ETHICAL DELIMMAS FACING SOCIAL WORKERS WHO PROVIDE SERVICES TO CLIENTS WHO USE MEDICAL MARIJUANA

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ETHICAL DELIMMAS FACING SOCIAL WORKERS WHO PROVIDE SERVICES TO CLIENTS WHO USE MEDICAL MARIJUANA

A Project

by

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Division of Social Work
Abstract

of

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This project was a collaborative effort in which the work and decision making was equally shared by the researchers. This study examined the ethical dilemmas facing social workers when providing services to clients who use medical marijuana. Marijuana is a Schedule 1 drug. For this reason, the federal government is hesitant to invest in further scientific research on the therapeutic benefits of medical marijuana. However, in 14 states, voters have challenged federal law and passed legislation legalizing medical marijuana so that patients with an identified medical condition may obtain a recommendation from a physician to use medical marijuana. The findings of the study suggest that although social workers are bound to use the NASW Code of Ethics as a guideline for practice, promoting the self-determination of clients, the controversial nature of medical marijuana laws test this obligation. Outside of unclear legislation, social workers also face the dilemma of understanding that clients may not obtain medical marijuana from a legal dispensary or caretaker, but rather choose an illegal method of obtainment. A third ethical dilemma identified for social workers that provide services to clients who use medical marijuana is the popular public notion that marijuana
can be a bridge to the abuse of other substances. The survey conducted for this study aimed to compare views of practicing social workers in the rural and urban settings of Mendocino and Sacramento Counties. As Mendocino County is notorious for its liberal stance regarding medical marijuana, it was hypothesized by the researchers that social workers practicing in Mendocino County would be more supportive of working with clients who use marijuana; however, results indicated that the opposite was true and Sacramento County social workers were more supportive in actuality. This study reinforces the importance of additional research on this topic. Implications for social work practice and policy are also discussed.

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_______________________
Date
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Chapter 1

PROBLEM STATEMENT AND OVERVIEW

Introduction

With the current controversy surrounding the topic of medical cannabis, or marijuana, it is difficult to open a newspaper or turn on a news show without reading or hearing a story that is either in support or opposition. As the Obama administration departs from past policy and local legislation continues to brew, debates are passionate and it is hard to imagine the time when discussion about medical cannabis occurred without issue between patients, doctors, and researchers. When public health workers and patients requested monetary support for further research, the political battle ensued and additional attention led to restriction (Abrams, 1998). Without federal backing, patient-centered research regarding medical cannabis was severely handicapped and thus current research is lacking. Current battles between patients, law enforcement and state and federal governments continue to intensify. And while legislation such as Proposition 215, or the Compassionate Use Act of 1996, allows for the use of medical cannabis with physician recommendation in California, unclear and ever changing laws, in conjunction with issues regarding the means by which the cannabis is being dispensed of, raise ethical dilemmas for helping professionals.

As the issue of medical cannabis remains unresolved, the position of the people within the state of California is also contrasting as to level of acceptance. People residing in rural areas within the state have conflicting views from those in more urban areas, and local political trends seem to influence the degree of support of the movement toward
legalization by helping professionals. An examination of these differing views amongst helping professionals was conducted.

Statement of Collaboration

This project was co-authored by Amy Baker and Sasha Randolph. All research and the writing of this project was conducted equally by both authors.

Background of the Problem

Marijuana is a Schedule I substance under the Controlled Substances Act (CSA). Schedule I drugs are classified as such based on the perceived high potential for abuse, the fact that there is no accepted medical use in treatment in the United States, and on a lack of accepted safety for use of the drug or other substance under medical supervision. Seems it doesn’t fit the criteria. The CSA constructed a method of placing psychoactive drugs on a five tier classification of schedules (McCarthy, 2004). The Federal government has historically (provide the date, from when etc) taken the stance that marijuana has no valid function medicinally, thereby deeming the drug illegal to use, have or sell for profit. As such, any individual who does so can be prosecuted and punished. Recently however, President Obama strayed from this position, causing quite a reaction from both supportive and opposing sides. In a three-page legal policy memo issued by the Justice Department on October 19, 2009, prosecutors were told that in states that allow medical cannabis, patients and caregivers should not be targeted for medical prosecution (Barrett, 2009). The policy indicates to federal prosecutors that it is a poor use of their time to detain people who use or provide medical cannabis in strict compliance with state law. It further states that prosecutors “should not focus federal resources in our states on
individuals whose actions are in clear and unambiguous compliance with existing state laws providing for the medical use of marijuana (Barrett, 2009).” This is a noteworthy departure from the position that the Bush administration held previously, which was that it would continue to enforce all federal laws regarding cannabis, regardless of state statutes. Bruce Mirken, communications director for the Marijuana Policy Project, cited the new policy as a major step forward in the federal government moving toward respecting scientific and practical reality (Barrett, 2009). Immediate concern has been voiced over the fact that the new policy is still vague and lacks clarity, which continues to allow the states to interpret as they see fit.

The state of California leads the nation with the most liberal laws governing the use of medical marijuana (Bock, 2000). In California, Proposition 215, the Compassionate Use Act of 1996, allowed identified patients to legally obtain marijuana for medical purposes. The enactment established that state voters recognized the palliative benefits of medicinal cannabis. While the drug is ultimately still illegal under the laws of the federal government, however, there continues to be a hesitation by workers in the helping profession to support patients who choose to utilize the medicinal properties of cannabis.

Many proponents of medical marijuana have questioned when the federal government, with surmounting supportive research on the medicinal properties of marijuana as well as societal support of lifting the ban on marijuana, will recognize and submit to the overwhelming evidence that marijuana is a valid form of palliative care.
Statement of the Research Problem

As one continues in the profession of social work, it is clear that gray areas plague the work and encounters with ethical dilemmas become commonplace, making it apparent that responsible practice can be questionable and blurred. Social work, as with all helping professions, commonly poses ethical dilemmas in interactions with clients as each situation one encounters in practice is unique and requires a dissimilar resolution. The National Association of Social Workers (NASW) Code of Ethics is a general guideline for ethical performance, and although it is a solid basis from which to base professional behavior, social workers must often use their own judgment and interpretations based on these guidelines in their daily practice and be willing to take responsibility for outcomes. As the basic purpose of practicing ethically is to further the welfare of clients, it is a necessary obligation that one has in practicing in this profession.

The controversy of medical marijuana provides a solid ethical debate for helping professionals in that the ever-changing county and state legislation governing medical marijuana are contradictory to federal law, leaving ample room for questionable agency policy and personal conviction to contribute to unclear boundaries for practice. As social workers, we are committed to respecting and promoting the right of clients to self-determination (NASW, 1996). As well, we have an ethical responsibility to the profession of social work to continuously research and seek education in ideas that promote competence of the profession (NASW, 1996). Obviously in respect to medical marijuana, federal law comes in direct conflict with the Code of Ethics that governs social work practice in that promoting self determination for clients may require
professionals to overlook written law and instead practice based on personal convictions as to the healing and palliative properties of medical marijuana for our clients. The biggest problem is that even with the guidelines provided by the NASW, the lack of current research specifically surrounding the issue of the ethical dilemmas confronting social workers who work with clients with medical marijuana recommendations leaves helping professionals with a gross lack of clarity or guidance.

**Purpose of the Study**

This study reviewed the ethical dilemma facing helping professionals in supporting the pursuit of their clients to utilize the legitimate medicinal properties in cannabis that may alleviate pain symptoms, due to the laws governing medical marijuana. By collecting and analyzing data regarding the personal views of helping professionals in both urban and rural areas (specifically in the counties of Sacramento and Mendocino), it is the hope of this study to gain knowledge of biases and diversity in opinions of professionals in the differing geographical areas. It is the hope that by furthering the limited research in the subject of medical marijuana, helping professionals may become more comfortable with the legitimacy of medical marijuana and thus the ethical struggle may be lessened in promoting the self determination of a client if that client so chooses to utilize the medicinal properties of cannabis.

**Theoretical Framework**

Patients who partake in medical marijuana as a method of alleviating pain or initiating a desire to consume food, regardless of societal acceptance, are attempting to increase personal control over their own bodies by transitioning from a state of
powerlessness. Essentially these patients are being empowered by their choice to live a higher quality of life by utilizing the palliative qualities of cannabis. Robbins, Chaterjee and Canda (1998) describe empowerment as the “process by which individuals and groups gain power, access to resources and control over their own lives. In doing so they gain the ability to achieve their highest personal and collective aspirations and goals.” As social workers, in the quest to promote client self-determination, the Empowerment Theory is a natural bridge in helping clients to achieve their own independence control over their own lives.

Using an empowerment perspective as a practicing social worker acknowledges that everything you do professionally will be “predicated, in some way, on helping to discover and embellish, explore and exploit clients’ strengths and resources in the in the service of assisting them to achieve their goals…and shed the irons of their own inhibitions and misgivings, and society’s domination (Salleebeey, 2001).” This embodies the dilemma that helping professionals face in respect to promoting the right of a client to choose the alternative method of medicinal marijuana for alleviating pain and restoring appetite. In utilizing the empowerment model as social workers, we are illustrating the “means by which individuals…become able to take control of their circumstances…thereby being able to work toward helping themselves…maximize their quality of lives (Adams, 2003),” the definition of self determination.

The researchers also utilized Interactionist Theory as a framework for this study in recognition that the motivations of individuals are affected, changed, shaped, or reinforced by their interactions with people in their environment and with society at large.
(Coleman, 2003). This theory draws from an understanding that a person’s perspective changes with each interaction they have with another individual, reshaping and reconstructing the opinions and views of both parties (Coleman, 2003). The researchers conducted a survey in which the opinions of social workers from rural Mendocino County and urban Sacramento County regarding medical marijuana were compared. Mendocino County is renowned for its highly liberal views regarding medical marijuana, and thus the researchers hypothesized that due to overwhelming community acceptance, social workers practicing there would have more tolerant views than their urban counterparts.

Definition of Terms

Schedule I drug:

Three characteristics: (1) “a high potential for abuse; “(2) “no currently accepted medical use in treatment within the United States;” and (3) a “lack of accepted safety for use of the drug or other substance under medical supervision.”

Compassionate Use Act of 1996, Proposition 215, Health and Safety Code Section 11362.5:

(A)Ensures that seriously ill Californians have the right to obtain and use marijuana for medical purposes where the medical use is deemed appropriate and has been recommended by a physician who has determined that the person’s health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraine or any other illness for which marijuana provides relief.
(B) To ensure that patients and their primary caregivers who obtain and use marijuana for medical purposes upon the recommendation of a physician are not subject to criminal prosecution or sanction.

(C) To encourage the federal and state governments to implement a plan to provide for the safe and affordable distribution of marijuana to all patients in medical need of marijuana.

Assumptions

This research assumes that there are valid medicinal properties in cannabis that may aid in offering a higher quality of life for patients requiring palliative care. It does not attempt to advocate for the legalization of marijuana. In highlighting the ethical duty of a social worker to advocate for client self-determination, it is the aim of this research to provide ample evidence that a client seeking the aid of medical marijuana should be encouraged rather than discouraged. This research also assumes that social workers have a wide range of opinions on the topic of medical marijuana and that some of those opinions are molded by the general opinion of their communities.

Justification

Research shows that there is overwhelming evidence of the medicinal benefits of cannabis, especially for patients during end of life care. In recognizing the ethical obligation of social workers to promote the self determination of their clients, this research will help to alleviate the dilemma that social workers face in working with clients who choose to use medical marijuana.
Limitations

The limitations of this research is the lack of currently recognized research available surrounding this controversial topic. The federal government has historically refused to recognize state legislation regarding medical marijuana, and the Clinton and Bush administrations were not willing to fund scientific research in order to adequately study the benefits that could be available with the use of medicinal marijuana. Also limiting is the small population of the study, which consisted of thirty participants who reside in California.
Chapter 2

LITERATURE REVIEW

Introduction

Valid research and literature available surrounding the topic of medicinal marijuana and the ethical dilemmas for social workers in regards to clients who use cannabis for its palliative properties is limited. This review will first focus on the history of the use of the marijuana both for its medicinal properties and as an intoxicant, as well as legislation supporting and arguing against that recognition. Next, this literature review will discuss methods of dispensing and obtaining medical marijuana, and, given the ethical dilemmas that arise for social workers and other helping professionals in regards to those options currently available, the ethical obligations that come into question in regards to medical marijuana. Subsequently, literature concerning the informal or formal acceptance of medical marijuana by helping professionals will be explored.

