The Addiction Professional's Guide to Addressing Medical Marijuana Use Part 2
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>> Hello, everyone, and welcome to today's webinar on What Addiction Professionals Should Know about Medical Marijuana Part 2, presented by Aaron Norton. It's great that you can join us today, my name is Samson Teklemariam and I'm with NAADAC, I'll be the organizer for this training experience.

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control panel that looks like the one on my slide here. You can use that orange arrow to minimize or maximize the control panel. If you have any questions for the presenter type them into the questions box. We'll gather those question and give them to our presenter during a designated live Q&A.

Lastly you'll also see another tab that says handouts. You can download the Powerpoint slides from the handouts tab and a user friendly instructional guide on how to access our online CE quiz and immediately earn your CE certificate. Please make sure to use those instructions in our handouts tab whenever you're ready to take the quiz.

Now, with no further delay I'll introduce you once again to today's presenter, Aaron Norton is a licensed mental health counselor and licensed marriage and family therapist who serves as executive director of the National Board of Forensic Evaluators. The adjunct instructor at the University of South Florida, southern regional director for the American mental health counselors association and president elect. Aaron is an experienced clinician, presenter and clinical supervisor. He was awarded the mental health counselor of the year award by the American mental health counselors association and counselor educator of the year by Florida mental health counselors association in 2016. He's been published in several journals and magazines in the addiction and counseling profession.

We're so delighted today invite Aaron to close out part two of this webinar series and special training that was going to be a part of the annual conference this year. As we've all adapted to technology, it's now a part of our virtual learning series. Aaron, whenever you're ready, the floor is yours.

>> All right. Welcome back, everybody. Once again, thank you very much to Samson and Alison for doing such a great job putting this together. How they have this down to an art and
science is impressive.

Yesterday, we got into the really nitty gritty details about medical marijuana and gave you a good overview. We try today cover a lot of material in a short period of time. We covered information on some of the medicinal uses of American, some of what the research shows about efficacy for medical marijuana for various disorders. We talked about some of the adverse health effects. We talked about important questions to ponder when you're examining the law and medical marijuana in your state.

Today we're going to be focusing a lot more on clinical application, how do you take all that information that we talked about yesterday and apply it in a meaningful way in your practice going forward with your clients.

Also, you know, we do have, of course, you have all of your handouts here on the control panel. But if for some reason you wanted to access the handouts after today and you lose them or don't have them, there's also a link right here that you can use to access some of the information, including some of the templates which we'll be reviewing today in pretty good detail.

Going to be really unveiling the decision matrix that was designed for clinical mental health counselors encountering medical marijuana use in mental health and substance abuse treatment settings. This is a matrix we created and published in the advocate magazine in 2019. And I started working on this matrix probably more like a few years ago when I -- when we legalized medical marijuana here in Florida and my interns who I supervise were perplexed as to what they should be doing in their treatment settings when clients present with medical marijuana.

Some work in programs where a client might be refers, say, for example in an effort to get their driver's license back or
maybe because they have an open DCF case and their children have been removed from their household because of neglect or abuse that's substance connected. Or maybe the terms of their probation. And then even though the client is being referred, maybe because of marijuana use, the client gets into treatment and then says, you know what? I don't have to abstain because I got an medical marijuana card because I'm good? The clinicians are like, what do we do now? They have a legal prescription. That is why we created this tool.

We wanted to have a process that would give you a little bit of structure, help you to examine some things that are important to examine in these cases and then maybe help to guide your decision making a little bit, your clinical decision making in terms of what to do or not do. We wanted it to be reasonable and evidence based and to be very much backed up by various guidelines that are published by reputable sources. That is how we got this tool. That is what we're going to be reviewing today.

Now, to complicate things a little bit, you know, I have this hypothesis. I know there's been some research done on this already. There have been at least a few studies. My hypothesis has been any time a state legalized medical marijuana, the very first people to get cards, a lot of them are going to be recreational users and also people who have substance use disorders who would like to be able to continue their heavy and prolonged use without fear of legal ramifications.

Sure enough, that seems to be what is panning out in the research is that the majority of people who obtain medical marijuana cards, they're really not a different crowd than the people who are already using marijuana regularly prior to it being legalized medically in their states. And, you know, certainly I think the longer that medical marijuana is legal in
a state, the ratios start to change maybe and you start to see more of the people who are really using marijuana primarily for medicinal purposes rather than recreational purposes. You kind of start by opening the floodgates so to speak.

I mentioned to you yesterday that every client I ever had who tried to get a medical marijuana card got one, no problem. It's not hard to get. They often tell me you can walk in and tell them almost anything, I get headaches or I get stressed or any reason at all will seem to do. Here in Florida we have a statute that tells you what conditions medical marijuana can be prescribed for, there's also this ambiguous phrase that says or similar conditions basically. Because of that, some of the medical marijuana providers just sort of say almost any condition will somehow do.

Because of that, it makes it a little bit harder because it raises a question of how do you differentiate between someone who has a legitimate medical use of marijuana, and they're probably not a high risk client for addictive problems connected to it. How do you find out who maybe is just kind of getting the cards so they can get high? Because in some settings, that actually is going to make a difference.

So it puts prescribers, unfortunately, are often not experts in addiction. Some are. We're going to talk about board certified specialists today who have that extra expertise in addictions. Many physicians have less training than you would have as an addictions professional in this area. So they can use us. We can play a very important role in the process of trying to differentiate between use and misuse or abuse or cannabis use disorder or whatever verbiage you'd like to use it to call it.

Even the word marijuana abuse or the phrase substance abuse is kind of a phrase of contention right now because a lot of
people think it's a pejorative term and it would be better to be more descriptive and use the terminology like a substance use disorder.

I'm going to start with the guidelines of things you can look for when a client is using medical marijuana that might be yellow flags. When I say a yellow flag, what I mean is these things do not prove that a client has a problem with marijuana. These are things that say, okay, there might be something going on here and maybe we ought to look into it some. We ought to explore with this client.

The first one is when a client is combining their marijuana with synergistic substances or other forms of chemical self-medication. One thing I do like about -- one of the many things actually I like about marijuana being legal in my state, medicinally. I'm starting to notice things -- I don't know if you have the Medscape app, but the cool thing about that app is you can look up any medication, including medical marijuana and you can go to a section where it talks about adverse effects and you can read other medications that it interacts with in a negative way. Or synergistic substances.

You can see using that app other maybe substances or medications my client is taking, do they tend to be contraindicated to take alongside their medical marijuana. That body of knowledge is beginning to grow anyway. I think we'll see it continuing to grow.

If they're taking medical marijuana but they also drink heavily or they're also using other recreational drugs, they're using maybe other depressants, prescriptions like Xanax and Clonopin and other substances raises the question why do they need these things? It's a yellow flag to look into things.

When clients run out of their prescription early or supplement it with illicit or recreational substances. In my
state this is a problem because technically I shouldn't use the word prescription here. It's still legal to prescribe medical marijuana. The prescriptions are federally regulated. Once a physician puts it on a script pad, it's a DEA regulated item. It's not legal to prescribe a Schedule I drug. What physicians do in states where it's legal, is they provide a recommendation for medical marijuana. And then the client, like in our state in Florida, the client can now go through a process to get their medical marijuana card and then they go to a dispensary to select their marijuana and obtain it regularly.

From there on, it's self-dosed. I mean, the physician can provide all the recommendations that he or she wants, but ultimately the client gets to decide how much they take when and so forth. That makes the running out of prescription early part kind of a benign or pointless thing to have it in my state. But maybe it works differently in other states, I don't know.

Frequent changes in physicians. The time of day in context in which the medication is taken is important. So, you know, when you have a client who you maybe as part of an assessment you ask them if they use medical marijuana and situations like driving -- I should pause also to remind you that we talked a little bit about this yesterday. When I'm using the phrase medical marijuana today, I'm really going to be more talking about THC specifically and not CBD. Because CBD is not the public health risk and it's not an addictive.

If you use a client if they use THC, what are they going to tell you? No. If you ask them when did you take your THC today and then you ask them -- then, you know, when did you go to work or when did you come here? How did you get to work? They tell you driving, you'll get different answers when you sort of piece it together bit by bit instead of directly asking that question a lot of times.
Because, obviously, just because something is legal doesn't mean it's safe to use in every context. If you had a client who was being prescribed Xanax, that client knows that it's right there on the warning label and hopefully their prescriber is doing a good job of informed choice, making sure they know not to be driving under the influence of their medication. It doesn't mean they won't do it. That is a yellow flag to start looking into things further.

