

PHASES OF TREATMENT: STABILIZATION

As discussed earlier, a Phases-of-Treatment Model (e.g., Hoffman & Moolchan, 1994) can be useful in planning and organizing the focus of counselling sessions. The underlying premise of these models is that the types of issues addressed in counselling sessions will vary somewhat systematically over the course of treatment. Several examples of this approach to treatment were suggested (see Chapter 6 for a review).

This guide adopts a three-phase model consisting of a Stabilization Phase, an Action/Maintenance Phase and a Tapering Phase.

- In the Stabilization Phase, the primary focus is on engaging the client, getting the client stabilized on methadone and achieving functional stability with respect to drug use and other immediate biopsychosocial needs.
- In the Action/Maintenance Phase, the focus of treatment planning shifts from short-term goals to longer-term goals. For example, goal areas related to obtaining employment, strengthening social support systems, improving family relationships, planning leisure activities and addressing concurrent disorders would become more prominent in counselling sessions. At the same time, monitoring and maintenance and/or relapse-prevention strategies would be introduced to sustain the initial gains achieved in the Stabilization Phase (e.g., drug use) and to ensure that an optimal dose of methadone is maintained.
- In the Tapering Phase, the focus shifts back to methadone and the adjustment processes associated with coming off methadone.

Movement through each of these phases is not necessarily as linear as the phases imply. Sometimes clients will move backward and forward between phases. Or they may be working on issues associated with different phases simultaneously. Further, the phases are not a fixed series of steps, nor are they limited by time.

The phases are better understood as components of a dynamic continuum through which each client progresses according to his or her own needs and in his or her own time. For example, it is not only new clients who are in the Stabilization Phase. Clients who have relapsed and are attempting to re-address their goals might return to the Stabilization Phase. Indeed, there are some people for whom this pattern of stabilization–relapse is perpetual, and they may take a while or never progress to the Action/Maintenance Phase. Similarly, there should be no rush to get to the Tapering Phase.

MMT works best as a long-term treatment. Clients may terminate counselling in the Action/Maintenance Phase, having achieved their treatment goals, but remain on methadone indefinitely because they are not ready for tapering. Such clients would be encouraged to re-enter counselling if and when they should opt to taper off methadone.

Each of the next three chapters is concerned with one of the phases of treatment in our model. In each of these chapters, the issues most pertinent to the phase are identified and strategies to address the issues are discussed. Case examples are used to illustrate how to handle particular issues.

Issues Associated with the Stabilization Phase

Stabilization is the first phase of treatment. This phase addresses the following aspects of treatment:

- engaging the client
- addressing stigma
- orienting the client to MMT and to the program
- urine screening
- assessing the client
- treating acute medical and psychosocial problems
- achieving an optimal dose of methadone
- introducing harm reduction strategies
- treatment planning
- stabilizing other drug use (including alcohol)
- establishing functional stability.

Engaging the Client

Engaging the client presents some unique challenges in MMT. Methadone clients not only have to live with the stigma of being an “addict” or a “junkie,” they also live

with the added stigma of being a methadone user. It is unfortunate that methadone treatment is neither widely accepted nor well understood in North America. Many people still refuse to accept MMT as a legitimate treatment approach because they think of it as simply replacing one kind of substance dependence with another.

Even within the drug-using subculture, methadone clients are often looked down upon for choosing this form of treatment.

Counter Negative and False Beliefs

Many methadone clients internalize these negative and false beliefs and stereotypes, which can lead to chronic erosion of self-esteem and self-worth. Methadone clients commonly see themselves as bad people who are morally weak.

The MMT treatment team must make an effort to overcome these negative self-perceptions. It is critical that all members of the treatment team display attitudes of openness, honesty and respect. Hopefulness and empathy are integral components of the therapeutic relationship. To establish an effective helping relationship, the counsellor must convey an attitude of hopefulness about the client's ability to change, and the counsellor must display confidence in the client's capacity to grow. The counsellor must help the client to develop a sense of dignity and self-worth.

Validate the Process

Clients may arrive at a methadone program by a variety of routes and with varying degrees of certainty that MMT is for them. The counsellor's initial task is to understand and validate the process that has brought the client to this point. The more seamless the treatment system appears to be to the client, the more reassured the client will be that something positive can result. For example, if a client has been seen in another agency or by another worker in your agency, linkages must be made to these encounters to build on what has transpired, to communicate that there is continuity to the process and to avoid needless duplication.

