

2019 AMHCA
ANNUAL CONFERENCE



THE ADVOCATE

M A G A Z I N E

WWW.AMHCA.ORG ■ VOLUME 42/NUMBER 2 ■ SPRING 2019



JUNE 26–28

AMHCA.ORG/CONFERENCE

medical marijuana

what you
should know
about it

ALSO IN THIS ISSUE

Member Reflections /2
Election Results /6
Counseling Tips /8

FEATURE ARTICLE
Integrated Cognitive
Behavioral Therapy /12

THE QUARTERLY MAGAZINE OF THE AMERICAN MENTAL HEALTH COUNSELORS ASSOCIATION

Emerging Clinical Issues What CMHCs Should Know About Medical Marijuana

Few of us clinical mental health counselors (CMHCs) learned much of anything about medical marijuana in grad school, yet it is now legal in 33 states, the District of Columbia, Guam, and Puerto Rico, according to the National Conference of State Legislatures (tinyurl.com/nfoyl2gr). Marijuana is also the most commonly used (and abused) illicit substance in the United States, according to the National Institute on Drug Abuse (NIDA) (tinyurl.com/gndcl9d).

On one hand, we CMHCs want to help our clients learn to manage and cope with aversive emotional states using their internal resources rather than turning to addictive substances that so often provide short-term relief while enabling clients to avoid long-term solutions. On the other hand, we sometimes work with clients with co-occurring biomedical conditions that are very difficult to live with, and medical marijuana may give our clients much-needed relief.

Here are nine facts that I think CMHCs should know about medical marijuana.



FACT #1: **Not All Medical Marijuana Is Psychoactive and Potentially Addictive**

Five years ago, I watched a well-known Florida attorney named John Morgan tell Cable TV viewers that “nobody’s addicted” to marijuana. Having treated clients with cannabis use disorders for about 13 years by that point, I was concerned about such misinformation being disseminated to the public. I contacted the local news station, which then referred the concern to PolitiFact, a nonprofit political fact-checking resource owned by the Poynter Institute. After a thorough investigation, they rated the statement as “false,” and to his credit, Morgan acknowledged his mistake publicly and clarified his position (see tinyurl.com/yxqqtlsf).

It is true, however, that most people who have used marijuana do not become addicted to it. As clinical psychologist

By Aaron Norton, LMHC, LMFT, MCAP, CCMHC, CRC, CFMHE

Aaron Norton provides psychotherapy, clinical and forensic evaluation, clinical supervision, and professional consultation at his practice, Integrity Counseling, integritycounseling.net, in Largo, FL. Awarded Mental Health Counselor of the Year by AMHCA and Counselor Educator of the Year by Florida Mental Health Counselors Association (FMHCA) in 2016, he is an adjunct instructor at the University of South Florida, executive director of the National Board of Forensic Evaluators, and president-elect of FMHCA. Consulting editor of The Advocate Magazine and also AMHCA’s Southern Region director, he is finishing his doctoral dissertation in Counselor Education and Supervision at USF. Learn more at anorton.com; email him at: me@anorton.com.



Jordan Peterson, PhD, wrote in his book “12 Rules for Life: An Antidote for Chaos,” “Marijuana isn’t bad for everyone any more than alcohol is bad for everyone. Sometimes it even appears to improve people.” But he then describes how marijuana did not help some of his friends and clients, instead seeming to make matters worse for them.

As many as 30 percent of people who use marijuana develop a cannabis use disorder (ranging from mild to severe) tinyurl.com/gndcl9d, according to NIDA, and even the National Organization for the Reform of Marijuana Legalization (NORML), the leading U.S. pro-marijuana legalization thinktank, reports that nearly 10 percent of users develop a dependence (i.e., a moderate-to-severe cannabis use disorder). But if these figures are accurate, that means that approximately 70 percent of people who have used marijuana do not develop a disorder.

The prevailing opinion is that certain people have internal vulnerabilities—both biological and experiential in nature—that predispose them to developing a problem with marijuana. I contend that CMHCs who specialize in substance use and addictive disorders can play a key role in identifying people who have—or are at risk of developing—a problem with marijuana.

