THE CAMPBELL COLLABORATION

Title registration for a review proposal: Functional Family Therapy (FFT) for young people in treatment for illicit non-opioid drug use

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Submitted to the Coordinating Group of:
___ Crime and Justice
___ Education
_x_ Social Welfare
___ Other

Plans to co-register:
_x_ No
___ Yes ___ Cochrane [Note the use of revman 5 will be required if the review is co-registered with a Cochrane review group]
___ Maybe

TITLE OF THE REVIEW

Functional Family Therapy (FFT) for young people in treatment for illicit non-opioid drug use.

BACKGROUND

Briefly describe and define *the problem*

Illicit non-opioid drugs such as cannabis, amphetamine or cocaine are strongly associated with delinquency, poor scholastic attainment, automobile accidents, suicide and other individual and public calamities (Deas & Thomas, 2001; Essau,

2006; Rowe & Liddle, 2006). The European Monitoring Centre for Drugs and Drug Addiction estimates that drug-induced deaths account for approximately 4% of all deaths of Europeans aged 15-39 (EMCDDA, 2010).

More than 20 million of the 12 to 25 year-olds in the US, and more than 11 million of the 12 to 34 year-olds in Europe have used illicit drugs during the month prior to survey interviews in 2009 (SAMSHA, 2010; EMCDDA, 2010). Not all young drug users progress to severe dependence, however many do need treatment and research calls attention to the significant gap between young people classified in need of treatment and young people actually receiving treatment (SAMSHA, 2010; NSDUH, 2007; EMCDDA, 2010). For example, 8.4 per cent of 18 to 25 year-olds in the US are classified as needing illicit drug use treatment, but less than one tenth of these young people actually receive treatment (NSDUH, 2007). Likewise among youth aged 12 to 17, 4.5 per cent were estimated to be in need of treatment for an illicit drug use problem, but only one tenth in this group actually received treatment (SAMSHA, 2010). The EMCDDA estimates that more than 1 million people annually receive some form of treatment for drug problems in the European Union (EU). The total amount of people having used illicit drugs during the last year is approximately 30 million in the EU (EMCDDA, 2010).

This 'treatment gap' can be linked with a public concern regarding the effectiveness and value of available treatments for young people, and by high rates of treatment dropout and post-treatment relapse to substance use (Austin et.al. 2005). However, at the same time researchers point to the fact that many research projects have empirically validated different kinds of treatment approaches for young drug users as effective (e.g. Rowe & Liddle, 2006; Waldron et.al., 2006; Williams et al., 2000; Austin et.al., 2005; Waldron, 1997). This indicates that something can and should be done to help young drug users in need of treatment, and also that the treatment should be as targeted as possible, in order to avoid dropouts and relapse.

Family based therapies represent promising approaches to the treatment of young substance users (Waldron & Turner, 2008; Austin et al., 2005; Rowe & Liddle, 2006; Waldron et al., 2006; Williams et al., 2000). While a number of studies show more or less positive results with family based therapy, there is a need to aggregate evidence to determine whether different family based therapy interventions work for young drug users (Williams et al., 2000; Austin et al., 2005).

Functional Family Therapy (FFT) is one of the oldest and best-known forms of family therapy (Alexander, 1973; Rowe & Liddle, 2003). Studies of Functional

Family Therapy (FFT) find that FFT is a promising and well established treatment for young substance users (Austin et al., 2005; Waldron & Turner, 2008; Hogue & Liddle, 2009). Williams (et al., 2000) and Austin (et al., 2005) in their review of Family-Based interventions list of number of program key components consistent with most guidelines for an effective treatment of youth with substance use problems. FFT incorporates a number of these components including providing comprehensive intervention services, using empirically validated techniques[1], offering parents support regarding the non-use of substances and focusing on the individual needs of the young substance abuser and his or her family (Austin et al., 2005; Hogue & Liddle, 2009; Waldron & Turner, 2008).

While there will be some overlap with a current FFT Campbell review in progress (Littell et al., 2007) there are also differences. Firstly, the focus of this review is on FFT specifically directed at treating youth and young people using illicit non-opioid drugs. Secondly, this review will include a wider age group. We will include 11 to 21 years olds compared to the Littell review that includes 11 to 18 year olds. Thirdly, in contrast to the Littell review, the primary outcome for this review will be reduction of drug use. Fourthly, secondary outcomes in this review will include treatment retention, adverse effects and costs, which are not currently included in the Littell review.

Briefly describe and define *the population*

The population to be included in this review is young people age 11-21 years enrolled in manual based Functional Family Therapy drug treatment for illicit non-opioid drug use (e.g. cannabis, amphetamine, ecstasy or cocaine).