Clarify Expectations

Clients may also land at the door of an MMT service without having adequately understood the nature of MMT or the alternatives available to them for treatment. As part of engaging the client, the counsellor should explore and clarify clients' expectations about MMT and confidence that it is the appropriate treatment for them.

This process should include the discussion of alternatives to MMT to ensure that a client's choice of MMT is an informed one. These alternatives include other pharmacological treatments such as buprenorphine or LAAM, or

non-pharmacological treatments such as therapeutic communities or outpatient counselling (see Chapter 3 for a more complete discussion of alternative treatments for opioid dependence).

Confidentiality

Confidentiality issues must be addressed at the outset of the treatment process. Clients need to be reassured about the privacy of what they discuss with their counsellor, but they are entitled to understand the limits to confidentiality. These limits are the usual ones that apply to counselling substance use clients, namely, the legal duty to report risks of harm to the client or others and suspicions of child abuse.

Child Abuse and Pregnancy

The issue of reporting suspected child abuse is especially important in MMT in cases where the client is pregnant, because the child will be born physically dependent on methadone (see Chapter 14).

The manner in which these confidentiality issues are addressed can have an important impact on the engagement process. Counsellors must be careful to ensure that clients fully understand their rights and the limitations to their rights, and accept the balance. Clients must also understand that MMT is a team approach to treatment and that information discussed in counselling sessions may be discussed with other team members.

A Fresh Start, a New Life, New Goals

For a new client, the first few weeks of methadone treatment can be the most critical in terms of his or her engagement and successful recovery. Many clients initiating methadone treatment will have a history of unsuccessful attempts to quit using drugs through other treatment approaches and, consequently, they may have negative expectations about success. The new methadone client has the opportunity to start afresh, to create a new life and to create new goals.

As well, the new client must also adjust to the treatment program. The client is confronted with learning a tremendous amount of information, including the program rules and regulations, philosophy, routines and culture.

The new methadone client is at a particularly impressionable stage on entry into treatment, and the methadone counsellor should seize this opportunity to connect and make a “positive imprint” on the client (McCann et al., 1994). During the first few weeks of treatment, a time often associated with physical and emotional discomfort by the new client, the counsellor should be accessible, supportive and encouraging.

Minimizing Barriers to Counselling

Clients who are unstable and leading chaotic, disorganized lives (e.g., clients who are experiencing housing problems or violence in their relationships) may have difficulty attending scheduled appointments. Psychopathology and continued drug use may also interfere with participation in counselling. It is unrealistic to expect these clients to attend punctually for scheduled appointments, and any efforts that the new client makes to engage in counselling should be positively acknowledged, supported and reinforced.

The new client often enters treatment feeling highly guarded and defensive. Ethnic and cultural differences may add to clients' uncertainties about treatment. Counsellors should make a special effort to reach out to these clients.

Brief, Frequent Interactions

Initially, the counsellor may emphasize brief, frequent interactions. These brief encounters are invaluable and serve a twofold purpose. First, they are appropriate for a new client who is not yet on a stable dose of methadone and who may be experiencing physical discomfort. Second, such an approach responds to the typical new client's apprehensiveness and anxiety about engaging in counselling and trusting a professional.

Brief check-in visits between scheduled counselling appointments are a means of developing the client–counsellor bond and monitoring the progress of the transition into treatment.

Practical Barriers

Barriers to engaging in counselling may also be practical. Clients may need assistance with the logistics of accessing the clinic daily (e.g., money for transportation). Problem solving or advocacy may be required to resolve scheduling conflicts (e.g., hours of work and/or school or probation requirements).

Child care obligations may be an impediment to methadone pick-up or participation in counselling. When possible, MMT clinics should have policies and procedures to provide child care support for clients who must bring their children to the clinic with them or must stay at home when the child is sick.

The counsellor who makes a special effort to recognize and relieve some of the stress associated with the transition into a treatment program can be regarded as trusted and helpful. This can have a significant impact on the client's continued engagement (McCann et al., 1994).

CASE STUDY

Tanya is a 34-year-old single mother with four children ranging in age from two to 16 years. She has been involved with child welfare services for the past year on a voluntary basis. Tanya has a 10-year history of opioid use, mainly prescription opioids, and she has sought treatment voluntarily. During Tanya's first three weeks of methadone treatment, she was often late for her appointments or she failed to attend the clinic. Her counsellor noted her difficulty attending her appointments and casually approached Tanya in the waiting area of the clinic.

