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Redefining Retention: Recovery from the Patient's Perspective[†]

Shannon Gwin Mitchell[*], **Rika Morioka**[**], **Heather Schacht Reisinger**[***], **James A. Peterson**[****], **Sharon M. Kelly**[*****], **Michael H. Agar**[******], **Barry S. Brown**[*******], **Kevin E. O'Grady**[********], and **Robert P. Schwartz**[*********]

[*]Research Scientist, Friends Research Institute, Inc., Baltimore, MD

[**]Co-Investigator, Lighthouse Studies, Johns Hopkins University, School of Public Health, Baltimore, MD

[***]Qualitative Investigator, Iowa City VA Medical Center, Iowa City, IA

[****]Research Scientist, Friends Research Institute, Inc., Baltimore, MD.; Research Scientist, George Washington University, School of Public Health and Health Services Department of Epidemiology and Biostatistics, Washington, DC

[*****]Research Scientist, Friends Research Institute, Inc., Baltimore, MD

[******]Consultant, Ethknoworks, Santa Fe, NM

[*******]Professor, University of North Carolina at Wilmington, Wilmington, NC

[********]Associate Professor of Psychology, University of Maryland, College Park, College Park, MD

[*********]Medical Director / Senior Research Scientist, Friends Research Institute, Inc., Baltimore, MD

Abstract

This study examines the process of discharge and treatment reentry for six participants who entered treatment voluntarily but were administratively discharged from methadone treatment programs. The participants completed semistructured interviews at treatment entry and at four, eight and 12 months post-treatment entry. Grounded theory methodology was used to examine the phenomenon of treatment reentry from the perspective of the patients, who often viewed their recovery as an accumulation of positive changes. Differences in terms of the patients' goals and motivations for seeking treatment from those of the treatment programs, combined with difficulties encountered during the treatment process eventually led to discharge. However, these patients were then able to navigate their way through the treatment system in different ways in order to remain in treatment. The authors conclude that failure to abide by treatment clinic rules do not necessary constitute "treatment failure" from the perspective of patients, who often wish to remain in treatment even if it is not progressing optimally from the program's perspective. As a result, the recovery process can be more fragmented and is often characterized by a series of cyclical treatment episodes rather than continuous time in treatment, thereby impeding their progress towards recovery.

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Please address correspondence and reprint requests to Shannon Gwin Mitchell, 1040 Park Avenue, Suite 103, Baltimore, Maryland 21201.

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Methadone treatment is highly effective in reducing heroin use (Mattick et al. 2009; Simpson, Joe & Brown 1997; Ling et al. 1996; Strain et al. 1994) although rates of premature discontinuation (including drop-out and discharge by the program) have been a consistent problem over the decades (Reisinger et al. 2009; Deck & Carlson 2005; Simpson & Sells 1982). It has been reported that retention of one year for methadone treatment is necessary to achieve behavior change (Hartel & Schoenbaum 1998; Simpson, Joe & Brown 1997; Hubbard et al. 1989; Simpson & Sells 1982). Nonetheless, multisite studies have shown that patients often stay in treatment less than one year, even in this "long-term" treatment modality (Hartel & Schoenbaum 1998; Simpson et al. 1997; Hubbard et al. 1989). Following premature discharge, most individuals have been found to have engaged in problematic behaviors, including criminal activity (Hanlon et al. 1998; Maddux & Desmond 1981), illicit drug use and HIV risk behaviors (Ball & Ross 1991). In addition, prematurely discharged patients have an increased risk of contracting HIV/AIDS (Metzger et al. 1993) and increased mortality rate as compared to retained patients (Degenhardt et al. 2009; Woody et al. 2007).

Longer retention in drug abuse treatment has been shown to be associated with better patient outcomes (Zhang, Friedmann & Gerstein 2003; Maddux & Desmond 1997; Nurco, Kinlock & Hanlon 1994; Hubbard et al. 1989), and the first 12 months of treatment are considered critical to patient success (Hartel & Schoenbaum 1998; Simpson, Joe & Brown 1997). There is also evidence that patients with prior treatment experience may stay in their subsequent treatment programs longer than those without that history (Hser et al. 1997).

