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CLINICAL CASE ROUNDS

The Cannabis Ask: What's a Psychiatrist to Do?

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For Clinical Case Rounds for this issue, we asked two child and adolescent psychiatrists who are experts in concurrent disorders to provide short written responses as to their approaching to the clinical scenario described below. We then asked two additional psychiatrists who are experts in ethics to provide a commentary on ideas raised in the case and the responses. We hope you find these thoughtful considerations useful for challenges you may find in your own clinical practice.

The Clinical Case

Scenario 1

Raphael is a 19-year-old male who lives with his mother and younger sister in a large urban centre. Raphael was recently discharged after a third admission to a young adult psychiatric unit in the last 12 months. Each hospitalization was associated with overdoses of a mix of prescription and over-the-counter medications following interpersonal conflicts. Raphael has been re-referred to a specialized Dialectical Behaviour Treatment (DBT) program for adolescents and young adults. Raphael previously completed half of this program prior to his last hospitalization.

Raphael presents to you for his follow-up outpatient psychiatric appointment for medication review. He currently takes escitalopram 20 mg QAM and quetiapine 25 mg PRN for "anxiety, agitation and/or insomnia." Raphael shares that he thinks the DBT is not helpful and a waste of his time. He also shares that he experiences significant reduction in anxiety and dysphoria when he smokes cannabis. He asks you whether you would be willing to write him a prescription for medical marijuana. He explains that his mother nags him about his cannabis use but she would be accepting of its use if the psychiatrist would prescribe medical marijuana. It is confirmed with the mother that that is her stance.

Scenario 2

Scenario 2 is the same as Scenario 1, except you have learned that a recent thorough outcome evaluation of the DBT program that Raphael attends was found to have disappointing outcomes, much less than that found in controlled trials reported in the literature. In fact, the pre-post change scores were not much different than the change scores for the waitlist control group in the published trials.

Scenario 3

Scenario 3 is the same as Scenario 1, except Raphael is 15 years old.

Clinician response #1

by Dr. Courtney

Scenario 1

The short answer is that I would not prescribe cannabis to Raphael. The key part to my clinical response is the manner in which this limit (to not prescribe) is set and the lead-up to my response to his request.

Raphael's presentation is marked by high-risk behaviours, with multiple admissions to hospital prompted by overdoses on medications. Engaging this youth in high intensity and specialized outpatient services to mitigate these risks is of utmost importance. This is a typical profile of a patient seen in the Youth Addictions and Concurrent Disorders Service at the Centre for Addiction and Mental Health (CAMH); and so, the treatment plan proposed is in the context of particular resources being available.

My approach would be to start with a comprehensive assessment. This assessment would begin with Raphael's mother (and other caregivers) present, should he be agreeable. In youth who have experienced high service-utilization, they are most often willing to have the caregiver(s) present for the assessment. This process allows for me to get multiple perspectives of what is driving the hospitalizations and the substance use. Moreover, I can assess communication patterns between Raphael and his caregivers *in vivo*. Lastly, it allows me to build rapport and trust with both Raphael and his caregivers, so that both are willing to engage in treatment. Of course, there is time for Raphael to meet with me individually to discuss any concerns he wishes to discuss in a more private setting.

Within the context of a standard psychiatric assessment, the risk assessment is a priority in this context, given multiple overdoses. It is important to make sure the question of prescribing cannabis does not distract from a good safety management plan. Many young people I see similar to Raphael have a long-standing history of suicidal ideation and self-harm (with or without suicidal intent). Establishing the time course, antecedents and functions of these self-injurious thoughts and behaviours will help co-formulate Raphael's presentation. The term "co-formulation" here is used with intent, in that I am often checking with Raphael my hypotheses around the causes of his difficulties and seeing if they fit from his perspective. Other safety considerations include aggression, driving and risks for his younger sister's emotional and physical safety.