The counsellor asked Tanya what would be helpful to her. Tanya disclosed that she could not afford public transportation on a daily basis and that she had been walking to the clinic, which was a substantial distance from her home. Some days, she simply felt too tired and/or too overwhelmed by her child care responsibilities to attend.

The counsellor and Tanya discussed some solutions. The counsellor gave Tanya a letter for Social Services advocating for additional monthly funding for a public transportation pass. During the interim, bus/subway tokens were made available by the clinic.

With shorter absences from home, Tanya and her counsellor were able to work out some additional babysitting options. They continued to schedule regular appointments but introduced reminder notices in the form of telephone calls or messages left where she picked up her methadone. The counsellor also encouraged Tanya to call and reschedule appointments any time.

When difficulties persisted, the counsellor encouraged Tanya to drop in for brief meetings without an appointment any time she was in to pick up methadone.

Eventually, Tanya began to keep regular contact with her counsellor. The phone also became a useful tool in building their counselling relationship, as it allowed Tanya and her counsellor to maintain regular contact when she had to stay with her children.

The counsellor's supportive efforts to accommodate and reach out to Tanya were instrumental in engaging Tanya in the counselling process.

Orientation to MMT

Orientation to MMT is an important part of the process of engaging clients in treatment. Clients need to be oriented to the nature of the treatment process, the physical context of the treatment and the people involved in the provision of the treatment.

Legal Rules and Procedures in MMT

MMT is a legally regulated treatment. There are many more rules and procedures for clients to understand and follow than is typical of other substance abuse treatments. For example, there are expectations concerning urine screenings, the timing of methadone pick-ups, the ingestion of methadone, missed doses, and the criteria for take-home privileges (carries), in addition to the usual expectations related to attendance at treatment sessions and appropriate behaviour.

Clients may be overwhelmed, confused or offended by the rules and regulations of an MMT program. Counsellors should be sensitive to the likelihood that this level of structure may be new and difficult for the client.

Expectations of the MMT Program

Counsellors need to ensure that clients are familiar with all of the expectations of the MMT program and that the process of informing the client aids rather than hinders the engagement process. Written treatment agreements and use of a client handbook can help to inform the client and provide a record to consult should misunderstandings arise; see *Methadone Maintenance Treatment: Client Handbook* (CAMH, 2001). However, care should be taken to ensure that literacy problems do not undermine this process.

Patience and understanding in explaining the rationale for various policies and procedures can go a long way toward offsetting any tendency clients may have to interpret the rules as punitive and symbols of mistrust. Practical problem solving may be necessary to help the client comply with the rules and procedures of MMT.

Familiarity with Physical Layout of the MMT Clinic

Orientation also involves making sure that the client is familiar with the physical layout of the clinic. This includes access routes, waiting areas, any provisions for child care, washrooms, the dispensing area and the location of various team members.

Walking the client around the setting is also a chance to introduce the client to team members he or she has not yet met. Counsellors should assume that clients are anxious about becoming involved with other members of the treatment team. Personal introductions help to facilitate smooth transitions. They also communicate the message that the client is valued and that the team is working together in his or her best interest.

Urine Drug Screening

During orientation, counsellors need to be especially sensitive to client reactions to urine drug screening (UDS) procedures, which may be perceived by the client as intrusive and punitive.

UDS has been an integral component of MMT programs since their inception and is a legally required regulation in both Canada and the United States.

UDS is used to confirm the diagnosis of opioid dependence, to determine if a client on methadone is taking his or her methadone, to provide an objective measure of the client's progress, to detect whether the client is taking illicit or other non-prescribed drugs, to assist in achieving an optimal dose of methadone and reduce the risk of

harmful drug interactions. It can be beneficial to the client as an objective indicator of progress, which may provide personal satisfaction, or be useful in persuading others (e.g., the courts) that the client has made significant progress. UDS results can also be used as an objective basis on which to decide to grant take-home dose privileges.

Limitations of Urine Drug Screening

UDS is often advocated because the screen is able to detect and deter drug use. However, there are serious limitations, especially if the results are used punitively. UDS detects only what is currently in the urine, which is dependent on the type, amount and timing of drug use. It is widely recognized that the combination of self-report and UDS provides the most accurate picture of drug use (Ward et al., 1992).

