REHAB MATTERS

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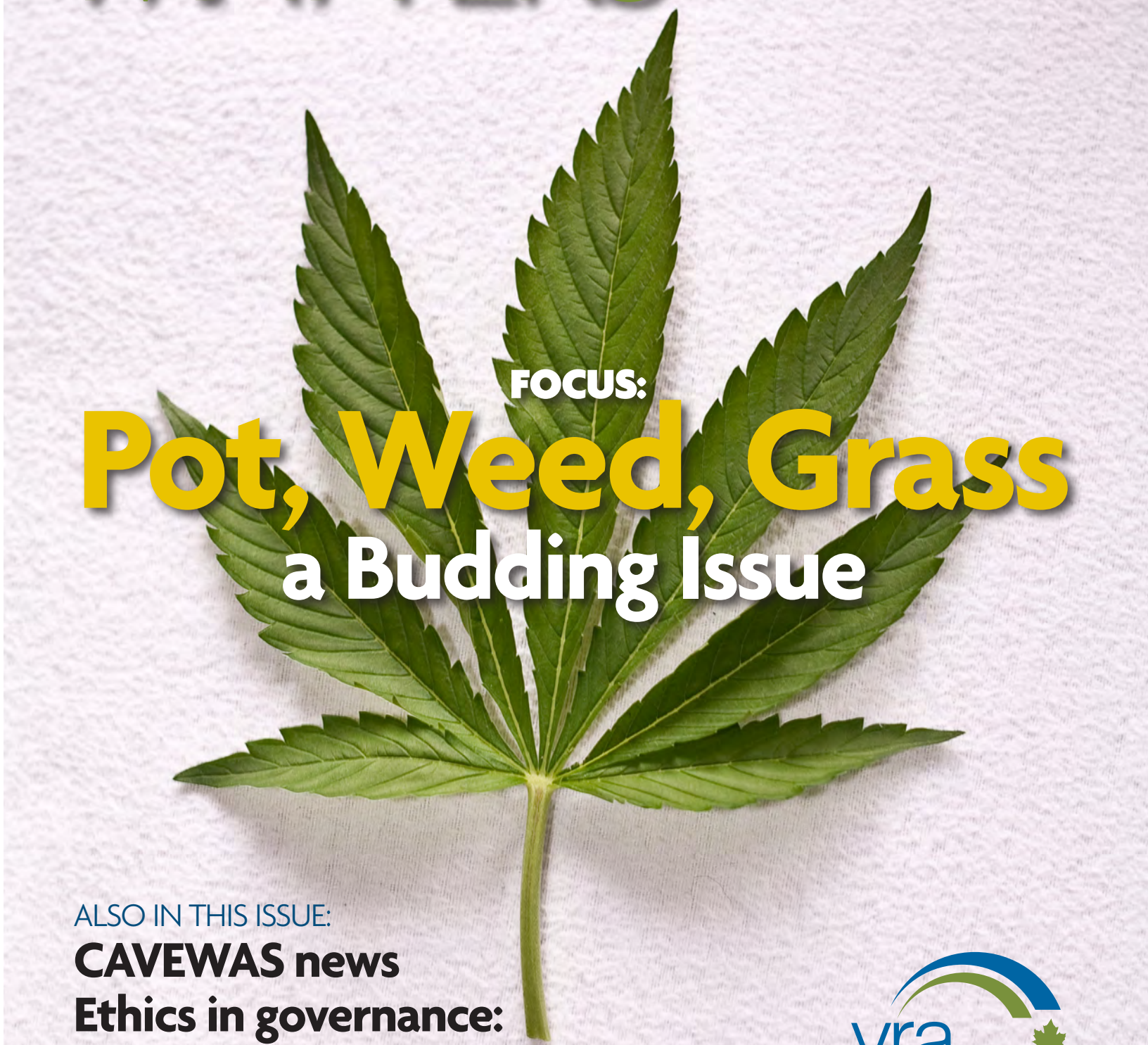

FOCUS:

Pot, Weed, Grass
a Budding Issue

ALSO IN THIS ISSUE:

CAVEWAS news

Ethics in governance:
The good, the bad, and the ugly

Pain-related work disability

vra CANADA

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**Dates are subject to change without notice*

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FROM THE **PRESIDENT**

As you are probably aware, the membership voted at the AGM for VRA to cease granting the RRP designation effective December 31, 2017. This decision marks the next step in a long path to raise our professional standards and to allow VRA to focus on developing and delivering education intended to specifically prepare for and maintain professional excellence.

