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WHAT ADDICTION PROFESSIONALS SHOULD KNOW ABOUT MEDICAL MARIJUANA

DECEMBER 4, 2019

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>> SAMSON TEKLEMARIAM: All right, and we will begin.

[The broadcast is now starting. All attendees are in "listen-only" mode.]

Hello, everyone and welcome to today's webinar on What Addiction Professionals Should Know About Medical Marijuana presented by Aaron Norton. It's great you can join us today. My name is Samson Teklemariam, and I'm the Director of Training and Professional Director. I'll be the organizer of today's event. This online training is produced by NAADAC, the Association for Addiction Professionals. And closed-captioning is provided by CaptionAccess.

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after this webinar. No. 3, if applicable, submit payment for CE Certificate or join the NAADAC. The fee for non-members is $25 for two CEs. And then within 21 days of completing your quiz, a link to download the certificate will be emailed to you.

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This only applies to those who are attending this live. If you are watching the recorded version, there are no means of posing questions. Instead, you have access to a Q&A document that will be on our website. And without further delay, let me introduce you to today's presenter. Aaron Norton is a mental health license counselor and marriage life therapist who serves at the National Board of Forensic Evaluators. Adjunct professor the University of South Florida and President-elect and chair of education for the Florida mental health counselor association. And experienced clinician, presenter and clinical supervisor, Aaron was awarded mental health counselor of the year by the American mental health counselor association and counselor educator of the year by the Florida mental health association in 2016. And he has been published in several journals and magazines. In fact, one excerpt of his most recent article is attached to the handout on your GoToWebinar control panel.

NAADAC is delight to do provide this webinar to you presented by this accomplished trainer. So Aaron, if you're ready, I'll hand this over to you.

>> AARON NORTON: Welcome, everyone. I'm excited to be here with you as I'm passionate about this topic. With a lot of presentations and different conferences,

sometimes I come into a room, and there might be a handful of people, and sometimes there's a lot of people.

And this particular topic has always had a lot of people. Usually, what happens at any conference is every seat is filled, and there are people in the hallway trying to get in. You can't get in because it will produce a fire hazard if they were to try and get in and block the aisles. It is such a popular topic. And it's popular because it's new. It's emerging. It involves a complex overlap between clinical expertise, legal expertise, it's controversial in some ways, it's scientific. And there's so many counselors I have talked to who are really looking for direction on how the legalization of medical marijuana and some places recreational marijuana is really affecting our profession and work as professionals. And one thing I'll get out there quickly, there are some handouts as you know in the GoToWebinar control panel that are available to you. But there are additional supplemental materials you can access by using the link that you see on the screen.

App.box.com/V/medical marijuanaAMHCA2019.

So that link is there if you like to download additional resources that are not part of the handouts in the GoToWebinar control panel.

Now, something I really like to cover right upfront is that there is a great deal of bias that we have in our profession. Of course, we're all biased. We're human beings and we come in with our unique experiences as clinician and human beings. And our own beliefs about the life and world and how things should work. And those biases play a significant role in how we approach this topic. I have my biases about this topic. I'm actually going to tell you what my biases are in a few moment. Because I think it's good for us to be looking within ourselves as we deal with new emerging issues in the field and separate what is our belief system as counselors, and what evidence is available to us, and what does that evidence dictate?

On that note, we're not alone as counselors. Prescribers, people who can prescribe medical marijuana have a great deal of ambivalence about medical marijuana. And in many different studies, very recently published, health professionals, number

one, seem to support the use of medicinal marijuana. They want it to be an option at least. But there was a unanimous lack of self perceived knowledge surrounding all different aspects of medical Cannabis. And health professionals are often very concerned about the direct patient harms and indirect societal harms that relate to the issue of medical marijuana. So if you're ambivalent, you're in good company. And this is a great -- hopefully this will be a great start getting the information we're going to cover today.

We're going to cover a lot in a short period of time, because we're going to review the difference between THC and CBD. And some of the disorders treated by medical marijuana, or at least my guess is most of you are not prescribers. We'll talk a little bit about adverse health effects, side-effects and risks. The positions of our professional associations. We'll have a list of question that are good for you to answer about medical marijuana laws in your state if you're in a state where you do have legal medical marijuana. We'll relate this to the differences between the risk reduction or harm reduction and recovery paradigm. And will differentiate between therapeutic medicinal use of marijuana and abuse or misuse of the substance.

And we'll talk about preventative strategies to implement and then, finally, and this part, I'm hoping will be particularly helpful for you. The clinical decision matrix for medical marijuana. So you are a counselor, maybe, in the addiction field, or in a mental health setting. And the client comes in with a medical marijuana card. How do you handle the situation? We've created a decisional matrix. So you can go through step-by-step to arrive at a sound clinical judgment on how to proceed with such a case some of that will be the major emphasis. And what I'm going try to do is move through the informational didactic part of today's webinar. So we can get to the clinical application piece of the second half of today's webinar.

This topic, as I've mentioned is a complex overlap between ethics. What is ethical in our field? What are some legal ramifications, requirements, and standards that apply? And what's clinically sound? What will help a client to function in the context of the society? What will best ameliorate their symptoms? And many times, these three different arenas will clash sometimes on the issue of medical marijuana.

So that brings us to our first polling question. And the question is: Go ahead.

>> SAMSON TEKLEMARIAM: Yes, thank you, this is Samson. Marijuana is an addictive substance. True or false. 30% of you responded. As you're responding, we'll give you 10 more seconds. Please note, it seems like you're sending in questions. Any question you have for today's presenter, you can send them into the questions box and we'll make sure they get answered in the live Q&A in the order which they are received. About 75% of you answered the poll. I'll give you 5 more seconds.

Excellent. Thanks so much, everyone. We're going to close the poll and share the results. And I'll turn this back over to Aaron.

>> AARON NORTON: All right. So one thing I'll tell you right off the bat, 90% of you said this is true. This is a very different ratio I see with other groups that I launched this polling question with. Usually, there's a substantially larger percentage of attendees who actually say false to this question. I mean, not larger than true. Usually the majority of clinicians say true. But usually a much larger percentage than 10% say false. I'm going to guess that has a lot to do with this particular association. You are all addictions professionals, so, hopefully, you would have more extensive knowledge about marijuana than some of the other clinical groups I presented with. But what's interesting all the clinical groups I presented with have professionals working with clients who are sometimes presenting with medical marijuana.

Now, as it stands, I would tend to agree with the conclusion that you've reached. In fact, on a local TV station, and the Tampa Bay Area where I live in Florida, we of course in Florida do have medical marijuana. And I'm going to go ahead and throw my cards on the table here and let the you know that I am a supporter of medical marijuana in the sense I do think it should be an option for prescribers with their patients. And, so, I actually loaded and support of medical marijuana in my state. I'm simultaneously a harsh critic of medical marijuana. And, hopefully, that will become a little bit clearer with some of the slides I'll cover today.

So I'm both a strong supporter and a strong critic, in some ways, an opponent of medical marijuana. So, I, too, am ambivalent. Whenever I see medical debate about

medical marijuana, one attorney got on to a medical show on cable, and he told people voting on this issue that nobody is addicted to marijuana. And I was concerned about that because of my experience working with so many clients with diagnosable Cannabis disorder throughout my career.

So I contacted the show, and talked to them and said, you have an attorney on there. He's not a healthcare professional and he misinformed the public. And this is a pretty important issue and you might want to fact check this. They decided to fact check this and turned it over to POLITIFACT. And they interviewed me and some addiction specialists. They talked to NIDA. They talked to university researchers. They reached out to DSM-5. And they concluded statement was false. To his credit, when confront 0 with the conclusion, he agreed he misspoke and apologized and redacted his statement. But the larger point he was trying to make is that there are other addictive substance that are legally options for prescribers, and it doesn't make sense to single out medical marijuana when opioids and benzodiazepine and others are prescribed. That is a defensible and valid position. But it's important for us to acknowledge it is in fact an addictive substance. At least potentially addictive so, that brings us to our second polling question.

>> SAMSON TEKLEMARIAM: Thanks, Aaron. Your second polling question will pop up on your screen in just a moment. It asks in 2017, the World Health Organization concluded that cannabidiol poses blank public health risk. You'll see four different options there. Looks like some of you are answering. Just a reminder please keep the questions coming in the question box. And you'll see it in the control panel and you'll see the few handouts that Aaron referred to. And we'll refer to it again throughout the presentation. 5 more seconds.

Excellent. Thank you so much, everyone, for voting and interacting with the presenter poll. We will go ahead and close this poll and share the results. And I'll turn this back over to Aaron.

>> AARON NORTON: Okay. So your answers are very interesting here. What I will say is that the 15% of who said, no are, in fact, correct. It is true that the report published by the World Health Organization in 2017, they said that CBD poses no public

health risk. And that is a surprising finding to some, and maybe not as much to others. But that was the conclusion of the report. Which we actually have here on the next slide.

