PHASES OF TREATMENT: ACTION/MAINTENANCE

The Action/Maintenance Phase draws its name from the Stages-of-Change Model (Prochaska & DiClemente, 1982). The client is in the Action Stage with regard to longer-term rehabilitation goals, but in the Maintenance Stage in terms of consolidating the gains of the Stabilization Phase. (See Chapter 6 for additional information about the Stages-of-Change Model.)

The primary focus of the Action/Maintenance Phase of treatment is to help clients achieve a higher level of social adjustment in their community and in their interpersonal relationships. Clients are now ready to begin to make more lasting lifestyle changes in such areas as vocational plans, leisure activities and family relationships. They are also ready to address more complex issues such as chronic illnesses or concurrent disorders.

The Phases-of-Treatment Model is useful for setting treatment priorities. However, the transition between phases is fluid. Rarely will clients have met all of the criteria for completion of the Stabilization Phase before beginning to address any of the issues usually associated with the Action/Maintenance Phase. Clients may also be well into the Action/Maintenance phase only to relapse and find that stabilization issues have once again become the priority of counselling (Hoffman & Moolchan, 1994; Kaufman & Woody, 1995). Therefore, counsellors need to continually reassess and intervene in flexible and appropriate ways, matching the intervention with the client’s needs.
Issues in the Action/Maintenance Phase

The following issues should be considered in the Action/Maintenance Phase of MMT:

- avoiding the complacency trap
- renegotiating the treatment plan
- strengthening the therapeutic alliance
- psychosocial rehabilitation
- case management
- consolidating Stabilization Phase gains
- drug use
- take-home medication
- extended absences from the MMT clinic
- urine drug screening
- methadone maintenance with minimal counselling or medical maintenance.

Avoiding the Complacency Trap

Completion of the Stabilization Phase of MMT is a major milestone. Ideally, the client is stabilized on an optimal dose of methadone, her or his drug use is under control and acute problems have been resolved.

At this point it is tempting to think that the crisis is over and begin to relax. Counsellors must be alert to this natural tendency in both themselves and their clients.

The achievement of stability is the basis upon which more lasting lifestyle changes can be made. To begin this process, counsellors must review and renegotiate the treatment plan.

Renegotiating the Treatment Plan

Assessment and treatment planning are ongoing processes (see Chapter 7). However, the transition to the Action/Maintenance Phase is a special point in the treatment process that should be marked by a formal renegotiation of the treatment plan. Motivational interviewing techniques can be helpful in this process.

By taking this formal step, the counsellor acknowledges that the client has reached a major milestone. It is an opportunity to congratulate the client on having achieved some important goals. But, it is also a point at which to talk about how to move on in a manner that will avoid the complacency trap.
Client needs are usually hierarchical. It may be difficult for a client to think about vocational plans while getting stabilized on methadone and struggling with drug use. Even in circumstances where the client has articulated longer-term goals from the outset of treatment (e.g., improving family relationships), it is useful to revisit these in the light of increased stability.

Researchers have noted that MMT clients are difficult to engage in enhanced services such as vocational counselling, psychotherapy and family treatment, or services designed to address chronic medical conditions (Ball & Ross, 1991; Kraft et al., 1997; Widman et al., 1997). Whether they are any more unwilling than other substance-using clients is unclear. What is evident, however, is that renegotiating the treatment contract to focus on longer-term rehabilitation goals is usually more challenging for the counsellor than it was to obtain the client’s commitment to the goals of the Stabilization Phase.

It may be difficult to mark the change in phase at a particular point in time, given the fluid nature of the transition process. Nonetheless, counsellors’ attempts to do so should be consistent with the realities of the case. The Phases-of-Treatment Model can be useful in helping the client understand the counselling process and remain committed to it. Marking the transition by renegotiating the treatment plan can help the client relate to the process and enhance the therapeutic alliance.

