Title Registration Form

Campbell Collaboration Social Welfare Coordinating Group

1. Title of review

Cognitive-behavioural therapies for young people in outpatient treatment for illicit non-opioid drug use.

2. Background and objective of this review

(Briefly describe the problem and the intervention)

Illicit non-opioid drugs such as cannabis, ecstasy, amphetamine or cocaine are widely used among young people in the western countries. The latest US National Survey on Drug Use estimates that 8.9 million young people in the US, aged 12 to 25, are current users of illicit drugs. The highest rate of illicit drug use is found among young people aged 18 to 20. In this age group 21.6 percent have used illicit drugs in the past month, while the rate is 3.3 percent among persons aged 12 to 13 (Substance Abuse and Mental Health Services Administration [SAMSHA] 2008a: 19).

Among the different kinds of illicit non-opioid drugs, cannabis is the most frequently used. The latest report from the European Monitoring Centre for Drugs and Drug Addiction estimates that 11 million young people in Europe, aged 15-24 years, have used cannabis within the last year (the average percentage for youth cannabis use across European countries being 16.7 percent), 2.6 million have used ecstasy (the average percentage for youth ecstasy use across European countries being 1.8 percent), 2 million have used amphetamine (the average percentage for youth amphetamine use across European countries being 1.3 percent) and 2 million have used cocaine within the last year (the average percentage for youth cocaine use across European countries being 2.6 percent).

Drug use among young people is strongly associated with delinquency, poor scholastic attainment, suicide and other individual and public calamities (Essau 2006: 129, Rowe & Liddle 2006: 5). Not all young drug users progress to severe dependence, however many do need treatment and surveys call attention to the significant gap between young people classified in need of treatment and young people actually receiving treatment. For example 8.4 percent of 18 to 25 year olds in the US are classified as needing illicit drug use treatment (based on the criteria specified in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorder, DSM-IV), but less than one tenth of these young people actually receive treatment (Young Adults' Need for and Receipt of Alcohol and

Illicit Drug Use Treatment: 2007). Likewise among youth aged 12 to 17, 4.5 percent were estimated to be in need of treatment for an illicit drug use problem, but only one tenth in this group actually received any (SAMSHA 2008a: 83).

Professor McLellan, a leading researcher in the field, links this 'treatment gap' with a public concern regarding the effectiveness and worth of the available treatments for young people. McLellan argues that "a significant portion of Americans – even those working within healthcare settings – feel that 'nothing works' for substance abuse [among young people]. For instance, the Services Research Outcomes Study found in 1998 that while adult patients improved significantly in drug abuse programs, adolescents actually increased their alcohol and drug use" (McLellan 2006: xii). However, at the same time McLellan like many others (e.g. Rowe & Liddle 2006, Waldron, Turner & Ozechowski 2006) point to the fact that there have been significant scientific advances in the research regarding treatment to young people and that many research projects have empirically validated different kinds of treatment approaches as effective (ibid.).

Cognitive-behavioural therapy is one of the intervention forms that has been most researched in recent years and it has shown promising potential among young drug users (see e.g. Waldron & Kaminer 2004, Vaughn & Howard 2004, Becker & Curry 2008, Waldron & Turner 2008, Liddle et al. 2008). This review will evaluate current evidence about the effects of cognitive-behavioural therapies for young people in treatment for illicit non-opioid drug use.

3. Define the population

(Who is included and who is excluded?)

The population will be young people, less than 25 years of age enrolled in outpatient drug treatment for illicit non-opioid drug use (e.g. cannabis, amphetamine, ecstasy or cocaine).

<u>Exclusion criteria will be:</u>
Pregnancy
Opiate addiction (either natural or synthetic opioids, legal or illegal; e.g. morphine, heroin, methadone)
Drug treatment in restrictive environments like prisons or other types of locked institutions (e.g. detention centres, institutions for sentence-serving juvenile delinquents)
Compulsory treatment e.g. mandated by court sentences.

4. Define the intervention/s

(What is given, by whom, and for how long? What are the comparison conditions?)

Interventions that will be included in this review are cognitive-behavioural therapies for young people in outpatient treatment for illicit non-opioid drug use.