History of the use of marijuana as both an intoxicant and for medicinal properties

Drugs, by definition of the Merriam-Webster online dictionary (2009), are substances that are used as a medicine or narcotic. The illegal use of drugs is measured by any use, possession, or distribution of narcotics that are unlawful under the ground breaking Controlled Substances Act of 1970. The Controlled Substance Act placed drugs into five categories, or schedules; the schedules are organized according to their perceived potential for abuse (U.S. Drug Enforcement Agency, 2009). Drugs can be classified using different measures such as chemical structure, clinical therapeutic use, potential health hazards, liability to nonmedical use, effects on specific neural or other
physiological systems, and influence on certain psychological and behavioral processes (U.S. Drug Enforcement Agency, 2009; Schilit & Gomberg, 1991). The Controlled Substances Act currently lists marijuana as a Schedule I drug, a classification given to drugs that have the highest potential for abuse of the drug, as well as having no currently accepted medical use in treatment in the United States (U.S. Drug Enforcement Agency, 2009; McCarthy, 2004). Currently, there is public debate regarding whether or not the federal government should reclassify cannabis from a Schedule I drug to a Schedule II drugs, based on reports that there is evidence that cannabis provides relief from many different ailments (Bock, 2000; Grinspoon, 1995).

Despite the current classification of marijuana by the Controlled Substances Act, chronicles of the therapeutic properties of cannabis sativa date back nearly 5,000 years ago (US National Commission on Marijuana and Drug Abuse, 1972; Grinspoon, 1995; Mathre, 2001; Ogborne, et al., 2000; Eidelman & Voth, 2002; Kane, 2001; Feldman & Mandel, 1998; Capaldini, et al., 1998; Barnes, 2006, Russo, 1998). Chinese physicians realized the therapeutic effects of cannabis, or marijuana, approximately two thousand years ago, as is evidenced in the writings of Chinese Emperor Shen-Nung in the Chinese pharmacopoeia (Mikuriya, 2007). At this time, cannabis was grown for its use as fiber, and the emperor prescribed it for several medical issues, including gout and rheumatism (Mikuriya, 2007). The use of marijuana spread from China to India, where prior to the 10th century B.C., bhang, a cannabis preparation, was used as an anesthetic (US National Commission on Marijuana and Drug Abuse, 1972). Religious use of cannabis in India was thought to have preceded its medical use. The hemp plant is considered holy to the
Hindus, as there is said to be a guardian that lives in bhang. “Bhang is the joy giver, the sky filler, the heavenly guide, the poor man’s heaven, the soother of grief…No god or man is as good as the religious drinker of Mang. The students of the scriptures of Benares received bhang before they sit to study. At…holy places, yogis take deep draughts of Mang that they may center their thoughts on the Eternal…” (The Indian Hemp Commission, 1894, p.174). From India, the use of marijuana spread to North Africa, where it was used to restore appetite in addition to is use to alleviate pain. It was valued in treating dysentery, malaria, anthrax and fevers. Sotho women smoke cannabis before childbirth to induce partial stupefaction. The Bushmen and Kaffirs used cannabis for centuries as a medicine and as an intoxicant (Bey & Zug, 2003).

Marijuana reached Europe as early as 500 A.D. In 1545 the Spanish brought marijuana to the New World. The English next introduced the drug in Jamestown in 1611, where it became a major commercial crop alongside tobacco and was grown as a source of fiber (Mikuriya, 1973; Szasz, 1992).

In North America, marijuana was listed in the United States Pharmacopoeia from 1850 until 1942 and was prescribed for various conditions including labor pains, nausea, and rheumatism. In 1906, The Federal Pure Drug and Food Act passed in the United States, requiring that all medications contain information about their contents (Szasz, 1992). In 1914, the Harrison Narcotic Act was passed and intentionally encumbered any form of distribution for opium, cocaine, and their derivatives. Originally passed as a record keeping law, the act ultimately became a ruling of prohibition (Szasz, 1992).
In addition to its medicinal properties, cannabis was widely cultivated by farmers in the United States for fiber, food, and oil. The fact that the plant was so versatile and valuable made it threatening to the timber, synthetic fiber, and petroleum industry. One person who had a large hold in the profits of these industries was Randolph Hearst. During that same time period, DuPont patented processes for manufacturing plastics from oil as well as paper and coal from wood pulp. If the successful cultivation and use of cannabis continued, the products that DuPont, Hearst, and others were marketing at the time would face grave financial strife. Using power and pull, Hearst and others with interest had Harry J. Anslinger appointed as the head of the U.S. Federal Bureau of Narcotics (now the Drug Enforcement Administration) (Sloman, 1998). A campaign conducted by the U.S. Federal Bureau of Narcotics sought to portray marijuana as a powerful, addicting substance that would lead users into narcotics addiction; thus the term “gateway drug.” Subsequently, Hearst and others had Harry J. Anslinger appointed head of the newly created Federal Bureau of Narcotics, now the Drug Enforcement Administration (DEA). The government led a campaign against cannabis that was built on fear and racism tactics used to frighten the American public into believing that the plant was an extremely dangerous drug that promotes violent acts and that was primarily used by Mexican immigrants and African Americans (Sloman, 1998). When the Marijuana Tax Act was passed by Congress in 1937, cannabis became far more expensive and thus less accessible with the newly implemented higher taxes for those wishing to cultivate, distribute, or use the plant (Bock, 2000; Sloman, 1998). With minimal public knowledge regarding the use of cannabis for its medicinal properties, the
mission to mislead the American public through fear and suppression of information and research by the federal government was successful (Bock, 2000; Sloman, 1998). Reports largely centered on the popular assumption that Mexican immigrants who were bringing the drug into the United States and African Americans in the south were the disproportionate users of cannabis. Newspapers printed stories of minorities primarily using cannabis and committing violent acts as a result (Bock, 2000). Harry Anslinger approached a congressional meeting held by Congress to determine whether cannabis should be legalized and announced that there, “are 100,000 total marijuana smokers in the United States and most are Negroes, Hispanics, Filipinos, and entertainers. Their satanic music, jazz, and swing result from marijuana use. This marijuana causes white women to seek sexual relations with Negroes, entertainers and others (Sloman, 1998, p. 68).” He needed the public to fear cannabis in order to be successful in its prohibition, and the passing of the Marijuana Tax Act based on fear, lack of knowledge and racism marked the beginning of the eventual accomplishment.

Legislation surrounding medical marijuana

Since the presidency of Richard Nixon, the federal government has significantly increased its involvement with drug laws. The Reagan and Bush administrations both brought with them a strong climate of “zero tolerance” in regards to the War on Drugs. Subsequent passing of strict laws and mandatory sentences for possession of marijuana, as well as in heightened vigilance against smuggling at the southern borders have been a result. As well, the Comprehensive Drug Abuse Prevention and Control Act of 1970 passed and consolidated all previous anti-drug laws concerning narcotics and other illicit

At the time that the Controlled Substances Act of 1970 passed and classified marijuana as a Schedule I controlled substance, the majority of marijuana was imported from Mexico (Goode, 2007). In 1975, the Mexican government agreed to eliminate the crop by spraying it with the herbicide paraquat, raising fears of toxic side effects, and ultimately succeeding in the desired outcome. When 45 marijuana samples from Mexico were analyzed for paraquat, six out of the 45 or an estimated 13% of the marijuana samples were found to be saturated with the paraquat (Goode, 2007). This changed the tide of where marijuana was most popularly imported, thus paving the way for Columbia to become the world’s main supplier.

Regardless of the shift however, the War on Drugs was successful in creating a shift from reliance on imported supplies of marijuana to domestic cultivation (principally in Hawaii and California) due to heightened penalties and stronger border control (Goode, 2007). Beginning in 1982, the Drug Enforcement Administration turned increased attention to marijuana farms in the United States in response, and there was again a shift in the culture of cultivating marijuana, from outdoor to the indoor growing of plants. Indoor gardens were specially developed for their more inconspicuous size and high yield, and after over a decade of decreasing use due to lessened accessibility, marijuana smoking began an upward trend once more in the early 1990s (Sloman, 1998).
The National Organization for the Reform of Marijuana Laws (NORML) was founded in 1970 by Keith Stroup, a graduate of Georgetown Law School, in direct response to the prohibition and the harsh legal penalties that were instated as a result of the era (Stroup, 2009; Barnes, 2000). With lifetime prison sentences and a plethora of state and federal laws for the possession of marijuana being so irrational, NORML was focused on changing the legal status of marijuana for all users, as well as to begin legal action to allow patients access to its medical use. Assistance by the Alliance for Cannabis Therapeutics (ACT) and the Drug Policy Foundation (DPF) helped in the more than twenty years of consistent legal action, which ultimately was brought before Francis Young, the chief administrative law judge of the DEA (Randell, 1989; Bock, 2000; Barnes, 2000). A motion to remove marijuana from its Schedule I category, making it available by prescription was brought forth. Over 5,000 pages of evidence was brought before Young as proof that marijuana had medical value and was safe for therapeutic or palliative use in the year 1988, causing him to rule that marijuana did in fact meet the criteria for removal from Schedule I classification (Randell, 1989; Bock, 2000).

Unfortunately, in 1989, the Director of the DEA, John Lawn, refused to recognize Young’s decision and kept the classification of marijuana as a Schedule I drug (Randell, 1989).

Since the prohibition, voters in 35 states have actively fought alongside NORML against the prohibition of marijuana in passing legislation recognizing the therapeutic value of marijuana (Randall & O’Leary, 1993; Stroup, 2009.) The city of San Francisco, a community that was particularly devastated by the AIDS epidemic, passed a resolution
in 1991 recognizing the medicinal properties of marijuana (Stroup, 2009). Pharmaceutical companies in the United States have been allowed to develop a prescription pill called Marinol that is composed of delta-9-tetrahydrocannabinol (THC), the primary psychoactive chemical in the marijuana plant (Stroup, 2009). It is ironic that this plant, which is easily grown in America’s backyards, is classified as Schedule I, while a pill consisting of the same primary psychoactive chemical contained in that plant can be developed legitimately by a pharmaceutical company and sold for profit. In 1996, California voters approved Proposition 215, also known as the Compassionate Use Act of 1996, which exempted certain medical patients and their caregivers from criminal liability under state law for the possession and cultivation of marijuana. The Act allows patients with a valid doctor's recommendation, and the patient's designated Primary Caregivers, to possess and cultivate marijuana for personal medical use, by adding Section 11362.5 to the California Health and Safety Code (California Medical Association, 2010). The law was supposed to protect the patient, the primary caregiver, and the physician from criminal or civil liability (Health and Safety Code Section 11362.5). This law has caused much conflict in the United States between advocates for state law and those who support a stronger federal presence, as it is in direct conflict with the federal prohibition that unfortunately overrides all state laws.

On January 01, 2004, Senate Bill 420, the Medical Marijuana Program Act (MMP), was additionally enacted into law, requiring the Attorney General to adopt “guidelines to ensure the security and non-diversion of marijuana grown for medical use.” (Health & Safety Code, § 11362.81(d).1) The MMP further requires that the
California Department of Public Health establish and maintain a program for the voluntary registration of qualified medical marijuana patients and their primary caregivers through a statewide identification card system.

Though each county within California has their own statutes regarding the legal allowable amount of marijuana that a patient or caregiver can cultivate or possess, statewide laws for non-medical users of marijuana exist. Humboldt County allows for individual growers of medical marijuana three annual indoor harvests of 100 square feet, 99 plants and up to 3 pounds of dried marijuana at any one time. A medical marijuana user is allowed under the stated legislation to 12 immature plants and 8 ounces of cannabis at one time (Hecht, 2009).

Possession of marijuana is currently a misdemeanor under California Health and Safety Code Section 11357. Without the proper identification, possession by an individual of one ounce or less of marijuana is punishable by a maximum $100 fine as a medical marijuana patient or caregiver. Jail time is possible for larger amounts or for hashish, which is an optional felony (Stroup, 2009); however, under Proposition 36, which became effective on July 1, 2001, first and second time (possession only) offenders may request a treatment program rather than serving time in jail. This also allows the conviction to be expunged from record upon successful completion of the program (Stroup, 2009). Possession offenders and cultivation offenders alike can also avoid conviction by making a pre-guilty plea under Penal Code 1000, in which case their charges are dismissed upon successful completion of a diversion program. Possession
offenses are expunged from the record after two years under Health and Safety Code Sections 11361.5 and 11361.7 (Stroup, 2009).

*Ethical issues for social workers and other helping professionals surrounding medical marijuana*

An ever-present factor in the ethical dilemma of social workers advocating for their client’s right to use medical marijuana surrounds the historical and propagandized reputation of marijuana as being a “gateway drug” with the potential to lead the average user into the clutches of more serious and dangerous drugs. Even today, many people argue the belief that the use of marijuana by an individual may lead to the use and abuse of more addictive and harmful drugs. This argument as well as the argument that condoning the use of even medical marijuana is equal to condoning the use of all illegal substances is what opponents often refer to when stating that the approval of medicinal marijuana would send the wrong message to the youth of today, thus leading to greater drug use (Khatapoush & Halifors, 2004; Joffe & Yancy, 2004). A telephone study was conducted to assess what the effects of the legalization of marijuana for medicinal purposes had on the attitudes among youth and young adults in California. There were two thousand six hundred fifty one participants. The survey was designed to explore whether or not the passage of Proposition 215 had actually prompted youth to view marijuana as harmless and ultimately led to an increase their use of marijuana. The data was analyzed and results showed that the number of youth between the ages of sixteen and twenty-five using marijuana did not increase (Khatapoush & Halifors, 2004). Further,
research shows that marijuana use has actually decreased among the youth of America in the past few years despite more liberal medical marijuana policies (Armentano, 2007).

