

A randomised comparison of two levels of an intervention to work with relatives of alcohol and drug users in primary care

Introduction

Alcohol and drug problems are common and are associated with significant health and social problems. Close family members of people with alcohol or drug problems suffer stress-related physical and psychological symptoms that can be severe and long lasting, often prompting a higher use of primary care services, and hence resulting in significant burden on healthcare resources.

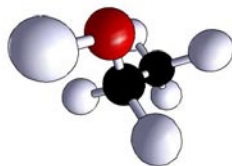
The service response to problem drug and alcohol use is generally focused on users rather than affected family members. Results from studies focused on families, however, suggest that brief psychosocial interventions can be effective at reducing both stress related psychological and physical symptoms experienced by family members affected by addiction problems and costs associated with health and welfare service demands made by affected family members.

We had previously developed a brief psychosocial intervention to reduce stress related symptoms and increase coping amongst family members affected by alcohol and drug problems - the '5-Step Intervention'. As part of a preliminary evaluation and feasibility study, 91 primary care professionals including General Practitioners, Health Visitors and Practice Nurses were trained to deliver this 5-Step psychosocial intervention. Thirty seven tests of the intervention were delivered and results for family members showed a significant decrease in psychological and physical symptoms of stress from baseline to end of intervention follow-up and significant changes in behavioural coping, with family members reducing some of the less helpful ways of coping.

The present study aimed to evaluate the effect of this intervention in a larger study with a randomised experimental design including a comparison briefer intervention.

What we did

The brief psychosocial intervention we had developed was designed to be delivered by a primary health practitioner (GP, Health Visitor, etc). For this study we



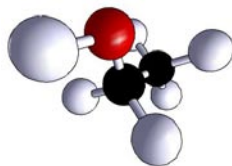
developed a second version of this intervention (a self-help manual) which would be less intensive - family members could take the self-help manual home and work through it at their own pace, and would not have the face-to-face contact and encouragement arising from the more intensive method.

We then conducted a prospective cluster randomised comparative trial of these two levels of intensity of the intervention, delivered to family members recruited by primary health care professionals from 74 primary care practices in two study areas within the West Midlands and the South West regions of England.

The more intensive intervention (we called it the 'full' intervention (FI)) was a revised version of the one used and reported in the feasibility study, based on the stress-strain-coping-support model of addiction and the family. This FI included up to 5 face-to-face sessions during which the professional used a range of strategies to help family members identify sources of stress, obtain relevant information about substances, explore coping behaviours and consider and attempt to enhance available social support. Each professional delivering the intervention used a Manual which provided guidance on how to deliver each of the 5 steps. In addition, each family member was provided with the self-help version of the same manual (see below).

The briefer intervention (BI) that served as a comparison consisted of one face-to-face session with a family member during which the primary care professional introduced the self-help manual. The self-help manual was based on the manual for professionals, and was designed to help family members identify sources of stress, gain access to specific information related to substances, explore coping behaviours used in response to the impact of the problem and consider available social support. The family member was encouraged to take the manual and work through it in his/her own time. The difference between the two conditions was therefore the intensity of face-to-face contact with the primary care professional.

We initially recruited 197 primary health professionals from 136 primary care practices in our two study areas (the West Midlands and the South West regions of England). Following dropout either side of training there were 168 primary health professionals aiming to deliver one or other of these interventions: 78 aiming to deliver the full intervention and 90 the brief intervention. Together, these pri-



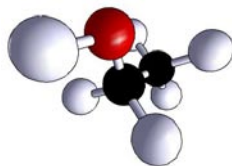
many health professionals worked with 143 family members affected by the alcohol or drug problem of a relative, 51 of whom received the full intervention and 92 the brief intervention. In order to join the study, family members needed to 1) consider that the drinking or drug taking of a relative had been a major source of distress in the last six months; 2) have a relative with an alcohol or drug problem who had been drinking or consuming drugs problematically at some point during the last six months; and 3) have been living under the same roof at some point in the last six months, or had face-to-face contact at least three times a week, with their relative with the alcohol or drug problem. Family members were excluded if they: 1) experienced alcohol or drug problems themselves and/or 2) had severe mental health problems. All recruited family members were seen on at least one occasion by the professional delivering the intervention and 129 (90 %) were followed up at 12 weeks.

