Facts & Myths About Marijuana: Providing a safe workplace

COAA Best Practices Conference
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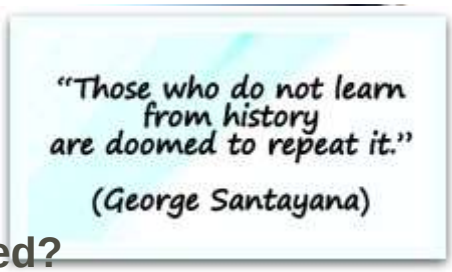
Today's agenda

- **What we'll cover**
  - **Some "big picture" observations**
  - **Cannabis overview**
  - **Recreational usage**
  - **Medical usage**
  - **Dealing with the worker taking medical marijuana**
- **What we won't**
  - **Assessing dependency/ SAEs**
  - **Duty to Accommodate/Legal considerations**

Overall message

- "It's complicated!"
- https://clra.org/p/marijuana+and+the+safety+sensitive+worker

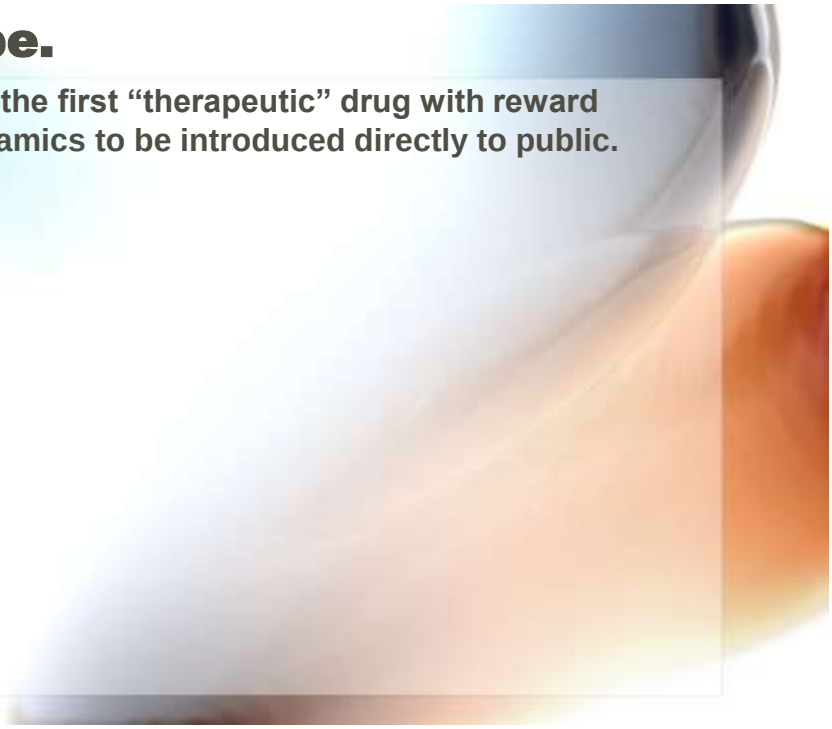
Big Picture



- Why are we confused?
- Today's cannabis situation is unparalleled:
  - Is it because a reward-causing drug has been released for public use?
  - Is it because it has been alleged to have useful medical effects?
  - Is it because it is available by prescription?

Nope.

- **Not the first "therapeutic" drug with reward dynamics to be introduced directly to public.**

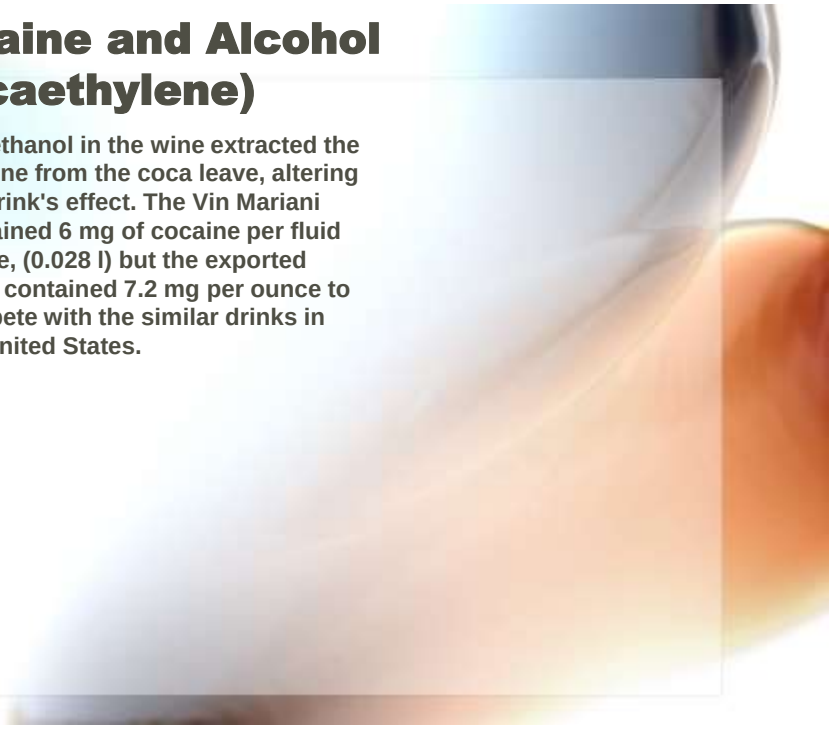


Cocaine

- Ernest Shackleton Antarctica in 1909, and Captain Scott in 1910
- Used in World War I, also.
- "Bolivian Marching Powder"

