Medication Assisted Treatment for Opioid Addiction Phased Approach

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7 Phases of Treatment

In This Chapter...

The consensus panel recommends that medication-assisted treatment for opioid addiction (MAT) as provided in opioid treatment programs (OTPs) be conceptualized in terms of phases of treatment so that interventions are matched to levels of patient progress and intended outcomes. The sequential treatment phases described in this chapter apply primarily to comprehensive maintenance treatment, rather than other treatment options such as detoxification or medically supervised withdrawal. When MAT is organized in phases, patients and staff better understand that it is an outcome-oriented treatment approach comprising successive, integrated interventions, with each phase built on another and directly related to patient progress. Such a model helps staff understand the complex dynamics of MAT and the potential sticking points and helps counselors organize interventions based on patient needs.

The model described in this chapter comprises either five or six patient-centered phases for planning and providing MAT services and evaluating treatment outcomes in an OTP, including the (1) acute, (2) rehabilitative, (3) supportive-care, (4) medical maintenance, (5) tapering (optional), and (6) continuing-care phases.

Rationale for a Phased-Treatment Approach and Duration

Research on the effectiveness of organizing MAT into phases is limited, partly because MAT is a relatively long-term process, often with no fixed endpoint and with a variety of possible approaches, and partly because patients often leave and then return to MAT, which makes systematic studies difficult. Although research is limited, the consensus panel believes that the notion of phased progression is implicit in treatment and underlies most of a patient's time in MAT. Many OTPs operate according to an informal phased-treatment model, and others use phases at least to develop treatment plans.

Hoffman and Moolchan (1994) recognized the value of treatment phases in OTPs and described a highly structured model. This chapter builds on, adapts, and extends their model as part of an overall strategy for matching patients with treatments. The phases described below are suggested as guidelines—a way of organizing treatment and looking at progress on a care continuum—and as an adjunct to the levels of care specified by the American Society of Addiction Medicine in its patient placement criteria (Mee-Lee et al. 2001*a*) and referred to by accreditation agencies.

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The model is not one directional; at any point, patients can encounter setbacks that require a return to an earlier treatment phase. Therefore, the chapter includes strategies for addressing setbacks and recommendations for handling transitions between phases, discharge, and readmission. In terms of medication, the model includes two distinct tracks, one of continuing medication maintenance and the other of medication tapering (medically supervised withdrawal). The implications of both tracks are discussed. Although most patients would prefer to be medication free, this goal is difficult for many people who are opioid addicted. Maintaining abstinence from illicit opioids and other substances of abuse, even if that requires ongoing MAT, should be the primary objective.

Variations Within Treatment Phases

The phase model assumes that, although many patients need long-term MAT, the types and intensity of services they need vary throughout treatment and should be determined by individual circumstances. For many patients, MAT is the entry point for diagnosis and treatment of, or referral for, other health care and psychosocial needs. In general, most patients need more intensive treatment services at entry, more diversified services during stabilization, and fewer, less intensive services after benchmarks of recovery begin to be met (McLellan et al. 1993; Moolchan and Hoffman 1994).

The consensus panel emphasizes that treatment phases should not be viewed as fixed steps with specific timeframes and boundaries but regarded as a dynamic continuum that allows patients to progress according to individual capacity. Some patients progress rapidly and some gradually. Some progress through only some phases, and some return to previous phases. Treatment outcomes should be evaluated not only on how many phases have been completed or whether a patient has had to return to an earlier phase but also on the degree to which the patient's needs, goals, and expectations have been met. As described in chapter 4, assessment of patient readiness for a particular phase and assessment of individual needs should be ongoing.

Duration of Treatment Within and Across Phases

Decisions concerning treatment duration (time spent in each phase of treatment) should be made jointly by OTP physicians, other members of the treatment team, and patients. Decisions should be based on accumulated data and medical experience, as well as patient participation in treatment, rather than on regulatory or general administrative policy.

