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Involuntary Termination from Substance Use Disorder Treatment: Unknown Phantoms, Red Flags, and Unexplained Medical Data

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Abstract

In the United States, all treatment programs receiving public funds are required by law to regularly submit admission and discharge data, inclusive of the forced/involuntary termination or administrative discharge of clients, to their local state authorities. In some states, this requirement even extends to programs not receiving public funds. The aim of collecting discharge data—collected under the auspices of the Substance Abuse and Mental Health Services Association [SAMHSA]—is to assist state and county authorities, funders, and accreditors to monitor recovery-focused program performance. However, investigation here undertaken shows that published discharge data from many state treatment settings are perennially and grossly underreported or misreported. This paper reports on evidence that point to systemic failure of regulatory supervision of treatment settings and the ethical breach in duty and consequent legal culpability in reporting medical data. Policy and practice implications are discussed.

Keywords: medical data, administrative discharge, termination, addiction treatment, premature discharge

The current “opioid epidemic” has put a national spotlight on drug addiction and captured mainstream media attention that has exposed widespread problems in access to care in the treatment system in the United States (Democratic Staff of the Senate Committee on Finance, 2016). Even though it is well-documented that increased access to treatment accompanied by successful treatment engagement and retention can reduce drug-induced deaths (Proctor, Herschman, Lee, & Kopak, 2018), in 2017, an estimated 72,287 people died from overdoses (Centers for Disease Control and Prevention, 2018), a roughly ten percent increase from the year before when more than 63,600 drug overdose deaths were reported (Hedegaard, Warner, & Miniño, 2017).

Closing the treatment gap to decrease the number of deaths would therefore entail increasing positive outcomes and treatment success rates, reducing the number of premature terminations, and eliminating the revolving door of substance use disorder treatment (White, 2008). Unfortunately, over 50% of those admitted to addiction treatment have one prior treatment episode, and 1 in 5 have three or more prior admissions (SAMHSA, 2014b).

Successfully remaining in addiction treatment requires clients to navigate rules, regulations, and staff expectations (Chang, Chiu, Gruber, & Sorensen, 2017; White, Scott, Dennis, & Boyle, 2005; Williams & Taleff, 2015). Addiction treatment agencies contribute to widening the treatment success gap by prematurely terminating service delivery through the disciplinary practice of administrative discharge (AD). Administrative discharge amounts to the removal of the client from the treatment setting by program-initiated/treatment staffs’ actions, often abruptly, by terminating the relationship with a client on terms set solely by the provider (Williams, 2015a, 2015b; Williams & Taleff, 2015). According to the 2014 report addressing administrative discharge data, 7.2 percent or 106,454 cases were recorded nationally (SAMHSA, 2014a).

An untold number of people enter and return to treatment with a history of administrative discharge, assuming, of course, that terminated clients are still willing to return to treatment after

going through the experience of having been essentially kicked out of treatment at the time when what is needed is sustained care in a recovery-enriched social environment (Reisinger et al., 2009; Williams & White, 2015). Their lives and those of their families are negatively affected and compounded when faced with symptomatic deterioration (inability to access medication (e.g., methadone), incarceration, and trying to reenroll into treatment, especially when dealing with mandatory waiting periods for readmission following service termination (Deck & Carlson, 2005). An undetermined number of terminated clients have certainly returned to problematic drug use, criminal offending, and overdosed not long after experiencing administrative discharge (Knight et al., 1996; Svensson, & Andersson, 2012; Woody, Kane, Lewis, & Thompson, 2007; Zanis & Woody, 1998). In all, there is heightened risk of morbidity and mortality associated with the administrative discharge practice.

Consequently, closing the treatment gap is a high priority for the U.S. Department of Health and Human Services (HHS), National Institutes of Drug Abuse (NIDA), The National Institutes of Health (NIH), and other federal institutions and state agencies. However, if the currently available discharge data does not accurately reflect the reality of AD incidents, federal and state agencies may be amiss when prioritizing their policy and research agendas.