Recreational marijuana has been associated with addiction liability, though its ability to generate dependence is far less significant than that associated with either alcohol or pharmaceutical agents such as morphine, Phenobarbital, valium, or other such medications that are common to the legitimate practice of medicine (Cohen, 2009). Still, physicians continue to prescribe medications that have the ability to be just as addictive as medication—whose benefits outweigh potential side effects—already approved by the federal government. Never in history has there been a reported death from a marijuana overdose, which cannot be said of most other drugs (Nadelmann, 2004). A major reason that patients prefer medical marijuana to other pharmaceuticals is that it works to relieve pain and quell nausea as well as aiding in the reduction of anxiety, improvement in mood and that it acts as a sedative (Harvard Mental Health Letter, 2010; Joy, et al., 1999; Wade, et al., 2003; Berman, et al., 2004; D’Arcy, 2007). Pain is cited as the most common symptom for which people seek medical treatment in the 1999 report by the Institute of Medicine (Joy, et al., 1999). In the same report, it is clearly stated that cannabis has the ability to provide adequate and effective management of chronic pain (Joy, et al., 1999).

Also a factor for social workers and other helping professionals is the ethical dilemma surrounding the fact that in the United States, marijuana is considered a Schedule I controlled substance under the Federal Controlled Substance Act (CSA) in
Title II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 (Seamon, Fass, Maniscalco-Feichtl, & Abu-Shraie, 2007; Bock, 2000; Grinspoon, 1995). To be a Schedule I drug there are three characteristics: (1) “a high potential for abuse; “(2) “no currently accepted medical use in treatment within the United States;” and (3) a “lack of accepted safety for use of the drug or other substance under medical supervision (McCarthy, 2004).” The National Organization for the Reform of Marijuana Laws (NORML) has been for decades petitioning the Bureau of Narcotics and Dangerous Drugs for the reclassification of marijuana as a Schedule II drug so that it could be prescribed by physicians. In Alliance for Cannabis Therapeutics v. Drug Enforcement Administration, the courts were officially petitioned to reclassify marijuana as a Schedule II drug; however, the court upheld the established DEA test to determine whether a drug is in “currently accepted medical use,” which excludes marijuana. The test requires that 1) “the drug’s chemistry must be known and reproducible; 2) there must be adequate safety studies; 3) there must be adequate and well-controlled studies proving efficacy; 4) the drug must be accepted by qualified experts; and 5) the scientific evidence must be widely available (McCarthy, 2004).” With all of the money available to fight the War on Drugs and a huge lack of support from the federal government to further research on possible medicinal qualities of cannabis, medicinal marijuana falls short of meeting these qualifications.

Policies enacted by the federal government regarding the use of medical marijuana are largely directed toward physicians and dispensaries rather than patients,
thus sandwiching the patient in the middle of the struggle between the provider and the government. Social workers are to use the National Association of Social Workers (NASW) Code of Ethics as a guideline for practice and advocate for the right to self-determination by their clients; however, federal laws surrounding medical marijuana make this task extremely difficult. Often in practice social workers managing cases for patients who use medical marijuana ultimately must face the ethical predicament of whether or not to advocate for the client’s legal right to use their prescribed medication, which may aid in the relief of chronic pain but is still against federal law.

While several states now have initiatives or legislation regarding medical marijuana, California’s Proposition 215 law clearly states the intention of California voters. Also referred to as The Compassionate Use Act of 1996, the initiative outlines its purpose, which is that “seriously ill Californians have the right to obtain and use marijuana for medical purposes where that medical use…has been recommended by a physician who has determined that the persons health would benefit from the use of marijuana in the treatment of cancer, anorexia, AIDS, chronic pain, spasticity, glaucoma, arthritis, migraines or any other illness for which marijuana provides relief (Health and Safety Code Section 11362.5; Pickerill & Chen, 2007). Though the intent of the act appears clear, the fact that the laws of the federal government clash with these state guidelines has caused much confusion and hesitance. A policy entitled, “The Administration’s Response to the Passage of California Proposition 215 and Arizona Propositions 200,” was released in December 1996 under Barry McCaffrey, the Director of the Office of National Drug Control Policy. The policy stated that physician
recommendations for Schedule I controlled substances were not consistent with the public interest. It threatened that any such action would lead to the revocation of the physician’s registration to prescribe controlled substances (McCarthy, 2004). The policy further stated that the Department of Justice and Health and Human Services would send a letter to the practitioner associations and licensing boards informing those groups of the policy (McCarthy, 2004). Physicians are very aware and thus cautious that if they choose to prescribe or recommend the use of cannabis, there is the risk of the federal government threatening to revoke their license (McCarthy, 2004; Manderson, 1999). Likewise, many patients are weary of possible repercussions from government officials for using cannabis, despite the therapeutic benefits they may find from the use (Manderson, 1999; Capaldini, et al., 1998).

Presently in the Netherlands, Canada, Austria, Spain, Finland, Portugal, and Germany, it is legal to prescribe marijuana for medical purposes. In the United States, thirteen states—including California—allow for a physician to prescribe medicinal marijuana. For this to take place, state ballots with initiatives to legalize medical marijuana have been approved, often by large margins (Nadelmann, 2004). It is not solely physicians who believe in the use of medicinal marijuana and actively oppose federal law to the contrary; the American Nurses Association (ANA) also supports providing safe access to marijuana for its palliative properties (American Nurse, 2006). Again however; while it is legal to prescribe medicinal marijuana according to the 13 states law, it is illegal according to the Federal government for physicians to prescribe medicinal marijuana in all 50 states. This causes a conflict for physicians as they work to
ensure that the best interest of their patient is being served and no harm is being done, while the option to offer medicinal marijuana without the fear of the federal government charging or arresting the physician is not available. The American Medical Association (AMA) notes that a physician’s focus should be on “what is best for the individual patient and not the avoidance of a burden to the family or to society.” (American Nurse, 2006). Yet, this is not what happens, as the physician is not able to freely look at what options are in the best interest of the patient out of a rational concern for possible repercussions.

The duty of a physician is to the health of the patient. That duty should not be sacrificed to avoid prosecution by the federal government due to mere conversations concerning what is in the best interest of their patient. The right to have medicinal marijuana is a principal of social justice, liberty and equality (Hathaway & Rossiter, 2007). In Conant v. Walter, patients and physicians claimed first amendment rights protecting physician-patient communications concerning the use of medical marijuana (McCarthy, 2004; McCarberg, 2007). The federal court decision in Conant v. Walter allows physicians too freely to discuss cannabis treatment with patients. It also allowable for the physician to testify in court regarding the recommendation for the patient without fear of reprisal; however, federal law prohibits the use, possession and distribution of cannabis for any purpose because it is a Schedule I controlled substance (McCarthy, 2004; McCarberg, 2007), which again creates a conflict for the physician as the two laws conflict with one another in working toward a patient’s best interest. Much in the same way that this conflict is problematic for physicians, it is also problematic for social workers who understand the conflict and must decide whether or not to advocate for the
right of their client to self-determination.

The United States functions under a form of government called federalism, meaning that the federal, state, and local governments co-exist with one another. Each recognizes the limits and powers of the other while maintaining some degree of autonomy (Seamon, Fass, Maniscalco-Feichtl & Abu-Shraie, 2007). The federal government can only legislate in constitutionally identified areas, such as intellectual property, immigration, and bankruptcy. Historically, states have had the sole authority to legislate in the areas of health, safety and welfare (Seamon, Fass, Maniscalco-Feichtl & Abu-Shraie, 2007). However, in regards to the matter of medical marijuana, the federal government has continued to be involved under the commerce clause. Article I, section 8, clause 3 of the Constitution specifically states that Congress has authority to legislate in areas that involve commerce (Seamon, Fass, Maniscalco-Feichtl & Abu-Shraie, 2007), which has allowed the federal government to continue to have a voice and be involved in state law. In the incidence that there are two conflicting laws, one being federal and one being state, the more strict law prevails. By allowing medical users to be prosecuted federally, the U.S Supreme Court has served notice that federal law holds precedence over state authority (Hathaway & Rossiter, 2007).

Under previous, more conservative administrations, there has been no active interest in exploring the idea of having marijuana reclassified or even in conducting research to examine any benefits of marijuana or cannabis. Historically, only two major comprehensive reviews evaluating the scientific basis for marijuana have been conducted. The first study was done by the Institute of Medicine (IOM) and the other by
the American Medical Association. Both studies concluded that there was a lack of rigorous data to support the use of marijuana as a medicine (Joffe & Yancy, 2004).

In November 2007, while campaigning for president, Barack Obama was quoted as saying, “My attitude is if the science and the doctors suggest that the best palliative care and the way to relieve the pain and suffering is medical marijuana then that is something I’m open to because there’s no difference between that and morphine when it comes to just giving people relief from pain. But I want to do it under strict guidelines. I want it prescribed in the same way that other painkillers or palliative drugs are prescribed.” (firstread.msnbc.msn.com). Since securing the office of President, Obama and his administration have not stood solidly on a stance either for or against medicinal marijuana, but only to say that end of life care will have to be revisited and that this exploration could also include the topic of the use of medicinal marijuana. Attorney General Eric Holder, during his first major press conference under the Obama administration, saw an immediate, controversial public reaction after announcing that the Drug Enforcement Administration (DEA) would no longer raid medical marijuana dispensaries that comply with state law (Dickinson, 2009). Instead, Holder stated that the focus would be on drug traffickers who attempt to use current medical marijuana laws as cover for large operations. Drug czar Gil Kerlikowske has stated that the actual legalization of marijuana is not part of the vocabulary of the Obama administration (Miken & Lovell, 2009).
Outside of the dilemma for social workers regarding the issue of the classification of marijuana is the issue surrounding the method of obtaining medical marijuana. Cannabis dispensaries provide the option for patients to legally obtain cannabis with a prescription from an establishment, rather than purchasing the substance illegally from an individual. Use of a dispensary lowers both physical and legal risk to a patient. In 1992, Dennis Peron opened the first known medical cannabis dispensary in San Francisco, California (Gardner, 2007; Feldman & Mandel, 1998). As a leading advocate for medicinal marijuana following his partner’s diagnosis with AIDS, Peron aimed to provide cannabis to individuals suffering from chronic pain linked to illness in a safe haven that could provide a safe, relaxing, and comfortable environment (Gardner, 2007).

Very little research is available regarding medical cannabis dispensaries—also often called clubs—though Feldman and Mandel (1998) did conduct an exploratory ethnographic study of the San Francisco Cannabis Buyer’s Club (SF CBC) using interviews and participant observation (Feldman & Mandel, 1998). The Members of the club talked to the researchers about how they had utilized the club as well as how they had benefited from the use of medical cannabis, citing that the club offered a social support network that was essential to improving the quality of life for individuals suffering from life threatening medical conditions. Interviewees discussed feelings of depression and isolation due to their diagnosed medical conditions and found solace in others at the club who may be experiencing similar emotions induced by their own conditions (Feldman & Mandel, 1998). These were the same issues that Peron was trying to offer refuge from with the opening of his dispensary in 1992, years prior to the passage
of Proposition 215.

A patient must meet with a physician and have a valid medical diagnosis in order to receive the recommendation by a physician to use medical cannabis. For patients who meet criteria for the legal use of medical marijuana, a review of benefits, risks, safety concerns, side effects, and potential hazards are discussed with the physician. The physician needs to screen the patient for potential drug interactions and risks associated with marijuana use (Seamon, Fass, Maniscalco-Feichtl & Abu-Shraie, 2007). The Medical Board published standards for physicians when recommending medical marijuana. The physician’s should 1) review the history and complete a good faith examination of the patient, 2) develop a treatment plan with objectives, 3) provision of informed consent including side effects, 4) periodic review of the treatments efficacy, 5) consultations as necessary, 6) keep proper records that support the decision to recommend medical marijuana (mbc.ca.gov/board/media/releases). A Treatment Consent form and an Authorization for Use form are kept by the patient in their possession to provide medical documentation and a basis for legal defense against prosecution (Debondt, 2006). After obtaining the medical documentation, patients are granted access into a dispensary by providing the written recommendation and showing proof of residency in California. Staff at a dispensary or club must verify that the patient’s recommendation is valid by contacting the prescribing physician, and then the patient is able to utilize all services offered by the dispensary. Cannabis dispensaries often offer edibles, oils, tinctures, creams, teas, and the cannabis plant in bud form as options for patients.
Cannabis and cannabis based medicines as palliative care

Marijuana has been used for its medicinal properties for thousands of years. Ancient China used marijuana to control pain in childbirth, appetite, and constipation (Furler, Einarson, Millson, Walmsley & Bendayan, 2004; Grinspoon & Bakalar, 1995). With the assistance of cannabis, patients have cited significant improvements in appetite, anxiety, muscle pain, nausea, depression, and nerve pain (Grinspoon & Bakalar, 1995; Corless, et al., 2009). Recent studies suggest that cannabis helps with pain, HIV and AIDS complications, nausea and vomiting, and a plethora of other ailments (Coomber, et al., 2003; Russo, 1998; Sidney, 2001; Schwartz, et al., 1997; Denoon, 2003). In 1990, forty four percent of oncologists that were surveyed suggested smoking marijuana as a method of relief from nausea induced by chemotherapy (Grinspoon & Bakalar, 1995). Additionally, thirteen to forty nine percent of patients experiencing tingling, numbness, weight loss, headaches, tremor, constipation, tiredness, diarrhea, and memory loss also found significant relief with the use of cannabis (Grinspoon & Bakalar, 1995; Corless, et al., 2009). Cannabis has also been found to lower the intraocular pressure in glaucoma, which is why until 1991, the Food and Drug Administration (FDA), permitted ophthalmologists to prescribe cannabis to patients when other treatments had failed. After 1991, when new glaucoma medication was introduced, this practice ceased (Economist, 2002).