When we say that marijuana is addictive, it is helpful to clarify that marijuana addiction is primarily attributed to a specific chemical called Δ -9-tetrahydrocannabinol (THC). Marijuana contains many other chemicals, and some of those chemicals are also termed “medical marijuana.” When the term “medical marijuana” is used, it likely refers to one of two compounds—THC or cannabidiol (CBD). Unlike THC, CBD is non-addictive, and the World Health Organization (WHO) has declared that it poses no threat to public health (see tinyurl.com/yyfa472a to view this report).

Therefore, when you read or hear about “medical marijuana” in the news, or when a client tells you that he or she is using medical marijuana, it is important to determine whether THC (which poses a risk of addiction) or CBD (which does not), is the subject of discussion.

continued on page 13



FACT #2:

By Law, Medical Marijuana Can Only Be Prescribed for Certain Disorders

When a state legalizes medical marijuana, the conditions for which it can be prescribed are often carefully identified in statutes. If you live in a medical marijuana state, it is important for you and your clients to know which disorders qualify. For example, Florida Statute 381.986 permits medical marijuana to be prescribed for the following conditions: cancer, epilepsy, glaucoma, human immunodeficiency virus/Acquired Immune Deficiency Syndrome (HIV/AIDS), post-traumatic stress disorder (PTSD), amyotrophic lateral sclerosis (ALS), Crohn's disease, Parkinson's disease, and multiple sclerosis. Note that the only mental disorder included in the legislation is PTSD. In my experience, however, prescribers have prescribed medical marijuana for several other mental disorders, including Attention Deficit Hyperactivity Disorder (ADHD), Panic Disorder, Obsessive-Compulsive Disorder, and Generalized Anxiety Disorder.

How do they get away with this? My guess is that they are very liberally interpreting a clause in the statute clarifying that medical marijuana can also be prescribed for "medical conditions of the same kind or class as or comparable to those" previously mentioned. Prescribers may reason, for example, that because people with PTSD tend to experience anxiety, people with any anxiety disorder should also be treatable by medical marijuana.

Other states are more or less restrictive in terms of qualifying conditions. For example, Alabama only allows medical marijuana to be prescribed for "severe, debilitating epileptic conditions," whereas California, after listing several conditions, includes a very general and comprehensive allowance for "any other chronic or persistent medical symptom that substantially limits the ability of the person to conduct one or more major life activities (as defined by the Americans with Disabilities Act of 1990) or, if not alleviated, may cause serious harm to the patient's safety or physical or mental health." You can view a list of conditions that various states permit at tinyurl.com/nlzsgat, but I always recommend going straight to the statute on your state legislature's website and reading it for yourself.



FACT #3:

Medical Marijuana Is Helpful for Some Disorders—Not Others

Because there is so much misinformation about medical marijuana, it is important to find current, objective, and unbiased resources to sift fact from fiction. Even a very reputable

and seemingly unbiased resource, like *Science Daily*, a website that provides summaries of the latest and greatest articles published in peer-reviewed academic journals, can be very confusing—try it yourself! Visit sciencedaily.com, type "marijuana" in the search bar, and start reading the headlines. It won't take long to find seemingly contradictory titles. Is marijuana good for glaucoma, or bad for it? Does it tend to reduce the prevalence of opioid abuse or not? Does it help sleep, or does it interfere with sleep quality? What's a CMHC to do? Wouldn't it be nice if there were one objective, reliable resource that laid out what the research does and doesn't say about medical marijuana?

Turns out there is. Personally, I favor the National Academies of Science, Engineering, and Medicine (NASEM) 2017 report, "The Health Effects of Cannabis and Cannabinoids: The Current State of Evidence and Recommendations for Research." (Download the PDF at tinyurl.com/yxvjfu99.) NASEM's 468-page report presents nearly 100 research conclusions about medical marijuana, lumping them into different levels of strength ranging from conclusive or substantial evidence down to no or insufficient evidence.