While a substantial minority of opioid-dependent individuals (approximately 20%) have a single treatment experience and are found to show continuing abstinence over periods up to 12 years post-treatment (Simpson & Sells 1982; Robins, Davis & Goodwin 1974), it has long been recognized that opioid dependence is frequently a long-term condition characterized by lapses, relapses and remissions over many decades (Anglin, Hser & Grella 1997; Biernacki 1986). First treatment entry is typically delayed, with an average of seven to nine years of drug use between problem onset and initial treatment experience (Dennis et al. 2005; Anglin, Hser & Grella 1997; Simpson et al. 1997; Hubbard et al. 1989). However, succeeding treatment experiences are often associated with greater treatment retention, indicating that there may be a cumulative treatment effect (Nosyk et al. 2009). The recovery process itself has been described in terms of a "drug treatment career" in much the same way as the repeated cycles of cessation and drug use patterns exhibited by many substance users have been described as a "drug use career" (Hser et al. 1997).

Retention rates in drug treatment programs have long been considered an important measure in evaluating treatment effectiveness (Ball & Ross 1991). In studies of retention and treatment effectiveness, focus is placed on an individual treatment episode. This can be seen as consistent with an acute care model of treatment programming, such that each episode is considered as a distinct experience rather than as part of a process of treatment involving multiple treatment experiences (McLellan et al. 2000). A treatment episode is then considered unsuccessful if a patient leaves shortly after admission or is asked to leave because of noncompliance with clinic rules, regardless of whether or not the patient re-enters another treatment program shortly thereafter. From this point of view, retention is defined from the perspective of the treatment program and refers to the length of time that the patient spends in treatment within a particular treatment facility. When examined in

terms of single episodes, program staff can become demoralized by the seemingly small and short-lived effects of treatments, a response that may be unwarranted if a more contextual and longer-term view of retention were adopted.

Retention in methadone treatment may be closely related to compliance with program rules (Reisinger et al. 2009). Patient compliance with treatment requirements is often poor in drug treatment programs (Coviello et al. 2006), although it may mirror that of compliance to the treatment of other chronic diseases, where patients may follow some but not all of their prescribed course of treatment (McLellan et al. 2000).

In recent years, there has been renewed interest in understanding addiction from the standpoint of a recovery model, such that relapse remains a continuing threat post-discharge thereby warranting the inclusion of additional strategies to avoid relapse and permit continuing growth (McKay 2009). In light of this change in emphasis from acute to continuing treatment, efforts have been made to extend treatment episodes post-discharge for both unsuccessful and successful patients. A random assignment study found that discharged methadone patients could be successfully reengaged and readmitted to methadone treatment at 90 days post-discharge through outreach case management as compared to passive referral (Coviello et al. 2006). This study also found that 5% of its discharged participants died between baseline and six-month follow-up, underscoring the need to reengage discharged patients. The authors concluded that programs should attempt to change their procedures to better retain patients in treatment rather than focusing solely on reengagement post-discharge.

Although retaining patients in a particular drug abuse treatment episode in a particular program may be desirable, it may not always be possible or appropriate. This qualitative study focuses on the experiences of six methadone patients who were involuntarily discharged from treatment but who were readmitted to another treatment program in order to continue their treatment episode.

METHODS

Participants

This research was part of a larger longitudinal study examining entry and engagement in methadone treatment among 351 new admissions to six methadone programs located in the Baltimore metropolitan area (see Schwartz et. al. 2008 for a description of the larger study). For the present analyses, six study participants were selected for inclusion from the larger qualitative treatment entry sample based on self-report and clinic records, which indicated that these patients had been administratively discharged from their original methadone program and had voluntarily entered another methadone program within 12 months of study enrollment. (See Reisinger et al. 2009 for a description of the larger qualitative sample.)

