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It's Time to Stop Kicking People Out of Addiction Treatment

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Interventions by professional helpers that are later recognized as ineffective or even harmful have a long and colorful history. Some of the most widely practiced of such interventions have left later generations pondering, "What on earth were they thinking?" Lectures on the history of addiction treatment stir feelings of enlightened condescension amidst tales of treating morphine addiction with cocaine and other such idiocies, but occasionally a conference attendee asks the tough question: "How will the current era of addiction treatment be judged in the future?" And, of course, that is the rub, because it is so difficult to clearly see our own professional miscues and mistakes without the benefit of historical hindsight. This essay explores one practice—administratively discharging clients from addiction treatment—that we suspect will be judged harshly by historians of the not so distant future.

Administrative Discharge: Definition and Criteria

Administrative discharge (AD)—also referred to as "disciplinary discharge," "discharge for cause," or "discharge upon staff request"—is the adversarial termination of services due to a client's failure to comply with program rules and expectations. The reasons for AD vary by modality but generally include:

- Failing to participate in service activities, e.g., missing counseling sessions
- Threatening, or appearing to threaten, the physical or psychological safety of others
- Breaking rules regarding relationship boundaries, e.g., having phone or face-to-face contact with family members or friends during a "blackout" period, verbal abuse (profanity, racial slurs), or "fraternization" (sexual or other inappropriate activity with another client)
- Refusing to live within rules established for communal living (e.g., hygiene, assigned chores, disruptiveness, quiet

hours, and punctuality for treatment activities)
- Failing to pay service fees
- Possessing contraband in the treatment facility (e.g., illicit drugs, cigarettes, prohibited food items)
- Using alcohol or unprescribed drugs, or
- Failing to secure medication for a psychiatric condition.

The AD status is distinct from successful treatment completion (sometimes referred to as "planned discharge" or "graduation"), client termination of service participation against staff advice (also referred to as "against medical advice," "absent without leave" or "drop-outs," or referrals to another treatment resource (also referred to as "transfers").

Administrative Discharge Patterns

A review of the addiction treatment literature reveals a number of key findings related to current administrative discharge practices.

Definitional Problems Discharge categories and their definitions differ across programs, but there is evidence that discharge rates by type of discharge vary across community-based and prison-based treatment programs (Pelissier, Camp & Motivans, 2003) and vary from therapist to therapist within the same treatment program (Najavits & Weiss, 1994).

Discharge Status and Clinical Outcomes In adult populations, addiction treatment retention and completion are predictive of positive outcomes, and failure to complete treatment (including those administratively discharged) is predictive of worse outcomes (Price, 1997; Grella, Hser, Joshi, & Anglin, 1999; Wallace & Weeks, 2004). The role of discharge status on adolescent treatment outcomes is less clear, with one study noting superior outcomes for successful completers (Winters, Stinchfield, Opland, Willer & Latimer, 2000), and one study noting no significant differences between treatment completers and non-completers (Godley, Godley, Funk, Dennis, & Loveland, 2001).

Administrative Discharge Profiles Adult and adolescent non-completers are more likely to have clinical profiles marked by younger age, greater problem severity (although some studies report a positive link between severity and retention) psychiatric impairment (i.e., depression, conduct disorder, antisocial personality disorder, schizophrenia), history of perpetration of violence, less motivation for recovery, and less recovery supports in their family and social network (Godley, et al, 2001; Hser, Maglione, Joshi, & Chao, 1998; DeLeon & Jainchill, 1986; Agosti, Nunes & Ocepeck-Welikson, 1996; DeLeon, Melnick, Kressel, & Wexler, 2000; Pelissier, Camp & Motivans, 2003).

Administrative Discharge Prevalence and Level of Care Patterns At the present time, 18% (288,000 thousand) of the 1.6 million people admitted to publicly funded addiction treatment in the United States are administratively discharged (compared to 49% who complete treatment, 24% who leave against staff advice; and 9% who are transferred) (Substance Abuse and Mental Health Services Administration, 2002). Rates of AD are not uniform across levels of care. The highest to lowest rates of AD are found in methadone maintenance (30.7%), long-term residential (24.8%), outpatient (23.7%), intensive outpatient (19.8%), detoxification (9.4%), short-term residential (9%), and inpatient hospital treatment (4.6%) (SAMHSA, 2002).