Cocaine and Alcohol (Cocaethylene)

- **The ethanol in the wine extracted the cocaine from the coca leave, altering the drink's effect. The Vin Mariani contained 6 mg of cocaine per fluid ounce, (0.028 l) but the exported drink contained 7.2 mg per ounce to compete with the similar drinks in the United States.**



Is it because it has been alleged to have useful medical effects? Nope.

- Other conditions for which cannabis drugs were often prescribed in the late 19th century were loss of appetite, inability to sleep, migraine headache, pain, involuntary twitching, excessive coughing, and treatment of withdrawal symptoms from morphine and alcohol addiction. At least 100 major articles were published in scientific journals between 1840 and 1900 recommending cannabis as a therapeutic agent for various health conditions. Reports in the literature described its effectiveness over a wide range of ailments, including gynecological disorders, such as excessive menstrual cramps and bleeding, treatment and prophylaxis of migraine headaches, alleviation of withdrawal symptoms of opium and chloral hydrate addiction, tetanus, insomnia, delerium tremens, muscle spasms, strychnine poisoning, asthma, cholera, dysentery, labor pain, psychosis, spasmodic cough, excess anxiety, gastrointestinal cramps, depression, nervous tremors, bladder irritation, and psychosomatic illness.
- By 1896 several useful new resin derivatives were developed. In a cooperative venture, Eli Lilly and Parke Davis developed a very potent domesticated *indica* strain called *Cannabis Americana*.

Because....

1. **This is the first time this (well worn) phenomenon has occurred post internet.**
   - **Knowledge (both fake and real) is now in the hands of the people**

2. **Medicine is being practiced by the legal profession, and government edict**
   - On August 11, 2016, Health Canada announced the new *Access to Cannabis for Medical Purposes Regulations* (ACMPR). These new regulations will replace the *Marihuana for Medical Purposes Regulations* (MMPR) when they come into force on August 24, 2016, and are being implemented as a result of the Federal Court ruling in the case of *Allard v. Canada*. These new regulations will allow for reasonable access to cannabis for medical purposes for Canadians who have been authorized to use cannabis for medical purposes by their health care practitioner.
   - **R. v. Smith, 2015 SCC 34 (next slide)**

Smith case

- Medical marijuana products are available for those who need them, but not in dry form. The practical effect is that the marijuana must be smoked, not taken orally or applied topically. On the evidence, the Court held, the restriction "subjects the person to the risk of cancer and bronchial infections associated with smoking dry marihuana, and precludes the possibility of choosing a more effective treatment", thereby also "forcing a person to choose between a legal but inadequate treatment and an illegal but more effective choice" (at para. 18).
- "One difficulty is that it places enormous power in the hands of first-instance judges, power they have not necessarily been trained to wield. An old joke has it that lawyers are smart people unable to cope with blood or numbers. There is a lot of blood and a lot of numbers in these cases"
- http://www.administrativelawmatters.com/blog/2015/06/23/an-age-of-facts-r-v-smith-2015-scc-34/

Relax…the government is going to fix all this….

"I don't see much sense in that," said Rabbit.

"No," said Pooh humbly, "there isn't. But there was going to be when I began it. It's just that something happened to it along the way."

A.A. Milne, *Winnie-the-Pooh*

Marijuana

- Complex mixture of > 420 chemicals; 66-113 are cannabinoids; psychoactive ingredient is delta 9 tetrahydrocannabinol: "THC"
- Cannabidiol – not psychoactive (?)
  - Interacts with THC in complex fashion
- MJ in 60's typically 3-5%, now typically 10%, can be 40% (hash oil, BC bud), or 95% plus – "dab", "shatter" or "budder"
- Fat soluble (vs. EtOH)
- Long ½ life

Receptor sites

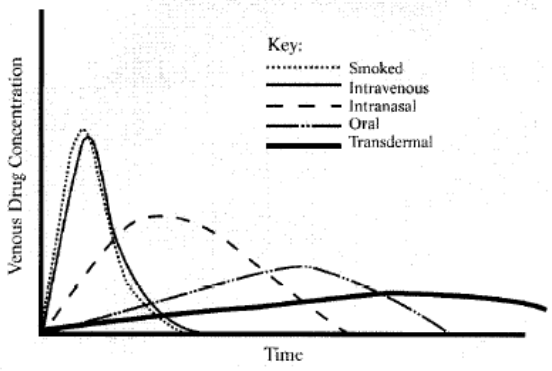
- **CB1/2 receptors**
  - **GPR55; GPR18;TRPV1**
- **Endocannabinoid system**
- **Anandamide**
  - Anandamide, also known as N-arachidonoylethanolamine or AEA, is an endogenous cannabinoid neurotransmitter. The name is taken from the Sanskrit word ananda, which means "bliss, delight", and amide.