Emotion dysregulation often underlies both self-harm and substance use. Naming the emotion dysregulation and coming to a mutual understanding of what is driving the emotion dysregulation will help address both prominent issues. Diagnostic assessment may also help. Emotion dysregulation is commonly a component of ADHD, PSTD and/or borderline personality disorder, among other disorders. Fully assessing for cannabis use disorder as well as stage of change is imperative. It is also vital to screen for use of other substance use disorders, particularly opiate use. While some youth find these labels aversive, many find it helpful to know that their condition is a recognized and studied cluster of symptoms and feel validated by this experience (Courtney & Makinen, 2016).

The validation that comes from co-formulation and collaborative diagnostic review can be a meaningful way to build rapport. Furthermore, developing a treatment plan that matches the formulation and diagnosis can give Raphael the impression that I have understood his difficulties and see another way out other than self-injurious thoughts and behaviours, or a prescription of cannabis. As such that when the limit is set with respect to not prescribing cannabis, it is received with minimal resistance. In setting the limit, it is important to avoid a debate with the client. There is certainly a role for motivational interviewing techniques in this process, namely: express empathy, develop discrepancy, roll with resistance and support self-efficacy. Providing education on the risks of cannabis use requires thoughtful timing and delivery, so as to make your perspective clear and genuine, while maintaining rapport.

My own reasons for not prescribing cannabis include: (1) the absence of evidence that it helps with depression or anxiety in the long-run (Botsford, Yang, & George, 2020), (2) the substantial body of evidence that cannabis can increase the risk of psychosis (Large, Sharma, Compton, Slade, & Nielssen, 2011), dependence-related burden (Imtiaz et al., 2016) and affect adolescent brain development (Lubman, Cheetham, & Yücel, 2015), (3) the presence of some evidence that it may increase the risk of depression (Gobbi et al., 2019) and cognitive impairment (Ganzer, Bröning, Kraft, Sack, & Thomasius, 2016). I acknowledge that at this time, the potential therapeutic effects of cannabis (or associate compounds, like cannabidiol) are really not known given the lack of studies. For example, in the next decade, we may find out that prescribed cannabis, or its related compounds, is an effective harm-reduction approach to cannabis dependence, similar to how buprenorphine can reduce harms associated with opioid use disorder (Woody et al., 2008); however, that evidence is not established at this time.

In our clinic we have access to social work therapists. For complex situations like this one, one social worker can work with the youth and another can work with caregivers. This separation allows the youth to build trust with their own therapist, while the one working with caregivers can give ideas on how to communicate overall and problem-solve around conflicts at home.

I would also further explore Raphael's experience in DBT. What did he not like about it? Were there parts he did like? Was there a misunderstanding of what he was expecting from it? Was his negative experience related to his developmental stage at the time of accessing it? I have had many clients who have told me they did not think they were ready for DBT at one point, but then ready when older; after motivation has changed, as well as capacity for reflective thought. It is also important to acknowledge that not all clients with emotion dysregulation and self-harm benefit from DBT; other approaches might be just as effective for them (McMain et al., 2012).

Scenario 2

The extent to which outcome evaluation in real-world settings can be mapped onto well-controlled, highly selected samples from RCTs is uncertain. I would want to know more about this scenario prior to commenting on the quality of the DBT program. Which outcome measurement instruments were used? What time points were used? What is the training of the staff? Are there measures of fidelity to the model that were taken? How were clients assessed for the intervention? Which components of DBT were offered? Were caregivers (e.g., parents) included in the DBT skills training groups? How long is the therapy program? These questions are all points of potential deviation from the RCTs which will affect expected results. Many clinics are not able to fully implement DBT with all of its components due to limited resources and long waitlists. There is some evidence that skills training only (Linehan et al., 2015), or a shorter course (McMain et al., 2018) may be just as effective as full DBT in adults with borderline personality disorder. In our clinic, we do offer a skills group for young people with emotion dysregulation and impulsivity (which often includes substance use and self-harm), which has been shown to be superior to waitlist controls (McMain, Guimond, Barnhart, Habinski, & Streiner, 2017). For Raphael, I would offer this to him and see how he engages to further assess.