Our main outcome measures were two validated and standardised self-completion questionnaires measuring physical and psychological symptoms of stress (Symptom Rating Test) and behavioural coping (Coping Questionnaire) experienced by the family members. The interventions aimed to reduce both symptoms and coping.

Findings

Family members in both groups showed significant reductions in symptoms of stress and coping behaviour. Symptoms scores were significantly reduced from 32.2 (sd = 12.2) to 28.7 (sd = 14.6) in the full intervention arm ($p < 0.01$) and from 34.0 (sd = 12.1) to 30.0 (sd = 12.9) in the brief intervention arm ($p < 0.01$). Coping scores were significantly reduced from 51.7 (sd = 16.6) to 43.7 (sd = 19.6) in the full intervention arm ($p < 0.001$) and from 52.0 (sd = 13.6) to 44.4 (sd = 18.6) in the brief intervention arm ($p < 0.001$). However, no significant differences in outcome were found between the two trial arms. More details of these quantitative findings are in Copello et al, 2007.

There was a sizeable qualitative component to the work, including interviews with family members who had taken part and with the professionals. Importantly, analysis of these qualitative interviews showed that both family members and professionals expressed a preference for more intensive face-to-face contact than that



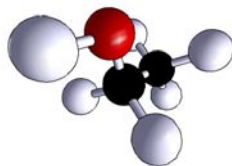
provided within the brief intervention arm.

Family members who received the full intervention were appreciative of being able to talk to a professional who had time to listen and who appeared interested, understanding and caring. The self-help manual itself was reported to contain active ingredients for change, and a number of family members described transformations in their ways of coping with the problem whether they received the full or brief form of intervention. A common constellation of changes included increased consciousness of the nature and extent of the relative's drinking or drug use and its family effects, an acknowledgement of the family member's own needs and rights, a strengthening of resolve to assert plans and expectations, and a calming effect with reduction in stress symptoms. Many participants were unable to describe changes, however, and the following principal limitations of the intervention were described: prior familiarity with the material, perception that the intervention did not go far enough, belief that it was incapable of effecting change for the substance misusing relative, and a perception that sufficient professional expertise or sympathy was not always available in primary care.

At the end of the project, professionals were overwhelmingly positive about the family member intervention and about primary care as the appropriate site. Difficulties were encountered, however, in identifying and engaging affected family members, who were often excluded by primary care practitioners on grounds of the complexity of their problems or the level of their distress. Shortage of professional time and other practice-related factors added to the difficulty. Active work by a professional was often necessary in order to make the link between presenting symptoms of physical or mental ill-health and the existence of a family substance misuse problem. When family members were identified and recruited, the professionals were usually positive about what was achieved. Nearly all were in favour of an approach that combined giving a self-help manual with some follow-up contact with a family as needed. More details of these qualitative findings are in Orford et al, 2007a,b.

Implications

These findings suggest that the brief intervention was associated with similar changes in the main outcome measures, namely changes in family members'

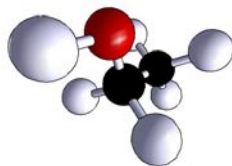


symptoms and coping behaviours, when compared to the full intervention. The changes in both arms of the trial are in line with findings from the feasibility study. In addition, it was also evident that a number of those professionals who were trained were able to deliver the intervention to family members, although recruitment of family members was different in the two arms.

In light of the present results and when the likely cost of the interventions is considered, one conclusion is that the briefer form of the intervention should be the one to be implemented in primary care on cost-effectiveness grounds. However, because both family members and professionals expressed a preference for more intensive face-to-face contact than that provided within the brief intervention arm, this 'cost-effectiveness' argument may not be the only important one: there is an interesting dilemma here, related to the tension between cost savings on the one hand, and patient involvement and choice within health services on the other. There may also be a need for further research to be undertaken to explore in greater depth what both professionals and family members meant by 'more intensive contact' and to see if this could be provided in other ways.