Moreover, if the data represent a conservative estimate, it is unlikely that this practice will not receive the attention and widespread criticism it deserves, thus hampering any attempt to bring about a legitimate, system-wide reduction in this practice. The problem of under-reported data on AD is particularly severe when discharge is listed as “transferred to another facility” or “left against staff/medical advice” rather than as administrative discharge (SAMHSA, 2014). Ultimately, inaccurate administrative discharge data may prevent authorities, auditing, accreditation, and funding bodies from being aware of the need to hold treatment systems accountable for a clinical practice that almost certainly contributes to the treatment success gap.

The Keepers of Administrative Discharge Records

The United States Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) compiles an annual Treatment Episode Data Set–Discharges (known as TEDS-D), maintained by the Center for Behavioral Health Statistics and Quality (CBHSQ) (Inter-university Consortium for Political and Social Research [ICPSR], n.d.).

The TEDS data are collected from state administrative data sets, which the states collect directly from their facilities. SAMHSA aggregates and reports the TEDS data from the states and jurisdictions in a national census data system that records annual discharges from substance abuse treatment facilities (ICPSR, n.d.).

An Intriguing Mystery

TEDS-D compilation began in 1999 and was first published in 2002, with the latest publicly available data set is from 2014. A most interesting question is why and how the administrative discharge rate dropped a staggering 7.7% in one year (from 15.9% in 2002 to 8.2% in 2003), a difference of 49,130 administrative discharges without any future reoccurrence of such a drop (see Table 1).

This article reports findings from a digital archeological excavation of the archives of TEDS-D, which revealed statistical clues, unearthed data artifact, and illuminated digital remains that were pieced together in attempting to solve this mystery.

Table 1
Treatment Episode Data Set – Discharges (TEDS-D): 2002 to 2014

Year	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013	2014
Number of states and jurisdiction reporting	22	26	28	34	42	46	47	45	47	49	49	50	48
Discharge records submitted	792,513	937,499	1,105,644	1,519,415	1,689,794	1,740,879	1,907,193	1,804,858	1,839,079	1,922,385	--	--	--
Eligible records	765,705 (97%)	888,432 (95%)	1,046,522 (95%)	1,454,768 (96%)	1,502,285 (97%)	1,629,363 (98%)	1,626,740 (85%)	1,620,588 (90%)	1,697,010 (92%)	1,742,114 (91%)	1,634,695	1,601,220	1,479,813
Completed	310,605 (40.6%)	361,023 (40.6%)	423,139 (40.4%)	601,445 (41.3%)	712,948 (47.5%)	734,693 (45.1%)	758,648 (46.6%)	756,318 (46.7%)	748,996 (44.1%)	762,083 (43.7%)	731,573 (44.8%)	708,940 (44.3%)	639,910 (43.2%)
Dropped out	203,650 (26.6%)	226,602 (25.5%)	232,302 (22.2%)	343,071 (23.6%)	386,322 (24.5%)	422,613 (25.9%)	408,363 (25.1%)	404,456 (25.0%)	442,670 (26.1%)	453,073 (26.0%)	423,346 (25.9%)	406,796 (25.2%)	381,664 (25.8%)
Terminated by facility	121,878 (15.9%)	72,748 (8.2%)	79,303 (7.6%)	115,192 (7.9%)	114,479 (7.6%)	105,918 (6.5%)	102,976 (6.3%)	110,691 (6.8%)	120,502 (7.1%)	127,404 (7.3%)	117,297 (7.2%)	120,017 (7.5%)	106,454 (7.2%)
Transferred	64,495 (8.6%)	93,292 (10.5%)	128,168 (12.2%)	189,474 (13.0%)	195,629 (13.0%)	239,938 (14.7%)	235,441 (14.5%)	221,448 (13.7%)	261,053 (15.4%)	264,255 (15.2%)	243,514 (14.9%)	248,651 (15.5%)	224,722 (15.2%)
Incarcerated	7,633 (1.0%)	10,475 (1.2%)	10,859 (1.0%)	22,168 (1.5%)	29,865 (2.0%)	33,769 (2.1%)	35,549 (2.2%)	36,191 (2.2%)	39,311 (2.3%)	41,080 (2.4%)	36,063 (2.2%)	34,159 (2.1%)	31,415 (2.1%)
Death	748 (0.1%)	1,070 (0.1%)	1,153 (0.1%)	2,106 (0.1%)	2,885 (0.2%)	3,710 (0.2%)	4,641 (0.3%)	4,482 (0.3%)	4,160 (0.2%)	3,983 (0.2%)	3,025 (0.2%)	3,255 (0.2%)	3,180 (0.2%)
Other	38,066 (5.0%)	56,264 (6.3%)	82,567 (7.9%)	97,260 (6.7%)	78,157 (5.2%)	88,722 (5.4%)	81,122 (5.0%)	86,002 (5.4%)	80,318 (4.7%)	90,236 (5.2%)	79,737 (4.9%)	84,402 (5.1%)	92,468 (6.2%)
Unknown	17,630 (2.3%)	66,958 (7.5%)	89,031 (8.5%)	24,052 (5.8%)	--	--	--	--	--	--	--	--	--

