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Naltrexone implants

In the first randomised controlled trial of naltrexone implants, Kunøe *et al*[1] identify two inclusion criteria in their methodology: being an in-patient and being 18 years or above. Exclusion criteria are given as psychosis, pregnancy and serious hepatic disease. Of 667 possible participants, 480 are excluded. In the results, the term 'ineligibility' is used to describe not completing treatment, starting maintenance and transfer to other clinics. Could the authors clarify when these additional criteria were decided upon and how many were excluded for each reason? Given that all 667 patients were receiving 'abstinence-oriented' in-patient treatment, it is notable that only a small proportion of patients was eligible for or wanted such treatment. The characteristics of the ineligible or refusal group could provide important information about which group of opiate-dependent patients are likely to benefit from naltrexone.

Data on opioid use throughout the period of treatment would be of value. In the non-abstainers we would expect both groups to use in the first few days, but behavioural extinction to occur in the naltrexone group.

Participants who had their implants removed were included in the analysis using their last response carried forward. If these patients could not be contacted, would it not be a more conservative assumption that they would have relapsed?

The patient group that was living in a controlled environment (prison or clinic) at follow-up was dealt with by using pre-admission data. This group is missing from the flowchart.

1 Kunøe N, Lobmaier P, Kåre Vederhus J, Hjerkinn B, Hegstad S, Gossop M, et al. Naltrexone implants after in-patient treatment for opioid dependence: randomised controlled trial. *Br J Psychiatry* 2009; **194**: 541–6.

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Authors' reply: We are happy to clarify. Of the 667 patients, 265 opioid-dependent patients entered in-patient treatment for induction onto agonist maintenance treatment and were therefore excluded. Also, patients who left their respective clinics prematurely were not eligible for participation ($n = 193$); 11 were excluded owing to psychotic symptoms, 8 owing to pregnancy, and 17 owing to extreme ALT/AST values.

This left 173 opioid-dependent patients satisfying inclusion criteria. However, the virtually complete novelty of naltrexone implant treatment in Norway at the time of recruitment probably means that these results are a poor basis upon which to base estimates of demand for this form of treatment.

The randomised trial period was followed by an implantation or re-implantation opportunity for all patients, meaning that the proportion of patients who entered in-patient treatment again at the end of the study to detoxify or stabilise is probably higher than it would be in future clinical samples. Reporting it as a result or as part of a figure could be regarded as misleading.

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Assertive community treatment teams

Killaspy *et al* present disappointing results from their randomised controlled trial examining the effectiveness of assertive community treatment (ACT).[1] They found that it did not reduce admissions and bed usage.

However, as Professor Burns' editorial in the same issue points out, this finding should not come as any great surprise to us.[2] Assertive community treatment has never really been shown to be effective in reducing admissions in the UK. Professor Burns avers that this is because of community mental health teams (CMHTs) actually being active comparators rather than treatment as usual. I think there is another important reason.

UK assertive outreach teams have always had engagement as their primary focus. This is understandable in view of their client group, a group that has not engaged with traditional CMHTs. Thus, innovative approaches to engagement, such as meeting in less stigmatising settings, have been the hallmark of UK assertive outreach teams, along with providing practical support.

However, the key question is, what happens once the patient is engaged? I believe the focus of the team should then swiftly move towards recovery and social inclusion. The most important characteristics of this would include a strong strengths-based approach and a focus on helping patients back to employment, whether voluntary or paid. Other characteristics would include a clear relapse prevention plan made in collaboration with the patient and a strong network of supported accommodation.

Occupational therapists are invaluable in promoting such approaches in psychiatric care, both in terms of social inclusion and potentially in leading on 'return to work' initiatives.[3]

Similarly, strong links with the Local Authority are important in ensuring a good network of supported accommodation. This is facilitated by the presence of social workers with such links within the team.

However, it is interesting that in surveys done of assertive outreach team composition, it is the nursing profession that predominates.[4] Occupational therapy and social work input remains limited, while psychology input is concerningly rare.

Assertive outreach as an intervention has worked well abroad but needs to be modified to suit the needs of the UK population. The modification required, in my opinion, is a stronger focus on recovery and rehabilitation. This can be facilitated by ensuring that occupational therapists and social workers are an integral part of assertive outreach teams. It intuitively makes sense that a strong recovery approach, clear relapse prevention plans and good supported accommodation that is available for the patient who needs it, should together reduce admissions and bed usage. This is the assertive outreach model that needs to be evaluated in well-designed randomised controlled trials.

1 Killaspy H, Kingett S, Bebbington P, Blizard R, Johnson S, Nolan F, et al. Randomised evaluation of assertive community treatment: 3-year outcomes. *Br J Psychiatry* 2009; **195**: 81–2.