COMMENTARY

Medical Marijuana and Ethical Dilemmas for Chemical Dependency Professionals

As voter initiatives pass, where does this leave treatment professionals?

By Paul R. Weatherly, MA, CDP

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Discussions related to medical marijuana and its efficacy treating a variety of medically recognized conditions dominate many meetings with professionals in the addiction treatment community. What is discussed to a lesser degree are the ethical dilemmas related to admitting or choosing not to admit individuals into addiction treatment programs in states that allow qualified patients to use marijuana as part of a therapeutic regimen to treat their medical conditions. Ethical dilemmas are created by state laws that recognize a wide variety of medical conditions that may respond positively to medical marijuana that are in conflict with federal laws and ethical guidelines related to the field of addiction counseling. Issues that complicate these ethical dilemmas come from how state laws and regulations vary in determining the amounts of processed and unprocessed marijuana a medical marijuana user may possess during any given time interval, how states may or may not define a therapeutic dose, frequency of dosing and questions regarding use of substances prior to, during or after attending addiction treatment group or individual counseling sessions and how is relapse defined for a medical marijuana patient. Further complications arise regarding conflicts between state law allowing MD, ND, DO or ARNP's to recommend the use of medical marijuana to their patients and federal law banning sale, production and possession of marijuana, the Uniform Disciplinary Act, the Americans With Disabilities Act, U.S. Department of Transportation rules and regulations, as well as state laws and regulations regarding addiction treatment and the professional responsibilities of addiction treatment providers. This article will look at the issues arising in Washington State.

Washington State law specifically creates immunity from prosecution for MD, ND, DO and ARNP's to have conversations with patients regarding the use of medical marijuana to treat a terminal or debilitating condition. It requires medical marijuana patients with qualifying conditions to be issued documentation allowing them to possess both processed and unprocessed marijuana that may be used as an affirmative defense if they are arrested and/or prosecuted for possession of marijuana. In addition, the law defines what constitutes a terminal or debilitating condition and the process that allows for individuals to petition the state to add non-recognized conditions to this list. State regulations developed by the Washington State Department of Health determine the amount of processed and unprocessed marijuana a qualified patient may possess during a 60-day time interval. Washington State law also defines the core competencies for chemical dependency professionals and their responsibilities to patients in addiction treatment programs.

A qualified health care professional may have discussions with patients who have qualifying terminal or debilitating medical conditions regarding the use of marijuana as part of a therapeutic regimen only after a thorough physical examination that is age and gender appropriate specific to the condition and a history of the failure of standard treatments has been documented in the patient's medical record. These discussions are allowed in regard to the health care professional's first amendment right of free speech. In other words, a qualified medical marijuana patient does not have to have a prescription to use marijuana, only a recommendation. Because the patient does not have a prescription to use marijuana, addiction treatment providers can determine whether or not they are willing to admit a medical marijuana user into their treatment program.

Information that requires consideration by the treatment provider and chemical dependency professionals includes the following: If a program is receiving federal funding to provide addiction treatment services directly or indirectly through distribution by the state, the program is at risk of losing that funding if they admit or allow patients to use medical marijuana. Patients who may be protected under the Americans With Disabilities Act lose their protection if they are known to be using a substance listed on schedule one of the uniform controlled substances act. All medical marijuana patients must be listed with the Washington State Department of Health. There is very little literature that defines the term "therapeutic dose" so a medical marijuana patient determines the amount of the dose and frequency of dosing he or she determines adequate to receive relief from the symptoms of their terminal or debilitating condition. Providers must thoroughly review medical marijuana documentation to assure that the condition being treated is recognized under Washington State law and therefore legitimate documentation. Medical marijuana documentation from other states is not recognized in Washington because the recommender must be licensed to practice in Washington and interstate transportation of a controlled substance is violation of federal law. Finally, Washington State law defines the core competency of a chemical dependency provider to receive specific training that is "all oriented to assist alcoholic and drug addicted patients to achieve and maintain abstinence from mood-altering substances and develop independent support systems."

