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Ohio Mental Health Professionals' Attitudes, Knowledge, and Experience Regarding Medical Marijuana

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Increasing positives attitudes toward medical marijuana (MM) is evident by the number of states who have authorized MM and in national surveys. Based on 177 participants responding to an anonymous electronic survey, the study found that Ohio licensed counselors and social workers hold generally positive views about MM regardless of one's license or supervisory status. Participants' attitude toward national legal adult use and opinion regarding recreational use significantly predicted participants attitude toward national legalization of MM, but age, having a chemical dependency license, and personal use of MM did not add to the prediction model. In addition, most reported having clients who use marijuana and directly asked about MM, yet nearly all had clients they believed should not use MM and would be reluctant to refer if a history of substance abuse was present. Additional concerns about MM were expressed by participants, and the training needs for practice and future directions for research are discussed.

Keywords: medical marijuana, mental health professionals, attitudes, clinical practice

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As marijuana is by far the most used illicit substance, with an estimated over 40 million Americans reporting use during their lifetime, and over 3.5 million people meeting the criteria for a cannabis use disorder in 2017 (Center for Behavioral Health Statistics and Quality, 2017), the use of medical marijuana (MM) for the treatment of mental disorders is complicated. In addition, attitudes toward MM are reported as generally positive across the United States (Quinnipiac University, 2016; 2018). In 1996 the citizens of California passed Proposition 215, which codified the use of MM (Compassionate Use Act, 1996), making it the first state to do so. Twenty years later, Ohio House Bill 523 was signed by the Governor, authorizing the use of MM via the Ohio Medical Marijuana Control Program, which is operated by the State of Ohio Board of Pharmacy, State Medical Board of Ohio, and the Ohio Department of Commerce (Ohio Medical Marijuana Control Board [OMMCB], n.d.). The November 2020 elections resulted in additional states approving MM and non-medical adult use, bringing the number of states, which includes the District of Columbia, to do so to 36 and 17, respectively. However, the stipulations and possession limits, as well as the allowed route of administration, vary from state to state (National Conference of State Legislatures, 2021). The remaining states except Idaho, Kansas, and Nebraska allow for cannabidiol (CBD) products that have no or low amounts of tetrahydrocannabinol (THC), the active ingredient in marijuana (National Conference of State Legislatures, 2021). As of May 2021, nearly 198,000 Ohio citizens were registered to use MM, and there were over 158,000 individuals who had acquired MM through the dispensary system since the program became operational (OMMCB, 2021).

The potential for counselors and other mental health practitioners to encounter clients who currently use, will be using, or have questions about the use of marijuana for the purpose of treating their mental health symptoms, is and will continue to increase. Therefore, counseling professionals are interfacing with the process, such as navigating through conflicting policies and state and federal laws as well as educating clients about potential benefits and risks of use. Counselors need to understand the process to obtain MM and discern when and whom to refer for an assessment. Also, it is vital for a clinician to possess knowledge about MM research, have a clear understanding of how to do an assessment of substance use disorders, and know the criteria for cannabis use disorder.

Acquiring a MM Card and Ohio Law

According to the Medical Marijuana Control Program (MMCP, 2020), for a client to be eligible to purchase MM in Ohio, they must meet the criteria of a qualifying diagnosis and be recommended by a qualifying physician (i.e., those who have obtained a Certificate to Recommend MM though the State of Ohio Medical Board). In terms of mental health diagnoses, these conditions include posttraumatic stress disorder, Alzheimer's disorder, Tourette's syndrome, and pain that is chronic or severe and is intractable (MMCP, 2020). There are several other mental health diagnoses that have been considered by the OMMCB, including anxiety disorders and autism spectrum disorder, but those petitions to have them added to the list of qualifying diagnosis were not approved (State Medical Board of Ohio, 2020). According to the OMMCB (n.d.) website, the first step to acquire MM in Ohio is to make an appointment with a recommending physician who will provide an in-person assessment and register them, making a recommendation to OMMCB that allows for the acquisition of a MM card and the ability to purchase MM from a dispensary. A list of physicians who have a Certificate to Recommend is provided on the OMMCB website. Counselors are eligible to write a letter confirming the mental health diagnosis; the letter is needed to provide documentation to the recommending physician. Once clients activate their cards online, they are eligible to purchase MM in Ohio. No prescriptions for MM are given at the initial appointment. The MM card is valid for one year and must be renewed via the recommendation of the referring physician or some other MM certified physician. To our knowledge these services are not covered by insurance, and the cost and appointment length will vary by physician. Dispensaries will only take cash and give, at maximum, a 90-day supply (MMCP, 2020). A client can designate a caregiver to purchase MM on their behalf, but that person must register with the OMMCB.

