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Psychotropic Medications and Driving Assessment: Medical Marijuana

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Presenters

- **Erin Dessau**, Senior Safety Research Advisor; Safety, Policy and Education, Ministry of Transportation of Ontario
- **Lisa Hamilton,** Professional Practice Defense Attorney and Partner, Bell Temple
- **Nellemarie Hyde,** Occupational Therapist and Certified Driver Rehabilitation Specialist
- **Kara Ronald,** Occupational Therapist, Deputy Registrar, COTO

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Overview

1. Introduction
2. Ontario's Drug Impaired Driving Strategy
3. Effects of psychotropic medications, including cannabis, on driving ability
4. Professional rules of conduct when assessing clients taking medical marijuana: emerging practice context
5. Conscious competence: COTO's guide to ethical decision making
6. Medical Marijuana & On-road Assessment: A Decision Tree

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History of Cannabis

2700 BC – Ancient Emperor Shen-Nung
1800's – Queen Victoria
1906 – FDA Pure Food and Drugs Act
Early 1900's – Demonized for racist and political reasons
1931 – 29 States outlaw cannabis
1936 – "Reefer Madness" released
1941 – Cannabis removed from medical formulary
1940's-1950's – Stigmatization of marijuana counter culture
1971 – "War on Drugs" – Cannabis classed as Schedule 1 drug – highly addictive

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History of Cannabis

Canadian Context:
- 1921 – Cannabis banned in Canada
- 2001 – Medical cannabis legal in Canada with a license
- Fall, 2013 – ADED ON Chapter meeting: How to assess clients taking medical marijuana – panel discussion
- 2015 – Justin Trudeau campaigned (and won) on legalization of marijuana
- 2018 – Targeted date of legalization

Now what???

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Jacques

- 52 y/o male sustained TBI and multiple L/E fractures in MVA in 2013
- Husband and father of 3 teen girls living in urban centre in northern Ontario
- Chronic pain, limited mobility, fatigue, reduced verbal/visual memory and attention

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Tyler

- 41 y/o single male diagnosed with MS at age 35
- Primary MS symptoms: increased tone, impaired coordination in L/E
- Age 39 was the driver in at fault MVA
- Sustained a TBI
- Nueropsych report – deficits in judgement and problem solving
- Parents have power of attorney for finances.

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Erin Dessau, MTO Research and Policy

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Psychotropic Medications

Psychotropic / psychoactive / psychopharmaceutical:

- A chemical substance that changes brain function and results in alterations of perception, mood, consciousness or behaviour

- Wikipedia

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Psychotropic Medications:

Examples:

Antidpressants - cipralex, zoloft, paxil, wellbutrin, effexor, trazadone, amytriptiline
Antipsychotics - abilify, seroquil, haldol, risperidone
Analgesics – **opiods (oxycontin, morphine, codeine, hydrocodone**)
Analgesics – NSAIDS (naproxin, ibuprofen, aspirin)
Analgesics – other (**cannabis, alcohol**, tylenol)
Stimulants - caffeine! ritalin, **nicotine**, adderall, concerta, dexedrine,
Mood stabilizers – lithium, olanzapine, valproic acid, lamotragene,
Anxiolitics – **Barbituates (-barbitols), Benzodiazpenes (valium, ativan, xanax, -ezapams, -zolams)**

- Wikipedia

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Cannabis

Contains:

- 400 + chemicals
- Cannabinoids (Cannabinol, Cannabidiol (CBD))
- Tetrahydracannabinol
- Terpenes

- Wikipedia

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Cannabis

Administration:

- Inhaled
  - Smoked
  - Vaporized
- Oral ingestion (pill, oil in foods, tincture)
- Oral mucosal (mouth spray)
- Topical

Sources:

- Dr. Lionel Marks de Chabris
- Health Canada: Access to Cannabis for Medical Purposes Regulations - Daily Amount Fact Sheet (Dosage)

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Cannabis

Dosing:

- Not our area of expertise!
- 1g/day reasonable, 1-4 g/day not uncommon, > 5g / day likely recreational
- Side effects are dose dependent – Start low and go slow
- Oil slower onset, therefor fewer side effects

Sources:

- Dr. Lionel Marks de Chabris
- Health Canada: Access to Cannabis for Medical Purposes Regulations - Daily Amount Fact Sheet (Dosage)