**Strengthening the Therapeutic Alliance**

It is widely recognized that the strength of the therapeutic alliance is the basis upon which progress in the counselling process occurs (Luborsky et al., 1986; McLellan et al., 1988). During the Stabilization Phase, the emphasis is on building the relationship. Empathy and support are the crucial aspects of the alliance.

As the client progresses to the Action/Maintenance Phase, there should be a subtle shift in the development of the therapeutic alliance. The counsellor must begin to balance an empathic, understanding and supportive style with one that challenges the client to face more difficult issues.

The complacency trap is a threat to the therapeutic alliance because, for one thing, coasting inevitably leads to the realization that counselling is not progressing. (For a more detailed discussion of the therapeutic alliance, see Chapter 6.)
Psychosocial Rehabilitation Issues

A wide variety of psychosocial issues may be pertinent to any MMT client. A list of potential issues is provided below.

Although many of these issues will have been apparent from the outset of treatment, it is usually best to try to achieve stability with regard to medication, drug use and the client’s social situation before taking them on. Of course, an urgent need with respect to any of these issues would be a priority of the Stabilization Phase.

POTENTIAL PSYCHOSOCIAL REHABILITATION ISSUES

- vocational planning
- leisure counselling
- enhancing social support systems
- improving family relationships
- addressing legal problems
- parenting and child welfare issues
- budgeting and financial planning
- social skills training
- stress management
- relapse prevention
- pain management
- polysubstance use
- harm reduction
- anger management
- eating disorders
- depression
- anxiety and phobic disorders
- trauma issues
- grieving issues
- sexual and gender identity issues
- sexual dysfunction
- adjustment to chronic illness

The rehabilitation issues of the Action/Maintenance Phase are aimed primarily at social and psychological adjustment.
Vocational enhancements can be a crucial dimension of this process. Vocational goals may involve getting a job or improving vocational opportunities, but they may also address more fundamental impediments to employment such as literacy and learning disabilities (Kaufman & Woody, 1995).

Strengthening the client’s social support system is another important aspect of social adjustment. Family relationships and peer networks are often the main focus of these efforts. Also, improvement in a variety of social or coping skills may be critical to social adjustment.

Finally, legal issues may be ongoing, as the process of dealing with custody issues or criminal charges can be lengthy. Helping clients obtain legal assistance, and developing objective indicators of progress to present in court, are among the strategies to consider.

Other aspects of the rehabilitation process will be more concerned with psychological adjustment. Although increases in the client’s self-efficacy and self-esteem are fundamental to an improved attitude and optimism about the future, there may be a wide range of psychological or psychiatric issues to address. These will be easier to diagnose if the client’s drug use has stabilized. If concerns about concurrent disorders persist to the Action/Maintenance Phase, it may be desirable to obtain a psychiatric consultation.

Health issues can also be a priority of the Action/Maintenance Phase. These may include pregnancy, dental needs or issues related to chronic diseases such as HIV infection and chronic viral hepatitis.

In general, how psychosocial rehabilitation issues are addressed is not unique to MMT. However, the reader may find it useful to review Chapter 5 for additional conceptual information concerning enhanced psychosocial services in MMT. Also, chapters 11 to 14 provide additional practical information concerning issues related to polysubstance use, concurrent disorders, infectious diseases and pregnancy.

Some of the identified psychosocial issues may be addressed within the framework of the ongoing individual counselling. In multifunctional settings, specialized individual or group interventions may be provided by other counselling staff (e.g., vocational counselling, family treatment or relapse prevention counselling). If you are not working in a multifunctional setting, referrals to other community agencies may be necessary to obtain appropriate services.
When addressing psychosocial issues in the Action/Maintenance Phase, two issues should be foremost in the counsellor’s mind.

- The first is the difficulty often experienced in involving MMT clients in enhanced services. Allowing ample time for an exploration of longer-term rehabilitation goals is essential to ensure that the client is committed to the goals. This is especially important in situations where referrals are required because dropout is typically higher at these transition points.

