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Key Arguments in Unilateral Termination from Addiction Programs: A Discourse on Ethical Issues, Clinical Reasoning, and Moral Judgments

Izaak L. Williams CSAC
Addiction Clinician, Department of Psychology,
University of Hawaii, USA

Michael J. Taleff PhD MAC CSAC
Addiction Clinician, Lecturer, Social Sciences Department,
University of Hawaii, USA

Abstract

The potential for administrative discharge or premature termination of a patient's treatment by rank-and-file program staff in the field of behavioral health and human services delivery is a routine occurrence. According to the most recent data by the Substance Abuse and Mental Health Services Administration (2014a), over 126,000 clients or 7.3% of admissions were expelled from drug addiction treatment in the U.S. Despite these occurrences, written policies outlining checks and balances in the use of administrative discharge procedures to ensure a more objective and methodological approach are under-researched and written polices are a likely exception. However, despite the sizable impact of this phenomenon on staff and patients—often spurring contentious debate in clinical staff meetings—an anemic body of literature exists in this important area of mental health ethics. This article examines key issues in the debate for and against discharge, and concludes with discussion oriented around empirical ethics as a course of action to further constructive dialogue and administrative discharge protocols to this controversial and highly polarized decision making process with moral, ethical, and clinical dilemmas underpinning administrative discharge.

Keyword: administrative discharge, unilateral termination, involuntary treatment termination, substance use treatment, empirical ethics, models of addiction, epistemic closure

In general addiction clinical practice, unilateral termination of program services—referred also to as forced termination, premature discharge, emergency termination, disciplinary discharge, administrative discharge (AD), and program-initiated termination—is euphemistically called "kicking" or "throwing" patients out of treatment. Administrative discharge as defined here is unilateral program staff action toward clients deemed "non-compliant" for mostly rule infractions or safety violations.

At the core of this article lay the internal workings of arguments sequentially both for and against AD. This article begins with consideration extended to review of the substance abuse and prevention literature on the subject matter. In this context, discharge is situated in clinical practice, and as such, serves as a backdrop to ethical issues and moral judgments regarding administrative discharge. Discussion follows on ethical issues, clinical reasoning, and moral judgments in arguments in favor and opposed to administrative discharge.

Background

Few articles can be found in the literature devoted to discussing the practice of administrative discharge in drug addiction programs (Reisinger et al., 2009; Svensson & Andersson, 2012; Tozman & DeJesus, 1981; White et al., 2005). For instance, White et al. (2005), provide a broad overview of AD objectives (cited in Table 1 and Table 2 below) using data from interviews with U.S. "colleagues around the country" (p. 3), to argue strongly against the practice of AD as the threat of behavioral regression, health determination, and (self-inflicted) harm far outweighs the possibility of any conceivable gain from its use. Generally, policy regulation allows program staff to exercise broad discretion on what rule infractions qualify for discharge. As such, selective information processing and cognitive biases, misconceptions about addiction dynamics and emotional reasoning add far-reaching consequences, leaving a host of moral judgments and ethical liabilities to swamp the decision-making process (Taleff, 2010; Van Hoose & Paradise, 1979). White et al. (2005) framed their position statement another way, that is, notwithstanding extreme acts of violence, White et al. (2005) were inclined to side with the notion that a ban be instituted against the AD practice.

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Svensson & Andersson (2012) take a similar stance based on interviews with a relatively small sample (n = 35) of patients administratively terminated from methadone or buprenorphine medication-assisted treatment (MAT). As Svensson & Andersson (2012) illustrated from their findings in Malmö, Sweden, most discharged patient were unable to maintain sobriety, faced a high risk of mortality, and inexorably returned to prostitution, crime, and heroin abuse—a lifestyle strikingly similar to pre-treatment circumstances. Additionally, discharge accompanied a three-month long exclusion from all medication-assisted maintenance treatment mandated by national guidelines for MAT in opioid dependence.

Reisinger et al. (2009) conducted qualitative interviews (n = 42) with patients prematurely discharged from six U.S. methadone treatment programs in Baltimore, Maryland within the first 12 months of treatment. Thirty-five percent fell into the category of administrative discharge for not complying with program rules. Patient perspectives on discharge hinted at sudden and unexpected changes in program rules and inconsistent rule enforcement; insurmountable conflict with primary counselor (n = 7) in conjunction with flat-out refusal to switch the patient onto the caseload of a different counselor; late or nonpayment of fees; positive drug tests including tampering, adulterating, or substituting the urine sample; missing three consecutive days of medication; and scheduling conflicts with methadone program hours (e.g., employment work hours). At the heart of these observations, Reisinger et al. (2009) noted a mixture of arbitrariness, unfairness, unnecessary policy, and stringent procedural regulations over the running of methadone maintenance services seen and experienced by patients. This had a secondary effect of fostering disaffection, thereby opening a salvo of frustration among patients and program staff that mounted discernable influence on administrative discharge.