Cognitive-behavioural therapy focuses on the client's thoughts and how they are transformed into behaviour. Abuse is perceived as learned behaviour and the assumption is that by increasing awareness of thought and behaviour patterns you can change them (Beck et al. 1993, Poulsen 2006). Specific cognitive-behavioural interventions can have different modalities (individual, group, family) and they can consist of different components in many combinations. Some of the components often included in cognitive-behavioural interventions are self-monitoring, avoidance of identified cues stimulating craving, altering reinforcement contingencies and coping-skills training (Kaminer & Waldron 2006).

Outpatient is defined as treatment that does not include overnight stay in a hospital or other treatment facility. Outpatient programs are the most common form of treatment. For example in 2007 88 percent of clients under age 18 were in outpatient care (SAMSHA 2008b: 24).

Exclusion Criteria:
Interventions delivered purely by non-professionals (e.g. volunteers)
Residential treatment/inpatient treatment

Comparison
Comparison conditions will include no intervention, waitlist controls, and other types of psychosocial interventions than cognitive behavioural therapies.

5. Outcome/s

(What are the intended effects of the intervention? Primary and secondary outcomes should all be mentioned.)

Primary
Abstinence or reduction of drug abuse and improvement of psychosocial functioning are the primary outcomes of interest.
Reduction of Drug abuse:
- Measured through biochemically tests (e.g. urine screen measures for drug use)
- Measured through self-reported estimates on drug use
- Measured through psychometric scales (e.g. Addiction Severity Index (ASI, originally version developed by McLellan et al. 1980)

Psychosocial functioning:
- Measured through psychometric scales (e.g. Diagnostic and Statistical Manual of Mental Disorders (DSM, originally version developed by American Psychiatric Association in 1952, the last version

DSM-IV published in 1994 (American Psychiatric Association 1994, 2000) or broader quality of life measures (e.g. as described by Kind 1994)
- Measured through levels of involvement in education and work (self-reported or reported by authorities, files, registers)
- Measured through crime rates (self-reported or reported by authorities, files, registers)
- Measured through frequency of risk behaviour, e.g. injecting drugs, prostitution (self-reported or reported by authorities, files, registers)

Secondary
Retention
Adverse effects
Costs

Outcomes will be considered in the following intervals:
- Short term effects, end of treatment to less than 6 months
- Medium term effects, 6 to 12 months
- Long term effects, more than 12 months

6. Methodology

(What types of studies are to be included and excluded? Please describe eligible study designs, control/comparison groups, measures, and duration of follow-ups.)

Randomized controlled trials (RCTs), cluster randomized trials and quasi randomized trials will be included in this review. Quasi experimental designs (QEDs) will be included in this review. By QEDs we are referring to quantitative effect study designs, where a counterfactual can be established (e.g. before and after studies with prospective parallel groups and baseline controls).

The rationale for including quasi experimental designs in this review is as follows:
To seek international evidence and include studies from countries, which do not have a tradition for doing RCTs in the area of substance abuse and to increase the number of studies for moderator analysis, while attending to the issues related to the methodological differences between the studies.

For duration of follow up see section 5 above.
Control groups will include no intervention, waitlist controls, or alternative interventions.

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7. Review team

(List names of those who will be cited as authors on the final publication)

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8. Roles and responsibilities

Please give brief description of content and methodological expertise within the review team. It is recommended to have at least one person on the review team who has content expertise, at least one person who has methodological expertise and at least one person who has statistical expertise. It is also recommended to have one person with information retrieval expertise. Please note that this is the *recommended optimal* review team composition.

- Content: Ditte Andersen & Lars Benjaminsen
- Systematic review methods: Krystyna Kowalski
- Statistical analysis: Trine Filges
- Information retrieval: Anne Marie Klint Jørgensen

9. Potential conflicts of interest

(E.g., have any of the authors been involved in the development of relevant interventions, primary research, or prior published reviews on the topic?)
None Known

10. Support

Do you need support in any of these areas: methodology and causal inference, systematic searches, coding, statistics (meta-analysis)?
No

11. Funding

Do you receive any financial support? If so, where from? If not, are you planning to apply for funding?
Where? SFI Campbell

11. Preliminary timeframe

Approximate date for submission of Draft Protocol (please note this should be no longer than 6 month after title approval. If the protocol is not submitted by then, the review area is opened up for other reviewers):
Protocol submission: May 2010

Title registration submission date:
10 Sept. 2009
07 Oct. 2009
20 Nov. 2009
27Apr. 2010

Title registration approval date:
28 April 2010

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