Drug Administration, Distribution and Elimination

- phar·ma·co·ki·net·ics
- ˌfärməkōkəˈnediks/
- *noun*
- the branch of pharmacology concerned with the movement of drugs within the body.

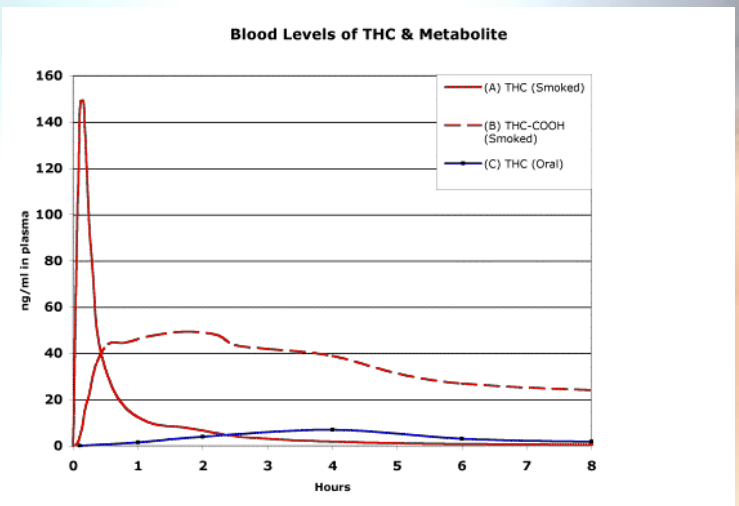
Route of Administration

FIGURE 1. Venous Drug Concentrations After Different Routes of Administration



Comparison of Rates of Delivery of Smoked, Intravenous, Intranasal, Oral, and Transdermally Applied Drug.

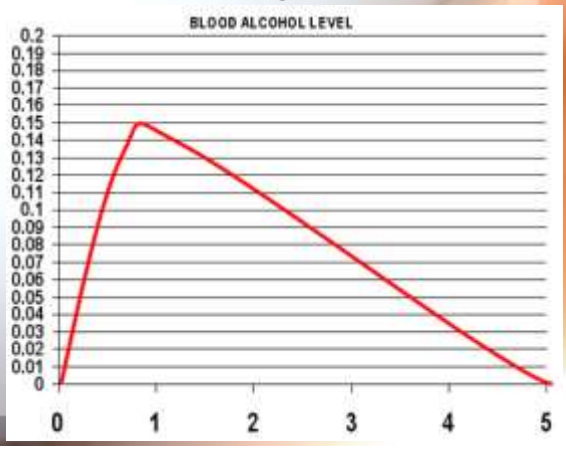
Same dose, different route



Drug concentration

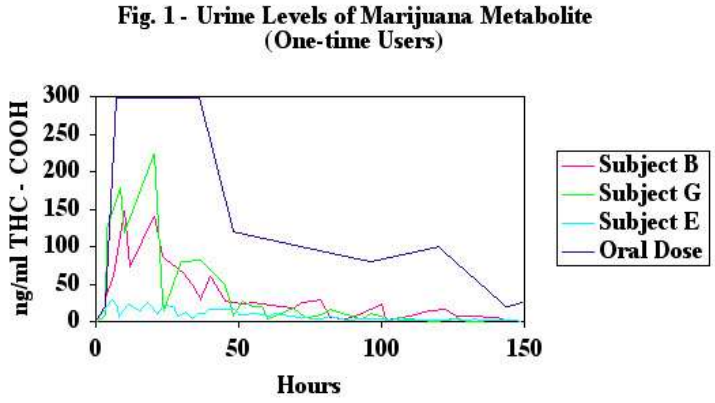
Alcohol

- Sedative/hypnotic
- Rapidly absorbed, slowed by food, water soluble
- Eliminated by first order kinetics, (slower in women), 10 gm/hr
- Converted to acetaldehyde then to acetate
- One drink in North America = 13.6 grams EtOH



THC

- Elimination non-linear!



So how long does marijuana "last?"

- **It depends!**
  - Occasional and recreational users have lower plasma THC concentrations than regular and frequent users
  - The bioavailability of Δ^9-THC varies according to the depth of inhalation, puff duration and breath-hold. The systemic bioavailability of THC is ~23-27% for heavy users and 10-14% for occasional users
  - In comparison to smoking and inhalation, after oral ingestion, systemic absorption is relatively slow resulting in maximum Δ^9-THC plasma concentration within 1-2 hours which could be delayed by few hours in certain cases . In some subjects, more than one plasma peak was observed
  - The half- life for an infrequent user is 1.3 days and for frequent users 5-13 days .
  - After smoking a cigarette containing 16-34 mg of Δ^9-THC, THC-COOH is detectable in plasma for 2-7 days . A clinical study carried out among 52 volunteers showed that THC-COOH was detectable in serum from 3.5 to 74.3 hours. Initial concentration was between 14-49 ng/mL. This was considerably less than the THC-COOH detection time of 25 days in a single chronic user.