Also when they're seeking an absence of symptoms or euphoria or high versus functionality. Remember, I told you a little bit yesterday about Dr. Smith. He is a writer of medical marijuana textbooks a physician who prescribes medical marijuana and he's designed many medical marijuana products. And when I did some training with him one thing he talked about was that sometimes clients will tell him that their dosage is not working. And he will ask them what do you mean it's not working? And they'll often respond by saying, well, I don't feel it. He'll say what do you mean by you don't feel it? And they'll say, you know, that feeling. Are you talking like that pleasant sensation, that euphoric feeling? And they'll say yes. That's not the purpose of medical marijuana.

In fact, his position is if you're feeling high or euphoric then you're overmedicated. Medically for the conditions that medical marijuana is believed to treat, you would expect people to be able to respond medically to smaller doses that wouldn't likely impair them or create for that matter euphoria or a high. If the client is gauging success of the medication by whether they feel something pleasant, then their using the wrong gauge.

What's the right gauge? The right gauge really for medicine across the board is to be able to function. To no longer have clinically significant impairment or distress associated with a particular problem or to be able to function
in the context of a society, not to feel something pleasant. Remember, we talked yesterday about every time I feel a high or euphoria, there's a guarantee there's going to be a depletion of neurotransmitters on the end and that's sort of the way it works.

Another potential warning sign is when a client has a history of related -- substance related problems with other substances. Because this opens the door that, you know, you guys have probably all heard the phrase cross addiction, the phenomenon where someone can develop a problem with controlling a particular addictive impulse. Because an impulse is any pattern or behavior that activates reward circuitry in the brain. The client can stop their alcohol consumption and then find themselves using an incredible amount of marijuana and feeling dependent on it. A client can stop that and develop a problem with sugar or fats or carbs or gambling or sexual addictions and the list goes on and on and on.

Is there evidence of impairment? Remember like I said yesterday, if I can tell that my client is high when they come into my office, then other people can as well. I assume anyway. And are there one or more diagnoseable substance use disorders?

With that in mind, let's get straight into what are the diagnostic criteria for cannabis use disorder in the DSM? We begin with a problematic pattern of cannabis use leading to clinical significant impairment or distress. A few things to highlight, it's got to be a pattern. So if somebody uses a substance a handful of times and then maybe something bad happens from one of those times they use it, is that really a problematic pattern? Or are those, you know a couple blips on the radar screen or a few isolated cases, an exception to how they usually conduct themselves?

I think the word pattern is a very important word for us to
pay attention to. I once saw a case in a residential substance abuse treatment program where a clinician diagnosed an adolescent with cannabis use disorder and the adolescent swore that they had only used marijuana one time and that one time was behind the school and the school resource officer caught the kid and some other kids and then the kid got a possession charge and the kid got referred for treatment. In order to bill insurance presumably, the clinician diagnoses cannabis use disorder. That's a terrible idea because there's no significant evidence in that particular case to suggest this individual was lying. That they didn't have a problematic pattern of marijuana use. An isolated event is not a disorder, it's a choice, it's a decision. Sometimes it's even a mistake and then we learn from mistake and move on. Those are not disorders. Pay attention to the verbiage. It all means something in the DSM as well as in legal documents and that sort of thing.

It has to be a problematic pattern. We have patterns of behavior that are not problematic. I drink water every day but I would not say that that is a problematic pattern. And it has to lead to clinically significant impairment or distress. Okay. So impairment involves my ability to function in the context of a society. And the stress is my sense of well-being and welfare. We have to decide if somebody has impairment or distress, is it clinically significant impairment or distress?

That's kind of vague. That's kind of a judgment call, isn't it? Then they offer you 11 different symptoms and they say here would be the evidence of having a clinically significant -- impairment or distress. In the same 12 month period a person would have to have at least two of these 11 things apply to them. Let's look at those 11 things.

We have the first seven on the screen right here. First is that cannabis is often taken in larger amounts or over longer
period that was intended. Again, the key word here is often. What I see sometimes is that clinicians pay attention to the taking in larger amounts or over a longer period but they ignore the word often. Based off a couple isolated events, at least as far as we can tell they'll say well, two times, that's often enough so I'm going to say that that criteria was met. I don't think that's really the intention of that criteria.

So this would be something like a person who says, all right, I'm only going to have this much. I'm only going to vape, you know, in the evenings. But they find repeatedly that they are using at times when they intended not to or for a longer period of time than they planned on or intended to or they're using more quantity wise of the THC than they intended to or planned on.

The second is a persistent desire or unsuccessful efforts to cut down or control it. Now, the word or versus and is important because anytime you see or in diagnostic criteria that tells you it could be one or the other it doesn't not have to be both. What is a persistent desire? It would an individual who has a nagging voice within them that says this is a problem, I should do something about it but they find themselves not doing anything about it. That voice will not go away within them because a part of them knows better. That might qualify as a persistent desire.

Unsuccessful efforts would involve an individual making an effort to either quit or to cut back or reduce their THC use, but find themselves unsuccessful doing so. And probably repeatedly so.

The third symptom is a great deal of time spent in activities necessary to obtain it use it or recover from its affects. It seems to be absorbing a great deal of the person's time. I had a friend in school and then in my early days of
college, a very good friend. He was a pretty active guy. He played in a rock band. He was involved in his church. He was involved with his family. He was involved with sports. Then he kind of discovered the wonders of marijuana. And then what I saw over a four-year period was he went from a kid who would kind of use it a little bit to a guy who just worshiped it and just every day it's like that was the center of his world was marijuana. It was like he had -- like the marijuana altar in his bedroom with marijuana tee shirts and his music and he was obsessed would it. It seemed to be about all that he would do after a while was just kind of sit around and get high. He stopped doing all of the other things that were important in his life.

It was probably absorbing hours of time a day for him, so I would say that would be an example of a great deal of time being spent.

Craving is that strong desire or urge. A craving is not oh, it would be nice if -- or yeah, I'm kind of in the mood for that. But I think a craving is that strong desire or urge, almost feeling compelled to use this substance.

Then the fifth symptom is recurrent use resulting in a failure to fulfill major obligations at work school or home. So this is when I'm using in situations or circumstances and it's interfering with my ability to fulfill important responsibilities I have in life. I'm not going to mention who it is because it's a political character. There's an individual in recovery who said what got him into recovery was when he was sitting at home, staring at the TV, smoking pot and getting high, and he was just like in the zone. Like, nothing else in the world seemed to exist except for what he was seeing on TV in that very high state.

His wife came home and she started yelling at him. She
said do you not hear the baby crying in the crib and you're just sitting here looking at TV. Then he recognized oh, my god, the baby is crying in her crib. And that was his kind of moment where he realized -- it wasn't just that event, a whole series of events. That's when he started to realize he's not going to be an attentive parent if he continues to do what he's been doing. That was the event that sort of -- it was his version of a bottom, so to speak as some people call it in the recovery realm.

So the next -- other examples of that symptom being met would be things like -- it seems like every high school has a wooded area nearby because that's the place where kids are supposed to go to skip school and do things. So let's say that you're a high school student and you skip school with your buddies and you get high and you love it. You think that was a great experience. Certainly much more interesting than what's going on in algebra class. You do it repeatedly. Then another interesting thing starts to happen where your grades start to slip and your attendance dips and you're not doing as well with school. Or you come home and you have an intention of perhaps doing your homework or studying but you let up and then you kind of didn't get around to the studying part or the homework part and your grades begin to slip.

Another example I hear a lot from people is because they really got into their marijuana use they stopped other important things like their sports. I know they're going to drug test me for the football team, so I guess I won't play football anymore. I've heard clients talk about those experiences when we're doing the assessment.

Continued cannabis use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of cannabis. They love to be wordy in the DSM.
They say it's creating problems in your relationships or with getting along with people. If you, for example were in a relationship -- I had a client talk to me about how he was spending $500 a month on marijuana and if he was not spending that $500 on marijuana, then he and his wife would be able to pay their bills. But he couldn't -- felt like he couldn't stop even though he wanted to. Meanwhile, his wife is incredibly angry and frustrated with him and doesn't understand why he is choosing marijuana over her.

I have a colleague who divorced her husband because of a very similar situation involving marijuana where he just kind of sat around and did nothing but get high all of the time. That was not working for them. Those would be examples for the social interpersonal -- a lot of clients talk about stories about they get high and don't show up for important family events they said they would go to because they don't want to show up high. And they'll get high than go. Once they're high, anyway, they don't feel like going anymore. That would be an example.