The report concluded that the evidence is moderate, conclusive, or substantial for at least some therapeutic benefit for chronic pain, chemotherapy-induced nausea or vomiting, patient reports of spasticity associated with multiple sclerosis, and short-term sleep outcomes for several biomedical conditions. Conversely, it concluded that there is limited, insufficient, or no evidence to support that medical marijuana is helpful for:

- Increased appetite and decreased weight loss associated with HIV/AIDS,
- Clinician-measured spasticity associated with multiple sclerosis,
- Tourette syndrome,
- Anxiety symptoms,
- PTSD,
- Improved outcomes (i.e., mortality) after a traumatic brain injury,
- Dementia,
- Glaucoma,
- Depressive symptoms in individuals with chronic pain or multiple sclerosis,
- Cancers,
- Cancer-associated anorexia,
- Irritable bowel syndrome,
- Epilepsy,
- Spasticity associated with spinal cord injury,
- Amyotrophic lateral sclerosis,

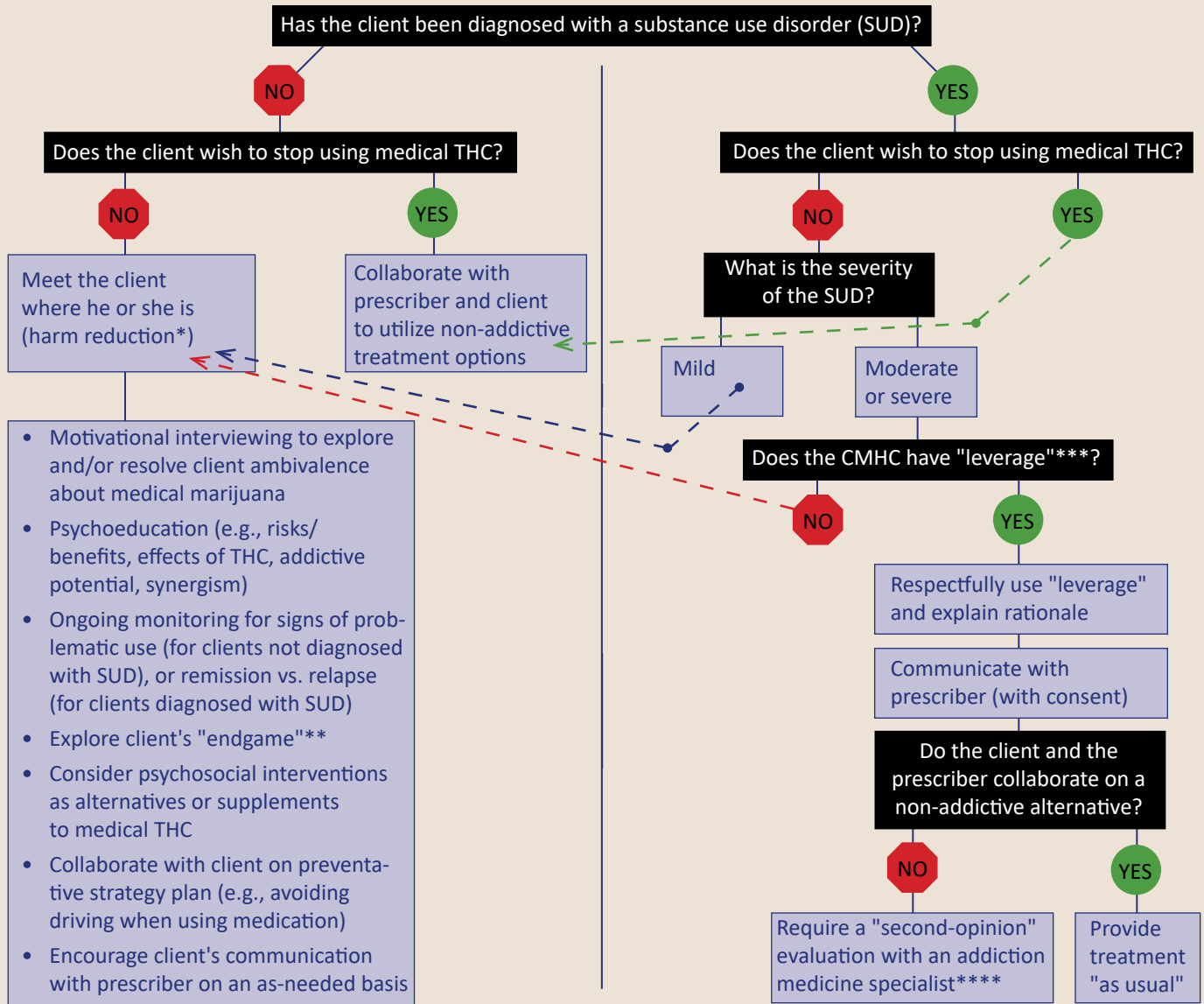
continued on page 15

Emerging Clinical Issues

Decision Matrix

Decision Matrix for CMHCs Encountering Medical Marijuana Use in Mental Health and Substance Abuse Treatment Settings

CLIENT PRESENTS WITH MEDICAL MARIJUANA CARD (USES MEDICAL THC)



Definitions

- * **Harm reduction:** A treatment and prevention approach focused on decreasing health and socioeconomic costs and consequences of addiction-related problems, whether or not the client is still using an addictive substance
- ** **Endgame:** Used in this article, endgame refers to the long-term (vs. short-term) strategies and approaches the client will use for his or her presenting problems. In other words, because addictive medications used daily over long periods of time tend to produce tolerance, what will the client do

- *** **Leverage:** Resources or outcomes pursued by a client that may be conditional to successful treatment completion (e.g., successful compliance with probation/successful avoidance of incarceration)
- **** **Addiction medicine specialist:** A physician or psychiatrist who is certified by the American Society of Addiction Medicine (ASAM), with expertise in prevention, screening, intervention, and treatment for substance use (asam.org)

- Motor symptoms associated with Parkinson’s disease,
- Dystonia,
- Addictions to other drugs, and
- Schizophrenia/psychosis.

