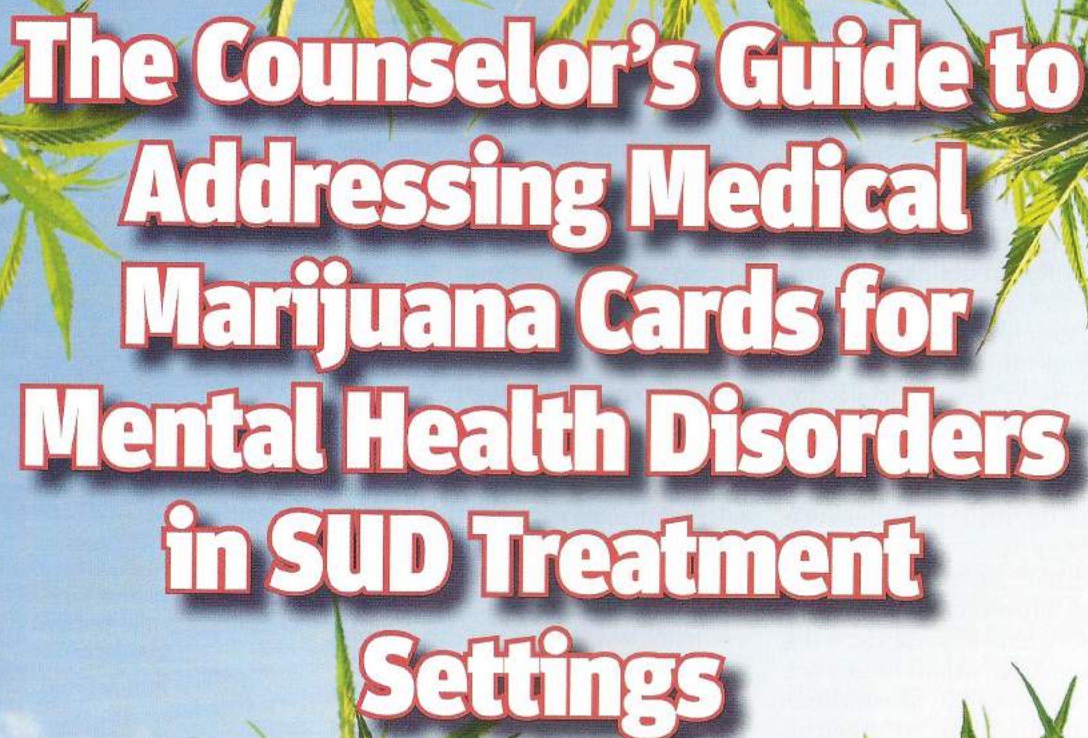
The Counselor's Guide to Addressing Medical Marijuana Cards for Mental Health Disorders in SUD Treatment Settings



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As of this writing, thirty-five states and the District of Columbia have legalized medical marijuana (hereafter referred to as "cannabis"), and an additional seven states have legalized cannabidiol (CBD) oil only (DISA Global Solutions, 2021). Possession of cannabis—medicinal or not—remains illegal under federal law (DEA, n.d.). Although medical cannabis sales were already increasing prior to the COVID-19 pandemic, they have soared in the past year, especially among individuals with mental disorders (Boehnke, McAfee, Ackerman, & Kruger, 2021; Erblat, 2020; Vidot et al., 2021).

Though cannabis can be used as medicine, it is also a potentially addictive substance. Approximately 4.8 million Americans aged twelve and older suffered with cannabis use disorder in 2019 (SAMHSA, 2020), and approximately 30 percent of Americans who used it in the last twelve months meet the diagnostic criteria for a cannabis use disorder (Hasin et al., 2015; NIDA, 2020b). Cannabis is the most commonly used illicit substance in the United States, and it is therefore not surprising that cannabis use disorder is more prevalent than all substance use disorders (SUDs) apart from alcohol and tobacco use disorders (SAMHSA, 2020).

A growing body of research suggests that most Americans who obtain medical cannabis cards are recreational users, heavy smokers, and/or individuals likely to have cannabis use disorders rather than individuals with a legitimate medical need for cannabis (Caputi & Humphreys, 2018; Cooke, Freisthler, & Mulholland, 2018; Pedersen, Tucker, Seelam, Rodriguez, D'Amico, 2019; Roy-Byrne, 2017). Anecdotally, we (the authors) and other substance use professionals we have conferred with have frequently encountered scenarios in which individuals with cannabis use disorders who present for mandated treatment and are told they will have to abstain from cannabis and other addictive substances to successfully complete treatment often say something like, "Then I'll just get a medical card so I can keep using."