Procedure

Participants completed semistructured interviews at treatment entry (baseline) and at four, eight, and 12 months post-baseline. The interviews were developed and conducted by trained and experienced ethnographers. Interviews were conducted in participants' homes, other locations in their neighborhood, or at Friends Research Institute's Baltimore office in order to enhance the comfort and convenience of the participants. Each semistructured interview lasted between 30 and 90 minutes and covered the participants' drug use history, attitudes and experiences concerning their treatment program, as well as reasons for leaving and subsequently re-entering treatment. All interviews were recorded, transcribed, reviewed for accuracy, and entered into Atlas.ti qualitative coding software for analysis. The study was approved by Friends Research Institute's Institutional Review Board.

Analysis

Data were analyzed using a modified grounded theory approach (Strauss & Corbin 1991), initially limiting the content analysis to a dictionary of prescribed codes developed for the project, and then allowing for emergent themes from the narratives. After identifying the six interviews of participants who had transferred to a new program within the year, the set of interviews for each participant was coded initially for how the participant moved into their new treatment program (e.g., facilitated by program and without a lapse in treatment; not facilitated and without a lapse in treatment; and not facilitated and with a lapse in treatment). After this initial phase of categorization was completed, subcodes were developed by the first author (SGM) and two coauthors (RM and RPS), who met as a team, discussed and reached consensus concerning thematic content and comparative coding. These secondary analyses further refined the transfer/treatment retention phenomenon, including: initial goals for treatment, problems encountered during treatment, progress towards goals, reasons for discharge, and new program entry.

RESULTS

Characteristics of Participants

The mean age of the six participants was 37 years, three were African American, three were Caucasian, and five were male. The number of years of drug use (heroin and/or cocaine) ranged from eight to 27 years, with the mean length of 15.8 years. The mean lifetime number of prior enrollments in drug treatment programs was 4.2 times. All participants reported using both cocaine and heroin, had experienced significant opioid withdraw symptoms and had a history of involvement in criminal activities.

Why They Entered Treatment

All participants reported being motivated to enter treatment because of a critical event or being at a stage in life that prompted emotional and psychological growth, causing them to reflect on their drug use. None of the participants in this sample had been mandated to receive drug treatment by the criminal justice system. Many demonstrated a lifetime perspective, both regarding their use and their recovery. For example, a 37-year-old Caucasian male with a record of frequent incarcerations said, “And most of the time, I’m thinking about how harmful drugs are and what they do to people, and you know, what I’ve done to my family, you know my sons.” When asked what motivated him to seek help from a treatment program, he replied “ … because I looked at my past, the wreckage of my past.”

Participants often described certain events that led them to increase their resolution to stop drug use. These events included gaining custody of children, the birth of a new child, release from incarceration, and possibilities for schooling and better employment. A 32-year-old Caucasian woman who grew up in a family of severe drug and sexual abuse and who lived in a neighborhood flooded with illicit drugs explained her motivation to stop using drugs.

> I was every day running for it, the Ready. Every day, I found myself running for it. That’s when I stepped back and took a look at myself. … My 15-year-old is coming to live with me, you know, he caught me, and that pretty much upset me. … But I’m trying to stop for him, because it hurts him, you know, make sure his friends don’t say, your mom’s a drug addict. I know they used to when they were younger. I don’t want him to be having to go through that again.

Consistent with prior research that found older age and longer drug-use histories being associated with treatment entry (Hser et al. 1997), the participants who returned to treatment programs revealed psychological growth, perspective, and maturity when examining their drug use careers.

Goals for Treatment: Taking a Long-Term Perspective

The patients in this study talked about their goals for treatment in terms of "getting back into life" with a long-term perspective. Many articulated that they fully intended to be in some sort of treatment for many years to come. When contemplating moving to a new place, one participant who had been abstinent for nine months at the time of his follow-up interview explained that he was thinking of going to a transitional house related to a treatment program instead of living alone because he did not believe that nine months of abstinence was sufficient, given his long addiction career.

> I'm leaning more towards where I want to be free a little bit, but my mind is telling me "don't do that, you ain't ready yet" … You need to go to a transitional house cause your foundation ain't strong enough yet. They say it usually takes a year or two before you actually get a nice strong foundation where you can overcome obstacles out there. … I had twenty-two years of experience of being a drug addict. I can't erase it in nine months.