The Board has been very busy this summer and has struck a working committee to begin the process of developing a mutually agreed-upon and legally reviewed Memorandum of Understanding (MOU) between VRA Canada and CVRP. Members representing VRA are Jennifer Chladny, Roselle Piccininni and Tricia Gueulette. Representing CVRP are Sean FitzGerald, Thea Aldrich, and Warren Comeau. Gail Kovacs is also sitting on this committee as an advisor.

VRA committee members have presented a draft MOU to the board to obtain feedback. The Presidents of each Society will be gathering this feedback at the local level. Our goal at the end of this process is to have an agreement that reflects defined mandates, roles and responsibilities for each organization, strong service guidelines, and a clear and easy continuing education approval process at a minimum. This is your opportunity to become involved in this process and I encourage you to connect with your Society! We will continue to share more as the MOU takes shape.

As we move forward, the Board's vision is to continue building strong educational and professional development pathways within VRA as the centre of excellence for VR in Canada. To this end, we will be completing a membership survey this fall, geared towards gathering information that will help us to develop membership service initiatives and a strong growth strategy for VRA. There are many people in Canada working to help people with disabilities return to work who are not yet connected to VRA. Our goal is to continue to support our current members with initiatives that meet their needs, as well as to grow VRA to attract new members.

Ensuring there is a strong VR industry in Canada is important on many levels. All people should have the right and opportunity to participate in society, fully and with dignity, and have the opportunity to advance their vocational and life goals. From an economic perspective, this work becomes even more critical when you consider that Canada has an aging workforce, and the employment rate for people with disabilities in Canada in 2011 was only 49% compared to 79% for Canadians without a disability (Turcotte, 2014). Canada needs your expertise in order to continue to grow and thrive and VRA will continue to play a crucial role in supporting professionals who work in this field.

Tricia Gueulette
President

FROM THE **MANAGING EDITOR**

The road to decriminalizing cannabis use in North America started as far back as 1993 in Oregon. It was not until 1996 that California became the first American state to make the use of medical cannabis legal. It took 16 more years until Colorado and Washington both legalized it for recreational use.

That prolonged timeline should not be lost on our current Canadian government as they seemingly rush headlong towards what many experts believe will be a hastily cobbled legislative and public relations event in 2018 which many feel will not reduce black market trade but rather solidify and increase it, flouting one of Trudeau's key arguments for legalization.

In Washington State, the black market trade in cannabis has exploded since legalization, caused in part by the high taxes levied on licenced outlets who simply cannot compete with the illegal suppliers. If provincial and/or federal taxes levied on cannabis are onerous here in Canada, we can expect the same outcome.

Because of differing legislation, neighbouring states of Nebraska and Oklahoma are being swamped with weed which has been purchased legally in Colorado. If provincial regulations, including taxation, are not standardized from coast to coast to coast, it's likely the same thing will happen here. A case in point – in Ontario, thousands of citizens regularly drive to Quebec for beer since it is considerably cheaper. They have done so for decades, despite legislation that made this practice illegal until 2012.

Interestingly enough, in the three years since three American states legalized recreational marijuana, there has been no significant change in use by teenagers in those states, according to the Drug Policy Alliance, a leading U.S. organization. Nevertheless, according to the Canadian Paediatric Society, one in seven teens who are heavy users will develop mental disorders, something that needs to be on the minds of every parent, not to mention teachers, school administrators and law enforcement as well.

While arrests for possession in those jurisdictions where marijuana use is no longer prohibited have dropped, fatalities and serious injuries from traffic accidents have in fact increased due to cannabis induced impairment. Although this could be mitigated through road-side driver testing, the Canadian federal government has yet to set legal THC limits and invest in developing accurate testing equipment. Once again, lawmakers have placed the cart before the horse.

For years Health Canada has said that quitting smoking is the best thing one can do to improve one's lifespan and overall health; in fact, just one day after quitting, the risk of a heart attack starts to decrease. Smoking is smoking is smoking and governments at all levels have spent fortunes in taxpayers' money to dissuade people from smoking, reducing the number of Canadians over 15 who smoke cigarettes from almost 50% in 1965 to less than 20% today. The dangers of smoking and of second-hand smoke to innocent bystanders could increase if marijuana legalization results in a rise in the number of smokers in Canada.

