/10.1111/j.1530-0277.2007.00536.x

Deck, D., & Carlson, M. J. (2005). Retention in publicly funded methadone maintenance treatment in two western states. *The Journal of Behavioral Health Services & Research, 32*, 43–60. https://doi.org/10.1097/00075484-200501000-00004

Fletcher, A. M. (2013). *Inside rehab: The surprising truth about addiction treatment—and how to get help that works*. New York, NY: Viking Press.

Flynn, P. M., & Brown, B. S. (2008). Co-occurring disorders in substance abuse treatment: Issues and prospects. *Journal of Substance Abuse Treatment*, *34*, 36–47. https://doi.org/10.1016/j.jsat.2006.11.013

Forman, R. F., Bovasso, G., & Woody, G. (2001). Staff beliefs about addiction treatment. *Journal of Substance Abuse Treatment*, *21*, 1–9. https://doi.org/10.1016/S0740-5472(01)00173-8

Frimpong, J. A., Guerrero, E. G., Kong, Y., & Kim, T. (2016). Abstinence at successful discharge in publicly funded addiction health services. *The Journal of Behavioral Health Services and Research*, *43*(4), 661–675. https://doi.org/10.1007/s11414-016-9497-8

Gjersing, L., Waal, H., Caplehorn, J. R., Gossop, M., & Clausen, T. (2010). Staff attitudes and the associations with treatment organisation, clinical practices and outcomes in opioid maintenance treatment. *BMC Health Services Research*, *10*(194), 1–8. https://doi.org/10.1186/1472-6963-10-194

Hoffmann, N. G. (2019, January 26). *Beyond the biopsychosocial interview: Assessment from intake to outcome*. Paper presented at the Evolution of Addiction Treatment Conference, Los Angeles, CA.

Hoffmann, N. G., & Kopak, A. M. (2015). How well do the DSM-5 alcohol use disorder designations map to the ICD-10 disorders? *Alcoholism: Clinical and Experimental Research*, *39*, 697–701. https://doi.org/10.1111/acer.12685

Kim, J., Sabino, E., Zhang, J., & Okano, S.Y. (2015). *Alcohol and drug treatment services: Hawai'i, 5-year trends* (2010–2014). Honolulu, HI: University of Hawai'i, Center on the Family.

Koob, G. F., & Volkow, N. D. (2016). Neurobiology of addiction: A neurocircuitry analysis. *The Lancet Psychiatry*, *3*, 760–773. https://doi.org/10.1016/S2215-0366(16)00104-8

Lee, H. S., & O'Malley, D. (2018). Abstinence-only: Are you not working the program or is the program not working for you? *Journal of Social Work Practice in the Addictions*, *18*, 289–304. https://doi.org/10.1080/1533256X.2018.1489259

Linn-Walton, R., & Pardasani, M. (2014). Dislikable clients or countertransference: A clinician's perspective. *The Clinical Supervisor*, *33*, 100–121. http://dx.doi.org/10.1080/07325223.2014.924693

Littlefield, A. K., & Sher, K. J. (2016). Personality and substance use disorders. In K. J. (Ed.), *The Oxford handbook of substance use and substance use disorders* (Vo1. 1, pp. 351–374). New York, NY: Oxford University Press.

McGovern, M. P., Lambert-Harris, C., Gotham, H. J., Claus, R. E., & Xie, H. (2014). Dual diagnosis capability in mental health and addiction treatment services: an assessment of programs across multiple state systems. *Administration and Policy in Mental Health and Mental Health Services Research*, *41*, 205–214. https://doi.org/10.1007/s10488-012-0449-1

McGovern, M. P., Xie, H., Segal, S. R., Siembab, L., & Drake, R. E. (2006). Addiction treatment services and co-occurring disorders: Prevalence estimates, treatment practices, and barriers. *Journal of Substance Abuse Treatment*, *31*, 267–275. http://dx.doi.org/10.1016/j.jsat.2006.05.003

National Association of Social Workers. (2013). *NASW standards for social work practice with clients with substance use disorders.* Washington, DC: Author.

National Association of Social Workers. (2017). NASW Code of Ethics. Retrieved from https://www.socialworkers.org/About/Ethics/Code-of-Ethics.aspx

Office of the Surgeon General. (2016, November). *Facing addiction in America: The Surgeon General's report on alcohol, drugs, and health*. Washington, DC: U.S. Department of Health and Human Services.

Proctor, S. L., Herschman, P. L., Lee, R., & Kopak, A. M. (2018). The role of patient payment method in premature discharge from methadone maintenance treatment. *Substance Use and Misuse*, *54*, 97–105. https://doi.org/10.1080/10826084.2018.1504081

Reamer, F. G. (2000). Ethical issues in direct practice. In P. Allen-Meares & C. Garvin (Eds.), *The handbook of social work direct practice* (pp. 589–610). Thousand Oaks, CA: Sage.

Reisinger, H. S., Schwartz, R. P., Mitchell, S. G., Peterson, J. A., Kelly, S. M., O'Grady, K. E., ... Agar, M. H. (2009). Premature discharge

from methadone treatment: Patient perspectives. *Journal of Psychoactive Drugs*, *41*(3), 285–296. https://doi.org/10.1080/02791072.2009.10400539

Rupp, C. I., Beck, J. K., Heinz, A., Kemmler, G., Manz, S., Tempel, K., & Fleischhacker, W. W. (2016). Impulsivity and alcohol dependence treatment completion: Is there a neurocognitive risk factor at treatment entry? *Alcoholism: Clinical and Experimental Research*, *40*, 152–160. https://doi.org/10.1111/acer.12924

Spithoff, S., Meaney, C., Urbanoski, K., Harrington, K., Que, B., Kahan, M., ... Sullivan, F. (2019). Opioid agonist therapy during residential treatment of opioid use disorder: Cohort study on access and outcomes. *Canadian Family Physician*, *65*(10), e443–e452.