A similar discussion relates to the difference in cost between the professional groups. No differences in outcome were found between General Practitioners, Health Visitors and Practice Nurses, suggesting that the latter two groups should be favoured when possible as the cost associated with these two groups is lower than that for GPs. Considering the value of opportunistic interventions in addiction, however, it could be argued that it is important for everyone in the primary care setting/team to be able to respond to the needs of family members, particularly when brief interventions are available. The particular role that GPs play in primary care also needs to be taken into account, and it may be that they have a particular role in the identification of family members, which might imply a division of roles, where GPs become more involved in screening, with other primary care staff being more involved in delivering the intervention.

As in previous work, recruitment of primary care professionals posed a number of challenges. Service support costs were available and helped to reimburse those professionals taking part in the study. Uptake however was low and engaging primary care professionals in this type of work remains a challenge. Of interest was that, despite there being equal number of professionals in each arm, those in the

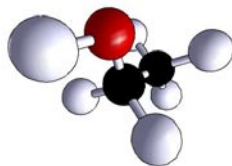


brief intervention arm went on to recruit almost twice the number of family members than those in the more intensive intervention arm (92 vs. 51).

There are two further important issues that need to be considered when interpreting the results of this trial. First, the nature of the professional sample. Professionals were self-selected and likely therefore to include those with positive attitudes towards the patient group and the type of work. Secondly, randomisation was by practice. Several options were considered in relation to randomisation. The more conventional design would have involved randomisation of the individual patient to intervention arm. Difficulties with potential contamination within practices and difficulties in implementing the operation of a randomisation set of procedures within each practice within the trial resources, led to the decision to use the design reported that involved randomising each practice as a cluster. Statistical analysis suggested that the clustering effect was not significant. The absence of any differences between groups at baseline also increases our confidence in the comparability of the samples from the two trial arms.

In summary, the study results suggest that it is feasible to recruit primary care professionals to deliver brief interventions to family members affected by alcohol and/or drug problems. When comparing two levels of intensity of an intervention, however, it was clear that both interventions led to significant change in outcome measures which included symptoms of stress and coping behaviours. Both patients and primary care professionals were positive overall about the interventions and scope for improvements were identified.

This project has led to significant further work. The 5-Step intervention has also been utilised in secondary care (Templeton et al, 2007), and in other countries (eg Italy, Velleman et al, 2007; Arcidiacono et al, 2007). The success of these projects has led to an AERC-funded implementation phase, where entire primary care practices and specialist substance misuse teams have been trained to become more 'family focused' in their work, using elements of both this 5-Step intervention and of Social Behaviour and Network Therapy (eg Copello et al, 2002; UKATT, 2005). This implementation work is ongoing within other settings too, and is becoming gradually more widely embraced,



Further Information

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Arcidiacono C., Fioretti G., Velleman R. and de Georgio U. (2007) Professionals' evaluation of the '5-Steps Method' for helping family members of substance misusers in the context of the Italian Health Services. *Drugs: Education, Prevention and Policy*, in press.

Copello A., Orford J., Hodgson, R., Tober, G. and Barrett, C. (2002) Social Behaviour and Network Therapy: Basic principles and early experiences. *Addictive Behaviors*, 27, 345-366.

Copello, A., Templeton, L., Orford, J., Velleman, R., Patel, A., Moore, L. and Macleod, J. (2007) The relative efficacy of two levels of a primary care intervention for family members affected by the addiction problem of a close relative: a randomised trial. *Addiction*, under review.

Orford, J., Templeton, L., Patel, A., Copello, A. and Velleman, R. (2007a) The 5-Step family intervention in primary care: I. Strengths and limitations according to family members. *Drugs: Education, Prevention and Policy*, 14, 29-47.

Orford, J., Templeton, L., Patel, A., Velleman, R. and Copello, A. (2007b) The 5-Step family intervention in primary care: II. The views of primary healthcare professionals. *Drugs: Education, Prevention and Policy*, 14, 117-135.

Templeton, L., Zohhadi, S. and Velleman, R. (2007) Working with family members in specialist drug and alcohol services: Findings from a feasibility study. *Drugs: Education, Prevention and Policy*, 14, 137-150.

Velleman, R., Arcidiacono, C., Procentese, F. and Copello, A. (2007) A 5-Step intervention to help family members in Italy who live with substance misusers. *Journal of Mental Health*, in press.

UKATT Research Team (2005) Effectiveness of treatment for alcohol problems: findings of the randomised UK Alcohol Treatment Trial. *BMJ*, 331, 541-544.

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