OASAS Guidance on Administrative or Involuntary Patient Discharges from Opioid Treatment Programs

HIGHLIGHTS:

- New York State Opioid Treatment Authority (SOTA) approval for administrative or involuntary discharges is no longer required since the conclusion of the COVID-19 federal Public Health Emergency (PHE)
- Guidance from the NYS Office of Addiction Services and Supports (OASAS) and the Federal Substance Abuse Mental Health Services Administration (SAMHSA) recommend limiting administrative or involuntary discharges to rare instances
- According to SAMHSA's 2015 Federal Guidelines for Opioid Treatment Programs (OTPs),
  - Reasons *to consider* administrative or involuntary discharge include:
    - Non-payment of fees
    - Disruptive conduct or behavior
    - Violent conduct or threatening behavior
    - Anticipated incarceration without access to medications for opioid use disorder (MOUD)
  - Inappropriate reasons to consider administrative or involuntary discharge include:
    - Continued substance use
    - Missed days of dosing
    - Non-adherence to counseling or group activities in the OTP
  - Special considerations for pregnant persons are required
- All efforts should support continuing methadone treatment using person-centered goals prior to a final determination of administrative or involuntary discharge

I. PURPOSE

For the duration of the COVID-19 federal public health emergency (PHE) that began in March 2020, the NYS Office of Addiction Services and Supports (OASAS) was not regularly permitting opioid treatment programs (OTPs) to independently perform administrative or involuntary discharges. Instead, OTPs were required to direct their requests for administrative or involuntary discharges to the OASAS State Opioid Treatment Authority (SOTA) for authorization. With the conclusion of the federal PHE on May 13, 2023, permission from OASAS for administrative or involuntary discharge is no longer required.

This guidance document reviews SAMSHA's 2015 federal guidelines and NYS OASAS regulations regarding administrative or involuntary discharge and outlines appropriate and inappropriate applications of this practice using a regulatory framework and the current standards for the delivery of person-centered care.

As a result of these changes, administrative or involuntary discharge will be limited to rare circumstances with the goal of maintaining more individuals in treatment for longer periods of time.

II. DEFINITIONS:

II. DEFINITIONS: Administrative or involuntary discharge is defined as a staff-directed involuntary termination of treatment services. *(Hereafter, "administrative or involuntary discharge" will be simplified to "administrative discharge.")* Termination by administrative discharge differs from treatment completion, leaving against clinical advice, or other voluntary discharge, and contrasts with the person-centered approach expected in other health care settings.[1] Premature withdrawal from opioid use disorder (OUD) treatment for any reason is strongly associated with recurrent opioid cravings, return to use, and increased risk for fatal and non-fatal overdose.

Person-centered care is a treatment approach that includes patient preferences when developing treatment plans and goals. The OASAS guidance document entitled Person-Centered Care Guidance for OASAS Certified Programs introduces the key elements of person-centered care service delivery models.

III. FEDERAL REGULATIONS AND GUIDELINES FOR OTPs:

The federal regulations 42 CFR § 8.12 and federal guidelines encourage long-term treatment retention, and, whenever possible, discourage administrative discharges from treatment. Accordingly, "as long as they [patients] can benefit from and express a desire to continue treatment. Programs should make every effort to intervene productively in a patient's situation before resorting to administrative withdrawal." Federal Guidelines for Opioid Treatment Programs (samhsa.gov) (p.26).[2]

Administrative discharges of pregnant persons must be considered carefully because of the potential impacts that discontinuing methadone may have on pregnancy outcomes. Treatment teams must develop plans that prioritize the continuation of methadone treatment. As such, the federal guidelines refer to the administrative discharge of pregnant persons as "a medically high-risk undertaking." Moreover, 42 CFR § 8.12 explicitly requires that OTPs maintain policies and procedures that address the special needs of pregnant persons.

A. Administrative discharge approaches

The 2015 federal guidelines outline several approaches to administrative discharge (also called involuntary withdrawal in the guidelines) that are not explicitly addressed in 42 CFR § 8.12, the relevant federal regulation for OTPs. From these guidelines, administrative discharge from treatment is acceptable under unique circumstances after exhausting all other continuation of care options, and "must follow due process to protect the patient's rights to treatment."