Just because research does not yet support the efficacy of medical marijuana for a particular disorder does not mean that it doesn’t help; it just means that we can’t yet demonstrate with a high burden of proof that it does. Still, since some state statutes permit physicians to prescribe medical marijuana for several of the disorders that the NASEM report concluded were not yet supported by research, it begs the question of whether legislators are prematurely listing qualifying conditions.



FACT #4: **Many Health Risks Are Associated With Marijuana**

Part of the controversy about medical marijuana centers around a well-established body of research demonstrating that marijuana can be harmful to human beings. For example, the aforementioned NASEM report found moderate to substantial/conclusive evidence that marijuana use correlates with (though may not cause):

- Respiratory symptoms and more frequent episodes of chronic bronchitis (for long-term smokers),
- Increased risk of motor vehicle crashes,
- Increased risk of overdose injuries including respiratory distress among pediatric populations,
- Lower birth weight among offspring of mothers who smoke marijuana,
- Impairment in the cognitive domains of learning, memory, and attention,
- The development of schizophrenia and other psychotic disorders,
- Increased symptoms of mania and hypomania,
- A small increased risk for depressive disorders,
- Increased incidence of suicidal ideation, attempts, and completion,
- Social anxiety disorder, and
- The likelihood of developing addictions to other substances.



An additional major risk is the development of a cannabis use disorder, which may or may not include physiological symptoms such as tolerance and withdrawal. Daily medical marijuana users often develop tolerance to marijuana, which means that they either will require more of the substance to get the same effect, or they will get diminished effect from the same dosage. And the higher the dosage, the greater the likelihood that the client will experience the above risks.



FACT #5: **Medical Marijuana Prescriptions Vary in Dosage and How It’s Taken**

One concern about medical marijuana centers around the traditional route of its administration—inhaling of marijuana smoke, which raises concerns about increased risk for respiratory problems. However, medical marijuana is often applied through nasal sprays, vaping (i.e., inhalation of smokeless vapors), oral ingestion, topical, and even vaginal/rectal means, possibly reducing risk of respiratory problems.