In regards to aiding in the treatment of multiple sclerosis (MS), cannabis has been found to be most effective in allowing patients to be able to sleep at night. Patients
afflicted with MS report having burning sensations in their limbs, particularly at night making it difficult to sleep. When MS patients smoked marijuana at night before going to bed, they were actually able to sleep (Economist, 2002). Research surrounding Sativex has focused on patients with a diagnosis of multiple sclerosis and the pain associated with the disease. Sativex is a natural cannabis extract that is liquid in form and is sprayed directly into the mouth (D’arcy, 2007; Davis, 2005, Wade, 2003; Rog, et al., 2005; Collin, et al., 2007). The major benefit of this spray that is made from marijuana plants bred for specific active components called cannabinoids is that it provides almost identical effects as cannabis without the harmful effects of smoking (Wade, 2003; Rog, et al., 2005; Collin, et al., 2007).

Cannabis and cannabis-based medicines have also been prescribed to assist HIV/AIDS patients, cancer patients, patients suffering from glaucoma, and with end of life pain management. The scientific evidence that has surfaced from recent studies showing that cannabis can and does alleviate symptoms associated with chronic pain (Abrams, et al., 2003; Abrams, et al., 2007) has helped to slowly shift the media enhanced stereotypical picture of the rebel with long hair and tie-dyed shirt with a joint in hand to an ordinary middle-aged American struggling with MS, cancer, HIV or AIDS (Nedelmann, 2004). The primary argument for the use of cannabis as palliative care is in the treatment of terminally ill patients is to prevent unnecessary suffering from chronic and unbearable pain that persists until death. Palliative care focuses on providing comfort and acceptance for the patient. The care is collaboration between a team of doctors, nurses, social workers, and patients and their loved ones. The goal of palliative
care is to help relieve suffering and to provide the best possible quality of life for patients and their families. The key benefit of palliative care is that it customizes the treatment to meet the specific needs of the individual. Palliative care can be provided at anytime during a patient’s illness and can be given in conjunction with hospice care. Hospice care is generally focused on terminally ill patients who no longer seek treatments and are expected to live for six months or less. With the current massive public attention being focused on health care in the United States, it is imperative that there is recognition given to how the health care bill will affect end of life care. If the United States is going to forge forward and change how we spend money on health, we must also change how we spend money on death. Individuals currently in the last chapter of their lives are accounting for potentially eighty percent of the total health care bill. Advances in palliative care could mean that those last years of life do not have to be a moral, medical, and financial nightmare.

Although doctors in Canada do legally prescribe medicinal marijuana, there is question and a need for additional evidence regarding the correct dosage for patients when dealing with pain. Currently doctors and patients determine the current amount to authorize, which typically is between 1-3 g per day (Comeau, 2007). There is a need for more research in the use of medicinal marijuana. There are approximately 2,400 cannabis clubs that buy, sell, and give medical marijuana in various forms in California. Reports estimate 350,000 uses of medical marijuana and estimate an annual market of two billion dollars (O’Brien, 2009). Nearly nine percent of Californians have smoked marijuana in
the past 30 days (O’Brien, 2009). There is reportedly twice as many cannabis clubs in San Francisco than there are McDonalds restaurants, obviously illustrating that the demand for medicinal marijuana is there. With the legalization of marijuana, making it a Schedule II drug, the states could regulate, control and profit from the sale of the marijuana. This would also assure that the quality and strength of marijuana be regulated like all other medications and distribution restrictions could be imposed to prevent misuse (Dresser, 2009).

Conclusion

Ultimately, the dilemma of advocating for what is in the best interest of the patient is heightened by the limited research regarding benefits or potential harm (Fisher, Johnston & Leake, 2002). Although current legislation in multiple states allow for a patient to obtain medical marijuana, it continues to be illegal in all 50 states under federal law, regardless of method of attainment or any other factors. With the continued conflict between state and federal laws, patients and helping professionals are caught in the middle of the battle making the choice for social workers to advocate for patient rights to self-determination a considerably complex task.

Very little research was found by the researchers that specifically addressed ethical dilemmas facing social workers in regards to medical marijuana or social worker views regarding medical marijuana. In order to provide a better understanding of the ethical dilemmas facing social workers who are providing services to clients that use
medical marijuana and the context of the views of social workers, further research on this topic must be conducted.
Chapter 3

METHODOLOGY

Introduction

This chapter presents the research methodology utilized to conduct this study. The research question, design of the study, the variables, the population chosen to study, the instruments used, and the procedures used for gathering and analyzing the data will all be looked at in this chapter. Finally, this chapter will review how human subjects consented to be a part of the research and were protected in the process.

Research Question

This study was designed to investigate the following question: What, if any, ethical dilemmas face helping professionals in Mendocino and Sacramento Counties with a Master’s Degree in social work who are working with clients using medical marijuana?

Research Design

The design of this quantitative study is a cross-sectional survey in that it takes a group of respondents and evaluates what attitudes they hold about medical marijuana. The researchers used a criterion sample of helping professionals in various areas of social work who held a Master’s degree in social work. This study was quantitative in that the goal was to answer the question of how helping professionals view medical marijuana; either as a hindrance to their ability to work with a client, or simply as a given right of their client. Additionally, the researchers were attempting to answer the question of whether urban (Sacramento County) or rural (Mendocino County) were more liberal in their views of the legitimacy of medical marijuana. As well, the design was quantitative
due to the researchers’ statistical analysis of the data (Weinbach & Yegidis, 2009).
Quantitative research is defined as empirical because of its utilization of “experience and
observation as a route to knowledge.” (Rubbin & Babbie, 1989). Because the study
population, who were a cross section of the target population, participated and answered
the study questions only once at one point in time, the research was cross-sectional
(Thyer, 2001).

Survey research is used to collect information on attitudes, knowledge, beliefs,
values, and past or current behaviors (Thyer, 2001). This type of research compliments
explanatory studies by allowing for numerous questions to be asked about a single topic.
They aid in summarizing the characteristics of a large population and allowing for the
possibility of making refined descriptive assertions (Rubbin & Babbie, 1993). Surveys
are very common and have been a very important part of social work research. They are
important tools in both basic and applied research that are used to measure the
demographic characteristics of people in addition with their opinions, preferences, and
beliefs (Weinback & Yegidis, 2009). Cross-sectional research designs, “…entail
measurement of some characteristic in a defined sample or group at a given point in
time” (Weinback & Yegidis, 2009). After acquiring that snapshot, the researchers seek to
draw conclusions based on the data given or to answer questions or test hypothesis about
the relationships between variables (Weinback & Yegidis, 2009). Cross-sectional survey
designs are often used in social work research.

Variables

In this study, the dependent variables were the ethical challenges for helping
professionals with a Master’s degree in social work who are working with clients that use medical marijuana. The independent variables were: 1) the age of the participants, 2) the gender of the participants, 3) the field of practice of the participants, 4) the amount of years that the participant has been practicing social work, and 5) whether the participant currently practiced social work in a rural or urban setting.

Study Population

In order to make the research as specific as possible, the researchers used criterion sampling to find research participants (Marlow, 2005). The criterion was that the study population consisted of professionals in the field of social work in Mendocino or Sacramento County that hold a Master’s degree in social work. By utilizing a non-random purposeful study population, this study can be more confident in generalizing the findings.

Convenience sampling was also used in that the researchers surveyed participants that they were familiar with from their own professional settings and were able to request participation through publicized work emails or social networking websites (Weinback & Yegidis, 2009).

Sample Population

The sample population was professionals working in the field of social work in Mendocino or Sacramento County that all held a Master’s degree in social work. A total of thirty (30) participants were surveyed; fifteen (15) participants from Mendocino County and fifteen (15) participants from Sacramento County. The population surveyed included females and males of various ages and with a range of years of experience in the
field. Participants worked in different fields of social work as well, whether in schools, hospitals, Child Protective Services, Adult Protective Services, Mental Health, Alcohol and Other Drugs, or some other field.

Instrumentation

There were twenty-three questions developed for the survey (See Appendix A). The first five questions were multiple choice and intended to gather the demographic information of the participant. Those questions identified gender, age, county of practice, years of employment in the field of social work and field of practice. The remaining eighteen questions were more personal in nature and pertained to the experience of the participants working with clients who have prescriptions for medical marijuana and what variables impacted their practice.

The survey questions were all closed-response questions, which the researchers realize can be beneficial in some respects and problematic in others. Definitively analyzing data is much easier when utilizing closed-response questions; however, it may also fail to “provide an appropriate set of alternatives for the respondent” (Thyer, 2001). In this study, the researchers attempted to make the questions as simplistic as possible—with as little need for alternatives as possible—while still successfully collecting the information necessary to answer the question at hand.

Data Gathering Procedures

Data was collected from professionals in Mendocino and Sacramento Counties at the convenience of the participant. Prior to contacting potential participants, the researchers first set up an account with internet survey tool Survey Monkey, and entered
survey questions into the tool, creating a Consent to Participate as well as an actual survey. Participants were then recruited through the utilization of public professional emails and social networking sites, with the qualifications that the participant possess a Master of Social Work degree and be currently working in a social work setting in either Mendocino or Sacramento County. Whether contact was made through email or a social networking site, the researcher gave a brief introduction of herself and her partner as well as to the survey and thesis subject. The participants spent between ten and fifteen minutes completing the consent form and survey. Ultimately, participants in Mendocino County completed fifteen surveys and participants in Sacramento County completed fifteen surveys.

Data Analysis

The researchers used the program offered by Survey Monkey, the data-gathering instrument, to analyze and chart the information collected from the survey. The research identified the differences and similarities in participant’s responses. The researchers then examined the questions and responses and organized them into common themes, analyzing frequencies of the independent, and dependent variables. Cross-tabulations and chi-square tests were also performed to compare the various independent and dependent variables.

Human Protection Protocol

The authors followed the guidelines established by The Protection of Human Subjects Committee for the Division of Social Work, California State University, and Sacramento and prior to administering the survey; the Human Subjects Application was
submitted for approval to the Committee. The survey was approved as “minimal risk,” indicating that the anticipated risk to the human subjects was no more than what one would normally encounter in daily life. Risk to the human subjects was minimized by asking them about indirect rather than direct questions that would be viewed as more personal in nature.

Each participant of this study was given a consent form (See Appendix B) that was required in order to proceed to the survey. The consent form gave an explanation of the purpose of the survey as well as the procedures, risks, and their right to not complete the survey. The consent form also stated that the confidentiality of the participants would be strictly upheld for protection of privacy. The consent was given by participants by clicking on a box indicated they agreed to participate in the survey and understood their rights. Confidentiality was further upheld by not collecting names or other identifying information from participants and having no tracking system of participants available through Survey Monkey. Participants were also informed that should they choose to participate in the survey; the researchers would be unable to remove anonymous data from the database.

Summary

This chapter addresses the quantitative methods that were used in this research study. The study population was described, as well as recruitment methods for participants. This chapter further examined the variables of the study and data collection methods and explained the closed-response survey questionnaire;
Procedures for protection of human subjects were also explained. The results of the data will be analyzed and presented in the following chapter.
Chapter 4
DATA ANALYSIS

Introduction

This chapter examines the results of the survey, which explored if there was a difference between the views of social workers when working with clients who use medicinal marijuana. The survey asked the thirty participants in the study twenty-three multiple choice questions with answers to choose from that related to their experience in social work. The survey results were later analyzed to answer the question of whether a social worker’s professional setting, rural or urban, would impact the responses from the participants. There was a total amount of thirty Masters in Social Work (MSW) participants from Mendocino County to represent the rural setting and Sacramento County to represent the urban setting. Each county had a total of fifteen participants.

Demographics

The first five questions of the survey were intended to collect demographic information from the participants. Participants were first asked to note whether they practiced social work in Mendocino County or Sacramento County. The participants were then asked a series of questions to include their gender, age range, field of practice and years in the field of social work.