Note: *-- = no record of statistic

A Search for Red Flags

Before embarking on a quest to understand how the termination rate showed such a steep drop over one year, several potential explanations deserve initial consideration. First, progress appeared to have been made over the whole period in obtaining discharge data across all reported categories: completed, dropped out, terminated by the facility (administrative discharge, AD), transferred, incarcerated, death, other, and unknown. As Table 1 highlights, between 2002 and 2014, 4,731,928 drop-outs occurred with an average rate of 25.3% between 2002-2014, with a high of 26.6% and a low of 22.2%. Notably, transfer rates increased from 8.6% in 2002 to 15.2% in 2014. Since the earliest reported year of AD data, advances in addiction treatment, and the burgeoning emergence evidence-based practices (e.g., contingency management) have occurred, including the increasing acceptance of motivational interviewing now reportedly used by 90% of treatment programs (SAMHSA, 2017).

However, in this case, a future decline in the rate of treatment dropout would also be expected. Perhaps better training and practices better aligned with the principles of stepped care resulted in addiction treatment centers initiating more referrals and transfers, “reflecting greater levels of care available and a trend toward assertive linkage between multiple levels of care in response to changing needs of the patient” (Williams & White, 2015, para. 4).

However, by comparing the number and percentage of distributions in each available TEDS-D year across discharge categories, a more complete picture appears as to whether transfer rates between 2002 and 2003 coincided with a reduction in ADs. In

reviewing Table 1, an increase of 27,797 transfers between 2002 and 2003 was noted: an increase in the overall rate of transfer of just 1.9%. It is very possible that lag in data reporting may have distorted the TEDS data. That is, some discharges that really occurred in year X were entered into the TEDS-D system in year Y because a facility was late in reporting that data. These discharges would still be counted as year X discharges, but they wouldn't show up in the data files until the next year. Generally, states submit data to the TEDS-D system on a monthly or quarterly basis, but they can also submit late data. The date of the discharge determines the year in which the individual record is placed. Those late reported numbers would be entered into the master database, and the changes would be reflected in the next extract.

Sometimes, changes within a state's data system might affect its ability to collect certain types of data. Generally, if data shows major jumps in trends, especially one-year jumps, something within the state (or states) may have affected data reporting. Similarly, if there was a change in the type of data the state could obtain from facilities, a “new trend” might begin and be observed. However, if the change was a reporting error, states will go back into the system to correct the problem, and corrections would be reflected in later extracts of the data. In other words, if the massive disparity between the “transferred” rate and “terminated by facility” rate in 2002-2003 were originally due to reporting error, remnants of the error would not visibly remain, as the disparity would have been retroactively corrected in subsequent TEDS-D reports.

