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Efficacy of the Community Reinforcement and Family Training for concerned significant others of treatment-refusing individuals with alcohol dependence: A randomized controlled trial

Gallus Bischof[a,*], Julia Iwen[b], Jennis Freyer-Adam[c], Hans-Jürgen Rumpf[a]

[a] University of Luebeck, Luebeck, Germany
[b] University of Hamburg, Hamburg, Germany
[c] University of Greifswald, Greifswald, Germany

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ABSTRACT

Background: The Community Reinforcement and Family Training (CRAFT) is a promising approach for Concerned Significant Others (CSOs) of alcohol-dependent individuals (ADI) that aims to engage treatment-refusing patients in alcohol treatment and to improve CSO functioning. To date, only two randomized controlled trials (RCTs) of CRAFT-based treatment for CSOs of ADI are available, both conducted in the U.S. For the first time, this study analyses the efficacy of CRAFT in a sample of CSOs outside of the U.S.

Methods: Participants were recruited through the treatment system (general practitioners, psychotherapists, addiction counselling services) and through media solicitation. After brief screening, 94CSOs were randomly allocated to an immediate intervention condition (II) or a wait list condition (WL) that received the CRAFT intervention after 3 months. Data for the follow-up assessments at 3 and 6 months was provided by 78CSOs (II N = 42; WL N = 36). In addition, a follow-up assessment (f-u) was conducted after 12 months (Response rate 92%).

Results: At 3-month f-u, II revealed significant higher ADI engagement rates (40.5%) compared to WL (13.9%); after WL received the CRAFT intervention, engagement rates did not differ between both groups at 6- and 12-month f-u. CSOs in both groups reported significant improvements in terms of mental health and family cohesion after having received the intervention, i.e. II at 3-months f-u and WL at 6-month f-u.

Conclusions: Data show that CRAFT is effective for treating CSOs of alcohol dependent individuals in terms of treatment engagement and improvement of CSOs mental health and family cohesion.

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1. Introduction

Substance Use Disorders mostly have a strong impact on the social network of affected individuals. Concerned significant others (CSOs) of individuals with substance use problems show elevated rates of psychosocial impairment (Copello et al., 2005; Velleman et al., 1993) and elevated costs for health care services (Ray et al., 2009; Svenson et al., 1995). Furthermore, only a small minority of individuals with substance use problems ever enters treatment (Grant, 1996; Stinson et al., 2005). Traditional treatment approaches based on the 12-step facilitation therapy like Al-Anon have pointed out that CSOs are powerless and should engage in "loving detachment"(Al-Anon Family Groups, 1995).

However, a series of interventions for CSOs of treatment refusing individuals with substance use disorders have been developed and have challenged the idea of powerlessness and have promoted means for CSOs to promote behaviour change by taking an active role. The Johnson Institute Intervention (Johnson, 1986), based on the Minnesota Model of Addiction, was designed in the sixties to promote treatment entry by setting up a family confrontation. More recently, other approaches that use a less confrontational style have been developed but have not been tested against controls (Landau et al., 2004).

As pointed out in a systematic review (Roozen et al., 2010), most scientific evidence so far supports the efficacy of the Community Reinforcement and Family Training (CRAFT; Smith and Meyers, 2004). CRAFT is a behavioural approach designed to simultaneously improve CSO wellbeing and to promote treatment entry of the indi-

* Corresponding author at: University of Luebeck, Department of Psychiatry and Psychotherapy, Ratzeburger Allee 160, 23538 Luebeck, Germany.
E-mail address: gallus.bischof@uksh.de (G. Bischof).

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vidual with substance use problems by changing environmental contingencies. However, only five RCTs have been conducted so far, three dealing with drug users (Brigham et al., 2014; Kirby et al., 1999; Meyers et al., 2002) and two with individuals with alcohol problems (Miller et al., 1999; Sisson and Azrin, 1986). Among these, one study examined CRAFT as an adjunct treatment for drug dependents already in treatment (Brigham et al., 2014) and three out of four studies addressing CSOs of initially untreated individuals with alcohol/drug problems used only Al-Anon as comparison group. As Al-Anon rather discourages family involvement in order to promote treatment entry, effects on treatment entry (primary outcome in all four studies addressing CSOs of untreated individuals with alcohol/drug problems) may have been overestimated (Kirby et al., 1999; Miller et al., 1999; Sisson and Azrin, 1986). Finally, all studies conducted so far were restricted to the US. Given the differences between the substance use treatment systems in the US and Europe, further studies are necessary to prove the efficacy of CRAFT and its generalizability.

This study presents data on the first RCT comparing a unilateral intervention for CSOs of alcohol dependent individuals (ADI) initially unmotivated for treatment conducted outside of the US. According to the study design using a 3-month-waiting list as controls, significant differences between groups were expected for the 3-month follow-up, while alignment between groups and outcomes comparable to previous studies on CRAFT were expected for the 6- and 12-month follow-up after controls received the CRAFT-intervention.