Tozman and DeJesus (1981) argued that as it is with each position declaring its station to have a "corner on the truth," clinical practitioners tend to argue the regressive effects of AD while overlooking the unintended therapeutic benefits caused by or strongly correlated with discharge insofar as to: (a) restore order to the treatment milieu, (b) maintain integrity of treatment, (c) act as a prosthetic— a source of external behavioral control imposed on clients lacking internal control mechanisms, and (d) motivate shift from passive resignation (compliance) to active engagement (adherence) in treatment. Tozman and DeJesus (1981) concluded that different conceptual windows through which to view AD results in each side of the debate rubber-stamping different therapeutic and counter-therapeutic declarations to gird their stance. That is, rigid, dogmatic adherence to personal beliefs stilt arguments for and against AD and, in turn, add ethical, clinical, and moral filament to each respective position.

This article, in outlining a detailed examination of key ethical and clinical issues in the debate for and against discharge, highlights the clash between two mainstream addiction theories. With particular emphasis on how each position conceives of discharge and reasons with teasing out answers to the question of how to premise termination. The addiction professional code of ethics is embodied in the question of whether to terminate or not. Despite its relevance, the promotion of empirical ethics is not considered in either side of the AD argument as the current dearth of literature envisages. This article concludes with brief commentary on the need for empirical ethics to give guidance and a framework to program staff members from which to work when faced with AD.

Administrative Discharge is Morally Wrong

To clarify an actual definition of moral judgment as it is used here, morality is comprised of four basic components or principles: non-malfeasance, beneficence, justice, and utility (Atkinson, 1991). As Atkinson (1991) noted:

> "Such principles imply an 'ought', that is 'people ought to behave in certain ways'— out of a desire not to harm others [i.e., non-malfeasance], or to be of positive help to others [i.e., beneficence], or to treat others fairly and equally [i.e., justice] or, lastly to ensure the best possible outcome for the majority [i.e., utility] (p. 103).

In this way, as Atkinson (1991) explained, when these four basic principles overarch behavior, motivation is governed more so by what is most appropriate or "ought to be" than out of submerged self-interest (pp. 103-104). In addition, to determine the best possible course of what 'ought to be', moral judgments lying in decision-making surrounding AD must be balanced on the scale of ethical issues and clinical reasoning.

Ethical Issues, Clinical Reasoning, and Moral Judgments

The stance against discharge is strongly grounded in the disease model of addiction, with compulsion and loss of control as defining features. This position parlays the core tenets of the disease model and induces a philosophical slant that considers AD antithetical to addiction treatment recovery. In this case, resorting to discharge for just about any violation save extreme cases of violence is counterproductive since the patient is essentially discharged for a manifestation of her/his disease. Table 1 presents the case against AD and ethical issues.

The interpretations of the abovementioned ethical violations are themes that muddle addiction and relapse dynamics, thus fusing together the framework against program practices that endorse AD. On one ethical front, the position against AD lies on one-third of patients with a substance use disorder, diagnosed with a psychiatric problem and meeting the abuse criteria (DSM-IV) across multiple drug categories (SAMHSA, 2014b). That is, co-occurring disorders compound addiction-related neurological and physiological impairments to further hamper and constrict free will. As such, staunch opposition to AD is generally centered on high severity, chronicity, and complexity in patients' clinical profiles, associated with eroding or depleting cognitive capacities and decision-making abilities.

On the other ethical front, the burden of AD is placed on treatment staff. This position views AD within the context of program-related variables and the client–clinician relationship, such that AD-related factors are described as qualities of the program and staff (Masson & Sheeshka, 2009). Discharge seems to be a universal issue in the addictions and behavioral health field, especially when relatively

