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NON COMPLETERS OF OPIATE DETOXIFICATION PROGRAM

A.K. NIGAM[1], R. RAY[2], B.M. TRIPATHI[3].

Seventy two opiate dependent patients were admitted in de-addiction ward for detoxification. Twenty five patients (36.2%) left or were discharged prematurely and hence called non-completers. Demographic features, drug use characteristics and severity of withdrawal were found unrelated to the attrition.

Attrition of the original cohort is an inherent problem along patients undergoing treatment of drug dependence. Too many patients leave treatment before maximal benefit are presumed to occur. During opiate detoxification 30-50% of patients drop out of treatment(Backland and Lundwall, 1975; Millman *et al.*, 1981; Bickle *et al.*, 1988; Vining *et al.*, 1988). Several researchers have investigated the factors related to non-completion of treatment. Age, employment, status, social class, social stability and nature of treatment yeilded inconsistent findings. Often high level of anxiety, depression, sociopathy, impulsivity and low frustration tolerance have been associated with drop outs (Backland and Lundwall, 1975; Wilson and Whelan, 1983). Craig (1984) in his review reported that often the predictors failed to generalize from one study to another. By and large it has been felt that longer period of inpatients stay is associated with better outcome and less likelihood of relapse (Kaplan and Meyerowitz, 1969). However the relationship is not exactly linear between length of stay and outcome and some may do well after a relatively short period of ward stay (Gossop, 1978). We cannot remain complacent about patients dropping out and effort must be made to predict such a phenomenon and minimise its occurrence. The present study examined the demographic features, drug use profile and withdrawal symptoms among the subjects who were non-completers to treatment.

MATERIAL AND METHOD

The subjects were part of a study evaluating effectiveness of buprenorphine against clonidine in opiate detoxification. The patients were voluntarily admitted to our ward following screening and counselling at the OPD. They were expected to stay in the ward for at least ten days for completion of drug regime. The patients were mostly dependent on heroin, only males between 15-50 years and included in the study with informed consent.

All the patients received randomly either oral clonidine (0.3 -0.9 mg/day) or sublingual buprenorphine (0.6 - 1.2 mg/day) in three divided doses for 10 days. Twenty five patients (36.2%) out of a total 69 subjects included did not complete their detoxification and left prematurely. They are called non-completers and form the study sample. Out of the 25 patients an equal percentage received either of the compounds. Information on socio-demographic parameter, drug use history were obtained with the help of an interview schedule. Subjective and objective opiate withdrawal symptoms were rated daily with the

1. Senior resident, 2. Additional Prof. and 3. Associate Prof., De-Addiction Center, Department of Psychiatry, A.I.I.M.S., New Delhi 110 29.

help of a rating scales (SOWS and OOWS-Hendelsman *et al*., 1987).

RESULTS

Reasons for non-completion were broadly three -

a) those left against medical advice (n = 11), reasons often were: being bored, incomplete relief of withdrawal symptoms, severe craving;

b) those discharged on disciplinary grounds (n = 10), reasons were: fights with other fellow patients, threatening behaviour towards staff, possessing drugs;

c) absconded (n = 4)

DEMOGRAPHIC FEATURES

Mean age of completers was 28.7±7.2 as against 27.5±4.8 years of non-completers. Eighty six percent had education for ten years and below, but none were illiterates. Only 8.3% were currently unemployed and 46% were married. In none of the above variables the no-completers was different from the completers.

DRUG USE PROFILE

As seen in table 1, none of the parameters related to drug was different in the two groups.

SEVERITY OF WITHDRAWAL SYMPTOMS

Patients left on various days while undergoing treatment, however 80% dropped out by the 5th day. Peak opiate withdrawal scores for both the groups were comparable. For subjects receiving clonidine mean subjective and mean objective withdrawal scores were : completers - 20.2 and 5.2 and non-completers - 19.7 and 4.3 respectively. For subjects receiving buprenorphine, mean subjective scores were 16.2 vs. 11.6 and mean objective scores 3.9 vs. 4.1 respectively for completers and non-completers. The differences were not statistically significant.

Table-1 : Opiate use profile

	Completers (n = 44)	Non-completers (n = 25)	Std. Error of difference of two means
Amount consumed in the previous month (gm/day)	1.5±.9	1.6±.9	(N.S.)
Heaviest use ever (gm/day)	2.9±1.6	3.4±2.0	(N.S.)
Duration of use (yrs.)	4.7±2.6	4.8±1.9	(N.S.)
Age of initiation (yrs.)	23.±97.2	22.4±5.0	(N.S.)

DISCUSSION

Drop out is a rule across all drug treatment modalities and is very much expected . However, this issue of treatment completion and retention is incompletely understood. Our patients were non-psychotics admitted voluntarily, and with consent. The detoxification procedures, and ward rule were explained in the OPD prior to admission. Yet 36% had left before the treatment was over. This figure is similar to studies quoted earlier (Backland and Lundwall, 1975; Millman *et al.*, 1981; Vining *et al.*, 1988).

In absolute terms retention are higher for methadone maintenance and lower for drug free outpatient and in drug free residential therapeutic community (DeLeon, 1991). Often the reasons for leaving were personal viz. want to get high, drug problem is not serious enough and attempt to consume drugs in the ward. These reasons leading to self and disciplinary discharges found in our study were very similar to earlier reports (Gossop, 1988; DeLeon, 1991).

None of the variables examined here predicted treatment completion. It may mean demographic features, clinical information and severity of withdrawal symptoms are poor predictors.

Patients' attitude to treatment and personality attributes need to be studied. Their own estimate of how long they needed treatment correlated well with actual length of stay (DeLeon, 1991). Intrinsic motivation, circumstances leading to treatment, amount of family pressure or even pressure exerted by the patient to get admitted are crucial for better compliance. Co-ercion may even be therapeutic (Gossop, 1978). Increased family involvement and changes of patient's perception are likely to reduce drop out.

Finally, non-completion may not necessarily mean treatment failure. We are currently engaged in a study assessing outcome of patients who left prematurely.

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