Common Objectives for the Use of Administrative Discharges

In reviewing the literature and interviewing colleagues around the country about AD practices, we found five primary objectives that treatment professionals hope to achieve through the use of administrative discharge:

Objective #1: to protect the integrity of the treatment milieu. Administrative discharges are used to prevent and respond to disruptive behaviors that negatively impact the treatment environment. In this

view, individuals who are acting out are sacrificed for the greater good of other clients. Many readers would concur that therapeutic milieu is a crucial but fragile dimension of addiction treatment that can be compromised or lost. The AD stands as the ultimate instrument for preserving that milieu, even if applied in an inconsistent manner.

*Objective #2: to assure the best utilization of limited treatment resource. A*dministrative discharges are used to ration addiction treatment services to those who the treatment provider believes can most benefit from it. The AD practice assumes that programs have limited resources and clients who act out are wasting resources that more deserving others could be using. This objective is also met in some programs by discharging clients who cannot pay service fees on the grounds that the long-term financial integrity of the service organization takes precedence over the immediate needs of the non-paying client.

Objective #3: to protect the reputation of the treatment program. Administrative discharges are used to terminate services for clients who continue to use substances or exhibit other disruptive behaviors within the context of treatment. The assumption underlying such extrusion is that allowing clients to continue treatment while using would lead to a loss of community respect and support for the program. Rumors circulating within the using community regarding toleration of substance use during treatment could also damage the reputation of the program in the eyes of its most important constituents, including more compliant clients.

Objective #4: to prevent the treatment organization and its staff from enabling clients. Programs that use AD to achieve this goal assume that anything short of severing the service relationship with the AOD-using client would, by protecting the client from the consequences of his or her actions, constitute a form of professional enabling. In this view, there is therapeutic harm for continuing to treat the AOD-using client and therapeutic benefit (a motivational "wake-up call") resulting from treatment expulsion. Clients returning to treatment following AD who contritely confess that they weren't ready for treatment and that they needed a dose of reality add anecdotal support for this argument.

Objective #5: to fulfill the ethical obligation of terminating and (at least nominally) referring clients who fail to respond to program services The assumption guiding this objective stems from the need to protect clients from continuing exposure to treatments that are ineffective or potentially harmful due to the ideological biases or financial interests of the service provider (White & Popovits, 2001). Tempering this argument for AD is another ethical mandate: to not clinically abandon clients to whom one has pledged loyalty and availability.

These five objectives provide the primary rationalization underlying the majority of administrative discharges. These objectives make the act of administratively discharging the non-compliant client seem common sense, necessary and even noble. However, no program of qualitative or empirical research has been conducted to assess the validity of these objectives.

The Case Against Administrative Discharges

As noted, little research has been conducted to test the assumptions upon which current AD arguments rest, but numerous treatment agencies around the country are beginning to re-evaluate their AD practices. There are seven emerging arguments for stopping or significantly reducing the scope of client behaviors that can result in AD from addiction treatment and for developing programmatic responses that better benefit the client.

Argument #1. Administratively discharging clients from addiction treatment for AOD use is illogical and unprecedented in the health care system. A client is admitted to addiction treatment on the grounds that he or she has a chronic condition, the essence of which is the inability to abstain from or willfully limit their intake of psychoactive drugs in spite of

escalating problems related to such use. Significantly, the just-admitted client is told that AOD use is a violation of program rules and grounds for his or her termination from treatment. The client then consumes alcohol or other drugs in spite of the promised consequence—confirming the grounds upon which their diagnosis was made and their need for professional assistance. As a result of manifesting the primary symptom of the disorder for which the client was admitted to treatment, he or she is expelled from treatment.

We know of no other major health problem for which one is admitted for treatment and then thrown out for becoming symptomatic in the service setting. For other chronic health care problems, symptom manifestation serves as a confirmation of diagnosis or feedback that alternative methods of treatment and alternative approaches to patient education and motivation are needed. In marked contrast, symptom manifestation in the addictions field is grounds for expulsion from service.

Administratively discharging clients from treatment for alcohol or other drug (AOD) use is hypocritical and contradicts the very messages communicated by treatment center personnel to the larger community. The messages outward are that:

- The client is not in control of their alcohol and drug intake or its consequences
- The client needs professional treatment to reacquire such control
- Reacquisition of control over AOD use/nonuse decisions takes time and may be preceded by one or more episodes of relapse, and
- Long-term recovery is best supported by patience and support rather than punishment and abandonment.