Dosage is another important variable. According to Gregory Smith, MD, an expert medical marijuana prescriber and designer who wrote “Medical Cannabis: What Clinicians Need to Know and Why—Basic Science & Clinical Applications,” if a client feels a “high” or euphoria from medical marijuana, then the client is overmedicated (a perspective that many of my medical marijuana card-carrying clients are surprised to hear). This is because the purpose of medicine is not to provide a high, euphoria, buzz, or pleasant sensation, nor is it to completely alleviate pain, discomfort, or distress.

Rather, the purpose of medicine is to reduce symptoms sufficiently so that a person can function adaptively in society rather than walk around in a euphoric haze. To avoid this impairment, Dr. Smith notes that THC doses should be under 10 milligrams (mg). Additionally, most medical conditions should respond to CBD-to-THC ratios of 1+ (CBD):1 (THC) or higher, whereas recreational marijuana ratios are often 1 (CBD):15+ (THC).

Unfortunately, I doubt that medical marijuana dispensaries in Florida are reading Dr. Smith’s books or attending his lectures. In online searches of products in Florida’s dispensaries, I generally see dosages of 10 mg to 600 mg of THC, and CBD-to-THC ratios of between 1 (CBD):20 (THC), and 1 (CBD):826 (THC), raising the question of whether clients are being overmedicated.

continued on page 17

Clinical Applications and Resources Related to Medical Marijuana

Prescribing potentially addictive medications is generally contraindicated for clients with substance use disorders due to the risks of cross-addiction, according to the American Psychiatric Association's "Practice Guideline for the Treatment of Patients With Substance Use Disorders" (the PDF is at tinyurl.com/my5mj2o). It is therefore important for clinical mental health counselors (CMHCs) to assess whether a client taking prescribed marijuana has one or more substance use disorders (SUDs). Additionally, because of the potential for medical marijuana to exacerbate co-occurring mental disorders, other important questions include: Is medical marijuana appropriate? Do safer and more effective alternatives exist? Is the client using the medication safely?

Also consider situations in which a client who is court-ordered to participate in substance abuse treatment is also legally using prescribed marijuana. How does a CMHC determine that the client is recovering sufficiently and unlikely to be a threat to public safety under those circumstances? If a CMHC determines that a client's marijuana use is likely causing significant problems for a client, what can the CMHC do?

To further explore these questions, I recommend watching a recording of a two-hour webinar I presented for the National Board of Forensic Evaluators on "What Mental Health Professionals Should Know About Medical Marijuana," which can be viewed for free at youtu.be/TDQkztqlq8s. (To earn CEs for watching that webinar, register and pay a small administrative fee at nbfe.net/event-2983898.) Here are some of the strategies I recommend:

- 1. Conduct a thorough assessment to determine if a client meets the diagnostic criteria for one or more SUDs.** Depending on your role in the client's life (e.g., therapy or forensic evaluation), the setting you work in, and the resources available to you, such an assessment may include an in-depth clinical interview; the use of one or more structured interview tools; administration of tests designed to detect defensiveness, denial, and subtle attributes of individuals with SUDs (e.g., SASSI-4); urinalysis drug testing to corroborate self-report of recent use; collateral interviews; and reviews of records (e.g., legal records, primary care records, therapy records, etc.).
- 2. If there is not sufficient evidence to suggest that the client meets the diagnostic criteria for one or more SUDs, then consider a focus on harm reduction.** This may include exploring other treatment options (or encouraging the client to consult with a physician on other viable treatment options). Personally, I favor a conservative position: If a condition can be effectively treated without long-term use

of a potentially addictive medication, then it makes sense to use those alternative treatment options and avoid unnecessary risks. If, however, the client makes an informed choice—in collaboration with his or her medical team—to take prescribed medical marijuana, then it may be appropriate to educate the client on how to recognize signs that the medication is becoming problematic and how to take reasonable steps to reduce the probability of such an outcome.