Participants had often made positive life changes when they were interviewed at follow-up, but always based their life decisions on an assumption that they would need long-term treatment. One participant who had been off-and-on methadone for 12 years talked about his dream of going back to school, along with his expectations for long-term treatment. "Not that [I will be clean]. I probably won't be able to stabilize my life and break the cycle of getting high. [But] being able to get back to school. … That's what [the program] is going to do for me." He had accepted the possibility of living with methadone for the rest of his life. But just as with any other medical treatment, he expected methadone treatment to enable him to live a "normal life."

> For me, I may be on methadone the rest of my life. But if it means that I have a normal and stable life, I don't have a problem with it. … The program's been good to me. … I one day would like to be, maybe one day it comes where I won't be on methadone. But I have to be on methadone until God calls me up. I don't have any problem with that really. To me, I look at it the same thing as having cancer and getting radiation treatment, that's how it is for me.

Participants' goals for treatment went well beyond relinquishing drug use. What they really aimed at was "getting back into society," achieved essentially through the accumulation of positive life changes. This meant becoming a productive member of society, such as a better parent or spouse, with gradual changes in lifestyle that occurred in parallel to staying off illicit drugs. A 41-year-old African-American male described his hope for the future:

> A year from now, I'll probably still dealing with this, cause it's going to be a long process. Cause I don't want to just jump off of it and then back. … Hopefully but not in five years, I won't be still on that [methadone]. … Hopefully, I mean hopefully, I'll be better established you know with a job, and maybe a kid, you know, I want a kid, I do.

Achieving their goals often involved getting a decent place to live, having a job, going back to school, raising children, and forging meaningful relationships with others. This required a long-term commitment to recovery, and they did not expect to accomplish their goals overnight.

Rather than being a goal in and of itself, abstinence, achieved through treatment programs, made it possible for them to pursue their goals. Staying in programs also meant the possibility of eventually getting back into society for the participants, despite their repeated relapses and premature discharges. In sum, methadone treatment and its associated changes in drug use were the vehicles by which participants hoped to achieve their long-term life

goals. Treatment and abstinence were not the goals themselves. Participants often expected to be receiving methadone treatment for a year or more as they pursued those goals.

Problems Encountered During Treatment

While the participants aimed at getting back into society, treatment programs, from the participants' point of view, focused on having them achieve abstinence. Some participants felt that programs "push you in and push you out" applying rigid rules, regardless of patients' needs.

> A person has been out there for like years. … You can't tell me I got to be at this point in six months, you know. When I went back that time, she put me on contract [for] less than two months … I said it just so much unnecessary pressure. That's just a business up there. They're not trying to help you at all.

The participants in this study often felt that they, themselves, knew what activities worked best for them and what did not, based on their past treatment experience. They reported that they voiced their needs and preferences by requesting changes in counselors or modifications in their methadone dosage, but sometimes felt that they were not being heard. The perceived inflexibility of programs and their failing to accommodate patient needs created frustration and resentment. A telling example was a patient who had been abstinent for more than six months, juggling employment and treatment schedules, when he was assigned to a new counselor who started to enforce a program rule requiring group counseling attendance. This participant stated that he was unable to attend group meetings due to his work schedule, and that because of his past treatment experiences, he felt that such group sessions were not particularly helpful to him anyway. The counselor's unwillingness to accommodate his needs and preferences frustrated the participant.

> Now I want to do it [drug secession], and it's like my people are making it hard for me. But I understand that it's not nothing against me personally, you know what I mean, just like here they got rules. … I had everything straightened out and everything was going good. … I don't believe that a program should cater to one certain person but if you had a long history with treatment and drug abuse, and if you know what works for you, okay, well then give it a shot, you know, because I wasn't getting high for all them months and it works, you know.

In contrast, another participant, an unemployed 38-year-old African-American male, said that he wanted more group sessions.

