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Effective Treatments Emerge for Adolescent Marijuana Use

Adolescent admissions to substance abuse treatment increased by 45 percent between 1993 and 1998, and 57 percent of treatment admissions age 12-17 reported marijuana as the primary substance of abuse. This is not a problem that can be ignored since adolescent marijuana use is associated with emotional, behavioral, legal, and health problems, including unprotected sex.

The Cannabis Youth Treatment Experiment has now identified five effective treatments that can be used to treat adolescents depending on the severity of the marijuana use. These five treatment protocols will be released this fall so that treatment programs for youth all over the country will be able to utilize best practices that have been proven to show results with adolescents. Six months after intake to treatment these programs were able to increase the percentage of adolescents with no past month use 8 fold (from 4 percent to 34 percent) and the percent reporting no past-month abuse or dependence symptoms by 3 fold (19 percent to 61 percent). Treatment reduced days of use by 36 percent, and reduced the number of adolescents with past month substance related problems by 61 percent. The decrease in rate of use is better than all prior studies of adolescent outpatient treatment in community settings.

Data from the Substance Abuse and Mental Health Services Administration's (SAMHSA) Treatment Episode Data Set for 1998 show that 49 percent of all marijuana admissions to treatment are under age 20. While four out of five of these adolescents are going into outpatient treatment, little research has been done in this area and evaluations of practice have produced mixed results. SAMHSA's Center for Substance Abuse Treatment sponsored a cooperative agreement to develop treatment models that could be set out in written treatment manuals for replication elsewhere and conduct a field test of their effectiveness and cost.

The five treatment protocols include:

1. A brief, basic, low cost treatment consisting of five sessions over six weeks using motivational enhancement treatment and cognitive behavioral therapy. Patients have two individual sessions followed by three group sessions. This program is designed to motivate the patient to change marijuana use and identify high-risk situations that could increase the likelihood of relapse. The sessions help the patient establish a social network supportive of recovery and develop a plan for activities to replace marijuana-related activities.

2. Adding to the basic treatment model seven additional group sessions of cognitive behavior therapy to create a 12 week treatment program. This is a more intense version of the first therapy and is designed to help adolescents develop coping skills and alternative responses to cannabis use, and deal with problem

solving, anger, criticism, psychological dependence, and depression management.

3. Adding to the enhanced option (#2) three to four home visits for family therapy, six parent-education group meetings, and case management. This program is designed to improve family cohesion, parenting skills and parental support. It includes case management to promote parent engagement in the youth's treatment process. It also includes referral of parents to self-help support groups. The program allows counselors to tailor plans to fit a family's specific home situation.

4. A 14-session intervention of individualized counseling that could be used for victimized youth, in rural areas, or anywhere that group formation might delay or increase the cost of treatment. The focus of this intervention is to identify reinforcers that make abstinence from marijuana more rewarding than use. This therapy includes 10 sessions with the adolescent alone, two with the caregiver alone and two with caregiver and child.

5. An approach that integrates family therapy and primary substance abuse treatment throughout the 12-week program rather than as an add-on. This approach uses 12-15 family-focused treatment sessions as well as counseling sessions with both adolescent and parents. This type of therapy is designed to change the individual's relationships with family, peers and social systems, and includes case management to help resolve other problems.

All four study sites used option one. Two sites used options 2 and 3 with option 1 (incremental study arm). Two sites used options 4 and 5 with option 1 (alternate study arm). The researchers recruited 600 adolescents between the ages of 12-18 who reported using marijuana in the past 90 days, reported problems related to marijuana abuse or dependence and met criteria for outpatient, rather than inpatient, therapy.

What the researchers found:

- The brief intervention (#1) had significantly larger reductions in substance related problems with the lowest severity clients.
- The enhanced, more comprehensive intervention (#3) worked better with high severity clients.
- At the six month mark, the more comprehensive treatment caught up with the brief intervention for low severity clients and continued to be the most effective with high severity clients.
- The brief and individual behavior therapy interventions (#4) reduced use of marijuana significantly more than the integrated family therapy (#5) in the beginning. However, at the six months mark all improved further and the family therapy had caught up.
- The costs of all five of these therapies appear to be affordable as they are in line with what is currently being paid. The average weekly economic costs of the five types of outpatient treatment ranged from $105 to $244 per week. The cost differences reflected both weeks of treatment and hours of formal sessions and variations in cost of living, and similar factors.

The Cannabis Youth Treatment Experiment is a collaboration of the Center for Substance Abuse Treatment (CSAT) with researchers and providers from Chestnut Health Systems (CHS) in Bloomington and Madison County Illinois, the Alcohol Research Center (ARC) in Connecticut, Operation PAR in Florida, and the Child Guidance Center (CGC) in Philadelphia. The coordinating center director and chair is Michael L. Dennis, Ph.D. of Chestnut Health Systems of Bloomington, IL. The manuals will be released later in the fall by CSAT at www.samhsa.gov/csat and more information on the project is available at www.chestnut.org/li/cyt .

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