Phases of MAT

Acute Phase

Patients admitted for detoxification

Although the phases of treatment model is structured for patients admitted for comprehensive

maintenance treatment, some patients may be admitted specifically for detoxification from opioids (see 42 Code of Federal Regulations [CFR], Part 8 § 12(e)(4)). These patients usually do not wish to be admitted for or do not meet Federal or State criteria for maintenance treatment. Patients admitted for detoxification may be treated for up to 180 days in an OTP. The goals of detoxification are consistent with those of the acute treatment phase as described below, except that detoxification has specific timeframes and MAT endpoints. Detoxification focuses primarily on stabilization with medication (traditionally using methadone but buprenorphine-naloxone tablets are now available), tapering from this medication, and referral for continuing care, usually outside the OTP. During this process, patients' basic living needs and their other substance use, co-occurring, and medical disorders are identified and addressed. Patients also may be educated about the high-risk health concerns and problems associated with continued substance use. They usually are referred to community resources for ongoing medical and mental health care.

Patients admitted for detoxification should have access to maintenance treatment if their tapering from treatment medication is unsuccessful or they change their minds and wish to be admitted for comprehensive MAT. If these patients meet Federal and State admission criteria, their medically supervised withdrawal from treatment medication should end, their medication should be restabilized at a dosage that eliminates withdrawal and craving, and their treatment plans should be revised for long-term treatment.

Patients admitted for comprehensive maintenance treatment

The acute phase is the initial period, ranging from days to months, during which treatment focuses on eliminating use of illicit opioids and abuse of other psychoactive substances while lessening the intensity of the co-occurring disorders and medical, social, legal, family, and other problems associated with addiction. The consensus panel believes that front-loading highly intensive services during the acute phase, especially for patients with serious co-occurring disorders or social or medical problems, engages patients in treatment and conveys that the OTP is concerned about all the issues connected to patients' addiction. Exhibit 7-1 summarizes the main treatment considerations, strategies, and indicators of progress during the acute phase.

Goals of the acute phase

A major goal during the acute phase is to eliminate use of illicit opioids for at least 24 hours, as well as inappropriate use of other psychoactive substances. This process involves

- Initially prescribing a medication dosage that minimizes sedation and other undesirable side effects
- Assessing the safety and adequacy of each dose after administration
- Rapidly but safely increasing dosage to suppress withdrawal symptoms and cravings and discourage patients from self-medicating with illicit drugs or alcohol or by abusing prescription medications
- Providing or referring patients for services to lessen the intensity of co-occurring disorders and medical, social, legal, family, and other problems associated with opioid addiction
- Helping patients identify high-risk situations for drug and alcohol use and develop alternative strategies for coping with cravings or compulsions to abuse substances.

Chapter 5 details the procedures for determining medication dosage.

Indications that patients have reached the goals of the acute phase can include

- Elimination of symptoms of withdrawal, discomfort, or craving for opioids and stabilization

Exhibit 7-1

Acute Phase of MAT

Treatment Issue	Strategies To Address Issue	Indications for Transition to Rehabilitative Phase
Alcohol and drug use	• Schedule weekly drug and alcohol testing • Educate about effects of alcohol and drugs; discourage their consumption • Ensure ongoing patient dialog with staff • Intensify treatment when necessary • Meet with program physician to ensure adequate dosage of treatment medication	• Elimination of opioid-withdrawal symptoms, including craving • Sense of well-being • Ability to avoid situations that might trigger or perpetuate substance use • Acknowledgment of addiction as a problem and motivation to effect lifestyle changes
Medical concerns • Infectious diseases (e.g., HIV/AIDS, hepatitis, tuberculosis [TB]) • Sickle cell disease • Surgical needs, such as skin or lung abscesses	• Refer patients immediately to medical providers • Vaccinate as appropriate (e.g., for hepatitis A and B)	• Resolution of acute medical crises • Established, ongoing care for chronic medical conditions
Co-occurring disorders • Psychotic, anxiety, mood, or personality disorders	• Identify acute co-occurring disorders that may need immediate intervention • Identify chronic disorders that need ongoing therapy	• Resolution of acute mental crises • Established, ongoing care for chronic disorders
Basic living concerns • Legal and financial concerns • Threats to personal safety • Inadequate housing • Lack of transportation • Childcare needs • Pregnancy • Advocacy	• Assess needs • Refer patient to appropriate services • Work cooperatively with criminal justice system • Explore transportation options • Link to legal advocate, case-worker, or social worker • Identify financial resources • Provide ongoing case management	• Satisfaction of basic food, clothing, shelter, and safety needs • Stabilization of living situation • Stabilization of financial assistance • Resolution of transportation and childcare needs

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