But……..

- I am now being asked to estimate how long the drug might be detectable after using the newer formulations containing 80-95% THC
- There are no data!

But wait! There's more….

- Shatter

BHO = Butane Hash Oil

From the web:

- “Dabbing or smoking concentrates has become a popular thing in recent years. Marijuana concentrates allow you to get a fast and powerful high by using heat to extract the terpene and cannabinoid-rich resins from a marijuana flower. The methods for extracting concentrate from flowers can often be pretty volatile. Butane gas has been used as a way of extracting concentrates until recently when newer options have changed the whole game. This is good news for the many people out there who love dabbing and enjoy the intensity of the high attained from using concentrates. You’ll often hear this method referred to as the rosin tech.”

Budder

- **Pink Kush Weed Budder**
- Pink Kush weed budder is a new product McChronalds has made available. It comes in 1 gram packages for $100.
- **Type: Indica**
  Strength: 10 out of 10
  High: Heavy Duty High “Wheelchair Grade”
  Taste: Ultra smooth taste with that pungent Pink Kush aroma
  Amount Per Package: 1 Gram

“Wheelchair Weed?”

- **Urban Dictionary:**
- **Marijuana of such intense potency that it typically incapacitates its users, sending them into a state of mind-bending delirium.**
- ***“John smoked some of that wheelchair weed and sat in his beanbag chair listening to Thermo surf rap for like three hours.”***

- “In this episode of Medical Marijuana Tips and Tricks with Bogart, Bogart discusses marijuana Concentrates. Concentrates are marijuana derivatives such as the various Wax, Budder, Shatter, Oils, Hash and other concentrated forms of marijuana available from many Medical Marijuana dispensaries. Often sold as a dab or by the gram in a variety of forms and prices from legal Medical Marijuana Dispensaries.
- Bogart shows several varieties of concentrates and then shows some common ways for smoking the extracted marijuana with a glass water pipe and attachments. Bogart then demonstrates how to take a “Corn Dog” hit using the titanium nail attachment on a glass water pipe

- 4 in 1 Titanium Nail for dabbing. Combination joints that will fit male and female rigs with 14mm or 18mm. This all in one titanium nail is made in the USA of Grade 2 Titanium.

Girl does 8 Gram Dab

SMOKING A HALF GRAM OF WAX AROUND A JOINT! (TWAX)

Aaaand more....

- “Twaxing is applying wax directly to cannabis flowers inside of a bowl, blunt or joint. There are a few ways to Twax depending on what kind of concentrated cannabis you are using or how you are smoking it...”

- “Kief is a concentrated form of cannabis created by removing the resin glands, or trichomes, from the cannabis bud. Trichomes can be seen as the crystals or fuzzy coating of the flowers which falls off easily. These resin glands contain the largest portion of cannabinoids, the chemicals occurring naturally in Cannabis that get you high. By removing these glands from the plant material the concentration of these chemicals can be far greater in kief than in ground buds. Kief can be collected from grinders, containers or extracted using dry ice and other methods.”

You get the idea

- https://www.ruffhousestudios.com/category/marijuana-tips-and-trick/
- http://thebudguru.com/tag/gram
- Search “budder”; “shatter”; “how to take marijuana”; “how to pass my drug test”

- And what happens when you consume these massive amounts regularly?

"Marijuana Tolerance Break"

- "T-break"
- "Most veteran marijuana consumers have been there one time or another. You puff and puff and puff, but you don't seem to get that super baked feeling anymore. The quality of nugs or oil you are consuming likely isn't the problem. The problem is likely that your tolerance is through the roof."
- "The most difficult part of a tolerance break is breaking the psychological habit of smoking. In short, you need to remember how engaging and fun sober life can be. One way to do this is by keeping yourself busy, especially with physical activity. In general, when I take a tolerance break, I try to keep my week as full as possible with work, school, exercise, and projects to keep my mind off of cannabis and my body tired at the end of the day."

Demographics

- **Cannabis use, lifetime:**

CAS	2008	2009	2010	2011	2012
44.5	43.9	42.4	41.5	39.4	41.5

- **Cannabis use, past year:**

CAS	2008	2009	2010	2011	2012
14.1	11.4	10.6	10.7	9.1	10.2

- There was an increase in past-year cannabis use among adults aged 25 years and older to 8.4% in 2012 from 6.7% in 2011.
- The prevalence of past-year cannabis use among youth (35%) remains higher than that of adults (8.4%).