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Physiology

CBI receptors

- *brain*: substantia nigra, basal ganglia, limbic system, hippocampus and cerebellum,
- *peripheral nervous system*, liver, thyroid, uterus, bones and testicular tissue

CB2 receptors

- immune cells, spleen, gastrointestinal system,
- lesser extent in brain and peripheral nervous system

THC bonds to CB1 receptors
CBD bonds to CB1 AND CB2 receptors

Higher ratio of CBD to THC may result in fewer psychoactive effects
(- Dr. Marks de Chabris)

Atakan, Z, Ther. Adv. Pscyhomaracology, Dec 2012

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Addiction

Addiction vs. Dependence

Physical dependence involves the body developing a tolerance to the drugs effects, and withdrawal symptoms when the drug is stopped.

Addiction: The 4 Cs:

- craving
- loss of control of amount or frequency of use
- compulsion to use
- use despite consequences

(CAMH Website Resources)

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Addiction/Dependence

Examples (dependence)

- Caffeine
- Alcohol
- Benzodiazapines (valium, -ezapams)
- Opioids
- Nicotine
- Marijuana

- No specific reference

- Risk of addiction worse when young
- Much lower risk after 21 years of age

- Dr. Lionel Marks de Chablis

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Cannabis: Psychoactive Properties

euphoria
increased self-confidence
decreased anxiety
increased anxiety/paranoia
decreased awareness
decreased inhibition
logorrhea
altered judgement

reaction time,
short-term memory,
hand-eye coordination,
vigilance,
time and distance perception,
decision making,
attention / concentration.
visual tracking
impaired coordination

- Wikipedia, Effects of Cannabis

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CMA Guide: Medical Fitness to Drive

Immediate Contraindications to driving:

- Conscious sedation
- Stimulation
- Visual blurring, delayed glare recovery
- Impaired coordination or movement
- Impaired performance on skill testing
- Changes in behaviour, particularly risk taking
- Changes in thought or information processing

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CMA Guide: Medical Fitness to Drive

- Clients taking "drugs" known to have intended or side effects that can impair their ability to drive should be advised not to drive until the effects on themselves are known. (CMA guide, 9th edition)

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Criminal Code of Canada

Section 253(1)(a) makes it illegal to operate a motor vehicle…or to have care or control of a motor vehicle…while that person's ability to operate is impaired by the alcohol, drugs, or a combination of the two.

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Lisa Hamilton, Bell Temple LLP

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What We Know

- Cannabis has proven therapeutic properties and is legal in Canada for medical use
- Recreational cannabis use is going to be legalized (2018?)
- Psychotropic effects of cannabis affect driving ability
- Difficult to measure intoxication from cannabis
- Driving impaired is illegal (Criminal Code of Canada)
- Wide range of prescribed and recreational drugs can cause driving impairment

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What we don't know…

- When is it okay/legal/appropriate to take a client with prescribed cannabis on road?
- How do I assess for intoxication/impairment?
- How do I know client will not drive impaired in the future after I "pass" him/her?
- How do I differentiate from deficits attributable to disease/ injury vs. drug impairment? Does it matter?
- Can I be held responsible if I pass a client and he causes an accident while drug impaired?

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What we don't know…

- What are the best practices in the driver rehab industry?

(trick question)

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Jacques

- 52 y/o male sustained TBI and multiple L/E fractures in MVA in 2013
- Husband and father of 3 teen girls living in urban centre in northern Ontario
- Chronic pain, limited mobility, fatigue, reduced verbal/visual memory and attention

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Jacques

- Takes Oxycontin – insufficient for break through pain
- Prescribed cannabis – effective
- Vapes mostly at night and when goes out in community
- Struggles with stigma – "would hate for my daughters to find out"

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Tyler

- 41 y/o single male diagnosed with MS at age 35
- Primary MS symptoms: increased tone, impaired coordination in L/E
- Age 39 was the driver in at fault MVA
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Tyler

- Convicted of DUI – 2 year license suspension
- Cannabis prescribed and taken to manage MS symptoms prior to MVA
- Self titrates by "smoking a few puffs" throughout the day
- Reports he "performs best" while taking cannabis, does not experience "feeling high"

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CMA Guide: Medical Fitness to Drive

- Clients taking "drugs" known to have intended or side effects that can impair their ability to drive should be advised not to drive until the effects on themselves are known. (CMA guide, 9th edition)

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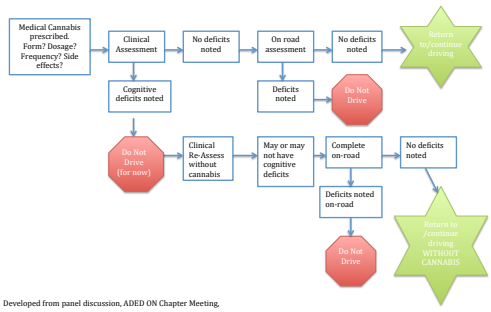
Assessment of Clients Taking Medical Cannabis: A Decision Tree



Developed from panel discussion, ADED ON Chapter Meeting.