MM card holders in Ohio are not permitted to smoke marijuana unless using a vaporizer to do so (MMCP, 2020). If card holder is caught with any other smoking devises (e.g., joint or pipe), they can be prosecuted (MMCP, 2020). Crossing state lines with marijuana can have legal implications from a federal point of view (MMCP, 2020). However, registered MM patients have medical confidentiality, and their caregivers are protected from arrest, prosecution, and discrimination in child custody matters (MMCP,

2020). Without a MM card in Ohio, possession is considered a minor misdemeanor; up to 100 grams of marijuana, carries a fine of up to $150 (Possession of Controlled Substances, 2019). Having up to 200 grams with no MM card is a 4th degree misdemeanor, can carry a fine of up to $250, and mat result in up to 30 days of imprisonment (Possession of Controlled Substances, 2019).

Effectiveness and Negative Impacts of MM

At the federal level, medical or recreational cannabis is an illegal Schedule I controlled substance, on par with heroin, LSD, and street fentanyl (United States Drug Enforcement Administration, 2020), although changing this designation has been a political discussion. Research on marijuana is negatively affected by regulatory barriers, funding limitations, and supply issues (National Academies of Sciences, Engineering, and Medicine, 2017). There are, however, some who have adopted clever methods to study high-grade marijuana found at many marijuana dispensaries by using mobile laboratories (e.g., Center for Health and Neuroscience, Genes, and Environment, n.d.)

Disorders Showing Beneficial Effects

Overall, systematic reviews of pharmaceutical THC with or without CBD for the treatment of mental disorders have found a low level of evidence that supports efficacy (i.e., Black et al., 2019; Hoch et al., 2018); however, for some disorders the evidence is more supportive. Persons with PTSD often use cannabis to cope with their symptomatology, and sleep improvement appears to be primary motivator (Bonn-Miller et al., 2014). Indeed, Metrik et al., (2018) found that veterans with PTSD who use medical cannabis report improved sleep and improvement in overall physical health. According to Cuttler et al. (2017), the response seems to be related to cannabis assisting in reducing the stress response as measured by: reduced stress rating scale scores, lowered blood cortisol levels, improved behavioral and emotional responses to stressors, and positive changes in autonomic response to stressors. They also reported disparities in the optimal dose, and those patients who use too low or too high of doses can see a loss in benefits or experience adverse effects. Moreover, there can also be significant interactions between psychotropic medications and MM, which is why MM use needs to be monitored by psychiatrists and

recommending physicians. Also, inhaled versus oral use can make a difference in response (Cuttler et al., 2017).

Although mental health providers may not directly treat chronic pain, they are often involved with clients who experience chronic pain as they frequently have other mental health symptoms (Feingold et al., 2017). Marijuana is commonly used for pain management; more than 600,000 Americans turn to cannabis for relief (O'Connell et al., 2019). There is substantial evidence of its efficacy in pain management. For example, in a randomized clinical trial of people who had pain, there was a reported 40% reduction of pain with use of marijuana (O'Connell et al., 2019). The National Academies of Sciences, Engineering, and Medicine (2017) concluded that there is substantial evidence that cannabis is an effective treatment for chronic pain in adults.

Pain management with MM has implications for the reduction of opioid use as several studies show people who were using opioids to manage their pain were able to reduce or discontinue opioid use when using marijuana (e.g., Corroon et al., 2017; Lucas & Walsh, 2017). Also, levels of depression and anxiety are higher among chronic pain patients receiving prescription opioids compared to those receiving MM (Feingold et al., 2017). Although using marijuana for opioid withdrawal is not approved in Ohio, it was under consideration to be a qualifying condition (Bergeria et al., 2020). Similarly, there is some evidence that suggests that CBD rich but not completely THC-free cannabis can benefit children with Autism Spectrum Disorders (Aran et al., 2019), but the OMMCB review did identify it as a qualifying condition. In general, there are very few to no clinical studies with data on pharmaceutical CBD to treat mental disorders, and additional research is needed to provide any conclusive evidence that would justify the qualifying disorders in Ohio.