> I told her [counselor] I need to get in more groups, because during the daytime, like I'm here, I have a lot of free time. It's a trigger for me … I don't' have nothing to do, nowhere to go and all these thought come to my mind. I be thinking of how, thinking of ways how to get high or this and that, you know, I don't want to go through that shit again.

Though differing in needs, both of these participants had a clear idea of what would be helpful for them. When their treatment programs did not respond to their perceived needs, conflicts often arose, eventually contributing to their premature discharge.

Another problematic aspect of treatment experienced by some participants had to do with medications and dosing. One participant, a Gulf War veteran, who had been suffering from bipolar and severe sleep disorders, stated that he found only a few medications to be effective for him, however, his doctor at the program was unwilling to prescribe those medications, citing their abuse and overdose potential. When he was unable to obtain the medications from the program's psychiatrist, the participant resorted to buying them illegally from the streets.

> I don't have a doctor here who prescribes it. So I mean I'll tell it, it's no secret, I buy my pills off the street. The pills that should be prescribed … because I am bipolar, I'm not able to rollercoaster. I also have a violent streak, which I try to keep control. I try not to put my hands on people.

This participant knew that his doctor did not want to prescribe the medications, but in his view, the doctor's concern did not justify denying him the only medication that he believed worked for him. While it is not clear from the interview which medication the patient wished to receive, contentious issues often arise in programs around the prescription of benzodiazepines. Some patients report these medications help their anxiety while others are addicted to them. Physicians are often reluctant to prescribe these medications for fear of their addictive potential as well as their potentially fatal interaction with methadone (if they are taken in excess).

Participants also felt frustrated when the programs did not adjust their methadone dosage. They believed that doctors at the programs often made dose adjustments when a decrease in medication was requested, however, once the dosage was reduced, it tended to stay at that level and was difficult to increase, even when a patient expressed the need to do so. A 41-year-old African American reported having difficulty convincing his counselor that he needed a higher dose, which had been reduced from 100 mg to 40 mg because of his continued noncompliance (according to his explanation). He requested that his methadone dose be increased back up to 60 mg. Yet, the participant reported that his counselor did not effectively communicate this request to the medical staff despite his claims of "staying clean" for three months. Eventually he resumed his use of heroin to supplement the methadone, and was discharged from the program.

> It wasn't half as much, maybe about thirty dollars a day. But that's still a lot though … That's in addition [to the methadone from the program] until I got to the dosage I wanted to be at. I wasn't holding.

In sum, having unmet needs and being noncompliant were often interrelated for these patients, who felt limited in their ability to effectively manage their treatment at the program, despite believing that they communicated their needs to program staff.

Progress towards Patient Goals

All six participants in this analysis experienced a lapse/relapse at one time or another during the course of their treatment, and were eventually considered a treatment failure by their programs. However, continued or intermittent drug use, whether opioids or other illicit drugs, did not necessarily mean treatment failure to the participants, who viewed abstinence as a means rather than an end. Instead, participants were able to see gradual but positive progress towards their larger life goals, in spite of their lapses. In fact, from their perspective, resumed drug use was sometimes viewed as part of the recovery process. One participant talked about relapse as a necessary experience that allowed him to recognize the changes in how he felt about drugs.

> I mean I've messed up once or twice. I got high once when I was in there, I didn't get caught for it, but it showed me what I'm not missing. You know what I mean? It was totally different. I didn't have fun, I actually felt bad. You know, which sometimes, I need to relapse to grow in the process, sometimes.

Through the experience of relapse, he realized that he no longer enjoyed drugs, and found changes in the way he thought about drugs. Instead of focusing on the number of days he stayed abstinent, the participant saw progress in building up of positive changes both in mind and behavior. Other signs of treatment progress reported by participants included their ability to stop "running" after drugs, avoiding criminal behaviors, keeping a job and a home,

and staying off one drug (often heroin) while dealing with other drug use (e.g., cocaine). In short, the participants saw their own achievements in being able to change their lifestyle from one centered on drugs to one more focused on work and family.

