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Premature Discharge from Methadone Treatment:

Patient Perspectives

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Abstract

Longer retention in drug abuse treatment is associated with better patient outcomes and research indicates the first 12 months of methadone treatment are critical to patient success. Nevertheless, large-scale multi-site longitudinal studies over the past three decades indicate that the majority of patients drop out during the first year of methadone treatment. Through an examination of 42 qualitative interviews with patients prematurely discharged from six methadone treatment programs in Baltimore, this paper highlights factors patients describe as contributing to their reasons for being discharged within the first 12 months of the treatment. The two most consistent themes are program-related factors and incarceration. The former factors are richly described through patients' words and underscore the ways in which patients' perceptions of control exerted by the program and by the medication and misunderstandings of program structure can lead to premature discharge. Patients' reasons for discharge were compared to counselors' reasons as indicated in discharge summary forms. An analysis of the patterns of agreement and disagreement are presented. Patient-centered program and policy implications are discussed.

Keywords

Methadone treatment; Discharge; Ethnography

1. Introduction

Methadone treatment has been a mainstay of the US drug abuse treatment system since its inception in the mid 1960s (Dole & Nyswander 1965) and today there are approximately 240,000 patients enrolled in such programs. These programs have been subjected to a large number of studies (Schwartz et al. 2006; Strain et al. 1999; Platt et al. 1998; Metzger et al. 1993; Ball & Ross 1991), and expert (NIH Consensus Statement 1997) and evidence-based reviews (Mattick et al. 2003) that have concluded that they are highly effective in reducing heroin use, HIV-risk behavior and sero-conversion, criminal behavior, and overdose death. While the retention rates in methadone programs far exceed those of other treatment modalities,

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drop-out among methadone patients remains a challenge to treatment service providers (Deck & Carlson 2005; Jackson 2002; Simpson & Sells 1983).

Data from four large-scale, multi-site longitudinal studies conducted over the past 30 years have yielded fairly consistent 12-month methadone program retention rates, ranging from 40% (Simpson & Sells 1983), 34% (Hubbard et al. 1989) and 54% (Simpson et al. 1997). Thus, the majority of patients enrolled in this "long-term treatment" drop out within the first year, leaving considerable room for improvement. Improving retention in methadone treatment is quite important as it has been shown that longer retention in treatment is associated with better patient outcomes and that the first year of treatment is critical (Hartel & Shoenbaum 1998; Simpson et al. 1997; Simpson & Sells 1983).

Understanding the patient-related and program-related factors that are associated with treatment retention and drop-out may provide insights into avoidable factors that contribute to premature discharge. Previous research on patient characteristics associated with greater treatment retention include older age of onset of heroin addiction (Magura et al. 1999; Ball & Ross 1991) and motivation or readiness for treatment (Joe et al. 1998), but not criminal justice status (Fallon 2001; Desmond & Maddux 1996). Prior number of attempts at methadone treatment also appears to be associated with greater retention (Koester et al. 1999; Rhoades et al. 1998).

Factors associated with the methadone programs rather than the patients also appear to play an important and perhaps key role in retention (CSAT 2005; Magura et al. 1998). As noted above, studies have found a wide range of retention rates across programs. The clinic directors' experience and hands on involvement in the clinic operation may have a significant impact on the patient outcomes (Ball & Ross 1991), including retention in treatment (Magura et al. 1999). In addition, higher average methadone dose also has been found to be associated with treatment retention (Strain et al. 1999; Caplehorn & Bell 1991).

In the present paper, we conducted in-depth, semi-structured interviews with 42 participants in six Baltimore-area methadone treatment programs in which the prime focus of the interview was to understand participant perspectives on their treatment experience and reason for discharge within the first 12 months of treatment. We further explored the institutional reasons provided by the treatment programs' discharge summaries for why those participants left treatment prematurely. The present paper is intended to: (1) understand premature methadone program discharge from patients' perspectives; and (2) compare patient and counselor perspectives on reasons for premature discharge.

2. Methods

This study was part of a larger longitudinal examination of entry and engagement in treatment among new admissions to six methadone treatment programs located in the Baltimore metropolitan area and described elsewhere (Schwartz et al. 2008). Samples for the present analyses were drawn from the 60 participants who were discharged within the first 12 months of treatment between December 2004 and June 2006.

From this pool of 60, 42 (70%) in-depth, semi-structured interviews were conducted. Out of the 18 discharged participants who were not interviewed, 10 were discharged without notification of the study staff, four were incarcerated during a four-month period when tape recorders were not allowed inside the corrections facility, and four were lost to follow-up. The interview period was limited to December 2004 and June 2006 because qualitative analysis of the interviews demonstrated we had reached saturation (Kuzel 1999) and no new themes were emerging from continued interviews.

All participants provided informed written consent at the time of their initial recruitment into the parent study. The study was approved by Friends Research Institute's Institutional Review Board.

The semi-structured treatment discharge interviews, developed by the ethnographic research team, were conducted by trained, experienced ethnographers. Interviews were conducted in participants' homes, other locations in their neighborhood, or at the research center site in order to enhance the comfort and convenience of the participants. Approximately a third of the interviews were conducted in jails. Each semi-structured interview lasted between 30 and 90 minutes and covered the participants' drug use history, reason for leaving treatment, their evaluation of their methadone treatment program (MTP), and attitudes concerning MTPs in general. The interviews were transcribed, reviewed for accuracy and completeness, and entered into Atlas.ti.

For each of the interviews, the participants' reason for discharge was categorized by two members of the ethnographic research team (HSR and EAM). The initial process was evolving and the number of categories expanded and contracted as additional interviews were conducted and analyzed. Over time, the categories were distilled into four domains: 1) program-related, 2) dissatisfaction with methadone, 3) life events/logistics, and 4) incarceration.

After the initial phase of categorization was completed, each discharge participant transcript was read and coded in detail by two different research team members who met, discussed, and reached consensus concerning content coding. Transcripts were coded 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 participants' narratives. The two team members who completed the consensus content analysis coding also discussed a participant's primary categorization in one of the four categories described above. If they questioned the original categorization of a participant, they brought the case to the full ethnographic team for final consensus on the participant's categorization.