There we go. Okay. Let me go back a space here. Nope. All right. Maybe it's not the next slide. Maybe it's couple of slides away. But let me just give you a brief overview then, because medical marijuana is a broad term. And that's one of the problems with news reports on this issue, and with debates, and discussions is that it's a very broad term. Usually when people are referring to medical marijuana, they're either referring to THC, tetrahydracannabinol, or they're referring to CBD, cannabidiol. And they are very different compounds in the same marijuana plant.

They operate differently on a cellular level. And THC is psychotropic where CBD is not considered psychotropic. THC can produce a euphoria and high and is addictive. But CBD does not produce a euphoria or high and not considered to be addictive, and it's not a controlled substance whereas, THC is and both of them are referred to as medical marijuana producing confusion. So I actually prefer for people to use terms like medical THC or medical CBD to differentiate which type of medical marijuana they're referring to.

Here is the report from the World Health Organization where they concluded that there was no public health risk associated with CBD. They did not make such conclusion involving THC just to illustrate the significant difference between those two forms of medical marijuana.

Yet, even that report from the CBD gets reported very differently in headlines. One of the confusing things about medical marijuana is that it sort of depends when information is reported to the public, what's the slant? What's the spin from the reporting source? Here are three different headlines about the same report from the World Health Organization. The first headline says: Compound in marijuana appears safe and non-addictive. Who says? The second one says, WHO report finds no public health risk or abuse for potential CBD. And the third one says, blow to anti-Cannabis campaigners WHO declares no health risk for medicinal marijuana. Third one is extremely misleading and a terrible headline. Very much deceptive. It does not say

there's no health Rick associated with medical marijuana. They were only talking about CBD. So this confuses the use of terminology when we're talking about and researching medical marijuana.

To give you a good illustration of this, even ScienceDaily, which I think is a wonderful news resource in our field. You can go to ScienceDaily, and you can sign up to get email updates for any kind of mental health related research. And they will publish these news stories about things that have been published in peer-reviewed professional and academic journals. They will break it down in terms easier for me to stomach as a clinician. And they will sometimes interview the experimenter and researchers. And they do a pretty decent job, even in the way they structured their headlines compared to other news sources. But let's look at what would happen if you went to sciencedaily.com and typed in medical marijuana and opioids or opiates. Here's one from August 2014, fewer related deaths. We get a reduction in opioid-related deaths. Next headline, in November 2016, marijuana could help treat drug addiction and mental health study suggests. Then when we move on to December 2017, marijuana use may not aid patients in opioid addiction treatments. So now they're saying, hold on a second. Maybe that other research was wrong. And then we get another one. Medical marijuana could reduce opioid in older adults. So at least it would help more experienced population in the U.S.

But then we move on to February 2018, study questions link between medical marijuana and fewer opioid deaths and fewer association appears to be changing as medical marijuana laws and opioid epidemic change. Maybe we're not right. And then we move to April, 2018. The relationship between legal Cannabis and opioid prescribing further examined and new conclusions being reached that, again, maybe not so helpful for in terms of reducing opioid-related problems. Then we go to April 2018. People who use medical marijuana are more likely to use and misuse other prescription drugs. Almost the opposite of the original headlines.

And then we move forward to June 2019, medical marijuana does not reduce opioid deaths. All right. We go couple of months later, and all of a sudden, yes,

marijuana actually does reduce opioid deaths. August 2019. So you can see there's so many contradictory results coming out in studies. And, so, one thing is that [Lost audio]

So it's a great treatment or they tell you it's the opposite. But I'm here to tell you there's evidence for both sides, because this is a very complicated issue. So always be a little bit skeptical when somebody make it sound easy and clear what the research says about medical marijuana.

Now, I was originally thinking about these headlines. Wouldn't it be so nice if there was one authoritative resource where they reviewed all the evidence, the totality of studies out there about medical marijuana and they vary clearly told us, look, here's what we know and don't know yet based on the research, and they did a good thorough job. And they were nice and unbiased and systematic in their approach. And very objective.

Turns out I think there is such a resource. It was published in 2017 by the National Academy of Sciences and engineering and medicine. You can access it in the box folder link. You can Google it and download it for free from the Internet. It's about 460 pages. It's great read field goal you're trying to find out more about medical marijuana. It's also a wonderful treatment for insomnia if you're having trouble sleeping at night. And that brings us to our third polling question.

>> SAMSON TEKLEMARIAM: Thank you, Aaron. Go ahead and launch this polling question on your screen. You should see it in just a moment. The full question asks according to the National Academy of engineering and medicine, the evidence is greater for which use of medicinal marijuana? There was no enough space there. So I'll ask that one again. According to the National Academy of Science engineering and medicine, the evidence is greater for which use of medicinal marijuana? We'll give you about 10-15 seconds. Almost half of you have answered. Again, just another reminder. It looks like you guys are using the questions box. Any question that is come up for our presenter, please send it into the questions box and we'll answer them in the order which they are received. Yes, 75% of you answered. We will close the poll and turn this back over to Aaron.

>> AARON NORTON: All right. 63% of you said chemo induced nausea and vomit k was the treatment that was for which we had the greatest amount of evidence medical marijuana can be helpful. And I would agree with you. That is, indeed, the finding from the National Academy of Science engineering and medicine that have the greatest amount of support behind it. So let's dive in quickly to what the report shows and doesn't show. There we go.

One thing I like about this report is they take and create levels of evidence based on the totality of the research available. The top level is conclusive evidence. They have lengthy definition for conclusive evidence. But you can think of it as look, it's very much a fact. The thing we can come up with in the scientific community. Then substantial evidence. Moderate evidence. Limited evidence. Then no or insufficient evidence to say anything about it. Of the various different medical conditions that's been well-researched in terms of medical marijuana use, there's only one symptom condition or disorder for which the academy concluded that we can conclusively say medical marijuana is helpful for.

And that one symptom disorder is chemotherapy induced nausea and vomiting. And/or orally administered and research wasn't about smokable marijuana and that sort of thing. The second category of substantial evidence, there's 2 symptoms of condition disorders which there's substantial evidence that medical marijuana can be helpful. Only one symptom or condition disorder for which there is moderate evidence. 5 for which there is limited evidence. And, finally, 11 of the symptoms conditions or disorders that are researched. The burden of proof was no evidence or insufficient evidence. What this basically tells you if we look at it graphically, we can say conclusive say anything about the medical marijuana. Enthusiastic trainer and that is so well accomplished and researched, you can be susceptible about the message you're receiving if you consider the evidence in that very thorough investigation by the National Academy of Science and engineering and medicine.

So, some of the medicinal uses of THC versus CBD. This is an interesting thing, because many of you know there's a lot of research about THC can exacerbates bipolar disorder and psychotic disorders. In fact, could potentially even trigger or bring out the

full-blown potential, the genetic potential for clients who have predisposition for bipolar disorder or psychotic disorder. But CBD, there's new research that it might actually be helpful for anti-psychotic, almost opposite of THC.

Pain relief is a common reason for which THC is prescribed. Reduced multiple sclerosis and the reduction of nausea or vomiting secondary to chemotherapy, you'll see that for both THC and CBD. Also for HIV/AIDS for patients with H.I.V or AIDS, some additional use of THC. There's an interesting thing many people say that medical THC helps out with PTSD, but only thing we can say fairly conclusively about that is that any study, there was a 7 week short-term study with individuals with PTSD, there was only one symptoms that was reduced from medical THC, and that one symptom was nightmares related to the traumatic experiences. And interesting thing about that, there's also a lot of research that THC reduces the amount of time the brain spends in REM stage sleep which happens to be where most of the dreams happen. So you might think of it as THC reduces dreams, and, therefore, reduces PTSD related nightmares, but it tells us very little about overall the effective treating of the context and getting relief from other symptoms? We just don't know. We can only know anecdotally.

Anti-inflammation is a medication for it as well.

Dosing considerations. I'm not a prescriber. I'm not qualified to tell people what to do with their dosing. Most of you probably are not as well. So I'm going refer to a great prescriber, Dr. Greg Smith, who wrote a great medical marijuana textbook that's used in some medical school programs. And himself manufactures and designs medical marijuana products and is a prescriber. He says that most conditions treated by medical THC respond to ratios that are one part THC, to one or more parts CBD. Whereas, recreational marijuana, the ratio is more like 15 or more parts THC to one part CBD. In other words, people do not need marijuana that is anywhere near as potent as the THC content as recreational marijuana in order to adequately treat most medical conditions.

