

Correspondence

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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, Hjerkin 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.

- 2 Burns T. End of the road for treatment-as-usual studies? *Br J Psychiatry* 2009; **195**: 5–6.
- 3 College of Occupational Therapists. *The Value of Occupational Therapy and its Contribution to Adult Social Service Users and their Carers*. College of Occupational Therapists, 2008 (<http://www.cot.org.uk/MainWebSite/Resources/Document/The%20value%20of%20OT%20and%20its%20contribution.pdf>).
- 4 Wright C, Burns T, James P, Billings J, Johnson S, Muijen M, et al. Assertive outreach teams in London: models of operation. Pan-London Assertive Outreach Study, Part 1. *Br J Psychiatry* 2003; **183**: 132–8.

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Killaspy *et al*'s longer-term follow-up¹ to the REACT study² replicated their original finding that ACT teams had no advantage over CMHTs in reducing in-patient care and concluded by questioning further investment in ACT in the UK. We found this interesting because we have evidence for a reduction in in-patient bed use locally, albeit using a different methodology.

The Sandwell Assertive Outreach Team has been operating for over 5 years, serving an ethnically and socioeconomically diverse urban population of approximately 280 000. The team has remained adherent to the Department of Health Policy Implementation Guide³ and has a mean score of 3.7 on the Dartmouth Assertive Community Treatment Scale.⁴ We retrospectively reviewed our performance in terms of number of admissions and bed-days for all 73 patients who have been with our service for over 3 years. We compared these results with data for the same population in a similar period prior to transfer of care to our team. The results are summarised in Table 1.

We are conscious of a local trend for referrals to our service to be initiated as patients relapse and therefore transfer of care often occurs on discharge from hospital. Improvements seen in 1-year figures may be due to a period of remission in keeping with the natural history of the illness, but the fact that improvements are maintained over 3 years in patients with frequent relapses would suggest that this is less likely to be a significant factor.

A possible explanation for the reduction in bed use might be that our assertive outreach team offers daily home treatment for patients in relapse and at risk of admission instead of involving the crisis and home treatment team. We are not aware of this aspect of assertive outreach being reported elsewhere in the literature about UK services and suggest it produces better outcomes by preventing patients with a history of disengaging from mental health services having to develop a therapeutic relationship with a new team at a time of crisis.

We feel that these before-and-after findings provide evidence to suggest that assertive outreach was locally responsible for

reducing bed usage over several years in a population previously characterised by poor engagement and multiple admissions. Burns *et al*⁵ found that fidelity to ACT staffing practices did not explain variation in outcome between trials and concluded that we should research the practices of teams. It would be interesting to know whether other services report a reduction of in-patient bed use and whether a programme of active daily visiting with medication in relapse played a part. We suggest that this aspect of assertive outreach could be incorporated in future research into effective components of the model.

- 1 Killaspy H, Kingett S, Bebbington P, Blizzard R, Johnson S, Nolan F, et al. Randomised evaluation of assertive community treatment: 3-year outcomes. *Br J Psychiatry* 2009; **195**: 81–2.
- 2 Killaspy H, Bebbington P, Blizzard R, Johnson S, Nolan F, Pilling S, et al. The REACT study: randomised evaluation of assertive community treatment in north London. *BMJ* 2006; **332**: 815–20.
- 3 Department of Health. *The Mental Health Policy Implementation Guide*. Department of Health, 2001.
- 4 Teague G, Bond G, Drake R. Program fidelity in assertive community treatment. Development and use of a measure. *Am J Orthopsychiatry* 1998; **68**: 216–32.
- 5 Burns T, Catty J, Dash M, Roberts C, Lockwood A, Marshall M. Use of intensive case management to reduce time in hospital in people with severe mental illness: systematic review and meta-regression. *BMJ* 2007; **335**: 336.

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Author's reply: The 36-month outcomes of the REACT trial¹ that ACT shows no clinical advantage over support from standard CMHTs bemuses ACT proponents. Grewal & Cowan report reductions in in-patient service use for ACT patients in Sandwell, but their results are confounded by the national reduction in bed use since the implementation of the National Service Framework for Mental Health, a common problem with before-and-after studies of ACT in the UK. Glover *et al*² showed how crisis resolution teams reduced admissions across the country, but ACT teams failed to impact further on this. The Sandwell ACT team's provision of a crisis service may therefore have influenced their outcomes. Nevertheless, it is noteworthy that although in-patient service use was the primary outcome in the REACT study, there were no statistically significant differences in other outcomes between the two treatments, including social functioning, symptoms, needs, attitudes towards medication, adverse events, substance misuse and quality of life.³

The lack of efficacy for ACT in the UK appears to be related to the degree to which comparison services replicate critical aspects of ACT.⁴ In the REACT study, the CMHTs shared with the ACT teams four of the seven key components: primary clinical responsibility; community-based; team leader doing clinical work; time-unlimited service (the others being daily team meetings, sharing of case-loads, and operating 24 hours a day).

A consistent finding in studies of ACT is that it is more acceptable to 'difficult to engage' patients than standard care, but although UK ACT services are engaging patients, as Shetty rightly states, they are not building on this to deliver the evidence-based interventions likely to improve clinical outcomes. In some cases this is due to inadequate specialist staffing, although this was not an issue in the REACT study. A survey of 222 English ACT teams in 2003 found that only half had a psychiatrist, a fifth had a psychologist and very few had a substance misuse or vocational rehabilitation

Table 1 Bed usage for 73 patients of the Sandwell Assertive Outreach Team before and after transfer to the team

	Year prior to transfer	Year after transfer	3 years prior to transfer	3 years after assertive outreach treatment
Admissions per patient	0.92	0.48	2.39	1.21
Admissions per patient per year	0.92	0.48	0.8	0.4
Bed-days per patient	63.6	30.5	156.7	80.1
Bed-days per patient per year	63.6	30.5	52.2	26.7