On the other hand, it is clear that many medical cannabis users use cannabis for legitimate medical reasons, seeking much-needed relief, and such users have to contend with stigma about their medical use (Boehnke, Gangopadhyay, Clauw, & Haffajee, 2019; Satterlund, Lee, & Moore, 2015). Many counselors have been trained to treat SUDs, but few have been trained on the recognition of legitimate medical cannabis use. Many of us foster pejorative viewpoints about medical cannabis, our personal experiences and political or spiritual beliefs can impact our perspectives on this issue, and our ethical codes challenge us to avoid imposing our biases on our clients.

How then do we do our jobs well? How do we provide effective and quality substance use treatment while also ensuring clients have access to appropriate medical care? If we require clients to abstain from medical marijuana while in treatment, can we be accused of "practicing medicine without a license?"

In this article, we contend that counselors need more training on differentiating between problematic and medicinal use of cannabis as well as implementing a rational approach to addressing scenarios in which clients with cannabis use disorders present for treatment with medical cannabis cards. We encourage counselors to develop case conceptualizations when assessing clients, and we offer two examples of theoretical conceptualizations of addictive personalities. Finally, we introduce a decisional matrix that counselors can use to choose a course of action when clients present with medical cannabis cards.

A Psychodynamic Perspective: Signs of an Addictive Personality

To understand the components of the addictive personality, we must first determine whether there are similarities between those individuals' characteristics and characteristics of individuals without addictive personalities. For example, marijuana use may function as a means of rebelling against domineering parents, of defying a nagging spouse, or of refusing to conform with the standards of a social group that condemns marijuana use. When serious problems exist in teenagers' relationships with their parents, a vicious circle may develop in which the adolescents' misuse of marijuana increases their parents' hostility and criticism, and as a result the adolescents defy their parents even more strongly with heavier marijuana use.

Another example is evidenced when passive individuals use alcoholism to defy harsh, domineering spouses or between callous, hostile individuals and their passive spouses, the former of which rebels through abuse of a substance to defy others. Such substance misuse may be persistent or intermittent, and some of these individuals may exhibit periods of severe substance use for a length of time exceeding a year. These individuals are usually dependent, immature, and may unconsciously feel that they periodically mask their independence by defying their families with a substance use spree.

Can we thus suggest that those who misuse substances are cursed with an addictive personality disorder, or can we assume that substance misuse and addictive personalities are intertwined? We are certainly aware that people who become addicted to substances first become acquainted with the effect of the drug through the suggestion of acquaintances who are regular users or perhaps addicts. The people who become users subsequently become addicts, though not *all* those who experiment with substances do.

Perhaps individuals with personality disorders are most likely to become addicts. A sizable number of people who become addicted began to experiment with substances during their adolescent years. Can we therefore surmise that they must have begun their adolescent experimentation to become addicts and therefore have addictive personalities? Or can we surmise that once they become addicted to a substance they develop addictive personalities? Or can we merely assume that all it takes to develop addictive personalities is to become extremely

passionate about something and develop an obsession with or fixation on that subject, which could include substances? Simply said, an overindulgence in anything—video games, food, sex, or substances—evidences the pattern of an addictive personality.

In summary, we propose that, from a psychodynamic perspective, individuals with the following characteristics are more likely to develop cannabis use disorder:

- Obsessive traits
- Compulsive lying
- Excessive needs
- Manipulative
- Potential for criminal behaviors
- Difficulty learning from experience
- Interpersonal conflicts
- Excessive adventure or sensation seeking
- Ambivalence towards authority
- Emotional immaturity
- Low frustration tolerance

It must be noted, however, that many of these criteria overlap with personality characteristics of individuals who are high in sociopathy. A comparison of the lists of personality characteristics of individuals with alcoholism and those with sociopathy, such as that by Cleckley (1988), suggest more differences than similarities in the personality traits of the two groups.

A Biopsychosocial Perspective: How Nature and Nurture Cause Addiction

Of the approximately thirty thousand genes human beings possess, eighty-nine have been linked to a higher probability of developing a SUD (NIDA, 2008), yet no single gene has ever been discovered that guarantees individuals will develop a cannabis use disorder (or any other SUD, for that matter). Meanwhile, NIDA (2020a) identified several risk factors (i.e., aggressive behavior in childhood, lack of parental supervision, low peer-refusal skills, drug experimentation, availability of drugs at school, community poverty, parental substance use) and protective factors (i.e., self-efficacy, parental monitoring and support, positive relationships, good grades, school antidrug policies, neighborhood resources) that influence the development of SUDs.