There are four general situations described in the federal guidelines document for which administrative discharge is considered appropriate:

1. **Non-payment of fees**
2. **Disruptive conduct or behavior**
3. **Violent conduct or threatening behavior**
4. **Anticipated incarceration without access to medications for opioid use disorder (MOUD)**

These four outlined situations in the federal guidelines provide general approaches. Programs must consider each patient's needs and situation individually using person-centered principles.

Implementation considerations:

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- Program policies and procedures outlining the program's mitigation (or risk reduction) strategies to be used before resorting to administrative discharge
- Adherence to federal guidelines that emphasize early and intensive interventions for problematic behavior
- Analysis of all clinical and psychosocial aspects impacting the patient's situation or behavior in addition to the clinical and psychosocial consequences of administrative discharge
- Patient record documentation of each step addressed in these processes including detailed patient responses to these steps
- Special consideration for the discharge of a pregnant person
- Transition from methadone to another MOUD is preferred over discharge without MOUD

Person-centered strategies that align with federal guidelines should be utilized prior to considering administrative discharge

1. **Nonpayment of fees:** Although allowable, discharging a patient from a program because of non-payment is strongly discouraged and may be considered patient abandonment. [1,3]

Person-centered strategies include:

- Referring to a more affordable OTP, such as a publicly funded program
- Addressing transportation costs

- Exploring payment schedules and insurance eligibility; applying for insurance if eligible
- Reducing take-home dose schedule to limit frequency of visits and associated fees

OASAS-funded programs are additionally subject to statutory and administrative requirements including sliding fee scales, and other mechanisms to support individuals in need of services with financial limitations.

2. **Disruptive conduct or behavior:** There is no consensus on the definition of disruptive behaviors; however, behavioral problems often are cited as the cause for administrative discharge. These cited behaviors have included onsite drug sales, repeated loitering, or violation of treatment program rules that significantly impact other program participants and staff. Given that these cited problems may be behavioral manifestations of a substance use disorder or a mental health condition, non-reactive therapeutic interventions geared towards addressing these behaviors must be implemented prior to considering administrative discharge.

   Person-centered strategies include:

   - More frequent counseling opportunities with the patient's primary counselor or mental health team
   - Trauma-informed treatment approaches
   - Engagement with a certified recovery peer advocate (CRPA)
   - Adjusting the patient's medication dispensing time to a time when fewer program participants are present or changing the dispensing location within the program's premises to a quiet examination room or the parking lot
   - Reduced number of pick-up days to limit opportunities to engage in disruptive behaviors.
   - Use of a designee for medication pick-up
   - Satellite medication unit dosing

3. **Violent conduct or threatening behavior:** According to SAMHSA's guidance, "violent conduct or threatening behaviors include assaults or attempted assaults and direct and credible threats of violence towards other patients, program staff members, or visitors. If practical under the circumstances and with due regard for patient and OTP staff safety, before administrative discharge, it is recommended that the OTP conduct a crisis assessment to address suicide risk, danger to self or others, urgent or critical medical conditions, and immediate threats."

The safety of the OTP's patients and staff is the priority when violent or threatening behaviors occur, and programs should perform necessary measures to secure safety. [11]

- Where appropriate, programs may consider dispensing sufficient take-home medication doses directly to the patient or to a third party for a transition of care or providing a viable plan to obtain medication (e.g., off-site or satellite medication units).

4. **Anticipated incarceration without access to MOUD: This situation applies to individuals incarcerated outside of New York State in jurisdictions that** do not permit medically supervised withdrawal management or continued MOUD in their carceral systems.

   Person-centered strategies include:

- Collaboratively planned taper between the provider and patient preceding voluntary discharge from the OTP.
- Educating the patient about The MAT in Jails and Prisons Act, Chapter 432 of the Laws of 2021 which requires NYS carceral settings to provide all MOUD options to incarcerated individuals effective October 7, 2022.

B. Special situations: Discharge of pregnant persons

Tapering off methadone during pregnancy can result in adverse outcomes, including first trimester fetal loss and premature delivery in the third trimester.