There were a total of twenty five females (83.3%) who participated in the survey and five men (16.7%) who participated in the survey (Table 1). Of the twenty five females that participated in the survey, ten were from Mendocino County (66.7% of total rural participants) and fifteen were from Sacramento County (100% of total urban
participants). Mendocino County had five male participants representing a 33.3% participation rate. There were no males from Sacramento County who participated in the survey.

Table 4.1

*Gender of Study Participants (N=30)*

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<th>Sacramento County</th>
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<td>100%</td>
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</tbody>
</table>

The largest percentages of participants from Mendocino County were between the ages of 36-45, making up 40.0% of the total rural participant population. There were 13.3% of rural participants between the ages of 25-35, while 26.7% were between the age of 46-55 and 20.0% were between the ages of 56-65. Neither county had any participants that were 66 years of age or older. The vast majority of Sacramento County participants were between the ages of 25-35, making up 46.7% of the urban population. Following were participants between the ages of 36-45, making up 26.7% of the urban participant population, while 20.0% were between the age of 46-55 and 6.7% were between the ages of 56-65. When combining both urban and rural practice settings, the greatest amount of response totals was from the 36-45 age groups.
Table 4.2

*Age of Study Participants (N=30)*

<table>
<thead>
<tr>
<th>AGE</th>
<th>Mendocino County</th>
<th>Sacramento County</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>25-35</td>
<td>13.3%</td>
<td>46.7%</td>
<td>30.0%</td>
</tr>
<tr>
<td>36-45</td>
<td>40.0%</td>
<td>26.7%</td>
<td>33.3%</td>
</tr>
<tr>
<td>46-55</td>
<td>26.7%</td>
<td>20.0%</td>
<td>23.3%</td>
</tr>
<tr>
<td>56-65</td>
<td>20.0%</td>
<td>6.7%</td>
<td>13.3%</td>
</tr>
<tr>
<td>65+</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

When asked what field of social work participants were employed in, social workers in both counties reported the highest number of responses from Child Protective Services (CPS). In Mendocino County, CPS employees made up 53.3% of the participants and in Sacramento County, that number was 80.0%, combined for a total of 66.7% of respondents. Social workers in the field of mental health represented the second largest number of participants with 26.7% from Mendocino County and 13.3% from Sacramento County. Following the mental health profession, Mendocino County reported an equal number of respondents in Alcohol and Other Drug (AOD), Hospital social work and the “other” category, with 6.7% of participants representing each. Sacramento County participants also reported 6.7% participants in the “other” category, but had not participants practicing in AOD. There were no participants that reported practicing social work in a school setting from either county.
Table 4.3

*Field of Practice of Study Participants (N=30)*

<table>
<thead>
<tr>
<th>FIELD OF PRACTICE</th>
<th>Mendocino County</th>
<th>Sacramento County</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>26.7%</td>
<td>13.3%</td>
<td>20.0%</td>
</tr>
<tr>
<td>AOD</td>
<td>6.7%</td>
<td>0.0%</td>
<td>3.3%</td>
</tr>
<tr>
<td>CPS</td>
<td>53.3%</td>
<td>80.0%</td>
<td>66.7%</td>
</tr>
<tr>
<td>Hospital</td>
<td>6.7%</td>
<td>0.0%</td>
<td>3.3%</td>
</tr>
<tr>
<td>School</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Other</td>
<td>6.7%</td>
<td>6.7%</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

Concluding the demographic information, the participants were asked how many years they had been working in the field of social work. Of all participants in Mendocino County, 20% have worked in the field for less than five years, while only 6.7% of the total participants from Sacramento County indicated being in the field for less than 5 years. The majority of participants in Sacramento County reported having worked in the field of social work between 6-10 years with 40.0%, while 13.3% of Mendocino County participants had the same range of work experience. Participants from Mendocino County with eleven to fifteen years of work experience represented 26.7% of the total respondents and 20.0% of Sacramento County participants fell into the same range. The largest group of Mendocino County participants indicated they had been practicing social work for sixteen years or more, while Sacramento County had 33.3% of their participants who fell into the same category of work experience. In all, social workers from both
counties totaled 36.7% in the category of sixteen or more years of professional experience, making it the largest collective category.

Table 4.4

*Years of Professional Experience of Study Participants (N=30)*

<table>
<thead>
<tr>
<th>YEARS OF PROFESSIONAL EXPERIENCE</th>
<th>Mendocino County</th>
<th>Sacramento County</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5</td>
<td>20.0%</td>
<td>6.7%</td>
<td>13.3%</td>
</tr>
<tr>
<td>6-10</td>
<td>13.3%</td>
<td>40.0%</td>
<td>26.7%</td>
</tr>
<tr>
<td>11-15</td>
<td>26.7%</td>
<td>20.0%</td>
<td>23.3%</td>
</tr>
<tr>
<td>16+</td>
<td>40.0%</td>
<td>33.3%</td>
<td>36.7%</td>
</tr>
</tbody>
</table>

*Personal Views*

*What factors may impact your professional practice as a social worker?* In the following section, personal views to include religion and politics will be examined in respect to the effect each may have on professional practice by responding social workers. The goal of the researchers in asking these questions was to analyze whether factors that may impact professional practice may also have an effect on the willingness of a social worker to support a client who may use medical marijuana. Represented in the following tables,

*Factor one: religious views impacting professional practice.* The participants were asked if they felt that their religious views impacted their professional practices. Overwhelmingly, 66.6% felt that religious views did not at all impact their professional practice, with 13.3% indicating that their religious views may somewhat impact professional practice and 20.0% indicating that their religious views had very little
impact. None of the participants in Mendocino County indicated that their religious views greatly impacted their professional practices.

Sacramento County urban participants differed from their rural counterparts with 26.7% stating that they did not feel their religious views at all impacted their professional practices. Religious views were felt to have very little impact by 20.0% or urban participants, 33.3% felt their practice was somewhat impacted by personal religious views and 20.0% felt very little impact on professional practice by their religious views.

Table 4.5

Impact of Religious Views on Professional Practice by Study Participants (N=30)

<table>
<thead>
<tr>
<th>RELIGIOUS VIEWS IMPACTING PROFESSIONAL PRACTICE</th>
<th>Mendocino County</th>
<th>Sacramento County</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at All</td>
<td>66.7%</td>
<td>26.7%</td>
<td>46.7%</td>
</tr>
<tr>
<td>Very Little</td>
<td>20.0%</td>
<td>20.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Somewhat</td>
<td>13.3%</td>
<td>33.3%</td>
<td>23.3%</td>
</tr>
<tr>
<td>Greatly</td>
<td>0.0%</td>
<td>20.0%</td>
<td>10.0%</td>
</tr>
</tbody>
</table>

Factor two: political views impacting professional practice. The participants were next asked if they thought their political views impacted their professional practice. In Mendocino County, 6.7% of participants felt that their political views did not impact their professional practice at all while the largest majority of 53.3% indicated that their practice was impacted very little by political views. Additionally, 33.3% of rural respondents indicated that their views made somewhat of an impact on professional practice and 6.7% indicated that it was impacted greatly. In Sacramento County, urban
participants making up 13.3% indicated that their professional practice was not impacted at all by political views, with the same number of participants indicating that their practice was impacted very little by political views. The highest responses from urban social workers was with 40.0% who felt that their political views somewhat impacted their professional practice, followed by 33.3% who indicated that their political views greatly impacted their professional practice.

Table 4.6

Impact of Political Views on Professional Practice by Study Participants (N=30)

<table>
<thead>
<tr>
<th>POLITICAL VIEWS IMPACTING PROFESSIONAL PRACTICE</th>
<th>Mendocino County</th>
<th>Sacramento County</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at All</td>
<td>6.7%</td>
<td>13.3%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Very Little</td>
<td>53.3%</td>
<td>13.3%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Somewhat</td>
<td>33.3%</td>
<td>40.0%</td>
<td>36.7%</td>
</tr>
<tr>
<td>Greatly</td>
<td>6.7%</td>
<td>33.3%</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

Legalization and Community Acceptance

The next section continues to explore personal views of participants as well as perceived community views, delving closer to the topic of medical marijuana. Ironic considering the blatantly liberal views in regards to marijuana in Mendocino County, when asked if they supported legalization of marijuana, participants in Mendocino County indicated that 46.7% support legalization while 73.3% of participants in Sacramento County support legalization. In Mendocino County, 26.7% of participants did not support legalization of marijuana, and another 26.7% were also unsure if they
supported legalization. In Sacramento County 13.3% did not support the legalization of marijuana and 13.3% were unsure if they supported legalization.

Table 4.7

Support for Legalization of Marijuana by Study Participants (N=30)

<table>
<thead>
<tr>
<th>SUPPORT FOR LEGALIZATION OF MARIJUANA</th>
<th>Mendocino County</th>
<th>Sacramento County</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>46.7%</td>
<td>73.3%</td>
<td>60.0%</td>
</tr>
<tr>
<td>No</td>
<td>26.7%</td>
<td>13.3%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Unsure</td>
<td>26.7%</td>
<td>13.3%</td>
<td>20.0%</td>
</tr>
</tbody>
</table>

What is the level of acceptance for medical marijuana in your community? When Mendocino County participants were asked their perception of the level of acceptance for medical marijuana in their community, 60.0% indicated that community acceptance was overwhelming. This was in contrast to Sacramento County, in which a mere 13.3% indicated that community acceptance was overwhelming. Both counties reported 0.0% felt that there was no community acceptance at all for medical marijuana. Mendocino County also had no response indicating very little acceptance, while the remaining 40.0% of rural participants felt there community somewhat accepted medical marijuana. In Sacramento County, 20.0% of participants indicated that they felt there was very little community acceptance of medical marijuana, while the largest majority of urban participants, totaling 66.7%, felt that the community somewhat accepting of medical marijuana.
Table 4.8

*Perceived Community Acceptance of Medical Marijuana by Study Participants (N=30)*

<table>
<thead>
<tr>
<th>COMMUNITY ACCEPTANCE FOR MEDICAL MARIJUANA</th>
<th>Mendocino County</th>
<th>Sacramento County</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at All</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Very Little</td>
<td>0.0%</td>
<td>20.0%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Somewhat</td>
<td>40.0%</td>
<td>66.7%</td>
<td>53.3%</td>
</tr>
<tr>
<td>Overwhelming</td>
<td>60.0%</td>
<td>13.3%</td>
<td>36.7%</td>
</tr>
</tbody>
</table>

When asked if they felt that a physician should be able to prescribe medical marijuana to patients, the responses from participants from each county were identical, with 73.3% stating that they agreed with a physician’s ability to prescribe medical marijuana and 13.3% disagreeing. Additionally, 13.3% in both counties were unsure of how they felt in regards to this issue.

Table 4.9

*Should Physicians Be Allowed to Prescribe Medical Marijuana, Opinion of Study Participants (N=30)*

<table>
<thead>
<tr>
<th>SHOULD PHYSICIAN’S BE ABLE TO PROVIDE MED MARIJUANA PRESCRIPTION</th>
<th>Mendocino County</th>
<th>Sacramento County</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>73.3%</td>
<td>73.3%</td>
<td>73.3%</td>
</tr>
<tr>
<td>No</td>
<td>13.3%</td>
<td>13.3%</td>
<td>13.3%</td>
</tr>
<tr>
<td>Unsure</td>
<td>13.3%</td>
<td>13.3%</td>
<td>13.3%</td>
</tr>
</tbody>
</table>
Clients Use and Symptoms

*Are you aware of the typical symptoms that would allow a person to obtain a prescription for medical marijuana?* When participants were asked if they were aware of the symptoms that would allow a person to obtain a prescription for medical marijuana, a majority in each county stated they were aware how. Mendocino County had 66.7% and Sacramento County had 46.7% for a combined average response of 56.7% confirming their knowledge in this matter. Both counties had reported 6.7% of respondents stating that they did not know what typical symptoms may be to warrant a prescription. A total of 26.7% in Mendocino County and 46.7% in Sacramento County state that they were unsure of the symptoms that would allow a person to obtain a prescription for medical marijuana.

Table 4.10

*Awareness of Possible Symptoms for Obtaining Medical Marijuana Prescription by Study Participants (N=30)*

<table>
<thead>
<tr>
<th>AWARENESS OF PRESCRIPTION WARRANTING SYMPTOMS</th>
<th>Mendocino County</th>
<th>Sacramento County</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>66.7%</td>
<td>46.7%</td>
<td>56.7%</td>
</tr>
<tr>
<td>No</td>
<td>6.7%</td>
<td>6.7%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Unsure</td>
<td>26.7%</td>
<td>46.7%</td>
<td>36.7%</td>
</tr>
</tbody>
</table>
Have you ever worked with a client who had a prescription for medical marijuana? When asked had the participants ever worked with a client who had a prescription for medical marijuana, the majority for Mendocino county 93.3% and Sacramento County 80.0% indicated that they had worked with a client who had such a prescription. This made for a combined average of 86.7% of the participants had worked with a client who had a prescription for medical marijuana. Both counties mirrored a response of 6.7% that had not worked with clients with a medical marijuana prescription. Additionally, Sacramento County participants had 13.3% that were unsure.