- 3. If evidence suggests that the client meets the diagnostic criteria for one or more SUDs, then additional strategies may be warranted:**
 - If the SUD is mild, consider a harm-reduction approach and determine if the client reaches remission status using such strategies.
 - If the SUD is moderate to severe, an abstinence-based approach is preferable, as the probability of achieving remission while still using an addictive substance is lowered. In this case, CMHCs may:
 - Interface with the prescriber** (with client consent), communicating the client's diagnosis (including specific symptoms) and the American Psychiatric Association's guideline on avoiding addictive medications for clients with SUDs, recommending that the physician consider other treatment options if medically viable (see sample letters and templates at app.box.com/v/MedicalMarijuana).
 - Provide counseling for harm reduction.** For example, this may include coaching the client on avoiding driving or operating heavy machinery when using the medication, becoming knowledgeable of places where the client cannot legally administer the medication based on state law, etc.
 - Provide psychosocial alternatives that are within the scope of practice of CMHCs.** For example, a client using medical marijuana for insomnia might benefit from cognitive behavioral therapy for Insomnia (CBT-I) if the CMHC is appropriately trained on that protocol.
 - Refer the client for a second opinion with another prescriber,** perhaps focusing on prescribers with adequate training and expertise in treating patients with SUDs, such as board-certified addiction medicine specialists, and communicate with the physician about the rationale for the referral (with appropriate client consent).



FACT #6: **Medical Marijuana Card Holders Are Not Protected From Employment Discrimination**

Because marijuana is illegal under federal law, and because the Americans with Disabilities Act specifically excludes “any employee or applicant who is currently engaging in the illegal use of drugs” from protection against employment discrimination (see tinyurl.com/y245cvbg), federal law does not currently protect medical marijuana users. Additionally, state statutes often include similar clauses and prohibitions. For example, Florida Statute 381.986(1)(j)5c specifically delineates that medical marijuana “in a qualified place of employment, except when permitted by his or her employer,” is not permissible under state law.

Also, medical marijuana patients who work in jobs designated as “safety-sensitive” by the U.S. Department of Transportation—such as boat captains, pilots, bus drivers, pipe layers, bridge painters, workers on assembly lines that produce controls for public transportation, and myriad other jobs—risk violation of 49 CFR Part 40, which can result in being pulled for safety-sensitive job duties and/or termination from employment (see tinyurl.com/qccry4j). Therefore it is important for your clients to understand that they risk job loss or other employment sanctions if they use medical marijuana.



Fact #7: Many Medical Marijuana Users Are Recreational Users and/or Addicts Seeking a Legal Means to Use or Abuse Marijuana

Several recent studies have focused on characteristics and attributes of medical marijuana patients, finding that they often abused marijuana illegally for many years before obtaining a medical card. This probably will not surprise CMHCs. We are accustomed to working with clients who are addicted to other legally prescribed medications (such as opioids, benzodiazepines, and stimulant medications designed to treat ADHD), and who obtained their prescriptions legally. The same can be said for medical marijuana users.

I want to be clear here. I’m not talking about people who have medical disorders that marijuana can effectively treat and who used illegal marijuana as medicine in an adaptive and responsible way prior to legalization of medical marijuana in their respective states. I’m specifically using the term abuse to denote a cannabis use disorder, which refers to a maladapt-

ive pattern of marijuana use that leads to or causes clinically significant impairment or distress. I have had numerous clients with diagnosed substance use disorders tell me, “I can’t wait to get my medical card,” and many of them do. Obtaining a medical marijuana card does not magically make one’s marijuana use adaptive, healthy, functional, or legitimately medical in nature.



FACT #8: **Most Medical and Psychological Professional Organizations Oppose Medical Marijuana**

The prescription of medical marijuana is either strongly opposed, or at least cautiously discouraged, by the American Medical Association, American Psychiatric Association, American Society of Addiction Medicine, American Academy of Pediatrics, NAADAC (the Association for Addiction Professionals), and the U.S. Department of Veterans Affairs (VA). These organizations cite lack of evidence of efficacy, substantial health risks posed by medical marijuana, the need for additional research, and the availability of effective and lower-risk alternatives. Criticism is especially sharp for prescriptions to children and adolescents (due to developmental impairment) and for prescription of medical marijuana for psychiatric disorders, which tend to be much more effectively treated by other means, including safer medications and psychotherapy.