Prior to administrative discharge from OTP services, providers of pregnant persons must consider the following pregnancy related person-centered strategies:

- Exhausting all supportive measures including engagement of certified recovery peer advocates (CRPA), community care management/family navigator agencies, family/other significant relationships, and specialty care providers such as prenatal care specialists, primary care providers, mental health treatment providers, and public health/home care nurses
- Transferring to another OTP or transfer to a higher level of care instead of medically supervised withdrawal
- Transitioning to buprenorphine therapy with continuity care in an outpatient substance use disorder program, in a primary care setting or with a prenatal specialist

[1] Per 14 NYCRR §815.7(e) None of the foregoing shall apply to an emergency discharge where the patient is determined reasonably to be a danger to others. A provider may make an emergency discharge immediately upon making such a determination, subject to the patient's right to appeal after the patient is discharged

- Ensuring access to low threshold re-entry to methadone treatment during the pregnancy or post-partum period

C. Standard of care for administrative tapering of methadone

In most instances that do not involve an actual or imminent threat, any person (pregnant or non-pregnant) who is administratively discharged from an OTP must receive treatment guided by the same standards of care expected with a voluntary medically supervised withdrawal from medication. The goal is to follow a withdrawal schedule that is clinically grounded, empathic, and person-centered using the following principles:

1. Administrative discharge is associated with a poor prognosis given the high probability of return to use and vulnerability to overdose and death.
2. Rigidly administered or brief methadone tapers should be avoided and replaced with slow, collaborative tapers that include adequate take-home doses and frequent clinical reassessments with the counseling and medical staff. For many patients, this slow process may be utilized to reassess decisions to taper off methadone, treatment goals and any existing barriers to continuing treatment at the OTP.
3. Person-centered overdose prevention and intervention strategies should be offered
    - Naloxone in addition to other harm reduction tools such as drug testing strips should be provided to patients at the earliest opportunity and again at discharge
    - Referrals to harm reduction agencies such as drug user health hubs, in case of return to substance use.
4. Clinical interventions for the management of withdrawal symptoms expected during a methadone taper should be documented in the patient record.
5. Guidance documents, such as the SAMHSA TIP 63 (see section B), should be referenced for additional information.
6. Clear understandable patient instructions that include all medical and non-medical follow-up or referral appointments should be provided.

D. Applying the 2015 Federal Guidelines For OTPs when considering administrative discharge:

The federal guidelines' standard approach to administrative discharge **does not include nor encourage** the following criteria for administrative discharge:

1. **Continued drug use**
2. **Missed dosing**
3. **Non-adherence to counseling or group activities in the OTP**

The SAMHSA TIP 63 Medications for Opioid Use Disorder recommends that providers avoid discharging patients from treatment solely because of continued substance use if the benefits of treatment continue to outweigh the risks.

IV. NEW YORK STATE REGULATIONS

In addition to the federal regulations and guidelines that shape access to methadone treatment, states can enact laws which impose additional restrictions on OTPs beyond the federal regulations. Therefore, the states' role in increasing and maintaining accessibility to OTPs and methadone is vital to providing treatment to more individuals with OUD. OASAS standards for OTPs are included in 14 NYCRR Part 822. Provisions that define minimum standards for patient's rights are contained in 14 NYCRR Part 815.

NYS laws, OASAS regulations, OASAS local service bulletins (LSBs), OASAS guidance, and OASAS minimum standards for state-certified addiction service providers may be found under Laws and Regulations page of the OASAS website.

NYS OASAS

A. Standards for OASAS-Certified Programs (2019)

In 2019, NYS OASAS issued standards for OASAS-certified outpatient programs, including OTPs, explicitly protecting individuals from administrative discharge resulting in denial of methadone or buprenorphine.

1. Key points:
    - Few instances would warrant administrative discharge. If required (because of staff and patient safety), the OTP must provide the patient viable opportunities to continue their medication wherever possible.
    - Poor engagement in treatment services (e.g., patient not participating in counseling) or continued substance use do not warrant administrative discharge.
    - OASAS' standards for their programs are aligned with the federal OTP guidelines.

