Treatment of Adolescents with Cannabis Abuse or Cannabis Dependence

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Adolescents

Youth of 12 through 18 years of age

Why emphasis on adolescents?

- Age of first use of cannabis has gone down
- With early age of initiation, the risk of developing a cannabis use disorder increases
- With early age of initiation, cannabis use disorder develops more quickly
- With early age of initiation, the cannabis use disorder becomes more resistant
- With early age of initiation, the odds of co-morbidity are higher
- Treatment demand has gone up

Cannabis Use Disorders

- Abuse
- Dependence

Criteria for dependence (DSM)

- Tolerance
- Withdrawal symptoms
- Consumption too high (own judgment)
- Persistent craving
- Spends much time on the drug
- Loss of social and other contacts
- Continuation of consumption despite knowing that it is harmful

Two types of adolescents

- **Youth with cannabis use disorder, but nothing else**
- **Youth with cannabis disorder plus co-morbidity and/or psychosocial problems**

Do we need two types of treatment?

Diagnosis setting, etc.

- Should be multi-focal
- Should be based on known risk and protective factors (including family functioning, peer relationships)
- Should be multidisciplinary
- Should be based on reliable and valid measures
- Findings should be recorded

Motivational Enhancement (ME) (also called Motivational Interviewing)

- Should be part of every treatment
- Therapist should be trained in ME

How about youth who are difficult to reach?

Example: Schulschwänzer

- Try to dissociate them from the group
- Go look for alliances (zB, Schulplicht Beamter)
- Apply some force (Druck) or coercion (Drang)
- Involve their families

Internet

- Good method to reach youth with just a cannabis use disorder?
- International examples: Quit the Shit, Jellinek (NL), USA, Australia
- Tailoring or not?
- Drop-out is high when treatment is intended

(Rather) brief interventions

- **Cognitive Behavioural Therapy (CBT)** not yet proven effective in adolescents. No clear superiority over individual or group counselling
- **Contingency Management:** reward for appropriate behaviour
- **Combination** of interventions?

Moving on to adolescents with multiple problems

Best approach: multi-focal outreaching family therapies

Multiple-focal outreaching family therapy

- Indicated for youth with multiple problems (stepped care?)
- Again: Zoom in on established risk and protective factors
- Work according to protocol and training requirements
- Leave your office
- Be outreaching

Present-day treatment practice in Europe

- Sessions in office
- Once every 14 days on average
- Limited number of topics dealt with in therapy

Needed for multi-focal outreaching family therapy

- Sessions at least once a week. Lots of telephone calls
- 24-Hours availability
- Do not talk with just the adolescent. Also with family, friends, school, court
- Sessions also at home and elsewhere out of office
- Therapist = therapist, case manager, trouble shooter

Training into multi-focus family therapy

- Takes at least 6 months
- Video- or audiotapes of sessions needed. To be translated in English
- Evaluation of treatment fidelity and treatment competence
- Regular consultation/supervision by telephone and mail
- Accreditation (sometimes commercial)

Requirements

- Work as a team. Directed by a supervisor
- Establish close contacts with schools, courts, police, other treatment agencies
- No ivory tower, no bureaucracy

Four multi-focal family therapies

- MDFT (Multidimensional Family Therapy)
- MST (Multisystemic Therapy)
- FFT (Functional Family Therapy)
- BSFT (Brief Strategic Family Therapy)

Positive effects of multi-focal family therapy

- Less use of drugs and alcohol by the adolescent
- Less delinquent and disruptive behaviour
- Less internalizing problems: anxiety, depression
- Better functioning at school
- Better family functioning

Which family treatment to prefer?