Negative Impacts of Marijuana

Gorey et al.'s (2019) and Sledzinski et al.'s (2019) reviews, among others, document the many direct negative impacts THC may cause, including prenatal and adolescent brain maldevelopment and impaired adult brain function and structure, as well as secondary impacts (e.g., driving automobiles, educational outcomes). Indeed, marijuana does impair cognitive skills used for driving, and all states have driving under the influence

of drugs laws that include marijuana intoxication. There is also some strong concern about the use of E-cigarettes or vaping products being associated lung injury (Centers for Disease Control and Prevention, 2019). The use of vaping marijuana more than doubled in the past two years among teens (National Institutes of Health, 2019). In addition, marijuana may increase the likelihood of developing psychotic symptoms (e.g., Aran et al, 2019; Sledzinski et al, 2019).

There are a host of secondary effects of marijuana use too. Hasin (2018) concluded those primarily consist of increased cannabis use and cannabis use disorder, high potency marijuana, and unintentional child exposure. Another adverse secondary effect is the development of amotivation syndrome, which includes periods of prolonged apathy, lack of interest, passivity, and problems with communication (Meier & White, 2018) and predicts lower self-efficacy (Lac & Luk, 2018). It is not clear whether cannabis use causes amotivation syndrome or if people who show great levels of amotivation tend to become cannabis users. Reflecting many of these concerns, the American Academy of Addiction Psychiatry (2019) proposed model state laws that included: a ban on recreational use of cannabis until age 21, to not denote psychiatric indications such as PTSD, anxiety and depression as qualifying conditions, educate public about potential harms of cannabis, provide state level regulation that includes funding of high-grade analytical equipment to test cannabis, and maintain public registry that reports annually on adverse outcomes. The tracking of adverse outcomes is particularly critical for the benefits of marijuana use can be accurately evaluated.

Knowledge and Attitudes of Professionals Regarding MM

As counselors will be dealing with clients who not only are using MM but may be interested in the clinician’s opinion of this treatment, it is important that we have adequate knowledge of both the benefits and negative impacts as well as the ability to identify misuse. Moreover, it is also important to follow the *American Counseling Association* (2014) ethical code. For example, Standard A.4.b, Personal Values, addresses not letting our beliefs interfere with a client’s decisions regarding treatment. Being aware of one’s attitudes is crucial so that they can be bracketed appropriately. Section C, Professional Responsibility, of the *Code of Ethics* is relevant too as it stipulates counselors should

practice within their boundaries of competence (Standard C.2.a) and monitor effectiveness (Standard C.2.d). To accomplish that with the growing number of cannabis-related issues that confront clinical practice, it suggests counselors must become knowledgeable about MM in Ohio, which at a minimum would include familiarity with the process and the ability to direct clients to the appropriate resource, specifically the OMMCB webpage.

Most research on attitudes toward MM have focused on medically focused fields. Despite support among the general population, physicians are more reserved regarding the use of MM (e.g., Charuvastra et al., 2005; Kondrad & Reid, 2013) as are other health care-related professionals (e.g., Lusk & Paul, 2017; Moeller & Woods). In a small sample of Ohio physicians sampled in Summer 2018, Lombardi et al. (2020) found most did not hold positive attitudes toward MM as only 12% of their respondents had acquired or planned to acquire their Certificate to Recommend MM.

Very few studies have explored attitudes and knowledge of counselors regarding the use of MM marijuana in the treatment of mental health disorders. The only specific study we identified was conducted by Wildberger et al. (2019), who surveyed a national sample of substance use clinicians and found that participants held mixed views toward MM. For example, 73% supported legalization of marijuana for medical purposes, yet 63% believed that MM marijuana is often abused. Overall, there is a lack of research regarding mental health counselor's knowledge and attitudes.

Purpose of Study

This study attempts to bridge that gap in information about mental health practitioners in attitudes, knowledge, and experiences regarding MM by focusing on Ohio practitioners. There is little research regarding professionals' attitudes toward MM; we were not able to find any research that specifically surveyed mental health professionals in Ohio. Understanding counselors' attitudes and knowledge about the process, as well as understanding what information they need to know, is a good first step in guiding counselors in the complexities of this process.

Procedure and Methodology

We developed an anonymous 26-item Qualtrics survey for mental health professionals in Ohio, where MM is legal but adult (i.e., recreational) marijuana use is not.