I'm not saying, you know -- like we talked about yesterday. 70% or so of people who have used marijuana in the last 30 days are not meeting these criteria. We are obviously talking about a subset of people who use marijuana. The seventh system is important activities given up or reduced because of marijuana use. I think we have already talked a little bit about that.

Recurring use in situations in which it is physically hazardous. The interesting thing here is nothing bad has to happen. You don't have to get into an accident or get a DUI for the eighth symptom to have been met. What you have to do is be able to say there have been at least handful of times when you were driving and you were impaired. When you could feel the effects of the substance or possibly impaired. The problem with
getting into this symptom is that in research on driving and marijuana, even if you can show objectively on a driver's driving course that the people with the THC pill are performing more poorly than the people with the placebo pill or the control group, their perception often is that they're not performing poorly. That makes it a little bit hard for clients to be good historians with this symptom even if they're trying to.

If you see three DUIs on their record that probably tells you enough. Also handling firearms or operating heavy machinery. Those kinds of things could be considered physically hazardous when in an impaired state.

Ninth symptom, cannabis use continues despite having a recurrent physical or psychological problem likely to be caused or exacerbated by cannabis. There are a few key things I want to point out. One of them is knowledge of having. Okay. Many clients you might think that their marijuana use is creating a problem with a physical or psychological condition that they have. But if they do not know that, then you do not count this symptom. This symptom isn't about are they having a physical or medical problem, per se. Or psychological problem for that matter. This system is about do they know it and they're still doing it. That also shows a loss of control in addition to impairment.

And you have to be able to say it's likely that that marijuana use caused or exacerbated -- now a common one that I see that people meet this criteria for with cannabis is what a lot of people call amotivational syndrome and that's where users get lethargic and have lower levels of energy and don't do as much goal oriented activities. If there's good evidence of that and the clients knows that but they continue anyway then I'll tend to count this criteria.

The tenth is tolerance. Over time it takes more and more
for the client to get the same effect they used to get from less. Or they're using the same amount as always but they're not getting the same high they used to, which is kind of inevitable if you're using it heavy and prolonged you'll develop a tolerance. I have a lot of clients -- I don't ask them do you find that it takes a markedly increased amount of cannabis in order for you to achieve intoxication? If I ask that question they'll say no or stare at me like I'm crazy. If I ask them, if you found over time it seems to take you more weed or higher quality weed, maybe different strains of it to get the effect you used to get? They'll often tell me yes to that question. That's tolerance.

Withdrawal in the case of cannabis we have diagnostic criteria. This is when a client is using cannabis daily or almost daily over at least a few months. Then they suddenly stop their marijuana use and then at least three of these symptoms develop within a week, a week's time, so it could be immediately, it could be three days later, but those symptoms include depressed mood, and at least one of the following physical symptoms. So let me tell you the symptoms that clients most commonly report to me. They most commonly report anxiety, sleep disability and it's both. They have a hard time falling asleep, but they also report strange and vivid dreams and it's often not in a good way. Like, it's more like in a troubling way. That's a common thing clients report to me.

We talked a little bit yesterday about when people are using marijuana, especially heavy and prolonged use, they spend less time in REM sleep which means they're not getting vivid dreams to the extent other people do. When they withdraw from cannabis and start to have cannabis dreams their system freaks out over it. It takes a period of time to sort of adjust to that.
These symptoms in my experience, they tend to go away within a month's time. And it's kind of interesting because some clients with that extra anxiety they will be hating us in mandated treatment settings because they say my life is worse without it. Thank you for that. When they get to week two, three, four, five, six, seven and eight, then they're saying, actually this is a lot better. I think more clearly. Like I said yesterday, it's like I was in a cloud all these years but I didn't know it because I forgot what a clear sky looked like.

If you decide that your client meets at least two of these 11 symptoms you're not done with your diagnosis yet. Because there are several things you have to determine. Number one, you have to specify if the client is in remission or not. Early remission means the client has gone for at least three months without any symptoms but less than 12 months with the exception of craving. They're allowed to have craving on month four and still be in early remission.

You could say they're in sustained remission which means that they haven't experienced any of the symptoms except, again, possibly craving, for at least 12 months. Once they hit the year mark or beyond they're in sustained remission. You would have in sustained remission if it had been over 12 months. If they're in a long-term intensive residential substance abuse treatment program and they've been in that program for six months where it's much harder to access marijuana, then you're going to say cannabis use disorder and you might say, comma, in early remission because it's been six months, comma in a controlled environment because they have less access and that might be part of why they've gone for that long without those symptoms.

You're still not done because you have to decide what the current severity is. If it's two or three symptoms, it's mild.
That's what we used to call in DSM-IV language cannabis abuse. If it's four or five symptoms we call it moderate. Six or more symptoms we call it severe. Moderate to severe is what we used to call cannabis dependence.

You can have a pretty darn long diagnosis. The diagnosis can read cannabis use disorder, comma severe, comma in remission, comma in controlled environment. Notice the way it looks on paper. That phrase would tell anyone who reads it a great deal of things. They would know the client has met six of the 11 symptoms in the 12 month period. They would know it's been three months since the client has experienced any symptoms, but less than 12 months. They would know the client is currently in an environment where they have limited access to cannabis and that's a great deal of information to be able to communicate in a one line diagnosis when you think about it.

So now having gone through this diagnostic criteria, let's apply it. Let's practice here. What I'm going to do is I'm going to play a brief video. It is only about three and a half minutes long. We watch this video, what I'm going to be asking you to do is to pay attention to the yellow flags. Remember, when I say yellow flags, I don't mean surely this client is experiencing a cannabis use disorder because we see this. What I mean is this is something that tells me that they might meet the symptom, I need to explore further. In a 3:30 vignette how could you diagnosis someone with a substance abuse disorder? Physicians will often throw a label out there with a small brief interaction.

But for you, hopefully you have the luxury of being able to spend more time with your clients doing a more thorough assessment so you would not diagnose a client off a 3:30 minute exposure to them. You're going to try to note any warning signs you might see that could tell you that the client could be
meeting some of these symptoms. All right, so let me pull that up.

[ Inaudible ]

>> All right. So hopefully you all were able to write some notes down as you watched that video segment. I'll also say here real quickly, I'm not necessarily a fan of shows like Celebrity Rehab. I like that they get conversation going about important topics like addiction, but I kind of don't like people's problems being broadcast for entertainment purposes at the same time. It just feels like some shows are more interested in that. But, hey, these vignettes give us a good video recording that we can use to try -- as an example for training and educational purposes to be able to pinpoint some potential signs that a client might have a use disorder.

What I'm now going to do is try to use some handy dandy technology here to show you on my iPad the substance use disorder assessment check list. This is a tool that you have in your handouts. And we're going to go through it and we are going to look for some of those signs and symptoms of a cannabis use disorder. You know, you would tend to want to just put your client's name on the check list. The way that it's designed is you go symptom by symptom. If there's evidence that the symptom is met, you would check it off. Then in the middle column you would indicate which substances the client meets that system for, and then in the column on the right when that symptom was most recently experienced. You need to know that to figure out remission status.

So the first symptom the substance is often taken in larger amounts or over a longer period than what intended. I've kind of forgot, Samson to ask you this, but I assume the chat box is working great and that attendees have access to it. I'm wondering if we would be able to have -- open up for some people
to type into the chat box what are some things they saw in that video clip that might be a yellow flag for this symptom.

>> So they don't have the chat box, per se but they do have the questions box. Anything Aaron asks you to reply to, just go ahead and type it into the questions box. I'll see it. They're coming in. I guess they understood that already. A few people are saying that she reported using daily. Smoked ten blunts, daily use, smoked all day. So, yeah, we're getting some feedback now. Trouble breathing, increased tolerance.

You won't be able to see these unless you have the questions box open. We have gotten almost 100 or so responses. Adverse actions.

>> Yeah. And remember, we're only looking at symptom one for right now. So for system one, it sounds like a bunch of you said, well, there's daily use going on. Symptom one, we have to be able to say there's some kind of a sign she's taking more cannabis than she intended to or that she's using for longer periods of time than she intended to. We don't know this for sure. The yellow flag is that there's a scene where she's sitting in what might be an apartment on a couch. She is with friends. One of them says this is ridiculous. We just smoked 12 blunts and now you want another one. We're just about to go. Then she says my goal is to get so high I don't want to go anymore.