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Driver Rehab Assessment

- History of drug use (client report or medical file)
- Licensed to use medical marijuana
- Where the drug is obtained
- When the drug is taken (times of day, frequency)
- How the drug is taken (inhaled, injected, swallowed, oil drops, etc.)
- Dosage
- Consider combinations of drugs
- Review effects (intended or side effects) of drugs

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Driver Rehab Assessment

- Vision screen – acuity, ocular movement
- Cognitive / Behavioural assessment of current abilities
- Observations! Drowsiness, edginess, inappropriate behaviour, eyes, odour

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Driver Rehab Assessment

- Coordination
- Trail making A & B, CTMT
- UFOV
- Insight
- MVPT

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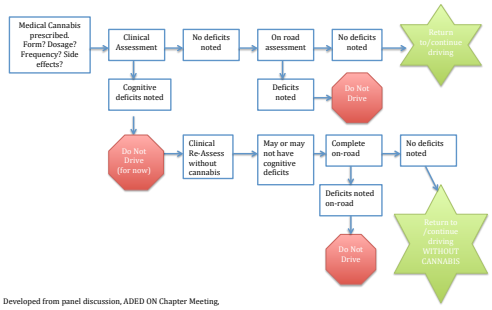
Driver Rehab Assessment

On-road assessment
- Emergency braking
- Decision making at complex intersections
- Lane changes in traffic
- Risk taking behaviour
- Distractibility
- Speed maintenance on all road types
- Speed of decision making
- Visual perception – vehicle positioning in lane, at intersections, passing vehicles

Assessment of Clients Taking Medical Cannabis: A Decision Tree



Developed from panel discussion, ADED ON Chapter Meeting,

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Driver Rehab Assessment

Recommendations

- Refer to decision tree:
  - Return to driving
  - Self monitor for psychotropic symptoms
  - Do not drive
  - Monitoring by an addictions specialist
  - May inform MTO
- "Treatment Agreement"

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Kara Ronald, Deputy Registrar, COTO

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References

- Wikipedia
- https://www.canada.ca/en/health-canada/topics/cannabis-for-medical-purposes.html
- CMA Driver's Guide, 9th Edition
- Marijuana Impaired Driving – NHTSA, July 2017
- CCMTA Medical Standards for Drivers
- Medical Cannabis and Impaired Driving: Preliminary research review (June 27, 2017)

Ontario's Drug Impaired Driving Strategy

Canadian National Rehabilitation Conference, October, 2017
Erin Dessau, Ontario Ministry of Transportation

Overview

- Ontario Road Safety Snapshot
- The Road Safety Research Office
- Prevalence of Drug Use and Driving
- Ontario's Drug Driving Strategy

2

Ontario Road Safety Snapshot

- For 16 years in a row, our fatality rate per 10,000 licensed drivers has been ranked the lowest or second lowest in North America.
- Always more we can do:

3

Road Safety Research Office: Vision

- Continue as a Centre of Excellence, provincially and federally acknowledged, in road safety policy research.
- Develop strategic partnerships with international researchers and road safety stakeholders to advance research directly relevant to our programs.
- Conduct leading-edge research to address emerging road safety trends.

4

Road Safety Research Office: Mandate

- Keep Ontario's roads among the safest in the world by:
  - Evaluate the effectiveness of Ontario's road safety programs;
  - Conduct applied research to inform policy and program development and to guide road safety marketing and public education campaigns; and,
  - Support our enforcement partners by providing the best tools possible.