The questions on the survey included demographic information, questions regarding client marijuana use as well as personal views regarding marijuana, and experience with MM, personally and professionally. The questionnaire and procedures were approved by the John Carroll University Office of Institutional Review. A survey link was emailed to licensed counselors and other mental health providers in Ohio, which encouraged snowball sampling (i.e., respondent referral of others to participate). Internet provider addresses and other identifying data were not collected to ensure anonymity. Among the 204 people who accessed the questionnaire, 190 supplied answers, but 8 individuals left many questions blank and thus were removed from the sample. Moreover, to maintain sample homogeneity, among those who answered most questions, 3 were removed as they did not report a mental health license, and 2 respondents held only a psychology license. *SPSS Version 26* was used for data analyses, and despite substantial differences in the likelihood of the null hypothesis for the various analyses, a probability of .050 or less was used as the level of significance.

Participants used for data analyses (n = 177) predominately identified as female (86%) and White, non-Hispanic (86%) or African American (10%) with an average age of 42 (range 23 – 75, SD = 13). Almost 14% of the sample reported using MM. Among participants who identified as a counselor (80% of the sample, n = 141), 19% reported holding a Licensed Professional Counselor (PC), license, 25% a Licensed Professional Clinical Counselor (PCC) license, and 36% a PPC with a supervision credential (PCC-S). The remaining participants (n = 36) reported being social workers; 1% reported being a Licensed Social Worker (LSW), 7% reporting having a Licensed Independent Social Worker (LISW) credential, and 12% indicated they held an LISW with a supervision designation (LISW-S). Among the counselors and social workers, 14 % (n=21) and 25% (n=9), respectively, also had a chemical dependency license (17.5% of sample). Amongst the sample with CD licenses, 2 participants were Licensed Chemical Dependency Counselors (LCDC), 10% were Licensed Independent Chemical Dependency Counselors (LICDC), and 6% maintained a LICDC Clinical Supervisor license (LICDC-CS). Respondents primarily were employed at an agency (45%), private practice (30%), or educational setting (16%).

Results

Most participants strongly agreed (45%) or agreed (37%) that "medical marijuana should be legal in every state," with 4% and 3% disagreeing or strongly disagreeing, respectively. However, significantly fewer strongly agreed (16%) or agreed (30%) that "recreational marijuana should be legal in every state" whereas 13% disagreed and 15% strongly disagreed with the statement. Given expected cell restrictions for chi square, an overall chi square was not interpretable, but the proportion of those strongly agreeing compared to other groups differed significantly (χ^2=36.93, df =1, $p < .05$) as did the proportion of those disagreeing and strongly disagreeing compared to the other respondents (χ^2=26.23, df =1, $p < .05$). Despite the difference, as indicated in Table 1, these items were significantly correlated (.59) yet differentially associated with more positive views of recreational marijuana, personal use of MM, and self-reported age. More specifically, the 5-point Likert ratings on one's "personal opinion of recreational marijuana use" (strongly disapprove to strongly approve) and personal use of MM (i.e., yes or no) were correlated significantly with attitudes toward national legalization of MM.

Table 1

Descriptive Statistics and correlations of selected study variables

Variable	M	SD	1	2	3	4	5
1. MM legalization	4.19	.97	---				
2. AU legalization	3.22	1.27	.59*	---			
3. Opinion of AU	3.01	1.22	.59*	.79*	---		
4. MM use	.14	.34	.25*	.41*	.36*	---	
5. Age	41.67	13.22	-.06	-.20*	-.24*	-.13	---
6. CD license	.18	.38	-.08	-.16*	-.15	-.05	.20*

Note: n = 177. * $p < .05$

Similarly, national legalization of adult use (i.e., recreational marijuana) significantly correlated with one's personal approval of recreational marijuana and with personal use of MM. However, views of recreational use were significantly correlated with age while views of MM were not (r = -.06). Being a counselor (no/yes) or social worker (no/yes), the type of counseling license (PC, PCC, PCC-S), the type of social worker license (LSW, LISW, and LISW-S), and supervision license status (no/yes) were not associated significantly with views of national medical or legal adults use; however, having a chemical dependency license (no/yes) significantly correlated with views of recreational use but not medical use. Given the intercorrelation of these variables, we used simultaneous regression to examine the unique association of personal views of marijuana, attitude toward recreational legalization, personal MM use, age, and having a CD license with one's attitude toward MM use, which was significant ($F[5,169] = 22.11$, $R^2 = .40$). As indicated in Table 2, the regression weights show only one's attitude toward state legalization and opinion about recreational marijuana use were significant. When these 2 variables were alternatively entered using hierarchical regression model, both still made a significant

Table 2

Simultaneous regression results for national MM legalization

Variable	B	SE	β	t	p	95% CI
Constant	2.27	.28				
AU legalization	.26	.08	.35	3.43	.001	[.11, .42]
Opinion of AU	.27	.08	.34	3.42	.001	[.11, .42]
MM use	-.02	.19	-.01	-.11	.913	[-.39, .35]
Age	.01	.01	.08	1.32	.189	[-.00, .02]
CD license	.04	.16	.02	.27	.790	[-.27, .35]

Note. n = 177. AU = adult (recreational) use

addition to the model ($R^2 = .39$), accounting for nearly all of the variance explained in the 5-variable model.

