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The Cannabis Youth Treatment study: Implications for Employee Assistance Programs

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A resurgence of youthful illicit drug experimentation during the past decade has sparked an increase in the number of drug-related evaluations and consultations conducted by employee assistance (EA) professionals. One of the most frequent and troublesome of such requests involves the parent who is concerned about his or her child's experimentation with cannabis (marijuana, hashish, blunts). During the past two decades, America has witnessed the increased availability and potency of cannabis and a significant lowering of the age of onset of regular cannabis use. American teenagers report more past-month cannabis use than all other illicit substances combined and more daily use of cannabis than alcohol. These changes have brought an increase in cannabis-related problems among young people. Cannabis is now the leading substance reported in adolescent arrests, emergency room admissions, and public treatment admissions, the latter having increased 115% (from 51,081 to 109,875) between 1992 to 1998.¹ These changes

have brought an increase in cannabis-related problems among young people and concerns about how to address these problems within the family, school, workplace, and the wider community.

As concerns about youthful cannabis use have risen, EA professionals have been called upon to help young employees, parents concerned about their children and by employers desiring a drug-free workplace. The consultations offered by EA professionals have been handicapped by the absence of reliable, science-based information regarding the short and long-term effects of cannabis and the effectiveness of various prevention and intervention programs. To magnify this challenge, EA professionals have been under considerable pressure to reduce the escalating costs associated with the treatment admissions and re-admissions for adolescent psychiatric and substance use disorders. This article will try to answer two questions within this larger arena of concern:

- 1) Are there relatively brief (6-12 week) low cost interventions that are effective in treating adolescent cannabis abuse and dependence?
- 2) What role can the EA professional play in supporting the long-term recovery of adolescents during and following their treatment for cannabis abuse or dependence?

The CYT Study

In 1997, the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA) responded to requests for the development of evidence-based treatments for cannabis abuse/dependence by funding the Cannabis Youth Treatment (CYT) study. The CYT study is the largest and most scientifically rigorous randomized study of adolescent substance abuse treatment ever conducted in community-based settings.

The CYT study randomly assigned 600 adolescents who met DSM-IV criteria for cannabis abuse or dependence to one of five types of short-term, outpatient treatment. Each of the experiments compared the effectiveness of various treatments and each experiment was replicated in a community-based clinic and in a major medical research center. The treatments varied in theoretical orientation, delivery format (individual, group, family), and service components and duration (6 to 13 weeks). Service procedures within each of the five treatments were meticulously detailed in treatment manuals to enhance model fidelity as they were being implemented and tested across the study sites. Copies of the five treatment manuals utilized within the CYT study are available at no cost from the National Clearinghouse for Alcohol and Drug Information (1-800-729-6686).

Seventy-one percent of youth admitted to the CYT study completed

treatment and more than 90% of the study group were interviewed 3, 6, 9, and 12 months following their discharge to evaluate the sustained effects of treatment. The adolescents treated had an average age of 16, were predominantly male (83%), white (61%), enrolled in school (87%), involved in the juvenile justice system (62%), and, of particular interest to EA professionals, had an unexpectedly high rate of employment (47%).

During the three-month treatment phase, all interventions reduced cannabis use and cannabis-related problems and these reductions were sustained through the twelfth month of follow-up. From intake to 12 months, participation in treatment was also significantly associated with reductions in family problems, attention deficit and hyperactivity problems, arguing/ violence, illegal activity, school absenteeism, and school problems. The CYT study also underscored the role adolescent treatment can play in enhancing the productivity of parents. In the three months following the treatment of their child in the CYT study, parents reported a 42% reduction in their days of stress at home and a 57% reduction in their days of missed work (compared to the three months prior to treatment). Thirty-month interviews to re-assess all these factors are now being conducted.

Implications for EAPs

There are many lessons to be drawn from the CYT study, but three lessons have special implications for those working within employee assistance programs.