There are potential health benefits to using marijuana and these are currently being investigated in clinical trials. They include pain management, relief of muscle spasms for those with MS and seizure reduction in children with epilepsy; more studies will likely find other benefits. Clearly, legalization is an issue that warrants careful deliberation and not a rush towards an arbitrarily-imposed deadline.

Bob Cross
Managing Editor

Medical Marijuana

Vocational perspectives and impacts

By Peter Campbell
BA (Hons), RRP, CVRP, CCVE

According to Health Canada, the number of people registered to use marijuana for medical purposes is 167,754 as of March 31, 2017. In comparison, the total number of registrants for use of medical marijuana as of March 31, 2016 was 53,649 and on the same date in 2015 the number was 18,512 (Market Data, Licensed Producers Medical Marijuana, Health Canada March 31, 2017). This exponential growth suggests that the number of people using marijuana for medical purposes may be expected to grow further making medical marijuana a reasonably commonplace treatment for some ailments. This proliferation raises questions regarding medication and work; some specific to marijuana and others more widely applicable.

The Legal Conundrum for Employers

According to Kees Kort, a lawyer at Hicks, Morrie LLP who had specialized in labour and employment law for 40 years, employers face duelling legal obligations with regard to medical marijuana use. "The employer is obligated to ensure the safety and health of the workplace. The employer is also required to provide reasonable accommodation when they know or ought to have known such accommodation is required for an employee to complete the essential duties of their occupation." Mr. Kort further described that the accommodation responsibility "extends to the point of undue hardship, must offer meaningful work and be dignified in nature". Mr. Kort explained that undue hardship includes and may be triggered by health and safety considerations. Therefore health and safety considerations in the case of medical marijuana constitute an undue hardship upon the employer. The employer has the right to revisit the need for the accommodation from time to time.

With regard to medical marijuana the principles of accommodation and a safe workplace may come into conflict around the prospect of impairment relayed Mr. Kort. Furthermore Mr. Kort stated that as of now there is no test to accurately measure impairment from marijuana. Lastly, Mr. Kort described a secondary concern, "impaired is the inability to complete the duties and tasks of one's job. This makes impairment a job dependent matter. Specifically, impairment may mean something different for a typist than a truck driver".

To what extent have decisions in Canada informed us generally?

In French v. Selkin Logging 2015, Mr. French, a logger and a cancer survivor, smoked marijuana several times

throughout the workday to manage chronic pain. Although a doctor had told the complainant he could use marijuana if it worked, the complainant did not have any formal documentation permitting him to lawfully possess and use marijuana for medical purposes. Prompted by safety concerns, the employer told the complainant he could not continue working if he continued smoking at work.

Although there was no evidence that marijuana use had ever affected the complainant's performance, the British Columbia Human Rights Tribunal concluded that the employer's "zero-tolerance policy" was a bona fide occupational requirement. The Tribunal found that the dismissal was not discriminatory.

The case before the Alberta arbitration board Calgary (City) v. Canadian Union of Public Employees, 2015, the individual was responsible for operating a grader on city streets. To reduce pain caused by a back injury, he obtained a permit for medical marijuana and began using small amounts at night before going to bed. After the individual underwent an Independent Medical Examination, the employer decided the employee could no longer occupy a safety-sensitive position and accommodated him in a non-safety sensitive job.

The board of arbitration found that the IME was based on inaccurate information from the employer. It found there was no evidence of substance abuse or impairment at work. The employer was ordered to reinstate the employee to his former position as a grader operator. However the arbitrators ordered the employee to undergo random marijuana testing in the future, to ensure he would not be impaired at work.

In M obo another v. V. Gymnastics Club, 2016 a newly hired gymnastics coach advised her employer that she used prescribed cannabis to treat an ailment and that it did not cause impairment or interfere in her work duties. This was based on an colleague complaining the coach "was stoned" at work. The employer extended her probation by one month and warned against impairment in the workplace. The employer then instituted a "zero tolerance" policy. After a year of employment at a performance review the coach was suspended and given a medical questionnaire. This was completed by a treating physician and the employer refused to allow the coach to return to work if she used marijuana. The Tribunal concluded that the information provided by the employee's doctor did not appear to suggest

Continued on page 8

Continued from page 7

that the employee's work was compromised by her use of medical marijuana and denied the employer's application to dismiss the complaint to the BC Human Rights Tribunal.