Similarly, Dr. Smith says if your patient is feeling higher euphoria, they're overly medicated. Many clients, they're pursuing a higher euphoria and getting it. When I did

an online review of products sold in clinics in Florida, I see dosage of 10 milligram to 6 milligram of THC. And CBD ratio that is more like from 20 to 826 parts THC to one part CBD with most ranging from one part CBD and 20 parts THC and 60 parts CBD which is greater than what Dr. Smith and other medical marijuana prescribers are recommending. So what might be good might be medically appropriate, and then there's what's actually happening out there. And the two are not always the same thing.

I'm not going to spend time on this slide, because hopefully as an additional professional, you have an understanding of short-term and long-term effects of THC. But if you want to go back and review them, you can always look at this slide or look at some other supplemental information you have.

You need to know in newer research, approximately in 30% of people who used marijuana in the past 12 months have a diagnosable Cannabis use disorder. But that means 70% of people who used marijuana in the past 12 months. 70% of them do not therefore have a Cannabis use disorder.

And we're now on polling question No. 4.

>> SAMSON TEKLEMARIAM: Thanks, Aaron. Yep. Everyone, you will see your fourth polling question pop up on your screen in just a moment. The question asks marijuana related motor vehicle accidents increase nationwide on which date of every year? You'll see four answer options there. January 1, April 20, November 24, or December 29. It looks like half of you have voted. Thank you, again, for all of you sending in your questions. We've got about 7 or 8 questions in the queue that are content related. Please keep those questions coming. We'll make sure to answer those in the order they are received. About 5 more seconds to answer this poll.

Excellent. Thanks so much, everyone. I'm going to close the poll and share the results. And I'll turn this back over to Aaron.

>> AARON NORTON: All right. 65% of you said April 20th. And, so, you are correct. Interesting thing about this polling question is that I have, and giving the same polling question to many, many different audiences in different parts of the country, and even in some other countries. The college students are the most accurate at answering

this question. They are great knowing that April 20 is going to be the date every year where motor vehicle answers are nationwide related. This is kind of a code, a number that signifies, hey, let's get high. And, so, some people celebrate April 20th at 4:20 p.m. by smoking marijuana. And sometimes they continue to smoke it and drive that even or night and maybe get into an accident that is deemed marijuana related.

And there's an interesting study on that that you can look at later if you like to. But kind of pointing here that of course when we talk about how prescribers, one of their concerns is about public safety risk, this would be a good illustration of that. Now, there are big challenges in Cannabis research. We know so very little. There's so little that we can conclusively say about medical marijuana. There's honestly little about what we can say about recreational marijuana because of how research works. Because the idea of medical marijuana or recreational marijuana, you have to create some different groups. You have to select participants, wild age ranges and population and divide them into different groups. One group might be a controlled group. One takes a placebo. And then you have a THC group that THC would be further divided into subgroups that have different dosages and frequency of THC use.

And then what you would do is you would make sure that this THC or water pills are administered religiously for many, many years. Preferably decades. Then afterdeck cades of doing this, you would look at the statistical differences in the various outcomes between the different groups that were randomly assigned and then you can say things that are conclusive about the effects of marijuana. Of course as many of you have guessed, that study does not exist. Not only because it would be so much time and money and effort and energy and, so, many things wrong with such a long-term study, but also imagine trying to get that study through an institutional or review bored or ethics panel.

Yeah, I'm I'm going to give THC to teenagers, and I'm going to give it to them regularly throughout their lives and see how much it messes them up or doesn't mess them up. That's just never going to work. So instead, we do correlational research. We find people who are already doing this. And then we look for statistical differences. And we try to control statistically for different variables that seem to be confound but we can't

do that 100%. And then we'll do short-term studies. But that doesn't tell us anything about the long-term effect of marijuana. Or we can use animal studies. And rats, for example, and they have a short lifespan and they're not human. So generalize ability and long-term effects, we may never know.

So let's move on the positions of our professional association and organizations. I'm not going to go through every last detail, but I am going to show you some of those positions and hit a few highlights. Interestingly, the American Medical Association, which is first on the list, when they published their updated position on medical marijuana 2017, I saw many headlines, especially, in very pro-marijuana publications that said American Medical Association now approves of medical marijuana. But when you read the statement for yourself, it doesn't look like that all to me. They said they believe one Cannabis is a dangerous drug and such is a public health concern, number two, public health based strategies, rather than its incarceration should be utilized in handling of individuals possessing Cannabis for personal use. And educate the public on the health effects of marijuana. And they urge legislatures to delay initiating full legalization of marijuana. And they encourage FDA warning label on medical marijuana products that says marijuana has a high potential for abuse.

Not exactly an enthusiastic endorsement. And then we have the American Academy of Pediatrics, and long story short, they do not recommend medical marijuana for adolescent because of the adverse effected on the developing brain. That brings us then to the American Psychiatric Association. They is a there's no current scientific evidence that marijuana is any way beneficial to the treatment of any psychiatric disorder and in contrast, evidence supports the idea that it can be harmful actually. So they're not really supportive of medical marijuana. They also published a second position statement that same year ceiling out PTSD saying that they do not think medical marijuana in the research is an effective treatment for PTSD. They have not changed their position since 2013 though. And this is an interesting thing. Some people thought about could there actual be disadvantage of medical marijuana in terms of psychotherapists for those who do counseling for mental or emotional disorders?

One of those argument is that medical marijuana could interfere with exposure and response prevention protocol. So for those who do response and prevention therapy for anxiety disorder, phobia and so forth, one of the requirements is to try and have the client not be on any potentially addictive medication while they're involved in the protocol. Why? Because what needs to happen is we have to expose them either through flooding or through systematic desensitization of graduated exposure to the very stimuli that are generating or producing the anxiety. And we have to repeatedly expose in incremental doses without any bailout, taking a substance that physiologically settles you down in the moment rather quickly after you take it, interfere with that process. It prevents the brain from experiencing the anxiety. And if it can't get experience from it repeatedly over and over again and get it to it fine, then the brain does not habituate. So another interesting argument is that one of the Universal variables associated with all psyche therapies, regardless of counseling theory involved is that pretty much all of them involve approaching something directly and head on rather than avoiding it. And, so, some people will frame the taking a pill that very quickly makes you feel differently as an avoidance strategy.

Also, there's the idea that in general, taking any psychoactive substance that is potentially addictive can prevent the brain from habituating or adjusting learning how to manage unpleasant or intense emotions over time for them if you have high euphoric and in the aftermath, you have a depletion or shortage of neurotransmitter available and there's a period of dysphoria so medical THC may perhaps contribute to the roller coaster ride. And the belief that I cannot handle this. It is so bad I need to take a pill in the moment in order to function. And then, finally, interfering with memory consolidation, because even the short-term effects of THC is to impair short-term memory and psychotherapy and is very much requires the client to be able to have short-term memory so they can internalize the experience and the information in therapy sessions and consolidate and integrate that information on that experience into their system going forward.

So that's an argument. Now the book you see on the right-hand side isn't about medical marijuana. But it's an interesting book that kind of plays to this philosophy

called The Coddling of the American Mind written by a cognitive-behavioral therapist Greg Lukianoff and Jonathan Haidt, a social psychologist at the American mental health counselor association in a conference many years ago. And the basis of the book is unintentionally, we're reinforcing the idea that young Americans cannot handle things. And they're rising to be the occasion to prove us correct. And they provide some compelling and interesting argument and data about that possibility.

Now, ASAM, the American society of addiction medicine. These are experts on addiction. They support the decriminalizing medical marijuana like everybody else. They do not support legalizing it. And they would like more research. And that's pretty much the position of all of the major associations. They're not excited about it. They don't want to criminalize it though. They want to treat it clinically. And they want more research and discourage legalizing medical marijuana. The VA is pro-inhibited from prescribing medical marijuana for any patients. Physicians working for VA are prohibited recommending they get it from somewhere else. They're federally-funded and you can't use Federal Tax dollars to break the laws. But additionally, their pharmacy do not carry it. One thing important to know is that if you're working with a Veteran who gets the services at a VA and they're taking medical marijuana, they are generally encouraged to communicate that they're taking the medical marijuana to the VA treatment team. That will not disqualify them from services at the VA in any way. And it's important for prescribers to know what a patient is taking even though they might be getting it from somewhere else so they can factor that in when they're making decisions about client care.

Also, their employees are prohibited from using it so that's important to know about. So who doesn't have a published position? Well, basically, all the associations on this page do not have any published position on medical marijuana. And I think the reason why is they are not physicians. They're not prescribers. All of the other association that we just fueled are either prescribers or they are addictions experts. And these associations have a broader focus of non-prescribers primarily.

So it kind of makes sense to me they wouldn't have a published position. Medical marijuana is becoming increasingly popular and as of this point, we have 33 states that have legalized medical marijuana and Washington, D.C.

And then we have 10 states that have even legalized recreational marijuana. I learned that when I was presenting in Seattle a few weeks ago and I was walking around downtown and I was like, my goodness. This entire downtown area is a one giant hot box because people are walking around smoking at a great deal some of questions to ponder about medical laws in your state, because this is a national audience so you're going to have different laws state-to-state.