Discovering “Unknown” Phantoms

Further inspection of the trends in the TEDS-data offers another plausible explanation for the observation: one of sample size. The idea here is that the later years

are more reliable because of the much larger sample of participating programs. In 2002, 22 states and jurisdictions reported data. In that same year, there were a total of 1,897,932 admissions in all reporting states and jurisdictions and 765,705 reported eligible discharge records, of which 121,878 (15.9%) were reported as cases of forced termination or administrative discharge. At first glance, it might seem that the percentage of forced terminations has decreased as a function of sample size. However, at second glance, in 2003, 26 states and jurisdictions reported 72,748 forced terminations (8.2%). The number of people transferred in 2003 was 93,292 (10.5%) compared to 65,495 (8.6%) in 2002. Sampling as such appears to be uniform across the discharge categories, except for “terminated by facility” and “unknown” in 2002 and 2003. Discharges classified as transfers clearly do not provide a satisfactory explanation for how the rate of AD nose-dived 7.7 % between 2002 and 2003 while the rate of “unknown” discharges reports a three-fold increase in the same period.

An interesting artifact surfaces in “unknown” (the last discharge category in Table 1), which refers to data submitted that did not indicate any discharge status. From 2002 to 2003 there was a 5.3% positive difference; a colossal 43,328 increase in returns for that specific category. For example, in 2002 the state of Illinois reported 63,927 forced terminations—that is, a little over half of all ADs reported in that year—and 12,882 “unknowns.” But in 2003, Illinois reported 13,607 terminations and 61,735 “unknowns”—or over 95% of all “unknowns” recorded in that category in 2003! What phenomenon unique to Illinois would qualify for so many discharges being reported as “unknown”? According to SAMHSA’s CBHSQ, there is no documented information that explains the Illinois data.

Conclusions and Implications

Although the percentage of forced terminations decreased as a primary function of sample size from 2004-2014, the absolute number does not appear to have radically changed. The roughly 7.1% ($\pm 0.5\%$) yearly consistency of AD statistics is a very important finding given its impact on terminated clients and broader social systems of care (e.g., emergency medical services) and one that does not reflect well on the treatment systems stewardship of public tax dollars and scarce resource allocation. Take for instance, a recent study by Proctor et al. (2018) of payment method and discharge type among 4158 patients across 33 methadone maintenance treatment (MMT) facilities found “insurance patients evinced a significantly higher administrative discharge rate relative to self-pay patients (76.7 versus 48.4%, respectively)” (p. 5).

It is a disheartening fact that the system has not substantially reduced the absolute number of forced terminations over the available TEDS-D years. Thus while the AD rate has remained relatively constant over recent years, the sheer volume of people annually subject to the practice of forced termination represents both an increase in the frequency of terminations and a critical un-numbered group of individuals whose lives are being impacted. To that affect, the Office of Science Policy and Communications, National Institute on Drug Abuse (NIDA) seems equivocal at best in issuing a clear policy stance on the issue of AD. In response to the striking number of clients subjected to administrative discharges (as documented in this article), NIDA commented,

Unfortunately, we’ve not uncovered any further information regarding data related to termination of patients from treatment. This remains an important issue,

which we will continue to inquire about. I'm sorry we can't be more helpful at this time (J. B. Stein, personal communication, May 5, 2017).

Most interestingly, SAMHSA has not staked out a policy stance on this issue either. ICPSR describes the data collection for which SAMHSA has ultimate responsibility as follows:

TEDS includes data from facilities that are licensed or certified by the state substance abuse agencies to provide substance abuse treatment, or that are administratively tracked for other reasons, and that are required by the states to provide TEDS client-level data . . . The scope of discharges included in TEDS is affected by differences in state reporting practices, availability of public funds, and public funding constraints (n.d., para. 4).

Furthermore, ICSPR also draws attention to the fact that

In all States, treatment programs receiving any public funds are required to provide the data on both publicly and privately funded clients. In some States, programs that do not receive public funds are required to provide data as well.

TEDS collects this data from the States on all admissions and discharges aged 12 or older (n.d., para. 1).

The rates of AD in Table 1 are very conservative estimates of the actual statistics. In fact, there is significant indication of perennial underreporting of ADs across all reporting years of TEDS-D in multiple states and from some of the largest treatment systems (see Table 2 below). As can be seen from Table 2, the proportion of ADs from treatment settings in certain states appears to be grossly, if not flagrantly, underreported. State administrative systems, while routinely collecting information on treatment

discharges, are chronically failing to take responsibility for holding both themselves and treatment settings legally and ethically accountable for accurate substance use disorder medical data submitted to SAMHSA. The policy implications are striking, and, considering the moral dimensions of this practice, cannot be understated.