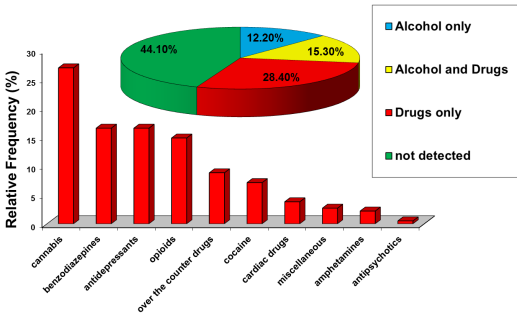
5

Prevalence of Drug Use and Driving

- Prior to February 2011, testing of fatally injured drivers was done on an ad-hoc basis.
- Drug use among the general driving population was generally unknown.
- To address emerging trends related to drug presence among fatally injured drivers, the Office of the Chief Coroner began testing all fatally injured drivers in 2011.

6

Prevalence of Drug Use among Fatally Injured Drivers



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Prevalence of Drug Use among Drivers

- Looking at fatally injured drivers alone is not enough
- 2014 Roadside Survey for Alcohol and Drugs
  1. Estimate prevalence
  2. Establish a baseline for future comparison
  3. Understand demographics of drug using drivers

1 in 10 drivers on our roads have drugs in their system.

70% of these drug positive drivers have cannabis in their system.

8

Attitudes and Behaviours Survey

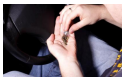
- A bi-annual online survey to gain insight into road safety issues including drug-impaired driving

- Key Findings
  - 5% of Ontario motorists admit to driving after taking illicit drugs
  - 14% of Ontario motorists admit to driving after taking prescription medication that has a warning on the label against driving.
  - Only half of survey respondents believe that police are equipped to identify drug-impaired drivers.

9

Drug Impaired Driving Research at MTO

- Tools for Enforcement
  - Oral fluid screening devices
  - Standard Field Sobriety Test



- Research for Policy & Program Development
  - Simulated driving performance
  - Collision risk & culpability
  - Remedial monitoring technologies
- Looking Forward

10

Tools for Enforcement

- Oral Fluid Screening Devices

  - In partnership with national road safety stakeholders, this project validated three oral drug screening devices on the market. All worked well.
  - Recently completed pilot testing (in conjunction with Federal colleagues) to test operational effectiveness of devices in a Canadian environment with favourable results.
- Standard Field Sobriety Test

  - Evaluation of the SFST to assist enforcement partners by maximizing its effectiveness at detecting drug-impaired drivers at roadside.

11

Research for Policy & Program Development

- Simulated Driving Performance
  - Partnership with the Centre for Addiction and Mental Health (CAMH)
  - Determine the THC level that impairs driving performance, which is the equivalent to a blood alcohol concentration (BAC) of .08%; and,
  - Compare medical and recreational cannabis users on a variety of factors associated with use and driving.

12

Research for Policy & Program Development

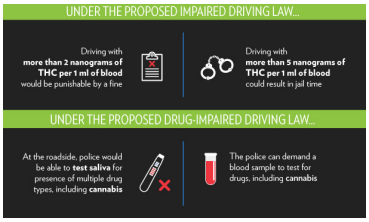
- Collision Risk
  - Using Ontario-specific data from 2014, we are comparing drug prevalence from fatally injured drivers (Coroner files) to that among randomly sampled drivers (Roadside survey).

- Remedial Monitoring Technologies
  - Investigating technologies for remediation and monitoring for drugs, analogous to Ignition Interlock for alcohol.

13

Drug Driving Strategy – Federal

- The federal government has announced its intent to legalize recreational cannabis in July 2018.



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Drug Driving Strategy – Provincial

- Young (under 22)
- Novice
- Commercial Drivers

- Drivers age 21 and under, and novice drivers have a higher risk of collision due to inexperience.
- 1 in 5 fatalities on Ontario roads occur in collisions involving commercial vehicles.

15

Looking Forward

- Conduct a 2017 roadside alcohol and drug survey prior to Federal legalization to establish a baseline for comparison.
- Evaluate recently implemented countermeasures to ensure policy is effectively reducing drug impaired driving.
- Continue to investigate how cannabis and other drugs impair drivers and the impact on driving performance.
- Continue to investigate differences between recreational and medical cannabis users, various ingestion methods and their impact on road safety.

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Thank You!

For More Information:

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Senior Research Advisor, Road Safety Research Office
Ontario Ministry of Transportation
T: 416-235-3631 **E**: erin.dessau@ontario.ca

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Professional Rules for Occupational Therapists in the Emerging Practice Context

Lisa E. Hamilton
Bell Temple LLP

BELL TEMPLE LLP

Rules, Rules, Rules!