Table 1: Dimensions of argument against AD

Contraindication of Treatment Recovery	Addiction and Relapse Dynamics	Ethical Mandate Violated
AD is a punitive action that confounds drug use with deviant behavior, violating the essence of drug treatment. AD is often misused to resolve milieu management issues (White et al., 2005), motivate treatment compliance, and prevent enabling.	Continued drug use or relapse is a sign of disease symptom manifestation and the confirmation of the need for chronic disease management. AD is contradictory to the progressive deterioration of the will reflected in addiction dynamics (White et al., 2005, p. 4)—a fundamental goal of treatment. AD is a fear-based appeal that has moderate to insignificant short-term effects on inducing compliance and has negligible lasting impacts on motivating change in behavior, because it is often used as a form of punishment rather than a logical or natural consequence of discipline.	**Fidelity**: "Creation of an environment that is therapeutic while staying true to policies and procedures that advance and reflect the principal goals of treatment as promised" (Williams & Taleff, 2015, p. 3; citing Hemphill, 2013).
AD violates the very essence of addiction by failing to therapeutically address emotional disequilibrium, behavioral, disorganization, and "characterological obstacles to recovery initiation, engagement, and maintenance" (White et al., 2005, p. 4).	AD severs patient from a safe treatment atmosphere often without adequate alternative care in place and thus acts as a centrifugal force drawing patients back into an "addictive lifestyle" or immersing them in "drug-saturated social environments" (White et al., 2005, p. 4). AD for rule infractions (e.g., for refusing staff order or violating curfew) fails to clinically engage factors that are possibly connected to addiction dynamics *(e.g., client breaks phone policies to call dealer for a hit or leaves the facility, breaking curfew to obtain drugs.)*.	**Non-maleficence**: Actions deemed ethically 'good' if it prevents harm and avoids making matters worse (Taleff, 2010; Williams & Taleff, 2015).
AD is a program-centered practice structured to serve the interest of treatment staff at the expense of benefiting or furthering client care.	AD constitutes the clinical abandonment of patients in need of treatment care, pro-social recovery support networks and resources, and social engagement in therapeutic milieu. AD promotes the discharge of negative emotions (e.g., counter-transference or reactance) and arbitrary service termination as a de facto method of problem solving for clinical issues (e.g., practitioners can use AD to reduce burdensome caseload) and difficult complex addiction cases (e.g., remove client with personality disorder). AD is treated as a sign of patient failure and its use represents an accountability and performance measure; however, little or no onus is on accounting for the role program service delivery plays in egressing client care and then subsequently countermanding it via AD (e.g., mismatched level of care placement intensity and treatment approaches with patient conditions and clinical profiles and little individualization in treatment methods, approaches, and 'one size fits all' modalities).	**Beneficence**: Treatment services and interventions, first, seek to avoid doing harm and act responsibly and in goodwill, "within the limits of competence" (Welfel, 2006, p. 35). Meeting the client where they are at and not leaving them there but better off after treatment (Welfel, 2006).
AD is reset on the assumption that choice and decision-making ability are dichotomous volitional control states, within which patients exercise sufficient free will to assert personal agency.	AD fails to leave room for volitional control on a continuum, extending beyond an "all or nothing" profile; erosion of autonomous self-control, a factor in cognitive style (residual); physiological aspects of addiction; co-occurring disorder; and underlying neurological conditions.	**Autonomy**: Viewed as a value, and clinicians are obligated to leverage power and institutional influence to make an effort in good faith to deny or circumscribe clients' choice, when the impact of such choice is deemed incompetent and may result in self-harm (Sjöstrand et al., 2013). Trumping or overriding incompetent client decisions for the sake of protecting or promoting autonomy in the long run (SjöStrand et al., 2013). Clinicians recognize that clients are not wholly responsible for themselves given degree of impairment (e.g., self-defeating behavior), and some degree of paternalism is required to promote and protect autonomy (Howe, 2002).
Program practice of AD encompasses rule rigidities and is subject to boundary regulations.	While programs have rules that clearly spell out behavior that warrants AD, written policies and procedures outlining guidelines for how AD ought to be exercised and under what circumstances, and standards are mostly ignored. Moreover, critical influences on AD practices are highly subjective; for example, the effects of program modality or philosophy, staff background and experiences, client characteristics, and even waiting lists. "Does front-end service demand lower thresholds for deviance that generate back-end extrusion?" (White et al., 2005, p. 7).	**Justice**: Maintains clients are not above the rules and the application of regulations elucidates firm limits. Justice has a strong moral aspect of fairness that entails equal treatment relevant to matching services to variable differences that bare impairment (Welfel, 2006). Implicit in justice is due process (Strike & Soltis, 1985) in the sense of acknowledging that not all clients are alike and therefore not all rules.

minor rules are broken and insufficient time is invested in finding and implementing other feasible options (e.g., see discussion on 'no show' appointments by Maher and Garside, 2010). This sets the impression that such rules give clinicians a legitimate way out when they are unable to resolve certain behaviors. By contrast, some clinicians insist on retaining such patients, when a program transfer is necessary—owing to billing purposes, therapeutic narcissism, or program omnipotence (Goldberg & Leibenluft, 1989)—and finally, rid the patient using AD, simply proclaiming the client willfully persisted in breaking the rules by choice. Thus, AD is typically advocated for extreme behavior (e.g., hitting a staff member or selling drugs to a peer client), resulting in staff imploring the program to seek interventions that deal with such behavior, which is characteristic of addiction—breaking the rules of society, family, or the legal system.

To remedy such situations, once identified, trainings that offset AD should be necessitated (e.g., learning how to formulate sound treatment contracts, understanding key concepts and principles of behavioral learning theory and the stages of change), enabling staff to address such behavioral issues without resorting to AD. Such trainings should also focus on staffs' emotional baggage, resulting from clients' obnoxious behavior combined with feelings of frustration, intense emotional reactions (anger, stress, or anxiety), or other psycho-emotional strain, given that such negativity would not bode well for a client. In this case, clear thinking takes a hit, negatively skewing any kind of rational thinking and inviting inconsistent decision making. For example, AD acts as a quick fix to resolve practitioners' stress and strain induced by client misbehavior. Here, clinicians' counter-transference or reaction formation is one of the primary factors effectuating AD, which tends to be a solution more for the treatment staff than the clients (White et al., 2005; Williams and White, 2015).

For run-of-the-mill cases of addiction seen in treatment, chronicity, high severity, and complexity (chronic medical conditions and co-occurring psychiatric conditions layered in clinical profiles) are often accompanied by diminishing social capital and minimal recovery support. Thus, AD is a highly problematic practice since it increases the likelihood of regressively leading to the deterioration of a patient's condition. As Williams and White (2015) note:

> "There is no scientific evidence that ADs, or so-called therapeutic discharges—have any therapeutic value as a motivational fulcrum for recovery-related behavioral change…[The] practice contributes to further clinical deterioration (e.g., escalation of problematic drug use, criminal offending, incarceration, etc.) and re-enmeshment in [pre-treatment lifestyle] at the exact time the patient is in greatest need of a recovery-enriched social environment" (para. 12).