The use of UDS results in a punitive manner will discourage clients from reporting drug use voluntarily, as well as encourage attempts to beat the screening system. The result will be mistrust and less accurate information about drug use, which will undermine all aspects of the counselling process.

Furthermore, there is little evidence that UDS effectively deters drug use (Ward et al., 1992). Beliefs that the risks of a punitive response will be offset by a deterrent effect are probably misguided. In short, it is imperative that UDS be presented to clients and used as a helpful clinical tool and not as a means of surveillance.

Minimum Legal Requirements for Urine Drug Screening in Ontario

The publication entitled *Methadone Maintenance Guidelines* (College of Physicians and Surgeons of Ontario et al., 2001) sets forth the minimum requirements for UDS in Ontario. The frequency of screening is normally greater during the Stabilization Phase to assist in establishing an optimal dose of methadone and to achieve stability with regard to drug use.

To be valid, collecting the urine sample must be supervised to some degree. Usually, clients are observed to ensure that they are alone and have minimal opportunity to alter the sample.

Observation of any sort is, of course, a serious invasion of the client's privacy. MMT programs need to strike a balance between minimizing the falsification of urine samples and the risk of humiliation and mistrust among clients. Taking the temperature of the sample, which should be body temperature, can also be a useful monitoring procedure. However, this is by no means foolproof because clients know what temperature the sample should be. In addition, a variety of adulterants can potentially mask the detection of drug use.

Emphasize Trust and Collaboration

Once again, emphasis is placed on trust and collaboration. On the one hand, if clients understand and accept UDS as a clinical component of the treatment, and the use of the results confirms this, there will be little incentive to falsify urine samples. On the other hand, if test results are used punitively there will be no end to the creativity demonstrated to beat the system, and the system will be seen to reward the most devious.

When Results of Urine Drug Screens Are Disputed

UDS involves sophisticated technology. There are different methods of analysis, which typically involve a trade-off of sensitivity versus specificity. The sacrifice to sensitivity will normally be an increased risk of a false positive. However, false positives can also occur for a variety of other reasons, such as misidentification of samples, contaminated sample bottles or laboratory apparatus, reporting and transcribing errors, or the confounding effects of medication the client may be receiving.

Although some clients may be tempted to lie about their drug use, especially where punitive consequences apply, counsellors should treat all denials as an indication of a possible error. MMT programs should have protocols that describe the procedures to be followed to investigate the possibility of error, including procedures for retesting samples.

All counsellors should receive training in UDS procedures. This will allow them to respond in an informed manner to client concerns about the accuracy or legitimacy of the procedures. All MMT programs should designate an individual(s) with intimate knowledge of the UDS technology (typically the physician) who will collaborate with the laboratory to investigate possible false positives. Where no basis for the complaint can be found, the laboratory result should be accepted as correct.

Counsellor's Role Regarding Urine Drug Screening

UDS procedures are introduced early in the Stabilization Phase at a time when client mistrust and ambivalence is likely to be highest. The client will likely greet the procedure with mistrust and embarrassment. The counsellor should be prepared to acknowledge this, respond empathetically to the client's discomfort and present the rationale for the UDS procedures.

Counsellors who have doubts about the justification for the procedures or are uncomfortable with UDS procedures should discuss their concerns with their supervisor or the prescribing physician. Otherwise, they are likely to communicate

these misgivings to the client and create resistance in the client or undermine the teamwork required to effectively deliver MMT.

Assessing Client Needs

Assessment is an important function of the Stabilization Phase of treatment. All new methadone clients should receive a comprehensive psychosocial assessment (see Chapter 7 for details). The psychosocial assessment of the client begins upon the client's entry to the program.

Ideally, a full assessment is completed and a detailed treatment plan is developed before treatment begins. However, in practice, some aspects of the treatment plan may be implemented before others are developed. For example, there may be urgent issues to address (see below), or the client may be anxious to begin using methadone before other potential treatment goal areas are explored.

The counsellor will have to exercise discretion in balancing and prioritizing among the principal issues to be addressed in the assessment process. These issues can be formulated as questions: Is it clear that MMT is the right treatment? Are there acute medical or psychosocial issues to address? How quickly can the use of methadone begin? What treatment goals does the client have in addition to the treatment of opioid dependence?