So what that statement implies to me, when she had our friends go over and they were going to be going out together, was the plan, you know, we're going to just kind of sit around and smoke all night or was it we're going to meet up and go someplace together. Now is the plan changing because of her fixation on marijuana use? That would be my yellow flag question to tell me I might want to look into that some more and ask questions and learn some more.
If that is true, that the plan did get diverted, is that a pattern? Does that tend to happen a lot with her? Does she have friends say maybe, we know how this is going to go. She's going to say we're going to go at 10:00 to the club together but in reality we'll be sitting around at midnight passing out joints.

System two, a persistent desire or unsuccessful efforts to cut down or control the use of the substance. Well, we don't know if the symptom is met obviously. We know she's checking herself into a residential program. If it was because she recognized that she needed to quit and that she was being unsuccessful doing it on her own, then, okay, maybe. That's a yellow flag. You are going to residential treatment. Why? What brought you to residential treatment? Why did you decide that was important? Were you required? Was it because you're in debt and they offered you a whole bunch of money to go on a TV show about people in rehab and that's why you went? That might be different than if you went because you were struggling to stop on your own.

She also said something else. Those of you who are great with motivational interviewing you might have caught onto this nugget that she threw out in the video clip where she said, I feel like I'm addicted to it, but part of me feels like there's nothing wrong with it. And, also, examine her facial expressions when she talked about things like I smoke every day. Probably every hour. She had a look of disgust on her face or shame or disappointment. Those are yellow flags to me that say maybe there has been a persistent desire. Maybe she's known for a while I really need to stop with this. Maybe she's even tried to stop it unsuccessfully. These are yellow flags to look into a little bit more.

A great deal of time spent in activities necessary to
obtain it, use it or recover from its effects. I'm going to pretend -- I'm putting checkmarks for yellow flags. If this was a real client and you were solidifying these symptoms you would mark something like THC. If this is a client like many of mine who use multiple substances, maybe you'd have alcohol over here, tobacco over here. No one else will be able to read my indecipherable 5-year-old physician looking language on these forms. As long as you know that's what matters.

Let's say that in this case all of these things are current because they're still happening. I might just put something like this for current. If it was most recently in January of 2012 -- it's not really working very well because of the syncing here but you get the idea. I'm going to put that there. There is all going to be helpful because you'll need that information to formulate your diagnosis.

Now we have craving as the next one. Now, we don't know for sure, but the fact that she's using so much so frequently and so often would to me suggest that we probably have some pretty strong and intense desires to use, but of course we would want to look into that further to really kind of solidify that.

Recurrent use in situations -- resulting in a failure to fulfill major role obligations. Maybe some of you could put in the questions box, do you remember anything that suggests her marijuana use was interfering with role obligations?

>> We've got some quotes. It looks like people wrote down that skipped auditions, stopped going to auditions. Wouldn't go to auditions. Found that even after she smoked she still didn't want to go. If she didn't smoke she didn't want to go. So she kind of felt stuck there.

>> Yep. She said if I'm not high, I don't want to go. If I get high, I don't go anyway. She says she's in financial trouble. She clearly needs the work. She said that she hasn't
been going on auditions because -- she directly linked that to her marijuana use. I think we can say this is met. It's not even a yellow flag.

Recurrent intersocial and personal problems. Well, the yellow flag here is mom. Mom is expressing a great deal of worry and discontent. She's afraid of her daughter dying. I don't know that how realistic that fear would be with marijuana but I'm assuming there have perhaps been negative effects on relationships with people like her mother or other family members. The next one is important activities given up or reduced because of use of the substance.

She did pretty clearly state that. And then this one, I used to say was not met. Then I had clients challenge me. I play this video when I used to be substance abuse groups with mandated clients. I'd play the video, give them the check list tell them what everything means and I'd ask them to look for the yellow flags. You'd be amazed at how people who say marijuana is not addictive will conclude she's got a disorder and throw her under the bus. It primes the pump to open the door about them talking.

The physically hazardous situations clients challenge me. There's the scene where she's on the couch with her friends. Then what happens next they get in the car. She's not in the driver's seat but who is in the driver's seat? All these people who just got high are getting into a car and driving around, I think that's a physically hazardous situation. They pointed out it didn't say she has to be the driver, she has to use. I was like, okay, thank you guys for educating me on that potentially yellow flag there.

We have use continued despite knowledge of a persistent psychological problem. Amotivation syndrome is when the individual in this case acknowledged when I get high I get lazy
and don't want to do anything and I essentially do not function. And that is a psychological problem that the client believes is connected to their marijuana use and yet she continues using anyway.

We don't know for sure about tolerance -- yes, we do really. I mean if you're smoking every day every hour and you're not feeling high enough after 12 blunts you've got tolerance going on.

Withdrawal, who knows because nothing in the video tells us she's stopped for any significant period of time. You'd have to watch the rest of the season.

Then we count up the number of symptoms. Clearly we have more than six. We're going to check off severe substance use disorder for cannabis. She's not in remission. And she is in a controlled environment, but she just got into it so I wouldn't add that into my diagnosis in this case.

If all those yellow flags, if I looked into them further and decided the criteria is very clearly met, then I would have diagnosed cannabis use disorder, severe. Hopefully that's a quick demonstration of how you can use the check list as one of your tools for assessing whether somebody has a disorder or not.

But let's talk about what happens if there's not sufficient evidence to warrant a substance use disorder diagnosis. If you determine that the client seems to be using but not have a disorder you might consider things like educating, providing education as a preventive measure. You might do motivational interviewing to see if maybe there's more about this client really opened up about. Because maybe there's some resistance or something along those lines. You might use -- focus on teaching them some psychosocial interventions that can supplement their medication.

If they're taking medical marijuana for anxiety what I ask
them was would you be interested in ways to manage your anxiety in addition to using your prescription? What would your ideal outcome be for example to not really need the prescription medication in order to manage your anxiety well? Most people will tell me yes and that opens the door for me to do some work with them on other options to manage the condition if it's something within my scope of practice to help them with anyway.

You might monitor for evidence of use and you might use -- misuse and you might use your analysis testing for that purpose. You might even talk to the client about, you know, has your physician talked to you about whether there may be an option of a lower THC content or whether CBD might be a good option? And talking about how they do have the option of asking their prescriber about that and seeing if it might be an appropriate thing to try out to reduce risk if the prescriber has not already worked with them on that.

You wouldn't be telling them oh, yeah, just stop using the THC and use CBD instead. Now you're practicing medicine without a license. I'm assuming the vast majority of you, that is not within the scope of your practice who are on this webinar. So you don't ever tell a client what to do with their medication. We'll talk more about that later on.

My question always is what's the end game? Because if you're using pretty heavy and prolonged, you're probably going to develop a tolerance and you'll need more to get the same effect. Maybe it will stop having the medicinal effect it is now. What's the end game here? What would you like the future to look like ten years from now? Do you still want to be using this or do you want to have some other means to manage these symptoms?

Again, you do want to be careful about stepping on the toes of the prescriber if it's not within your scope of practice.
But it's appropriate for you to offer psychosocial interventions. If you're pretty clear the client does have a substance use disorder diagnosis and it's mild, it's possible that a risk reduction or harm reduction approach might be viable. It might be appropriate. Maybe the client doesn't need to stop their use of medical marijuana. Maybe they just need good precautions so that they're no longer meeting any of those 11 symptoms and they're in remission. Maybe that's feasible for this client.

If it's moderate to severe, then the likelihood of remission lowered. The more severe the disorder, the harder it is to achieve remission if you're still using it. The DSM doesn't define remission by whether you're still using the substance or not. It defines it by whether you are experiencing any of those 11 symptoms with the exception of craving. So it's possible that a client could continue using their medical THC but still be in remission if those 11 symptoms haven't been met for at least three months excepting the craving symptom.

If you have leverage you can use it. You have a client who has gotten three DUIs. That client's DUIs were marijuana related. It's clear to you they have a severe cannabis use disorder after an in depth evaluation. Instead of working on their severe cannabis use disorder, they went and got a medical marijuana card so they wouldn't have to stop using. Then you're in this position, when you complete them successfully you're supposed to be saying the prognosis is good and that they are in remission and, therefore, you understand that they may now be able to get their driver's license back.