- **Cannabis, average age of initiation:**

CAS	2008	2009	2010	2011	2012
15.6 years	15.5 years	15.6 years	15.7 years	15.6 years	16.1 years

- **Compare with alcohol at about 18 years**

Impairment

- **But what employers care most about is impairment (affecting workplace safety)**
- **"Impairment is any decrement in task performance"** **CLRA paper**

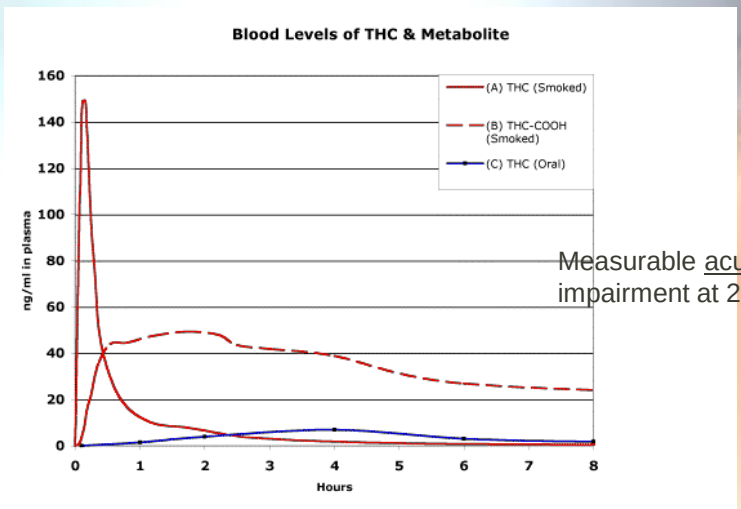
Concept of Impairment vs. Intoxication

- "What I do on my own time is my own business"
- Impairment:
  - Acute vs. Withdrawal (Subacute) vs. Chronic
  - Older concepts too crude
  - Psychological
    - Mood
    - Perception
    - Cognitive skills
  - Physical
    - Gross motor
    - Fine motor
    - Special senses

Major Point

- Alcohol and Marijuana are <u>TOTALLY DIFFERENT DRUGS!!</u>

Remember this slide again....



Measurable acute impairment at 2-5 ng/ml

Acute impairment

- It is well known that exposure to such substances impairs psychomotor performance and patients must be warned not to drive or operate complex machinery after smoking or eating cannabis or consuming psychoactive cannabinoid medications (HC 2013)
- A recent systematic review and meta-analysis concluded that, after adjusting for study quality, cannabis use was associated with a seven-fold estimated risk of being involved in a fatal accident, benzodiazepine use was associated with a two-fold estimated risk of a fatal accident, and opiate use with a three-fold estimated risk of a fatal accident. (HC 2013)

Marijuana Impairment

- Covered extensively in CLRA paper:
- ***"marijuana use impairs critical cognitive functions, both during acute intoxication and for days after use".***

  Volkow et al, "Adverse Health Effects of Marijuana Use", N Engl J Med 2014 Jun 5;370(231) 2219-2227
- ***After about a month of discontinued use, chronic cannabis users have demonstrated performance deficits in psychomotor speed, attention, memory, and executive functioning as compared to non-using controls*** ***Grant, Gonzalez, Carey, Natarajan & Wolfson, 2003; Medina et al., 2007***

Chronic Impairment

- **Crean's paper is the best to review:**
- ***Cannabis appears to continue to exert impairing effects in executive functions even after 3 weeks of abstinence and beyond. While basic attentional and working memory abilities are largely restored, the most enduring and detectable deficits are seen in decision-making, concept formation and planning. Verbal fluency impairments are somewhat mixed at this stage. Similar to the residual effects of cannabis use, those studies with subjects having chronic, heavy cannabis use show the most enduring deficits."***

And remember.....

- Humans Don't Just Use One Drug!

Marijuana and the safety sensitive worksite

- ***"One study that examined association between cannabis use and cognitive performance, mood and human error at work found that cannabis use was associated with impairment in both cognitive function and mood, though cannabis users self-reported no more workplace errors than controls. Users also displayed lower alertness, slower response organization, working memory problems at the start, and psychomotor slowing and poorer episodic recall at the end of the working week."*** *Madras 2015*

WHO paper, 2015:

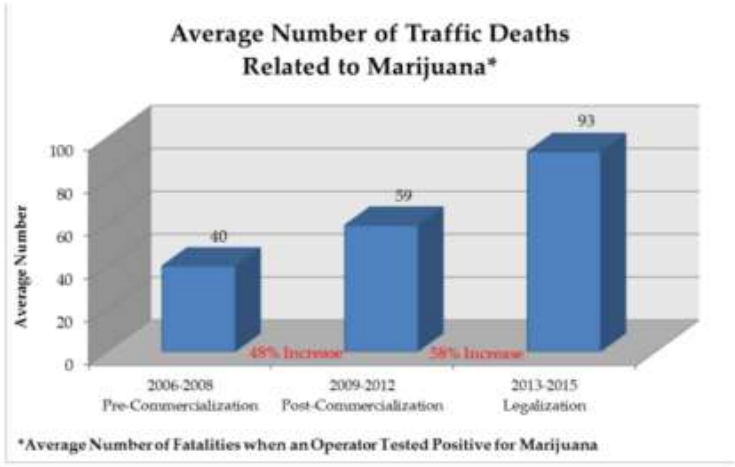
- *"There is ample evidence indicating that neurocognitive impairment from cannabis persists from hours to weeks.*
- *A return to a non-intoxicated state does not ensure a full return of neurocognitive function in the workplace[182]. In a summary of the dilemmas that cannabis for medical use has created for the workplace, it was pointed out that ensuring safety of workers who are under the influence or who recently consumed cannabis is not possible[183]".*

Does Marijuana increase risk of car accidents?