The NAADAC code of ethics offers five principles that offer implicit but not explicit guidance regarding medical marijuana. They are Trustworthiness, Compliance with The Law, Rights and Duties,

Preventing Harm and Duty to Care. Subsequently problems arise regarding the admission and treatment of medical marijuana patients. Conflicts between state and federal laws make it difficult for chemical dependency providers to balance compassion for the patient with the consequences of civil disobedience. Because chemical dependency professionals are not on the list of health care providers protected under Washington law they are risk of practicing outside of their scope and jeopardizing the creation of working relationships with their patients. Conflicts in laws and opinions regarding the efficacy of medical marijuana compounded by Federal legal definitions that marijuana has no medical value compromise a chemical dependency provider's ability to improve the options and choices a medical marijuana patient may have to treat acute medical issues related to addiction to alcohol or other drugs. Lack of knowledge in the chemical dependency provider community about marijuana and its potential for use as a medicine and various risks to the user's health dependent upon the route of administration complicate the chemical dependency professional's ability to evaluate the myriad of mixed messages patients and providers receive regarding marijuana. Lastly, the question of what degree does the use of marijuana to relieve symptoms of a recognized medical condition impair a patient's ability to make progress meeting goals and objectives on a treatment plan and will this ultimately require the termination of the patient/counselor relationship requiring potential life and death decisions to be made by a chemical dependency professional.

This overview of the problem does not come without an overview of some basic solutions. Each agency providing addiction treatment services in Washington would be well served to develop policy and procedure for admitting or choosing not to admit qualified medical marijuana patients into their program. For agencies making the choice to do admissions, issues like therapeutic dose verified by testing parameters defining the limits of THC metabolites should be defined. Rules related to dosing pre-treatment, during treatment and post-treatment should be concretely stated and definitions regarding how the agency defines relapse need to be clearly presented to medical marijuana patients. Finally, expectations and training for providers regarding documentation regarding conditions for admission or referral, progress or lack of progress attaining treatment goals and criteria for discharge would need to be implemented.

For chemical dependency professionals, each will need to make decisions regarding the personal values, biases and understandings of their responsibilities as providers of services to alcoholic and drug addicted individuals. These decisions will ideally incorporate the guidelines provided in the NAADAC code of ethics, research and discussions with peers about the implications of attempting to provide addiction treatment services to qualified medical marijuana patients. These decisions will ultimately inform how each individual provider will engage in the discharge of his or her duties providing services to the community of patients requesting addiction treatment services.

This article in many ways only scratches the surface of the problem. It poses many more questions than it answers. But in consideration of all the many mixed messages that exist about marijuana as a medicine, recreational diversion, legalization/decriminalization, creator of tax revenues, etc. it is important that conversation begin somewhere.

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Essentially, this process opens up communication of information through the "crossroads" of our brain, i.e., the orbitofrontal, insula, and anterior cingulate cortices, which brings awareness from our bodily sensations into our executive attentional areas, i.e., the dorsomedial, ventramedial and dorsolateral prefrontal cortices.

Significantly, the neural pathways related to this level of embodied self-awareness are relatively slower than the pathways related to other intellectual activities (e.g., solving a math problem). This is due to the fact that interoceptive pathways involve unmyelinated nerve fibers (Fogel, 2009). Myelinated nerve fibers speed up transmission of energy and information through neural circuits. Therefore, in considering brain processes, this level of embodied self-awareness is going to be much slower and take more time to develop (particularly in early recovery) than the relatively rapid fire ideas and thoughts about oneself that enter the mind as "self-awareness." In short, this practice may entail slowing down, taking a deep breath into our body and trusting the information that comes from our physiology (i.e., from our "gut" and our "heart") — information that can guide our response to an emotional event in recovery (Woodford, 2012).

In summary, when the processes of paying attention and increasing emotional awareness are engaged in the middle prefrontal region of the brain, several important functions of the brain are enhanced that are essential for developing a relationship with oneself and others in recovery; namely, attuned communication, empathy, insight and intuition (Siegel, 2007). Although these functions are severely compromised by addiction, when we repeatedly slow down and reflect on our emotional experiences, we are working out the muscles of our mind to increase our ability to respond well to high-risk situations in recovery. Over time, this process strengthens new neural pathways related to self-regulation and emotional development (Fosha, Siegel, & Solomon, 2009), which is at the heart of developing an integrated sense of self that can weather the storms of life in recovery.

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