- Guide to the Code of Ethics
- Standards for Occupational Therapy Assessments
- Professional Misconduct Reg.
- *Human Rights Code, 1990*
- Standards for the Prevention and Management of Conflict of Interest
- *Health Care Consent Act, 1996*

2

What to reach for:

Code of Ethics

- **Respect and trust** are the values and principles that underpin all of the rules of professional practice.
- Use these principles when faced with novel situations, such as changes in the law
- To best avoid complaints and lawsuits, consider not only whether you actually comply with the rules, but also how you may be perceived by others: the client, other stakeholders, your peers and regulator

3

What to avoid:

Professional Misconduct:

Contravening, by act or omission, a standard of practice of the profession or failing to maintain the standard of practice of the profession.

| 4

What to avoid:

Professional Misconduct:

Giving information about a client to a person other than the client or the client's authorized representative except with the **consent of the client or the authorized representative or as required or authorized by law**.

| 5

What to avoid:

Professional Misconduct:

Discontinuing professional services that are needed unless the discontinuation would reasonably be regarded by members as appropriate having regard to,

i. the member's reasons for discontinuing the services,

ii. the condition of the client,

iii. the availability of alternate services, and

iv. the opportunity given to the client to arrange alternate services before the discontinuation.

| 6

What to avoid:

Professional Misconduct:

- Attempting to treat a condition that the member knows or ought to know he or she does not have the knowledge, skills or judgment to treat.
- Failing to advise a client …to consult another member of the College or, if appropriate, a member of a health profession …where the member knows or ought to know that the client requires a service that the member does not have the knowledge, skills or judgment to offer or is beyond his or her scope of practice.

| 7

What to avoid:

Professional Misconduct:

Engaging in conduct or performing an act relevant to the practice of the profession that, having regard to all the circumstances, would reasonably be regarded by members as **disgraceful, dishonourable or unprofessional**.

Engaging in conduct that would reasonably be regarded by members as conduct **unbecoming** an occupational therapist.

| 8

What to avoid:

Professional Misconduct:

Practising the profession while the member is in a conflict of interest.

| 9

Standards for Prevention and Management of Conflict of Interest:

"A conflict of interest, whether it is **actual, potential or perceived,** needs to be addressed."

"If not addressed, a conflict of interest may compromise the confidence, trust and respect the client has in the occupational therapist or the organization that is represented by the occupational therapist.

This makes conflict of interest a significant issue of concern to Registrants and the College."

| 10

Standards for Prevention and Management of Conflict of Interest:

Recognizing Conflicts of Interest:

"An occupational therapist will reflect upon and recognize:…

Strongly held opinions, biases or beliefs pertaining to … disability…or other grounds protected by human rights which affect their ability to meet client's needs"

| 11

Standards for Prevention and Management of Conflict of Interest:

Preventing Conflicts of Interest:

"An occupational therapist will…

Advise clients and stakeholders of alternative service options, which may include provision of a **referral** to a third party to give service on the OTs behalf when in a **potential, actual or perceived conflict of interest**."

| 12

Standards for OT Assessments:

"Public concern about the **assessment process and/or results** is …revealed through the complaints process. Concern about the quality of assessments and assessment reports has been **one of the more frequent issues raised with the College."**

| 13

Standards for OT Assessments:

"The OT will establish a personal scope of practice, know the **related legislative and organizational requirements** and determine his/her own competency to practise within this scope prior to accepting referrals for assessment."

| 14

Standards for OT Assessments:

"The OT will consider and apply assessment methods that are client-centred, evidence-based and supported by clinical judgement and experience."

Remain current with related evidence and occupational therapy practice"

| 15

Standards for OT Assessments:

"The OT will ensure he/she has sufficient pertinent information to proceed with analysis."

"Determine, when gaps in information are identified, whether the assessment can be properly completed, and whether the assessment represents a fair and appropriate evaluation."

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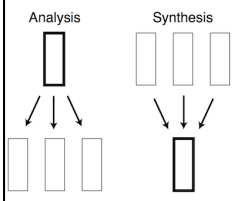
Standards for OT Assessments:



"The OT will form an opinion and/ or make recommendations based on a **synthesis** of the information and in relation to the request for services.**"**

"Analyse all relevant information collected about the client using logic, rationale, and a balance of subjective and objective information as a basis for clinical reasoning."