Is it legal for medical use or recreational use or both and for your clients to know? Does the law differentiate between THC and CBD? Also important for clients to know. What conditions can marijuana be prescribed for? For example, here in Florida, there's only one mental health that you can prescribe medical marijuana for. And that disorder is PTSD, ironically, which was singled out by American Psychiatric Association and other organizations as not being particularly helpfully treated by medical marijuana by the evidence we have so far. And what's the process for getting the prescription? That's an important question. Who is an approved vendor? Where can they go to get legally regulated medical marijuana? What are some restrictions and limitations of the medical marijuana use? Where are they allowed to use it and not use it and what conditions? And what places or context is it illegal to possess it or use it?

So, here in Florida, it's only legal for medicinal use. This is a case in point. And there's only certain conditions you can prescribe it for. However, you will notice that there's a catch-all phrase that says, or medical condition of the same kind or class comparable to those enumerated above. Only mental disorder you can prescribe it for is PTSD. But in reality, I've had clients tell me it's been prescribed for ADHD, Generalized Anxiety Disorder, for every mental disorder under the sun. And some prescribers liberally interpret that clause to such an extent they're pretending any disorder is up for grabs just because PTSD is listed. It's an interesting interpretation in my viewpoint. In Florida, you can't use it in public transportation or any place of employment unless your employer allows you to. And you can't use it in certain

government location or in certain forms of public transportation or vehicles, you can't use it as well.

And, of course, in all 50 states, it's still illegal under Federal law. It's not protected by Americans with Disabilities Act and their employment ramifications. Someone might say I've been legally prescribed medical marijuana. They test positive maybe on a post accident drug test at the workplace. And then they get terminated for violating drug-free workplace policy. But they say, I have a disability. And you're discriminating against me by taking away from me my right to adequate treatment. But under the A.D.A., any illegal drugs under Federal law is not protected. So, that's something for your clients to know about. And it's definitely not permissible in any U.S. Department of Transportation regulated safety sensitive job. This is not just airplane pilots or bus drivers, or tugboat captain. But this includes people on the assembly line or manufacturing or circuit board that will go into a plane or car. Painters for bridges because it's being used for public transportation and so forth. So those occupations, there's pre-employment drug screens and random drug screens, and if anybody shows up positive for of any those, even though they have a legal prescription, they have violated DOT regs and they must go before ASP and have an appropriate evaluation and treatment.

Technically, they can also be arrested under Federal law even in a state where it's legal. Not that it really happens very often, but it's possible. All right. That brings us to our decision matrix. This matrix was originally published as the distribution matrix for clinical mental health counselors and encountering medical marijuana use in mental health and substance abuse treatment settings and it's basically a flowchart I created where I took the position and best practice guidelines of various organizations and some different treatment, common practices and substance abuse treatment and I created a decision matrix that would help counselors make decisions when clients present with medical marijuana cards.

There's a PDF version of this which you have available in the GoToWebinar control panel. You can also use the box folder to access this. But I also have created an electronic version of it where you go in and it asks you a question and you answer it.

And it tells you what to do next and continues guiding you through the process. And we'll talk about that in just a bit here.

But let me give you some information that contributes to this matrix. First there's an interesting finding and it was recently published. Medical and recreational users nationwide had many more similarities than differences, and the differences were small, suggesting that only a few medical users were likely targeting medical conditions.

In other words, I don't know if any of you in a state where medical marijuana is legal experienced this. But in my state, when we were debating medical marijuana, and deciding whether the voters would approve it or not, I had a number of clients who have substance use disorders, sometimes Cannabis use disorders and other substance use disorders who would say, I can't wait for it to be medically legal so I can get my medical marijuana card. Well, what condition do you think needs to be treated with medical marijuana? Well, none. I just want to be able to use it and not have any ramifications for arrest.

So what's really happening a lot of times, I'm not saying certainly not everybody, and I don't even know I can say the majority, but a lot of people who were recreational users or maybe even who had diagnosable disorders were getting medical cards with the intention of just continuing to do what they were already doing rather than a medical application. They just kind of find a reason and find a prescriber who finds a reason to support it. Much like I work with some college students who don't have ADHD by any means, but who might go to their campus medical office and talk about not being able to concentrate or focus or remember things so they can get Adderall prescription so they can spend all night studying to cram for an exam. But that's not really medical use in my opinion.

So then the key part is how do you know? How do you tell? Because there are people who have medical conditions for which medical marijuana could be alleviate their symptoms and help them function well in the context of a society, to bring them tremendous relief with very little risk. How do you differentiate those clients from a client who are just playing the game to get the medical card so that they can continue to use recreationally or to misuse the substance?

That's where we come in as addiction professionals, I think. Generally, some things to look for is, does this individual combine the medical THC with other addictive substances? Perhaps as some form of chemical medication? Or perhaps they're pursuing a higher euphoria. Do they tend to run out of prescription early or supplement it with elicit or recreational marijuana? They go to ray dispensary and they kind of choose their own doses and it's not -- the reason why, it's legal under Federal law, a physician cannot write medical marijuana on a script pad and legally determine the dosage and so forth. They can only recommend it. The client takes the recommendation to the dispensary and they kind of choose the part they want and they self-diagnosis and decide how much they want and so on.

So it's hard to say this is met here because of the way it's set up. Third thing, frequent changes in physicians. That's an interesting thing. The time of being context which the medication is taken. And so, for example, if you ask a client who shows up with a medical marijuana card, you can see the red eyes and the kind of slowness and the glossy eyes, and to you they look like they're under the influence of something. And then you might ask them, well, when did you last -- if you ask them, do you drive under the influence of your medical marijuana? They will say, no. If you ask them, when they last took it, they will tell you. And if you ask them how they got here, they will say I drove and you can connect the two oftentimes. But that would be a sign that there could be something problematic going on.

And seeking absence of symptoms versus euphoria. So you might have a client taking medication that will say I don't think it's working. I remember when Marinol prescribed by a doctor, they would say it's not working. What tells you it's not working? They would say I don't feel it. What do you mean I don't feel it? I don't feel that pleasant sensation. So, in other words, they're not looking for -- they're not defining it as working by is it eliminating or reducing my medical symptom? They're defining it as do I feel something euphoric? Do they have history of other abuse? I always tell clients and I can tell you're high the moment you walk in here, that probably means other people can. And if other people can, are those people employers? Are they customers and co-workers? Who are those other people? And could that create issues for you?

And then, finally, do they have one or more diagnosable substance use disorders? Because that would tell you they're at an increased risk for non-therapeutic use of marijuana.

Now, you guys are familiar with the diagnostic criteria of Cannabis use disorder. So I'm not going to bother going through it. For others groups, sometimes I'll go through this in greater detail. You should hopefully all know there's a diagnosis Cannabis withdrawal. And that indeed, Cannabis is an old DSM-4 terminology. You can be physiologically addicted to marijuana. Where you can have withdrawal. DSM-5, we no longer differentiate between physiological dependence and psychological dependence and we use a different terminology. But you can have a Cannabis withdrawal if you're a frequent smoker and you suddenly stop, you can experience any of these 7 things. The good news is, it will alleviate within a month's time.

And I hear this all the time from clients I've worked with who are using marijuana heavily and daily and didn't think there was anything wrong with it and they have to stop maybe because of legal ramifications or whatever and, so, they do. And then they're barely dysphoric for weeks. And saying things like, man, obviously, that marijuana was really good for me, because without it, thing really suck. I was better off on it. But then get them past that one month point or so, and they're saying, oh, my goodness, it's like I'm seeing clear skies for the first time in years. And I didn't know that the skies were cloudy to begin with. But now I know. So I hear things like that a lot of times.

So what if there's no evidence or not enough evidence that the client has a diagnosable substance use disorder? What do you do then? Well, if they're using it and not abusing it, first thing I might say, if it ain't broke, don't fix it. Just because a client is using a potentially addictive substance, there's a problem or for us to do something about it. If you have a client using medical marijuana and there's no evidence it's creating any problem for them and there's nothing to fix as far as we're aware, but you still might do things like education. You might do some motivational interviewing to make them more ambivalent about medical marijuana.

You might help with psycho intervention. And what other resources do they have to manage their chronic pain so they're not overly dependent on the prescription for that.

Or if it's being used for PTSD. As it is here in Florida sometimes, what are other alternatives for treating the PTSD? And are they interested in those interventions to reduce the dependence on the medication? You might monitor the evidence of abuse or unsafe use going forward.

And sometimes, the clients are willing to reduce the THC content to reduce risk or maybe even switch from THC to CBD to lower risk. But the question is is that medically appropriate from the prescriber's manage point? And, you, as a counselor would not be qualified to answer that question in my opinion. And then you might consider incorporating these recommendations into a report if you're doing an evaluation like your forensic evaluator, for example.