Current administrative discharge practices in addiction treatment contradict these messages. We would hope that the days are numbered in which the addictions field can argue that addiction is a primary health care problem while its clinicians continue to treat the primary symptoms of addiction as bad behavior subject to "disciplinary discharge."

Expelling a client from addiction treatment for AOD use—a process that often involves thrusting the client back into drug-saturated social environments without provision for alternate care—makes as little sense as suspending adolescents from high school as a punishment for truancy. The strategy should not be to destroy the last connecting tissue between the client and pro-recovery social networks, but to further disengage the client from the culture of addiction and to work through the physiological, emotional, behavioral and characterological obstacles to recovery initiation, engagement, and maintenance. People with AOD problems should be afforded the same continuity of service contact that those with other chronic health and behavioral health problems are afforded (White, Boyle, & Loveland, 2003).

Argument #2. Administratively discharging clients from treatment for AOD use reflects a fundamental misunderstanding of the role of volition in addiction and recovery. The very essence of addiction is a progressive deterioration of the will—the erosion of volitional power to not use alcohol or other drugs or to regulate or stop such use once it is initiated. Volitional control over AOD use decisions should be viewed as a desired outcome of addiction treatment, not a required ticket of admission to treatment. If an individual could consistently exert such control, he or she would, by definition, not need addiction treatment. For those addicted and those recovering from addiction, free will exists, not as a dichotomous state, but in degrees of lost and reacquired power to maintain congruence between intent and actions. Treatment and sustained recovery involve a progressive rehabilitation of the will. Accountability for AOD use decisions makes sense only to the extent one has re-acquired the power to consistently assert one's choice over such decisions.

Argument #3. Administrative discharge currently casts the role of the treatment agency as one of persecutor, and misjudges the meaning and consequence of AD on the client. The synergy of addiction-related pain and hope of a better life

constitutes the critical catalyst of recovery initiation. To function as a motivation for change, painful consequences must be personally meaningful and directly linked to one's AOD use. Extruding an AOD-using client from treatment as a strategy of motivation assumes that extrusion from treatment will be experienced as a personally painful loss and further self-confirmation of the severity of the client's AOD problem. This is often not the case. First, it is typically only the secondary losses following such extrusion that tend to have meaning for the AOD-using client, e.g., loss of job, revocation of probation, lost custody of children. Without such secondary losses, we suspect the AD experience has little meaning or therapeutic effect, and shifts the role of the treatment program in the eyes of the client from that of benefactor to another source of the client's problems. Moreover, such losses create further despair and depression for the AD client, further promoting a return to AOD use.

Argument #4. Administratively discharging clients from treatment for rule violations is often the endgame in a process of escalating negative countertransference. Countertransference is the "total emotional reaction of the therapist to the patient" —a reaction that involves the therapist's beliefs about the client, his or her feelings for the client, and his or her overall attitude toward the client (Imhof, 1991). The euphemisms for the AD practice—"throwing" or "kicking" someone out of treatment—would suggest the act involves a discharge of anger from the staff toward the offending client. Such anger springs from a client's ability to stir feelings of disappointment, ineptitude, and frustration within service providers. The AD can constitute the abrupt end of a therapeutic relationship that has deteriorated into a contempt-laden struggle for power and face, e.g., "my way or the highway."

For recovering staff, countertransference can be further intensified by their personal recovery processes. John Wallace (1974) describes how early recovery is often characterized by a rigid preferred defense structure (PDS) (e.g., black/white thinking, denial, overcompensation, intellectualization) that therapeutically distances the individual from their past. With recovery stability, time and maturity, this early PDS softens or is abandoned completely. Service workers for whom these defense structures remain brittle may need to respond to the lapsing and relapsing client with particular harshness to distance themselves from their own vulnerability for relapse. Recovering workers may also perpetuate the act of AD as a process of intergenerational hazing, replicating rituals of expulsion that were common during their own treatment experiences. Staff with histories of unresolved addictions in their family and social histories may be similarly plagued by countertransference problems with the lapsing/relapsing client.