In addition to interviews, the discharge summary reports for all program participants who prematurely left treatment were collected from clinic records and compared to the participants' explanations as to why they were no longer attending treatment. The participant's primary counselor was responsible for completing the discharge summary report. Each form has space for a short narrative regarding the patient's treatment progress. It also lists eight categories (completed treatment no substance use in past 30 days; completed treatment some substance use in the past 30 days; referred for further treatment; did not complete treatment; program decision to discharge due to non-compliance with rules; client stopped attending; incarceration; and, death) for the counselor to choose from to classify the reason the patient is no longer in treatment. The categories are standardized across the State of Maryland for reporting purposes.

3. Results

3.1 Characteristics of Interviewed Discharged Participants

Forty-two participants out of the total discharge sample of 60, were interviewed for this study. The length of treatment prior to discharge of the total sample ranged from 2 days to 363 days, with an average treatment length of 138 days. Of the interviewed participants, twenty-seven (64.3%) were African American and 15 (35.7%) were Caucasian. The mean age was 40.4 years, 25 (59.5%) were men, 31 (73.8%) reported injecting heroin, and the sample had a mean of 2.8 lifetime drug abuse treatment episodes. As shown in Table 1, overall characteristics of those interviewed were comparable to the non-interviewed discharge sample.

3.2 Reasons for Discharge: Comparison of Participant Interviews and Program Discharge Reports

In this section, we describe the four categories that finally emerged from our 42 interviews with participants who were discharged within a year of entering treatment. These four themes attempt to categorize participants' perspectives on why they left treatment. Table 2 provides a descriptive comparison of the participants who were categorized into each of the four themes.

3.2.1 Program-Related Reasons—Program-related is a broad category that covers conflicts with program staff, administrative detoxification for nonpayment of fees, breaking program rules, and general dissatisfaction with the program. This broad category describes the plurality of patients who left methadone treatment (n = 17; 40.5%). The subcategories below provide more detail about what constitutes this category. Nearly two-thirds of the patients in this category were male, and nearly two-thirds were African American. On average, they remained in treatment 140 days.

3.2.1a Disagreement with Program Rules: Several participants expressed frustration or disagreement with program policies and procedures, often because they believed the rules hindered their ability to progress in the life changes they were attempting to make. Frustration mounted when participants felt the rules were being inconsistently applied or continuously changed. Program-related problems that led to participants leaving or being discharged from treatment often developed over time with one frustration building on top of another.

One discharged participant with whom we talked was homeless and was focused on obtaining a job in construction, his past occupation. He had a specific plan for getting back on his feet and he did not see changing his living situation as a top priority. He believed that his counselor, on the other hand, saw things differently.

> Participant (P): See, I'm trying to get my take home so I can go back to work so I don't have to go there every day. (...)Every time she {his counselor} asked me to do something before I got take home I would do it and I'd get thrown something else. And then she finally came up to me (...) and she goes, "Well, you don't have a stable house here. [You can't,] no matter what you do." You know. So I was really bummed. (...) "I'm out of here." So that very next day I think I was on another program, just so happened it fell my way. I got lucky, you know.[1]

- 43 year-old white man who was in treatment for two months prior to discharge

This participant believed he had a clear understanding of the rules as they were laid out to him. He had a sense of what he needed to do in treatment to successfully obtain take homes, but he felt his counselor had changed the rules as they went along. He was hopeful that the new methadone program to which he transferred understood his needs.

A 39-year-old African American grandmother who was discharged after 4.5 months from admission, instead saw the rules at the program as inconsistently and unfairly applied. She was a grandmother struggling to stay off heroin and care for her grandchildren, but the program

[1]Standard notations have been used in transcribing and editing the quotes for the paper. Place names and other identifying information have been removed.
The notions are as follows:
--, To denote the speaker interrupting himself or herself in the flow of conversation.
... To denote longer pauses in speech.
(...) To denote omitted text for the sake of clarity or brevity for the paper.
[—] To bracket words that are "best guesses" because they are not clear on the recording. Also includes short interviewer responses within larger flow of the interviewee's responses.
{—} To denote words that were inserted by the authors either to remove identified place names or to provide clarity.

had a policy that did not permit patients to bring children to the clinic. At the same time, she believed she saw patients from the clinic using drugs without consequence.

> P: I was babysitting the kids when they had detoxed me off of {the MTP} and I was very upset about that. Because they just detoxed me off just like that. And there's plenty people go to that program and they be taking pills, different stuff and they [not] getting detoxed. I think it was wrong because--, that's why I took it to the board. (...)
>
> Interviewer (I): Okay, okay. So do you want to talk a little bit about what went on while you were there?
>
> P: Nothing I was just watching my grandkids. It was like they was kind of like act like they didn't want no kids there. Like I bring the kids with me right. I bring my grandkids. They was like even if I give somebody five dollars for holding my grandkids so they could sit on the steps. They still ain't want no kids there.

The participant was upset by what she saw as unfair handling of policies and procedures and an inconsistent application of rules depending on the patient. She stated this feeling specifically when comparing her discharge for breaking the "no children" rule to drug use around the clinic, but she later implied the "no children" rule was inconsistently applied as well. It is, of course, possible that there were other reasons from the point of view of the counselor that this participant was discharged beyond the child care issue. Fortunately for the participant, she transferred to another clinic that provided childcare—and where she felt she was treated fairly.

3.2.1b Conflict with Program Staff: Clearly, the previous participants also had conflicts with program staff; however, at least seven individuals discussed conflicts with staff as the main reasons they left treatment and this did not include those participants who were discharged for late or nonpayment of fees or those with work conflicts. Some had conflicts with their counselors, which escalated into confrontations for which they were discharged from the clinic. Some of these participants asked to be transferred to another counselor because of a conflict with their present counselor, but were refused by the program director. The next participant, a 37 year old African American woman, is an example of a participant who asked the director for a change in counselors. When she did not see the results she wanted, she took it a step further.

> P: Well, it started with me and my counselor. We just we wasn't hitting it at all, so when I would go to the Director and he was saying, you know, that he believes in his staff and I didn't think that that was right, so I went over top of them. And it was like when I went over top of them then the next day I'll have problems with the clinic and due to the big peoples came out there and, you know, they came back and they was threatening me, talking about I can tell anybody whatever I want to tell them, you know, its up to me. I just really wasn't happy there so I stayed dirty all the time. And it's like now that I'm at a new clinic everything is just fine. I been doing good, I am so proud of myself because I got like five or six clean urines and stuff. I'm getting ready for my first take home.

- 37 year-old, African-American woman discharged after five months

This participant was officially "referred" to another clinic across town, according to her discharge summary report.