Scenario 3

Raphael's age does affect how I would manage this situation. The importance of caregiver involvement becomes more prominent. If resources are available, family therapy may be considered as the evidence is favourable for adolescents with substance use disorders (Tanner-Smith, Wilson, & Lipsey, 2013). There may be a lower threshold for which I consider recommending more intensive treatment options (like specialized inpatient treatment or residential treatment). It does not change my decision to not prescribe cannabis. Some practitioners may end up recommend N-Acetylcysteine (NAC) if he does meet criteria for cannabis use disorder, based on one RCT in adolescents (Gray et al., 2012). I tend not to for several reasons. Firstly, the outcome that significantly separated NAC from placebo was with respect to urine drug screen results and risks clinical care that "chases lab results". The more clinically relevant outcome of self-reported use was not significantly different between NAC and placebo in this trial. Second, an attempt to replicate the results in adults did not show a difference between NAC and placebo (Gray et al., 2017), suggesting that the result in the adolescent sample may be spurious. Lastly, there are opportunity costs. Focusing attention on obtaining, dosing and ensuring adherence to NAC detracts from time that could be spent on psychological approaches, which are still first line treatments.

Raphael's presentation is not uncommon in our clinic. A multimodal, multidisciplinary approach to care is needed. It is expected that a youth presenting to our clinic in this way would likely be followed for several years; potentially with ongoing crises and frequent appointments initially and eventually a reduction in crises, self-harm behaviour, reduced substance use and infrequent follow-up. My repeated experience with this trajectory of improvement gives me a lot of hope and motivates me to keep working with these youth presenting with very challenging situations.

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Clinician Response #2

by Dr. Hammond & Dr. Rizwan

Introduction

This case illustrates an increasingly common dilemma faced by pediatric healthcare providers and child psychiatrists today: how to respond when an adolescent or young adult patient treated for a mental health condition or their parent/caregiver requests that you write them a prescription for medical cannabis. This clinical dilemma would not have come up 10 years ago. Broad cannabis-related legislative changes over the past 25 years have made the use of cannabis for medical and recreational purposes legal in Canada (CAN) and the United States (US) (on a state-by-state basis) and has led to major societal shifts in attitude and use patterns by North Americans (Hammond, Chaney, Hendrickson, & Sharma, 2020). How you choose to respond to 'the ask' carries high stakes. Especially, as rates of mental health problems and suicidal behavior among North American youth are rising, and with suicide being the 2nd leading cause of death in this age group (Curtin & Heron, 2019). Problematically, current practice parameters do not address this topic and offer limited guidance on how to respond to the ask. Further, in this shifting practice landscape it is increasingly less clear what *high-quality evidence-based mental health care* - care that integrates best available research evidence with clinical expertise and the patient's unique values and circumstances - looks like (Straus, 2005).

Based upon the background information provided, the child psychiatrist has already conducted a thorough assessment of the mental health features of Raphael's presentation, but a comprehensive evaluation of his substance use is lacking and needed to further inform formulation and treatment recommendations. The patient's constellation of symptoms, which include anxiety, dysphoria, agitation, oppositionality, insomnia, interpersonal conflict, and impulsive self-harm behaviors are suggestive of a mood disorder along with possible disruptive behavioral disorder and borderline personality traits. His course of treatment in the past year includes medication treatment with escitalopram and sub-therapeutically-dosed quetiapine, and partial engagement in a dialectic behavioral treatment (DBT) program. The patient's recent history, which includes three psychiatric inpatient hospitalizations in the past year (each for impulsive overdose), indicates a clear need for modification to his current treatment plan. Taken at face value, Raphael's request for a medical cannabis prescription seems almost reasonable given his course and lack of response to treatment over the past year. More importantly, it highlights a major knowledge gap in the child psychiatrist's formulation that should be clarified and targeted as part of Raphael's care planning. By asking for a medical cannabis prescription, Raphael provides his psychiatrist with additional salient information, namely, that he uses cannabis regularly and his use of cannabis is for affect regulation motives. This new information should serve as a starting point for how the psychiatrist handles the ask. Two issues intersect at the crux of this clinical scenario: (1) what does the best available research evidence tell us about the safety, potential efficacy, and risk for adverse outcomes related to using dispensary purchased cannabis products to treat the patient's mood disorder; and (2) how should the patient and his family's

values and circumstances be incorporated into your care planning and influence your medical recommendation.