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Standards for OT Assessments:

"**The OT will maintain documentation** that includes consent, assessment procedures used, results obtained, and analysis and opinion/recommendations. The documentation will reflect **client-centered practice and clinical reasoning**."

"Document **client participation in, and limitations of the assessment process** (including discussions with the client and any advice given to the client) in the assessment process."

| 18

Standards for OT Assessments:

"The OT will ensure that relevant assessment information is communicated (e.g., results, opinions, recommendations) to the client in a clear and timely manner, unless doing so could result in harm to the client and/or others. The occupational therapist will provide opportunity for clarification and feedback from the client."

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Other Legislation:

Human Rights Code, 1990

Prohibits discrimination on protected grounds, including disability, in the context of health care services.

Imposes a duty to accommodate, up to the point of undue hardship.

Appropriate accommodation:

- respects dignity
- responds to a person's individualized needs
- allows for integration and full participation

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Other Legislation:

Health Care Consent Act, 1996

A person is presumed to be capable of consenting to a health care service if the person is **able to understand the relevant information** pertaining to the service, including the **reasonably foreseeable consequences of a decision or lack of decision**, unless there are reasonable grounds to believe the contrary.

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Reducing the Risk of College Complaints in the Emerging Practice Context:

- ✓ Be aware of your views about the use of psychotropic medications and ensure that clients are not prevented from pursuing treatment due to stigma or assumptions about his or her mental health challenges.
- ✓ Use available assessment tools to apply objective standards.
- ✓ Explain your decisions using plain and honest language, not technical jargon.
- ✓ Choose words that are respectful and focused on the client's needs and interests.
- ✓ Perform an ongoing assessment of your practice to determine if changes should be made

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thank you!

BELL TEMPLE LLP
Litigation Lawyers

| 23

Psychotropic medications and functional driving assessments: Should clients taking medical marijuana be assessed on-road?

College Expectations

Kara Ronald, OT Reg. (Ont.)
Deputy Registrar

Canadian National Driver Rehabilitation Conference
October 13, 2017

College of Occupational Therapists of Ontario
Ordre des ergothérapeutes de l'Ontario

Jacques

- 52 years old
- Father of 3 teenage girls living in Northern Ontario
- Sustained a TBI and lower extremity injuries 4 years ago in a MVA
- Chronic severe pain left leg, limited mobility, short term memory impairment and fatigue
- Medications: Oxycontin, medical cannabis

College Expectations

Conscious Competence

- Understand your practice environment
- Be aware of your resources
- Understand any “rules” and how they apply to your practice
- Be professional
- Use your judgement – have a reasonable rationale for any action or inaction