In January 2017, the National Academies of Science, Engineering, and Medicine (NASEM) announced the publication of "a rigorous review of scientific research published since 1999 about what is known about the health impacts of cannabis and cannabis-derived products—such as marijuana and active chemical compounds known as cannabinoids" (2017a, p. 1). The oft-cited NASEM report identified substantial or moderate evidence for the following risk factors for developing a cannabis use disorder or problematic cannabis use:

- Being male
- Being male and smoking cigarettes
- Earlier age of initial cannabis use
- Greater frequency of cannabis use
- A diagnosis of major depressive disorder
- Use of drug combinations
- Oppositional behaviors during adolescence
- Younger age of initial alcohol use
- Nicotine use during adolescence
- Substance use by parents of adolescents
- Antisocial behaviors during adolescence
- Childhood sexual abuse
- History of psychiatric treatment
- Increased severity of posttraumatic stress disorder symptoms

The same report provided moderate evidence that attention deficit, anxiety, personality, alcohol use, tobacco use, and bipolar disorders are *not* risk factors for developing cannabis use disorder (NASEM, 2017a).

Based on the evidence of both biological and environmental risk factors correlating with a higher probability of developing one or more SUDs, NIDA (2020a) proposes a model in which individuals

1. start with a biological predisposition based on genetics, gender, and the presence of one or more mental disorders;
2. are exposed to environmental circumstances (e.g., chaotic home, childhood abuse, parental drug use and/or prodrug parental attitudes, prodrug peer influences and/or community attitudes, low academic achievement);
3. access addictive substances, which then
4. activate brain mechanisms, which then
5. result in addiction.

Avoid Recommending Medical Marijuana to Clients with Mental Disorders

Intended to represent a "consensus" among the scientific community, the aforementioned NASEM report outlined five "weight-of-evidence" categories: conclusive, substantial, moderate, limited, and no or insufficient evidence to support the association (NASEM, 2017a). NASEM concluded that, of the twenty conditions researched between 1999 and 2017, only one met the criteria for conclusive evidence, with an additional two meeting criteria for substantial evidence and one meeting the criteria for moderate evidence. Of the remaining sixteen conditions, five met criteria for limited evidence and eleven met criteria for no or insufficient evidence (NASEM, 2017b).

It is particularly notable that none of the conditions in the conclusive, substantial, and moderate categories were mental disorders, whereas there was substantial evidence of a relationship between cannabis use and the development of psychoses, and moderate evidence of a relationship between cannabis use and manic or hypomanic symptoms; increased risk for depressive disorders; increased evidence of suicidal ideation, suicide attempts, and suicide completions; and increased incidence of social anxiety disorder.

Although additional research on medical cannabis has been published since the NASEM report, we consider this report to be an effective reminder that there is a great deal more that we cannot yet say about medical cannabis compared to what we *can* say, and that cannabis use is associated with increases in mental health symptoms for some users.

Counselors should also be aware of what the major medical associations have concluded about medical cannabis.

The American Medical Association (AMA)

The AMA resolved that cannabis "is a dangerous drug and as such is a public

health concern" (2017, p. 2). However, like all of the associations we mention in this article, they encouraged additional research on medical cannabis and prefer that cannabis use be treated as a public health concern rather than criminalized.

The American Academy of Pediatrics (AAP)

The AAP concluded that, "Given the data supporting the negative health and brain development effects of marijuana in children and adolescents, ages zero through twenty-one years, the AAP is opposed to marijuana use in this population" (Ammerman, Ryan, & Adelman, 2015, p. 586).

The American Psychiatric Association (APA)

The APA declared, "There is no current scientific evidence that cannabis is in any way beneficial for the treatment of any psychiatric disorder. In contrast, current evidence supports, at minimum, a strong association of cannabis use with the onset of psychiatric disorders," and that "Adolescents are particularly vulnerable to harm, given the effects of cannabis on neurological development . . . The APA does not endorse cannabis as medicine" (2018, p. 1–2).

The APA also published a practice guideline that reads, "Whenever possible, medications with low abuse potential and relative safety in overdose should be selected for the treatment of patients with a co-occurring SUD" (Kleber et al., 2010, pp. 36). This would imply a position that medical THC be avoided if possible when clients have one or more SUDs.