- The second important issue for counsellors is their ethical obligation not to take on issues or provide interventions for which they have not been adequately trained or supervised. The wide range of issues that arise in an MMT case, coupled with a lack of agency or community expertise in addressing them, can present real dilemmas for the counsellor.

MMT programs should identify their limitations with respect to competencies and take appropriate steps to ensure the availability of alternative program or community resources. At the least, arrangements should be made to provide back-up clinical consultation in areas where competency is limited. In some situations, Internet access may be useful in arranging back-up clinical consultation.

**Case Management**

Case management becomes increasingly important during the Action/Maintenance Phase (see Chapter 6 for a description of the case management function) because clients are likely to be involved with more than one service provider. For example, aside from MMT counselling the client may also be referred for vocational planning and be involved in the resolution of child welfare issues. Case co-ordination is crucial in these situations.

Normally, the MMT counsellor would assume the role of case manager and take responsibility for initiating contacts to ensure that effective case co-ordination occurs. Periodic case conferences should also be arranged, especially in more complex cases. Where feasible, other members of the MMT treatment team should be involved in case conferences.

**Consolidating Stabilization Phase Gains**

Longer-term rehabilitation goals can remain the focus of the Action/Maintenance Phase only if the gains of the Stabilization Phase are maintained. Counsellors should routinely take time in counselling sessions to monitor stability issues and introduce strategies to anticipate and prevent threats to stability.
Drug Use
Continuing drug use will be one of the most important considerations in this process. Keeping an open dialogue is critical. As the frequency of urine drug screening decreases, reliance on self-reports increases. Counsellors should be alert to disincentives to self-disclosure such as loss of privileges, embarrassment and perceived disappointment of the counsellor.

The quality of the therapeutic alliance will be a major factor in how forthcoming clients are about their drug use. The use of self-monitoring cards and procedures can help to make this process more informative. In circumstances where drug use is contractually linked to privileges, such as take-home medication, assigning greater weight to unreported drug use detected by urine screening might reduce the disincentive to self-report.

In assessing the degree to which new or continuing drug use is a threat to stability, we advocate a performance-based approach rather than one based on arbitrary limits. Is there objective evidence of reduced stability related to drug use (e.g., reduced compliance with program expectations or with the treatment plan; increased criminal activity, or a failure to meet social obligations)? A risk factor analysis is a useful approach to exploring levels of drug use and helping clients to set appropriate limits for themselves.

Maintaining stability with regard to drug use also involves a shift in emphasis from avoidance strategies to coping strategies. This, of course, is a relapse-prevention orientation (Annis et al., 1996) that can be integrated within the broader rehabilitation goals of the Action/Maintenance Phase.

Urgent Issues
Completion of the Stabilization Phase involves addressing urgent biopsychosocial issues that are undermining stability. These specific issues need to be carefully monitored to avoid recurrence. Maintenance of stability will involve developing strategies to prevent the recurrence of these issues. The nature of the urgent issues addressed in the Stabilization Phase may signal either client vulnerabilities or environmental stressors that need to be explored in the process of renegotiating the treatment plan.

The recovery process is often punctuated by stressful life events that can be a threat to stability for the MMT client. Such events can become the immediate priority of counselling, but would normally be considered a natural part of the Action/Maintenance Phase unless these events lead to a major relapse and a return to the Stabilization Phase.
**Methadone Dose**

The prescribing physician will monitor MMT clients to ensure the continued optimization of the dose of methadone. However, counsellors should be alert to any signs that the dose needs adjustment, including symptoms of side-effects or opioid cravings or withdrawal.

**CASE STUDY**

Michelle is a 41-year-old woman with a 20-year history of drug use. She primarily used heroin, cocaine and alcohol. She has been in MMT for one year. During the Stabilization Phase of MMT she ceased working in the sex trade, drug dealing and other criminal activities. In addition, she left her long-term partner, who has continued to use drugs, and moved to a new apartment in a different neighbourhood.

