THE CAMPBELL COLLABORATION

Title registration for a review proposal: 12-step programmes for reducing abuse of illicit drugs

Submitted to the Coordinating Group of:
Social Welfare

TITLE OF THE REVIEW

12-step programmes for reducing abuse of illicit drugs

BACKGROUND

Briefly describe and define *the problem*

United Nations Office on Drugs and Crime estimate that between 18 and 38 million people worldwide are problematic drug users, and the majority of these use illicit drugs (UNODC, 2009). Drug abuse is strongly correlated to a range of social problems; including crime, prostitution, homelessness etc. and the social costs of these problems are high in many countries. Therefore, there is a strong political interest in the effectiveness of different treatments for abusers of illicit drugs.

12-step programmes for reducing drug abuse is a well-known and widespread treatment in many countries. Originally, the 12-step program emerged as self-help groups for alcoholics (Alcoholics Anonymous), but the idea has dispersed to a wide range of addiction types. The idea behind the 12-step program is that the addicts work their way into recovery by going through "Twelve Steps" starting with the recognition of being an addict and ending with the capability of helping others out of their addiction (Narcotics Anonymous 2008). The 'twelve steps' are accompanied by 'twelve traditions' providing guidelines for the self-help groups (ibid). A central element in the 12-step self-help groups is that participation is voluntary and that the 12 steps are carried by the addicts themselves, not by professionals.

The most widespread 12-step program for reducing drug abuse is Narcotics Anonymous (NA), which emerged from Alcoholics Anonymous in the late 1940s.

Today NA has more than 50,000 weekly meetings in 130 countries (Narcotics Anonymous 2007). NA is for all drug addicts, regardless of the particular drug or combination of drugs used. Other 12-step groups restrict themselves to specific type of drug abuse, such as Cocaine Anonymous, Pills Anonymous and Marijuana Anonymous (www.ca.org; www.pillsanonymous.org; www.marijuana-anonymous.org).

The 12-step concept is also used in programmes provided by professionals (12-step facilitation programmes). These can take place either in an individual or group setting, but use the 12-step concepts in the treatment. An example is the Twelve Step Facilitation Outpatient Program, which is a manualised program for clients with substance abuse disorders (alcohol or narcotics). In this program, the addict participates in one-to-one individual facilitation sessions, as well as in group treatments with the primary goal being to facilitate active involvement in e.g. Narcotics Anonymous (Nowinski, 2006).

Despite the extensive use of 12-step programmes, no systematic review exists on the effectiveness of the interventions in relation to reducing drug abuse and socially related outcomes. The objective of this review is to evaluate current evidence about the effects of 12-step programmes for drug addicts.

Briefly describe and define *the population*

The population will be persons, who abuse different illicit drugs of all kinds. We impose no age restrictions as 12-step programmes are used for all age-groups (although mainly for adults). The population included in this review can be abusers of both illicit drugs and alcohol; however participants with an exclusive alcohol problem will be excluded.

Exclusion criteria will be:
Drug treatment in prisons or other types of locked institutions
Compulsory treatment e.g. court-mandated sentences

Briefly describe and define *the intervention*

Interventions that will be included in this review are Twelve Step programmes (like Narcotics Anonymous) and other Twelve Step Facilitation programmes, which use the twelve steps in the treatment.

Included interventions are carried out in self-help groups or by professionals in an individual or group setting. Furthermore, the Twelve Step Facilitation can take place as inpatient (e.g. rehab centres with overnight stays) as well as outpatient (treatment without overnight stays) settings, whereas self-help groups will always be based in the local community. Twelve step interventions using a manual where the twelve

steps are defined will be included. The Twelve Step Facilitation programme can be combined with other treatment elements, but the 12-step element of the programme should be well-defined and should be the main intervention/treatment.

The duration of treatment in Twelve Step programmes can be very long. Membership of e.g. Narcotics Anonymous is typically for a very long periods of time (according to NA, members have on average been clean 9.1 years (NA, 2007)). On the other hand, programmes run by professionals will typically have durations of 4-8 weeks. Because of this difference, inclusion in the intervention in this review is based on enrolment into the treatment.

Comparison

Comparison conditions will include no intervention, waitlist controls and other types of interventions (such as other types of psychosocial or medical treatment, e.g. methadone). In most cases, the comparison group will receive some treatment.

Outcomes: What are the intended effects of the intervention?

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 (0-6 months after enrolment into treatment
- Medium term effect (6-12 months)
- Long term effects (more than 12 months)

OBJECTIVES

The objective of this review is to evaluate current evidence about the effects of 12-step programmes for drug addicts.

METHODOLOGY

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

Randomized controlled trials (RCTs), cluster randomised trials and quasi randomised trials will be included in this review. Furthermore, quasi experimental designs (QEDs) will be included. By QEDs we refer 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: Quasi-experimental studies can inform the relationship between 12 steps programmes and substance abuse treatment outcomes. In particular, quasi-experimental studies can shed light on whether findings are externally valid and, where appropriate, such studies may be combined with randomized controlled trials thereby increasing the number of included studies and improving our ability to conduct relevant moderator analyses.

For duration of follow up see outcomes section.

Control groups will include no intervention, waitlist controls, and other interventions.

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SOURCES OF SUPPORT

Internal funding:
SFI Campbell

External funding:

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 RESPONSIBILITIES

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: 16.06.2010

Draft protocol submission date: November 2010