Lastly, my question for people is what is your end game? Because if right now you're taking medical THC multiple times a day every day, then we could say there's a chance, a good chance that over time you will develop tolerance and have less effect you're getting from it now. And, so, if that happens, then over time, it will stop addressing the medical issue as efficiently. And you'll either need increase in dosage or something else, or the symptoms return and they're just as bad as they were to begin with in some cases, but it takes any high doses to get relief at all. And do you want to use this for the rest of your life? Or is it your goal to get off of it eventually? How can we plan for that? How can we incrementally over time provide resources and help to do so? You have to look at is that appropriate in any specific case?

If, however, you are clear, the client has one or more diagnosable substance use disorder, which by definition leads there's clinically significant impairment or distress associated with the medical marijuana, then the strategies I recommend are different. You have to look although severity. Is that mild? If it's mild, then maybe some harm reduction work might be viable. Maybe they can modify the use so they're in remission even though they're still using. That happens sometimes. But if it's moderate to severe, then the probability that responsible moderate use of an addictive substance is long-term will be viable reduces significantly. It may not be so bad for months, but with time, people tend to start having problems with it again.

So, in that scenario, you would ask do I have leverage or not? Leverage means is the client seeing me just because they want to? Or is the client seeing me because they need or want something from somebody else that is seeing me as a prerequisite for? Are they seeing me because they lost their driver's license due to a DUI and they need treatment successfully to get the license back. Are they seeing me as a term of probation to enter a treatment and demonstrate abstinence for a significant period of time? And then be discharged with a positive prognosis. Are they seeing me because they were able to get what's called downward departure, were found guilty of a felony, but the court decided to use a rehabilitative approach versus a punitive approach and here they are. And my goal is to be able to show that there's a reduced risk to the public safety because of the intervention I'm doing with the client.

If you have leverage, use it. If you don't have leverage, meet the client where he or she is at. And work with them as best as you can. Whether they want to stop using it or not. Those are my recommendations. They're kind of consistent with the ASAM mentality if you're familiar with the ASAM treatment criteria.

If you decide they're misusing the substance, they have diagnosed substance abuse disorder and they're problem is highly problematic. Physicians don't know what you know. We spend the most time with client out of all the healthcare professionals. It might be hour a week or several hours a week. You might see them once a month or maybe a lot less frequently than that. Physicians have shorter interactions with the client. The client givers them information and the client may not be forthcoming with the information. And the physician may not know the client has 4 DUI and couple of possession charges.

To if it's abuse versus use, and you have ledger, then we generally would suggest that you require the client to sign a release and allow you to interface with the prescriber. Client has a legal right to refuse that. But that's the same as their legal right to refuse treatment and there could be legal ramifications for that if they're discharged unsuccessfully in that scenario. So I generally have them sign a release. If they refuse to do that, I'm kind of in a bind, because on one hand I'm supposed to treat them. I

determine this is clinically viable and they're not going to change it and they're refusing to allow me to communicate with the client what's viable.

So my hands are tied because I can't treat them under this condition some of those scenarios, I would tell them, if you can't sign a release, I understand, that's your right. But I won't be comfortable working under those condition and here's why. And I give them the rationale. Most of the time, they sign it under these conditions. If then you might interface with the prescriber. We'll be looking at the prescriber require any non-prescribe officer nature of the background and disorder? Are there any dosage adjustment? Would it appropriate to refer them to a second opinion to a specialist? And can we consider counseling for harm reduction? Can we do alternative therapy like exposure to therapy, CBT, for insomnia. But the bulk of cases in insomnia are cases where the cause of the insomnia really comes down to thoughts and behaviors and not an underlying biomedical condition.

And, so, let me move on then to what that interface with the prescriber might look like. Like I talked about this already. Physicians, they're not the enemy in my viewpoint. They just don't necessarily know what we know. And we have an area of expertise and they have theirs. So we need to share with them what we know so they can do their job as a prescriber with the right information available to them. Ed American Psychiatric Association published guidelines for treating patients with substance use disorders and they take a very conservative approach in this guideline to prescribing any potentially addictive medication for a client with one or more substance use disorder.

So if you're doing -- you might write a letter. And you might, after securing appropriate consent, you would notify the physician of the client and present treatment and reason for the admission, the presenting problems, the referral source and the diagnoses, and be specific about the symptoms of one of more substance use disorder the client meets and how you know that. If you're convinced their medical marijuana is problematic, refer to the APA and to ASAM guidelines about avoiding medical marijuana prescriptions in these cases. Because physicians will listen more to the medical authorities than obviously non-prescribers like us. And frankly, I don't blame them

because it makes sense it would probably be more credible for them coming from more prescriber authorities. And you indicate treatment plan will include psychoeducation and psycho intervention alternatives. Drug testing procedure if applicable. And notified of any changes in prescription and extended invitation for collaboration. Those are things I recommend when you interface with a prescriber.

Now let's say the physician is non-responsive. Though never change anything with the medical marijuana and business as usually. Then you might consider using your leverage and refer the client to an addiction medicine specialist for a second opinion. Why do that? Here's the dilemma. The addiction expert, you, says there's a problem here. The prescribing expert, whoever is prescribing the medical marijuana says I'm obviously not concerned about that problem. So we have two conflicting opinions. So it makes sense to find somebody who has dual expertise in both addiction and is a prescriber, a medical doctor who can prescribe and see if you can get an opinion from that person to sort of mediate the difference of an opinion. That's a logical way to think of it. So board certified medical specialist is a sensible and logical professional who can make that determination, because they have both areas of expertise.

In my experience, I've never had a client go to an addiction medicine specialist and get a different opinion than mine. But it can happen. But they usually agree with the doctor and you document well and you send the information to the physician so they have access to the information to make the clinical determination. If the specialist says there's great viable determinants and you don't need to address this underlying medical issues and I recommend these alternatives. Then you might recommend sending the client to work with that physician on those alternatives and get off of the medical marijuana.

You might do the same thing if it was a client addicted to benzodiazepine or opioids.

Now, let's apply the matrix to some specific case scenarios. Let's now get into our clinical applications and still have some time for questions and answers at the end. Now, I didn't realize this until today. But originally, I was going to click on this link here

while presenting. And then show you the electronic decision-making matrix and take these case scenarios step-by-step, screen by screen through the process. But I discovered I can't do that through today's venue.

So instead, there's the link. And what I would encourage you to do if you want to see what I can see on my screen that you can't see right now, because I'm going to go into the decision matrix, the electronic version. You can follow along by opening your browser in the same link. The link is SurveyMonkey.com/R/medicalmarijuana decision matrix. I'll give you a moment to go into another device if you would like to follow along and see what this actually looks like. This is a free resource available to you that I created. And I find it very useful, and some other people do so, too, so I'm hoping you will also find it useful. Our first scenario is Gabriela.

Gabriela is a 53-year-old client and has a diagnosis of multiple sclerosis. She parts pated in a full mental health evaluation at the recommendation of her primary care physician due to the complaints of her depression and was diagnosed with a major depressive disorder that was likely secondary to MS. So that was due to another medical condition. She was then referred to you for therapy for her depression. She mentioned that her physician has prescribed her mild dosage of the medical THC to control spasticity.

This includes by the way, a link to a 2-hour recording of a webinar with some information about, a little similar to what we're talking about today but not as updated and it tells you about the development of the tool and so on. but scroll down to the bottom of the page, use this matrix to answer the questions beginning on the next page and then click the green button. And what you'll see is a question. Does the client meet DSM-5 diagnostic criteria for one or more substance use disorder? In this case, do we see any evidence from the a little bit of information in the scenario that this client meets diagnostic criteria for one or more substance use disorder Senate bill well, I would say, no, we do not see any evidence of that.

Let's assume we do a thorough assessment and we really conclude there's no evidence. Then what you do is you click No. And then you would click next. And that brings you to your next screen. Which asks, does the client want to stop using medical

THC? Now, let's assume that this client says, no, I think it's working fine for me. And the doctor recommended it. I'm going to keep using it. I don't see any problem with it. Then we're going to click No, and then we'll click next. And then you get to a page that says, harm reduction approach indicated. Meet the client where he or she is at. It defines harm reduction and it gives you multiple strategies that you can use or consider using, because they may or may not be all appropriate for this client. The strategies you consider using just to help make sure this doesn't become a problem down the road.

So, in other words, if it ain't broke, don't fix it. This is a simple scenario in that sense. But let's move on to our second scenario.

