

Rising Cannabis Use Disorder Cases Prompt Treatment Providers to Expand Services

By **Morgan Gonzales** | January 21, 2025

Experts warn that rates of cannabis use disorder (CUD) are increasing due to more favorable perceptions of the drug and higher concentrations.

Providers already treating substance use disorders (SUDs) have the tools to treat CUD – a move that could increase care access and strengthen revenue streams. However, better treatment modalities may still be needed.

“If you are a provider who already treats any other SUD like alcohol or opioids, you could treat this as well,” Dr. Alta DeRoo, chief medical officer of Hazelden Betty Ford Foundation, told Addiction Treatment Business. “If you do any type of addiction, the principles of treating the addiction are the same.”

Center City, Minnesota-based Hazelden Betty Ford Foundation was created in 2014 through a merger of the Hazelden Foundation and the Betty Ford Center. It operates 17 treatment centers in California, Colorado, Florida, Illinois, Minnesota, New York, Oregon, Washington and Wisconsin.

Hazelden treats patients with CUD with a short detox period, often half a day to one day. Clinicians can provide comfort medications to calm nerves or treat insomnia, as well as the drug N-Acetyl Cysteine (NAC), which DeRoo described as “the best thing that we have to treat cravings.” Patients can then transition to residential treatment and receive behavioral therapies in one-on-one or group settings. These therapies include cognitive behavioral therapy (CBT), motivational enhancement treatment and contingency management.

Patients’ stays usually last between 14 and 30 days and are reimbursable by insurance. Providers must also be sure to address underlying or co-occurring behavioral health conditions like depression or anxiety, DeRoo said.

Treating cannabis makes financial sense, De Roo said, since providers don’t need to develop any additional infrastructure and use treatment modalities also used for other conditions.

Public perception

Cannabis is the [most-used](#) psychoactive substance in the U.S. About 13% of adults in the U.S. use cannabis products, according to Yale Medicine. About 10% of people who use cannabis will become addicted and about 30% of current users meet the criteria for addiction.

The most recent version of the DSM recognizes cannabis withdrawal as a syndrome, unlike previous editions. Research has demonstrated that regular cannabis use impacts the brain, reducing the

number of cannabinoid receptors by 15% to 20%, according to Dr. Deepak Cyril Dsouza, professor of psychiatry at Yale School of Medicine.

“This is a phenomenon that you will see with other drugs that are known to be associated with abuse,” Dsouza said. “The withdrawal syndrome is characterized by perturbations in mood. They get more anxious. Their sleep is disrupted. This is one of the most important reasons why people go back to using cannabis when they try to quit.”

Hazelden Betty Ford Foundation sees hundreds of patients each month for a range of use disorders, but usually encounters one patient a month seeking treatment for cannabis use, according to DeRoo. When a patient does seek treatment for CUD, they present with “their life falling apart.”

Despite the side effects and consequences of CUD, getting patients into treatment is challenging. The general public’s perception of marijuana has changed over time – the drug is now more socially acceptable and increasingly perceived as safe.

As perceptions of marijuana have become increasingly positive, patients are [less likely](#) to seek treatment. Yet products containing THC, the main psychoactive substance in cannabis, are becoming increasingly concentrated and available.

“Because it doesn’t carry some of the same stigmas as other types of substance use, where the detrimental impact is a little bit more obvious ... they can kind of suffer in silence,” Suzette Glasner, chief scientific officer at digital SUD treatment provider Pelago, told ATB. “They can fly under the radar a little bit more easily for longer periods of time and I think that’s part of the reason why people will use it for a lot longer before entering treatment than perhaps some of the other substances that bring people to treatment.”

New York City-based Pelago provides tobacco, alcohol, cannabis and opioid use disorder programs via telehealth. The provider [launched its cannabis treatment program](#), which includes cognitive behavioral therapy, motivational enhancement therapy and contingency management, in April 2024. Like Pelago’s other SUD treatment programs, the cannabis treatment program is reimbursed on a 100% at-risk basis.

Need for further research

While offering CUD treatment may be a no-brainer for SUD providers, more work remains to be done to improve treatment modalities, according to Dsouza.

While a combination of CBT, motivational intervention and contingency management is the “gold standard,” according to Glasner, [research](#) suggests that the efficacy of psychosocial interventions, including motivational enhancement therapy, cognitive-behavioral therapy and contingency management, have only “modest” efficacy at treating CUD.

An [article](#) published in the International Review of Psychiatry stated that end-of-treatment abstinence rates using these methods range from 13% to 43%. The durability of abstinence from cannabis use is “generally poor,” although at least one study found an abstinence rate of 37% that lasted for over a year.

Providers may prescribe some drugs off-label for CUD. Hazelden may prescribe a patient N-Acetyl Cysteine (NAC), one drug that has shown [some promise](#) to reduce cannabis use and promote abstinence, though scientific research is mixed. No drugs exist that have been approved specifically for CUD.

“Unfortunately, there are no good treatments for cannabis use disorder, and certainly there are no FDA-approved pharmacological treatments for cannabis use disorder,” Dsouza said. “Most of the non-pharmacological approaches used in cannabis use disorder are basically ... knockoffs of behavioral treatments that are used for other use disorders. These are not treatments that are designed specifically to address cannabis use disorder but have been borrowed from, say, nicotine use disorder, alcohol use disorder and so on. They’re not very specific, and quite honestly, they’re not very good.”

Opinions differ on whether a specifically curated treatment modality matters. The general principles of methods like contingency management and CBT are applicable across use disorders, according to DeRoo.

Increased research on specific cannabis use disorder treatments, including both behavioral interventions and pharmacological options, is key to improving the treatment landscape, Dsouza said. These modalities must also be paired together for optimal benefits. Stifling quick progress is the pace of scientific research, which Dsouza says moves at a “glacial pace.” He anticipates no major progress in the next five years.

In the meantime, providers and researchers alike hope for increased awareness of CUD. The federal government, school systems, doctors and health systems could all increase educational efforts to teach young people the potential of CUD.

SUD treatment providers may also need to increase their attention on the disorder.

“My hope is that there’s going to be increasing recognition of the need to address this in a more specialized and targeted way,” Glasner said. “The treatment industry, just by virtue of seeing more parents and young people concerned with this, may need to make some shifts to address [cannabis use disorder] in a more targeted way among young people. I haven’t really seen it happening yet, but I’m just seeing the writings on the wall.”



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