2. Methods

The randomized controlled trial received approval from the University of Luebeck ethics committee. It included two arms, one Immediate Intervention (II) and a 3-month Wait List (WL). The wait list design was chosen because we included a proactive recruitment strategy in which GPs, Psychotherapists and Counseling Centres could refer CSOs to the project and because no structured "treatment as usual" concepts for CSOs are available in Germany. Follow-up assessments were conducted at 3, 6 and 12 months. We expected to find significant differences at the 3-month follow-up, given that in CRAFT studies conducted in the US, treatment engagement usually took place within the 12-week timeframe of the CRAFT intervention (Smith and Meyers, 2004). For the 6- and 12-month follow-up, we expected no group differences, but we did expect further improvement in CSOs mental health and ADI treatment entry rates, consistent with previous studies on CRAFT.

2.1. Participants

CSOs were recruited through general practitioners (GPs), psychotherapists and outpatient treatment facilities. All GPs, psychotherapists and treatment facilities in the vicinity of Luebeck in northern Germany received flyers providing information about the study. In addition, the study was described in two professional journals for the local Medical Association of Schleswig-Holstein and Mecklenburg-Western Pomerania, representing the catchment area of the recruitment site. After 4 months in the study, participants were also recruited via local newspapers.

To participate in the study, CSOs had to meet the following eligibility criteria: (a) having a close one meeting diagnostic criteria for alcohol dependence (American Psychiatric Association, 1995); (b) spending at least 20 h per week with, or living together with the ADI; (c) at least 18 years of age (both the CSO and the ADI); (d) absence of severe violence (violence that made medical assistance necessary according to the CSO); (e) absence of substance specific treatment for the ADI within the last 3 months; (f) willing to participate in research and giving informed consent for participation. Exclusion criteria were: CSOs holding a current DSM-IV diagnosis of alcohol or drug use disorder or ADI fulfilling criteria for comorbid drug use disorders.

2.2. Screening

CSOs were first interviewed for eligibility through a screen by phone. The interviewer briefly explained the purpose of the study and then ascertained eligibility through diagnostic information on the ADI concerning alcohol and other drugs, history of treatment (including self-help group participation), drinking behaviour of the CSO, and the amount of contact between CSO and ADI. CSOs found ineligible received a brief counselling session and were referred to appropriate community resources if necessary. CSOs found eligible were informed about the study, particularly the randomization procedure, and were scheduled for intake as soon as possible. In two cases, alcohol dependence could not be fully confirmed due to missing information. However, due to severe adverse consequences these cases were considered "probably dependent" and CSOs were included in the study.

2.3. Assessment and randomization

2.3.1. Baseline assessment. At the beginning of the first appointment, CSOs had to fill out an informed consent form, followed by a series of questionnaires containing the baseline assessment.

The assessment battery contained the following measures:

CSO status: CSOs completed a questionnaire on sociodemographic status, the Beck Depression Inventory (BDI; Beck, 1978), the Symptom Checklist (SCL-90-R; Derogatis, 1992), the Mental Health Inventory (MHI-5; Berwick et al., 1991), the Satisfaction with Life Scale (SWLS; Diener et al., 1985), a brief Scale measuring Sense of Coherence (SOC; Schumann et al., 2003), the Relationship Happiness Scale (RHS; Azrin et al., 1973; Sisson and Azrin, 1986) covering relationship satisfaction in 10 areas of life using Likert scales and the Pictorial Representation of Illness and Self Measure (PRISM; Reinhardt et al., 2006), an instrument measuring degree of suffering (from the alcohol consumption of the ADI), adopted for the situation of CSOs. The PRISM is a visual measure that asks CSOs to indicate the place the alcohol dependence of their ADI currently has in their life; with lower values indicating a higher degree of suffering.

ADI Status: As done in the previous CRAFT studies, all information concerning the ADI was exclusively collected from the CSOs. Assessment of ADI status included standardized questions on previous help-seeking. Adverse consequences from drinking were assessed with a German translation of a nine-item scale derived from the "Health and Daily Living Form" (Moos et al., 1985).

2.3.2. Randomization. Following the assessment, participants had to draw a sealed envelope that contained cards indicating if the CSO was assigned to II or WL, the latter beginning three months later, after the 3-month follow-up assessment.

2.3.3. Follow-up assessment. Follow-up assessments were completed with the CSO at intervals of 3, 6 and 12 months after the baseline assessment. As primary outcome variable, treatment utilization by the ADI was assessed by asking whether s/he received treatment for alcohol problems available in the community, including specialised in- or outpatient treatment and/or self-help groups. Treatment utilization was restricted to any form of active treatment participation requested by the ADI and comprising at least one full session at the facility, e.g., receiving brief intervention or counselling by a physician not intended by the ADI (e.g., during a visit due to health issues other than alcohol) was not counted as

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