Behavioural family counselling reduces drug use in opioid-dependent men

Fals-Stewart W, O'Farrell TJ. *Behavioral family counseling and naltrexone for male opioid-dependent patients. J Consult Clin Psychol* 2003;71:432-442.

QUESTION: In men who are opioid dependent, is behavioural family counselling and taking naltrexone in the presence of a family member more effective than individual-based treatment without family involvement?

Design

Randomised controlled trial.

Setting

2 substance-abuse clinics, USA.

Participants

124 opioid-dependent men, fulfilling DSM-III-R criteria, and living with a non-substance-abusing spouse or family member. Mean age of participants was 32 years. People allergic to or with contra-indications to naltrexone, requiring in-patient treatment, receiving counselling for abuse of other substances, and people receiving methadone maintenance therapy in the preceding 30 days were excluded.

Intervention

Participants were prescribed naltrexone (50 mg/day) and randomised to 24 weeks of behaviour family counselling or individual treatment. Both groups received 1 individual and 1 group session per week for the first 16 weeks, followed by 1 weekly individual session for the last 8 weeks. In addition, the behaviour family counselling group received 1 weekly family session for the first 16 weeks, and were required to take naltrexone each day in the presence of a family member. In the individual treatment group, family involvement was not requested.

Main outcome measures

Abstinence from opioids assessed by Time Line Follow Back (TLFB) interview. The TLFB uses a calendar and memory aids to obtain retrospective estimates of daily drug use. The study also examined compliance with naltrexone therapy, assessed by participants' reports and attendance at treatment sessions. Psychosocial functioning was measured with the Addiction Severity Index (ADI).

Main results

During treatment and at 12 months follow up, abstinence from opioids was greater in the behaviour family counselling group than in the individual treatment group (percentage of days abstinent: 81.3% *v* 70.2%; *p* < 0.01 during treatment; 69.3% *v* 56.3%; *p* < 0.01 at 12 months).

During the 24 weeks of treatment, compliance with naltrexone was higher in the behaviour family counselling group than in the individual treatment group (total number of days of compliance 102.6 days *v* 79.4 days; *p* < 0.01). The behaviour family counselling group attended more treatment sessions compared with the individual treatment group (34.2 sessions *v* 26.5 sessions; *p* < 0.05). At 12 months follow up, the scores on the Drug, Family-Social, Legal and Psychiatric subscales of the ADI were significantly higher in the behavioural family counselling group compared with the individual treatment group.

Conclusions

Behaviour family treatment improves outcomes compared with individual treatment in men with opioid dependence. However, it is not clear which components of the behaviour family treatment are responsible for these benefits. The results may not be generalisable to other populations as only a minority of opioid-dependent men eligible for the study took part, as many declined to take naltrexone.

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COMMENTARY

Naltrexone effectively antagonises the use of heroin.¹ Despite this, non-compliance with oral naltrexone formulae has been a significant impediment to its adoption as a major treatment. Periodic relapse to heroin use is common, even in people who perform well on oral formulae.²⁻³

Fals-Stewart *et al* suggest that "Behavioural Family Counseling" (BFC) is the important ingredient in improving adherence to oral naltrexone. Previous research suggests that adherence to oral naltrexone maintenance is improved by support from family and salient others. A large cohort study indicated that supervision of oral naltrexone, most commonly by the mother or other family members, was associated with improved oral naltrexone maintenance at 6 months.³

The aims of BFC in this paper were to reduce conflict and improve communication between the patient and family members. However, the people randomised to BFC were asked to take their daily naltrexone in the presence of a family member, as part of a "recovery contract". In fact the 16 BFC sessions largely established and monitored this "recovery contract" in which the family member observed and verbally reinforced the patients daily naltrexone ingestion. Importantly, the study design does not separate the more conventionally defined BFC activities from this focus on establishing and reinforcing adherence to oral daily naltrexone. Rather than conventional BFC activities of the current study being the singularly most important ingredient, the other activities under the guise of BFC that focused on compliance with daily oral naltrexone are likely to have improved the acceptance of naltrexone supervision by both patient and supervisor. Simply stated, conventional BFC, which does not focus on compliance but rather on reducing conflict and improving communication between patient and family members may not yield the positive outcomes noted in this study. Future studies are required to elucidate the importance of each of these factors.

The findings of this paper are extremely important to clinical practice. An increasing body of literature suggests that programmatic activities can be initiated which increase adherence to oral naltrexone in people addicted to heroin, and therefore improve treatment outcomes. Collectively this research indicates that the provision of oral naltrexone outside a framework that encourages this compliance is both an outdated and unacceptable clinical practice.

It should be noted that a number of sustained release preparations of naltrexone, which appear to maintain therapeutic blood levels for 1 to 5 months have been developed.⁴⁻⁷ This approach, which removes the onus on patients to use daily oral naltrexone, will no doubt be the subject of considerable empirical scrutiny over the forthcoming years.

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