If they're not clinically any better off now than they were when they came to you, is that ethical? Is that clinically appropriate? Is it okay to complete them successfully because they have a medical marijuana card when their symptoms haven't
changed at all and haven't benefited from the treatment? Of course not.

Leverage is, look you have a severe substance use disorder, getting a medical card doesn't change that. Just like if a client had a Xanax addiction that was severe and they were trying to get their license back and the mere fact they have a legal prescription for Xanax doesn't mean you'll be able to complete them successfully. So the same is true for medical THC.

If you don't have leverage you might meet the client where here or she is at and work with them as best as you can.

If they have a cannabis use disorder, and they have a medical marijuana card, here's some options for what you can do in terms of interventions. You can interface with the prescriber and caution the prescriber against prescribing addictive medications. That's within my scope of practice. I can say I'm concerned about this client's use of their medical THC because they meet the criteria. I think it's likely they'll meet remission status if they continue to use the substance, even though they have a medical marijuana card and it may be legal.

It's okay to tell the prescriber about that. The prescriber still gets to decide what's medically appropriate, the client and the prescriber get to make an informed choice on what to do with that. You can communicate from an addictions standpoint what is going on to that prescriber.

The prescriber may consider nonaddictive medication alternatives or dosage adjustments or referral for a second opinion with a specialist. You can consider counseling for harm reduction and consider alternative interventions targeting the presenting problem, warning the medication to begin with and you can refer to treatment or recovery groups if it's appropriate or
to a higher level of care if needed. Sometimes you have a client who says if I stop my marijuana use my anxiety will get so bad I will not be able to function. I've been through this, and I become suicidal when I'm withdrawing from marijuana. That might be a client who needs to be in residential when they withdraw so they can get through the withdrawal period in a safe environment until they're balanced out.

So how do you interface with prescriber? The physician may not have the same information you have. It's not like most of them are walking around deciding how they can help people be addicts. The patients give them the information the patients want to give them and keep the rest to themselves. They do the best job they can with what they have available. They don't know what you know. You would communicate that to them. Of course, you would need a release of information to do this. We'll talk more about that in a moment.

Physicians are often pressed for time and they don't have the expertise you have as a mental health or substance abuse professional. They rely on your expertise sometimes. They often care about their work and their patients, but sometimes they may not take your seriously because you're not a physician. That can happen.

You don't have to tell them, in my opinion, you can reference resources a physician might be more likely to trust. In this guideline, the APA basically says yeah, avoid using addictive medications with clients who have substance use disorders.

If you're doing a clinical evaluation you might write a letter. You'll secure appropriate consent from the client to do this. You'll notify the reason for their admission, their referral sources, diagnoses or symptoms and be specific. If you're convinced their medical marijuana is problematic. Then
go quote the APA guidelines about avoidance of addictive medication and the ASAM guidelines about avoidance of medical marijuana prescription. ASAM, they talk about how they would prefer the prescribers not use medical marijuana for clients with substance use disorders. This is a group of physicians, the American Society of addiction medicine, they're experts in addiction. A physician might be more likely to listen to those resources.

The treatment plan will include alternatives if applicable discuss your drug testing procedures and ask for an updated prescription list. And/or in this case, confirmation and recommendation for medical marijuana. Because when you do that, when you get that list from the physician, that proves that the physician got the information and that is the physician of testing in the case you get a drug test result. Here are the things the client could test positive for.

And then you might extend an invitation for additional collaboration if the physician is willing to do so. If the physician does not respond, you might consider using your leverage. You might consider referring the client to a trusted addiction medicine specialist for a second opinion. On rare occasions clients have taken me up on this. I have had occasions when a client comes in and whether it's Xanax or an opiate or THC, it's clear to me the medication is an issue to them. I write a letter to their prescriber who doesn't ever respond.

What I do, I say, okay, here's the problem. I'm not a physician and I can't tell you what to do ultimately with your medication. What I can tell you is as a professional is I'm not going to be able to complete this successfully because you're not in remission, nothing is changing just because you have a card now that you didn't have before. I'm going to recommend
something to you. I would recommend that you go to -- maybe I recommend them to go to their own physician and work it out with their own physician. I might say I'd like for you to attend an evaluation with a board certified addiction medicine specialist. They're physicians so they're qualified to advice you about your medication but they're also addiction experts. They may have that expertise that your prescriber may or may not have.

I have never had a board certified addiction medicine specialist disagree with my opinion so far in these cases. They always seem to agree, yeah, medical marijuana is not appropriate in this case. Or benzos aren't appropriate and here are other alternatives and sometimes the client will start working with that specialist from that point forward instead of their original prescriber.

Then you can more or less put the responsibility on the client to resolve the situation somehow if what they want is a successful completion.

Having given you this information, let's look at specific cases. Now I haven't included a link here. This link is going to be posted in I believe the chat box. Maybe the questions box. This link is an electronic version of the matrix, the decision making matrix. I'm going to show you how to use it today with a few different scenarios we have here on the screen. Scenario one, Gabriella is a 53-year-old and she's been diagnosed in multiple sclerosis. She participated in a mental health evaluation at the recommendation of her physician. She was diagnose would a major depressive disorder that was likely secondary to her MS.

She was referred to you for therapy for her depression. She mentioned her physician has prescribed THC to control spasticity. Let's go to the decision matrix and let's try to use it for this particular case. Does the client meet DSM-V --
when you go to this link, the first page is information about the matrix. And then you click next. And then you start getting into sort of a decision tree scenario.  

The first question is does she meet criteria for one or more substance use disorders. Well, let's go back to the vignette. Now let's assume that you do a thorough evaluation with Gabriella. But based purely of what you see in this paragraph, is there any evidence of her having a substance use disorder? I don't think -- there's nothing in that paragraph that suggests that to me. So let's assume you do a thorough assessment. You probably wouldn't find -- unless there's some big surprise here, you might not find there are any symptoms of a cannabis use disorder. Let's assume you conclude she does not meet criteria for a substance use disorder. Not only for cannabis but for any substance. Any potentially addictive substance.

If that's the case, then you're going to click no. Click next. Second question. Does the client want to stop using medical THC? Well, nothing in the vignette suggested she wanted to. It is being prescribed for spasticity and it's a mild dosage. Let's assume for a moment that she doesn't want to stop. You've asked her and she says I think I want to give it a shot. Then look at that, we're already at the end. Harm reduction approach indicated. Meet the client where he or she is at. It defines what harm reduction is. It's a treatment and prevention approach that focuses on decreasing health and socio economic health and consequences of substance related problems.

She doesn't seem to have a problem as far as we're concerned. So not everything on this is going to make any sense to do with her. The old saying, if it ain't broke don't fix it. If you have no evidence a client has a substance use disorder, they're taking a mild dosage of medical THC for what appears to
be a legitimate medical purpose, then why would you interfere with that if you can get away with not interfering with it? Maybe you do education where at least she knows this is a potentially addictive medication and maybe you educate her on warning signs, maybe it's becoming a problem. What are the things your physician has told you about what you can take to avoid having a problem? For example, not driving when you're taking the medication or within a certain timeframe of taking it. Do you know about that? If you don't, what would you think about having a conversation with your prescriber about it and learning about those things?

And then you would monitor. Just look for -- as you work with her, are there any signs it's becoming a problem. Is she showing up impaired in session, for example? You might talk to her about her end game. Let's say she starts using it regularly and maybe it eventually does become more heavy and daily use. Then there's a potential for tolerance. Does she know about that? And is her long-term goal to continue using it or does she want to eventually not be using it? Those are important questions.

Is she noticing any drawbacks to her use? Is it noticing it's harder for her to have energy or accomplish things she wants to accomplish. You kind of on an ongoing basis do an assessment with her and some prevention work. You may do very little with her that deals with her medical marijuana prescription. You might be primarily focusing on other things with her. So that's that case vignette. Case scenario one.

Let's look at our second scenario though. Alejandro was referred to you because of a DUI charge. He had a previous DUI, it was marijuana and alcohol related. Disorderly intoxication charge and a possession of marijuana charge. He's court ordered to complete outpatient substance abuse treatment. When he heard
he would be expected to avoid the use of illicit drugs he
secured a medical marijuana card for ADHD. Let's go to the
decision matrix.

Does he meet the diagnostic criteria for one or more
substance use disorders? You just heard me say when we watched
that three and a half minute video you would never diagnose a
client based on a snippet of information like this. But I'm
going to throw out a few things for purposes of this exercise.