While AD can involve a specific toxic chemistry between a particular client and a particular service professional or service provider team, the pervasiveness of the AD suggests a much broader phenomenon may be at work. The AD may constitute a form of reverse "creaming"[1] through which the least attractive, least engaging, and most troublesome and time-consuming clients are skimmed from the caseloads of overworked and underpaid staff. Such processes might reflect a manifestation of the social stigma of addiction acted out inside the treatment milieu. The fact that African American and Hispanic clients are over-represented among those administratively discharged from addiction treatment (Illinois Office of Alcoholism and Substance Abuse, 2002) also suggests the need to examine the particular sources of such over-representation and the potential need for specialized and more culturally appropriate strategies to lower AD rates among people of color.

[1] "Creaming" is a euphemism for the practice of only admitting those clients who have the most financial resources and the best prognosis for recovery.

Argument #5. Administratively discharging clients often involves behaviors that are unrelated to, or have only a weak connection to, the prospects or processes of recovery or safety issues within the treatment milieu. One example is the use of AD as punishment for sexual activity between clients in addiction treatment. One is hard-pressed to find other arenas of health care in which sexual prohibitions are a condition of continued service access. Sexual activity between clients can constitute a legitimate clinical issue (behavior previously linked to addiction or that serves as an obstacle to recovery) and a milieu management issue (effect of behavior on other clients/staff), but this issue is best addressed clinically as part of the treatment process rather than as a disciplinary issue warranting expulsion from treatment. The exception to this principle would be when sexual behavior breaches the boundaries of physical safety or crosses criminal law (e.g., sexual harassment or sexual assault.)

The benefit/harm ratio of AD policies should also be examined related to other behaviors that have achieved an unwarranted level of importance and whose linkage to recovery initiation is weak or unclear, e.g., expelling clients for smoking, possessing contraband (e.g., tobacco, food/candy, caffeinated beverages, music or books), profanity, making phone calls, failing to go to or get out of bed on time, insubordination (refusing a staff order), missing meals, and oversleeping. Such issues should be addressed within the larger context of treatment and the helping relationship, not constitute grounds for service termination.

Argument #6. Administratively discharging clients from treatment projects casts the blame for treatment failure on the client and prevents treatment programs from evaluating and refining clinical practice. AD can flow from treatment technologies (or the problems in implementation fidelity) that fail to adequately engage the client or, in failing to meet the client's needs, leave the client to act out his or her historical pathology. For example, it is not uncommon to see a client with very high problem severity, complexity, and chronicity placed in a level of care of such brevity and low intensity that there is little likelihood of positive clinical outcomes. Alternatively, clients may be sent through the same treatment protocol again and again, even when the evidence suggests they likely need something different. When the predictable relapse occurs, the client is then extruded from treatment and subjected to environmental consequences on the grounds that he or she "had their chance." We would argue that such mismatches are not chances, but set-ups for failure, and that administratively discharging clients under such circumstances prevents programs from critically evaluating and improving their services.

Argument #7. Administratively discharging clients from a publicly funded addiction treatment program for failure to pay service fees constitutes clinical abandonment and is a breach of professional ethical principles and (potentially) legal and regulatory standards. It is normal business practice (and in some states a regulatory requirement) to assess clients entering publicly funded addiction treatment a co-pay portion of their total service fees based on each client's assets and income. It is also a normal business practice to make reasonable efforts to collect such fees. The question is whether inability to pay such fees due to either lack of financial resources or unwillingness to allocate resources toward this debt are grounds for termination of on-going treatment services. It may be, for example, that a person has legitimate and reasonable higher priorities for the limited funds they possess in early recovery, e.g., shelter, food, needs of their children. Reasonable payments plans should be negotiated as an alternative to service termination. It is our opinion that terminating publicly funded addiction treatment services for inability to pay is neither ethically nor clinically appropriate and that this category of AD should be now and forever abandoned. This position would not prevent organizations from pursuing collection of fees subsequent

to treatment through other means (e.g., payment plan, work programs).

