THE CAMPBELL COLLABORATION

Title registration for a review proposal: Brief Strategic Family Therapy (BSFT) 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

Brief Strategic Family Therapy (BSFT) 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 percent 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 percent 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 was 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).

Studies of Brief Strategic Family Therapy (BSFT) find that BSFT is an efficacious treatment for young substance users (Waldron & Turner, 2008; Austin et al., 2008). Williams (et al., 2000) and Austin (et al., 2005) in their review of Family-Based interventions list a number of program key components consistent with most guidelines for an effective treatment of youth with substance use problems. BSFT incorporates a number of these components including providing comprehensive intervention services, using empirically validated techniques[1], offering parents and peers 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; Waldron & Turner, 2008; Horrigan et al., 2004; Robbins et al., 2002).

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 Brief Strategic 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)
Exclusive alcohol use

Briefly describe and define *the intervention*

BSFT is an outpatient family systems approach to young people's substance use and related problems that relies on both strategic and structural interventions (Robbins & Szapocznik, 2000; Szapocznik et al., 2003). BSFT is designed to address aspects of family functioning and family interactions that have been shown to be associated with young people's drug use and behavioural problems (Robbins et al., 2009; Austin et al., 2005).

BSFT contains three intervention components:

- joining

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

- diagnosing
- restructuring

Joining occurs at the individual level (the therapist establishes a relationship with each family member) and at family level (the therapist 'joins' with the family system to create a new therapeutic system). Diagnosing and restructuring occurs at family level. BSFT focuses on identifying inappropriate family alliances, family boundaries and maladaptive interaction patterns, and to develop new patterns (Waldron & Turner, 2008). The intention is to provide the family with tools to overcome the young person's drug use and family dysfunction that often accompanies youth drug problems (in the systemic perspective). Maladaptive family interaction patterns are corrected and BSFT provides skills building strategies to strengthen the family (Horrigan et al., 2004).

BSFT is a short-term problem-focused intervention. The average length of treatment is 12-16 sessions, however the program is flexible and can be tailored to individual needs (Robbins et al., 2002). Likewise BSFT is flexible in location and can be implemented in clinical or community facilities or in the family home (Robbins et al., 2002). The program has been developed to work with minority groups that emphasize family and interpersonal relationships, e.g. families belonging to ethnic minorities (Szapocznik et al., 2003).

Comparison conditions will be 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 Brief Strategic 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 study 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 BSFT, 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: 20.06.2011

Draft protocol submission date: 29.06.2011