Discharge and Program Reentry

Though all six participants were administratively discharged from their original programs for behaviors that were interpreted by the programs as indicating a lack of commitment to their recovery, all six participants went on to continue their drug treatment at another program. Among them, only one individual received a referral from the original program because she was found to be pregnant at the time of discharge, and a 30-day administrative methadone detoxification during pregnancy is often avoided because of the potential impact on the fetus of opioid withdrawal, relapse and the nonadherence to prenatal care associated with active opioid dependence that ensues following discharge from treatment. The remaining five participants found new treatment programs on their own, although transferring to another program without the assistance of their original program often led to a series of negative consequences as a result of the inability to arrange a seamless transition between programs.

Without a referral from the discharging program, some participants in this study found it difficult to secure immediate entry to a new program due to encountering long waiting lists at the new programs. This created a temporary break in treatment, forcing them to return to the streets. A man who was discharged after six months in his original methadone treatment program went back to the street in order to obtain drugs, even while being detoxified off methadone.

> She took me off too soon, and that's not good at all. It's just going to send you right back out in the street. And it would, you know, because you're not ready, and then you are going to be extra pressed, feeling that anxiety on you … Shoot 'cause, I mean, when I was detoxing I felt terrible, every bone in your body…

He was not ready to discontinue methadone treatment, yet the physical discomfort of detoxification made him return temporarily to street drugs. Another participant who was discharged from a program after threatening a patient described the agony he had experienced on the street before he was able to reenter another treatment program.

> I was out there in the street approximately about four or five weeks before I got on another program, and they were the longest four or five weeks in my life. It was just, it was chaos, turmoil. A lot of negative thought, a lot of wishing that I would die, a lot of my old habits coming back into play. I wanted to get what I need to be normal, you know, because at this point in time, for me, if I was doing dope it's not to be high, it's to be functional.

This participant knew how to obtain methadone in the community and tried to remain on it by buying diverted methadone whenever possible, but his lack of money forced him go back to heroin at times, which was less expensive for him to purchase on the street than methadone.

> I'd rather do methadone than do heroin. … When I didn't have enough money to buy a bottle, then of course, I'd have to buy heroin.

The participants who were being detoxed and discharged from their original methadone programs reported purchasing street drugs or diverted methadone to be functional, rather than to get high. Even the most proactive participant, one who was able to find and enter a new program before being completely detoxed in his original program, resumed his use of street drugs in order to continue working while waiting to enter his new program.

> Everything was ok until maybe like two months ago, and I started using again. … I'm not doing it because I want to, like to get high. Not now. Now I'm doing it [using heroin] just to make it until I start the other program.

Because of his decision to obtain street drugs rather than utilize other recovery support services in the community, he created additional financial pressures on himself, which led him back into the vicious cycle of using drugs to work and working to get the drugs.

> I got put off [the program] and being out in the streets, man, I mean and I was getting work, but I was working to use and using to work. So the cycle started all over again.

In essence, when treatment programs discharged patients without a referral, positive progress made while in the programs was sometimes reversed, at least temporarily.

Finding New Treatment Programs

The five participants who did not receive a referral when discharged all found a new program on their own initiative by making calls to programs and asking peers who might know about program openings. One decided that he did not want to be on methadone again, and inquired about other types of treatment.

> I talked to some people and one of the guys that I talked to was a graduate of [a program] and they confirmed that it's one of the best programs. So I shot for it. By the grace of God, I got lucky and got a number that I wasn't supposed to have to the administration director. … so I was calling her directly I didn't have to go through a middle man, you know what I mean. I was burning her ear off, and I had my mom on the other end burning her ear off, so you know we persuaded her to get me in there.

While the participants were not socially active in general, and tried to avoid old friends and family members who were drug users, many were able to rely on assistance from other support sources, such as a parent, a spouse, a fiancé, and a church pastor, to help them get through the transition and find a new treatment program. In the case of a 30-year old man, it was his wife who found a new methadone program that better suited his needs in terms of location and treatment hours. For the homeless man who lived in an abandoned house, it was his friends helped him buy street methadone, which allowed him to be functional and not return to heroin use.