- **OASAS regulations** reiterates the program's responsibility to provide or arrange a clinically appropriate taper of MOUD (methadone or buprenorphine). See. 14 NYCRR §822.16 (f)

B. Amended PART 815 Patient Rights, amended October 1, 2022

The amended Part 815 regulation sets forth the minimum standards to protect the rights of patients in substance use disorder (SUD) treatment and does not condone nor support administrative discharge; rather, it outlines a minimum process by which the patients' rights to treatment in the SUD treatment setting may be protected.

- Patients have the right to receive in writing the reasons for a recommendation of discharge and to be informed of the process to appeal.
- No treatment intervention or action can include delay or denial of any clinical, medical, or other required services vital to the health or recovery of the patient.
- Patients can consent or refuse treatment recommendations from the program.
- Providers may NOT discharge a patient solely for their refusal to participate in a recommended service. See. 14 NYCRR §815.7

The procedures outlining the required elements of the review process to be conducted prior to the final discharge recommendations require that the program director and medical director:

- Review the recommendation to discharge to ensure that the reason(s) is fair, not arbitrary or capricious, and is serious enough to warrant discharge
- Review and evaluate the patient's total response to treatment, in light of the recommendation to discharge
- Confer with staff at a multidisciplinary meeting to discuss the patient's response to treatment and the recommendation to discharge
- Confirm that, within reasonable clinical judgment, all incremental strengths-based and trauma-informed interventions have been tried but without success, including consideration of transfer to another provider
- Ensure that no opioid full agonist taper shall begin until after completion of the aforesaid process and all efforts to transfer the patient to another provider of opioid full agonist medications have been exhausted
- Ensure that no patient is discharged without a plan which has been reviewed previously and approved by a clinical staff member and the clinical supervisor
- Confirm that the portion of the transition plan which includes referrals for continuing care is given to the patient prior to leaving the program.
- Confirm that the patient, and their family/significant other(s), is offered overdose prevention education and training, and a naloxone kit or prescription

V. CONCLUSIONS

Since the conclusion of the COVID-19 PHE, OTPs will no longer be required to obtain approval for administrative discharges. There are few circumstances in which administrative discharge is considered appropriate under the federal OTP guidelines. Clinicians must consider if their approaches to administrative discharge are person-centered, fair, and aligned with both federal and state guidance. When applied appropriately, administrative discharge will be limited to rare circumstances, permitting more individuals to remain in treatment longer.

VI. CHECKLIST FOR OTPS CONSIDERING ADMINISTRATIVE OR INVOLUNTARY DISCHARGE OR WITHDRAWAL FROM TREATMENT

- ☐ Does your patient's scenario fit into one of these four groups?
  - Non-payment of fees (financial barriers that cannot be overcome)
  - Disruptive conduct or behavior
  - Violent conduct or threatening behavior
  - Anticipated incarceration without access to MOUD

- ☐ Have all clinical and care management approaches been considered? Examples:
  - Reduced pick-up schedules using take-home flexibilities (up to 28 days)
  - Change time interval for pick-ups
  - Alternative medicating location (exam room vs. medication window vs. parking lot)
  - Explore payment schedules and insurance eligibility or a referral to a more affordable program
  - Addition of mental health provider or certified recovery peer advocate (CRPA)
  - Alternatives to home OTP: off-site or satellite medication units and mobile methadone units (MMUs)
  - Use of a designee or proxy for methadone pick-up
  - Utilization of telehealth versus in-person counseling or medical/dose adjustment visits

- ☐ Is transfer to another program possible if discharge is unavoidable?

- ☐ If the patient is tapering off methadone, involuntarily or voluntarily:
  - Was the patient encouraged by all clinical staff to transition to an alternative MOUD option (e.g., buprenorphine from methadone)?
  - Was the patient counseled by all clinical staff on the risks for return to use and subsequent risk of fatal overdose if not on MOUD?
  - Was the patient encouraged to re-enter care when ready?
  - Has the patient received comprehensive overdose prevention and intervention education, including referrals to harm reduction programs?
  - Does the patient and their significant others/family have adequate supplies of naloxone?

VII. REFERENCES

1. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6338434/pdf/nihms961577.pdf
2. https://store.samhsa.gov/product/federal-guidelines-opioid-treatment-programs/pep15-fedguideotp
3. https://jswve.org/wp-content/uploads/2020/01/10-017-108-JSWVE-2020.pdf.