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Title

Helping drug dependent parents and their children: Is Behavioural Couples Therapy (BCT) a realistic option?

Presenter

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SUMMARY

Background

There is limited evidence on effective interventions for children and families affected by parental drug use. Behavioural Couples Therapy (BCT), a USA-developed psychosocial intervention for the treatment of addiction, is recommended by NICE for discordant couples, where one partner is substance-dependent and the other is not.

BCT has been consistently shown to increase rates of abstinence, improve couple relationship functioning, reduce domestic violence, and is cost effective, when compared to individual-based treatment. Notably, BCT has been shown to improve outcomes for children with a substance-dependent father. However, BCT has been poorly implemented and no trials have been conducted in the UK.

Aims

To test whether BCT can be successfully delivered within NHS addiction services in the UK, whether it is possible to extend the intervention to concordant drug-dependent couples in opioid substitution therapy (OST) with children (aged 0-16yrs) living in the home, and whether it was possible to collect outcome data on families.

Methods

Mixed methods feasibility study, aiming to recruit 18 couples via Substance Misuse Services into the BCT programme from June 2016–June 2017. Inclusion criteria: one/both parents receiving OST (discordant/concordant), living with at least one child (0-16 years). Data collection: baseline/end-of-treatment measures on substance use, couple relationship functioning, parenting/child welfare, health economic data, and qualitative interviews with study couples, non-study drug-dependent parents; BCT therapists and referrers. Analysis focused on uptake/attrition/completion rates, barriers/facilitators to implementation, and acceptability of BCT.

Results

Thirteen couples (7 concordant, 6 discordant) with 30 children (17 living at home) were enrolled. All families reported complex needs related to multiple health/social problems. Only 7/13 couples engaged in the intervention following enrolment. None completed the 12-session programme. Session attendance rate for the cohort was 15%. Average number of sessions completed was 3.5. Qualitative interviews with 13/26 participants, 10 non-study parents, 6 BCT therapists (3 nurses, 3 psychologists) and 5 focus groups with 24 NHS addiction staff were conducted.

Multiple barriers to implementation were reported including patient-level, clinician-level, organisational/treatment-level and structural-level obstacles to engagement/retention, acceptability/suitability and delivery of BCT. Strategies which facilitated successful implementation were also identified as well as potential solutions to implementation issues. Couples who engaged in BCT reported some positive benefits and BCT therapists welcomed the opportunity to work with couples/families. However, parents and professionals voiced reservations about BCT in relation to its suitability, acceptability and flexibility for OST patients, parents with complex needs, existing service delivery models and the Scottish culture.

Discussion

Adaptations to the intervention model itself, and its delivery, may be necessary to improve implementation. Findings also suggest an ideological shift is required, towards a more integrated family-focused, ecological approach. Structural changes in joint working between health/social care and child/adult services are also required to facilitate joint care planning.

Conclusion

The delivery of BCT in the UK will likely require a radical rethink and shift in current systems and processes of health care for families affected by parental drug use. Further research is needed to determine whether adaptations would result in more successful implementation and positive outcomes for families.

500 words