> The people who were my friends … some just kept trying to help me until I got on another program. … They would give me some money so I could buy street meth, which is what I would prefer to do instead of going into the dope line.

Despite the frustrations and challenges they experienced in treatment programs, the participants in this study returned to another program because they recognized positive effects of treatment and the progress they had made towards their goals, and that gave them hope for the future. They had implicit trust that as long as they were in a program, they would be able to make changes necessary to live a "normal life." And often, they did make further progress towards their goals after starting their new program. When a slot in a program became available, the homeless man was able to find a place to live, through the assistance of the new program. He felt that the new program "saved" him and made him hopeful for the future.

> I'd be a fool to think that I could go anywhere else [other than a program]. But something's going to come, and when the time is right, I'll leave. But as long as I'm doing what I'm supposed to do, something is going to fall into place. … I said I'm being groomed for a position too. … I said the position of recovery and

> employment, and when it comes, it's going to be all right because I just ain't going to stop until it comes. … The program once again saved me from being out on the streets because I don't think I would have made it another time.

A 40-year-old Caucasian man talked about his excitement over his new program and his hope for going to college.

> I have much gratitude for [the program] for giving me the opportunity to change my life 'cause I've never been this clean. … All these new situations … it's wonderful. I love it. You know, I've never felt this way before and I like it. I like being clean. … I've learned that [psychological] aspect of the addiction so now I can work on modifying it. I'm getting through the program to go to college. And if that doesn't work, I've already spoke to [a counselor], because I'm determined to go back to college.

The participants went through the cycle of hope and frustration as they went in and out of programs. Entering treatment made them hopeful for the future and motivated them for recovery, yet when the stress from juggling program requirements and family and work obligations made them tired and frustrated, they often lapsed/relapsed. Perceived difficulties in treatment programs, such as inflexible rules and insufficient dosage, also added to their stress and caused them to miss treatment, resume drug use, and ultimately to be discharged from their program. However, the participants in this study showed no indication of giving up at that point, and often fought to continue their treatment either at their original program or at a new treatment program. They expressed strong trust in the positive effects of treatment programs and revealed not just resourcefulness but resiliency by their actions. For these patients, treatment programs offered more than drug treatment and abstinence; treatment provided hope for the future.

DISCUSSION

The results of this study indicate that these patients adopted a long-term orientation focused more on life goals and viewed abstinence from drugs as a means to an end. In that regard, they valued remaining in treatment and were motivated to receive help, rather than relying or limiting themselves to a specific drug treatment program. There is significant logic to the idea that participants wish to continue to receive methadone, even if they need to change treatment programs in order to do so. Indeed, the evidence from clinical trials has shown that methadone treatment is associated with significantly greater reductions in heroin use than outpatient counseling or methadone detoxification programs (Mattick et al. 2009), and newly discharged methadone patients are at a higher risk of overdose death than those individuals who remain in treatment (Degenhardt et al. 2009; Woody et al. 2007).

Given these data, it would seem that while treatment programs should strive to retain patients in their programs, when all else fails they should arrange to transfer patients to other settings in order to retain them in treatment (even if at a different program). This process should involve the patient and the treatment center working together to identify a suitable alternative treatment option, whether based on location, treatment modality, or other salient factors. Such a process might help ensure that the patient remained engaged in treatment, and avoid the treatment gaps that are often associated with lost treatment gains, return to active drug use (at least temporarily), and negative health consequences. Intuitively, the treatment program that arranged to transfer the pregnant patient to another program realized that such a transfer was in the best interest of the pregnant woman and her fetus. It can be argued that this approach should not be reserved for pregnant women but should, where possible, become a routine part of practice.

This study also suggests that a patient-centered treatment focus, as recommended by the Institute of Medicine (2001), may enhance the treatment experience and optimize patient outcomes. A significant percentage of methadone patients are administratively discharged prematurely every year. Yet, many among these individuals were initially motivated to seek help and have the potential to change. In our larger study sample, at total of 41.6% were administratively discharged from their treatment program, highlighting the fact that the stories conveyed by the six participants in this qualitative are probably not unique.