Is cannabis a safe and effective treatment for mood disorders in young people?

Raphael reports a reduction in anxiety and dysphoria when he smokes cannabis. This acute subjective mood response to cannabis is well described in the literature (Buckner, Heimberg, & Schmidt, 2011) and is one of the most frequently cited reasons for requesting a medical cannabis prescription. Still, it represents only a 'snapshot' rather than the full continuum of effects of cannabis on mood. Cannabis-mood relationships are complex, often bidirectional, and frequently over simplified by the popular media (Botsford, Yang, & George, 2020). Popular media, cannabis marketing, and US state and federal legislators who have 'legislatively' designated/assigned mood disorders as an indicated condition for medical cannabis have inappropriately framed cannabis as an evidence-informed medical treatment for mood disorders. This misrepresentation has altered expectancies and openness to use cannabis by North American youth and parents (AAP, 2015). Despite this framing of cannabis as medicine, there is limited evidence from clinical trials that cannabis use is beneficial for the treatment of mood disorders, and no evidence supporting the use of cannabis products in young people with mood disorders (Sarris, Sinclair, Karamacoska, Davidson, & Firth, 2020). Cannabis is composed of over 100 phytocannabinoids, including delta-9-tetrahydrocannabinol (Δ-9-THC) and cannabidiol (CBD). Some of these cannabinoid compounds, primarily CBD, have shown promise for targeting mood symptoms in preclinical studies, but this line of research is in its infancy. Most of the preclinical research showing antidepressant effects have been done with adult animals. In contrast, studies conducted using adolescent animals have shown evidence of negative effects from cannabis exposure on brain development and mood outcomes (Renard, Krebs, Le Pen, & Jay, 2014).

As opposed to the limited safety and efficacy data on cannabinoids as medical treatments for youth mood disorders, there is substantial evidence converging from different levels of inquiry (preclinical, translational, clinical, and epidemiological studies) showing that exposure to cannabinoids during adolescence is associated with poorer mood outcomes (Botsford et al., 2020). Cannabis use and cannabis use disorders (CU/CUD) co-occur with mood disorders (i.e., depression, bipolar, and anxiety) during adolescence at higher rates than would be expected to occur by chance alone (Degenhardt, Hall, & Lynskey, 2003). In cross-sectional surveys youth frequently self-report using cannabis to cope with stress and low mood (Buckner et al., 2011). This case clearly illustrates that *cannabis use to cope with negative affect* is a clinically important phenomenon. Problematically, this acute mood response is typically short lived and regular cannabis use may exacerbate mood symptoms over time. Repeated administration of cannabis to cope with negative affect appears to strengthen the coupling of cannabis use and mood states through associative learning processes and feedback loops, resulting in increased distress and withdrawal symptoms when not using cannabis and increased risk for developing dependence on cannabis. Longitudinal data from meta-analyses and pooled analyses of birth cohorts show that (after controlling for pre-cannabis-exposure mood symptoms and other factors) cannabis use is associated with increasing frequency and severity of depression, anxiety, and suicidal thoughts and behaviors (STB) over time, and poorer long-term course of mood disorders (Gobbi et al., 2019; Moore et al., 2007), Youth who start using cannabis earlier and who report more frequent or heavy use and use of higher Δ-9-THC potency cannabis are at elevated risk for poor mood outcomes, suggesting dose-dependent relationships (Hammond et al., 2020). The role of sleep in mood and cannabis use relationships is also complicated. Mood disorders are prevalent in about 33-50% of patients with chronic sleep problems (Benca et al., 1997). Insomnia can contribute to low mood, and many youth report initiating cannabis to address sleep problems. The perceived short-term benefits of cannabis use that are initially reported, are often overshadowed by the long-term negative effects of cannabis use on mood and sleep, manifested most frequently during the withdrawal phase (Angarita, Emadi, Hodges, & Morgan, 2016). Depression, anxiety, and frequency of cannabis use generally track together in youth, especially in clinical populations (Jacobus et al., 2017; Moitra, Anderson, & Stein, 2016). Across clinical studies of adolescents and young adults treated for cannabis use problems, reductions in cannabis use or cannabis abstinence during treatment is associated with reductions in depression, anxiety, and sleep problems; greater remission of mood disorders; and 'normalization' of cannabis-related cognitive impairments (Arias et al., 2020; Hser et al., 2017; Jacobus et al., 2017; Moitra et al., 2016; Riggs et al., 2007).