Administrative Discharge is *Not* Morally Wrong

Ethical Issues, Clinical Reasoning, and Moral Judgments

Examining addiction cases in publicly funded treatment programs, Flynn and Brown's (2012) study on co-morbidity prevalence estimates "found that clients with non-severe mental illness were more common in substance abuse treatment than those with high severity" (McGovern et al., 2006, p. 5); this is consistent with Cacciola et al.'s (2001) findings. Further, Flynn and Brown "suggest that the small number of individuals with severe mental illness found in substance abuse treatment programs may be evidence of the reluctance of these programs to treat the severely mentally ill" (p. 38). By contrast, some studies "suggest that high-severity clients are also high-improvement clients" (Zhang, Friedmann, & Gerstein, 2003, p. 682). Thus, arguments in favor of AD typically extend to clinical interpretation corresponding more with the orthodoxy of both choice and moral models of addiction. Table 2 presents arguments in favor of AD and ethical issues.

The aforementioned reasons form an established foundation for antecedents precipitating AD considered to rest in conscious control and character foibles. In practice, the type of offenses that merit discharge show strong disagreement with the notion of patients' loss of control and impaired decision making, which is the central premise undergirding the disease hypothesis of addiction. Here, there is a need to add definition and clarity to treatment recovery cases by separating the severe cases from the overall treatment population and sorting mild and moderate cases as a proxy for volitional control, accounting for underlying biopsychiatric conditions that diminish the degree of personal responsibility and the extent of impaired free will (e.g., obsessive-compulsive disorder, neurohormonal dysregulation, psychosis in schizophrenia) (Glannon, 2009). As Hoffman observed with the DSM-5 nomenclature for substance-related addiction disorders, clients can be classified in more clearly defined groups with:

> "…the vast majority of those with a mild diagnosis likely can moderate use and achieve remission. On the other hand, the vast majority of those who meet the criteria for a severe diagnosis will require abstinence to achieve remission. The greater challenge will be to make that distinction for those with a moderate diagnosis. There, the pattern of positive findings (i.e., some criteria might be more indicative of a loss of control) more so than weighting criteria as differentiating the pattern of positive criteria might be the distinguishing feature of those who require abstinence from those who might benefit from some moderation or behavioral adjustment approach. (N. Hoffman, personal correspondence, April 17, 2014).

In this light, clinicians are less apt in using the "disease" argument to justify loss in control and decision making, a topic that remains definitively unsettled in the literature (Buchman, Skinner, & Illes, 2010; Hammer et al., 2003: Reinarman, 2013). In addition, the percentage of patients who complete the entire treatment program but exhibit marginal behavioral changes can partly explain the use of AD. The bottom-line is that AD is not always used as a last resort or a non-punitive measure, especially when "enough is enough." Clinicians may prematurely resort to AD as a front-line option to prove a point and deter future occurrences of the same behavior to protect the treatment milieu or view AD as the great equalizer needed to restore equilibrium to the treatment setting, and/or as a method of punishment to encourage wholesale cooperation from the group (Boyd & Richerson, 1992). AD can also be applied as a therapeutic attempt to maximize the number of patients complying with treatment (Goldberg & Leibenluft, 1989) or reiterate the importance of set limits on drug use (McCarthy & Borders, 1985). This is because the idea of emotional affects

Table 2: *Dimensions of argument in favor* of AD

Objective	Rationale	Ethical Mandate
Maintain safety and uphold the integrity of therapeutic milieu and recovery-oriented atmosphere.	Disruptive behaviors negatively impact the treatment environment and interfere with the treatment of others causing emotional, social, and behavioral issues to contagiously spread bad morale and encourage similar norm-breaking behavior. Bringing drugs into program or "possessing contraband in the treatment facility (e.g., illicit drugs, cigarettes, prohibited food items). Refusing to live within rules established for communal living (e.g., hygiene, assigned chores, disruptiveness, quiet hours, and punctuality for treatment activities)" (White et al., 2005, p. 2). "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)" (White et al., 2005, p. 2). See also Williams and Taleff (2015) for a discussion on ethical addiction decision making regarding non-fraternization policy. Threatening, or appearing to threaten, physical or psychological safety or react violently.	**Fidelity**: To act in good faith and commit to the interest and well being of clients, which should take precedence. Loyalty to client interest is not dependent on "inconvenience or uncomfortableness" (Welfel, 2006, p. 36).
Assure that the conservation of scarce treatment resources are efficiently spent on the "right" client, highlighting the financial integrity of the program.	Failing to pay service fees. To demonstrate to a patient that his/her behavior is not consistent with recovery.	**Non-maleficence**: Clinicians are called on to carefully follow standards for evidence on treatment interventions that are unlikely to harm clients while monitoring treatment progress, even if this means doing nothing (Welfel, 2006, p. 33).
Protect the reputation of the treatment setting.	Continuous consumption of alcohol or other drugs Taking unprescribed mood- or mind-altering drugs or abusing medications.	**Beneficence**: Treatment services and interventions seek first to avoid doing harm and act responsibly and in goodwill "within the limits of competence" (Welfel, 2006, p. 35). Meeting the client at their present station and not leaving them there, thus rendering them better off than what they were (Welfter, 2006).
Discourage the over-alignment of treatment staff with clients.	Failing to participate in service activities, e.g., missing counseling sessions. Repeatedly failing to follow the agreed-upon treatment plan. Motivational wake-up call. Failing to secure medication for a psychiatric condition.	**Autonomy**: Viewed as a right and does not prevent clients from making their own choices (Geppert & Roberts, 2008) and even allows them the freedom to make counterproductive, high stakes decision or regrettable actions that cut against their own best interest (White & Popovits, 2001, p.164). It limits the extent of clinicians' influence to basic knowledge appeals, that is, advice and education, which allow informed decision making that strikes balance, and not overruling it (Draper & Sorell, 2002; Napier, 2013; Welfel, 2006).
Discontinue treatment services provided to a non-responding/non-receptive client.	Physician feels treatment is ineffective. Patient is very dissatisfied with care (see Sommer & Roybal, 2010 for case discussion). Client refuses to become an active participant in doing treatment.	**Justice**: Clients are not above the rules and the application of regulations makes firm limits clear, which is implicit in justice and due process (Strike & Soltis, 1985; Taleff, 2006). Justice has a strong moral aspect of fairness that entails equal treatment relevant to matching services to variable differences that bare impairment (Welfel, 2006).

