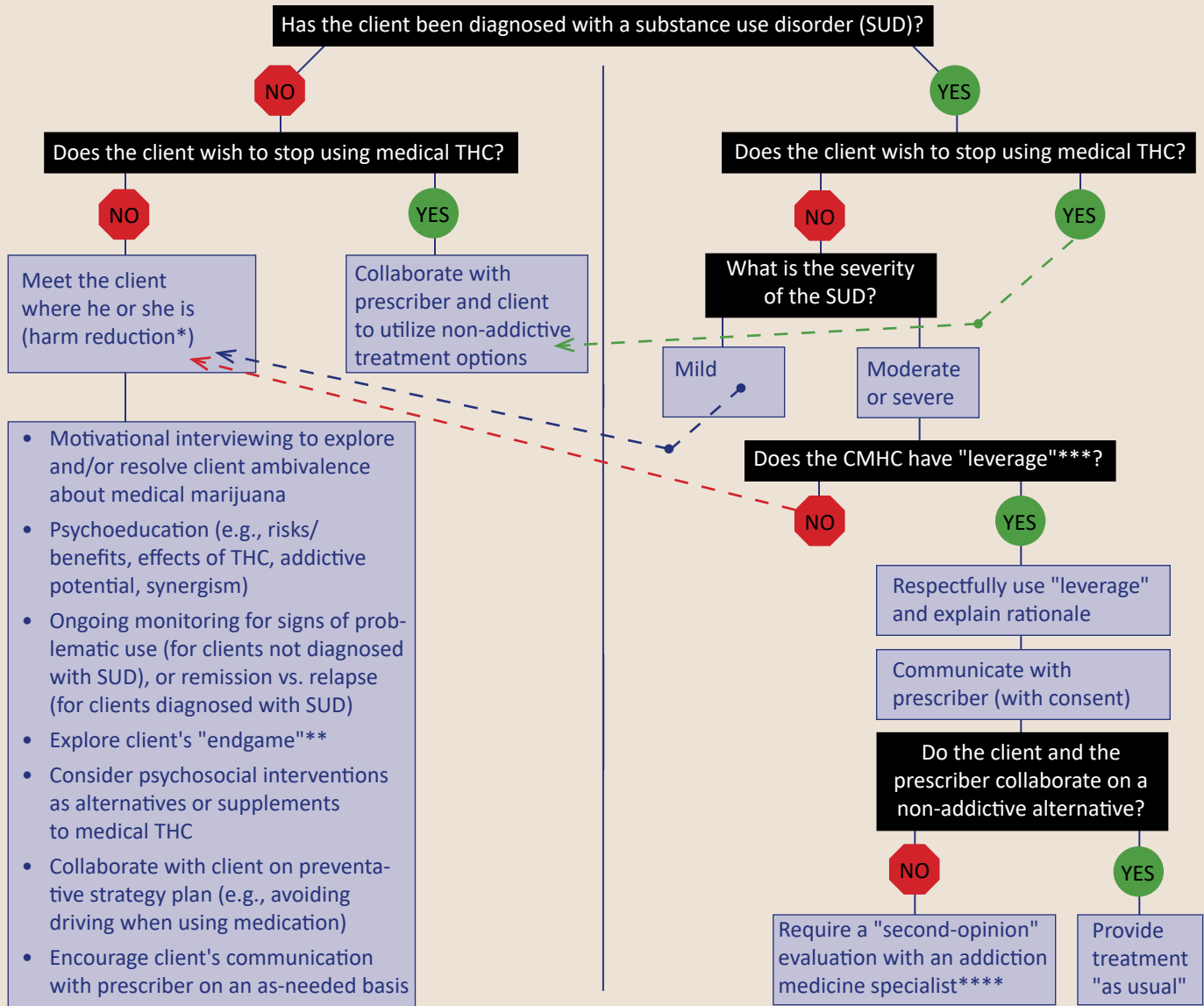


Emerging Clinical Issues

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)

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:**
 - a. If the SUD is mild, consider a harm-reduction approach and determine if the client reaches remission status using such strategies.
 - b. 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:
 - i. **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).
 - ii. **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.
 - iii. **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.
 - iv. **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).