Overall recommendations

Based on the case narrative and on research evidence showing moderate-to-strong evidence for harm and insufficient evidence for safety and efficacy, our overall recommendation is to advise against providing a medical cannabis prescription for management of Raphael's mood disorder.

Instead, we recommend strategically modifying Raphael's treatment plan to focus on four domains: (1) educating Raphael and his mother about cannabis-mood relationships and popular media misconceptions; (2) screening for regular cannabis use and CUD and incorporating into his treatment evidence-based prevention or interventions targeting his cannabis use and cannabis use-mood associations; (3) making his care planning and treatment more family-focused; (4) adjusting his medication treatment to optimally address his mood disorder; and (5) using motivational interviewing (MI), behavioral reinforcement, and family-based techniques to enhance treatment engagement. Brain maturation and psychological and emotional development continue into the mid-twenties (Gotay et al., 2004) and growing evidence shows that cannabis use during young adulthood is also associated with poorer mood outcomes (Leadbeater, Ames, & Linden-Carmichael, 2019). Further, young adults who use medical cannabis are more likely to experience cycles of tolerance and withdrawal and develop cannabis-related problems compared older adults (Tucker et al., 2019; Woo, van Reekum, Rosic, & Samaan, 2020). Given this, our medical recommendations for Raphael would not vary based upon his age, although the implementation of these recommendations may be impacted by his willingness to involve his mom in care planning and family-based interventions. Concerns about the quality of the DBT program do not shift our risk-versus-benefit calculation about medical cannabis in this clinical scenario, which is largely based upon the research evidence. It is our perspective that medical cannabis is not a reasonable treatment alternative in this case. Especially, as there are a number of other interventions or strategies that could benefit this patient without exposing him to an 'experimental' treatment that allows for limited physician oversite and monitoring, has insufficient evidence for safety and efficacy, and may cause harm. Concerns about the DBT program would, however, cause us to seek out and recommend alterative intensive outpatient treatment programs, ideally with a DBT or family focus. As Raphael lives in a large urban centre, we do not foresee this to be a major obstacle to his care.