The American Society of Addiction Medicine (ASAM)

ASAM "supports the use of cannabinoids and cannabis for medicinal purposes only when governed by appropriate safety and monitoring regulations, such as those established by the FDA research and postmarketing surveillance processes," adding that clinicians should educate patients about the known medical risks of marijuana and "counsel persons suffering from addiction about the need for abstinence from marijuana and synthetic cannabinoids and the role of cannabis and cannabinoid use in precipitating relapse" (2015, p. 7).

Given the relative lack of evidence that medical cannabis is efficacious for mental disorders, the evidence that cannabis can exacerbate symptoms for some clients with mental disorders, the lack of support among medical associations for the prescription of medical cannabis for mental disorders, and the fact that the prescription of medications is beyond the scope of practice of most licensed counselors, social workers, and licensed psychologists (in most states), we propose that counselors should avoid recommending medical cannabis for their clients with mental disorders.

For similar reasons, attorney Anne Marie "Nancy" Wheeler, in an article published in the American Counseling Association's *Counseling Today* magazine, wrote,

> *If you recommend or endorse use of marijuana by clients who have been diagnosed with such conditions, this could be viewed as being below the standard of care for licensed professional counselors and could expose you to civil liability, a licensure board investigation, and possible sanctions* (2018, p. 16).

The Counselor's Decision Matrix for Addressing Clients with Medical Cannabis Cards

Norton (2019) created a decision-making matrix designed to help counselors when making decisions on how to address clients presenting for substance use or mental health treatment with medical cannabis cards. The matrix was first published in *The Advocate Magazine*, the official magazine of the American Mental Health Counselors Association (AMHCA), in 2019. An electronic version of the decision matrix can be accessed online at https://www.surveymonkey.com/r/MedicalMarijuanaDecisionMatrix and can be completed by counselors for their own cases at no cost and without entering any protected health information. Because CBD is not psychoactive, does not produce euphoria or a "high," and is not considered a public health risk according to the World Health Organization (WHO, 2018), the matrix is concerned with medical THC and not medical CBD.

First, counselors should determine whether clients meet the diagnostic criteria for cannabis use disorder and/or any other SUD, and if so, the severity of the disorders (e.g., mild, moderate, or severe). Because clients often underreport substance-related problems, and because ethical codes (AMHCA, 2020) and literature in both clinical and forensic evaluation (Ackerman, 2010) concur, we recommend that counselors use multiple sources of data whenever possible, including thorough clinical interviews; administration and interpretation of substance-related tests (e.g., the substance abuse subtle screening inventory-4, urinalysis drug screen); collateral interviews (e.g., interviews with spouses, family members, previous therapists); and records reviews (e.g., records from primary care physicians, previous treatments, arrests).

Second, determine whether clients *want* to stop using medical THC. If they do want to stop, refer the clients to their prescribers to consult about alternative options for addressing the medical conditions for which medical THC is being prescribed and/or for assistance with tapering off of or discontinuing medical cannabis. If needed, consider referring clients to other medical specialists who can help them identify alternative treatment options. Consider incorporating any recommended alternative treatments into clients' treatment plans, if appropriate, and then provide treatment as usual.

If clients do not wish to stop using medical THC, then the question of whether the clients have one or more addictive disorders is important. If they do not have an addictive disorder, then counselors may offer the option of helping these clients develop psychosocial skills for addressing the conditions that are being treated with medical THC. Further, counselors may monitor for signs that clients' medical THC use is problematic, but otherwise, we recommend the "If it isn't broken, don't fix it" approach.

If, however, clients have a SUD, then we recommend different approaches based on the severity of the SUD. If the disorder is mild, counselors may wish to use a harm-reduction approach. "Harm reduction" refers to a treatment and prevention approach focused on decreasing health and socioeconomic costs and consequences of substance-related problems. Examples of harm-reduction strategies are listed in Table 1.