Scenario No. 2, Alejandro. Alejandro was referred to you because of a DUI charge involving alcohol. He has a previous DUI that was both marijuana and alcohol related, a disorderly intoxication charge and possession Maureen changer. He is court-ordered to complete outpatient substance abuse treatment successfully. When he heard that he would be expected to avoid use of illicit drugs while in treatment, he secured a medical marijuana card for ADHD. Does the client meet the criteria for substance use disorder? We already can assume there's been use and physical situations despite the legal charges, he's continue to do have problems that he's likely using to continue to use despite maybe psychological or social problems for the ramifications of use. But let's assume we did a thorough evaluation and we conclude indeed, he does have a substance use disorder, but let's say it was mild. A mild substance use disorder.

Let's go back to the first question. Does the client meet DSM-5 diagnostic criteria for one or more substance use disorder? Yes. So we'll click that and hit next. Question No. 2, does the client wish to stop using medical THC? Well, let's go with no. Because he just got it. Because they wanted it. Because he didn't want to stop using it. So we're going to say, no and hit next. Third question, what is the severity of the client substance use disorder? In this case, let's say we determine it as mild and click next. We're back to the same outcome. Use or harm reduction approach for this client.

Actually, I'm sorry. There seems to be -- that is not where we should have gone. We should have gone to the question of do we have -- yeah. Yeah. He doesn't want to stop. And it's a mild substance use disorder. So what you might generally do in this scenario, try a harm reduction approach first and see if the client can achieve remission status using that approach.

So let's move on to our third scenario then. And our final one before we start getting into your questions and answers. Scenario No. 3. Ron was discharged against medical advice. Prematurely in the opinion of the treatment team from him a residential substance use disorder treatment program with diagnoses of alcohol use disorder, severe and Cannabis use disorder, severe. He sought treatment reluctantly when his wife threatened to leave with the children. He was 42 years old. She pointed out and marijuana helped him to feel happier. And she wrote a recommendation for medical marijuana. He's seeing you because his wife insisted he see a therapist. This is a real case. If we go to the decision matrix and go back to the first part of the matrix, they happen we'll see again the first question is, does the client have criteria for one or more substance use disorder? Yes.

So we click Yes and then next. Question No. 2, does the client wish to stop using medical marijuana? Let's say, no. He just got it. He wanted it. He's not going to stop at any time soon. What is the severity of the client's substance use disorder? We're going to click moderate or severe. And hit next. And that brings us to question 4 if you're able to see this on your screen right now, because you're using the electronic matrix. Does the counselor have a leverage? Which is defined as resource or outcomes pursued by a client that may be conditional to successful treatment completion and then it gives examples. And in this case, that's a bit questionable. Do we have leverage or not? We don't have leverage -- well, we might have a little bit of leverage, because the wife is kind of hanging over his head that she will leave and take the kids with her and insisting he sees us. But there's not whole a lot of leverage to work with here.

I'm going to go with no on this case. And if we did that, we would once again end up with a harm reduction approach. Which is what I did with this client. And we did

some motivational interviewing to help resolve his ambivalence about quitting everything altogether, also while trying to do preventative work that would reduce the likelihood that the marijuana use would become problematic. But let's change the scenario a little bit. Let's say the answer was yes. That we do have leverage. Let's say, for example, he was trying to get his driver's license back or mandated referral and his employer expects to see updates and negative drug test results on drug screen at his place of work. In that case, there's leverage because if we discharge the client unsuccessfully, his employer will terminate him.

So we would consider using the leverage in this case. We would explain the rationale? Ask him if he would consent communicating with his prescribe sorry his prescriber has the same information we have and consider that when she is examining whether medical marijuana is a really the best fit for him or not. And then he asks consent with the prescriber. You can go yes or no on this. Let's pretend for a moment you say, yes and sign the release form. Hit yes and click Yes. That brings us to the next page which gives you a bunch of information how to interface with the prescriber. And it includes couple of handouts.

Those two handouts are templates that I use in my own practice that I've shared with you. Templates that I use when I want to communicate with a prescriber in a scenario like this. I have it in Microsoft Word form so I can type in the manipulatable parts and rest is pre-typed and that letter is thorough. It really does a good job of communicating in a fairly compact way all the important information the prescriber needs to know about a scenario like this. But I have two versions of the letter you can access on this page of the electronic scenario or matrix by clicking on those hyperlinks.

One of them is when, okay, I know this person has a substance use disorder, and I'm concerned that be the medical marijuana could be problematic. Other one is oh, no, I know there's problematic. There's no doubt in my mind. That one is more aggressively worded. And it quotes ASAM not prescribing medical marijuana in a case like this. The other one is worded differently. So you can choose which template is best to use, and you have my permission to steal things from my letter and make it your own.

So then let's see the next question. Do the client and prescriber collaborate on a treatment option? So if the prescriber doesn't change anything, I'm going to click No. Psychiatrist never responds to me. Never changes the prescription. Doesn't seem to do anything. And then [Audio dropped] And see a specialist. You can click Yes or no. Let's say the client says, no. If you hit no and hit next, then you'll see screen where you basically have to make a decision on is this big enough issue now that the client has refused to get a second opinion that I think it warranties an unsuccessful discharge? You have to say, yes or no. And then it will take you to different steps on what to do next based on how you answer that question.

But if we click the PREV or previous button on the bottom of the screen, go back a step. Let's pretend he says, oh, crap, you're going to discharge me unsuccessfully? Never mind. I will get the second opinion. Then you click Yes, and then hit next. And then it asks did you see the addiction medical specialist recommend non-addictive treatment option? And let's check yes and assume they do, because that's usually what happens.

Then the next screen says, incorporate the addiction medicine specialist in the client treatment plan and continue to see the specialist as needed and provide treatment as usual. So the decision matrix brings you through step-by-step rational process using best practice guidelines that have been published by very authorities to try to arrive at a sensible determination of what to do next.

But I should tell you, I'm not saying you always must do what this thing suggests. This is a tool to help you make decisions. What it really comes down to is you have to make your own decision as a clinician on what you think is the best course of action. So what I'm going to do next, also, as far as that electronic resource goes, I should tell you, I'm not going to launch this polling question yet. But I should tell you that you have my permission to use that electronic resource. There's no limit to the uses. You don't pay anything for it. It's free. You can share it with colleagues if you want. I just ask that you pay attention to the first page. You have to be competent as an addiction specialist to really use this tool. Ultimately, you're responsible for the clinical decisions you make, and not the tool. It's just an aid to help you with the decision-making process.

But it's backed up pretty well, I think, too. So what I'd like to do now is shift to some questions and answers. I'm glad that we have sufficient time to address a bunch of them. If we run out of questions, we might actually do another clinical scenario that one of you give us. Maybe with a real client you're working with without any confidential information being shared of course and we can use the tree, the decision tree to try to arrive at a decision. Let's talk about questions. Do we have any?

>> SAMSON TEKLEMARIAM: Yes, so we have a lot of questions. So I'll go one-by-one and you may want to go to the next polling question. I'll ask a question we most recently got in with the tool. So a lot of people, well, a very good number of people send us a message saying when they clicked done, the survey was complete. But then when they tried to use it again, it wasn't allowing them to use it again. It was saying you've already completed the survey. They got messages, a variety of messages that weren't allowing them to do it a second time. So they were asking about that.

>> AARON NORTON: Oh, no! Yeah, I wish I would have figured that out a long time ago while going through the scenario. So here's what I think happened. Last night, I made a few tweaks. And I think when I did that, I reset the settings by accident to one use only per person so, all I need to do is go in, which I can do right now while we're dealing with questions and answers. And I can change the settings so that you don't have to worry about that anymore. So you will have multiple uses. Because the way default settings are, you can only do it one time from the same device. But I can modify that and change that again so you now have the ability to take it multiple times.

I'll do that right now. And we can go ahead and move on to the next question while I figure that out.

>> SAMSON TEKLEMARIAM: Perfect. Thanks so much, Aaron. So everyone, just again as a reminder, as we're going through these questions, you can send your questions to the Q & A Box. But also if you have additional scenarios, something similar, you could send in that scenario to the Q & A Box F. there is a character limit, feel free to send your scenario in multiple Q & A Boxes. And we'll go ahead and collect that information. We'll propose another scenario and Aaron will be able to walk us

through with audio instruction and how to complete that scenario in the matrix, in the decision matrix. Marcy asks, what are the cognitive effects of medical marijuana? I do child custody evaluation and I'm interested in judgment and cognitive implications?

>> AARON NORTON: All right. So, you know, in very, very mild small doses of THC, you might not see a whole a lot of cognitive effects. But generally speaking, with THC, among the short-term effects of THC, we will see impaired short-term memory. And that is the single most in a literature, the most common short-term effect we can see that is considered to be cognitive. But also notice the short-term effects can be impaired motor coordination. Sometimes clients come in and they appear to be under the influence of marijuana. They will move slower than usual. Their reaction time might be different. Judgment may be altered.