In terms of how we would address 'the ask' during the session: We recommend first asking the young person and his or her parent about their experience with cannabis, what they have heard about cannabis's effects on psychiatric disorders, and where they are obtaining their information about cannabis (D'Amico, Rodriguez, Tucker, Pedersen, & Shih, 2018). This should be done in a non-judgmental way, from a position of curiosity, and using autonomy-supportive language. Responses to these questions should serve as a starting point to conduct a structured substance use evaluation that characterizes the patient's substance use history and assesses for signs/symptoms of acute and chronic use; evidence of withdrawal, tolerance, and cravings; and sequelae of use focused on cannabis but also querying about alcohol and other drugs. Since the patient's mother is present and participating, it will be helpful to obtain collateral and engage her in the discussion and care planning, as much as is possible and permitted by Raphael. Addiction is commonly referred to as 'the great masquerader' as it is often identified only after a patient presents for medical treatment for other issues (e.g., worsening psychiatric symptoms) that are subsequently discovered to be the sequelae of an untreated addictive disorder. In Raphael's case, it is important to determine if regular cannabis use and/or a previously heretofore unidentified and untreated CUD are contributing to his poor illness course and treatment response. Thus, it is essential to clarify the distinct contributions from cannabis use and his other psychiatric symptoms and determine how they interrelate. One way to do this is to perform a functional analysis and visually map out a timeline showing onset and changes in psychiatric symptoms in relation to onset and changes in cannabis use, adverse life events, and treatments. Given hints from the clinical narrative, we suspect that this evaluation will show that Raphael has been using cannabis regularly and likely meets criteria for a CUD. Parents are usually unaware or underappreciate the extent of their adolescent's drug use (Green et al., 2011). That Raphael's mom is aware of his cannabis use and that they argue about it suggests that he is using frequently and that his use is contributing to interpersonal conflict at home.

The evaluation and subsequent discussion of recommendations related to the ask could take place during that initial session or over the course of a few sessions. While being thoughtful about issues of confidentiality, as Raphael frames his mother as a gatekeeper who will support or reject the decision about medical cannabis based upon your recommendation, it is important to meet with both Raphael and his mother together to discuss your recommendations. We recommend being clear and open about your findings from the evaluation and reasoning and rationale for your recommendations. As part of this discussion, it is important to validate the patient's symptoms and educate that although acute cannabis intoxication can produce short-term relief from mood symptoms, that chronic use often results in a self-perpetuating cycle of habitual/compulsive use to avoid withdrawal states that worsens overall mood and functioning over time. During this discussion the psychiatrist should gauge the patient and parents' understanding of cannabis-mood relationship and provide empirical evidence contrary to popular beliefs. This is done most effectively by providing select curated talking points covering the current research evidence and, whenever possible, personalizing

these talking points by linking them to anecdotes from the youth's substance use evaluation. Educational resources can often aid understanding and we commonly use the *Partnership to End Addiction's Marijuana Talk Kit* (PTEA, 2017) and *NIDA's Marijuana Facts for Teens (NIDA, 2021)*. To increase knowledge transfer and retention, we recommend adopting an MI-technique for information exchange called the *elicit-provide-elicit model* that involves asking for permission to provide information, presenting focused information clearly and in manageable doses, and then checking back in to inquire about the patient and parent's understanding, interpretation, and response to what was stated (Miller & Rollnick, 2013). As repeated uses of cannabis to cope with negative affect reinforces the cannabis-mood feedback cycle, we recommend targeting this behavior with mindfulness training or by teaching the patient to use the psychotherapeutic technique of 'urge surfing', as these may aid in decoupling the relationships between negative mood states, craving, and cannabis use (Crane et al., 2017). Adaptive coping skills and healthy lifestyle choices should also be discussed and encouraged. It is important to avoid arguments or direct confrontation during these discussions and to be prepared and plan for how to address discord in the therapeutic alliance that may come up as a result of you not agreeing with the patient's perspective about medical cannabis. Involving the parent often helps provide a unified front with plan to implement some limit-setting, if necessary. It is important to provide Raphael with support, resources and treatment alternatives in lieu of prescription for medical cannabis. Lastly, optimizing his medication regiment and working with him in identifying barriers to therapy would help in aligning treatment goals.

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Commentary

by Dr. Giasson & Dr. Gupta

The cannabis ask: reconciling clinician and patient values in establishing the goals of care

Clinicians are doing ethics all the time in their daily work whether explicitly or implicitly. Formal structured approaches to clinical ethical decision-making complement this intuitive work by helping clinicians to organize their thinking about cases. This may broaden their perspectives, enable them to recognize ethical conundrums, and lead them to recast impasses as situations of competing values. To facilitate our thinking about the ethical dimensions of this clinical scenario, we drew upon three approaches intended to guide clinicians in their thinking without requiring prior formal knowledge or training in ethics: Phil Hébert's method outlined in his clinical ethics textbook, *Doing Right* (1), the "Four boxes" method of case analysis by Jonsen, Siegler, and Winslade (2), and the approach taught by our own Faculty of Medicine's clinical ethics program at the Université de Montréal (3) inspired by Bolly's text *Et l'éthique dans tout ça?*(4).