and behavioral contagion sways in support of AD: "clients who engage in symptomatic behavior may compromise the recovery of other patients and take away from the recovery-focused treatment atmosphere" (Masson & Sheeshka, 2009, p. 122). If patients choose to continue with their symptomatic behavior, despite the wherewithal to provide evidence-based treatments and therapeutic interventions, it could endanger the atmosphere of recovery and result in other patients refusing to comply or cooperate with the treatment program. Moreover, clinicians imbibing in "talk therapy" or "solution focused therapy" or prescribing to some other trendy therapeutic brand or counseling fad can dimensionally collapse into too much talk and excuse-giving to essentially condone and reinforce misbehavior; not only blurring the boundaries of the program but also imbuing the perception of rules not applying (Little, 2015a; 2015b). In sum, clients are not always cooperative or agreeable in obeying the rules or acting in goodwill. In this case, the assumption undergirding AD, presumably, is the act of setting clear and firm limits and essentially saying "no." Understood, 'no' is used as a method of enforcing staff—client boundaries and policy regulations to stop enabling and contain (via excluding a pattern of behavior continually fluctuating between minor rule breaking and near borderline 'out-of-control') chronically repetitive behavior falling short of violating the no tolerance policy or meeting the threshold for the de facto "three strikes and you're out" rule.

Clinicians are morally obligated to apply AD with the key ingredients of consistency, sound rationale, and manner of due process in the form of advanced warning to avoid the element of surprise to all patients (for further discussion, see Geller & Srikameswaran, 2006). Implementing AD to foster patient development in assuming responsibility and becoming aware of and using their own internal brake can potentially maximize client autonomy (Little, 2015). Regarding AD as a therapeutic maneuver contributing to personal growth helps prevent against the unpredictable (short-term) risks—e.g., relapse or resumption of drug use, criminal offending, mortality, homelessness, incarceration, health deterioration, and negatively charged affect evoking regressive acting out behavior—of the potentially dehumanizing practice of saying no and rejecting the act of rescuing in favor of long-term advantages—e.g., altering the manner of thinking and modifying character problems—capable of leading to personal growth (Casement, 1992; Cohen, 1963; Gutheil, 1985; Little, 2014).

To this effect, clinicians demonstrate a penchant for not over-assuming responsibility for patient change, which essentially is not the job of program staff. Moreover, shouldering such a burden could needlessly contribute program-related factors to AD (Masson & Sheeshka, 2009). Here, AD can also be perceived as a motivational enhancer or force to rectify drug use or problematic behavior. As noted by a participant, Masson and Sheeshka (2009) write, "sometimes it's a wakeup call to the patients to try something different or consider coming back at a later date when, they feel better able to take what's offered" (p. 119). Thus, the question remains whether symptomatic behavior is a proxy to an individual's degree of willingness to collaboratively engage in treatment, which in turn puts a question mark on whether the individual is positively influencing the treatment direction, which could also increase the chances of a poor outcome (Williams, in press-a). The discussion reiterates that dealing with persistent rule-breaking behavior is only a domain of the treatment program, not its primary function.

Conclusion

Both sides of the AD debate are afflicted with ideological priors that aid-and-abet bias that pits against or in favor of AD. Thus, belief systems and values motivating ethical reasoning appear to be plagued by one-sidedness that exaggerate risks and reinforce encrusted thoughts based on the false premises of moral judgments—a type of "epistemic closure" that ignores and clouds out information that does not conform to what the clinician holds true. This is why, generally speaking, administrative discharge decisions are a philosophically tortuous dilemma, and in clinical reality represent a metaphorical thorn in the side of addiction ethical matters. Partially because as Anglin maintained:

> Lack of best practices guidelines have at the worst contributed to or, at the best, ignored this issue, and should be reengineered to lower the AD rate significantly, especially in the case of some modalities, e.g., methadone maintenance…Research and service priorities at NIDA and CSAT also need restructuring to address the problem of AD, with a sustained empirical examination of their causes, evaluation of program changes designed to reduce AD, and experimental study of alternative practices (cited in White, Scott, Dennis, & Boyle, 2005, p. 6).