Lesson 1. *Cannabis-related disorders constitute serious, debilitating disorders that can dramatically affect the developmental trajectory of adolescents and the overall health of their families.*

While marijuana use is trivialized and sometimes glamorized in the popular media, its regular use can produce serious effects

on personal, interpersonal, family and occupational functioning. These effects can be dramatically amplified through lowered age of onset of regular use, greater frequency of use, and through interaction with co-occurring mental disorders. Among those already at risk for them, marijuana use is one of the main predictors of the early onset and severity of schizophrenia and other severe mental disorders. Weekly or more frequent cannabis users are far more likely than non-users to have problems at home, school, or with the law -- problems that rapidly declined among those youth who stopped using marijuana following their treatment in the CYT study.

EA professionals have an important role in carrying the message to employers, employees, their families, and allied professionals that problems related to cannabis use are on the increase and that adolescents who continue to use cannabis in spite of adverse consequences should be recognized as needing intervention on par with adolescents with other drug choices generally perceived as more dangerous than cannabis. The significant problems experienced by the adolescents and families in the CYT study challenge the still prevalent "it's only marijuana" response (particularly among "Baby Boomer" parents) to adolescent cannabis use. The message that adolescent cannabis use can constitute a serious, debilitating disorder needs to be widely disseminated through the normal EA channels of communication: employee newsletters, web based information services, drug-free workplace training seminars, wellness workshops, and supervisor referral training sessions.

Lesson 2. The severity of adolescent cannabis problems and their responses to treatment are quite variable.

The five CYT treatments were all relatively brief (6-13 weeks), affordable, and able to positively impact many of the youth

seeking treatment services. Each was associated with major (50% or more) reductions in cannabis use, symptoms of dependence or abuse, behavioral problems, family problems, school problems, and illegal activity. At 12 months, nearly a third of those youth completing CYT treatment were living in the community without any marijuana use or substance related problems. The good news of adolescent treatment is that there are brief, low cost treatments that can have a significant impact on the lives of many young people and their families.

The more troublesome side of the treatment outcome story is that, for another subgroup of adolescents, cannabis use has become a more chronic condition. In CYT, 41% of the adolescents had failed multiple prior efforts to quit cannabis use, a quarter had been to formal treatment before, and a third were re-admitted to treatment in the year following their discharge from the CYT study. This does not mean that there is no hope for the resolution of such chronic problems, but it does suggest that different models of intervention over a longer period of time will be required to fully resolve such problems.

EA professionals face two significant challenges in the application of Lesson 2: (1) locating providers who offer effective treatments for adolescent substance use disorders, and (2) convincing insurance and managed care gatekeepers to authorize more intensive interventions over longer periods of time (particularly inpatient or residential stays) for those adolescents with more chronic cannabis use conditions.

As EA professionals develop or revisit their community resource referral network, they should take the time to educate adolescent treatment providers about the CYT research that empirically supports the effectiveness of brief interventions for nearly a third of adolescents, while emphasizing

that many others will require more intensive, variable, and longer programs of recovery. It is also important for EA professionals to present the CYT findings to benefit designers, managed care plans, and self-insured employers in an attempt to structure access and coverage in a way that acknowledges the realities and pattern variability of adolescent recovery from cannabis abuse and dependence. EA professionals can play an important role in overcoming the current pessimism about treatment effectiveness and advocate for the implementation of evidence-based, low cost treatments that can effectively serve many adolescents and their families. At the same time they also need to recognize that, for some adolescents, cannabis use can constitute a more chronic, relapsing condition.

Lesson 3: Nearly half of treated adolescents vacillate between periods of recovery and periods of drug use and drug-related problems in the year following their first treatment episode. Post-treatment recovery support services could greatly benefit these youth and their families.

Treatment is often viewed as a time-limited event that either works (complete and enduring abstinence following treatment) or does not work (any drug use following treatment). This dichotomized view is challenged by the findings of the CYT study. Following their treatment in the CYT study, 60% of adolescents had some period of recovery but the pattern of recovery was quite variable. Twenty-nine percent went into recovery but later relapsed; 7% went into recovery, relapsed, but then got back into recovery; 15% failed to respond to treatment right away but improved in the months following treatment; and 9% recovered right away and stayed in recovery through the first year following treatment.