We already know he's had multiple charges. Two of those --
that includes a DUI charge. Statistically, a person who has a
DUI charge has driven under the influence several times without
getting a DUI. Probably he meets the criteria. Let's assume he
does for a moment here. Disorderly intoxication. Okay, that's
evidence of at least the possibility of a social or
interpersonal problem caused or made worse by the effects of the
substance

here's a guy who keeps getting arrested and each time he
gets arrested, it's not pleasant for him. He's having to pay
fines or deal with responsibilities or obligations, experience
some restrictions on his freedom or liberties. Yet he continues
anyway

I'm going to say there's probably enough here to say that's
likely he at least has a mild use disorder at the very least.
Let's assume that's true for a moment though after doing a
thorough evaluation. Does he want to stop using it? Clearly
not, he got his card so he could continue using it without -- in
hopes of not having to abstain while he's in treatment. I'm
going to say no, he doesn't want to stop using it.

What's the severity? Let's assume it was mild after a
thorough evaluation and just see what happens. When it's mild
and he doesn't want to use it, and you don't have any leverage,
you would end up right back in the same place as the previous
client. But if we change one thing here -- I'm going to go back to the previous screen here. If we change one thing and we say that he was -- actually first let me go back to that previous screen.

If he's mild, then maybe he can reach remission without having to stop using the substance. That could be a viable approach and we would probably explore that possibility. But let's say that after a thorough evaluation you concluded he had a moderate or severe substance use disorder. If that were the case, then things would change a little bit. And then we find out whether you have leverage or not. In this case you do have leverage. You would say yes because he's here to get his license back after a DUI.

What it says next is use of leverage. Consider using leverage. Consider an example of why a client was referred for driving under the influence. You may explain to the client you've been tasked with providing treatment for the client's cannabis use disorder and a successful completion with a positive prognosis would be construed that the client is no longer posing a risk to the driving public. You may explain that obtaining a medical marijuana card does not address the safety and well-being of the client and the driving public. Just as a client with a opioid related charge cannot obtain a prescription and expect successful completion.

Explain about his or her presence and treatment. The circumstances leading up to the treatment requirement, the client's diagnosis and the goal of treatment. The next question, does the client consent? In my experience, clients in this kind of scenario generally do not consent. They say, heck no, you ain't talking to my prescriber. So client does not consent. The client refuses to sign a release, the counselor would have to agree whether he or she will continue to work with
the client. This may not be feasible if the client is still using an addictive medication.

Next question, do you want to terminate this client or not? Let's say yeah, if you're not going to let me communicate with the prescriber unfortunately I won't be able to help you in this program. If that's the case you go to an unsuccessful discharge and it explains practices to try and pull that off.

In my experience what will happen at this point is the client will say, okay, fine, I'm not going to violate probation or find a new provider, so, fine, you can do it then. Then I'm going to go back and say that the client does consent to communication. Now, things are going to change. Client consents to communication. If a client consents in writing a letter can be mailed to the prescribing physician informing had physician of the client's presence in treatment, the nature and purpose of treatment, et cetera.

Here's an example of phrasing that can be considered. For this I'm going to actually show you what such a later might look like by pulling up one example here. Let's do the one -- this version of my letter is for a scenario -- actually I'll do a completed letter for you. That would probably be a better idea. Give you an actual example. Okay, maybe I don't have the example. I thought I did. See if this one's it. Nope. All right, we'll just use this one.

This is the way my letter is structured. I greet the physician, I say this letter was written to inform you that the above mentioned patient has been admitted to an outpatient substance abuse treatment. And then I describe the circumstances. Usually I'll say something like a client was referred because of an incident to a DUI arrest on January 1, 2020. That was marijuana or alcohol related or whatever the case may be.
Over here in this area where it says this diagnosis, I'm going to include the client's diagnosis. Cannabis use disorder, severe. Alcohol use disorder severe, whatever the case might be. I'm going to check off the specific 11 symptoms that the client meets in which substances the clients meets at four.

Here the patient has advised me that -- then I put he instead of he or she in this case because it's Alejandro -- is being prescribed a potentially addictive medication at your practice. Although I'm not a physician and not qualified to advise the patient on a medication regimen, from a substance abuse treatment perspective it's my impression that -- then I usually say something like the client's THC use poses a safety risk as the client has repeatedly driven under the influence of marijuana or I might say it's my impression that the client would benefit from a recovery treatment protocol if there's a viable medical alternative to medical marijuana. You get to decide what you put in there as your reasoning.

I discussed with my patient that it may exacerbate his disorder and trigger relapse. I would recommend adherence to the practice guideline for the treatment of patients, whenever possible, medications should be selected for the treatment of patients. I inform the patient of the following clinical recommendations offered by the American society of addiction medicine. I've advised the patient to consult with you.

And then I quote ASAM's position that clinicians educate their patients about the known medical risks of marijuana use, including the use of an accidental exposure to edible products and the use and risk of synthetic cannabis. Clinicians should counsel persons suffering from addiction about the need for abstinence from marijuana and the role of cannabis and cannabinoid use. This is a direct quote from ASAM.

Then I say as a preventive measure, in this case ADHD, will
be incorporated into the patient's treatment plan. The patient will be participating in regular drug testing, please provide us with confirmation of any current prescriptions from your office. Your assistance is appreciated don't hesitate to reach out.

This is a form letter. There are very few things in this that I manipulate for each client. I manipulate the list of diagnosis and which symptoms are met but most of this is a template. And this is my letter I use if it's a pretty severe problem with their marijuana and they have medical marijuana. I have a different one for if I'm not sure it's a severe problem that's much more softly worded. This is my more assertive letter to the prescriber but it's still saying, hey, you're the medication expert. You may not know about this so I'm communicating it to you. And do what you shall with this client.

Then the physician is either going to successfully address it or not. I provide links to those letters in the actual matrix itself, by the way.

Does the client or prescriber collaborate? Let's say that they do. We'll click yes. And it says great, consider incorporating the nonaddictive treatment approach into the client's treatment plan and continue to consult with the prescriber. The prescriber has replaced the addictive medication with something that is not addictive and is appropriate medically for the client, wonderful. Game over.

Let's say the prescriber does not work with the client on a nonaddictive treatment option. Now things get more complicated. Consider referring the client to another physician or prescriber with specialization in both biomedical condition and addiction like a board certified addiction medication specialist. They're medical doctors who have the expertise that counselors lack and they have specialized training in addictive disorders.
Does the client agree to see this special? We've kind of gone through what happens if they do or don't. Let's say the client agrees, click next. Does the specialist recommend a nonaddictive treatment option? Yes, they do. Incorporate that specialist's recommendations into the client's treatment plan. Now you can say, okay, a physician is on board saying you don't need the medical marijuana, you can use this instead. That physician is willing to provide that care or to collaborate with your prescriber to provide that care. I don't have to make the recommendation to the change of medication. My issue has been resolved as an addiction specialist because the client is no longer using the substance, it seems to be creating this significant problem that they're having.

I know that we want to have time for questions. I'll just do a quick run through of the third scenario. Ron was discharged against medical advice prematurely from a residential substance abuse treatment plan with diagnosis of alcohol use disorder and cannabis use disorder severe. He sought treatment reluctantly. He's 42, been using substances regularly since 14. He met with psychiatrist. She pointed out that because marijuana helped him to feel happier during his 20s he should consider it. He wrote a prescription for medical marijuana.

These are real cases by the way. This one was amazing. I could only assume that the psychiatrist didn't know what everyone else knows that's worked with this particular client. What did I do? Actually instead of taking time walking you through the matrix since you've already seen it, this was a case where I didn't have any leverage. In fact, notice it's not like he's really required to see me. There's not a whole lot -- it's not getting us anywhere. Let's do previous and go all the way back for a moment.

In this case I did not have leverage, that was the issue.
If I don't have leverage, then this client didn't have to do anything that I suggest he do, right? So what I did in this case was yes, he has a severe disorder. No, I do not have leverage. So I met him where he's at. I explained to him my concerns provided him education, tried to do some harm reduction but he really didn't want what I was selling. He wanted to get his wife off his back but he wasn't interested in recovery. He really wants to continue using marijuana regularly.

So what are you to do? Some clinicians might say I would discharge him unsuccessfully. From my private practice where he's not even required to see me I prefer to work with a client and meet where he's at because I think he'll do better probably working with me than he will if he's not. That's my personal preference. If it was mandated treatment program and I had leverage I wouldn't use the same approach. That's kind of what the decision matrix is doing is showing you it's a little bit different when you're using -- when you have leverage than when you do not.

