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▶ Transitioning opioid-dependent patients from detoxification to long-term treatment: efficacy of intensive role induction.

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Katz E.C., Brown B.S., Schwartz R.P. et al.

Drug and Alcohol Dependence: 2011, 117, p. 24–30.

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The drive in Britain to increase drug treatment exits will mean more patients detoxifying and in need of being linked to effective follow-on care to safeguard their lives and their recovery. Evidence from the USA that a simple counselling intervention can help make that vital link.

Summary The featured study tested two ways of promoting follow-on treatment after patients have been withdrawn (or 'detoxified') from opiate-type drugs – attempts to stabilise their abstinence and avoid the relapse which commonly follows withdrawal. Such initiatives are needed because by itself detoxification usually fails to lead to follow-on treatment. The study builds on previous work showing that involvement in long-term treatment following detoxification can be enhanced by methods including case management to coordinate care from various sources, and role induction counselling, which aims to establish a collaborative relationship within which the dependent user sees themself as a patient in need of further treatment.

Prior research from the same team had established that outpatient treatment entry and retention were promoted by a single role induction session with the counsellor who would also conduct the treatment, offered when the patient first attended to apply for treatment. Also in Baltimore, the featured study tested a similar but more extensive intervention as a means of promoting treatment engagement during and after a 30-day opiate detoxification involving stabilisation on buprenorphine/naloxone ('Suboxone') and then tapering doses. Also tested was whether adding case management would further improve engagement.

At the outpatient centre, between 2005 and 2008, 240 patients who had opted for a buprenorphine-based detoxification qualified for and joined the study. Typically unemployed and unmarried black men and women in their early 40s, all the patients

tested positive for opiates and used these drugs almost every day, and 55% were also positive for cocaine. On average they had two prior detoxifications.

The day after medical assessment and their first dose of medication, patients were assigned at random to three types of counselling conducted over five weekly sessions by the counsellor who would care for them during and after detoxification:
• the clinic's usual counselling beginning later in the first week of treatment, focused on the disease model of addiction and addressing issues and concerns raised by patients;
• intensive role induction, the first session of which took place on the same day as their medical assessment; guided by a manual, counsellors educated patients about detoxification and treatment, addressed their concerns and barriers to continued treatment, and emphasised the value of continuing care beyond detoxification to solidify recovery;
• intensive role induction combined with case management, both delivered by the same counsellor in the same sessions starting on the same day as the medical assessment; the case management elements aimed to promote (through advocacy and other concrete means) access to community resources (not just those available at the clinic) which might support the patient's efforts at recovery.

To avoid obscuring distinctions between the three counselling options, different counsellors were trained in and delivered each option. All the patients were also offered intensive outpatient group therapy for the five weeks of detoxification, and afterwards at least weekly individual and group counselling for an expected six months or indefinitely if needed.

Main findings

Compared to usual care, during detoxification both the tested interventions significantly increased (from on average two to just over three) the number of counselling sessions patients attended. Patients offered intensive role induction (but *not* when it was combined with case management) were also significantly more likely (68% v. 49%) to complete the detoxification process. However, this finding narrowly missed the study's criterion for statistical significance (though it remained a noteworthy tendency) when differences between patients had been taken in to account.

Compared to usual care, following detoxification role induction patients were non-significantly more likely to attend at least one session of follow-on treatment, though this finding failed to meet the study's criterion for a non-significant tendency after differences between patients had been taken in to account. Specifically, nearly 55% of role induction patients attended a session compared to 41% after usual care. Role induction patients also stayed in treatment significantly longer – on average 35 versus 16 days. Though a month in to their treatment the three groups of patients were equally satisfied with treatment, role induction patients felt significantly greater rapport with their counsellors then usual care patients. Again, all these differences were smaller and failed to meet criteria even for a non-significant tendency when role induction had been combined with case management.

The authors' conclusions

Role induction led to the greatest engagement with treatment. Compared to usual care, these patients on average attended more counselling sessions during detoxification, were

more likely to complete detoxification, rated their counsellors more favourably, and remained in treatment for longer following detoxification. Role induction combined with case management was less effective, significantly improving only counselling attendance during detoxification. The intensive form of role induction tested in the study may in these ways help transform the role of detoxification from a palliative to that of preparing patients to take greater advantage of longer term treatment.

Counsellors may have found it difficult to maintain quality when combining the rather different ways of working of role induction and case management within the same limited time frame, undermining the effectiveness of both interventions. Also, case management can generate frustration when community resources the patient has been led to hope for and expect are not available, perhaps why counsellors offering this combination were not rated more favourably than counsellors offering neither.

However, the advantage gained by role induction may have been partly due to the first session being scheduled the same day as the medical assessment and first dose of medication rather than several days later. All patients offered this early session with or without case management attended at least this one, but about a third of usual-care patients did not attend any counselling sessions. This would not however account for the relative failure of the combined intervention.

In sum, the study showed that a role induction intervention which staff find easy to implement and integrate in to their programmes can enhance patient involvement in detoxification as well as their transition to longer term treatment.

FINDINGS The timing of the first session of counselling seems likely to at least partly account for the advantage both tested interventions had in terms of counselling attendance during detoxification. Placing this to one side, the remaining ways role induction significantly bettered usual care after differences between patients had been taken in to account were confined to an extra on average across all patients two to three weeks in post-detoxification care, or three to four weeks among those patients who actually started this care, plus greater rapport with counsellors than usual care patients. Both impacts are worth having, but perhaps constitute an insufficiently consistent impact to make adoption of this five-session intervention seem essential to detoxification services aiming to promote completion and aftercare. In particular, even after intensive role induction, nearly half the patients did not go on to attend a single aftercare session.