In keeping with the noteworthy issues laced with AD raised by Anglin, pointing to practitioners wading into the murky waters of administrative discharge with unclear criteria and highly questionable standards in application of policy and procedural regulations, overly subjective interpretations and conclusions braised with problematic beliefs are therefore likely held fast to (Petersson, 2013). Here, most probably, such interpretations and conclusions palatable to administrative discharge or showing distaste for it are enshrined in dogma and indoctrination, and personally christened with emotional overinvolvement or program staff overalignment with clients (Petersson, 2013).

Setting aside the question for now, whether AD is motivated by implicit power seeking or elicited by the need to feel authoritatively in control or exclusively a black/white 'play it by the rule book' stance, misguided or abusive rule enforcement generally tends to upend alternative interventions viable to preventing the need for AD (Petersson, 2013). In this case, with narrow program oversight—if any—regulating the AD practice, solid ethical reasoning and moral judgments that show scruples are not necessarily trump cards that win out in clinical team meetings, but rather what feels right or wrong is often most persuasive as the first and final deciding factor in AD (Petersson, 2013).

Hence, program staff members concoct anecdotal tales from readmitted discharged patients and appeal to second-hand accounts to supply emotionally charged reasoning compelling for and against discharge, provoking, in turn, spirited discussion and sparking heated debate in clinical team meetings (Goldberg & Leibenluft, 1989; Tozman and DeJesus, 1981). And with it, a so-called 'devil effect' is likely to follow insofar as the negative sentiment generated in the meeting on whether to discharge the patient is subsequently rubbed on to certain program staff to overshadow more positive or 'good' trait characteristics (Taleff, 2006). Moreover, the team meeting around AD cases can be a frontrunner in profoundly affecting program staff members in

practice by ubiquitously lingering ominously over day-to-day clinical team interactions long after decisions have been made in debating the utility of discharge in the clinical meeting (Goldberg & Leibenluft, 1989; Tozman and DeJesus, 1981).

Within this debate, the arguments against AD highlight key observations by practitioners: (a) client behavior is not always related to addiction (b) completing treatment is not necessarily a strong predictor of doing well during or after the treatment (c) AD does not preclude patient change or foster post-treatment completion (d) AD can equate to meaningful primary loss, as misbehavior can be treated as a proxy for behavior related to and reinforcing addictive lifestyle, and (e) decision making that violates program rules cannot be used as positive proof of addiction-induced incapacity to make measured and logical choices (Tozman & Dejesus, 1981). As for arguments in favor of AD, addiction can be a mitigating factor to the extent of choices surrounding drug use (Carter, Mathews, Bell, Lucke, & Hall, 2014). The contrary position argues, in essence, the opposite of the above seen points with a different interpretation of the same ethical codes and principles underpinning them.

Empirical social research is needed to texture and inform ethical reasoning. For example, empirical investigation into the Substance Abuse and Mental Health Services Administration's national TEDS (treatment episode data set) over an eleven-year period (2002-2011; spanning the earliest and most recent available data) by Williams and White (2015) uncovered statistically significant over-representation of African Americans in rates of AD suggesting that this racial group is inordinately targeted for the most punitive form of intervention in addiction treatment.

Empirical ethics seeks to ground clinical-ethical reasoning to, in essence, strengthen or weaken justification for AD action or non-AD response (Williams, in press-b). For example, identifying patients with a history of AD and evaluating the qualitative experience of subsequent treatment rounds would help shed light on the level of motivational engagement and receptivity (among other indicators) to treatment processes as a meaningful metric of AD, or the link between AD and inevitable regression that amplifies negative effects. The addiction clinician in this situation uses or interprets an alternate set of facts, intermingling clinical reasoning with moral and value judgments in an attempt to deliver decisions that are ethically sound.

However, subjectivity too easily enters into and risks cluttering the decision-making process (Petersson, 2013). The full scope of the problem as it relates to the array of issues inherent to AD has yet to

Table 3: Administrative Discharge Ethics Questions Template

Fidelity	Non-maleficence	Beneficence	Autonomy	Justice
Does this course of action serve the interest and needs of program staff and the agency more so than the client?	Are there other alternatives that are less likely to harm the client and stand a chance at offering benefit or the prospects of a solution?	Is this decision deemed the most helpful?	Has the client been given options or choices to act on, but is unwilling or unable to cooperate?	Are negative thoughts or feelings directed at the client involved in the decision?
How does this decision promote the welfare of the client?	Is the client likely to feel better or benefit in the long run despite facing injury in the immediate here-and-now?	Will the action leave the client better off compared to where the client was at during the start of treatment?	Is the agency and staff assuming the majority of the client's responsibility? Put differently, How much weight is given to the client's preferences for treatment. Or does the agency's decision making process recognize that clients have a right to choose what they feel is most important and beneficial as an expressed right of choice?	Would a more well-liked or popular client be treated similarly given the actions of the client? This also means that a client related to a program staff member or with other social standing would be accorded the same way with such social status having no bearing on how staff apply and enforce the rules.
Is the judgment driven largely or in part by motivation to alleviate or avoid feelings of stress, anger, annoyance, or any other unpleasant or unwelcome psychological state?	What are the pros and cons of carrying out the clinical action in light of foreseeable consequences and the possibility of harmful events occurring? Framed differently, how much harm will the action likely cause the client on a Likert scale?	Has all that can possibly be done happened to help the client? Said another way, have all of the agency's resources and alternative interventions/methods been exhausted?	Does the client reasonably appreciate the consequences or implications of his/her behavior?	Is the policy for non-negotiable/no tolerance rule-infractions being applied the same across the treatment board?
Has program staff been transparent and upfront, showing honesty in their approach to working with the client?	What types of guidelines were used to arrive at such a decision for it to comply with non-maleficence?	How much cost will the decision weigh on the public and client's family system?	Do the client's actions interfere with the treatment of other clients or harm others?	Are interventions and treatment approaches matched to the client's unique needs as opposed to merely treating all clients the same in cookie-cutter fashion?