Policy Strategies to Reduce Administrative Discharge

Lowering the rate of AD within the American system of addiction treatment will require changes at policy, programmatic, and service relationship levels. A good starting point for policy level changes would be a NIH/NIDA- or SAMHSA-sponsored consensus panel to explore standards for, and alternatives to, AD within addiction treatment programs. The goals of the consensus panel would be to make recommendations regarding consistent AD definitions and AD data collection and reporting procedures (to allow country-to-country, state-to-state and program-to-program comparison of variance in AD rates), and to recommend policies and clinical procedures that could lower AD rates. In fact, standards could be set for 'best practices' in this regard. The Network for the Improvement of Addiction Treatment, a joint effort of the Center for Substance Abuse Treatment and the Robert Wood Johnson Foundation, has already started addressing these issues to achieve their goal of increasing retention in addiction treatment. Some state addiction authorities (e.g., Texas) are promulgating policies that prohibit the exclusion and extrusion of clients within particular program tracks (e.g., programs for co-occurring disorders) on such grounds as prior treatment failure or continued substance use. A similarly important policy step would be to prohibit publicly funded addiction treatment programs (via licensure standards and contractual requirements) from severing services on the basis of a client's inability or failure to pay service fees without making alternative and satisfactory arrangements.

The research infrastructure that supports addiction treatment needs to be encouraged and given incentives to pursue a research agenda related to AD practices, effects, and alternatives. There are critical influences on AD practices that need to be explored, including the effects of program modality/philosophy, staff background and experience, and client characteristics, as well as the potential influence of waiting lists on AD practices, (e.g., Does front-end service demand lower thresholds for deviance that generate back-end extrusion? Can successful interventions be developed for lowing the AD rate?).[2] As a field, we need to know the long-term effects of AD on addiction and recovery careers, e.g., do administrative discharges generate therapeutic, neutral, or iatrogenic effects on those discharged, and do these effects vary across demographic and clinical subpopulations? Research suggests that, for many clients, the period of time between their first treatment episode and achievement of their first year of sobriety can span an average of 3 to 4 treatment admissions over the course of 8 years (Dennis, Scott, Funk, & Foss, in press). If we shift from thinking about individual episodes of care to these longer treatment careers — then we must evaluate whether AD hastens the relapse process (accelerating the transition between lapse and full relapse), reduces the likelihood and speed of the client returning to treatment (given that it was a negative experience), and results in increased health, social and economic consequences for both the individual, the family, and society.

We also need to explore how service reimbursement systems influence the rate of AD in addiction treatment. Where service demand is high, there are no current incentives for client retention and completion, or disincentives for AD. There may, in fact, be incentives to process the largest numbers of individuals or service units with the minimum amount of staff resources by replacing the most difficult to treat clients with the easiest to treat. Ideally, there would be incentives for addiction treatment programs to engage, retain, and facilitate positive outcomes across episodes

[2] Feedback from key informants noted that such pressure increased as waiting lists grew longer and referral sources became more aggressive in their attempts to get their clients admitted to treatment.

of care/time with clients who present with the highest problem severity and the most chronic histories of relapse and re-admission.

Programmatic Alternatives to Administrative Discharge

There are several responses at the program design and service delivery levels that could potentially reduce AD rates. Pending scientific confirmation of the most effective strategies to lower these rates, the authors would recommend the following.

Recommendation #1. Create a culturally appropriate pre-treatment engagement and orientation process aimed at enhancing motivation for change (via recovery role modeling and motivational interviewing), heightening and yet moderating ambivalence (about continued use), identifying chronic self-defeating styles of interacting with professional helpers (learning how to be helped), resolving environmental obstacles to recovery, mobilizing recovery support resources within the family and kinship network, empowering the client/family to participate in the admission and level of care decisions, setting mutually agreeable goals with the client/family for each level of care, and supporting the client/family through any delay in service initiation. The purpose of such engagement efforts is to transition the client from the extrinsic (environmental) motivators that trigger entry to treatment to the intrinsic motivators that catalyze and sustain long-term recovery. This pre-treatment (recovery priming) level of care would also serve as a sanctuary within which clients who clinically deteriorate within other levels of care could be transferred for re-evaluation, stabilization and replacement in a suitable level of care.

Recommendation #2. Create a feedback loop between discharge processes and assessment and admission processes to determine the extent to which administrative discharges, clients leaving against staff advice, and transfers to other programs result from inadequate assessment, inappropriate admission, or level of care misplacement. Reducing failure to complete rates is likely contingent upon improving front-end assessment and placement decisions. Failure to consider alternatives to inpatient/residential care and forcing such high intensity levels of care when clients present legitimate needs to remain in their homes (e.g., caretaking responsibilities) often contributes to early treatment cessation. Developing more nuanced screening and assessment tools and more clinically flexible decision trees for admission/placement could potentially lower AD rates (Pelissier, Camp & Motivans, 2003).