Similar to this participant, the next quotation is from a 46 year-old African American man who was struggling with his addiction while at the program, so much so that he tried to substitute someone else's urine for his "dirty" urine. The program caught him breaking the rules and discharged him, but as he continued to talk about his discharge other underlying problems appear to emerge:

> And then me and my counselor, right? Which I thought she was a good lady--, she is a good lady but what I mean by what I thought she was in a [way] she was like trying to give me tough love. I'm a grown man. I don't need nobody, you know, I've been out on the streets long enough. I might not be the educated way that she is, you know, as far as to give counseling at this stage. But I just walked off.

- 46 year-old African-American man discharged after five months

Although substituting someone else's urine for his own was the reason he was discharged from the program, the participant did not believe that the "tough love" approach would work with him. His comments also highlight a common perception of patients who feel their "street" education was not respected when compared to their counselors' formal education.

3.2.1c Feetox: One of the program-related patient discharge issues that elicited strong reactions from the participants was discharge from the program because of nonpayment of fees. Maryland grantfunded programs are not permitted by state policy to discharge indigent patients solely for inability to pay clinic fees. However, some patients see programs giving mere lip-service to this policy rather than adhering to it. Four patients were discharged for being behind on payments.

> P: I went to go see {the physician}. I paid, um, we paid a couple weeks ahead, in advance, my wife and I both. But we had a lapse in between work and we fell not quite a week behind. They put us in a, in, what they call, feetox. It's a, in which they start detoxing you because you can't pay. And I said, "You can't give me an extension?" You know what I'm saying? And they were just—, they had just got my dose to where it should be at and the next day they feetoxed me. So it took them two weeks to up my dose to normal. Really upset me. (...) So I got disgusted. And then I tried to—, my wife stayed on the program about a month after I got detoxed off because I gave her my money to get her account caught up. And, um, I'm willing to seek other treatment but I called detox centers, It [costs]. It's all about money. It's all about money.

- 37 year-old white man discharged after one month of treatment

3.2.1d Schedule Conflicts: The last program-related issue that caused patients to leave treatment prematurely was scheduling conflicts between the methadone program hours and the patient working a newlyacquired job. Juggling schedules is a common theme for many methadone patients, as well as long, complicated public transportation routes to get to the one methadone program that had an open slot, trying to complete probation requirements, taking care of family obligations, and trying to find a job. However, if they manage to find a job, maintaining their methadone treatment program requirements and work schedule can be a difficult task. One participant worked 12-hour shifts, which did not allow him time to get to the methadone clinic before or after work during the clinic's hours. Another participant found a good construction job, but it came with a 1½-hour commute that did not allow him to make it to the clinic in time despite numerous efforts. Three individuals decided they had to choose work over maintaining contact with their MTP.

3.2.1e Other Program-Related Reasons: Two other reasons given by participants for being discharged were consistently positive drug tests and missing three consecutive days of medication. Generally, patients who continue to use illicit drugs in an outpatient drug-free treatment setting are referred to a higher level of care, such as an intensive outpatient program or inpatient rehabilitation program. The options in Baltimore for such treatment for methadone patients are quite limited and many patients will not accept these referrals for a variety of reasons, even if they are available. These reasons may include not wanting to discontinue illicit

drug use, not being able to leave their children to attend the program, not wanting intensive counseling, needing to continue to work or hustle for money, and other reasons. Missing consecutive doses may result from many factors, such as a brief incarceration or hospitalization, or a drug binge. Patients are generally not re-admitted unless they can prove they were incarcerated or hospitalized.

3.2.2 Dissatisfaction with Methadone—Another reason for leaving treatment prematurely that participants discussed was a desire to stop taking methadone. Nearly 12% (n = 5) of the discharged participants who were interviewed expressed that they did not want to be on methadone as their primary reason for leaving treatment. All were African American; three were female and two were male; their average age was 40. The reasons they no longer wanted to be on methadone were varied, complex, and mostly centered on the issue of control.

Several participants described a desire to be free of all addiction in their lives. Although an "addiction" to methadone was recognized as different from an addiction to heroin, the bottom line was that it was still viewed as an addiction to them. As one participant said, "I didn't want to become dependent upon methadone," while another described it as "substituting one drug for another."

The next participant has a similar perspective, but went about leaving treatment in a much more complicated way.

> "Between me and you, I got on the program and I know a lot of people that have been there for years and years, and with me, I got on it and, and it really didn't take to me, right? Because I didn't--, I started really depending, you know, on, on methadone. And I didn't--, well, I didn't want to be dependent on anything. That's why I joined the methadone program so I won't be dependent on heroin or nothing. And I did it for a while. It was working out at first. But then I seen myself abusing it. You know, at first I was using it for its purposes. Its purpose was to stop using heroin, do that, that'd keep the urges down, the desire down, and I'd do that, and I won't have to, you know, go out in the streets and hustle or, or do crime or steal or anything. And it was working, but then it got to the point where it, where it didn't work. Where I had to change my lifestyle as far as work, family, my granddaughter, babysitter, and daycare stuff. So I had to rearrange stuff in order to get there {the clinic} at that certain time every day and it became a little hectic. It became a little hectic. So, so the long--, the bottom line was I decided I wanted to get off the program because it became like a schedule, like I had to do this.

- 40 year-old African-American man discharged after three-and-a-half months

For this participant, much of his desire to be off of methadone was his perception that yet another drug controlled his life. He appreciated not having to engage in a criminal lifestyle, but was frustrated by the schedule he had to keep at the methadone clinic. Although his frustration with the strict schedule of a methadone clinic could also fall under the "program-related" category, the meaning and logic with which he describes leaving the clinic is framed in a desire to be free of addiction, much like others we interviewed. This participant took a more extreme approach, however, and started using heroin to get detoxified and discharged from the program. (The decrease and then subsequent increase was documented in his patient record at the treatment program.) When asked why he did not just tell his counselor he wanted to be detoxified, he said they would have told him he had not been at the program long enough and he did not "really want to step on toes or anything" because he wanted to keep a door open in case he wanted to return later in his life.

The descriptions of the desire to be off methadone became even more emotionally powerful when the participants' words and meanings painted a visceral portrayal of fear. As this participant said, "You know because I been on the program but I was scared of being dependent." The following 41 year-old African American man, who also spoke of taking methadone as substituting one drug for another, also expressed similar fears.

> P: I just didn't feel like I wanted to go along with it, you know, and I said to myself, even when I got on it, 60 days, I didn't tell them, but I said 60 days and I'm off this crap. That didn't even last 60 days. 'Cause the more close that I got to the month then the phobia setting in. (I: What kind of phobia?) The phobia of me not being able to be detox appropriately. And, somewhat abandoned, left out in the wilderness with a habit, once again.