Subbaraman, M. S., & Witbrodt, J. (2014). Differences between abstinent and non-abstinent individuals in recovery from alcohol use disorders. *Addictive behaviors*, *39*, 1730–1735. http://doi:10.1016/j.addbeh.2014.07.010

Substance Abuse and Mental Health Services Administration. (2014). *Treatment episode data set: Discharges—Concatenated, 2006–2011* [Data file]. Retrieved from https://www.datafiles.samhsa.gov/study-dataset/treatment-episode-data-set-discharges-2006-2011-teds-d-2006-2011-ds0001-nid13734

Substance Abuse and Mental Health Services Administration (2017). *National Survey of Substance Abuse Treatment Services[N-SSATS]— 2016: Data on substance abuse treatment facilities*. Retrieved from https://www.samhsa.gov/data/sites/default/files/2016_NSSATS.pdf

Substance Abuse and Mental Health Services Administration. (2018). *Treatment episode data set discharges 2017* [Data file]. Retrieved from https://www.datafiles.samhsa.gov

Svensson, B., & Andersson, M. (2012). Involuntary discharge from medication-assisted treatment for people with heroin addiction–Patients' experiences and interpretations. *Nordic Studies on Alcohol and Drugs*, *29*, 173–193. https://doi.org/10.2478/v10199-012-0012-0

Vaillant, G. E. (2003). A 60-year follow-up of alcoholic men. *Addiction*, *98*, 1043–1051.

Volkow, N. D., & Boyle, M. (2018). Neuroscience of addiction: Relevance to prevention and treatment. *American Journal of Psychiatry*, *175*, 729–740. https://doi.org/10.1176/appi.ajp.2018.17101174

Volkow, N. D., Koob, G. F., & McLellan, A. T. (2016). Neurobiologic advances from the brain disease model of addiction. *New England Journal of Medicine*, *374*, 363–371. https://doi.org/10.1056/NEJMra1511480

Walton, M. T. (2018). Administrative discharges in addiction treatment: Bringing practice in line with ethics and evidence. *Social Work*, *63*, 85–90. https://doi.org/10.1093/sw/swx054

Watkins, K. E., Hunter, S. B., Wenzel, S. L., Tu, W., Paddock, S. M., Griffin, A., & Ebener, P. (2004). Prevalence and characteristics of clients with co-occurring disorders in outpatient substance abuse treatment. *The American Journal of Drug and Alcohol Abuse*, *30*, 749–764. https://doi.org/10.1081/ADA-200037538

White, W. L. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices*. Northeast Addiction Technology Transfer Center, the Great Lakes Addiction Technology Transfer Center, and the Philadelphia Department of Behavioral Health/Mental Retardation Services.

White, W. L., Scott, C., Dennis, M., & Boyle, M. (2005). It's time to stop kicking people out of addiction treatment. *Counselor*, *6*(2), 12–25.

Williams, I. L. (2015a). Administrative discharge: The dilemma of perceived non-compliance. *Paradigm: Illinois Institute for Addiction Recovery*, *20*(1), 4–6.

Williams, I. L. (2015b). Is administrative discharge an archaic or synchronic program practice? The empirical side of the debate. *Online Journal of Health Ethics*, *11*(2), 1–5.

Williams, I. L. (2016). Moving clinical deliberations on administrative discharge in drug addiction treatment beyond moral rhetoric to empirical ethics. *Journal of Clinical Ethics*, *27*(1), 71–75.

Williams, I. L. (2018). Involuntary termination from substance use disorder treatment: Unknown phantoms, red flags, and unexplained medical data**.** *Journal of Human Services: Training, Research, and Practice, 3*(2), 1–19.

Williams, I. L., & Mee-Lee, D. (2017). Coparticipative adherence: The reconstruction of discharge categories in the treatment of substance use disorders. *Alcoholism Treatment Quarterly*, *3*, 279–297. https://doi.org/10.1080/07347324.2017.1322432

Williams, I. L., & Mee-Lee, D. (2019). Inside the black box of traditional treatment programs: Clearing the air on the original literary teachings of Alcoholics Anonymous. *Journal of Addiction Research and Theory*, *27*, 412–419. https://doi.org/10.1080/16066359.2018.1540692

Williams, I. L., & Taleff, M. J. (2015a). Sex, romance, and dating in treatment recovery: Ethical reflections and clinical deliberations on challenging addiction decision making. *Journal of Ethics in Mental Health*, 9, 1–7.

Williams, I. L., & Taleff, M. J. (2015b). Key arguments in unilateral termination from addiction programs: A discourse of ethical issues, clinical reasoning, and moral judgments. *Journal of Ethics in Mental Health*, *9*, 1–9.

Williams, I. L., & White, W. L. (2015, September 11). Kicking people out of addiction treatment: An update and commentary. *Selected Papers of William L. White*. http://www.williamwhitepapers.com/blog/2015/09/kicking-people-out-of-addiction-treatment-an-update-and-commentary-izaak-williams-and-william-white.html

Woody, G. E., Kane, V., Lewis, K., & Thompson, R. (2007). Premature deaths after discharge from methadone maintenance: A replication. *Journal of Addiction Medicine*, *1*, 180–185. https://doi.org/10.1097/ADM.0b013e318155980e