Recommendation #3. Create alternatives to reduce the misuse of residential/inpatient addiction treatment. As community caretaking resources tighten under the influence of fiscal austerity, people can be referred to residential addiction treatment not because they need such services but because there are no resources for what they do need, e.g., housing, monitored sequestration from the community. Advocating, supporting and utilizing community alternatives to address these needs (e.g., housing alternatives, day reporting programs, electronically-monitored home confinement) can prevent residential treatment programs from becoming revolving doors for persons not seeking and who do not need this level of addiction treatment services.

Mismatches between client needs and placement decisions can also flow from systems of placement criteria that rely primarily or exclusively on problem severity. Problem severity criteria direct people to residential treatment who do not necessarily need such resources (because of offsetting intrapersonal and interpersonal resources) or who have broader needs that conflict with residential placement. Such mismatches can lead to acting out and consequently to AD. More individualized, creative and assertive approaches are likely to reduce the frustration and acting out that currently lead to AD.

Recommendation #4. Minimize "rules" and maximize processes of

engagement and motivational enhancement. Excessive rulemaking can shift the focus of the treatment milieu toward one of control and compliance rather than relationship building and recovery, and sets up many unnecessary and unproductive authority conflicts between clients and service providers. A practice of collecting and passing on the wisdom of former clients to current clients (the peer-based message "It has been our experience that…" rather than the authority-based "Thou shall not…") might prove more effective.

There is precedence for such flexibility. Early in its history, Alcoholics Anonymous abandoned its excessive membership rules designed to keep out and kick out those characterized in the late 1930s and 1940s as "beggars, tramps, asylum inmates, prisoners, queers, plain crackpots, and fallen women" (AA, 1952/1981, p. 140). AA replaced such misguided exclusiveness with the simplest of admission criteria ("a desire to stop drinking") and a welcoming message ("keep coming back") that keeps its doors open to the still struggling, still-drinking alcoholic. That model of simplicity and inclusiveness is worthy of emulation.

Recommendation #5. Continue to reassess all changes in clinical status as a matter of policy, rather than relegate assessment to an intake function. Such reassessment opens the opportunity for early re-intervention prior to the onset of AOD use by clients in treatment. Lapse and relapse prevention and their management ideally begin during rather than after treatment. 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. In fact, for clients with the most severe conditions, this process of continuity of contact and reassessment should span multiple episodes of care over years, as is the case with the treatment of other chronic conditions like cancer, diabetes, hypertension and depression (McLellan, Lewis, O'Brien, & Kleber, 2000)

Recommendation #6. Assign a patient advocate, primary counselor, and/or knowledge about a program ombudsman immediately upon admission and assure that one-on-one time occurs daily during the earliest period of treatment. The goals of such intense professional and peer-based recovery supports are to constantly re-engage, re-motivate, process negative emotion, celebrate incremental progress and resolve problems that can escalate into premature service termination. The most crucial key to increasing treatment completion rates is the power of *relationship*.

Recommendation #7. Assure adequate doses of medication and the availability of recovery support services within methadone maintenance treatment (MMT) and detoxification programs. Inadequate dosing and lack of psychosocial supports contribute to drug supplementation via unapproved AOD use, staff-client conflicts, and poor treatment retention rates in MMT (Capelhorn, McNeil, & Kleinbaum, 1993; National Consensus Development Panel, 1998). When MMT clients with high tissue tolerance encounter low dose clinic policies, the results are often withdrawal distress, self-medication with alcohol and illicit drugs, and punishment of the client (via administrative discharge) rather than identification of the clinic's failure to provide competent treatment. Though less documented, a related problem is inadequate dosages during detoxification. Even where drugs like buprenorphine are prescribed to help withdrawal, their use may be discouraged under the misguided assumption that withdrawal discomfort will help motivate the recovery process. What is more likely is the client leaving against staff advice, failing to transfer from detox to treatment, or becoming agitated and getting administratively discharged from treatment. Adequate dosing is the single most important contributor to MMT retention, but adequate dosing alone is insufficient to stop AOD use among clients deeply enmeshed in drug-using subcultures. Better counseling and recovery support services can, by

enhancing disengagement from such cultures and facilitating engagement in local communities of recovery and the larger civilian community, reduce behaviors that lead to administrative discharge (McLellan, Woody, Luborsky, & Goehl, 1988; McLellan, Arndt, Metzger, Woody, & O'Brien, 1993).