- Depends on outcome desired (e.g., substance use vs. delinquency)
- Some treatments have been better studied than others (MDFT and MST better than FFT and BSFT)
- Depends on tradition and funding arrangements (health care vs. Justice)
- Influenced by commerce (MST and FFT)

5-LÄNDER FORSCHUNGSPROJEKT INCANT

International Cannabis Need of Treatment Study

Belgium, Germany, France, The Netherlands, Switzerland

Priorities Cannabis Research Action Plan

- Assess the importance of age of onset of cannabis use
- Cannabis dependence: assessment and course
- Relationship with mental health
- Treatment trial (emphasis on youth)

Chosen from literature review: MDFT

- 6 Completed RCT's (generally 1 year follow-up)
- MDFT more effective than (a) group counselling, (b) group family sessions, (c) individual CBT, (d) residential treatment
- Effective in white, black and Latino adolescents
- Effective in adolescents referred by Justice, schools, or self-referred
- Effective in young and older adolescents
- Effective on drug use, externalizing and internalizing symptoms, delinquency, school performance

Pieces of MDFT approach

MDFT intervenes into multiple systems of development and influence (family, peers, school, etc.). Four domains of attention/intervention:

- **Adolescent**
- **Parent(s)**
- **Family**
- **Extra-familial**

Outcomes: Strength of the evidence

- For reduction of substance use, MDFT qualifies for the maximal score of ***. MST gets **, FFT and BSFT *
- For reduction of criminality: MST ***, MDFT **, and FFT *
- The four therapies have never been compared with each other

Effects of MDFT – Maintained at least 1 year (1)

- Retention in treatment (90%)
- Reduction of substance use d = 0,6 – 0,8
- Reduction of problems associated with substance use d = 0,7
- Less delinquent behaviour d = 0,3 – 0,4
- Less externalizing symptoms d = 0,7
- Less internalizing symptoms d = 0,5

Effects of MDFT – Maintained at least 1 year (2)

- Less contact with delinquent peers d = 0,7
- Better family functioning d = 0,3
- Cost-effective (in the USA)

Conclusions drawn in the Cannabis Research Action Plan

- **MDFT is the best established substance abuse treatment**
- **Pilot study September 2004 – March 2005: European therapists will be trained in MDFT**
- **If MDFT appears to be feasible, a main study (RCT) will be considered (2006 – 2009)**

The INCANT Pilot Study: Five (combined) sites

- Belgium: Brugmann Hospital, Brussels
- France: Centre Emergence & CEDAT Mantes la Jolie, Paris
- Germany: Therapieladen, Berlin
- Netherlands: Parnassia & Palmhuis, The Hague
- Switzerland: Jugendberatung Stadt Zürich, Drop In (Basel), CONTACT (Bern)

Differences between INCANT treatment centres

- Funding
- Orientation: Addiction Care vs. Youth Care
- Medical or psychosocial Context
- Source of referral
- Type of clients
- Interventions offered
- Duration of treatment
- Capacity, disciplines

Adolescents with cannabis use disorder: Epidemiology Berlin (1)

- Not many from ethnic minorities
- Many from broken families
- Many have regular work or attend education
- Ill at ease with family

Profile: mostly white and native, often well-educated or with regular work, from broken families or unhappy with family

Adolescents with substance use disorder: Epidemiology Berlin (2)

- Cannabis use disorder more prevalent in addiction care than in youth & mental health care: 72% vs. 29%
- Idem, alcohol use disorder: 48% vs. 24%

Feasibility of MDFT

European therapists appeared trainable in MDFT, and did what they are supposed to do in MDFT

Conclusion with regard to the German INCANT Pilot Study site

"The German site, with its cohesive long-standing team of therapists under undisputed leadership of the supervisor, would qualify for the eventual INCANT main study. The therapists there have a keen eye for family and community work, are innovation-driven and well-motivated."

INCANT Main Study?

- Randomized Controlled Trial, 2006 – 2009
- MDFT vs. Treatment As Usual
- 60 vs. 60 Adolescents
- 1-Year follow-up
- Funding from multiple sources

General conclusions (1)

- Cannabis use disorders in adolescents deserve attention and may need treatment
- If no other problems are present, self-help or brief interventions may be indicated (ME, Internet, CBT)
- In case of multiple problems, multi-focal family treatment should be considered

General conclusions (2)

- Of these family therapies, MDFT has the best record
- MDFT is feasible in European context
- However, its cost-effectiveness in Europe needs to be proven