We're going to do some questions and answers, but before we do that I would love to launch one last polling question here. One polling question. Based on the information that you got yesterday and the decision matrix we went over today, your quasi informed opinion on p.m. can best be described as? Then you can use I'm a medical marijuana enthusiast.

Or I'm largely supportive of it with a tad reservation. I'm fairly neutral or ambivalent about it. I mostly don't think it's a good idea. I'm completely against it. This is for my curiosity with what your opinion is on what we covered today and yesterday on medical marijuana.

>> Perfect, thank you so much, Aaron. Excellent questions coming in as well. 50% of you have voted. We'll give you about ten more seconds to vote and as you are voting in the current
poling question, just a reminder we will have a live Q&A in just a moment and ask the questions that we have received in the order in which we've received them. We'll do our best to get as many in as we can, but please keep sending those questions into the box. We will close the poll and share the results and I'll turn it back over to Aaron.

>> I don't see the results on the screen right now, are they being shared?

>> Yes, that's right. You're the primary presenter, might be --

>> I see it now. Okay. So it's showing that 49% said I mostly don't think it's a good idea but I do see some legitimacy. I'm largely supportive of it with a tad of reservation followed closely by I'm neutral. 2% of you are very enthusiastic. Something I like to point out is it's okay for us to have very different perspectives and opinions on medical marijuana. The question is, even though you have your own beliefs preferences and biases and I have a recovery bias in that I think best case scenario is usually that a client doesn't have to use anything potentially addictive for medication purposes and can still function well and have a happy life, but I recognize there may be cases where that's just the best option available to somebody is to use medical THC.

So I want it to be legal, I want it to be well-researched. I want it to be regulated. I would prefer that people not call it medical when it's really recreational. I prefer us to be able to use a fairly objective process that honored the client's autonomy and we make appropriate decisions and I think the decision matrix provides a way for you to do that and have a good rationale for why you're making the choices that you make when you're working with clients.

With that being said, I think it would be a good time for
us to go into our questions and answers.

>> Perfect. Thanks so much, Aaron. Everyone, thank you so much for these incredible questions. Aaron, thanks for a wonderful presentation. So much comments about the tool that you showed them and everybody is super excited to use it. We sent you all the link in the chat box. Feel free to save that link, but it's also in the PDF handouts of the slide which will be on the website and is in the handouts tab of the go to webinar control panel.

Aaron, the first question comes from Marty. I agree with you -- you mention said in one of your Powerpoint slides that some benefit from inpatient during withdrawal, but do you have any advice that would help us get that patient authorized by either Medicaid or private insurance that would meet their medical necessity? We have found that cannabis use disorder is not always authorized for inpatient treatment.

>> I absolutely do. I have negative been able to get a client who I determined was authorized for residential treatment. The way I do it is I use this. I use the ACM criteria. I go through the six -- most insurance companies prefer or even require clinicians to use the ACM criteria. So I use the decision making matrix in the ASAM manual and I go through the six domains. I apply my rating level, my risk rating level and I explain specifically why I gave that risk rating level for that particular domain. At the end I'm able to show they meet criteria under ACM treatment guidelines for residential level of care.

In residential treatment programs in the United States, cannabis use disorder is the second most common or prevalent diagnosis among residential clients in the U.S. Lots of clients are indeed getting residential treatment in our country.

The question is, how good are we at building the case using
this criteria? It take as pretty severe case for me to say residential is what's warranted. Oftentimes part of what's happening is the client is not succeeding at a lower level of care like IOP, for example, and then that actually strengthens the case even more to justify residential because clearly, they're not reaching remission status on a lower level of care.

In the case of withdrawal, I might be able to document historical occasions in which the client stopped using on an outpatient basis, but became maybe suicidal while experiencing cannabis withdrawal or something like that and then ended up hospitalized. That kind of stuff really buffers or builds the case for residential treatment in a way that's easy to describe and show to insurance companies. I recommend use the Ashier CM criteria, use the six domains of the ACM criteria. Use the risk ratings system and be specific in your justification for why that level of care is needed.

I'm not saying you won't have problems even if you do that but I've found it seems to work really well for me.

>> Excellent. Thank you so much. I guess kind of along the same lines Rebecca really appreciated your recommendation about finding a board certified addiction psychiatrist or physician, are there any recommended strategies for locating such a resource to recommend to clients or to refer to if we're in a rural area and may not find someone with that addiction -- ASAM addiction specification?

>> I've got good news for you on that. Now is the best and easiest time to find a provider for your clients because of telehealth. So, for example, we have polled 650 clinical counselors in the country. We found that 35% of them provided telehealth prior to the pandemic. Currently 95% of them do. I think you'll see similar numbers with board certified addiction medicine specials. If your client lives in the middle of
nowhere Arkansas -- nothing negative about Arkansas, I like Arkansas -- but they live in the middle of nowhere and there aren't any specialists? Do they have internet? You can send the appropriate clinical background information to that specialist so they can do their job.

I think telehealth opens the door for those of us in rural areas to better meet these demands.

>> Awesome. Thank you so much. This is a really short one. Kenneth asks is withdrawal no longer a requirement for such a diagnosis when you were going through those differential diagnosis?

>> No. Withdrawal -- I don't know if the question is is withdrawal no longer a requirement to be diagnosed with a cannabis use disorder maybe?

>> Right, yes, I think that's what they're referring to.

>> No, what's required is out of the 11 symptoms that are listed, at least there has to be at least two the clients met in the same 12-month period. It can be any of the two on that list of 11. It doesn't have to be withdrawal. There are many clients who have a diagnosable substance abuse disorder but do not experience withdrawal.

>> Thank you so much. Rosalee seems like cannabis prescribers could care less what we think especially if a patient has been given the card. Sometimes a medical card feels like a rubber stamp. Have you had any success with these letters? What do you do when the letter prompts a conflict and you have to have a back and forth with that prescriber?

>> Prescribers usually aren't interested in spending enough time to even have a back and forth with me. So the vast majority of the time what happens is I get no response. When I do get a response, sometimes it's good. I found for harder drugs, like Xanax or something, often what will happen is the
physician will say I ain't prescribing that no more and make that clear and contact our office and let us know that. Marijuana is a bit different. I haven't gotten a whole lot of responses on that yet.

And so what I do, if I did get a response and the physician was like, how dare you tell me client to, you know, they have a problem and that, you know -- refer them back to me to look into nonaddictive options. You know, I'm not doing anything wrong. I'm saying from a substance use treatment perspective, this client meets these diagnostic criteria. I'm qualified to make that determination, that's within my scope of practice. I'm licensed to do that I'm an expert in that area. I'm saying there's an addictive disorder here and here's my impression. Because of that I'm going to ethically refer the client back to you, make sure you have access to the same info as me so you can do your job well because I don't know if you have the same info as me.

And in this case because this client -- it depends on the individual case, but if it's a scenario like the one I gave you earlier, clients had marijuana related DUIs, medical marijuana card is enough, I don't want to say that I'm in a conundrum because I can't treat the client who wants his driver's license back but I also am not qualified to tell him what to do with his medication. What I would like to do is get a second opinion from a board certified addiction medicine specialist who has that dual expertise. And if that physician doesn't like me because of that, that's great, that's fine. I'm doing the ethical clinical thing. I haven't had a physician yell at me. I once had one call me thank you for giving me that information. I would have never recommend this if I had known this information.

What's interesting is that physician had already told the
client based on my letter, I'm referring you to so and so who happened to be a psychiatrist who happens to be board certified addiction medicine specialist already for a second opinion. So they were kind of doing the same thing as me. I think physicians are more likely to respect you for being polite and ethical than for just kind of doing whatever they tell you to do. It's your license on the line so you have to do the appropriate thing clinically and ethically and you have to decide what that is.

Excellent. Thanks, Aaron. So this next question comes from Oscar, are we close to having the same information about THC levels in the bloodstream as we have now for alcohol levels? So that we can use that to educate our clients.

>> I don't think we are there yet but I am seeing new research in that area which makes me very optimistic. I'm also seeing new technologies that are being developed and tested out that would give like a THC Breathalyzer for example or things that might give you a clearer picture of the level of marijuana use within somebody's systems, you can get some very vague possibilities, like high -- number at a certain range might suggest that this is either heavy or prolonged user, a very recent user. A smaller amount might indicate they used to use and it's working its way out of your symptom. I don't think as far as roadside I don't think we're there yet but I'm hopeful we will be soon.