Finally, in Brown v. Bechtel Canada and another, 2016 the BC Human Rights Tribunal denied the employer's application to dismiss a complaint levied by Brown for his dismissal. Brown was pre-employment tested (negative) and at that time produced his prescription to use medical marijuana. When seen on-site smoking marijuana (at a work camp) he was fired. The Tribunal found that the employee was dismissed for reasons related to his use of medical marijuana and concluded that the employer had not provided any evidence that it took any steps to accommodate the employee.

In these cases, the threads of accommodation, workplace safety and impairment as identified by Mr. Kort are all evident. In general, the lack of impairment and disclosure resulting in a duty to accommodate appear to be upheld except in a case involving bona fide occupational requirement.

Impairment

According to Danial Schecter, MD, CCFP, Executive Director of Cannabinoid Medical Clinic in a presentation to the Vocational Rehabilitation Association of Ontario on November 7th, 2014, marijuana contains a number of cannabinoids, only one of which has psychoactive properties. Tetrahydrocannabinol or THC is the affective cannabanoid in this regard.

According to Alison McMahon, owner of Cannabis at Work, a company which advises on issues linked to the use of the drug for medical reasons, and helps firms find employees for the marijuana industry, marijuana can be bred for specific properties such as greater or lesser THC presence. "The type of strain of marijuana varies by a person's medical condition". Also, "impairment may be affected by a person's tolerance to the drug, the time when the drug was taken and the method by which it was taken. For example taking marijuana with a vapourizer has a quicker absorption effect than through ingestion. However ingested marijuana may have a longer effective time span."

Ms. Mc Mahon agreed that there is no test of impairment. She reported that tests exist to determine if a person has used marijuana including a mouth swab test that indicates use within a prior 4 hour period. However given the varieties of marijuana strains and their different concentrative levels of THC the presence, even recent presence, of marijuana may not be indicative of impairment. When taken together with impairment as a functional standard relative to job duties the situation of impairment from marijuana on the job becomes murky.

This raises questions for safety sensitive occupations in which impairment may hold the greatest risk for injury to self or others. What standards are being used if any? In the United States any US DOT (Department of Transportation) regulated employees are prohibited from using cannabis. This encompasses truck drivers, locomotive engineers and airplane pilots. Is a zero tolerance policy for medical marijuana a suitable answer for safety sensitive occupations? Ms. McMahon thought otherwise indicating a person cannot be impaired at work with marijuana use.

In Canada, an airline pilot testing positive for cannabis will lose his Medical Validation Certificate with an automatic and immediate removal from flying duties. The length of the suspension depends on the participation by the pilot in an approved rehabilitation program and on his oversight by a recognized multidisciplinary team. The program must be approved by Transport Canada. It is unclear if this standard has been updated to include medical marijuana.

The International Association of Chiefs of Police have developed a 12 step Drug Recognition Expert (DRE) protocol which can be used for detecting impaired driving. The methods of assessing impairment were described and the standard at which impairment was determined was the rendering of an opinion, "Based on the totality of the evaluation, the DRE forms an opinion as to whether or not the subject is impaired."

The DRE model suffers from drawbacks with respect to its applicability for addressing vocational/return to work issues. The protocol was created to assess degree of impairment for an unknown substance. In the case of medical marijuana the medication and quantities are known. The DRE protocol is applied to the standard of automobile operation predominantly and

the world of work contains many more varied task profiles. Consequently the DRE protocol may not be suitable for assessing impairment against different job tasks. Lastly, the DRE protocol does not inform accommodation needs at all.

Health Canada 2013 (Information for Health Care Professionals: Cannabis (marihuana, marijuana) and the cannabinoids) described the following performance effects from cannabis (THC), "Cannabis impairs cognition involving faculties such as short-term memory, attention, concentration, executive functioning and visuoperception" and, "Although no studies have been carried out to date examining the effects of cannabis or psychoactive cannabinoid exposure on psychomotor performance in individuals using these substances solely for medical purposes, it is well known that exposure to such substances impairs psychomotor performance".