Table 1. Harm-Reduction Strategies for Counselors

- Use motivational interviewing to help clients explore and/or resolve ambivalence about medical marijuana
- Provide psycho-education on risks and benefits of medical marijuana, the effects of THC, the addictive potential of THC, and synergism
- Provide ongoing monitoring for signs that clients' medical marijuana use is becoming problematic (if clients have no diagnosed SUD) and/or that clients are relapsing with symptoms of a SUD versus being in remission (for clients with a diagnosed SUD)
    - For example, is there evidence that clients are overmedicated? Do they appear to be "high," and is this noticeable to others? If so, how does it affect clients vocationally, socially, etc.? Are clients under the influence when driving or engaging in other potentially unsafe behaviors while under the influence of THC? Do clients appear to have impaired motor functioning or to be struggling with short-term memory, motivation, energy level, or physical activity? Do clients appear to be experiencing signs of possible respiratory problems? Are clients being assessed and/or monitored by the appropriate medical professionals? Are clients combining medical THC with other potentially addictive substances? Are clients' THC use cost prohibitive and creating or contributing to significant financial stress?
- Explore, with clients, what their "endgame" is, meaning the long-term (versus short-term) strategies and approaches clients will use for their presenting problems
    - For example, because addictive medications used daily over long periods of time tend to produce tolerance, what will clients do if (or when) the medical THC becomes less therapeutically effective? Do clients want to take medical THC for the rest of their lives? If not, what long-term goals could be pursued to help clients eventually decrease or stop medical THC use (under appropriate medical supervision)?
- Coach clients on psychosocial alternatives or supplements to medical THC
    - For example, what other strategies can clients being prescribed medical THC for chronic pain use to manage their pain? What other coping strategies are available for clients being prescribed medical THC for anxiety, PTSD, or insomnia? If counselors are competent to provide these psychosocial interventions, then they may do so consistent with client informed consent. Otherwise counselors may wish to refer out to other specialists as needed.
- Recommend that clients consult with their physicians/medical teams about other biomedical strategies to treat the same conditions being treated with medical THC
- Refer to biomedical specialists and physicians as needed if consistent with clients' informed choice
- Collaborate with clients on developing preventative strategy plans
    - For example, how to avoid driving when under the influence of medical THC
- Encourage clients to communicate with their prescribers about any concerns related to their medical THC (i.e., encourage clients to be informed patients)
- Speak with—and obtain informed consent from—clients about open communication between counselors and prescribers on an as-needed basis

If clients' SUDs are moderate or severe rather than mild, then a more intensive approach is likely warranted. The probability of achieving and maintaining remission status long-term is lower among clients with more severe symptom presentations, and the potential for cross-addiction is higher. Counselors should determine whether clients have "leverage," which we define as resources or outcomes pursued by clients that may be conditional to successful treatment completion. Clients with leverage would include, for example, clients who are court-ordered into treatment, or trying to get a driver's license reinstated after a substance-related driving offense, or attempting to maintain an employment position after a drug-free workplace violation. If clients have no leverage, then we recommend counselors meet these clients where they are, adopting the harm-reduction approach previously described. If *counselors* have leverage themselves, we recommend they consider respectfully using that leverage and explaining the rationale for why.

A Case Example

Consider an example in which a client was referred to a counselor because of a marijuana-related legal charge for driving under the influence (DUI). The counselor may explain to the client that the counselor has been tasked with providing treatment for the client's cannabis use disorder and that a successful treatment completion with a positive prognosis would be construed as a determination that the client no longer poses a risk to the driving public. The counselor may explain that obtaining a medical cannabis card so the client's cannabis use or possession is legal does not suitably address the clinical issue of the cannabis use disorder, nor the safety and well-being of the client and the driving public, just as a client with a benzodiazepine- or opioid-related DUI charge cannot simply obtain a prescription and expect successful treatment completion.

The counselor may further explain to the client the need to communicate with the client's prescribing physician about the client's presence in treatment, the circumstances leading up to the treatment requirement (i.e., the marijuana-related DUI charge), the client's diagnosis (including specific DSM-5 signs and symptoms of one or more SUDs), and the goal of treatment. If the client consents in writing, a letter can be mailed to the prescribing physician informing the physician of the client's presence in treatment, the nature and purpose of the treatment, the reason for referral (including circumstances leading to treatment requirement), the diagnosis of the client, specific symptoms met from the DSM-5,

treatment requirements, and other relevant information, including the counselor's opinion on whether the client's use of medical cannabis appears problematic from a substance abuse treatment perspective rather than a biomedical perspective.

The following is an example of phrasing that can be considered:

Although I am not a physician and am not qualified to advise the patient on medication regimen, from a substance abuse treatment perspective it is my impression that the client's THC use has created clinically significant impairment or distress as evident by the aforementioned DSM-5 symptoms of a substance use disorder. I discussed with the patient my concern that this medication may exacerbate the addictive disorder and potentially trigger relapse. I would therefore recommend adherence to the American Psychiatric Association's Practice Guideline for the Treatment of Patients with Substance Use Disorders, which indicates, "Whenever possible, medications with low abuse potential and relative safety in overdose should be selected for the treatment of patients with a co-occurring substance use disorder" (Kleber et al., 2010).