Exclusion criteria are:
Mental retardation or organic dysfunction
Imprisonment or treatment in other restricted facility
Engagement in other unspecified types of drug treatment, other than pharmaceutical interventions
Opiate addiction (either natural or synthetic opioids, legal or illegal; e.g. morphine, heroin, methadone)
Alcohol use exclusively

Briefly describe and define *the intervention*

[1] E.g. cognitive behavioural strategies, social skills training, contingency management, reframing (Austin et al. 2005)

Functional Family Therapy (FFT) is an outpatient program inspired by systemic family therapy, and rests on family system theory (Alexander, 1973). FFT focuses on family functioning, and reflects the premise that positive and negative behaviours both influence and are influenced by multiple relational systems (Sexton & Alexander, 2000).

FFT focuses on four specific principles that guide the process of change:
1. Engagement through alliance based motivation
2. Behaviour change that requires meaning change
3. Behavioural change goals that are obtainable and appropriate for the family's culture, ability and context
4. Intervention strategies that match and respect the unique character of the family (Sexton & Alexander, 2000)

The program is implemented in three interdependent and sequentially linked intervention phases;
1. Engagement and motivation
2. Behavior change
3. Generalization

Community resources are actively mobilized in the generalization phase. Behaviour is seen as indicative of the functionality of the family system.

FFT is a short term intervention including on average 8-12 sessions in mild cases and up to 30 sessions for more complex cases. In most cases the sessions are provided over a three month period (Sexton & Alexander, 2000). Treatment can be delivered in homes or clinical facilities.

Comparison conditions are no intervention, waitlist control, treatment as usual or alternative interventions, e.g. individual therapy.

Outcomes: What are the intended effects of the intervention?

Primary outcomes
Abstinence or reduction of drug use and improvement of psychosocial functioning are primary outcomes of interest.

Reduction of drug abuse measured by e.g.;

- Biochemically test (e.g. urine screen measures for drug use)

- Self-reported estimates on drug use
- Psychometric scales (e.g. Addiction Severity Index (McLellan et al., 1980))

Psycho-social functioning measured by e.g.;

- Psychometric scales or quality of life measures (Kind & Gudex, 1994)
- Involvement in education, e.g. grade point average, attendance (self-reported or reported by authorities, files, registers)
- Family functioning (e.g. the Beavers Interactional Competence (Beavers & Hampson 2000))

Secondary outcomes

- Retention (e.g. measured by days in treatment or completion rates)
- Crime rates (self- reported or reported by authorities, files, registers)
- Frequency of risk behaviour, e.g. injecting drugs, prostitution (self-reported or reported by authorities, files, registers)
- Adverse effects (e.g. measured by rates of suicide and over-doses)
- Costs

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

OBJECTIVES

The aim of this review is to evaluate current evidence on Functional Family Therapy for young people in treatment for illicit non-opioid drug use and to explore factors that might moderate positive outcomes.

METHODOLOGY

What types of studies designs are to be included and excluded?

The study designs included in the review are:

- Controlled trials:

- RCT - randomized controlled trials
- QRCT - quasi-randomized controlled trials (i.e. participants are allocated by means such as alternate allocation, person's birth date, the date of the week or month, case number or alphabetical order)
- NRCT - non-randomized controlled trials (i.e. participants are allocated by other actions controlled by the researcher)

Comparison conditions are no intervention, waitlist control, treatment as usual or alternative interventions, e.g. other interventions that are not FFT, individual therapy.

The rationale for including non-randomized study designs in this review is to seek international evidence and include studies from countries and research disciplines, 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 methodological differences between studies.

Your method of synthesis:

We will use meta-analysis if appropriate due to study design and quality.

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SOURCES OF SUPPORT

Internal funding:
SFI Campbell

External funding:
None

DECLARATIONS OF INTEREST

None known

REQUEST SUPPORT

Do you need support in any of these areas (methodology, statistics, systematic searches, field expertise, review manager etc.?)

AUTHOR(S) REVIEW TEAM

Include the complete name and address of reviewer(s) (can be changed later).This is the review team -- list the full names, affiliation and contact details of author's to be cited on the final publication.

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The lead author is the person who develops and co-ordinates the review team, discusses and assigns roles for individual members of the review team, liaises with the editorial base and takes responsibility for the on-going updates of the review

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ROLES AND RESPONSIBLIITIES

Please give brief description of content and methodological expertise within the review team. The recommended optimal review team composition includes 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.
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PRELIMINARY TIMEFRAME

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

Title registration approval date:

Draft protocol submission date: October 2011