Despite these generally favorable beliefs toward marijuana use, 96% answered yes to "do you think there are clients that are not good candidates for medical marijuana?" The most frequently endorsed reasons for this were history of substance abuse (62%), potential for substance abuse (53%), concerns about client drug seeking (41%), concern for being outside of one's scope of practice (23%), and confusion about state and federal laws (16%). The primary theme among the 12% who wrote something for the "other" response focused on negative side effects (e.g., psychosis, anxiety). Consistent with this, the question, "would you refer a client with a history of substance use disorder for a medical marijuana evaluation" was answered no by 30% of the respondents and most (54%) indicated they were not sure. This elevated concern about misuse among people with substance abuse issues is reflected in the different 5-point Likert rating responses (strongly disagree to strongly agree) to "marijuana may be a good substitute for pain control" and "think medical marijuana would be a good option in helping clients stop misusing opiates." More specifically, 56% agreed and 22% strongly agreed marijuana can manage pain, while 35% agreed and 11% strongly agreed that marijuana may assist with opiate misuse. There were no statistically significant professional differences in these attitudes.

Among the respondents 40% reported yes to "do any of your clients use medicinal marijuana for the treatment of mental health disorders," but 84% indicated yes to "have any of your clients used recreational marijuana for treatment of mental health disorders," which represents a significant difference. Moreover, 63% endorsed yes to "have you had clients present with questions/concerns about the use of medical marijuana?" but only 8% reported referring "a client to a recommending physician to get a medical marijuana card." Not surprising given most respondents reported being not at familiar (58%) or somewhat familiar (24%) regarding "the process of referring clients for assessment for MM," with only 4% who reported being very familiar and 13% who indicated they were familiar. Given this, 44% reported being very interested and 33% reported being interested in "more education on the use of medical marijuana for the treatment of mental health disorders."

Discussion

Most counselors and social workers licensed though the Ohio Counselor, Social Worker, and Marriage and Family Therapist Board agreed MM should be available to people who find it beneficial. This is consistent with opinions assessed as the national level among non-professionals as well as health professionals from different states. Participants' attitudes toward MM was predicted by beliefs about legalized adult use and personal opinion about recreational use of marijuana. Essentially, if one has positive views around the adult use of marijuana, they will likely have more positive views about MM. The degree these attitudes affect client interaction on the topic is not clear, but clinicians need to be mindful of potential bias given four in ten participants reported having clients who use MM and two times that number indicated they had clients that used illicit marijuana for mental health disorder treatment. Moreover, nearly two-thirds of the participants indicated they had clients ask them about MM, but few reported being familiar with the process to obtain a MM card, increasing the likelihood of relying on personal beliefs, explicitly or implicitly.

Despite the generally positive view about MM, nearly all believed there are clients who should not use MM marijuana and would not or were unsure that they would refer a person with a history of substance abuse for a MM evaluation. Beliefs about the use of marijuana for chronic pain, which is an Ohio qualified condition, and opioid misuse, which is not a qualified condition, were consistent with current Ohio law and more measured. That is, participants viewed MM use for chronic pain as more appropriate than for opioid misuse. Indeed, one of the primary concerns about the use of MM was the potential for it to be misused in addition to the potential negative side effects (e.g., psychosis). While the biased belief that MM is good for all is not evident, the different views regarding pain and opioid use suggest we hold different view of clients who report pain and those who may have substance use issues. Indeed, viewing someone as just a substance user may preclude one from sufficiently considering all potential treatment options, including MM. Additional reasons underlying why some clients are not good candidates for MM, which provides a justification to not refer for further evaluation, are illuminating. The concern identified by the largest number of participants was a history of substance abuse, and the third percentage largest was drug-seeking behavior, which is related to being concerned about misuse.

There also were referral concerns about conflicts between Ohio and federal law, which could be addressed though education about OMMCB processes. Nearly one-quarter of the participants indicated making a referral was outside their scope of practice; however, given the degree marijuana interfaces with clinical work, this may not be a tenable position, especially given the number of clients using or asking about MM will likely increase beyond its current baseline, which is frequent per this sample.