- 41 year-old African-American man discharged after one month

In the discharge interviews, it was a fairly common occurrence to hear participants express a preset and self-determined timeframe for being on methadone. His deadline of 60 days was very short on the time scale. The usual timeframe was six months. A 36 year-old African American woman, who set a timeframe of six months for herself, felt God intervened to keep her at the methadone clinic longer. However, even with intervention from a higher power, she decided one year was the maximum. At 331 days, she transferred to a drug-free residential treatment center where she was detoxified from methadone.

> P: You know what, God knew what was in my heart, so I didn't make a decision it just happened that way. [I: Okay.] I always said I wasn't going to stay no more longer than a year. So, it just happened in the time that it was suppose to happen. I wanted to do six months. But, six months grew into seven months, eight months, nine months. It goes worse and worse, worse for me. So, like I say, I don't know it was just some power greater than me.

- 36 year-old, African-American woman discharged after eleven months

For some it was the control methadone exerted over their lives, a control that reminded them of their addiction to heroin. Others felt it necessary to exert their own control in a predetermined way and set deadlines on their treatment. Either way, these participants were not able to reconcile their desire to control their own lives with methadone as an opioid-agonist treatment or as a treatment modality.

3.2.2a Counter Points to Those Who Were Dissatisfied with Methadone: As a check to insure rigor in ethnographic research, we often look for counter examples or "negative cases" to test our conclusions and theories (Agar 1996; Mays & Pope 2006; Morse 1999). Powerful counterpoints to the fears and desires of the previous participants were positive perspectives of methadone. Counter points that two participants expressed above and are often included in policy statements supporting opioid-agonist therapies include leaving a criminal lifestyle and removing the financial drain of supporting a drug addiction. Related to these points, other patients talked about finding stability and structure in the methadone program that helped them move on with their lives. However, one counter point very specific to methadone as a treatment modality was the perspective of two participants who also left their methadone program prematurely, one because he was incarcerated and the other because she was no longer with her boyfriend and lost her income source. For them, methadone took care of the physical concerns of withdrawal and allowed them to focus on their mental health.

> P: And like saying just in the amount of short time dealing with the staff there I was working on the mental part so the methadone program has helped too because I wasn't craving.

- 51 year-old African-American man discharged after one week of treatment

> It was the whole purpose of getting help anyway is the counseling and medication. Medication alone isn't going to get you well.

- 52 year-old white woman discharged after two months of treatment

These two participants' perspectives shed light on how differently participants can view methadone treatment. Although both had similar treatment outcomes to the other five in this category, they regret no longer being at their methadone treatment program, and the 51 year-old male, in particular, felt that leaving the program was not under his control.

3.2.3 Life Event/Logistics—In many ways, life events/logistics is a catch-all category; however, the complicated series of events that lead to changes in treatment status are important to consider. Three of the four participants in this category were women. Half were African American and half were white. They averaged 43 years of age. They also had the fewest number of days in treatment than any other group 43.3 days (range: 2-77).

Two of the women in this category left after financial problems led to evictions from their homes. The first participant's boyfriend, as mentioned above, was also her source of financial support. The second woman had plans to leave the state with her husband who had recently lost his job. He was not from Baltimore and he wanted to try to re-build their lives in his hometown; she was a life-long Baltimorean and was struggling with the decision to leave her family and the place she knew. She was only in treatment for two days and it was difficult to understand why she even enrolled in treatment; however, it was clear that the anticipation of moving was feeding her habit and keeping her out of treatment.

> P: I plan on getting back to another program. I need too. Right now, like I'm staying w my mother. I don't know what my situation is going to be. I don't know if I'm staying in Baltimore, see I don't even want to start with no program and then have to leave.

- 38 year-old white woman discharged after 2 days of treatment

Both of these women struggled with a series of stressful events in their lives which led to a decision to leave treatment.

Of the other two participants, one left treatment because she was at a program that took "over half the day" to get to on public transportation. After she left treatment, she was incarcerated, but found a program closer to her home after she was released. The other participant was hospitalized for 12 weeks to receive intravenous antibiotics for an infection in his hip. During our interview with him, he insisted that he plans to return to treatment after he leaves the hospital.

> P: Once I leave here though I'm going to get back out there. I just have to take my discharge papers to my counselor and go from there. But they know I'm here.

- 51 year-old African-American male discharged after 2 ½ months of treatment

3.2.4 Incarceration—In the discharge sample we interviewed, incarceration was one of the two main reasons patients were not retained in treatment, with 38.1% (n = 16), stating that they were no longer in treatment because of an arrest. Seven were white and the remaining nine were African American. Women comprised about one-third (n = 5) of the individuals who were incarcerated. Their average age was 39. Many of the arrests were for minor charges (e.g., trespassing, loitering) or system-initiated arrests (e.g., warrant issued for violation of probation); however, several were also related to personal drug use (e.g., possession, robbery

to obtain money to buy drugs). We did not ask participants directly what they were arrested for in an effort to maintain rapport; therefore, we do not have the self-reported reason for discharge for all participants we interviewed.

Although contact with the criminal justice system can be a catalyst for entering treatment (Nurco et al. 1995; Anglin & Hser 1990), it is also a major reason for premature discharge from treatment, and can have detrimental effects on those patients in methadone treatment (Fiscella et al. 2004).

While we were concentrating on conducting discharge interviews, the Baltimore City Police Department was pursuing the "broken window's theory" of policing in which "quality of life" infractions (e.g., loitering, open container) were pursued, leading to a marked increase in the number of arrests in the city (Janis 2007). This increase in petty arrests was described by our participants with anger and frustration.

> P: See and this here's getting to be really ridiculous. I've been living in a neighborhood twenty-five, thirty years and I can't even walk the streets in my own neighborhood without being pulled up and being charged with trespassing. That's ridiculous, I'm {age} years old, you know. I'm not being charged with narcotics, murder or rape. I'm being charged with trespassing, [I: Where you live?] that's ridiculous, this is a police state man. This is a police city, it's terrible you know. I mean when I was out there doing a little something-something I didn't have this happen. Then when you try to do right, man you can't even walk the streets, that's ridiculous, {interviewer's name}, you know. Seriously I got grandkids now. I don't need to be running up in no places like this {jail}.

- 51 year-old African-American man discharged after 7 days in treatment

This was a particularly troubling phenomenon when witnessing the disruption it caused in the lives of methadone patients trying to get their lives back together.