Table 4.11

<table>
<thead>
<tr>
<th>WORKING WITH CLIENT’S WITH MEDICAL MARIJUANA PRESCRIPTIONS</th>
<th>Mendocino County</th>
<th>Sacramento County</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>93.3%</td>
<td>80.0%</td>
<td>86.7%</td>
</tr>
<tr>
<td>No</td>
<td>6.7%</td>
<td>6.7%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Unsure</td>
<td>0.0%</td>
<td>13.3%</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

Were you aware of the method that your client used to obtain medical marijuana (dispensary, illegally)? Participants were asked if they were aware of how their clients with prescriptions obtained medical marijuana—such as from a dispensary—and the majority for each county responded that they did in fact know how their client obtained their medical marijuana. With 73.3% in Mendocino County and 66.7% in Sacramento County, those numbers accounted for 70.0% of the participant’s total averaged responses.
Only 26.6% in Mendocino County and 6.7% in Sacramento County responded that they were unaware of how the client obtained the medical marijuana and 0.0% of Mendocino social workers and 26.7% of Sacramento County social workers were unsure how the client obtained the medical marijuana.

Table 4.12
Awareness of Methods Used to Obtain Medical Marijuana by Study Participants (N=30)

<table>
<thead>
<tr>
<th>METHODS OF ATTAINMENT</th>
<th>Mendocino County</th>
<th>Sacramento County</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>73.3%</td>
<td>66.7%</td>
<td>70.0%</td>
</tr>
<tr>
<td>No</td>
<td>26.7%</td>
<td>6.7%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Unsure</td>
<td>0.0%</td>
<td>26.7%</td>
<td>13.3%</td>
</tr>
</tbody>
</table>

Do you believe that symptoms generally utilized to obtain a prescription for medical marijuana actually warrant a prescription? When participants were asked if the symptoms that a client had noted in order to obtain a prescription for medical marijuana actually warranted a prescription in their opinion, respondents from Mendocino County indicated largely indicated with 60.0% that symptoms sometimes warranted a prescription. A smaller percentage of 26.6% indicated that they rarely felt a prescription was warranted and 6.7% felt that the prescription was never warranted. No participant in Mendocino County felt that a prescription for medical marijuana was always warranted due to symptoms. In Sacramento County, an equal number of participants representing 13.3% for each category indicated that a prescription was never, rarely, or always warranted. Forty percent of Sacramento County participants felt that a prescription was sometimes warranted. The most common response between the two counties was that a
prescription was sometimes warranted, with an averaged response total of 50.0% for Mendocino and Sacramento County.

Table 4.13

Symptoms Warranting Prescriptions, Opinions of Study Participants (N=30)

<table>
<thead>
<tr>
<th>DO SYMPTOMS WARRANT PRESCRIPTION</th>
<th>Mendocino County</th>
<th>Sacramento County</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>6.7%</td>
<td>13.3%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Rarely</td>
<td>26.7%</td>
<td>13.3%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>60.0%</td>
<td>40.0%</td>
<td>50.0%</td>
</tr>
<tr>
<td>Always</td>
<td>0.0%</td>
<td>13.3%</td>
<td>6.7%</td>
</tr>
<tr>
<td>N/A</td>
<td>6.7%</td>
<td>20.0%</td>
<td>13.3%</td>
</tr>
</tbody>
</table>

Has a client’s use of medical marijuana negatively impacted your ability to work with that client? When participants were asked to respond to whether the client’s use of medical marijuana negatively impacted the participant’s ability to work with the client, Mendocino County and Sacramento County both responded with Never 20.0% of the time and Always with 6.7% of the time. Mendocino County responded Rarely 20.0% while Sacramento County responded with 26.7% of the time did the client’s use impact their ability to work with the client. Participants indicated Sometimes 46.7% in Mendocino County and Sacramento County indicated 20.0%. Sometimes had response totals of 33.3%, which was the highest combined total. Finally, N/A had a 6.7% response for Mendocino County and 26.7% response for Sacramento County.
Table 4.14

*Perceived Impact on Working Relationship with Clients Who Use Medical Marijuana by Study Participants (N=30)*

<table>
<thead>
<tr>
<th>ABILITY TO WORK WITH CLIENTS</th>
<th>Mendocino County</th>
<th>Sacramento County</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>20.0%</td>
<td>20.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Rarely</td>
<td>20.0%</td>
<td>26.7%</td>
<td>23.3%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>46.7%</td>
<td>20.0%</td>
<td>33.3%</td>
</tr>
<tr>
<td>Always</td>
<td>6.7%</td>
<td>6.7%</td>
<td>6.7%</td>
</tr>
<tr>
<td>N/A</td>
<td>6.7%</td>
<td>26.7%</td>
<td>16.7%</td>
</tr>
</tbody>
</table>

*Does the overall position of your employer in regards to medical marijuana impact your ability to work with clients using medical marijuana?* When the participants were asked if their employer’s overall position on medical marijuana impacted their ability to work with clients using medical marijuana, Mendocino County responded never 53.3% while Sacramento County responded 33.3%. The response total was 43.3%, which was the highest combined total for the counties. A total of 26.7% of Mendocino County participants gave a response of Rarely and Sacramento County responded with 20.0%. Both Mendocino County and Sacramento County had a response total of 20.0% for Sometimes. No Mendocino County responded with Always, while 26.7% of Sacramento County participants had the same response.
Table 4.15

*Impact of Employer’s Overall Position Regarding Medical Marijuana, Opinion of Study Participants (N=30)*

<table>
<thead>
<tr>
<th>IMPACT OF EMPLOYER POSITION</th>
<th>Mendocino County</th>
<th>Sacramento County</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>53.3%</td>
<td>33.3%</td>
<td>43.3%</td>
</tr>
<tr>
<td>Rarely</td>
<td>26.7%</td>
<td>20.0%</td>
<td>23.3%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>20.0%</td>
<td>20.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Always</td>
<td>0.0%</td>
<td>26.7%</td>
<td>13.3%</td>
</tr>
</tbody>
</table>

*Can medical marijuana negatively impact a person’s ability to be a functioning adult?* When asked if the participants felt that medical marijuana negatively impacted a person’s ability to be a functioning adult, both of the counties responded with Rarely, 26.7% of the time and Always 13.3%. Mendocino County responded 0.0% to Never while Sacramento County participants responded with Never 6.7% of the time. Sometimes had the greatest response totals with 60% from Mendocino County and 53.3% in Sacramento County and the total of 56.7% of the total participants.
Table 4.16

*Medical Marijuana as a Negative Impact on Ability to be a Functioning Adult, Opinions of Study Participants (N=30)*

<table>
<thead>
<tr>
<th>NEGATIVE IMPACT TO BE FUNCTIONING ADULT</th>
<th>Mendocino County</th>
<th>Sacramento County</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>0.0%</td>
<td>6.7%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Rarely</td>
<td>26.7%</td>
<td>26.7%</td>
<td>26.7%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>60.0%</td>
<td>53.3%</td>
<td>56.7%</td>
</tr>
<tr>
<td>Always</td>
<td>13.3%</td>
<td>13.3%</td>
<td>13.3%</td>
</tr>
</tbody>
</table>

*Can medical marijuana negatively impact a person’s ability to parent?* The participants were asked if they felt medical marijuana negatively impacted a person’s ability to parent. Mendocino County and Sacramento County participants both responded with Sometimes 60.0% and Always 13.3% of the time. The response of sometimes had the highest response total with 60%. Mendocino County had no responses of Never and 6.7% of Sacramento County participants answered Never. Slightly more than one quarter of Mendocino County participants responded with Rarely, while 20.0% of Sacramento County participants responded with Rarely.
Table 4.17

*Medical Marijuana as a Negative Impact on Parenting, Opinion of Study Participants (N=30)*

<table>
<thead>
<tr>
<th>NEGATIVE IMPACT ON PARENTING</th>
<th>Mendocino County</th>
<th>Sacramento County</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>0.0%</td>
<td>6.7%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Rarely</td>
<td>26.7%</td>
<td>20.0%</td>
<td>23.3%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>60.0%</td>
<td>60.0%</td>
<td>60.0%</td>
</tr>
<tr>
<td>Always</td>
<td>13.3%</td>
<td>13.3%</td>
<td>13.3%</td>
</tr>
</tbody>
</table>

*Is medical marijuana a bridge to the abuse of other substances?* When the participants were asked if they felt that medical marijuana was a bridge to the abuse of other substances, the responses for the counties varied. Mendocino County responded with Never 0.0%, Rarely 26.7%, Sometimes 66.7% and Always 6.7%. Sacramento County responded with Never 13.3%, Rarely 13.3%, Sometimes 60.0% and Always 13.3%. Mendocino County and Sacramento County responded with Sometimes 63.3% for the highest combined average response total.
Table 4.18

Feeling by Study Participants that Marijuana May Be a Bridge to Other Substances

(N=30)

<table>
<thead>
<tr>
<th>MARIJUANA AS A BRIDGE</th>
<th>Mendocino County</th>
<th>Sacramento County</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>0.0%</td>
<td>13.3%</td>
<td>6.7%</td>
</tr>
<tr>
<td>Rarely</td>
<td>26.7%</td>
<td>13.3%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>66.7%</td>
<td>60.0%</td>
<td>63.3%</td>
</tr>
<tr>
<td>Always</td>
<td>6.7%</td>
<td>13.3%</td>
<td>10.0%</td>
</tr>
</tbody>
</table>

Can a person become psychologically dependent on medical marijuana? When the participants were asked if they believed that a person could be psychologically dependent on medical marijuana, the responses again varied slightly. In Mendocino County, 0.0% of respondents answered never or rarely, while Sacramento County respondents held 6.7% in each of those categories, in addition to the same percentage in the Always category. Although a slightly higher percentage felt that medical marijuana led to a psychological dependence (13.3%), both counties found their majority in the Sometimes category with a combined average of 83.3% of respondents. responded with Never and Rarely, 0.0%. Mendocino County responded with Sometimes 86.7% and Always 13.3%. Sacramento County responded with Never and Rarely for a total of 6.7%, Sometimes 80.0% and Always 6.7%. Sometimes had the greatest amount of total responses with 83.3%.
Table 4.19

Belief of Study Participants that Medical Marijuana Can Lead to Psychological Dependence (N=30)

<table>
<thead>
<tr>
<th>PSYCHOLOGICAL DEPENDENCE</th>
<th>Mendocino County</th>
<th>Sacramento County</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>0.0%</td>
<td>6.7%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Rarely</td>
<td>0.0%</td>
<td>6.7%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>86.7%</td>
<td>80.0%</td>
<td>83.3%</td>
</tr>
<tr>
<td>Always</td>
<td>13.3%</td>
<td>6.7%</td>
<td>10.0%</td>
</tr>
</tbody>
</table>

Has your employer provided you with information regarding medical marijuana policies? Participants were asked if they have ever been provided with information regarding medical marijuana by their employer. A combined average from both counties of 90.0% responded that they had never been provided with any such information. In Mendocino County, 86.7% of the participants indicated that they had not been provided with any information regarding medical marijuana while 13.3% indicated that they had. Participants from Sacramento County reported similarly with 93.3% stating that they had not received any information regarding medical marijuana while 6.7% reported that they had.
Table 4.20

*Information from Employers Received by Study Participants (N=30)*

<table>
<thead>
<tr>
<th>DOES EMPLOYER PROVIDE MED MARIJUANA INFORMATION</th>
<th>Mendocino County</th>
<th>Sacramento County</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>13.3 %</td>
<td>6.7%</td>
<td>10.0%</td>
</tr>
<tr>
<td>No</td>
<td>86.7%</td>
<td>93.3%</td>
<td>90.0%</td>
</tr>
</tbody>
</table>

*Advocacy*

_Have you ever had to advocate for a client’s right to use medical marijuana?_

When the participants were asked if they have ever had to advocate for a client’s right to use medical marijuana, Mendocino County and Sacramento County both received 6.7% of respondents answering that they always had to advocate. The category receiving the majority of responses from both counties was that of Never, with 60.0% of respondents from Mendocino County and 73.3% from Sacramento County, making for an averaged combined response of 66.7% for Never. For Mendocino County, Rarely had a 6.7% response, Sometimes carried 26.7% of the response and Always had a 6.7% response. In comparison, 0.0% of Sacramento County participants reported that they rarely had to advocate, 20.0% reported that they sometimes had to advocate and only 6.7% felt that they always had to advocate for a client’s right to use medical marijuana.
Table 4.21

*Need to Advocate for a Client to Use Medical Marijuana by Study Participants (N=30)*

<table>
<thead>
<tr>
<th>ADVOCATING FOR CLIENTS USE OF MEDICAL MARIJUANA</th>
<th>Mendocino County</th>
<th>Sacramento County</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>60.0%</td>
<td>73.3%</td>
<td>66.7%</td>
</tr>
<tr>
<td>Rarely</td>
<td>6.7%</td>
<td>0.0%</td>
<td>3.3%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>26.7%</td>
<td>20.0%</td>
<td>23.3%</td>
</tr>
<tr>
<td>Always</td>
<td>6.7%</td>
<td>6.7%</td>
<td>6.7%</td>
</tr>
</tbody>
</table>