Focusing on retaining a patient at a treatment program when there is a lack of fit between the patient and program may be detrimental, driving the patient out of treatment altogether. When disputes or disagreements between the patient and the program arise, an ombudsman could be helpful in either resolving the dispute or assisting the patient in finding and entering a new treatment program, rather than losing them to discharge and the likely negative outcomes.

The prematurely discharged patients described in this article improved the quality of their lives in many ways once they entered treatment, and thus should not be considered "treatment failures" even if they failed to obtain total drug abstinence during their time in their original program. The participant reports in this study reveal that when a patient is noncompliant and is forced to leave a treatment program, it does not necessarily indicate a lack of motivation or engagement in treatment. When patients do not want to be discharged from treatment they may draw upon community resources to find alternative treatments or engage in other community-based support services, such as AA/NA or church participation. Indeed, such factors have been found to be associated with treatment readiness and their ability to make use of treatment resources (Schwartz et al. In press; Brown et al. 2004). Most of the patients in our study drew informational and emotional support from family members, peers, pastors and even needle exchanges to help them find and gain entry into a new program after their administrative discharge.

Involuntary administrative discharge is generally, by definition, a discharge initiated by a program physician order against the will of the patient, who would otherwise continue to receive methadone at the program. In other cases patients may drop out of treatment because they are unsuccessfully trying to control their care (e.g., change their dosing or counseling regimen). In this case even drop-out may actually represent a certain degree of engagement, particularly when the patient seeks care elsewhere after leaving the program.

Programs may benefit from redefining their meaning of "retention" so that the goals of patients and care providers can be realigned. When retention is viewed in terms of staying in treatment rather than time spent within a single treatment program, and the outcome of treatment is considered as an accumulation of these treatment experiences, new understandings of treatment progress emerge. Even among patients who are prematurely discharged, one may still see a dramatic reduction in drug use and a greater willingness and likelihood of returning to treatment (Powers & Anglin 1993). Reduction in drug use over time, as well as other changes that may not be apparent in a single treatment program experience, might be identified when a longer-term perspective is taken. Importantly, the reduction in drug use has public health and safety benefits in terms of reduced blood-borne disease transmission, overdose death and criminal behavior.

Based on the reports of the participants in the present study and other findings in the literature (Reisinger et al. 2009), the following practical suggestions may be useful to treatment program staff and administrators:

1. Identify patients' self-stated needs and goals relevant to drug treatment through good communication and trust building, and help patients better vocalize their needs and expectations.
2. Carefully examine and consider the patients' prior treatment experiences and meet them where they are in terms of treatment needs and expectations, rather than having a predetermined requirement for treatment for all patients.
3. Tailor treatment to the patients' work schedule. The patients value and need to earn a living and should not be penalized because of employment requirements. This will help reduce barriers to retention.
4. Work with the patients to try and resolve emerging problems, such as noncompliance issues. Rather than have counseling staff assume conflicting duties (i.e., confidant and reporter of rule infractions), it may be preferable to use an ombudsman to help resolve such conflicts.
5. When necessary, actively facilitate program transfer. Program staff should facilitate seamless and direct transfer of patients to other treatment programs and not administratively detox them without a meaningful referral, so that they may be "retained in treatment" elsewhere. This is an approach that should not be reserved only for select and vulnerable patients (e.g., pregnant women) but rather afforded to all patients, as is routinely done in medical care.

Study Limitations and Conclusions

This study has a number of limitations, including the limited sample size and the fact that the data come from one city and hence may not generalize elsewhere. Despite these limitations, it is clear that some involuntarily discharged methadone patients can and do seek admission elsewhere in order to continue their drug treatment. The available data from clinical and community trials support their efforts, given the increased risk of HIV seroconversion, arrest and incarceration and overdose death borne by out-of-treatment heroin-addicted individuals. Treatment programs should do what they can to retain patients in treatment, either at their facility or by arranging a seamless transfer to be "retained in treatment" and continue their care elsewhere.

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