However, Health Canada also states "This document should not be construed as expressing conclusions from Health Canada about the appropriate use of cannabis (marihuana) or cannabinoids for medical purposes".

While it appears agreed that cannabis may cause impairment the question remains open as to what degree impairment may occur, if at all, under appropriate medical supervision.

Vocational Considerations

In his presentation of 2014 Dr. Danial Schecter reported that 35% of his patients at the Cannabis Clinic were employed or in school. However given the exponential increase in registered users, it is assumed that the number and percentage of users seeking and maintaining employment is also increasing. In light of the information above, what practices may be useful for vocational rehabilitation professionals?

As always, listen to your client. This need not be expounded on greatly as it provides the framework for services that will be delivered and as we know contributes overarchingly to a successful outcome.

Communication between the Vocational Counsellor, client, treatment team and employer is warranted. With the treatment provider and client, issues can be explored and addressed such as: Does the prescription cause impairment? Can this impairment be reduced through dosage amounts, types and timing to mitigate effects at work? As seen in Calgary (City) v. Canadian Union of Public Employees and in M obo another v. V. Gymnastics Club, 2016 a lack of impairment, or the ability to complete all tasks of the job, was central to maintaining own occupational employment.

Discussion with the employer also appears warranted. Is the occupation in question safety sensitive or pose a safety risk? Are there workplace policies to be understood in a successful return to work? If so disclosure in a return to work plan negotiated by all parties allows the employer to make reasonable accommodation. Both Ms. McMahon and Dr. Schecter indicated the use of an Independent Medical Exam (IME) to satisfy the employer and employee that a return to work is safe to do. Ms. McMahon described an assessment performed by an occupational health physician versant in medical cannabis effects as a high standard. An alternate assessment for some circumstances may be a situational assessment which replicates workplace duties to determine if any accommodation is required. The results of such an assessment in a return to work plan, with the client's approval, may assuage employer concerns regarding performance. If accommodation is needed what type and for how long also require clarification among all parties.

The issue of disclosure with medical marijuana may change. Given the expectation of legalization of marijuana in 2018 "zero tolerance policies" regarding use may be challenged. If the client uses the drug without impairment the need to disclose to avoid dismissal on the ground of zero tolerance may no longer be a consideration in some instances. However for now, this remains a topic to be thought over in a return-to-work plan.

What of assessment in the case of the requirement to obtain alternate employment? Discussion with the client and treatment provider to develop a regimen that lessens side effects would reasonably be expected to increase the number of potentially viable alternate occupations. Can measures of cognitive function be undertaken to determine functional capacities to allow for effective occupational identification? Might a functional abilities evaluation assist in determining psychomotor function for the same purposes? In the situation of vocational assessment it appears some care is warranted in determining functional abilities for occupational identification, let alone pre-employment training.

Overall medical marijuana is a treatment for a variety of illnesses. To that extent it is expected to primarily alleviate symptoms and restore function. It is reasonable to expect this treatment to improve work performance as compared to an untreated person. That perspective, the improved performance of the individual, is a positive basis on which to begin return to work planning with the client and employer.

This article is written to prompt thought from VR practitioners on the area of medical marijuana and return to work. It is not intended as prescriptive or wholly encompassing of every potential consideration. With the increasing use of medical marijuana in Canada the likelihood and pleasure of serving a client in such circumstance increases as well. As a result VR professionals are encouraged to remain knowledgeable about issues surrounding medical marijuana so as to suit their professional scope of practice.

Peter Campbell is a vocational rehabilitation consultant in the Belleville, Ontario area. He has worked in the field for greater than 20 years most recently providing case management and assessment services. In his spare time he is a boxing coach at Belleville Bulldog Boxing Academy and is working to create a program for people with Parkinson's disease to increase strength, balance and motor coordination for those afflicted.

Understanding medical cannabis and accommodating employees

STEPHANIE CLEMENT

By Stephanie Clement, M.Ed.
Senior Trainer,
Banyan Work Health Solutions

The Situation

Cannabis is steadily becoming more commonplace in Canada as societal views are evolving and the use of cannabis is becoming less stigmatized, in particular due to its use for medicinal purposes. Health Canada estimates that, at the end of 2016, almost 130,000 Canadians had signed up with a licensed cannabis producer and that, over the next decade, Canada will see as many as 450,000 more medical cannabis users. While medical cannabis is being prescribed to help manage a wide variety of symptoms such as nausea from chemotherapy, weight/appetite loss associated with HIV/AIDS, chronic pain, inflammatory diseases, sleep disorders, stress and anxiety, the accommodation needs of workers who use medical marijuana is emerging as a prevalent issue facing Canadian workplaces.