*Do you believe that the NASW Code of Ethics obligates you to advocate for a client’s right to self determination, even in regards to medical marijuana? The final question of the survey asked the participants if they believed as a social worker that the NASW Code of Ethics obligates them to advocate for a client’s right to self-determination, even if it involves medical marijuana. The responses from the counties varied. Twenty percent of Mendocino County responded that they felt this was never true and 26.7% of respondents felt that they rarely, sometimes or always believed that it was the social worker’s obligation to advocate. In both the Never and Rarely categories, Sacramento County participants responded with 13.3%, jumping to 20.0% with a response of Sometimes and 53.3% with Always. Although both counties had the highest number of responses believing that it was always the obligation of the social worker to advocate, Sacramento County had a much stronger response.*
Table 4.22

*Sense of Obligation to Advocate for a Client’s Right to Self Determination by Study Participants (N=30)*

<table>
<thead>
<tr>
<th>NASW CODE OF ETHICS OBLIGATION</th>
<th>Mendocino County</th>
<th>Sacramento County</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>20.0%</td>
<td>13.3%</td>
<td>16.7%</td>
</tr>
<tr>
<td>Rarely</td>
<td>26.7%</td>
<td>13.3%</td>
<td>20.0%</td>
</tr>
<tr>
<td>Sometimes</td>
<td>26.7%</td>
<td>20.0%</td>
<td>23.3%</td>
</tr>
<tr>
<td>Always</td>
<td>26.7%</td>
<td>53.3%</td>
<td>40.0%</td>
</tr>
</tbody>
</table>

The researchers performed several chi-square tests from the data collected in this survey in order to analyze any correlations that were significant within the data. Nearly half of all participants reported that their religious views did not impact their professional practice at all. Survey questions did not ask for specific reasons as to why participants answered in the way that they did, whether they were simply not religious or made a concerted effort to keep their professional practice separate from their personal belief system. Of those participants that claimed religious beliefs had no impact on their professional practice, however, over half supported the right of a physician to recommend medical marijuana to patients, while one participant did not and one was unsure of their opinion. In contrast to this data, those participants that reported their religious beliefs as a factor that influenced their professional practice somewhat or greatly, one quarter did not support the right of a physician to recommend medical marijuana to patients and only
9.1% did support that right. This data is approaching significance, though further research that is more detailed would be necessary to achieve absolute significance.

Table 4.23

Correlation between the impact that individual religious views have on professional practice and whether or not the participant supports the right of a physician to recommend medical marijuana (N=30)

<table>
<thead>
<tr>
<th>Spectrum of Religious Views</th>
<th>Support right of physician to recommend medical marijuana</th>
<th>Do not support right of physician to recommend medical marijuana</th>
<th>Unsure if support right of physician to recommend medical marijuana</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Respondents</td>
<td>22</td>
<td>4</td>
<td>4</td>
<td>30</td>
</tr>
<tr>
<td>Religious views do not influence professional practice at all</td>
<td>54.5% (12)</td>
<td>25.0% (1)</td>
<td>25.0% (1)</td>
<td>46.7% (14)</td>
</tr>
<tr>
<td>Religious views influence professional practice very little</td>
<td>18.2% (4)</td>
<td>0.0% (0)</td>
<td>50.0% (2)</td>
<td>20.0% (6)</td>
</tr>
<tr>
<td>Religious views influence professional practice somewhat</td>
<td>18.2% (7)</td>
<td>50.0% (2)</td>
<td>25.0% (1)</td>
<td>23.3% (7)</td>
</tr>
<tr>
<td>Religious views influence professional practice greatly</td>
<td>9.1% (2)</td>
<td>25.0% (1)</td>
<td>0.0% (0)</td>
<td>10.0% (3)</td>
</tr>
</tbody>
</table>

A similar chi-square test was performed to analyze any significant correlation between the impact that participants reported their political views having on their professional practice and whether or not they supported the right of a physician to
recommend medical marijuana to patients. Only 10% of participants reported that their political views did not impact their professional practice at all and merely twenty percent indicated that their political views impacted their practice greatly. Because the largest majority of participants indicated that their political views impact their professional practice very little or only somewhat, it was difficult to note any significance.

Table 4.24

*Correlation between the impact that individual religious views have on professional practice and whether or not the participant supports the right of a physician to recommend medical marijuana (N=30)*

<table>
<thead>
<tr>
<th>Political views influence professional practice</th>
<th>Support right of physician to recommend medical marijuana</th>
<th>Do not support right of physician to recommend medical marijuana</th>
<th>Unsure if support right of physician to recommend medical marijuana</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Respondents</td>
<td>22</td>
<td>4</td>
<td>4</td>
<td>30</td>
</tr>
<tr>
<td>Political views do not influence professional practice at all</td>
<td>13.6%</td>
<td>25.0%</td>
<td>50.0%</td>
<td>10.0%</td>
</tr>
<tr>
<td></td>
<td>(3)</td>
<td>(1)</td>
<td>(2)</td>
<td>(3)</td>
</tr>
<tr>
<td>Political views influence professional practice very little</td>
<td>31.8%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>33.3%</td>
</tr>
<tr>
<td></td>
<td>(7)</td>
<td>(0)</td>
<td>(0)</td>
<td>(10)</td>
</tr>
<tr>
<td>Political views influence professional practice somewhat</td>
<td>31.8%</td>
<td>50.0%</td>
<td>50.0%</td>
<td>36.7%</td>
</tr>
<tr>
<td></td>
<td>(7)</td>
<td>(2)</td>
<td>(2)</td>
<td>(11)</td>
</tr>
<tr>
<td>Political views influence professional practice greatly</td>
<td>22.7%</td>
<td>25.0%</td>
<td>0.0%</td>
<td>20.0%</td>
</tr>
<tr>
<td></td>
<td>(5)</td>
<td>(1)</td>
<td>(0)</td>
<td>(6)</td>
</tr>
</tbody>
</table>
Although nearly all study participants from Mendocino County indicated that they had worked with clients with a recommendation for medical marijuana, a massive eighty percent of Sacramento indicated likewise. Sixty percent of study participants support the legalization of marijuana. A chi-square test was performed in order to assess any correlation between those social workers who had worked with clients with a recommendation for medical marijuana and those that support the legalization of marijuana. The chi-test was significant as it showed that over half of the study participants that have worked with clients who had a recommendation for medical marijuana also support the legalization of marijuana.
Table 4.25

Correlation between those participants that have worked with clients with a prescription for medical marijuana and participants that support the legalization of marijuana

(N=30)

<table>
<thead>
<tr>
<th></th>
<th>Support the legalization of marijuana</th>
<th>Do not support the legalization of marijuana</th>
<th>Unsure if support the legalization of marijuana</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Respondents</td>
<td>26</td>
<td>2</td>
<td>2</td>
<td>30</td>
</tr>
<tr>
<td>Have worked</td>
<td>57.7% (15)</td>
<td>50.0% (1)</td>
<td>100.0% (2)</td>
<td>60.0%</td>
</tr>
<tr>
<td>with a client who</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>had a prescription</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for medical marijuana</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Have not worked</td>
<td>23.1% (6)</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>20.0%</td>
</tr>
<tr>
<td>with a client who</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>had a prescription</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for medical marijuana</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unsure if worked</td>
<td>19.2% (5)</td>
<td>50.0% (1)</td>
<td>0.0% (0)</td>
<td>20.0%</td>
</tr>
<tr>
<td>with a client who</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>had a prescription</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for medical marijuana</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

A chi-square test was performed in order to test any correlation between those participants indicating a history of having worked with clients with a recommendation for medical marijuana and those participants indicating a negative impact on the working relationship with those clients who use medical marijuana. No participants that indicated they had worked with clients with a recommendation stated that there was no negative impact on the working relationship due to the client’s use of medical marijuana. This chi-square test was noted as significant to the data.
Table 4.26

Correlation between participants who reported having worked with clients who had a prescription for medical marijuana and participants who reported a belief that medical marijuana had a negative impact on that working relationship (N=30)

<table>
<thead>
<tr>
<th></th>
<th>Never worked with a client who had a prescription for medical marijuana</th>
<th>Rarely worked with a client who had a prescription for medical marijuana</th>
<th>Sometimes worked with a client who had a prescription for medical marijuana</th>
<th>Always worked with clients who had a prescription for medical marijuana</th>
<th>N/A</th>
<th>Response Totals</th>
</tr>
</thead>
<tbody>
<tr>
<td>All Respondents</td>
<td>6</td>
<td>7</td>
<td>10</td>
<td>2</td>
<td>5</td>
<td>30</td>
</tr>
<tr>
<td>Affirm a negative impact from medical marijuana on working relationship</td>
<td>100.0% (6)</td>
<td>100.0% (7)</td>
<td>100.0% (10)</td>
<td>100.0% (2)</td>
<td>20.0% (1)</td>
<td>86.7% (26)</td>
</tr>
<tr>
<td>Deny a negative impact from medical marijuana on working relationship</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>40.0% (2)</td>
<td>6.7% (2)</td>
</tr>
<tr>
<td>Unsure of a negative impact from medical marijuana on working relationship</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>0.0% (0)</td>
<td>40.0% (2)</td>
<td>6.7% (2)</td>
</tr>
</tbody>
</table>
Summary and Comparison

After analyzing all of the results from the survey, it was noted that there were far more women than men participants. The most responses came from survey participants between the ages of 36-45 with over sixteen years of experience in the field of social work. Social workers from Child Protective Services represented the greatest amount of participants from both counties.

Mendocino County social workers results indicated that their religious views did not impact their professional practice and that their political views impacted their professional practice somewhat to very little. Sacramento County social workers indicated that both their religious and political views somewhat impacted their professional practice. Both counties agreed with the legalization of marijuana and felt informed as to what the typical symptoms were that would allow a person to obtain a prescription and believed that a physician should be able to prescribe medical marijuana. Despite the consensus that marijuana should be legalized, Sacramento County participants indicated that the level of acceptance for people who use medical marijuana was only somewhat in the community, while in Mendocino County the participants felt the response from the community was overwhelming supportive of medical marijuana.

Both sets of participants indicated that they have had experience working with clients who have used medical marijuana and knew how the client had obtained the marijuana. There was also agreement between the urban and rural counties that sometimes the symptoms that clients were experiencing did warrant the prescription. A difference did arise in respect to how the question of whether a client’s use of medical
marijuana negatively impacted the social worker’s ability to work with that client.

Workers from Mendocino County indicated that their ability to work with clients who are prescribed marijuana was sometimes impacted, while workers from Sacramento County responded that either the client’s use was not applicable or that the use rarely had a negative impact on their ability to work with the client.

Again, both sets of participants agree that their employer’s overall position on medical marijuana has never impacted their ability to work with clients. Additionally, both rural and urban participants indicated that sometimes medical marijuana can negatively impact the client’s ability to be a functioning adult and parent. Another agreement between the two sets of participants was in that both indicated that they believed that sometimes medical marijuana can be a bridge to the use of other substances. The belief that sometimes medical marijuana is something a person can become psychologically dependent on was also agreed upon by participants in both counties.

Ironically, in respect to how controversial the topic of medical marijuana is currently, participants in both Mendocino and Sacramento County reported that they have never been provided with information regarding medical marijuana. This is especially interesting in light of the fact that Mendocino County is considered such a liberal county even in comparison to urban Sacramento County. Participants from both counties indicated that they had never had to advocate for a client’s right to use medical marijuana.

Researchers found it to be somewhat concerning that participants in Mendocino County indicated that only rarely and sometimes did they believe that it was their
obligation according to NASW Code of Ethics to advocate for a client’s right to self-determination by advocating for their right to use medical marijuana. Sacramento County participants indicated that it was always their obligation to advocate for the client. Before conducting and analyzing the surveys for this study, researchers hypothesized that with the overwhelmingly progressive attitude surrounding marijuana in Mendocino County would yield much more liberal views in support of medical marijuana by rural social workers. In reality, analysis of data indicated that although rural participants acknowledged overwhelming community support, social workers themselves were not as supportive or open to client use of medical marijuana. In fact, Sacramento County participants reported an overall more supportive and tolerant view of working with clients who are prescribed medical marijuana. Results of this survey did not address if the lack of support by rural social workers was out of frustration at having to consistently work with clients who use medical marijuana; however, the researchers feel this would be an interesting topic to explore and perhaps fill some gaps in the currently available literature.
Chapter 5

SUMMARY

Introduction

This chapter will include a summary of the analyzed data collected in this study. The purpose of this study was to examine ethical dilemmas facing social workers that are providing services to clients who choose to use medical marijuana. Also examined are agency policies regarding medical marijuana and the information provided by agencies to social workers in regards to working with clients who use medical marijuana. The researchers further wanted to identify whether rural and urban social workers felt differently regarding the rights of their clients to use medical marijuana. This chapter will also provide recommendations and discuss the limitations of the study, as well as the implications of the findings for social work practice, policy and future research.