Her initial drug use goal was to abstain from heroin and cocaine, and she has been largely successful in doing so. Originally, she was ambivalent about changing her alcohol use, and this issue was set aside while addressing the other more urgent problems she was more committed to working on. Eventually, free of heroin and cocaine, she became more aware of the negative moods and hangovers related to her weekly night out drinking, and she decided to stop using alcohol. On the basis of these achievements she was deemed to have completed the Stabilization Phase of treatment.

In the Action/Maintenance Phase, the changes made in the Stabilization Phase have been closely monitored, and they have been maintained. Michelle has been self-monitoring her cravings and motivation to abstain. She has used this information to develop and strengthen strategies to prevent relapse. Recently, following the death of her grandmother, she had a slip and used heroin. However, she was able to use her relapse prevention plans to avoid a full-blown relapse and has abstained since. This experience was used to strengthen her confidence to abstain.

In addition to these maintenance strategies, Michelle has added new goals and strategies to the treatment plan. She has obtained a part-time job at the hospital after initiating her involvement as a volunteer. She has added new, non-drug–using friends to her social support system. She has joined a running club and has set herself the goal of running a 10-kilometre race within the next year. She is currently investigating some vocational options, including going back to school to study nursing.

Michelle is continuing to make major lifestyle changes and build her confidence. She remains committed to both counselling and methadone maintenance.

**Take-Home Medication**

Take-home, or carry, medication can be offered to MMT clients as a therapeutic tool that helps them adjust to taking on more responsibilities in the community. In Ontario, the Methadone Maintenance Guidelines (College of Physicians and Surgeons
of Ontario et al., 2001) suggest that this would not occur until the client has been in treatment for two months and has achieved functional stability. Normally, clients become eligible for take-home medication in the Action/Maintenance Phase of MMT.

Although it may be an expectation of some MMT programs, complete abstinence is not a legal requirement for take-home medication. As discussed in Chapter 8, clients can achieve stability and meet the requirements of the Stabilization Phase without maintaining complete abstinence. However, continuing drug or alcohol use should be moderate, non-problematic and not undermine stability or the achievement of further social integration.

Introducing Take-Home Medication

Take-home medication is usually introduced gradually. Clients begin receiving one take-home dose and can increase in stages to a maximum of six take-home doses. The Methadone Maintenance Guidelines spell out criteria to consider in increasing the number of carries. These criteria concern time in treatment, functional stability and decreased drug use.

When clients become eligible for take-home medication, counsellors should make sure that they fully understand program expectations and safe handling procedures. Accidental ingestion of a methadone dose by a child or another person can be fatal. It is the client’s responsibility to ensure that the methadone is neither accidentally nor deliberately consumed by anyone else. A sample Take-Home (Carry) Agreement (Appendix C) and a sample reminder for clients about properly handling their carries (Appendix D) are included in this guide.

Clients can also be reminded to refer to their client handbook for advice about handling take-home medication; see Centre for Addiction and Mental Health, Methadone Maintenance Treatment: Client Handbook (2001).

Issues to Consider

Counsellors should consider the following issues when preparing clients to receive take-home medication:

- Take-home doses of methadone are normally dispensed in child-proof containers. Clients should not transfer the medication to any other containers.
- Ideally, medication should be stored in locked boxes in a refrigerator.
- Carry doses that are lost or stolen may not be replaced and have to be reported to the police to prevent harm to others.
- As a precaution against diversion, clients may be asked at any time to bring in the remainder of their carry medication.
• Take-home medication is a privilege that may be cancelled at any time by the prescribing physician.
• Clients are expected to use the medication as it was prescribed. Any concerns about the adequacy of the methadone dose should be discussed with the prescribing physician.

Contingency Management
Take-home doses are a source of status and convenience for MMT clients. Earning the right to take medication home has often been used as an incentive to promote desirable behaviours and/or discourage inappropriate behaviours.

Contingency management is an effective way to link the privilege of take-home medication to client behaviour (for more information about contingency management, see Chapter 5).