Any approach has its own perspective which serves to place more or less emphasis on various features of the case. Each of the three approaches emphasizes the critical space of interaction between patient, clinician, and social context, yet do so in slightly different ways. Hébert focuses considerable attention on the framing of the problem: what exactly raises ethical concerns in a given case? Jonsen, Siegler and Winslade are more oriented towards the substance of a case and to that end, they place patient's preferences, values and self-defined quality of life on an equal footing with evidence and clinician recommended outcomes. The Université de Montréal method stands out for explicitly acknowledging clinician and professional values which inevitably play a role in clinical decision-making. We make use of each of the key features of these approaches in our reflection on the central ethical issue at stake in this case, namely, establishing shared goals of care between doctor and patient.

Typically, a person comes to a psychiatrist seeking help with a problem. In the course of exploring the problem with the patient, the psychiatrist will eventually transform the problem into a diagnosis. She will then propose a treatment plan whose purpose, ideally, is to cure, or otherwise eliminate symptoms that make up the problem. However, even when there is ample data about the outcomes of treatment options for a given diagnosis, there is a gap between these data and what we ought to recommend to patients. Robust

research findings in support of specific clinical outcomes do not direct action: first psychiatrist and patient must agree that those outcomes are desired. As we know from clinical experience, there can be a considerable gap between what a clinician and a patient judge to be a desirable outcome in light of the person's problem. This often reflects a divergence between the psychiatrist's diagnosis and the person's understanding of her problem. Left unaddressed, this gap can generate non-adherence to a treatment plan by the patient and frustration in the treating team. Ideally, clinicians try to identify shared goals such that the treatment plan aligns with the patient's goals. But sometimes, despite best efforts, a shared goal cannot be established.

In the case under discussion, Raphael's stated problems are: 1. that he experiences anxiety and dysphoria, and 2. that his mother does not accept his preferred method (non-prescription cannabis use) of relief. His goal is to be rid of the anxiety and dysphoria by using a form of cannabis that is acceptable to his mother. Essentially, both commentators do not accept this goal at least as it concerns a cannabis prescription and the social sanction that Raphael seeks.

The process of finding common ground with a patient, when there is already disagreement, is rarely straightforward. Both commentators point to certain strategies that seem to open the way towards shared goals. For example, co-formulation is a method of case conceptualization that allows the clinician to see if her causal hypotheses of the patient's problem are shared and accepted by the patient. Motivational interviewing (MI) techniques on the other hand, provide patients with knowledge in a non-judgmental manner while encouraging patient autonomy in determining the problem and deciding what to do about it. However, both strategies tend to assume the clinician's view is more or less right, at least about the best way to address the stated problem, as the ultimate goal usually is to have the patient follow the clinician's advice.

But what are the alternatives? Instead of understanding the situation as a tension between opposing views, can it be reframed to open up a solution space previously unconsidered? Malherbe (5) refers to 'veiled agreements' [translation by authors] when both parties are in agreement, unbeknownst to themselves. Openness to the patient's goals in this case might include a shift from viewing a patient's substance use as the problem that needs to be treated, to viewing the substance use as a behaviour that the patient wants to continue with the fewest negative consequences. The spectrum of therapeutic intervention from cure to harm reduction is familiar to clinicians and may offer an opportunity for common purpose when there appears to be none. To be clear, we are not arguing that the clinician *should* adopt a harm reduction stance in Raphael's case. We merely want to point out that which stance to adopt for which patients at which point in time is a normative choice, operating in the background of treatment planning.