Besides the police strategies during that time, the participants often had legal problem from their past that may have increased their chances of being incarcerated during their treatment. When these past legal problems then surfaced while the participant was in treatment, it could lead to a disruption in their methadone dosing and treatment. Unfortunately, patients often did not inform their counselors so they could plan for the impending arrest.

> P: I was just determined to not let this get to me anymore as far as the drugs and... So, I be trying {the MTP}. And, you know, things were doing okay you know what I'm saying because you know I was starting to function. I wasn't taking my money and blowing it. I was using it for the right reasons and it was just I was functioning, you know, but unfortunately, I got a court order and I got locked up. [I: And, you said you knew that was coming.] I knew it was coming, I just didn't want to put it out there, I knew it was coming. I didn't want to tell them. I knew it was coming. I had a violation for drug court, because I didn't do a progress report and also I had a violation for not going to court for another case, and that was because I was out there using {prior to treatment}, you know. I stayed in jail from like July until like September. I came home and I said I'm gonna take this and run with it. I didn't want to get high no way any more. And, I just made up my mind that that was it. (...) I come home and I'm not goin' to mess with any of it. And I did you know. I did...

- 38 year-old African American man discharged after four weeks

As this participant stated, he knew his arrest was coming, but he "didn't want to put it out there", so he and his counselor could not plan for what might happen during his arrest or set

up a transition plan upon his release. However, he was drug-free during his incarceration and decided to "take this and run with it" when he returned home. This response was a very common one we heard from incarcerated individuals, either that they were remaining drug free upon their release from jail or that they planned to remain drug free. We did not confirm post-incarceration abstinence, but studies indicate that relapse after release is common (Nurco et al. 1991; Maddux & Desmond 1981).

In addition, several of the participants experienced barriers to returning to treatment after incarceration.

> P: And the rules is that as long as you report at least a day after you're released you can be reinstated on it, which I did. I went over there I got released {specific date} on a Monday. I went over there {specific date} that Tuesday. And of all paperwork--, I didn't have--, I couldn't find the paperwork that had my expiration date on it. But I gave them a copy of my arrest on my charge papers. They still got them. And they said that, and they medicated me that day, that Tuesday that night for {specific date}. And they said I wouldn't be able to continue on medication unless I had proof of my release and I could never find the expiration date on it. And the day that my counselor called me, what's her name, {name}, or something, she called me the day I was suppose to have met her which see I got arrested.

- 51 year-old African-American male discharged after 7 days of treatment

This participant had experience with re-entering treatment after an arrest prior to this incarceration and was still unable to navigate a system that required "release date" paperwork rather than just charge papers. One of the female participants was convinced that if she would have called the treatment program when she was incarcerated she would have been able to return, but since she did not call she did not even attempt to re-enter treatment. However, one of the reasons may have been the excruciatingly painful withdrawal she experienced while in jail. Experiencing withdrawal symptoms while in jail was a barrier to re-entering treatment, but we also found it was a barrier to ever entering treatment for many opioid-addicted individuals (Mitchell, et al., in press).

The pain from withdrawal, the strategies employed by the participants to deal with withdrawal, and the belief that methadone withdrawal is worse than heroin withdrawal all contributed to participants being less likely to return to treatment, especially when the incarceration lasted more than a few days. The lack of connection between the treatment and the corrections systems is a significant contributor to treatment interruption.

3.3 Comparison of Participant and Counselor Reasons

Included in this analysis is a comparison of participants' reasons for leaving treatment with the reason the counselor indicated on the discharge summary report (see Table 3). One challenge in making this comparison is that the counselor discharge form has pre-determined categories for discharge that offer an evaluation of the patients' conduct in treatment, while research participants were able to talk about why they were no longer in treatment in whatever way they chose. Although this may raise methodological questions when making the comparison, it is important to remember the purpose of the discharge summary report. It is a document that, in theory, travels with the participant to his/her next treatment episode, and so could affect treatment planning in his/her next attempt at recovery.

The lack of agreement between the reasons given by participants' for treatment discharge and the reasons provided by the counselor on the discharge summary seems to indicate that counselors frequently lack knowledge concerning the participants' situation at discharge (e.g., incarceration) or their stated reasons for discharge. Whether counselors do not know because

they are overburdened with a large caseload or because of the challenges of following up with patients after they have left treatment, it is difficult to improve services without feedback from those who decided to leave the program. For example, the non-descript category of "left before completing treatment" is the most common reason counselors filled in when describing why a patient was prematurely discharged from a program. More than 50% of participants who were incarcerated were listed in this category. On the other hand, the category that is most consistent between participant and counselor reasons is "program-related." Thirty-five percent were discharged for not complying with program rules, many of which included conflicts with counselors. This category is also the one with the most referrals of participants to other treatment programs. This referral may be beneficial to participants if they are able to find treatment at a clinic closer to their home or that more closely meets their expectations of treatment; however, it may also indicate a shifting of "problem" patients to other programs in the city.

4. Discussion

This study provides a rare glimpse into the methadone patient perspectives on reasons for their discharge from treatment. While methadone treatment has relatively high retention rates as compared to other ambulatory types of drug-abuse treatment, studies indicate that the majority of newly admitted patients are discharged within the critical first 12 months (Magura et al. 1999′ Simpson et al. 1999; Hubbard et al. 1989). Because good patient outcomes have been shown to be related to longer treatment retention (Hartel & Schoenbaum 1998; Hubbard et al. 1997), it is critical to understand the reasons patients leave treatment in order to formulate an effective strategy to proactively address possible drop-out.

Program-related reasons for discharge included a disagreement over program rules, conflict with counselor, "feetox," and schedule conflicts. These frequent reasons for discharge have nothing to do with the pharmacology of methadone or with therapeutic counseling. While it has been found that the clinic director sets the policy and tone for the clinic (Magura et al. 1999; Ball & Ross 1991) and MTP directors could reduce administrative discharge (Jackson 2002), it is generally up to the counselor to provide enforcement and interpretation of the clinic rules. This enforcement role may put the counselors in conflict with their therapeutic role. Clinic rules regarding issues such as take home doses, hours of operation, number of consecutive missed doses that are permitted, bringing children into the clinic, and a variety of other matters vary considerably and are of great importance to the patient population. These rules have not been a subject of study, although from the perspective of the patient, they play a key role in satisfaction and retention.