The client may arrive at the MMT program having had a detailed psychosocial assessment that concluded with a decision to enter MMT. Alternatively, the client may seek out the MMT program because it is presumed to be the best alternative. The counsellor must be sensitive to the path that has brought the client to the MMT program and be confident that the client has made an appropriate and informed choice to enter MMT.

Once it is clear that MMT is the treatment of choice and the client has been oriented to MMT procedures, the wheels will be set in motion to confirm the diagnosis of Opioid Dependence (by the physician) and begin prescribing methadone. Clients usually want to begin taking methadone as soon as possible. Thus, one aspect of the treatment plan may be implemented and become a focus of the counselling process before a full assessment has been completed and a more detailed treatment plan developed. The counsellor will need to assist the client to adjust to the procedures of the MMT program and arrive at an optimal dose of methadone (see below) while continuing to explore other treatment goal areas.

Assessment can be viewed as the first line of intervention. The information gathered in an assessment will help to establish an effective treatment plan. During this process the manner in which the new client is engaged typically sets the pattern for future interactions with the counsellor. A client's openness during the interview is directly correlated to the attitudes conveyed by the interviewer (McCann et al., 1994).

Responding to Acute Needs

It is not uncommon for clients to enter methadone treatment in a state of crisis with multiple pressing issues to be addressed.

Clients' needs are often greatest at the time they enter treatment. It may be essential for the counsellor to set aside the regular agenda to respond to specific problems immediately. These problems may be either medical or psychosocial in nature. Examples include severe pain, nausea, concerns about HIV infection, suicidal behaviour or other psychiatric concerns, a lack of shelter and/or food, a relationship crisis, threats to safety, child care problems and financial or legal difficulties.

Remember, an issue is acute either because it portends serious, imminent consequences or is intensely stressful for the client. It is, of course, fundamental to effective counselling to begin with the issues that are of greatest concern to the client.

The client will make most acute needs apparent. However, this is not always the case. In some instances, clients may be too embarrassed to raise an issue, minimizing the seriousness of their situation, or unaware that you are in a position to help. Counsellors should make a point of inquiring about whether there is anything going on in the client's life that is causing serious concern for him or her right now.

If a new client's acute needs are not responded to quickly, the client may drop out of treatment either because of a lack of confidence in the counsellor or distractions caused by the unmet need. If, on the other hand, the counsellor responds empathetically to the client's urgent needs in an efficient and effective manner, a sense of confidence in the working relationship can be fostered. However, to be effective, counsellors must first prepare themselves to address the types of issues clients are likely to raise. This includes having training in crisis intervention, having resources available for consultation or referral, and being familiar with the range of medical and social services available in the community.

CASE STUDY

Tanya was collecting general welfare assistance but she found it difficult to feed and clothe four children on such a small budget. She reported eating a meal only once a day, or sometimes fasting entirely, to provide food for her children. Tanya said that she did not mind having to go without for the sake of her kids. She said that the end of the month was a particularly difficult time for her financially and that during this time she usually had to fast for a few days.

In response to Tanya's inadequate food supply, her counsellor at the MMT program was able to give her weekly food vouchers for meals at a nearby cafeteria. In addition, her counsellor inquired about Tanya's use of food banks. Tanya said that she had never used a food bank before and that she felt ashamed to do so. Her counsellor discussed this option further with Tanya and gave her the names and addresses of some food banks in her area. The counsellor also offered to accompany Tanya to the food bank the first time she went.

The counsellor felt it was essential that Tanya's child welfare worker be aware of this issue, and she wanted to inquire about the possibility of accessing additional resources and support through child welfare services. Tanya agreed to sign a consent form to allow her counsellor to collaborate with her child welfare worker on this issue.

Developing a Treatment Plan

The development of clear goals and plans is a critical aspect of treatment. Although the client may have had a specific interest in going on methadone, she or he may be unfamiliar with counselling and have only vague ideas about what to expect or how counselling can help. The treatment plan serves to clarify both the purpose and goals of counselling, and it directs the focus of the counselling sessions.

A comprehensive assessment is the foundation for treatment planning. The purpose of the comprehensive assessment is to identify other problems or issues that the client would like to address. Setting priorities among the various potential goal areas is an important dimension of the treatment-planning process. MMT clients often have multiple problems, and it is all too easy to have too many problems surfacing at once, with the risk that none are addressed effectively.