>> Perfect, thank you. So helpful. We're getting, like, I guess a bunch of people wanted to know that. Thank you for that. Okay. Different direction here. Bernice from a criminal justice kind of program, what is the best way to specify in diagnostic terms that the patient who is one year clean was actually incarcerated for 11 months of that one year and is just now enrolling in treatment? Is this what they mean my
stipulated release? I don't really know what that meant in quotes.

>> I really don't know what stipulated release means myself. So I couldn't really answer that. I don't know if this helps, the client is in a restricted environment for 11 months. If they met the criteria for substance use disorder I would say that -- tack on that in a controlled environment specifier at the end. I guess I don't know the answer to the question.

>> Okay. And so the next question comes from Dylan. Dylan asks do you see one form of medical marijuana to be better than another form? He's asking especially because of those with a history of substance use disorder but they've been in recovery for a long period of time, like 30 years. So let me ask that one again.

Do you see one form of medical marijuana to be better than another if something has a history of substance use disorder but has been in recovery for a long part of their life, 30 years or more?

>> As I mentioned earlier -- and yesterday as well -- my belief is that it is best for if a client's medical condition can be adequately addressed without any addictive medication, then to me, that makes sense to take that route. A conservative route.

Now, in a case of marijuana, could CBD be a good viable treatment? Yesterday we showed you some of the things that CBD treats are the same thing that medical THC treats. What's it's being described for? If it's spasticity for MS. Has the client tried CBD? Would the physician be willing to talk to the client about that option. If it's got to be THC, then what mild dosages -- remember that Dr. Smith said that ten milligrams or less THC content with a CBD to THC ratio no higher than one part THC to one part CBD, we talked about this yesterday, that that
should adequately treat conditions that medical marijuana can help with.

That would be low THC content and that should be enough. So maybe that could be a precautionary measure for such an individual as well. I would look for a nonaddictive option that would appropriately control the condition. If not, if it's got to be THC then are there low dosages that could be used and could we introduce some other alternative strategies that might reduce the need for the medication as well.

>> Perfect, thank you so much. Melanie, great question. This is a short question. Why does some clients that are taking CBD products that state no THC still test positive for cannabis?

>> So here there's two things, number one I mentioned this yesterday. I'm not fan of clinicians using strictly the screening on site test, the dip sticks because you can have false positives more easily. I have read and heard that CBD for some of those tests could create a false positive for THC.

But when you take the urine and you ship it off to a lab for confirmatory testing procedures like gas chromatography, what the lab tells me is no, that won't cause a positive result for THC unless there is THC in that CBD and then it's an accurate result. One of the problems is there are products that are sold that say that they're CBD and have no THC that actually do have THC in them.

Remember the labs use threshold levels. So a small trace amount of THC they'll not call that positive. Hopefully that would reduce the likelihood of that scenario. But if the lab comes back with a possible result for THC, it's THC if they did confirmatory testing, it's not just CBD. Whether the CBD had THC in it, is another question. That's why I tell clients I don't recommend going to a convenience store and taking CBD. If you're taking it, do it through a medical provider so you know
what you're getting is related CBD without THC in it. I'm just saying in the sweeps that they did here in Florida, they found that a lot of the products coming from China that were sold as CBD had THC in them even though on the box it says it did not.

>> I'm going to try to squeeze in two more here. So one comes from Geraldine from Ireland, some of the young people I've worked with who have traumatic childhood experiences actually seem safer on cannabis and have used -- seen this being used or allowed. What do we have to offer them other than abstinence in addiction treatment?

>> Alternative psychosocial interventions for whatever it is they're trying to address. If the client is depressed or anxious would they rather develop the ability to handle their anxiety without needing a medication or would they prefer to require medication to do so? Most people seem to prefer being able to learn to self-manage with time. So that's what we offer them is the hope of growth and resilience and recovery. That's more than just abstinence, not using something.

I also don't know by your question if it's specifically THC that you're talking about versus CBD so that's something to consider. Just a side note, welcome from Ireland, I was there last year and had a wonderful time. I wish I could have gone back again this year, but unfortunately we got a pandemic.

>> Right. I had a trip I had to cancel too. Like Aaron said, welcome from Ireland.

Last question, this is more of an observation I think may take some time to chat through. I'll let you end with this one. So the question is, we are sort of in a generational cultural difference in the topic of marijuana. Where the emerging adult group has a tendency to use, view and perceive the marijuana issue as a substance use disorder differently than elderly adults who may actually be using it to treat glaucoma and the
Boomer generation may have gone their whole life never using substances and are now using marijuana thinking it's well-researched and safe and yet they tend to also use it for emotional issues like losing a loved one in their elderly age or losing their spouse.

Could you speak to that difference, that generational difference and the use and maybe if there are any cultural considerations between those two generations and how we assess and treat cannabis use disorder?

>> Yeah. For the past 20 years what I've seen is that younger people tend to have a different attitude about marijuana than older people. I feel like some of those younger people, they grew up and then their attitudes and viewpoints change about marijuana. I guess what I would say is we can educate people on what medicine is and what it isn't. Medicine is not something that makes you feel euphoric or good or high. Medicine is something that reduces the symptoms that are creating problems with your ultimate to function.

Good medicine is something that gets you closer to normal, not closer to abnormal as in a state of euphoric high. I think that's really the message that we have to teach across the board. Sound like maybe what you're saying is maybe some of the older Americans who are taking medical marijuana might be more likely to be using it legitimately but maybe younger people to have a good time or recreationally or to experience a euphoria or a high.

I feel like young people are wanting to try something out. They may find that uninteresting later on in life. So maybe that answers the question a little bit.

>> Thank you so much, Aaron. Everyone, thank you for these questions for this excellent discussion. We've got these questioned saved we'll try to relay these questions from part
one to Aaron and see if there's additional resources or handouts or, you know, maybe links to point you all to. So, Aaron's information is on the screen, also on the slide deck just as a reminder. Every NAADAC webinar has its own web page that houses everything you need to know about that particular webinar. Immediately following the event you'll find the online CE quiz link on the exact same website you used to register for this webinar.

That means everything you need to know will be permanently hosted at naadac.org. Look at the orange -- yellow arrows here on the screen. One is pointing to where the CE quiz link will be. If you're wondering where it is it will be on that same website. If you're wondering how to access your certificate after taking the quiz, make sure to download that PDF that gives you some clear instructions on how to do that.

Here is a schedule for our upcoming webinars. Tune in if you can. As you see there's some really interesting topics, great presenters, just like today. For example, you know, when our annual conference shifted from in person live in D.C. to virtual due to COVID-19 social distancing protocols, we reached out to Aaron Norton and he redesigned a full one day training to this interactive virtual learning experience.

As you see, we have a couple more presenters who are helping us with similar presentations coming up. So, please make sure to tune in. If you haven't done so already, please make sure to bookmark this web page. You can stay up to date on the latest in this new series. There's also a resource page with additional links, free trainings and resources on cultural competency and cultural humility.

As an additional resource, NAADAC, the association for addiction professionals has provided a COVID-19 resources page that includes six excellent free webinars covering top concerns.
in the addiction profession by leading experts in the field. NAADAC is also offering two specialty online training series. The first is clinical supervision in the addiction profession. You can visit naadac.org/clinical-supervision-online-training-series for more information on this exclusive content. This series complements our newest workbook on clinical supervision. Visit the NAADAC bookstore to purchase this newest collection to updated research on clinical supervision specific.

Our second series is on addiction treatment and military and veteran culture. To learn more, visit naadac.org/military-vet-online-training-series. This series was led and presented by a retired combat vet and licensed professional counselor.

Many benefits of joining NAADAC, if you're not a NAADAC member, you can go to naadac.org/join to take advantage of those benefits, all CEs from our webinar series are free for NAADAC members. NAADAC members have immediate access to our quarterly advanced in addiction recovery magazine, which is also eligible for CEs as well. Thank you all again for joining us today. Aaron thank you for this incredible presentation. Just as a reminder, a short survey will pop up in the end. You'll get in your thank you for attending e-mail. Share your feedback with us, any notes you have for us and the presenter and let us know how we can improve your learning experience.

Aaron, your valuable expertise, leadership and support in this field is cherished, thank you for your time and sharing this knowledge with us. I encourage you to take some time, browse our website, learn how NAADAC helps others. You can stay connect with us on Linkedin, Facebook and Twitter, have a great day, everyone.