Now, for high doses of THC, it's possible to get paranoia and psychosis or people who have genetic prediction for psychotic disorder or bipolar disorder. And you may also see people who are sleeping, I don't know if you want to consider this cognitive or not. But brain is in slow stage sleep and REM stage sleep and the implications for that, if you understand what's the sleep. In REM sleep, there's a lot of sleep consolidation where we're staying short-term memory into long-term memory. You may notice weird combination of stuff that happened just that day and stuff that happened years ago in the same dream in nonsensical ways. That's because the hippocampus is like a stack of paperwork you collected throughout the day that has all your short-term memories. It's like a piece of paper that in pile and at night while you're in REM stage sleep, your hippocampus communicate with the cerebral cortex and determines how to file these papers into the long-term memory filing cabinets.

So if I smelled an interesting smell today that reminded me of a trip that I took as a child in the mountains, then I might have a dream tonight that has to do with something related to that trip to the mountains. Because my brain is consolidating memory. If you have less time in REM sleep, you're going to have less dreaming and less consolidation of short-term memory and long-term memory. And you may see some immune system, it's controversial evidence about immune system functioning because of the effect on sleep.

And certainly, the degree to which you feel rested the next day. Do you feel fatigued and low energy? Or do you feel more active and energized may have something to do with whether you are taking in high quantities of marijuana. And also, the effect that it can have on slow age sleep. So, hopefully, that answers the question.

>> SAMSON TEKLEMARIAM: Excellent. Thanks, Aaron. Marcy, thank you for the question. Neck is from Eddie. Eddie asks can you address workplace issue and medical marijuana? Particularly, in manufacturing?

>> AARON NORTON: I can to a degree. Like I said earlier, understand that medical marijuana is not protected under the Americans with Disabilities Act. So someone on the assembly line manufacturing, it's probably a drug-free workplace environment. If it's a drug-free workplace environment, then medical marijuana, using that would be prohibited. And testing positive for it certainly would be a violation of the drug-free workplace. And additionally, it's like any other central nervous system depressant. Shouldn't be under the influence of it operating heavy machinery or physically dangerous to be doing, like driving, for example. So I think that would be another potential issue in a job like that.

Third, if that manufacturing position involves public transportation or transportation generally, it might be DOT regulated job. In which case, if we singled out medical marijuana as violating the drug-free workplace policy and that person was discovered, removed from the safety sensitive job duty and have to go under evaluation with an SAP like myself and be recommended for treatment and complete that treatment successfully before the employer can even consider returning them to safety sensitive duties. Which usually means a lengthy period of time being out of a job. Additionally, many states, they legally say you cannot use it in your workplace unless your employer accepts that and there's that. In another scenario, this may not necessarily deal with manufacturing, but people can tell you're in the influence of a substance, that can certainly be problematic as well.

And, finally, I would think are you moving as fast as you need to on this job? And as agile physically or efficient with what you're doing. And the problem is you can't trust the client's perception, because often the client will not perceive they're impaired even

though from a purely objective standpoint they are. Like if you have data that showed their work pace has decreased since they took the THC, those those would be some of the implication and there might be others.

>> SAMSON TEKLEMARIAM: Thank you for that question. Aaron, we do have a scenario that came in. I'm going to try to ask you two more quick questions to get those out of the way. And then I'll give that you scenario. Two quick question. Diana asks who is qualified to prescribe marijuana? And then another similarly quick question is if you can speak more to safety issues related to medical marijuana, like the slow reaction time and cognitive impairment while driving. That's from Rahal and Mallory.

>> AARON NORTON: I forgot to unmute myself. What was the first part of the question?

>> SAMSON TEKLEMARIAM: First part is from Diana. Who is qualified to prescribe medical marijuana?

>> AARON NORTON: Okay. So the answer to that is it depends on the state that you're in. And what that state's legislation says. So in our state, anybody who's legally allowed to prescribe any, I think it's Schedule I substance, and has participated in a brief training class, like one day class of medical marijuana and appropriately license to do credentialed by the state can prescribe it. So, there's that. Here in Florida, it could be different than other states. So you have to look at your state legislation.

But generally, I could say the only people who could prescribe it is people who can prescribe other potentially addictive medication. And there might be other hoops they have to jump through in their own state.

Second is speak background the safety issues. And I partially addressed that with a previous question about the manufacturing position I think. But to take it a step further, there's talks about increases and emergency department visits with incidents of marijuana use and more legalization. And it's mostly people can't overdose on smokable or vapable marijuana. As far as I know I've never seen an evidence of a single case. They can't technically overdose on ingestible THC, which is sometimes

you can take it in tremendously high concentration THC through orally basically. But even then, overdose, as we'll call it, will look more like being very, very sick and nauseous, and vomiting, and feeling panicky and things like that.

So sometimes there's ER visits for that reason. Some other safety concerns are people don't necessarily make the best decisions when they're high. Whether it's driving or it's, oh, you know what I'd like to do is show my buddy my new gun I got. And I pull it out and dutifully remove the magazine from it and hand it from my friend. But I don't remember or forgot there is around in the chamber still. And then maybe there's an accidental gunshot. So there's been documented cases of these kinds of things that happen as well. Any time that we're talking about negative effect on motor coordination, then you have to consider anything you do that involves you being physically coordinated that could be potentially dangerous could be a risk in terms of safety and well-being.

So there are some studies that show, like they will take driving rangers and measure different doses of THC, how efficient people are with driving on the driving range and they make more mistakes as THC dosage increases. So that illustrates the driving issue with safety. So I think those are some good things to consider. So I think I've answered both parts of that question.

>> SAMSON TEKLEMARIAM: Yeah, you did. Thanks, Aaron. Here is your scenario. So I'm going to read it for you. The scenario that was sent to us says, patient has a diagnosis of Cannabis substance use disorder severe and is on probation for unrelated charges. But mandated to avoid Cannabis and alcohol. Client is ambivalent on stopping both completely despite potential legal consequences. What would you suggest to motivate this patient besides MI techniques?

>> AARON NORTON: All right. So this is a scenario where a client is in treatment. They're mandated? I didn't -- one question I need clarification is, I know they're mandated to not use marijuana. Are they mandated though to participate in the treatment? And maybe the person who presented that scenario could clarify that? But let's say that they're seeing you and they're not mandated to see you. But they're mandated to say hey, I'm legally required to stop using marijuana. And I'm risking

probation, but I also have mixed thoughts about stopping it. And let's assume based on the question you are not going to do any motivational interviewing at all. Then how do you proceed? I'm sure in the motivational interview, I think psychoeducation, giving them the information you have on medical marijuana, looking why is it they're taking the medical marijuana?

And what symptoms are they trying to ameliorate? Maybe the reason why they're taking it is more because they want medical relief? What if we were able to find a specialist who could provide you with information on medical relief alternatives that won't put you at-risk of violating your probation? Would that be a cool thing to check out? And you might do some work. There's some overlap with motivation interview as I've described, but education and exploring alternatives could be good for them they're in mandated treatment and they're telling me I don't know if I'm going stop. Then there's couple of possibilities.

Maybe what they're saying is my problem is so severe, that even under threat of violating probation and incarceration, I don't think I'm capable of stopping. If that's the scenario, I would bump them to a higher level of care. If they're in residential treatment, they won't be able to act. They're going to be in a significant period of time without it, if during that time, they will adjust to not having it. And upon discharge, they will be at a a lot lower risk and go to a lower level of care from an IOP to a lower transition. So my patient is so severe they're not going to do it. And I don't have time to waste. So that might be an approach in that scenario is to bump them up to a higher level of care. The decision matrix --

>> SAMSON TEKLEMARIAM: Aaron, he did give the rest of the clarifications in that scenario if that will help. Yes, the second part. This is from Jeffrey. Thank you for sending this in for Aaron. He said just to clarify, patient is mandate to do have substance use evaluation and follow recommendations.

>> AARON NORTON: Ah. So in this scenario, I would use the ASAM criteria and the 6 different domains. Do the assessment and determine what level of care the client needs. In domain No. 5, which is continued use or relapse potential, we would have a high rating in this case. Because it sounds like this is a client who's saying, I

don't think I can stop on an outpatient basis. It might be good justification to recommend a residential level of care.

So you would have to look at, do they really meet the ASAM requirement for residential? Because, again, if the client is basically telling you outpatient isn't going to help me, because this is so severe, and I don't think I can stop, then I would be looking at residential level of care.

>> SAMSON TEKLEMARIAM: Thank you, Aaron.

>> AARON NORTON: If you were using the matrix for this, what would happen is you would end up in a position where you are sending the letter to the prescriber or not based on whether the client agrees to it or not. If the client agree to it, then you would get the prescriber to, you look at the prescriber recommend an alternative or not. If they do recommend an alternative to medical marijuana, is that enough for this client or for other reasons, does this client need to be bumped up to level of care? If the client won't allow you to communicate with the prescriber, then you look at non-successful discharge. This is an evaluation scenario though rather than a treatment scenario.