As is the case in most domains of counselling, a treatment plan generally consists of the identification of the problem or concern, a statement of the treatment goal or objective, a strategy by which the goal will be achieved and the criteria to be used to measure progress.

It is advisable that the counsellor develop a treatment plan in collaboration with the client as soon as possible after entry to the program and not later than within the first four weeks of treatment (McCann et al., 1994). This may not always be feasible when there are urgent issues to address or when difficulties arise with respect to the client's starting on methadone.

The client should actively collaborate in the development of the treatment plan and in monitoring progress. Both short- and long-term goals should be identified, and the plan should be reviewed at least every three months during the first year and every six months thereafter. Progress or lack of progress should be recorded, and the plan should be revised as necessary. Refer to Chapter 7 for more details on treatment planning.

Introducing Harm Reduction Strategies

The term *harm reduction* means different things to different people. The harm reduction orientation to MMT that underlies this guide is based on research evidence indicating that when the goals of treatment retention and abstinence appear to be in conflict, it is usually more beneficial to give priority to treatment retention (see Chapter 6 for a more detailed discussion of harm reduction and program philosophy).

Harm reduction is also based on the insight that it is in both the client's and society's best interests to try to minimize the adverse consequences of drug use when the client is either unable or unwilling to discontinue drug use.

Even in abstinence-oriented programs, there are three compelling reasons to introduce harm reduction strategies in the Stabilization Phase: (1) clients seldom achieve abstinence overnight; (2) relapse is a common event in treatment; and (3) some harm reduction strategies have little to do with whether or not the client continues to use opioids or other drugs.

Reduce Risk of Infectious Diseases and Other Harms

Infectious diseases are among the most pertinent risks to be addressed by harm reduction strategies. These include HIV infection, hepatitis B and C, tuberculosis and sexually transmitted diseases (STDs). Discussions of the risks associated with substance use, safer injection procedures and alternative routes of administration are essential aspects of a prevention approach. Other issues concern pregnancy, criminal behaviour and risks to general health, such as malnutrition.

Counsellors who work with methadone clients should have detailed knowledge of these issues and should feel comfortable initiating discussion about them.

Psychoeducational Approach

A psychoeducational approach will usually be the most effective way to proceed. The counsellor should systematically explore the areas of potential risk and introduce educational information at points pertinent to the discussion.

Information introduced in this manner generally has more impact than general information and/or education sessions. For example, it is usually best to introduce information about safer injection practices in the context of a discussion about the client's usual methods of drug self-administration. Similarly, information and strategies about safer sex and pregnancy are best introduced in a discussion about the client's sexual activity.

Printed materials such as brochures may be valuable supplements to the process of reducing risks, but generally they should not take the place of exploration of these sensitive areas together with the client.

Referral to Specialized Resources

In some instances the client's needs may be greater or more sophisticated than what can be addressed in counselling sessions. In such cases, the client should be referred to a more specialized resource (e.g., HIV clinic or birth control centre).

The counsellor must have knowledge of the existence of such specialized resources and take steps to facilitate the referral by making the appointment with the client from the office and possibly accompanying the client to the first appointment.

Some clients may wish to be routinely tested for HIV infection and hepatitis B and C, as part of their medical assessment. MMT programs should have protocols to cover HIV testing (for details see Chapter 13).

Dealing with the process and results of these tests can be traumatic for the client. Counsellors must be prepared to offer emotional support and practical assistance.

CASE STUDY

Hepatitis testing is a routine part of the medical assessment process at Tanya's MMT program. As a result of this testing Tanya discovered that she was positive for hepatitis B and C. She was very upset when she heard the test results, and she was most concerned about the fact that she may have transmitted these diseases to her children.

Her counsellor reviewed the most common means of transmission with Tanya, and she was strongly encouraged to take her children to her family physician for hepatitis testing. Tanya was also informed that there is a vaccine available to her children for hepatitis B. Safe sex practices were also reviewed as well as the importance of eating nutritionally and minimizing alcohol consumption.

Tanya was referred for specialized assessment and treatment for chronic viral hepatitis.

Establishing Optimal Methadone Dose

Achieving a stable dose of methadone for the client is one of the most important objectives of the Stabilization Phase.