- Smoking pot doubles car accident risk
  - Canadian Study, Dr. Mark Asbridge, Dalhousie, February 2012
  - Pot < 3 hours before driving
  - Meta analysis of 49,411 drivers
  - Strongest link with fatal accidents
  - 2004 – 4% of Canadians reported driving <1 hour after smoking. 1996 – 1.9%

Marijuana and Traffic Deaths

- www.factcheck.org



SOURCE: National Highway Traffic Safety Administration, Fatality Analysis Reporting System (FARS), 2006-2011 and Colorado Department of Transportation 2012-2015

Roadside testing?

- "Potalyzers"
- Acute impairment $\geq$ 5 ng/ml blood THC?
  - Controversial
  - Ignores subacute and chronic impairment
  - Ignores drug-drug interactions
  - Ignores non-linear excretion

No one has ever died?

- "Zero deaths – ever…."
  - Sort of true….
  - Very safe pharmacology (no LD50)
  - However…..

Cannabis use by the pilot and marginal weather conditions caused an Air Tindi flight to crash into a hill while on its way to Lutsel K'e from Yellowknife on Oct. 4, 2011, killing two Yellowknifers including the pilot, a Transportation Safety Board investigation has concluded.

Q. What is the fastest way to induce temporary insanity in Canadian citizen?

- A. Put the word "medical" in front of marijuana

- We tend to forget people believe in a LOT of medical treatments lacking any scientific evidence

Medical Marijuana

- Nausea
- Spasticity
- Neuropathic pain
- Best review: http://www.hc-sc.gc.ca/dhp-mps/marihuana/med/infoprof-eng.php

Dosing…from the web

- You can assume good market pot to have 18 percent THC; that is, for every gram of pot you have roughly 180 mg of THC. Accounting for at least 60 percent loss due to burning, you can expect a full bowl to deliver 18 mg of THC. Split it with a friend, and you each get almost 10 mg.
- Rolling a joint requires more pot than a bowl, but joints are actually slightly more efficient at combusting THC, by about 10 percent. A pinner with 0.4 grams of weed should deliver roughly 36 mg of THC, while a gram joint will dish out 90 mg of THC.
- If you pack the same amount of pot into a vape similar to a Volcano, you're looking at over 30 mg of THC.
- Assuming your BHO has 70 percent THC, and that losses for vaporizing should only be about 30 percent, you'll inhale 9.8 mg of THC, call it 10. Dabs can get as big as 50 mg, and scale accordingly.
- Bowl – 18 mg; Joint – 30 mg; Vape – 30 mg; Dab 10-50 mg and up

Best comment was from a user online!

"I almost died laughing at the wall of texts you all went through to answer an unanswerable question.
Without getting to in depth here there is no set amount of thc per a given mass of bud. 1g of indoor has more thc than 1g of outdoor will. Similarly 1g of a high potency strain will have more thc than a mid potency strain. Hell if you buy 2 grams of the same exact strain from two separate growers they'll have different amounts of thc based on how they were grown and when they were harvested. Not to mention all the other variables such as:
-where on the plant the bud was pulled from
-how long it was cured
-how much thc was lost in storage or stuck to the container
-how much light the bud was exposed to before you actually smoked it

I could be here all day but yeah I won't waste more time. There's a reason your doctor doesn't tell you how much to smoke like he does with pills: dosing with marijuana is nearly impossible and no two tokes are the same. Smoke until your symptoms are taken care of..."

From Health Canada website:

- **Cannabis is not an approved therapeutic product and the provision of this information should not be interpreted as an endorsement of the use of this product, or cannabis generally, by Health Canada.**
- Cannabis (marijuana, marihuana) is not an approved therapeutic substance in Canada and has not been issued a notice of compliance by Health Canada authorizing sale in Canada.

Pain Relief

- **Probably the most vociferous debate rages here!**
- **At risk of oversimplification, there are no good studies showing good pain relief in the diagnoses for which "medical" marijuana is most commonly used – back pain, joint pain and soft tissue pain**
- **Studies on neuropathic pain show moderate efficacy, on par with opioids**

Health Canada 2013 quotes

- A recent Cochrane Collaboration review concluded that the evidence in support of the use …..cannabis for the treatment of pain associated with rheumatoid arthritis is weak and given the significant side effect profile typically associated with the use of cannabinoids, the potential harms seem to outweigh any modest benefit achieved
- There are no clinical trials of smoked or ingested cannabis for the treatment of fibromyalgia.