The surprise in the study is that adding case management to role induction weakened the impact of the former and possibly also of the latter. Rationalising this, we can appreciate that in the same time (an hour) other counsellors had to devote to simpler tasks, the counsellors had to undertake the usual role of counselling at the clinic, to implement the additional role induction elements, and then to seek to engage outside services via case management. Role induction can be seen as systematising what counselling tries to do anyway, building on a familiar patient education and informing role. As well as cutting time for other tasks, case management would have taken some counsellors (and perhaps patients too) beyond their comfort zones and in to direct engagement with external services, yet without the time and resources to make this work. This post hoc speculation may not be valid, but still the finding stands as a caution against attempting too varied a therapeutic agenda.

While case management did not promote engagement with services provide within the

agency the patient was already attending, this is not its primary role or primary effect. It remains possible that the case management elements promoted linkage with external services and perhaps thereby promoted improvements in the patients' lives.

The need to promote aftercare

Completion rates for opiate detoxification vary considerably. In Britain for example, one study found that 60% of outpatients who chose their detoxification medication completed, as did 65% who accepted random allocation and were randomised to buprenorphine. Completion rates may have been elevated by careful pre-detoxification preparation, including elements of role induction and encouragement to reduce heroin intake, initiation by an experienced clinician, and daily clinical contact. In contrast, at another clinic just 36% of outpatients who sought detoxification from methadone maintenance completed the process, which was based on the palliative medication lofexidine, a less effective option than tapering doses of opiate-type drugs.

Completion is of course just the first phase. Without further support – and even when this is on offer – only a minority of patients can sustain opiate abstinence. In the British trials referred to above, in the first about a fifth of patients were abstinent from illicit opiates a month later without further treatment; at the same time in the second, 12% were neither using illicit nor prescribed opiates. Some form of follow-on care is especially important for patients who complete detoxification and leave devoid of the protection afforded by their previous tolerance to opiate-type drugs. Without effective support, the high rate of relapse can translate in to a high rate of overdose deaths.

Ways to promote aftercare

As the authors of the featured study point out, role induction is just one way of promoting aftercare. The various methods are not mutually exclusive and can have an additive impact, as demonstrated at the Salem Veterans Affairs medical centre in the USA. The centre offers a 28-day residential rehabilitation programme to its alcohol and/or drug dependent ex-military patients. To sustain sobriety, staff stressed the importance of aftercare but attendance was poor. A unique series of studies found that attendance radically improved as step by step researchers added enhancements, culminating in a report which suggested that there were consequent reductions in drinking and related problems. The steps included a contract asking patients to commit in writing (witnessed by the therapist) to regularly attend specified aftercare sessions plus education emphasising that this promotes abstinence, a reminder system featuring personal letters from the therapist, appointment cards, and automated telephone reminders prompting patients to attend the next session in a few days time, and awards consisting of medallions and certificates handed out during aftercare sessions. Further reinforcement took the form of a handwritten letter congratulating the patient on initiating aftercare followed by another after three sessions.

These and other methods including motivational interviewing, regular check-ups of whether how the patient is doing and whether they need further support, and incentives for therapists to promote aftercare, were among those trialled in the studies included in a US review which confirmed that promoting aftercare generally improves substance use outcomes. It found 11 studies which allocated patients at random or in a quasi-random manner to aftercare or continuing care versus minimal or no continuing care. In terms of

each study's main substance use outcome measures, seven of the 11 found a clear and statistically significant advantage for continuing care. The review's conclusions were endorsed by a panel of experts convened by the US Betty Ford Institute, who argued that extended and regular monitoring of the patient's progress was the key component of continuing care and the one with the greatest evidence of effectiveness. Both review and recommendations were based largely on studies of aftercare following residential treatment.

UK guidance and policy

UK national guidelines caution careful selection of patients fully committed to completing and sustaining withdrawal, and who will re-enter a supportive and stable social environment after discharge, among which may be seamless entry in to residential rehabilitation. The preparation phase and the detoxification interlude itself should be used to bolster psychological resilience and social supports. Patients whose attempt at abstinence is not working out should be offered immediate access to alternative treatments such as buprenorphine and methadone programmes. For patients who do complete withdrawal, a full programme of aftercare is vital to help avoid relapse and to identify when further support or alternative treatments are advisable. The general message is that detoxification without preceding stabilisation, preparation and aftercare, including the construction of a resilient post-detoxification life, is too often a band-aid measure which risks more harm than good.

This caution may become more relevant as services respond to the national UK drive to increase the proportion of patients who leave treatment. For opiate dependent patients, this will normally be via detoxification. If these numbers increase, aftercare too will increasingly be needed to safeguard the progress made during detoxification as well as health and lives, and to promote and embed recovery. But continuing/after care provision runs up against a strong contrary trend in current UK policy, which emphasises not continuing care, but exit from the treatment system. Without denying the need for long-term care for some patients, the English strategy on drug misuse said services needed "to become much more ambitious for individuals to leave treatment free of their drug or alcohol dependence so they can recover fully". Scotland's strategy too stressed the need for more patients to "move on from their addiction towards a drug-free life as a contributing member of society", implying a corresponding shift away from extended and/or indefinite treatment.

In both countries reintegration in to mainstream society and especially in to employment are seen as the bulwarks which can help prevent relapse and relieve the need for extended care. Much will depend on the receptivity of the broader society to the relapse-preventing reintegration of problem substance users, and especially problem drug users. Without sufficient receptivity in the form for example of routes in to suitable work opportunities, decent and stable housing, and social acceptance and support, extended care may be the most realistic way to prevent or intervene early in health- and life-threatening relapse.

Thanks for their comments on this entry in draft to Elizabeth Katz of Towson University in the USA and Wouter Vanderplasschen of the Universiteit Gent in Belgium. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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