Practice Implications

These data have several practice implications and point to several training issues, which three-quarters of the participants acknowledged a need for. Some of the issues could be anticipated given the relatively new MM laws in Ohio, and others are driven by the specific survey results. The practice implications can be conceptualized as knowledge based and interpersonally based. The first and primary practice implications are intrapersonal in nature: the need to self-assess one's views of marijuana as that will affect how information about MM is processed, being mindful our tendency to confirm our existing beliefs. Similarly, some reflection about how one identifies drug seekers or users is important, particularly those who may use injectable substances as negative clinical biases are documented (i.e., Couto e Cruz et al., 2018). That is, how does one determine if a client is potentially drug-seeking beyond having a history of substance abuse or whose pain is real and need of treatment. Without some education on the issue, counselors are likely to utilize stereotypes, often which can be negative, to conceptualize the client's behavior.

While it is unreasonable to expect mental health professionals to continually digest the evolving information regarding the benefits and risks of MM, counselors should be sufficiently knowledgeable about the topic to maintain their clinical competence, especially given the likelihood MM will be clinical topic. Knowledge to maintain competence also should include information about those who experience pain, which is very subjective and a common associated feature in clinical settings, yet one often addressed in a medical or an ancillary setting; however, the *Diagnostic and Statistical Manual* (DSM; American Psychiatric Association [APA], 2013) no longer includes pain disorder as previous editions did. Currently, pain disorder is subsumed under somatic

symptom disorder, which is characterized by “excessive thoughts, feelings, or behaviors related to somatic symptoms or health concerns” (APA, p. 311)—clearly topics relevant for counselors as they can have the skills to address such symptomatology. To differentiate pain disorder from somatization disorder, clinicians record somatic symptom disorder with predominant pain. Clients whose pain can be further characterized as persistent or severe, according to DSM specifier criteria, may be candidates for MM. Overall, one’s general view about marijuana, pain, and marijuana-seeking behavior needs to be examined.

Beyond intrapersonal awareness and general knowledge about MM, counselors need to be familiar with the process one goes through to obtain a MM card in Ohio. Just referring elsewhere or to the OMMCB website is not sufficient, especially given technological disparities that have become more apparent recently. Indeed, browsing the OMMCB website is strongly encouraged, and knowledge about its content may demonstrate a basic level of competence. Moreover, it should be the primary source of information for clients who seek information about MM. The site includes information directed toward patients, caregivers, and physicians. Indeed, the whole registration process is explained, including some videos, and there are links to other relevant resources as well (e.g., certifying physicians to perform evaluations, dispensary locations). In its essence, training on MM needs to include interpersonal reflections, general knowledge about risks and benefits of MM, and an understanding of the MM process in Ohio.

Future Research and Study Limitations

Given the paucity of research on mental health professionals’ attitudes and knowledge on MM, additional research is clearly needed. Moreover, examining the degree personal beliefs about marijuana affect clinical practice is an area worthy of investigation. Additionally, whether training on MM, substance misuse, and pain management can improve practice should be examined. However, the primary MM research need is further examination of its effectiveness and adverse effects on human participants, which would be helpful to clinical practice.

The strength of the assertations made in this paper are not on a solid foundation as the data underlying them suffers from substantive sample and measurement issues. More specifically, there are over 7000 people registered with the Ohio Counselor, Social Worker,

and Marriage and Family Therapist Board with an independent counselor license (i.e., PCC or PCC-S), and nearly 10,000 have a LISW or LISW-S license (personal communication, H. Pierre, Ohio Department of Administrative Services, February 25, 2021); however, the study included less than 2% of Ohio counselors and well below 1% of Ohio social workers. Given these small percentages and the process to procure the study sample, what the population of counselors and social workers in Ohio think about MM is not certain. In addition, the questions used to assess attitudes are not standardized, so the responses cannot be compared to other results. More significant is that the ideas and concepts used in the research are measured with a single question, which affects the reliability of measurement as well as the likelihood of finding significant associations.

Conclusion

Whether the ideas in this paper will be supported in future research is unknown. It is likely, however, the use of marijuana, whether it is legal or illegal according to local statues, will increase as access expands. This evolution will likely complicate decision making as clinicians are confronted with clients who have mental health concerns, substance abuse issues, and difficulties with pain management. Despite these uncertainties, one fact remains clear: MM will be an issue in clinical practice more frequently in the future, and mental health professionals must prepare for that in a way that is not biased by personal attitudes toward MM.

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