For all other clinical entities:

- http://www.hc-sc.gc.ca/dhp-mps/marihuana/med/infoprof-eng.php
- Section 4
  4.1 Palliative Care
- 4.2 Nausea and vomiting
- 4.3 Wasting syndrome and loss of appetite in AIDS and cancer patients
  - 4.3.1 To stimulate appetite and produce weight gain in AIDS patients
  - 4.3.2 To stimulate appetite and produce weight gain in cancer patients
  - 4.3.3 Anorexia nervosa
- 4.4 Multiple sclerosis, amyotrophic lateral sclerosis, spinal cord injury
  - 4.4.1 Multiple sclerosis
  - 4.4.2 Amyotrophic lateral sclerosis
  - 4.4.3 Spinal cord injury (or spinal cord disease)
- 4.5 Epilepsy
- 4.6 Pain
  - 4.6.1 Acute Pain
  - 4.6.1.1 Experimentally-induced acute pain
  - 4.6.1.2 Post-operative pain
  - 4.6.2 Chronic pain
  - 4.6.2.1 Experimentally-induced pain
  - 4.6.2.2 Neuropathic pain or chronic non-cancer pain
  - 4.6.2.3 Cancer pain
  - 4.6.2.4 Headache and migraine
- 4.7 Arthritides and musculoskeletal disorders
  - 4.7.1 Osteoarthritis
  - 4.7.2 Rheumatoid arthritis
  - 4.7.3 Fibromyalgia
  - 4.7.4 Osteoporosis
- 4.8 Other diseases and symptoms4.8.1 Movement disorders
  - 4.8.1.1 Dystonia
  - 4.8.1.2 Huntington's disease

For all other clinical entities:

- 4.8.1.3 Parkinson's disease
- 4.8.1.4 Tourette's syndrome
- 4.8.2 Glaucoma
- 4.8.3 Asthma
- 4.8.4 Hypertension
- 4.8.5 Psychiatric disorders
- 4.8.5.1 Anxiety and depression
- 4.8.5.2 Sleep disorders
- 4.8.5.3 Post-traumatic stress disorder
- 4.8.5.4 Alcohol and opioid withdrawal symptoms
- 4.8.5.5 Schizophrenia and psychosis
- 4.8.6 Alzheimer's disease and dementia
- 4.8.7 Inflammation
- 4.8.7.1 Inflammatory skin diseases
- 4.8.8 Gastrointestinal system disorders
- 4.8.8.1 Irritable bowel syndrome
- 4.8.8.2 Inflammatory bowel diseases
- 4.8.8.3 Diseases of the liver
- 4.8.8.4 Metabolic syndrome, obesity, diabetes
- 4.8.8.5 Diseases of the pancreas
- 4.8.9 Anti-neoplastic properties
- 4.8.10 Emerging potential therapeutic uses

Macleans Magazine

- **Are we overstating the benefits of medical marijuana?**
  - Christopher Labos, October 8, 2015
- "Skepticism about the health benefits of marijuana have been bolstered by a recent meta-analysis in the *Journal of the American Medical Association* commissioned by the Swiss Federal Office of Public Health. After reviewing 79 randomized trials, with 6,462 patients, researchers found evidence of moderate quality to suggest marijuana helps for chronic nerve pain, nausea due to chemotherapy, and spasticity due to MS—but that was it."
- "For many other diseases, including glaucoma, insomnia and anxiety, researchers found no evidence, or low-quality evidence, to support its use. Robert Wolff, the study's co-author, points out that if marijuana were a new medication, the lack of evidence means it would not be approved by the FDA or Health Canada."

Macleans Magazine

- **Medical marijuana prescription rate soaring in Canada**
  - Nearly 130,000 Canadians signed up with country's 38 licensed cannabis producers, a 32 per cent jump since September
    - The Canadian Press
    - February 23, 2017

Marijuana is pictured in a vending machine at the BC Pain Society in Vancouver, B.C., on Friday August 29, 2014. (Ben Nelms/CP

CPSA – Standard 16

- Issued April 3, 2014
- 5 key points

1. Physicians have a choice whether to use marijuana or not.
2. If you do there are 7 requirements to meet, notably you have to register with the College
3. Chart (medical document) must contain 12 information fields
4. Follow up specified. Must supply medical document to College
5. Physician must not dispense, provide or produce marijuana.

Details.....

- A physician who chooses to treat patients with marihuana must:
  - register with the College as an authorizer of marihuana for medical purposes,
  - attempt and find conventional therapies ineffective in treating the patient's medical condition or symptom(s),
  - assess the patient's risk of addiction using a standard addiction risk tool,
  - receive informed consent in accordance with the *Informed Consent* standard of practice,
  - review available prescription databases, including the Pharmacy Information Network (PIN) and the Triplicate Prescription Program (TPP) to obtain a patient medication profile,
  - comply with provincial and federal regulations, including Health Canada's Information for Health Care Professionals, and
  - complete a patient's medical document.
- A patient's medical document must include the:
  - patient's
    - given name and surname,
    - date of birth, and
    - personal health care number,
    - physician's registration number,
    - given name and surname,
    - business address and telephone number, and
    - facsimile number and email,
  - address of the location at which the physician treated the patient,
  - medical condition or symptom(s) marihuana is treating,
  - daily quantity of marihuana to be used by the patient expressed in grams,
  - period of use specified as a number of weeks or months (not to exceed one year) beginning on the day the patient's medical document is signed, and
  - physician's signature and date of signing.
- A physician completing a patient medical document must:
  - evaluate the patient on a regular basis to determine the benefits and risks of marihuana as treatment for the medical condition or symptom(s) stated in the patient medical document,
  - at minimum see the patient every three months following stabilization [1],
  - provide ongoing care to the patient for the underlying medical condition or symptom(s) for which marihuana is the treatment, including a process to identify misuse or abuse of marihuana,
  - provide the College with a copy of the patient's medical document within one (1) week of completing the medical document.