So, I might even say, well, you're required to do an evaluation. I'm not going to be communicating with a prescriber except to get information in that context. If I'm doing a forensic evaluation for a court, I'm not going to be telling people what to do for treatment except for in my report. I'm going to communicate with the prescriber just to get the record. So I probably wouldn't be using that part of this decision matrix if all I'm doing is purely evaluation. I would go back to the ASAM treatment and determine the appropriate level of care that way.

>> SAMSON TEKLEMARIAM: That's graded. Thank you so much and we're going to go back to the Q&A questions. So here's one question. Have you heard of B MD C? Brief marijuana dependence counseling? It was on evidence-based practice 5 or 10 years ago so I'm not sure how this applies today. Can you speak to that or other recommended treatment model for severe Cannabis treatment model?

>> AARON NORTON: I can't speak to that model because I'm not familiar with it. So unfortunately, I won't be a lot of help there. But I can say for severe Cannabis

substance use disorder in general, I don't treat it much differently than any other severe substance use disorder. The same techniques and interventions I would tend to use. If it's a client that I don't have leverage with and they're ambivalent about whether they want to stop, I would do more motivational interviewing or psychoeducational approaches for them I have no leverage and the client wants to cut back but not stop. I would do solution focused production or harmful reduction approaches to see if they can cut back. If that's unsuccessful and I have leverage, then I might talk to the client about bumping up to a higher level of care.

I do the standard stuff as if it was any other substance. That brings me to a larger point here. For some strange reason, a reason I don't fully understand, for many clinicians, they in their head almost have a default assumption that we treat Cannabis use differently than all the other substances. And I don't really know if that's true. Yeah, it's kind of looked different, because of the effect of the substance look different, the ambivalence about quitting is high with this group. And the denial and minimizing and the lack of insight about the drug connection between the marijuana use and other problems seems to be higher than with some other substance. Like say you have a client using heroin regularly, for example. It's hard to not see the direct effect of the substance use. But we're treating it the same way as other substances. If you look at the decision matrix, if you took every reference to medical marijuana and you replaced it with benzodiazepine or opioid prescription, the same process applies. We don't need to magically treat it as though it's a different ballgame than working with any other potentially addictive medication. The same approaches and techniques and interventions could still be helpful for working with this particular population.

That would be my initial thought anyway.

>> SAMSON TEKLEMARIAM: Thanks, Aaron. I think we have time for maybe two more. Randy from North Carolina expresses a concern about consequences while driving. And mentions that in states were recreational use is legal, aren't there still roadside sobriety test?

>> AARON NORTON: In the road of law enforcement, a really good test for roadside sobriety that relates to marijuana. When an officer pulls over an impaired

driver, signs of intoxication, like do they see bloodshot eyes or pupil dilated in any way? They use the test to see if the client can walk a straight line or recite the alphabet and so forth. If somebody uses marijuana, they may perform poorly on those various tests and that may give the officer probable cause to conclude that the driver is impaired. Now, the next part is, why are they impaired is this well, if it was alcohol, you would do a roadside breathalyzer. The client refuses or participate.

You can more objectively show they're under the influence of alcohol and that's probably what's causing the impairment. If it's marijuana, there's some new devices being tested out that might be able to show whether somebody is under the influence of at least smokable marijuana by doing an oral test of some kind. But it's very hard to objectively show the reason the driver is impaired because of marijuana. Except that historically, officers have been able to rely on the distinct odor of marijuana or marijuana paraphernalia in the vehicle. And the physical signs that the officer sees.

But now, with the vapable marijuana, it's harder to know. You might have the distinct odor, for example, of marijuana to rely on. So, now, maybe the person is vaping and the cartridge is right there and maybe they're not searching the car. So it is challenging. And I think what we're going to see in the future is more reliable technology that can be used on the roadside to link the marijuana use to the impairment. Those are my thoughts about that question.

>> SAMSON TEKLEMARIAM: Perfect. Thanks so much, Aaron. So we have time for one more. Let's see here. So, Kelly from oh, Walla Washington asks, do you think it's possible to help patient identify red flag for themselves when medicinal helpful therapeutic use crosses the line to risky harmful addictive use?

>> AARON NORTON: Yes, I do think that that is certainly do-able. And, again, you're going into issue where more severe Cannabis substance use disorder, those clients will have a hard time accepting that information. They're often skeptical about any scientific information. They will quote all kinds of resources that might say otherwise. They might go in one ear and out the other. But for many clients, some subset of clients anyway, some psychoeducation can go a long way. And you can especially, clients who maybe don't have a diagnosable Cannabis substance use

disorder or it's milder in severity. Then some simple education on, well, here's some potential signs your medical marijuana prescription could become problematic. That could go an awful long way. And I think you can teach clients that. So, that pretty much is the exhausted time we have for questions. Is that right?

>> SAMSON TEKLEMARIAM: Yes. Yes. I think that covers it. I am attempts to squeeze in one more. Aaron, we actually have a lot more questions coming in. So what we're going to do everyone, we're going to accepted these questions to Aaron in a Q&A document, including the ones that's asked and answers. And then we'll collaborate with Aaron to have the questions and answers completed and post it on the same website you use to register for the webinar. It will be posted within two weeks or less. So Aaron, okay, here is one additional question. This one comes from Stephanie. She asks, how have insurance companies responded to medical marijuana? Is company insurance or medical insurance?

>> AARON NORTON: That's a great question. As far as I know here in Florida, insurance is not paying for it. Because it's illegal under Federal law. So I don't think insurance companies are excited about purchasing illegal prescriptions under Federal law. I don't know if any of them do it. Much like banks won't loan money to marijuana growing businesses, because they don't want to violate federal laws. So it seems to be a private pay market as far as I am aware.

>> SAMSON TEKLEMARIAM: Great and we can end it here.

>> AARON NORTON: I can also tell you in the slides, for those who downloaded, there are reference and hyperlinks to the PDF. So you can click to get more information or read the sources that I used. And, of course, I'll be happy to answer follow-up questions. And I hope you find this tool helpful. Maybe give it a spin with some scenarios in your practice, and see what you think about it. And I'm hope to feedback if anybody would like to send me some.

>> SAMSON TEKLEMARIAM: That's great. Thanks so much, Aaron. And I just want to remind everyone that everything you need to know about each NAADAC presentation is on the NAADAC website you used to register for the webinar. So you

can watch the recording after the live session. Take the CE quiz and make a payment if you're not a NAADAC member. The NAADAC web address is www.NAADAC.org/medical-marijuana-webinar. If you would like to receive two CE for this event, if you're a NAADAC member, that CE Certificate is free. If you're not a NAADAC member, the charge is $25 for processing that CE Certificate. Please feel free to email us at CE@NAADAC.org.org with any questions you may have. That's C as in cat, E as in echo, @NAADAC. The CE quiz will be posted on the website you see on the screen within 5 to 10 minutes after this webinar is completed.

Upcoming webinars and events just like today, we have some really incredibly gifted presenters and training in advancing the addiction profession. Please mark your calendar two Wednesdays from now, December 18, 2019, same time. We will be very fortunate to have Ceci Knuckles present successful treatment on methamphetamine addiction. If you were part of our 2019 annual conference in Orlando Florida, you may remember an Epic standing room only, people standing on the floor, leaning in the hallways to listen, and this room was packed. And as we promised at the conference, we're bringing Ceci Knuckles back. You can learn more by going to our website. Www.NAADAC.org/webinars. You'll also see our 2020 webinar series is now available online and updated.

You can easily access this by going to NAADAC's webpage, clicking on the education tab, then you'll see a tab that says free webinars. And you'll see exciting new topics in 2020. Feel free to register. NAADAC offers two specialty online training. We'll be wrapping up Part 6 this coming Saturday, December 7 where Duane K.L. France, specialist and retired combat Vet will review evidence-based treatment regarding targeted nor military population. You can complete the series in any order. And you can access each course on-demand and self-paced. The webpage dedicate to do this series is www.NAADAC/military-vet-training-webinar-series.

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The other 6 part specialty series is clinical supervision in the addiction profession addiction. Even the most experienced clinical advisor in the field will admit clinical supervision in the addiction profession is much more complex than general supervision. There's a wide array of variables to consider and the most up-to-date research will be presented in this training series as a complement book which is now available in our NAADAC bookstore. Pretty easy to find web address. For your convenience, please visit www.NAADAC.org/bookstore.

And this will be presented from 3 to 4:00 p.m. on the stage of clinical supervision. It's actually an excerpt from Chapter 9 of the new workbook. If you have not yet joined NAADAC, join us on our webpage or you can email us NAADAC at NAADAC.org to learn more about all the exciting benefits of joining NAADAC, including over 145 free CEs, magazines, certificate programs and more. Thank you again, everyone, for participating in this webinar. And, Aaron, thank you for your valuable expertise on such a challenging topic.

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