How it Works

There are at least 113 active cannabinoids identified in cannabis. The two main ones used in medical cannabis are delta-9-tetrahydrocannabinol (THC) and cannabidiol (CBD). The specific illness and symptoms dictate which cannabis strain will be prescribed by a physician and what the recommended THC to CBD ratio should be – THC procuring a psychoactive effect and CBD without psychoactive effect. The form of consumption will also be determined by the physician (i.e. oil, pill, spray, vaporized, smoked). Dried cannabis herbs can be bought in both illegal dispensaries and legal licensed producers; spray (Sativex) and pills (Nabilone) are only available with a prescription in pharmacies.

Filling your prescription

There are currently no prescribing guidelines available for physicians. Some physicians are starting to research the topic and are becoming comfortable prescribing medical cannabis to their patients, including managing their patient's application process for access to Health Canada's Marihuana for Medical Purposed Regulations (MMPR) and registration with an approved Licensed Producer (LP). Additionally, in many cities across Canada, specialist clinics take the burden off treating physicians by adjusting dosage and choosing the right strain and facilitating the registration process, for patients who have been referred by their treating physicians. Once the licensed producer verifies registration information with the treating physician/medical clinic, the order is placed, and then shipped to the patient's home. Each shipment contains a verification card that the patient can produce should proof be required that the medication has been legally obtained.

Licensed Producers

All patients prescribed medical cannabis in dried herb or oil form should be obtaining their medication from a licensed producer registered with Health Canada. In February 2017 there were 32 licensed producers and 52 as of July 18, 2017. When seeking to understand if a patient is ordering from a licensed producer, verification of this regularly updated list of licensed producers can be accessed on Health Canada's website. Licensed producers ship across the country and each producer has different strains available with varying THC to CBD ratios. This is where the expertise of the specialized treatment team is optimal in choosing the right producer based on the product that is most ideal for each patient.

https://tinyurl.com/y9epdy7q

Does a workplace accommodation for an employee who takes medical cannabis mean allowing that employ-

ee to smoke or inhale cannabis in the workplace?

NO!

Medical accommodation does not override existing regulations or expectations for workplace conduct. For example:

- Anti-smoking laws apply to smoking cannabis in the same way they do to regular cigarettes;
- A prescription for medical cannabis does not mean an employee can arrive late or impaired at work;
- Safety must be ensured at all times.

Accommodating an employee who has been prescribed medical cannabis will depend on a myriad of factors, including the nature of the workplace, the occupational demands, and the needs of the employer and employee. Currently in Canada, most cities have a by-law stating it is illegal to smoke in public spaces, such as workplaces, restaurants, and nine meters from public doorways. In US states where cannabis has been legalized, it is still illegal to consume cannabis in public and is only allowed on private property. We can expect similar rules will apply in Canada when cannabis is legalized in 2018.

Currently, employers may have a drug and alcohol policy outlining steps to investigate situations where drug and/or alcohol abuse is suspected, as well as disciplinary measures in cases where drug and alcohol use is confirmed. These policies will remain in effect when cannabis is legalized in 2018. However, there is potential for an employee taking medical cannabis to be discriminated against within these existing policies. In the case of an employee testing positive for cannabis as a result of being prescribed medical cannabis, employers could consider a provision in their policy where this employee would not be subject to disciplinary measures. It may be worthwhile for employers to consider an addendum to current drug and alcohol policies that would highlight factors to be considered when an employee is taking medical cannabis (e.g. has it been obtained from a licensed producer). Should safety be a concern, the employer reserves the right to refer to third party service provider for management and identification of possible impact on work and accommodation needs.

Under Canadian privacy laws, employees have no obligation to divulge the medications they are taking to their employer. Consider a scenario where an employee is randomly tested and tests positive for cannabis – the employee may willingly divulge that he is taking medical cannabis but an employer may have a difficult time insisting he provide proof *unless* provided for in a medical cannabis policy. (It is important to bear in mind that some forms of cannabis are not psychoactive and therefore compatible with being productive and safe at work while helping with pain management or other symptoms). Having a clear and specific policy provision for cannabis will become that much more import-

ant once cannabis is legalized in Canada to avoid the potential "cannabis is legal so it's ok to smoke before coming to work" attitude.