Although setting and changing doses is the responsibility of the prescribing physician, MMT counsellors should have a thorough understanding of dose issues for the following reasons:

- Arriving at an optimal dose of methadone is fundamental to MMT. It is unrealistic to be part of the MMT treatment team and not understand methadone dose issues.
- Clients will invariably raise issues related to their methadone dose in counselling sessions.
- Counsellors have an important psychoeducational role in assisting clients to understand the dose-stabilization process.
- Counsellors typically spend more time with the client than any other team member and are in a good position to monitor the client's response to the methadone dose.
- Changes to a methadone dose are often made in consultation with the treatment team, with the counsellor providing valuable input about the client's progress to assist the physician in arriving at an optimal dose.

Dose Stabilization

The initial dose is set consistent with the client's history, signs and symptoms, but usually it does not exceed 15 to 30 mg per day (Kahan et al., 2000). The initial dose is deliberately set low to minimize the risk of overmedication. Lack of tolerance to the effects of higher doses can result in fatal methadone overdose.

Achieving an Optimal Maintenance Dose

Normally, the physician will try to achieve an optimal maintenance dose as quickly as possible. But there are important safety considerations. It takes five to 10 days to achieve a steady state level after the dose is changed. However, in the first week of treatment the dose may be increased every three to four days with careful monitoring.

Each dose increase will usually be in the 5 to 15 mg range to avoid overmedication. Once a daily dose of 60 mg is achieved, the rate and amount of dose adjustment will usually be no more than 5 to 10 mg every seven to 14 days.

For most clients, the optimal maintenance dose will be between 50 and 120 mg per day. There are, of course, exceptions. Some clients may respond well to a lower dose and others will require more. Individual differences in clients, related to their level of dependence and the way they metabolize methadone or other drugs and/or medications they may be taking, can result in wide variations in optimal dose.

Counsellors should avoid the common, but mistaken belief that keeping the methadone dose as low as possible is a primary objective of MMT. As Vincent Dole (1988) has argued, "There is no compelling reason for prescribing doses that are only marginally adequate."

Clinical Monitoring during Dose Stabilization

Counsellors can play an important role in monitoring client progress in the dose stabilization process. However, to do so they must be familiar with clinical signs of over- and under-medication, as well as the side-effects of methadone (see Chapter 3).

Optimal Daily Dose

The optimal daily dose of methadone is one that is sufficient to keep the client free of withdrawal symptoms over the full 24-hour period between doses and minimize the signs of overmedication or side-effects (see Chapter 3 for the symptoms of acute opioid withdrawal). However, the client's experience of withdrawal may be more subtle and subjective.

Counsellors should explore how the client is feeling throughout the day and whether she or he has observed any changes. The counsellor should be especially alert to potential withdrawal symptoms late in the 24-hour period when the serum methadone level is lowest.

Subjective symptoms of withdrawal can include drug craving, anxious feelings, depression, dysphoria, irritability, fatigue, insomnia, hot or cold flashes, aching muscles and/or joints, anorexia, nausea and restlessness (Brands & Brands, 1998; Leavitt et al., 2000). The presence of any of these symptoms may be an indication that optimal stabilization has not been achieved.

Potential Drug Interactions

The counsellor also needs to be alert to potential drug interactions. When used in combination with methadone, some other drugs (illicit or prescribed) can produce adverse reactions or alter the degree to which the methadone dose prevents the onset of opioid withdrawal. (See the summary of drug interactions in Chapter 3.)

Inadequate Doses

Reports of opioid use by clients have often been viewed as indicating the client's ambivalence to change and have resulted in reductions in methadone dose. In reality, such reports may be a strong indication that the methadone dose is inadequate. There are many clinical examples where increasing the dose under these circumstances has resulted in the discontinuation of illicit opioid use.

As a general rule, continued opioid use should be interpreted as an indication that the methadone dose may be inadequate unless there is good evidence that an optimal dose has been achieved. The physician may wish to test serum methadone levels (SMLs) as clients taking the same methadone dose can have very different SMLs because of individual differences in drug metabolism (Leavitt et al., 2000).

Getting Methadone to Home-Bound Clients

MMT clients in the Stabilization Phase of treatment are normally required to pick up their methadone on a daily basis. Occasionally, clients may be home bound for reasons related to their health, their children or domestic emergencies.

MMT programs should have policies and procedures to address such circumstances. These procedures must be developed in consultation with the dispensing pharmacists.