These different patterns of response underscore how fluid and fragile the post-treatment period is for most youth. Such fluidity calls for new service models that resemble not the “diagnose, treat, discharge” approach of the hospital emergency room, but approaches used in the longer term management of chronic disorders like diabetes, hypertension and asthma. These latter approaches focus on problem stabilization, recovery education, ongoing monitoring and support, and, when needed, early re-intervention. These approaches are also consistent with emerging behavioral health technologies drawn from the concept of disease management that seek to improve clinical and financial outcomes in the treatment of problems marked by high severity and chronicity.

EA professionals that offer (or have the potential to influence) managed behavioral health plan designs can encourage the development of disease/recovery management tracks as an alternative to traditional “compliance-based” utilization management that focuses on controlling micro-managed “units of service” toward the goal of reducing acute symptoms. Although some adolescents can greatly benefit from receiving brief, low cost treatment, the indiscriminate application of this approach is inconsistent with the variable patterns of cannabis use and recovery among adolescents found in the CYT study. The effectiveness of adolescent behavioral health treatment could be improved and its costs decreased if EA professionals took a more active role in developing recovery support structures specifically for adolescents within local communities.

EAPs can play a significant role in tipping the scales toward sustained recovery by: a) linking adolescents and their parents to indigenous sobriety-based support structures where they are available in the

community, b) linking adolescents and their families to professionally-directed treatment services, c) educating adolescents, families, and “gatekeepers” about the course and treatment of AOD problems, d) conducting longer term, more intensive follow-up and early re-intervention services for treated youth, e) working with benefits managers and insurance vendors to design plans that can support post-treatment recovery monitoring and support. In the world of adolescent treatment, so-called “aftercare” services are best viewed not an adjunct to treatment, but as one of the most crucial elements of successful treatment.

Conclusion

Adolescent cannabis abuse and dependence is a major problem that consumers of EA services are confronting with increasing frequency. While evidence-based, brief outpatient treatments for these problems do now exist, they will not replace the need for sustained recovery support systems in the adolescent’s natural environment. EA professionals can help create strong cultures of recovery within their local communities and can play important roles in recovery management through post-treatment follow-up, the provision of individual and family support, and educating employers and purchasers about post-treatment services that while necessary for sustained recovery are often not authorized or reimbursed. Providing such sustained recovery management supports may go a long way in breaking the cycle of repeated, self-encapsulated episodes of high cost acute care for adolescent substance use disorders.

The all-to-frequent revolving door of addiction treatment challenges the “treatment works” slogan and contributes to therapeutic pessimism among company managers, human resource and EA professionals, the public, treatment

providers and, most importantly, the youth and families who consume addiction treatment services. The fact that adolescents (and adults) may require more than one treatment intervention before their AOD-problems are fully resolved does not mean that treatment does not work, but it does call for rethinking the nature of addictive disorders and a redesign of both treatment and our approaches to managing care. The finding of the CYT study that a high percentage of adolescents remain precariously balanced between recovery and reactivation of abuse and dependence following completion of professionally-directed treatment suggests a potentially important role for the EA professional in linking these youth and families with on-going recovery support services following treatment. EA professionals can also use CYT findings to achieve clinical improvements and cost reductions by shaping benefit plans that reflect both the utility of brief interventions and, for some, the necessity of *disease and recovery management approaches* to the resolution of substance use disorders.

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(CYT) Experiment: Rationale, Study Design, and Analysis Plans. Addiction; and 3) Tims, F., Dennis, M., Hamilton, N., Buchan, B., Diamond, G., and Funk, R. (in press) Characteristics and Problems of 600 Adolescent Marijuana Abusers in Outpatient Treatment. Addiction. More information is on the web about the PETS (www.samhsa.gov/centers/csat) and CYT studies (www.chestnut.org/li/cyt).

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ⁱ Dennis, M.L., Dawud-Noursi, S. & Muck, R. (in press). The need for developing and evaluating adolescent treatment models. In S.J. Stevens & A.R.

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