In the common circumstance in which methadone treatment is in short supply, patients may have limited choices about which clinic they can attend. This circumstance may put some patients into a submissive and dependent relationship with the program (Hunt & Rosenbaum 1998). Some discharged study participants did not seem able to successfully negotiate clinic rules with the counselor or program administrators. Moreover, in clinics with high case loads, it may be difficult for patients to receive individualized attention. This situation has been exacerbated over the past several decades as the funding for methadone programs has been eroded, counselor case loads have increased and the number and variety of services received by patients has declined (Hubbard et al. 1997; Etheridge et al. 1995).

The financial pressure under which public programs operate may lead them to "feetox" patients. Although some providers may harbor a belief that it is "therapeutic" for patients to contribute fees even if they are indigent, the data seem to indicate the opposite. There is evidence from clinical trials that heroin-addicted individuals who are provided free treatment are more likely to enter and remain in treatment than those who are required to pay (Booth et al. 2004;

Kwiatkowski et al 2000). Given the higher costs associated with treatment admission related to staff effort and laboratory testing as well as the potential societal costs associated with relapse from discharged patients, the overall costs of discharging patients for non-fee payment may exceed the benefits of receiving the small fee payment.

Possible approaches to deal with program-related reasons for discharge include having rules clearly communicated to the patients at admission and throughout treatment, having a clearly described and fairly implemented system of appeal (CSAT 2005), which includes a patient advocate and appeal to an outside authority (such as the funder), and the ability to switch counselors when conflicts are insurmountable. It would also be interesting to consider separating the counseling function from the rule enforcement function to try to improve rapport with counselors and improve patient satisfaction. Another alternative would be to have a discharge team of clinical experts to review each case prior to discharge and to make alternative treatment recommendations or transfer to another program when discharge is determined to be the best course. Considering the increase in overdose deaths associated with premature discharge from methadone treatment (Clausen et al. 2008; Zanis & Woody 1998), discharge from treatment is to be avoided if possible and more research is needed to determine the best approaches to these issues.

The disconnect between the criminal justice system and the methadone treatment system has been a long-standing problem in most jurisdictions in the US. With few exceptions, such as at Rikers Island in New York, incarcerated methadone patients are not provided continued methadone treatment in jail, a gradual methadone dose reduction, or reconnection to the program upon release (Schwartz et al. 2007; Rich et al. 2005; Magura et al. 1993). This disconnect creates a strong disincentive for patients to enter methadone treatment and exposes them to overdose death and relapse upon release. Indeed, several international studies have now indicated that heroin-addicted individuals are at high risk of overdose death upon release from incarceration (Farrell & Marsden 2007). This increased risk of overdose death is particularly problematic given the large number of patients who may be arrested for minor charges or technical violations of probation or parole. Fortunately, there has been a growing interest in providing methadone treatment in correctional facilities (Smith-Rohrberg et al. 2004) and Baltimore began providing methadone during pre-trial detention to incarcerated methadone patients in January 2008.

It is ironic that some patients report not wanting to be on methadone for an extended period of time, fearing a “life-time” of methadone maintenance, when retention data indicates that the majority of new admissions drop out within the first year. Some patients do not appear to be able to tell clinic staff at admission that they intend to remain in treatment for only a limited amount of time because they may correctly assume that they might not be admitted to the program. A potential alternative to this false dichotomy of maintenance or detoxification would be to permit patients to enroll in the clinic for the length of time of their choosing at the outset and then to work with them to determine whether they chose to remain in the clinic for longer periods of time. This strategy might engage more patients than categorically refusing any patient but one who states a desire for maintenance therapy. Although short-term methadone treatment has been shown to have inferior outcomes to longer term treatment (O’Brien 2005), providing it might be a better engagement strategy if accompanied by patient education and a quick return to treatment following any relapse. A consistent, thorough, and evidence-based patient education program may be of use to deal with this pervasive issue.

In summary, there appear to be two treatment perspectives which emerge. The clinic can view its patients as consumers of service who expend their time and energy and sometimes their money to engage in treatment. The alternative view is the classic patient as the beneficiary of services for whom treatment is a privilege provided by the clinicians and the public health

service. Where the patients are viewed as consumers, the staff would be concerned with attracting them by making available hours that meet their need, flexible clinic rules and services such as child care appropriate to the patients' needs. Where the participant is a beneficiary of services, activities are done to the patient in line with the structure and system that meets the needs of the program as much as or more than those of the patient.

Of course, no health care system is unidimensional, yet the methadone treatment programs could usefully make effort to more largely view patients as consumers of services (Hunt & Rosenbaum 1998) than as the beneficiaries of the programs' largesse. Where patients are consumers, programs feel an increased responsibility to adapt procedures and services to meet the needs and concerns of its patients. That may involve the modification of rules to meet the scheduling needs of patients (e.g., use of hours that accommodate individuals' work schedule and child care responsibilities), as well as the incorporation of services to meet particular concerns (e.g, providing a play area for patients' children, linkages to mental and physical health and others).

In contrast, where the patient is viewed as a beneficiary of the program's largesse, he or she is given none or at best a narrow range of options in a more nearly inflexible treatment paradigm. Where the weight of emphasis is on the patient as beneficiary only, there is built into methadone programs a potential for conflict between patient and program. In conflict between two unequal forces, the weaker either yields without commitment, or leaves the situation when the conflict becomes sufficiently untenable, i.e., where the disadvantages of staying are seen to outweigh the advantages. Interestingly, several participants in this study resolved their conflict with their original clinic by leaving and successfully "shopping," as a consumer might, for another clinic. Thus regardless of the particular clinic's view, patients did not leave treatment because they were rejecting the idea — or work--- of behavior change. They left the clinic because the program wasn't meeting their needs and concerns. As consumers will, they went shopping for a program that would meet those needs and concerns.

Several limitations in this study should be noted. First, participants may not have been representing their reasons for discharge accurately because of social desirability or lack of insight. As interviews with discharged patients were not conducted at the actual time of discharge, it is possible that their memory of events may have been clouded or modified with the course of time. Finally, the counselor perspective on discharge was based solely on the discharge form and not on an ethnographic interview. Despite these limitations, the data provided by participants has provided a rare glimpse of their view of treatment and reasons for leaving treatment. It is hoped that these data can be used to improve approaches to treatment to afford patients and treatment programs improved outcomes.

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References

Agar, MH. Professional Stranger: An Informal Introduction to Ethnography. Vol. 2nd. Academic Press; San Diego: 1996.