Recommendation #8. Establish clinical supervision and internal discharge review protocol as frameworks to identify and resolve negative countertransference, address client-staff conflict/grievances, process level of care transitions, structure the process of service termination, and debrief AD decisions. Reducing administrative discharges is contingent upon a sound clinical infrastructure—the centerpiece of which is consistent and competent clinical supervision—and the development of internal mechanisms of review of all recommendations for administrative discharges.

Recommendation #9. Provide continuity of contact in a primary recovery support relationship that potentially spans multiple levels of care and multiple developmental stages of recovery. Many clients entering addiction treatment have histories of victimization and abandonment that make them hypersensitive (and prone to act out during) changes in intimacy levels within important relationships in their lives. Replacing constant relationship transfers (e.g., from the intake specialist to the inpatient counselor to the outpatient counselor to the continuing care counselor) with a more primary and sustainable recovery support relationship reduces the propensity for clients to behaviorally act out their anxiety surrounding such losses and transitions. Experiments are currently under way to provide such continuity through the use of peer-based recovery coaches.

Recommendation #10. Evaluate lapses, relapses and other disruptive behaviors clinically prior to their evaluation administratively. An episode of AOD use or unremitting AOD use has different meanings for different clients. It is best to evaluate what the current pattern of AOD use means in terms of a particular client's addiction and recovery careers. In this view, AOD use during treatment is another source of clinical data that, taken with other data, calls for a re-evaluation and refinement in the service plan. Lapses and relapses should be evaluated based on: 1) whether they involve a primary or secondary drug (secondary drug use may indicate an attempt to stave off primary drug relapse in the face of increased craving, cue exposure, or emotional distress), 2) the timing of use (e.g., stage of addiction/recovery; change in level of care), 3) the physical, psychological and social context of use; 4) the intensity of use (e.g., risk to self and others), 5) the duration of use, and 6) the client's response to use (e.g., meanings and motivations). The goal is to transform near lapses and lapses/relapses from windows of vulnerability for re-addiction to windows of opportunity for recovery enrichment. The latter is achieved by eliciting from the experience new motivations, perspectives and skills that can stabilize and strengthen the long-term recovery process.

Recommendation #11. Use transfers between levels of care, service modalities or service settings instead of AD as the primary response to AOD use and other disruptive behaviors. We would be the first to acknowledge that a client's AOD use or other behavioral indicators of clinical deterioration could render the client inappropriate for a particular level of care or program at a particular point in time. If such a client's behavior becomes unmanageable, the next best approach is to consider transferring the client to an alternative treatment approach or service setting. Flexibility seems to be the key to retention. Where the professional recommendation is for methadone maintenance but the client wishes to try a short-term trial of buprenorphine, we suggest trying the client's way with an agreement to try alternatives if the first approach does not work.

Recommendation #12. Leave the door open for readmission following AD or transfer attempt from any level of care. At the point of termination from a level of care, define the conditions under which readmission will be possible and continue to monitor people who have been

administratively discharged via recovery checkups (by phone whenever possible), linkage to recovery mutual aid resources and re-engagement in treatment (see Dennis, Scott & Funk, 2003 for recovery checkup protocol). Monitoring the status of extruded or transferred clients creates connecting tissue between service episodes and has the potential to shorten addiction and treatment careers. We believe as a matter of policy that all clients should be provided access to referrals for continuing care regardless of discharge status. The goal for clients with the greatest problem severity and lowest recovery capital (intrapersonal and interpersonal resources) is to find service combinations and sequences that have amplified effects in moving the client through recovery priming and initiation to recovery maintenance. The service relationship goal is to build a relationship that is sustainable even in the face of a client disengaging from, or acting his or her way out of, treatment. The message to each client is: "we are unconditionally committed to your recovery and that commitment continues regardless of your discharge status" (J. Schwartz, Personal Communication).