Summary

Little research has been done on the ethical dilemmas facing social workers who are providing services to clients who use or wish to obtain medical marijuana. The researchers hypothesized that professionals in Mendocino County would be more liberal in their views of the legitimacy of medical marijuana, based on the historical tolerance for marijuana in that county. The hypothesis that rural participants from Mendocino County would hold more liberal views was not isolated to the researchers, as several participants shared their views after participating in the survey and shared the same expectation with researchers. Somewhat surprising were the findings that overall, there was not a significant difference in the views of social workers who practiced in
Mendocino and Sacramento Counties in regards to medical marijuana. Analysis of the data in fact showed that social workers in Sacramento County supported the legalization of marijuana far more than their counterparts in Mendocino County. The results of the study also revealed that although there is clearly more reported community support for medical marijuana as well as more reports of having worked with clients who use medical marijuana by social workers in Mendocino County, the majority of participants in both counties felt that a physician should be allowed the right to recommend a prescription for medical marijuana.

The chi-square test results showed a correlation between the extents that religious views impacted the professional practice of individual participants and their belief that a physician should have the right to recommend medical marijuana to patients. Chi-square test results also approached significance between whether the participant reported having worked with clients who used medical marijuana and their belief as to the negative impacts of a client’s use of medical marijuana on the ability to work with that client. Chi-square tests showed little significance between the impact of the political views on professional practice by participants and their belief that a physician should have the right to recommend medical marijuana to patients.

Discussion

The purpose of the survey was to explore differences—if they indeed existed—between the views of social workers in the more rural setting of Mendocino County and the urban setting of Sacramento County in regards to medical marijuana. The researchers also compared possible impacts of religious views, political views and established
experience working with clients who use medical marijuana with the different views of
participants surrounding the topic of medical marijuana as well.

While less than half of the professionals who practiced in Mendocino County
supported the legalization of marijuana, Sacramento County participants overwhelmingly
supported the legalization of marijuana, with nearly three-fourths indicating as such. This
study did not further delve into the reasons that participants supported or did not support
the legalization of marijuana, as that was not the intent of the research. Rather, the
researchers attempted to establish any correlation between participant support of the
legalization of marijuana and the sense of obligation by participants to advocate for their
client’s right to self determination in choosing medical marijuana as a medication for an
established medical condition. It is interesting to note that all participants who answered
that they did not support the legalization of marijuana also reported experience working
with clients who they knew to have a recommendation to use medical marijuana. The
review of the literature touched on the idea that many individuals fear that the
legalization of marijuana could lead young adults and youth to further experimentation
with other drugs (Khatapoush & Halifors, 2004; Joffe & Yancy, 2004); however, further
research indicates that not only did attitudes among young Californians not become more
liberal with the passage of Proposition 215, but there was actually a decline in reported
marijuana use among young adults after the laws became more liberal (Armentano,
2007). More extensive research would be necessary to further explore possible reasons
for those having more experience working with clients who use medical marijuana not
supporting the legalization of marijuana.
There was statistical significance between the reported impact of the religious views of participants and their views regarding whether or not a physician should be allowed to recommend medical marijuana for patients. Although none of the literature reviewed addressed social workers’ religious views as an impact on professional practice—or how this may impact beliefs regarding medical marijuana—it is important to take note of this correlation. Personal experiences and beliefs that may be the cause of conflict of interest and interfere with the exercise of professional discretion and impartial judgment should be avoided at all cost (NASW, 1996). Although professionals practicing social work may understand this commitment, clearly they are not immune to falling short of that expectation.

Most interesting to the researchers as current students was that although all participants were currently practicing social work with a Master’s level of education and were fully aware of their responsibility to use the NASW Code of Ethics as a guideline to their practice, only slightly more than one fourth of participants in Mendocino County and slightly more than half of the participants in Mendocino County felt a sense of obligation to always advocate for their client’s right to self determination in choosing medical marijuana to manage an established medical condition. The NASW clearly states that social workers are to support and advocate for the right to self determination by their clients (NASW, 1996). These conflicting results support the idea that personal feelings and views definitely come into play in professional practice, whether intentional or otherwise.
Limitations

The limitations of this study include the number of participants in the survey (N=30), the participants themselves, the researchers who created the survey and analyzed the data and the lack of currently available research on medical marijuana. It is impossible for the findings of this study to be generalized to larger populations because of the limited number of participants and due to the fact that representative sampling was not utilized. It could be hypothesized based on specific data collected in the study that the participants’ biases based on personal experiences and beliefs systems may have influenced what was reported. As well, any bias that the researchers have may have affected the design of the study and analysis. In order to effectively further the research on this topic the study must be duplicated and a larger population needs to be sampled and representative probability sampling methods should be used. Additionally, because marijuana is a Schedule I drug, the federal government has not invested in allowing for a great deal of scientific research to be conducted.

Implications for Social Work Practice and Policy

This study did provide implications for social work practice and policy. Information gained from the analyzed data of this study will help to increase knowledge base on the general topic of the therapeutic benefits of medical marijuana and more specifically the ethical dilemmas facing social workers who are providing services to clients using medical marijuana. It is the hope of the researchers that the information gathered from this study will encourage others to do additional research on this topic.
In respect to implications on the micro level, ideally social workers should make an active effort to be aware of their own motivations, biases, beliefs and views so that they are more effective in working with clients of various populations. Helping professionals who may access the data presented in this study will hopefully take note to increase their own self-awareness so that personal motivations do not interfere with professional practice, thus heightening effectiveness in working with clients.

Considering implication on the mezzo level, the hope is that the findings in this study will allow for leaders of agencies to better prepare social work professionals in those agencies to understand the needs of their clients as well as to be clearer regarding agency policy. For example, it would be helpful for agencies to offer competency training on the topic of clients who utilize the therapeutic properties of medical marijuana to their staff. Being culturally competent should not be limited to knowledge of different races and religions, but rather any relevant way of life that may differ from our own. According to data drawn form this survey, a very small percentage indicated that they had received any sort of training or literature about agency policy on medical marijuana by their employer. This is despite the fact that participants from both counties have indicated that they work with clients who use medical marijuana. Current agency policies need to be examined to see if those policies allow for a client to determine what the best, legal method of treatment is for any identified medical conditions. Social workers practicing in these agencies also need to be made aware of said policies rather than practicing based on assumptions or rumor. These policy changes or clarifications could occur on various levels, such as unit or department wide trainings and NASW education recommendations.
Before implementing any policy change, further studies are warranted in order to ensure that said policies would not harm social workers or their clients in any way.

Recommendations

The purpose of this study was to examine the ethical dilemmas facing helping professionals—specifically social workers—who are providing services to clients who use medical marijuana. The following section is a list of recommendations developed for future and present social workers:

- Agencies shall educate social workers of agency policies regarding medical marijuana by offering competency trainings and written literature to social workers so that all may be a better understanding of said policies and thus an ability to serve clients better.

- Social workers shall initiate furthering their own knowledge regarding the therapeutic properties provided by medical marijuana by reviewing currently available, valid literature. This may aid in the lessening of personal bias and experience interfering with social work practice.

- Further research shall be done on this topic in order to better understand the ethical dilemmas facing social workers who are providing services to clients that use medical marijuana. Specific areas that shall be addressed include the items that were significant according to the chi-square tests. Other studies shall include larger populations and representative sampling methods.
Conclusion

This study was designed to investigate the question of what—if any—ethical dilemmas face helping professionals in Mendocino and Sacramento Counties with a Master’s Degree in social work who are working with clients using medical marijuana? The secondary purpose was to increase the amount of existing research on this topic as there presently is a negligible amount available. The findings from this study indicate that additional research should be completed on the topic so that there is a heightened level of understanding and awareness and that awareness can be applied to social work practice.

In 1999, California passed legislature which commissioned the University of California to establish a scientific research program designed to expand public scientific knowledge and awareness on alleged therapeutic usages of marijuana. In February 2010, the Center for Medicinal Cannabis Research published a report with the findings from that research in an attempt to answer the question of whether or not medical marijuana has therapeutic value. This has been the first successfully conducted clinical trial of smoked cannabis in the United States in more than twenty years, and the results provided evidence that cannabis is a promising treatment in selected pain syndrome caused by injury or disease as well as for muscle spasticity. With the topic of medical marijuana so prevalent currently, and evidence of ever changing legislation regarding the same topic, further research is necessary. Areas revealing significance with chi-square tests in this study also offered opportunity for further research. Participants who indicated that their religious views had a significant impact on their professional practice also tended to report at a much higher rate an opposition to the right of a physician to recommend medical
marijuana. The relationship between participant’s history of working relationships with clients that use medical marijuana and the perceived impact that said client’s use of medical marijuana may have on the working relationship with that client could also be an area of examination for future research. This study needs to be duplicated with a larger population in order to validate the findings. Additional in-depth studies could also further explore this topic and add to the body of available literature on the ethical dilemmas facing social workers who offer services to clients who use medical marijuana.
APPENDICES
APPENDIX A

Survey Questionnaire

COMPARING VIEWS OF SOCIAL WORKERS IN MENDOCINO COUNTY (RURAL) VERSUS SACRAMENTO COUNTY (URBAN) WHEN PROVIDING SERVICES TO CLIENTS WHO USE MEDICAL MARIJUANA

Questions

1. Gender- ◊ male ◊ female
2. What county do you practice social work? ◊ Mendocino ◊ Sacramento
3. Years in the field of social work
   0-5, 6-10, 11-15, 16+
4. Age- 25-35; 36-45; 46-55; 56-65, 65 +
5. Field of Practice
   Mental health, AOD, CPS, Hospital, School, Other
6. To what extent do you think your religious views impact your professional practice?
   Not at all, Very little, Somewhat, Greatly
7. To what extent do you think your political views impact your professional practice?
   Not at all, Very little, Somewhat, Greatly
8. Do you support the legalization of marijuana?
   Yes, No or Unsure
9. What do you think the level of acceptance is for medical marijuana by people in your community?
   Not at all, Very little, Somewhat, Overwhelming
10. Do you feel that physicians should be able to prescribe medical marijuana to patients?
    Yes, No or Unsure
11. Are you aware of typical symptoms that would allow a person to obtain a prescription for medical marijuana?
    Yes, No or Somewhat
12. Have you ever worked with a client who had a prescription for medical marijuana?
    Yes, No or Unsure
13. Were you aware of how the client obtained the medical marijuana (at a dispensary or illegally)?
14. Did you feel that the reasons the client had for obtaining a prescription were warranted?
   Never, Rarely, Sometimes, Always, N/A

15. Did you feel that the client’s use of medical marijuana negatively impacted your ability to work with the client?
   Never, Rarely, Sometimes, Always, N/A

16. Does your employer's overall position on medical marijuana impact your ability to work with clients using medical marijuana?
   Never, Rarely, Sometimes, Always

17. Do you feel that using medical marijuana impacts a person’s ability to be a functioning adult?
   Never, Rarely, Sometimes, Always

18. Do you feel that medical marijuana negatively impacts a person’s ability to parent?
   Never, Rarely, Sometimes, Always

19. Do you feel that medical marijuana is a bridge to the abuse of other substances?
   Never, Rarely, Sometimes, Always

20. Do you believe a person can become addicted to medical marijuana?
   Never, Rarely, Sometimes, Always

21. Have you ever been provided information regarding medical marijuana by your employer?
   Never, Rarely, Sometimes, Always

22. Have you ever had to advocate for a client’s right to use medical marijuana?
   Never, Rarely, Sometimes, Always

23. Do you believe, as a social worker, that the NASW Code of Ethics obligates you to advocate for a client’s right to self-determination, even if it involves medical marijuana?
   Never, Rarely, Sometimes, Always
APPENDIX B

Consent to Participate in Research

Please be aware that as a participant your responses will be kept confidence to the degree permitted by the technology used and no guarantee can be given for the confidentiality of electronic data. Should you participate in this survey, the researchers will be unable to remove data from the database should you, the participant, wish to withdraw it.

By completing this survey, you will be given consent to participate in this research survey.

◊ I agree

◊ I do not agree
APPENDIX C

Online Survey Appendix

1. Informed Consent

Yes, the software does provide the researcher with a record that captures the participant’s consent before starting the survey. That record is logged with a time and date stamp.

2. Secure transmission

Yes, the survey software does use https encryption and prevents a respondent from accidentally entering survey data via the http protocol instead of the https protocol.

3. Database security

Yes, access to the research database is limited to authorized persons by means of a username and password. The software company has signed a confidentiality agreement that prevents it from improperly accessing or disclosing the information contained in research databases.

4. Yes, the servers that contain the research data are located in a data center that has physical security and environmental controls.

5. Yes, the data is backed up nightly and there is a limited time period in which a deleted dataset can still be retrieved, but after which the data will be permanently destroyed.

6. Yes, the respondent’s IP address is masked from the researcher.
REFERENCES


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