Contingency management objectively links the privilege to performance. Used systematically, it works exceptionally well and also minimizes the perception that favouritism is being shown in permitting take-home doses. Drug-free urine screenings, regular methadone pick-up and attendance at counselling sessions are examples of pro-social behaviours that have been contractually linked to obtaining take-home medication. Threats of violence, diversion of methadone and urine tampering are examples of behaviours that may result in the suspension of take-home privileges.

Extended Absences from the MMT Clinic
For a variety of reasons such as vacation, work travel or illness in the family, clients may need to be away from the MMT clinic for longer than the six days covered by take-home medication. In such instances, carry medication may be extended for up to 14 days. Alternatively, guest dosing may be arranged with another MMT program near the client’s destination.

Urine Drug Screening
Urine drug screening continues in the Action/Maintenance Phase but usually at a reduced frequency. The Methadone Maintenance Guidelines (2001) suggest a frequency ranging from weekly to monthly depending on the length of time the client has been functionally stable. Evidence of drug use may lead the physician to request an increase in the frequency of testing.

A random schedule should be used to request urine samples. The randomization procedures should be such that that the length of the time between tests is
unpredictable. For example, a client on a monthly test schedule, and tested at the beginning of the month, should not be left feeling confident that he or she will not be tested for the rest of the month.

Urine collection procedures should be the same as in the Stabilization Phase.

**Methadone with Minimal Counselling**

There is no reason why the duration of counselling must coincide with the length of time the client is on methadone. Two types of issues can arise in the Action/Maintenance Phase. In one, the client may wish to remain on methadone but terminate counselling apart from the counselling routinely given by a physician when prescriptions are renewed (namely, at least every three months). In the other, the client may want to taper off methadone but continue in counselling. Either may be a legitimate option.

**Terminating Counselling**

Many clients find it helpful to remain on methadone long after they have achieved functional stability and a high level of social and psychological adjustment. These clients may reach the point where counselling is no longer required other than the supportive counselling offered by a physician when prescriptions are renewed (i.e., at least every three months). Counsellors should be open to this option.

The following criteria should be considered in assessing client readiness for termination of counselling:

- abstinence or consistent reduction in substance use for three months or more
- effective use of coping strategies to prevent relapse
- discontinuation of illegal activity
- socially stable living arrangements
- stable mental health
- appropriate adjustment to any chronic disease processes
- productive vocational activity (e.g., employment, training, homemaking, education)
- accessible support system of people who are not substance users
- enjoyable leisure interests that are unrelated to drug use
- consistent daily ingestion of methadone.

MMT clients who have terminated counselling but are continuing on methadone should be followed up periodically by their case manager to monitor their progress.
This treatment approach has been evaluated under the label “medical maintenance” and was found to be very effective for select, stable clients (Novick et al., 1994; Schwartz et al., 1999; Senay et al., 1993).

Clients should be encouraged to return to counselling if they elect to begin tapering from methadone.

Tapering from Methadone

Methadone maintenance is normally a long-term treatment lasting several years — or more. Once clients have achieved stability and begun to make changes in their lifestyle, they may believe they are ready to discontinue methadone.

Research is clear that for many of these clients this step will be premature. Clients who remain on methadone longer have better treatment outcomes.

When a client asks about tapering, the counsellor’s task is to review with him or her the criteria for readiness for tapering (see Chapter 10). (Clients using the CAMH handbook (2001) should at this point also be asked to review the chapter entitled “Looking Ahead on Methadone” as part of this process.) If the client meets the criteria, then he or she may be ready to move on to the Tapering Phase.

Clients may insist on tapering even when they do not seem to meet the criteria for readiness. Ultimately, it is the client’s decision, but there are some steps the MMT treatment team can take to minimize the risks. One is to plan a case conference of the treatment team and the client to discuss the appropriateness of the tapering decision. If the decision is truly unwise, the collective opinions of the treatment team may carry greater weight. If the client continues to insist, it will be important to try to exchange agreement on the decision with a commitment from the client that if tapering does not appear to be working, the client will return to methadone maintenance.

References