In addition to the patient's goals, the clinician's choice of position along the spectrum of cure to harm reduction is affected by several factors. We will discuss two such factors that reflect embedded ethical choices: 1. the interpretation of research data, and 2. the social status of a substance.

Applying population research data to an individual patient's treatment recommendations poses an enormous conceptual challenge. To what extent is a given patient similar to the research participants and his circumstances similar to those in the research? These questions arise in a great many cases in psychiatry in which the situations of real patients have a degree of clinical complexity that goes beyond the average study participant. To what extent is the use of the medication in the research similar to the clinical situation? This latter question is central when it comes to the practice of off-label prescribing, which is common in psychiatry (6). The confidence with which a clinician can make recommendations as to the potential, individual therapeutic effectiveness of a molecule based on such extrapolations will contribute to the clinician's positioning along the cure-harm reduction spectrum. Here Raphael wants to use medically prescribed cannabis as treatment for anxiety and dysphoria. Based on their analysis of clinical research data, the commentators are confident that this is an unlikely outcome of the treatment for Raphael. They also believe that cannabis may cause him serious harm, therefore, they will not prescribe it. However, if there is greater uncertainty about the outcomes, clinicians may be more willing to prescribe. Or, if clinicians consider the known harms to be relatively modest, they may be willing to prescribe. Or if there are important, known harms but clinicians judge these to be fewer than for the alternative course of action, they may be willing to prescribe. In this way, how clinicians interpret research data plays a role in influencing a clinician's ethical choice about the appropriate stance to adopt for a given patient.

Moreover, interpretation is not an objective exercise. The interpreter must exercise judgment about the meaning of data within the context of other data, and within the larger social context in which the studies are done. Haines-Saah and Fischer make this point in an article from an earlier issue of the *Journal* (7) in which they discuss the equity effects of legalizing cannabis. Focusing exclusively on the potentially negative *clinical* impact of cannabis legalization neglects the potentially positive *social* impact of reducing interactions with the legal system to which racialized youth are particularly subject. This does not mean that an

interpretation focused on clinical impacts is wrong. What it means is that where the interpreter chooses to place the emphasis in data interpretation is itself an ethical choice.

In the present case, the status of cannabis as a drug rather than as a medication may play a role in where we as clinicians choose to place emphasis. Substances considered to be medications are approved of by the medical community, at least for their specific indications. By contrast, 'drugs' are substances with no medical indication. Some substances can be part of both categories, such as amphetamines, which are used as a treatment for ADHD, and are also used and sold recreationally. Moreover, some substances migrate from one category to the other. Ketamine (and its derivatives, esketamine) are a good example of this, as the substance was first developed as an anesthetic medication that gained popularity as a drug in the 1990's. More recently, it is being researched and prescribed as an antidepressant treatment.

A substance gains the status of 'medication' through a socially sanctioned process of drug development and legal regulation. We emphasize 'socially sanctioned' here because this status is not only a matter of scientific knowledge about the substance. Again, off-label prescription illustrates this point. Medications (rather than drugs) can benefit from a type of 'halo effect' (8) in which they are judged to be safe and effective for certain uses *even in the absence of data* about those uses (9), precisely because they have already been socially sanctioned. The distinction between 'drug' and 'medication' then, is not only a matter of scientific evidence about the specific substances, but also of societal acceptability and professional norms of practice. This in turn can influence our decisions about whether or not to prescribe a substance, the weight we accord to the harms it may cause, and whether we consider its continued use desirable, neutral, or negative.

A final note about clinician-patient disagreement. In certain cases, a patient insists on a goal that the clinician finds unacceptable to the point where the clinician would consider assisting the patient to be poor, even unethical practice. While both commentators recommend avoiding debate or argument with the patient, honest disclosure that one does not agree with the patient's goal ensures that the ethical dimension of the clinician's judgment is made explicit and subject to dialogue within the therapeutic relationship.

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Conflict of Interest

The authors declare no conflict of interest.

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