Alternatives to Administrative Discharge for the Frontline Clinician

For the front line addiction counselor, we would suggest six strategies to lower AD rates.

Strategy #1. Find ways to rise above the paper and the procedures to personalize your services to clients. Spend time with your clients—with no paper and no treatment task agendas—to get to know each of them as individuals. Find ways to increase your one-on-one time with each client. The quality and frequency of positive contact may be more important than the time involved in any single contact. Continuity of kindness, respect, and regard go a long way in lowering the resistances that can arise within any helping relationship.

Strategy #2. Recognize each client's historical pattern of resisting change, including past self-defeating styles of relating to professional helpers. Anticipate that such styles will be replicated at some point within the current service relationship and explore with the client how to break such patterns to create a more positive treatment outcome (See White, 1996). It is important to realize that many clients are trapped in an immature stage of development in which they have fleeting moments of clarity one day, but then repeat the same mistakes the next.

Strategy #3. Hate the condition and love the person. When feeling anger, frustration and disappointment toward a particular client, separate the person from the disorder. Find and draw out the person masked by the disorder, and recognize that addiction can shroud the person in a most unlovable veneer. If anyone could get through this veneer, there would be no need for addiction counselors. Getting through the disorder to the person is the very essence of addiction counseling.

Strategy #4. Utilize peer or clinical supervision to process your feelings toward your most difficult clients and to brainstorm how to handle difficult problems. Seeking such support is not a sign of incompetence or lack of emotional fortitude. It is the very epitome of professionalism and an effective antidote to fatigue and burnout.

Strategy #5. Extend special effort to engage and counsel individuals with multiple prior episodes of treatment. At your worst moments, you must stem the propensity to see such clients as "retreads" or "losers." Remind yourself of these key points:

- Many people suffering severe and persistent addiction will require multiple episodes of treatment before stable recovery is achieved—yet over half do recover and this is one of the highest recovery rates of behavioral, psychiatric and many chronic health disorders.
- What I do as an addiction professional in this episode of care could shorten or lengthen my client's addiction career.
- There are developmental windows of opportunity that can open in all of our lives and forever change the trajectory of who we are at a most fundamental level.

- What I do or fail to do with this client at this moment could open or close this window of opportunity.
- I must find a way to seed the very essence of recovery within my relationship with this client.

Bill Wilson, co-founder of Alcoholics Anonymous, and Marty Mann, founder of the National Council on Alcoholism and Drug Dependence, were both treatment recidivists (ten prior treatments between them before finding sobriety). Their clinicians—Dr. William Silkworth and Dr. Harry Tiebout, respectively—through positive regard and perseverance found ways to tip the scales of their lives from continual re-addiction to relocation in the psychological and social worlds of recovery. Remind yourself that sitting among the recidivists you counsel could be the next Bill Wilson or Marty Mann, and that the ability to achieve or not achieve his or her personal and historical destiny may rest, in part, on the nature of what you bring to the service relationship.

Strategy #6. Respect the diversity of recovery pathways and styles. Each client has to find his or her own pathway to recovery. The good news is that there are many such pathways and styles of recovery initiation and maintenance. Our job as service professionals is not to program this pathway for each client, but to help each client use the building blocks of their own individual experience and those who have recovered before them to forge an approach to recovery that personally and culturally works. Recognize your own recovery pathway/style biases, educate yourself to alternative pathways and styles of recovery, and open yourself to the possibility that each client may find a pathway of recovery quite different than your own and quite different than any you have witnessed in the lives of your previous clients.

Summary

The addiction treatment field has a long history of administratively discharging clients for alcohol and other drug use and other prohibited behaviors. Such extrusion has been justified on clinical, ethical, and organizational grounds. It is argued here that this practice, as it has been extended to an ever-widening array of behaviors, is illogical, hypocritical, and counterproductive. Policy, programmatic, and clinical strategies are suggested as potential means of reducing AD Rates.

It is time that we as a field dramatically reduce the circumstances within which we expel clients from addiction treatment. It is time we asked ourselves: Would more than 200,000 clients be thrown out of addiction treatment each year if we really believed that addiction was a chronic disease from which recovery was not only possible, but a living reality in the lives of hundreds of thousands of individuals and families? Our clients are not at their best at the times they are on the verge of being thrown out of treatment, but we are quite often not at our best at such moments either. It is time we were.

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