The Marijuana Industry

- As “big pharma” enters the field, research/communication will be skewed as we’ve grown to expect
- Negative studies don’t get published
- “Off label use”

CNMMA
CANADIAN NATIONAL MEDICAL MARIJUANA ASSOCIATION

From Linked In: “The business of getting high…”

- **Renee M Gagnon**- Worlds first Federally Licensed Female Cannabis Pubco CEO - Inventor ACMMPR Retail - Speaker
- “So a year ago a very amazing woman ad executive cornered me at an event. She wanted to ask a question she seemed nervous to discuss. "When are we going to discuss the business of getting high?" She asks. "Well...that's a problem". Says me. Basically I feel we've kinda painted ourselves into a corner using the medical aspects as a wedge Yes it's working, but we risk losing an important personal, cultural and social aspect of Cannabis : high Largely because it's very, terribly, indescribably tricky to describe but super easy to inference once you've been high....”

Reply

- **Rob McPherson (**Board Member-Elect and Acting Chief Marketing Officer at Aquarius Cannabis)

- "I would be very wary of any cannabis business executive talking about getting high. Not only is it an area that has a polarizing effect on a great many in the public, but it puts forth an informalized articulation of a psychoactive impact on the brain. The industry needs to tread carefully, consistently and more formally when talking about "getting high", lest it be seen in the same light as an alcohol executive talking about "getting hammered" - it may not be the same, but that is irrelevant. What is relevant is that it will be seen as the same, and not very positively....."
- **Renee M Gagnon**
- Agreed. It's complicated. And full of minefields. But nonetheless less we must talk about it at times. Thank you! Glad to have your take.

Despite ALL the foregoing

- **Avoid the temptation to "put the drug on trial":**

Q. Does my client have a diagnosis?

A. Uh..yes

Q. Was he prescribed medical cannabis by a licenced physician?

A. Uh…yes

Thank you , nothing further.

Dealing with the MM worker

- Good worksite policies should be risk based/safety based.
- These workers have a disability – so duty to accommodate applies.
- Source of drug is irrelevant!
- **Marijuana use is incompatible with SS work.**
- So what to do? (next slide)

Practicalities

- Do proper performance management
  - Why does this "problem employee" have an HR file 1 page long?
- Keep good, written records
  - If it isn't written it didn't happen
- Do act. If an employee comes forward with a permit to possess, respond!
- You respond as per your policy, and its associated process
  - You do have a policy and process document, don't you?
- Train your supervisors
  - Ms. Kim Skeath, Mercer

Practicalities (con't.)

- Do test – but know why, how and for what reason.
  - Testing does <u>not</u> substitute for performance management
- Get good advice, follow best practices for disability management
  - Do not just accept the word of the prescribing entity
- Don't freak out! This is no different than any other impairing prescription drug.

The legal wild card

- This conflict will undoubtedly lead to one or more landmark human rights court decisions, which, judging by past performance, will not be based on science or medically rational.

- Nova Scotia board says insurance must cover man's marijuana prescription
  MIKE HAGER
  VANCOUVER — The Globe and Mail
  Published Thursday, Feb. 02, 2017

- Assembly line worker fights to use medical marijuana at work - Cannabis oil no more effective than 'candy,' says addictions expert
  CBC News Posted: Jan 31, 2017 11:04 AM ET

Futurizing

- Legalization
  - Renders current drug testing programs relatively useless
  - (Same reason we don't do urinary ethanol)
  - Drug dogs will be "hitting" on too many people to be useful
  - Laws will change (previous slide)
    - Worker using a legal substance has a right to work unless proven unfit via BFOR
  - Society will have a huge fight re drug driving
- Will the "medical" ruse fall under its own weight?
  - No further need of prescriptions
  - Unable to sustain the medical narrative

Summary points

- Marijuana is a complex set of chemicals, with complex actions
- It is pretty safe, pharmacologically speaking
- It's dangers come from impairment (and likely some impaired brain development and psychosis)
- It is addictive to 10-15% of users
- Some of its constituent chemicals will likely have medical applications
- Smoked marijuana is not an appropriate mechanism of drug delivery
- We have little experience with some of the high potency forms now emerging

Summary/Points to consider

- In my experience prescribing physician will not be following any defensible clinical schema – so “prescription” is not really relevant
- Very few prescriptions I see are for legitimate medical reasons
- Marijuana is not the drug of choice for ANY known medical condition
- Pending legalization will outflank the “medical” concept, just like prohibition and alcohol. Where this leads is anyone’s guess
- Marijuana is unacceptable in the SS worksite

Discussion/Questions