Depending on the counselor's comfort level, adding information about ASAM's recommendations when physicians are prescribing medical THC may be warranted, which would look something like the following:

Additionally, I have informed the patient of the following clinical recommendations offered by the American Society of Addiction Medicine, and I have advised the patient to consult with you regarding alternative medication options with low or no abuse potential:

(1) ASAM recommends that addiction medicine physicians and other clinicians educate their patients about the known medical risks of marijuana use, including the use of and accidental exposure to edible products, and the risks of use of synthetic cannabinoid receptor agonists; and

(2) ASAM supports the consensus of most addiction professionals that clinicians should counsel persons suffering from addiction about the need for abstinence from marijuana and synthetic cannabinoids and the role of cannabis and cannabinoid use in precipitating relapse, even if the original drug involved in their addiction is a substance other than marijuana.

The counselor may also inform the prescriber that the client has been referred to the prescriber for consultation on whether there are viable alternatives to medical THC that are clinically appropriate. The counselor may add something like the following:

As a preventive measure, psychoeducation on prescription abuse, synergism, cross addiction, and psychosocial interventions for [insert issues the medication seeks to remedy] will be incorporated into the patient's treatment plan. The patient will be participating in regular urinalysis drug testing. Please provide us with confirmation of any current prescriptions from your office. Your assistance is greatly appreciated.

In writing such a letter, the counselor is practicing due diligence by ensuring that the prescriber now knows what the counselor knows, shifting responsibility to the prescriber to determine an appropriate course of action from a medical viewpoint. However, the counselor is not taking on the role of the prescriber by determining whether it is ultimately viable for the client to use an alternative medication. Moreover, the counselor is quoting the published positions of medical authorities rather than relying on the counselor's own perspective.

If the client refuses to sign a release of information permitting communication between the counselor and prescriber, then the counselor will have to make a decision on whether to work with the client under such conditions. We caution against successfully completing a client from mandated treatment if there is not sufficient evidence that the client is in remission from a SUD and therefore has a positive prognosis. This may not be feasible if the client is still using an addictive medication.

After sending the letter to the prescriber, the counselor's next step will vary depending on whether the prescriber works with the client to use an alternative approach to medical THC. If the prescriber replaces medical THC with an alternative, the counselor can consider incorporating the nonaddictive treatment approach into the client's treatment plan, continue to consult with the prescriber as needed, and provide treatment as usual.

If the prescriber does not revert to a nonaddictive medication option, the counselor may consider referring the client to another physician/prescriber with specialization in both biomedical conditions and addiction, such as a board-certified addiction medicine specialist as recognized by ASAM. Addiction medicine specialists are medical doctors who have both the biomedical and medication expertise counselors lack as well as specialized training in addictive disorders. If the client agrees to see the addiction medicine specialist, obtain a written release of information and provide thorough referral information so the specialist has access to the same information as the counselor when making a determination and recommendation.

If the addiction medicine specialist recommends a nonaddictive and viable treatment alternative, then incorporate the addiction medicine specialist's recommendations into the client's treatment plan and continue to consult with the specialist as needed. If the addiction medicine specialist does not recommend an alternative to medical THC, we generally recommend that the counselor accept the specialist's opinion and utilize a harm-reduction approach for treatment. However, this does not mean the client will successfully complete mandated treatment, particularly if remission status is not reached (i.e., there is no evidence of any of the eleven symptoms of a SUD other than craving for a minimum of three months) and/or the prognosis is not favorable.

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If the client declines to see the addiction medicine specialist, the counselor will have to make a determination on whether to continue working with the client in a mandated treatment situation or whether the referral should be considered a requirement of successful treatment compliance. As previously stated, we would caution against completing a client successfully from mandated treatment if the client is not in remission from the SUD and/or the prognosis is not favorable. We would generally recommend discharging a client with a moderate or severe substance use disorder unsuccessfully from mandated treatment if the client will not discontinue addictive medication (with appropriate physician oversight) and will not agree to a consultation with an addiction medicine specialist. However, if the counselor chooses to continue working with the client, then the counselor might consider a harm-reduction approach.

Conclusion

As medical cannabis in the US continues to expand—both in terms of legality and popularity—counselors are increasingly confronted with scenarios in which they are tasked with providing substance use treatment for clients with co-occurring mental and biomedical conditions. It is our hope that as our understanding of medical cannabis continues to evolve, counselors will increasingly feel equipped to manage medical cannabis presentations in substance use and mental health treatment settings.

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