Stabilizing Drug Use

Clients entering MMT are dependent on opioids. The prescription of methadone is expected to be the principal means by which opioid use will be brought under

control. Continued use of opioids is a major factor in the process of establishing an optimal dose of methadone, as already described. This is particularly important to the extent that cravings or withdrawal symptoms are the stimuli for opioid use.

Risk Factor Analysis for Opioid Use

To assist in the stabilization of opioid use, counsellors should also use some form of risk factor analysis to identify the situations in which opioid use is occurring and plan, together with the client, strategies to immediately reduce the risks. Self-monitoring procedures may be helpful in identifying these high-risk situations. Initially, avoidance responses are particularly important (e.g., avoiding particular people with whom opioid use has been frequent). Other forms of coping responses (e.g., drug refusals) gradually become more prominent. These procedures are similar to those used to treat other substance use problems.

Using Other Drugs

Clients entering MMT may also be using other drugs. The first consideration will be a discussion of the client's goals and intentions. Clients entering MMT may or may not wish to discontinue the use of all other substances. An important consideration in this discussion should be the degree to which the continued use of other drugs undermines or interferes with clients' opioid use goal.

There are different perspectives with respect to the importance of abstinence from all psychoactive drugs. Irrespective of which perspective prevails in the MMT program, the desire to reduce or discontinue opioid use is a major step for the client and should not be jeopardized by arguments about the necessity for abstinence from all other substances.

As the stabilization process begins, there will be enough to do to effectively control opioid use. The issue of other drug use can always be revisited once progress has been made regarding opioid use or, alternatively, has not been made because of other drug use. There are many routes to abstinence, not all of which require an initial commitment.

Many clients will wish to address other drug use problems, and strategies to get other drug use (e.g., cocaine) under control may be an important priority. In such instances the risk factor approach described above would be applicable. (For additional details concerning the treatment of polysubstance use, see Chapter 11.)

Completion of the Stabilization Phase

Clients typically move through the Stabilization Phase in 30 to 90 days (Hoffman & Moolchan, 1994), but this phase may last anywhere from a few weeks, to a few months to more than a year.

Achieving functional stability can be used to mark the completion of the Stabilization Phase.

The following criteria are indicators of functional stability (Hoffman & Moolchan, 1994; Kaufman & Woody, 1995):

- An optimal dose of methadone has been established.
- Program participation has stabilized, as indicated by the following:
 - Methadone is picked up regularly.
 - Scheduled appointments are kept.
 - The treatment agreement is being adhered to.
- Cognitive stability has been achieved, as indicated by the following:
 - Drug cravings have disappeared or are under control.
 - The client is optimistic about recovery.
 - There is no indication of serious cognitive impairment.
- Alcohol and other drug use have stabilized at levels that are not incompatible with the use of methadone or associated with significant physiological, psychological, social or spiritual consequences.
- Social stability has been achieved, as indicated by the following:
 - Stable living arrangements have been established.
 - There is an absence of interpersonal crises.
 - Criminal activity has ceased or decreased.
- Day-to-day social functioning has stabilized.

When clients were asked about their own experience of stability, they offered the following descriptions:

- “being clean except for my meth”
- “having no more drug cravings”
- “being confident in my ability not to use”
- “when my methadone dose is at a level where I experience no withdrawal symptoms, I no longer use and I no longer want to use ... so I will be at a point where I can start thinking about putting the rest of my life in order”
- “when I can come here, drink my meth and feel like a normal person for the rest of the day, and I don’t have to wake up worrying about how I am going to get through the day.”

These descriptions capture some of the criteria to be considered in determining when a client is ready to move on to the Action/Maintenance Phase of treatment. However, it is important to emphasize that the achievement of “functional stability” is a clinical judgment and that clients will rarely meet all of the criteria all of the time at the point they are ready to move to the Action/Maintenance Phase.

CASE STUDY

Tanya has been in a methadone program for eight months. She has not missed a scheduled doctor's appointment in the past three months. Tanya has not missed a methadone dose since her first month on the program, and she reports no withdrawal symptoms or significant drug cravings. She provides urine drug screens as scheduled and abides by the rules of the program. She is no longer involved with child welfare services. She has not used opioids since her second month on the program, and she has begun to seriously consider stopping her cannabis use. She has kept every counselling appointment for the last two months and has reiterated her interest in weekly counselling sessions to begin addressing longer-term vocational and interpersonal goals. Tanya has completed the Stabilization Phase of treatment.

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