Anglin, MD.; Hser, Y. Legal coercion and drug abuse treatment: Research findings and social policy implications. In: Inciardi, JA., editor. Handbook of Drug Control in the United States. Greenwood Press; New York: 1990.

Ball, JC.; Ross, A. The Effectiveness of Methadone MaintenanceTtreatment. Springer-Verlag; New York: 1991.

Booth RE, Corsi KF, Mikulich-Gilbertson SK. Factors associated with methadone maintenance treatment retention among street-recruited injection drug users. Drug and Alcohol Dependence 2004;74(2):177–85. [PubMed: 15099661]

Center for Substance Abuse Treatment (CSAT). Medication-assisted Treatment for Opioid Addiction in Opioid Treatment Programs. Substance Abuse and Mental Health Administration; Rockville, MD:

Caplehorn JR, Bell J. Methadone dosage and retention of patients in maintenance treatment. The Medical Journal of Australia 1991;154(3):195–9. [PubMed: 1988793]

Clausen T, Anchersen K, Waal H. Mortality prior to, during and after opioid maintenance treatment (OMT): A national prospective cross-registry study. Drug and Alcohol Dependence 2008;94(13):151–7. [PubMed: 18155364]

Deck D, Carlson MJ. Retention in publicly funded methadone maintenance treatment in two western states. Journal of Behavioral Health Services & Research 2005;32(1):43–60. [PubMed: 15632797]

Desmond DP, Maddux JF. Compulsory supervision and methadone maintenance. Journal of Substance Abuse Treatment 1996;13(1):79–83. [PubMed: 8699547]

Dole VP, Nyswander M. A medical treatment for diacetylmorphine heroin addiction: A clinical trial with methadone hydrochloride. Journal of the American Medical Association 1965;193:80–4.

Etheridge RM, Craddock SG, Dunteman GH, Hubbard RL. Treatment services in two national studies of community-based drug abuse treatment programs. Journal Substance Abuse Treatment 1995;7(1): 9–26.

Fallon BM. The Key Extended Entry Program (KEEP): From the community side of the bridge. The Mount Sinai Journal of Medicine 2001;68(1):21–7.

Farrell M, Marsden J. Acute risk of drug-related death among newly released prisoners in England and Wales. Addiction 2007;103(2):251–5. [PubMed: 18199304]

Fiscella K, Moore A, Engerman J, Meldrum S. Jail management of arrestees/inmates enrolled in community methadone maintenance programs. Journal of Urban Health 2004;81(4):645–54. [PubMed: 15466845]

Hartel DM, Schoenbaum EE. Methadone treatment protects against HIV infection: two decades of experience in the Bronx, New York City. Public Health Reports 1998;113(Suppl 1):107–15. [PubMed: 9722816]

Hunt, G.; Rosenbaum, M. Hustling within the clinic: Consumer perspectives on methadone maintenance. In: Inciardi, JA.; Harrison, LD., editors. Heroin in the Age of Crack Cocaine. Sage Publications, Inc.; Thousand Oaks, CA: 1998.

Hubbard, RL.; Marsden, ME.; Rachal, JV.; Harwood, HJ.; Cavanaugh, ER.; Ginzburg, HM. Drug Abuse Treatment a National Study of Effectiveness. The University of North Carolina Press; Chapel Hill: 1989.

Hubbard RL, Craddock G, Flynn PM, Anderson J, Etheridge RM. Overview of 1-year follow-up outcomes of the Drug Abuse Treatment Outcome Study (DATOS). Psychology of Addictive Behaviors 1997;11(4):261–78.

Hunt, G.; Rosenbaum, M. “Hustling” within the clinic: Consumer perspectives on methadone maintenance. In: Inciardi, JA.; Harrison, LDLD., editors. Heroin in the Age of Crack Cocaine. Sage Publications, Inc.; Thousand Oaks, CA: 1998.

Jackson TR. Treatment practice and research issues in improving treatment outcomes. Science and Perspectives 2002;1(July):22–9.

Janis S. Arrests fail to cut homicide rate. Baltimore Examiner 2007:24.

Joe GW, Simpson DD, Broome KM. Effects of readiness for drug abuse treatment on client retention and assessment of process. Addiction 1998;93(8):1177–90. [PubMed: 9813899]

Koester S, Anderson K, Hoffer L. Active heroin injectors’ perceptions and use of methadone maintenance treatment: Cynical performance or self-prescribed risk reduction? Substance Use and Misuse 1999;34 (14):2135–53. [PubMed: 10573308]

Kwiatkowski CF, Booth RE, Lloyd LV. The effects of offering free treatment to street-recruited opioid injectors. Addiction 2000;95(5):697–704. [PubMed: 10885044]

Kuzel, AJ. Sampling in Qualitative Inquiry. In: Crabtree, BF.; Miller, WL., editors. Doing Qualitative Research. Vol. 2nd. Sage Publications; Thousand Oaks, CA: 1999.

Maddux, JF.; Desmond, DP. Careers of Opioid Users. Praeger; New York, NY: 1981.

Magura S, Nwakese PC, Demsky S. Pre- and in- treatment predictors of retention in methadone treatment using survival analysis. Addiction 1998;93(1):51–61. [PubMed: 9624711]

Magura S, Nwakeze PC, Kang SY, Demsky S. Program quality effects on patient outcomes during methadone maintenance: a study of 17 clinics. Substance Use and Misuse 1999;34(9):1299–324. [PubMed: 10419225]

Magura S, Rosenblum A, Lewis C, Joseph H. The effectiveness of in-jail methadone maintenance. Journal of Drug Issues 1993;23(1):75–99.

MattickRPKimberBCDavoliMMethadone Maintenance Therapy versus No Opioid Replacement Therapy for Opioid Dependence The Cochrane Database of Systematic Reviews, Issue 2, Art. No.: CD002209. DOI: 10.1002/14651858.CD0022209.2003

Mays, N.; Pope, C. Quality in Qualitative Health Research. In: Mays, N.; Pope, C., editors. Qualitative Research in Health Care. Vol. 3rd. Blackwell Publishing; Massachusetts, USA: 2006.

Metzger DS, Woody GE, McLellan AT, O'Brien CP, Druley P, Navaline H, et al. Human immunodeficiency virus seroconversion among intravenous drug users in-and out-of-treatment: An 18-month prospective follow-up. Journal of Acquired Immune Deficiency Syndromes 1993;6(9): 1049–56. [PubMed: 8340896]

MitchellSGKellySMBrownBSReisingerHSPetersonJARuhfA (in press). Incarceration and opioid withdrawal: The experiences of methadone patients and out-of-treatment heroin users. Journal of Psychoactive Drugs

Morse JM. Qualitative Generalizability. Qualitative Health Research 1999;9(1):5–6.