In the interest of full disclosure, I voted in favor of medical marijuana legislation in my state, primarily for political and philosophical reasons. Once again, however, I must question whether the widespread criticism of medical marijuana among our professional associations indicates that legislators who claim that the benefit of medical marijuana is well-established are getting ahead of themselves.



FACT #9: **CMHCs Who Coach Clients on Using Medical Marijuana Risk Allegations of Practicing Medicine Without a Physician’s License**

In the July 2018 issue of *Counseling Today* magazine, attorney Anne Marie “Nancy” Wheeler responded to a question posed

continued on page 18

by a CMHC, who wrote, “I am a licensed professional counselor working in a multidisciplinary practice focused on mental health and substance use disorders. The practice is owned by a psychiatrist. My state has passed legislation legalizing marijuana, but I am trying to figure out the potential risks to me if I endorse a client’s decision to use marijuana or make recommendations to the client on such use. Can you offer any suggestions?”

Wheeler pointed out that if a client has a substance use disorder, then “encouraging marijuana use could be viewed as detrimental” to the client’s health. Moreover, a state licensure board governing CMHCs may “take the position that your recommendation of marijuana use constitutes the ‘practice of medicine’ in your state.” Personally, I would add that prematurely advising a client to stop using medical marijuana could also be viewed as practicing without a license. I believe that CMHCs should be very careful about blanket orders about medication use and should collaborate with physicians on such cases.

So what is a CMHC’s role when discussing medical marijuana with a client? In my opinion, it is generally appropriate for CMHCs with adequate training and expertise to engage in the following four activities (though many other appropriate activities may exist):

1. **Assessment for the presence of one more substance use disorders**, including indicators that the medical marijuana may be helpful on one hand or harmful on the other, discussion of such findings with clients, and reporting of such findings to prescribers (with appropriate client consent).
2. **Exploration of the client’s perception of risks and benefits of medical marijuana.**
3. **Referral to appropriate and authoritative resources,**

such as the aforementioned NASEM report, the positions of professional associations’ reputable medical authorities (e.g., NIDA) on medical marijuana, and/or referral to a board-certified addiction medicine specialist (a physician with expertise in addictions) for a second opinion.

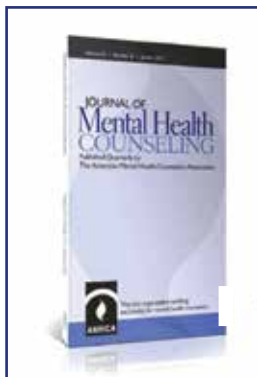
4. **Psychoeducation on evidence-based psychosocial interventions** that might serve as supplements or alternatives to medical marijuana in the treatment of various disorders.

For additional clarification of the decision process CMHCs may employ with clients who are using medical marijuana, refer to the decision matrix on page 14.

CMHCs May Play a Critical Role for Clients Considering Medical Marijuana

If you take one thing from this article, I hope it would be an appreciation of just how important your work can be in a health-care system that is increasingly focused on integrated care and how that role might apply in a medical marijuana scenario.

Generally speaking, CMHCs spend much more time with their clients than physicians do, and we have expertise in assessing for substance use disorders, helping our clients develop insight, and promoting an environment conducive to honest self-disclosure. Thus we are uniquely positioned to play an integral role in bridging the gap in a system with limited personal contact between physician and patient. To explore your role in this area further, refer to the box on page 16 about “Clinical Applications and Resources Related to Medical Marijuana.”



Take Advantage of Your Subscription to the *Journal of Mental Health Counseling*—FREE, With Your Membership in AMHCA

AMHCA members have free access to all electronic issues of the *Journal* and unlimited downloads.

Visit amhca.org/publications.jmhc

- for more information about the *Journal*,
- to access the *Journal* online; and
- to see *JMHC* guidelines for authors and learn more about submitting an article.