be thoroughly addressed general practice guidelines in the extant literature. To name a few: fallacious and critical thinking aspects of AD; specious and spurious arguments; procedures to monitor oversight; standard training requirements including workshops; clinical and ethical robustness of standard clear policy; pragmatic strategies including a set of ethical questions (see Table 3) to double-check the appropriateness of AD to formally guide clinical practice, particularly when dealing with complex scenarios bound to evolve into AD. Table 3 might also be used to formally review the details in post hoc for the discharge decision to determine whether staff actually made the right decision.

Notably, while arguments against AD suggest the possibility of serious harm, the limited clinical addiction literature fails to prove that the practice of AD counter-intuitively delivers therapeutic effects or is ineffective in motivating, modifying, or altering the trajectory of symptomatic behavior inciting the termination. Moreover, while anti-administrative discharge arguments assert a cause–effect relationship between termination and poor quality of life outcomes for discharged cases, that claim has yet to be substantiated. Taken together, the extant literature lacks conclusive or consistent findings based on empirical inquiry to accept truth claims about AD and such associations (Williams, in press-c).

Moreover, given the sparse anecdotal accounts and unreliable secondhand "data" based on post-discharge outcomes, robust follow-up data is needed to contextualize the practice of AD and offer evaluative feedback on the results of it as an institutionalized program practice. It is not whether the AD experience has a latent effect in priming discharged clients to comport differently in subsequent treatment episodes to effectively enhance the overall treatment experience and heighten the odds of treatment "completion." In a review of discharge data spanning the years 2006-2011 from U.S. states and jurisdictions reporting to TEDS, a strong association exists between treatment completion and AD discharge. That is, with each successive discharge up until the fifth discharge, the odds of treatment completion rise. Rigorous empirical analysis of the TEDS is still needed. In addition, research examination has not yet extended to better understanding of the general effect size between people who entered into addiction treatment but did not complete treatment via AD, but still went on to maintain what might be called a successful (long-term) recovery, make improvements or experienced a remission of symptoms or report a reduction in the severity of symptoms, gain valuable insight due primarily to the AD experience, or perceive positive benefits in changed thinking, behavior and attitude on the road to recovery. As the addiction services and treatment field historian, William L. White, declared: "We need a study that follows the consequences of this action [administrative discharge]. I don't know of any follow-up study of people who did not complete treatment [via administrative discharge] (Personal Correspondence, W. White, April 19, 2014). From the perspective of empirical ethics (Musschenga, 2005), the lasting consequences of this action are, for the most part, a largely unknown empirical reality that leans in either direction of the debate favoring and opposing AD in the field of drug addiction treatment and recovery.

References

Atkinson, J. (1991). Autonomy and mental health. . In P. J. Barker and S. Baldwin (Eds.), *Ethical issues in mental health* (pp. 103-126). London, UK: Chapman & Hall.

Boyd, R., & Richerson, P. J. (1992). Punishment allows the evolution of cooperation (or anything else) in sizable groups. *Ethology and Sociobiology,* 13(3), 171-195.

Buchman, D. Z., Skinner, W., & Illes, J. (2010). Negotiating the relationship between addiction, ethics, and brain science. AJOB *Nueroscience,* 1, 36-45.

Cacciola, J. S., Alterman, A. I., McKay, J. R., & Rutherford, M. J. (2001). FEATURES: Psychiatric comorbidity in patients with substance use disorders: Do not forget axis II disorders. *Psychiatric Annals*, 31(5), 321–334.

Casement, P. (1992). The setting of limits: a belief in growth. *Journal of Social Work Practice,* 6(1), 25–30.

Carter, A., Mathews, R., Bell, S., Lucke, J., & Hall, W. (2014). Control and responsibility in addicted individuals: What do addiction neuroscientists and clinicians think? *Neuroethics*, 7(2), 205–214.

Cohen, R. E., & Lester, G. (1963). Limit setting as a corrective ego experience. *Archives of General Psychiatry,* 8(1), 74–79.

Draper, H., & Sorell, T. (2002). Patients' responsibilities in medical ethics. *Bioethics*, 16(4), 335–352.

Flynn, P. M., & Brown, B. S. (2008). Co-occurring disorders in substance abuse treatment: Issues and prospects. *Journal of Substance Abuse Treatment,* 34(1), 36–47.

Geller, J., & Srikameswaran, S. (2006). Treatment non-negotiables: why we need them and how to make them work. *European Eating Disorders Review*, 14(4), 212–217.

Geppert, C. M. A., & Roberts, L. W. (2008). Ethical foundations of substance abuse treatment. In C. M. A. Geppert & L. W. Roberts (Eds.), *The book of ethics: Expert guidance for professionals who treat addiction*. Center City, MN: Hazelden.

Glannon, W. (2009). Neuroscience, free will, and responsibility. *Journal of Ethics in Mental Health,* 4(2), 1-6.

