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Is Administrative Discharge an Archaic or Synchronic Program Practice? The Empirical Side of the Debate

Izaak Williams
University of Hawaii, izaakw@hawaii.edu

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When historian William L. White was once asked how the current era of addiction treatment would be judged in the future, he described field historians, administrators and practitioners as one day looking back, scratching their heads, and with the practice of expelling patients from treatment in mind, asking themselves the befuddling question, "What the hell were they thinking?" (White, Scott, Dennis, Boyle, 2005)

The administrative discharge (AD) or expulsion of patients with substance use disorders is a near universal phenomenon in the addiction treatment and recovery field. While a subject of debate, AD in the treatment and recovery field literature mostly lapses into silence. A national dataset is brought into the foreground of this commentary in sorting the type of empirically driven descriptive information lending supportive data to the administrative discharge epistemology.

The latest data from the Substance Abuse and Mental Health Services Administration (SAMHSA) reveals that over 126, 718 clients, or 7.3% of admissions, were expelled from addiction treatment in the U.S. (SAMHSA, 2011). While the current data on AD permits idle speculation as to the prevalence of this practice, clinical reasoning and ethical arguments are largely unsupported by strong research backing. This is due in part to the scarcity of openly accessible state-level and program-specific regional data corresponding to the various types and levels of inpatient and outpatient treatment service modalities (e.g., detox, inpatient hospital, outpatient clean and sober living programs, transitional halfway houses providing in-house treatment). While greater transparency can be found in national level data culled from the Treatment Episode Data Set- Discharges (TEDS-D) maintained by the Center for Behavioral Health Statistics and Quality via SAMHSA, limitations exist as to the actual cases complimenting the data collected, rendering shallow data-driven perspectives on AD heretofore.

In accordance with program policies and regulations, from minor to severe rule infractions or safety violations, an examination of the reasons for warranting AD would shed light on the various categories of offences represented in the overall 7.3% administrative discharge figure. The TEDS-D dataset contains the variable “reason” (i.e., reason for leaving treatment), as well as tracks both those who completed treatment and those whose treatment was terminated by a facility for being “non-compliant”. However, “non-compliance” related discharges are not broken out into specific categories of program rule infractions inclusive of sexual misconduct or breaking the non-fraternization policy (for ethical discussion see Williams & Taleff, 2015), curfew violations, refusal to comply with treatment recommendations, etc. As it is, the non-compliant statistic is lumped into the TEDS-D within a near all-encompassing category of AD that reliably omits specific causes as to why a client was unilaterally terminated. Effectively ignoring the sequence of program actions to the gamut of minor and absolute breach of rules for which AD is applied. In relation, what is particularly misleading and problematic is that AD is overly misattributed to the client as confirmation of “non-compliance”. In turn, underlying program characteristics, philosophy, rules, protocols and policies, therapeutic environment, admission intake screening assessments, procedural approaches (limitations or lack

thereof), contributing to and inducing AD are largely overlooked performance measures in AD reporting procedures to single state agencies, county authorities, and other funding authorities and accrediting bodies (Williams & White, 2015).

Program-related factors, which possibly might otherwise reduce the potential for AD, such as clear guidelines to lower the rate of AD, formal training in de-escalation techniques, behavioral modification, crisis intervention, utilization of medication-assisted therapy, motivational enhancement interventions, and other modalities are statistically dislodged from the TEDS-D domain of administrative discharge. Leading in part to exaggerated claims about the prevalence of AD or 'non-compliant" client behavior, which obscures the need for program improvements. For instance, programs declaring AD to be the only suitable response rarely face any real accountability measures, the least of which requires the program staff to explain the efficacy of their decision-making process as the best approach, compared to perhaps other viable alternative interventions such as referral to another treatment program or linkage in care (Williams & White, 2015). The resultant effect is that staff members can, and do, underwrite AD without ethical or clinical justification since regulatory frameworks are highly variable in consideration of AD representing a recovery-focused program performance measure and lowering of such as a performance goal. Additionally, external review boards to examine AD decisions within the agency are most likely not in place to act as checks and balances against such practice (Williams & White, 2015).

With questions as to the prevalence and effect of AD looming over the debate, the TEDS-D data also suffers from selection bias. As not all states report TEDS-D data, there is a degree of variability in the data from year to year. For instance, in 2010, forty-six states and Puerto Rico reported treatment termination information to TEDS-D compared to the benchmark forty-two states in 2006. What this means is that many administrative discharges are unaccounted for, which serves to diminish confidence in the integrity of the discharge data. Moreover, not all facilities are required to report to the TEDS-D system. Notably, the exact percentage of facilities that report to TEDS-D has not been recently reported by SAMHSA, nor have they at least provided recent response rates in the information of their codebooks.

Additionally, there is inflation and underreporting of AD rates because the TEDS-D does not track treatment episodes in terms of one-to-one correlations. That is, a patient can be counted multiple times within the same year's data as entering and/or exiting treatment, yet the question as to how many times the patient was discharged from a program is left uncounted. The process of gathering and analyzing this information in tandem with clinical details would offer treatment facilities a better understanding of what components of their programs work and which need to be improved or discarded to improve clinical outcomes.

Furthermore, the severity of individuals' addictions in terms of diagnostic criteria at the time of discharge is an unknown. Many questions as to the severity, chronicity, and complexity of addiction cases go without answer within the fold of contentious polemics on the overreliance of AD within treatment programs. Other than what can be inferred from the "servsetd" variable (i.e., service setting: inpatient, outpatient, hospital, etc.) in the TED-D dataset, the mental health diagnostic variable "dsmcrit" is grouped into categories that primarily refer to different types of substance abuse/dependence (DSM-IV); a proxy to estimate the prognostic significance of AD

patterns. However, many states and facilities do not provide such information, with over 60% of the DSMCRIT variable information considered "missing/uncollected data."

Despite these gaps in data, programs tend to report a success rate, yet critical questions are left unanswered including why patients have been subjected to AD, and any outcomes associated with a patient's AD to future treatment episode(s) or lack thereof, such as patient motivation, treatment receptivity and retention among other important variable gains or losses and what those yield to treatment outcomes. To better understand the phenomenological dynamics inherent to the AD practice, the TEDS-D currently offers minimal evidence to support arguments either in favor or opposed to current AD practice. Without much detail in the hard data to offer information as to the number and type of patients administratively discharged from treatment or program factors that either mitigated or contributed to AD, the hard data is vague concerning whether or not to deem the practice anachronistic or a necessary program component for addiction treatment recovery. In fact, no large scale empirical study to date has tracked actual cases of post-termination consequences or client outcomes, which otherwise might assist field historians, administrators and practitioners, further examine the reliance on AD within drug addiction treatment programs. To this, William L White commented:

> Data on annual rates of administrative discharge are collected in the TEDS data set, but I have not seen a single paper analyze this data nor have I 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 (Personal Correspondence, April 24, 2015)

Published comprehensive studies of statistical significance can aid clinical practice by adding insight that informs the ethical and moral decision-making process. Yet arguments either in favor or opposed to extruding patients tend to rest on morally biased and ethically slanted reasoning falling in line with a particular ideology about the nature and dynamics of drug addiction. How empirical-based data yields to the debate over whether administrative discharge is a synchronically needed or unnecessarily archaic program practice is by and large unknown. In sum, the current state of national data on administrative discharge is an empirical affair to both sides of the ongoing debate, whereby future field historians, administrators and practitioners in the treatment and prevention field will one day look back with eyebrows raised wondering, "what the hell were they thinking?"

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