NIH Consensus Statement NIH Consensus Statement 1997. Nov. 17-19 Effectiveness Medical Treatment of Opiate Addiction1997156138

Nurco DN, Hanlon TE, Kinlock TW. Recent research on the relationship between illicit drug use and crime. Behavioral Sciences and the Law 1991;9(3):221–42.

Nurco DN, Hanlon TE, Bateman RW, Kinlock TW. Drug abuse treatment in the context of correctional surveillance. Journal of Substance Abuse Treatment 1995;12(1):19–27. [PubMed: 7752293]

O'Brien C. Opiate detoxification: what are the goals? Addiction 2005;100(8):1035. [PubMed: 16042623]

Platt, JJ.; Widman, M.; Lidz, V.; Marlowe, D. Methadone maintenance treatment: Its development and effectiveness after 30 years. In: Inciardi, JA.; Harrison, L., editors. Heroin in the Age of Crack-Cocaine. Sage; Thousands Oaks, CA: 1998.

Rhoades HW, Creson C, Elk R, Schmitz J, Grabowski J. Retention, HIV risk, and illicit drug use during treatment: Methadone dose and visit frequency. American Journal of Public Health 1998;88(1):34–9. [PubMed: 9584030]

Rich JD, Boutwell AE, Shield DC, Key RG, McKenzie M, Clarke JG, et al. Attitudes and practices regarding the use of methadone in US state and federal prisons. Journal of Urban Health 2005;82(3): 411–9. [PubMed: 15917502]

Schwartz RP, Highfield DA, Jaffe JH, Brady JV, Butler C, Rouse C, et al. A Randomized Controlled Trial of Interim Methadone Maintenance. Archives of General Psychiatry 2006;63(1):102–9. [PubMed: 16389204]

Schwartz RP, McKenzie M, Rich JD. Opioid addiction and incarceration: An overview. Medicine and Health, Rhode Island 2007;90(5):157–158.

Schwartz RP, Kelly SM, O'Grady KE, Peterson JA, Reisinger HS, Mitchell SG, et al. In-treatment v. Out-of-treatment Opioid Dependent Adults: Drug Use and Criminal History. American Journal of Drug and Alcohol Abuse 2008;34(1):17–28. [PubMed: 18161640]

Simpson DD, Joe GW, Broome KM, Hiller ML, Knight K, Rowan-Szal GA. Program diversity and treatment retention rates in the Drug Abuse Treatment Outcome Study (DATOS). Psychology of Addictive Behaviors 1997;11(4):279–293.

Simpson DD, Joe JW, Fletcher BW, Hubbard RL, Anglin MD. A national evaluation of treatment outcomes for cocaine dependence. Archives of General Psychiatry 1999;56(6):507–14. [PubMed: 10359464]

Simpson, DD.; Sells, SB. Effectiveness of Treatment for Drug Abuse: An Overview of the DARP Research Program. Hawthorn Press; 1983.

Smith-Rohrberg D, Bruce RD, Altice FL. Research Note — Review of corrections-based therapy for opiate-dependent patients: implications for buprenorphine treatment among correctional populations. Journal of Drug Issues 2004;34(2):451–80.

Strain EC, Bigelow GE, Liebson IA, Stitzer ML. Moderate- vs high-dose methadone in the treatment of opioid dependence: a randomized trial. Journal of the American Medical Association 1999;281(11): 1000–5. [PubMed: 10086434]

Strauss, A.; Corbin, J. Basics of Qualitative Research: Grounded Theory Procedures and Techniques. Sage; Newbury Park, CA: 1991.

Zanis DA, Woody GE. One year mortality rates following discharge from methadone treatment discharge. Drug and Alcohol Dependence 1998;52(3):257–60. [PubMed: 9839152]

Table 1

Characteristics of Discharged Participants (N = 60) by Interview Status

Variable	Interviewed (n = 42)	Not interviewed (n = 18)	Total sample (N = 60)
Age, mean (*SD*)	40.4 (7.9)	41.4 (8.1)	40.7 (7.9)
Male, number (%)	25 (59.5)	14 (77.8)	39 (65.0)
African American, number (%)	27 (64.3)	15 (83.3)	42 (70.0)
Inject (heroin), number (%) *	31 (73.8)	9 (50.0)	40 (66.7)
Number of days in treatment, mean (*SD*)	124.3 (92.9)	155.8 (123.8)	133.7 (103.1)
Lifetime treatment episodes, mean (*SD*)	2.8 (2.2)	2.4 (1.4)	2.7 (2.0)

* n = 17 for the discharged not interviewed sample, and N = 59 for the total discharged sample due to one participant who has reported never using heroin.

Table 2

Demographic and Treatment Characteristics of Interviewed Discharge Sample by Participant Reason for Discharge Category (n = 42)

	Participant Reason for Discharge Category			
	Program-Related	**Methadone**	**Life Event/ Logistics**	**Incarceration**
Number of Participants (%)	17 (40.5%)	5 (11.9%)	4 (9.5%)	16 (38.1%)
Average Age	42	40	43	39
Male (%)	11 (64.7%)	2 (40.0%)	1 (25%)	11 (68.8%)
African American (%)	11 (64.7%)	5 (100.0%)	2 (50.0%)	9 (56.2%)
Inject (%)	12 (70.6%)	2 (40.0%)	3 (75.0%)	14 (87.5%)
Average Number of Days in Treatment (Range)	140.2 (23-341)	139.4 (33-331)	43.3 (2-77)	120.5 (8-307)
Average Number of Lifetime Treatment Episodes (range)	2.5 (0-7)	5.0 (1-10)	3.5 (1-7)	2.3 (1-4)

Table 3

Participant and Counselor Reasons for Discharge

Reason for Discharge According to Patient		Reason for Discharge According to Counselor	
Program-related	17 (40.5%)	Noncompliant	6
		Left Before Completing Tx	4
		Referred	4
		Missing Form	3
Incarceration	16 (38.1%)	Noncompliant Incarceration	3
		Left Before Completing Tx	9
		Referred	1
		Missing	3
Did not want to be on Methadone	5 (11.9%)	Left Before Completing Tx	4
		Referred	1
Life Event/ Logistics	4 (9.5%)	Left Before Completing Tx	3
		Completed Tx	1
TOTAL	42 (100%)		42 (100%)