Goldberg, R. L., & Leibenluft, E. (1989). When is enough enough: The administrative discharge. *Psychiatric Quarterly*, 60(3), 265–272.

Gutheil, T. G. (1985). Medicolegal pitfalls in the treatment of borderline patients. *American Journal of Psychiatry*, 142(1), 9–14

Hammer, R., Dingel, M., Ostergren, J., Partridge, B., McCormick, J., & Koenig, B. A. (2013). Addiction: Current criticism of the brain disease paradigm. AJOB *Neuroscience,* 4(3), 27–32.

Hemphill P. (2013). Boundaries and ethics: I don't wanna talk about it. Presented at the National Conference on Addiction Disorders, Anaheim, California.

Howe, E. G. (2002). The paradox of paternalism and three steps careproviders can take to help all patients. *Journal of Clinical Ethics,* 13(1), 1–17.

Little, J. (2014). Rescuing—a universal phenomenon. *Australasian Psychiatry*, 22(6), 533–535.

Little, J. (2015). The therapeutic use of 'no'. *Australasian Psychiatry*, 1-3. doi:10.1177/1039856214568225.

Little, J. (2015). Hesitancies in saying 'no'. *Australasian Psychiatry*, 1-3. doi: 10.1177/1039856214568226.

Maher, J., & Garside, S. (2011). Outpatient 'no shows': Must I follow up? *Journal of Ethics in Mental Health*, 6(1), 1-5.

Masson, P. C., & Sheeshka, J. D. (2009). Clinicians' perspectives on the premature termination of treatment in patients with eating disorders. *Eating Disorders*, 17, 109–125.

McCarthy, J. J., & Borders, O. T. (1985). Limit setting on drug abuse in methadone maintenance patients. *American Journal of Psychiatry,* 142(12), 1419–1423.

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(3), 267–275.

Musschenga, A. W. (2005). Empirical ethics, context-sensitivity, and contextualism. *Journal of Medicine and Philosophy*, 30(5), 467–490.

Napier, S. (2014). When should we not respect a patient's wish? The *Journal of Clinical Ethics*, 25(3), 196–206.

Petersson, F. J. M. (2013). Excusing exclusion: Accounting for rule-breaking and sanctions in a Swedish methadone clinic. International Journal of Drug Policy, 24, e99-e104. doi: 10.1016/j.drugpo.2013.10.001

Reinarman, C. (2013). Addiction as accomplishment: The discursive construction of disease. In D. A. Sisti, A. L. Caplan, H. Rimon-Greenspan (Eds.), Applied ethics in mental health care (pp. 181-199). Cambridge, MA: The MIT Press.

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.

Sjöstrand, M., Eriksson, S., Juth, N., & Helgesson, G. (2013). Paternalism in the name of autonomy. *Journal of Medicine and Philosophy,* 38(6), 710–724.

Sommer, B. R., & Roybal, D. J. (2010). Treatment-resistant major depression and the capacity to terminate care. *Journal of Ethics in Mental Health,* 5(1), 1-4.

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(2), 173–193.

Strike K. A., & Soltis, J. F. (1985). *The ethics of teaching*. New York: Teachers College Press.

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

Substance Abuse and Mental Health Services Administration. (2014b). Treatment Episode Data Set (TEDS): About one-third of substance abuse treatment admissions had a psychiatric problem. Retrieved from http://www.samhsa.gov/data/.

Taleff, M. J. (2006). *Critical thinking for addiction professionals*. New York: Springer Publishing.

Taleff, M. J. (2010). *Advanced ethics for addiction professionals*. New York: Springer Publishing.

Tozman, S., & Dejesus, E. (1981). The positive side of administrative discharge (in a drug program). *Substance Use & Misuse*, 16(1), 135–139

Van Hoose, W. H., & Paradise, L. V. (1979). *Ethics in counseling and psychotherapy: Perspectives in issues and decision making.* Cranston, RI: Carroll Press.

Welfel, E. R. (2006) *Ethics in counseling and psychotherapy: Standards, research, and emerging issues* (3rd ed.). Belmont, CA: Brooks Cole.

White W. L., & Popovits R. M. (2001). *Critical incidents: Ethical issues in substance abuse prevention and treatment* (2nd ed.). Bloomington, Ill: Lighthouse Institution.

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. (in press-a). Administrative discharge: The dilemma of perceived non-compliance. *Paradigm*.

Williams, I. L. (in press-b) Moving clinical examination of administrative discharge beyond moral rhetoric to empirical ethics: A call for research. *Journal of Clinical Ethics.*

Williams, I. L. (in press-c). Is administrative discharge an archaic or synchronic program practice? The empirical side of the debate. *The Online Journal of Health Ethics.*

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

Williams, I. L., & White, W. L. (2015, September 11). Kicking people out of addiction treatment: An update and commentary. Available at http://www.williamwhitepapers.com

Zhang, Z., Friedmann, P. D., & Gerstein, D. R. (2003). Does retention matter? Treatment duration and improvement in drug use. *Addiction*, 98(5), 673–684.

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Address for Correspondence:

Izaak L. Williams
University of Hawaii
Department of Psychology
2530 Dole Street
Honolulu, HI 96822-2216

e-mail: *izaakw@hawaii.edu*

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