Table 2. Sample of treatment systems that appear to underreport or not report discharge data

State	Year	All Discharges	Terminated by Facility
California	2011	162,947	0
New Mexico	2011	12,581	28
Arizona	2011	17,571	0
North Carolina	2011	84,312	0
Arizona	2010	17,452	6
Arkansas	2010	15,859	17
New Mexico	2010	6,697	3
California	2010	171,017	0
North Carolina	2010	82,803	0
Arkansas	2009	26,547	4
Arizona	2009	16,482	0
California	2009	187,927	0
Arizona	2008	15,233	0
Arkansas	2008	32,408	0
California	2008	200,583	0
Indiana	2008	15,457	0
Mississippi	2008	7,171	24
North Carolina	2008	27,242	0
Arizona	2007	18,501	0
Arkansas	2007	15,469	0
California	2007	202,718	0
Indiana	2007	21,755	0
Mississippi	2007	7,066	35
North Carolina	2007	29,619	0
Arizona	2006	21,260	0
Arkansas	2006	963	0
California	2006	184,323	0
West Virginia	2006	4,308	0
Tennessee	2006	14,330	0
Ohio	2006	55,839	0
Arkansas	2005	4,304	38
Arizona	2004	21,897	0
California	2004	180,551	0
Arizona	2003	7,434	0
California	2003	44,212	0
California	2002	76,274	0

Treatment settings that do make a practice of administrative discharge may not be aware of better alternatives (Walton, 2018; Williams, 2015a), or may believe in forcing clients to confront the proverbial rock bottom as a spur to motivating change (White et al., 2005; Williams, 2015a). These settings may not even try to envision the existence of other possibilities. In one study, for instance, 317 staff members were surveyed concerning their beliefs about addiction treatment. There was strong support particularly among staff with less formal training desiring more frequent use of confrontation (46.4 %) and 35.7% agreed that “non-compliant patients should be discharged” (Forman, Bovasso, & Woody, 2001, p. 4). In other words, “although 75.7% of staff recognized that even motivated patients can be unsuccessful, more than a third of the staff still supported discharging noncompliant patients and almost half believed that confrontation should be used more” (Forman et al., 2001, p. 7). This finding is in line with research by Gallagher, Nordberg, and Lefebvre (2017) that revealed treatment staff were perceived by clients as espousing judgmental attitudes and resorting to punitive intervention, including terminating treatment, particularly when faced with the recurrence of clients’ substance use disorder symptoms (e.g., drug use).

Single state agencies, county authorities, other funding authorities and accrediting bodies (e.g., CARF) are charged with regulating recovery-focused program performance measures, thereby tracking the average annual change in discharge status as a performance measure. Certainly, the skill and the dedication of such auditors and state authorities vary considerably, who do less than they both could or should do, and the process leaves many questions of accountability, transparency, and ownership

unanswered (Williams 2016). Table 2, for instance, demonstrably gives the impression that some state authorities are falling woefully short in holding treatment settings accountable for the potential abuse, misuse, and misclassification of administrative discharge.

The practice of terminating clients’ medical service delivery treating their substance use disorders is neither rooted in evidence nor national consensus (Williams, 2016). In this era of evidence-informed practice, guiding policy making is needed that would tie a percentage of continued state funding to whether state authorities/auditors put quality checks and balances on AD, review cases of administrative discharge to assess the legitimacy of its use, and ensure publicly funded treatment facilities have practice guidelines, policies and procedures, supervisory training, and education to further regulate and ensure its proper ethical and clinical use.

Hence if there has not been a legitimate, significant decline in administratively discharging patients in this era of evidence-based practice, the existing data further reflect poorly on the treatment system as a whole. Taken together, provider decision-making is supposed to be driven primarily by healthcare outcomes, which leaves one damning question that inevitably persists: If the true rate of AD were revealed, would terminating addiction treatment services as a medical practice continue to collectively and systematically fail clients?

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