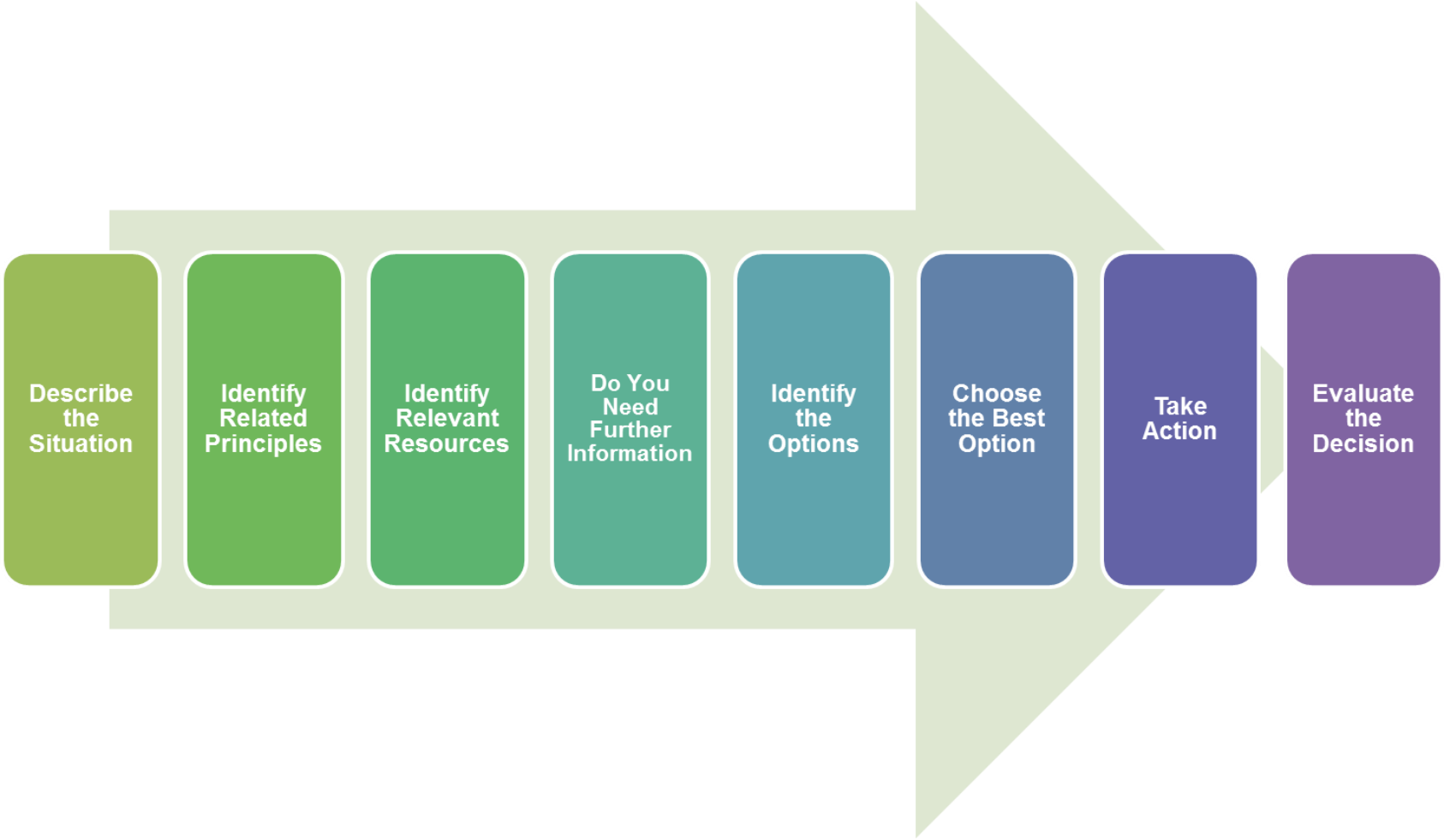
Problem Solving

Conscious Decision Making

Using a **methodical process** to figure out sticky situations can be helpful to take the emotion and anxiety out of decisions.

This will also help to **develop your rationale** for your decisions.

Conscious Decision-Making



Describe the Situation - Ask Yourself these Questions

1. What are the facts of the situation?
2. Who is the client?
3. Who are the other stakeholders?
4. What is the underlying issue(s)?

Identify the Principles Related to the Situation

Respect

- Client-Centred Practice
- Respect for Autonomy
- Collaboration & Communication

Trust

- Honesty
- Fairness
- Accountability
- Transparency

What are the Relevant Resources to Assist with Decision-Making?

1. Are there any relevant laws, regulations, standards or guidelines?

2. Are there any individuals with expertise in the area?

3. Is there any relevant literature?

Consider if You Need Further Information or Clarification

1. Do you understand the intent of the legislation, standard or guideline?

2. Is there related research, evidence or best practice?

3. Are there any missing facts?

Consider if You Need Further Information or Clarification

4. Have you identified the client's best interests?

5. Are all of the stakeholders and their interests identified?

Identify the Options

1. Apply the principles and any legislation, standards, guidelines or policy that apply

2. Consider the expected outcome and potential impact of each option

Choose the Best Option

1. Ask your peers for feedback - Do they agree with your choice?

2. Document the process & provide rationale for your decision

TAKE ACTION

Evaluate the Decision

1. How comfortable do you feel that you chose the best option?

2. What was the impact of your decision on those involved?

3. Would you make the same decision again, or do something differently?

Key Messages

- Be consciously competent
- Understand your accountabilities
- Know your own limits
- Leverage resources
- Listen to “messages from your gut”
- Consult with others
- Have sound rationale for your decisions

College Resources

Practice Resource Service

practice@coto.org

1-800-890-6570 ext. 240

‘Standards & Resources’

www.coto.org

@CollegeofOTs

Tyler

- 41 years old
- Diagnosed with relapsing remitting Multiple Sclerosis 6 years ago
- Sustained TBI in MVA 2 years ago (convicted of DUI)
- History of heavy marijuana use and prescribed medical cannabis for MS symptom management
- Experiences deficits in judgement and problem solving
- Parent have POA for finances

THANK YOU