A helpful strategy for employers will be to partner with their short-term or long-term disability carrier or with an independent third party service provider for guidance to ensure employee safety, and to obtain the required confirmation that the medical cannabis is obtained from a licensed producer and not a dispensary. For insurers, who have access to medical information, asking for the confirmation card will be possible and should become mandatory as part of case management of these cases, with obtaining medical cannabis from a licensed producer being considered 'under appropriate treatment' as per insurance terms. With the various forms of cannabis and THC to CBD ratios, most employees can take medical cannabis and be capable of working safely. If a THC dose is needed (psychoactive), this can be consumed after work hours and depends on how each individual patient metabolizes the option they are taking.

If an employee needs the increased THC to manage symptoms, then it is imperative that safety be evaluated and handled as with any other employee taking opiates. What can be done in cases, where driving and/or performing hazardous tasks would become unsafe because of impairment of mental alertness and/or physical coordination?

In the example of a heavy machinery operator where safety is a concern, an employer may not know which medications this employee is taking, but has noticed that something is off.....slow response time, day dreaming, etc. What options are available to ensure this employee is safe at work?

A Functional Capacity Evaluation (FCE) including cognitive abilities, may have value to ensure safety in specific tasks such as manual handling, sitting, standing, focus, concentration, fatigue, etc. With this information, appropriate temporary or long term work accommodations can be pursued.

As with any situation where medical accommodations are required, it is essential to clearly understand how medical cannabis impacts the employee's ability to meet occupational demands, and to then determine if certain shifts or times of day would be best because side effects are less problematic. Temporary assignments into an occupation that is a better fit to the current functional level or part time shifts should also be considered as suitable accommodation. A thorough assessment of the gap between the employee's current level of function and function required to meet physical and cognitive occupational demands is the key to accommodating employees taking medical cannabis.

The challenge for employers moving forward will be balancing the duty to accommodate employees with disabilities prescribed medical cannabis, while taking every reasonable precaution to ensure the safety of the workplace and seeking assistance to identify and properly manage solutions.

Challenges and red flags

While quality can usually be controlled for spray and pill form cannabis prescriptions because they are available in pharmacies, challenges exist for prescriptions for dried cannabis and cannabis oil. In 2018, when cannabis is legalized, it will be possible for anyone to obtain dried cannabis and cannabis oil from a dispensary where quality controls may be sub-optimal in comparison to Health Canada approved licensed producers. Requiring mandatory registration and ordering from a licensed producer for patients prescribed medical cannabis may help to ensure that dosage is properly controlled and that regular follow ups are scheduled to review dosage and side effects.

Not everyone is a suitable candidate for being prescribed medical cannabis. Situations that call for concern include:

- Anyone under the age of 25 (in fact, some doctors will not prescribe to patients under the age of 35).
- A history of addiction or sensitivity to cannabinoids or smoke, taking other medications that are contraindicated, and suffering from medical conditions that are contraindicated, such as schizophrenia, psychosis, liver or renal disease.
- Taking more than 3 grams per day**; with no regular medical follow up; where no dosage decrease in other prescription drugs such as opioids and benzodiazepines is seen; ordering from multiple licensed providers or from dispensaries, even when

References

Dr. Andrea Burry,
Medical Director,
Trauma Healing Centers –
May 2017 CLHIA conference

Health Canada
Medical cannabis consumer information:
https://tinyurl.com/ybrku9m8

Health Canada
Medical cannabis information for health care professionals:
http://tinyurl.com/ycsltz8b

Health Canada
List of approved licensed producers:
https://tinyurl.com/y6v58mpe

John Drudge, Rapid Interactive Disability Management Ltd. July 4th, 2017 conversation.

they become legal in 2018.

- Refusing to provide a copy of the order confirmation of licensed producer verification card.
- A sudden increase in dosage may be also be concerning as it may be an indicator of addiction.

** Data from various surveys published in the peer-reviewed literature have suggested that the majority of people using smoked or orally ingested cannabis for medical purposes reported using between 10 - 20 g of cannabis per week, approximately 1 - 3 grams of cannabis per day.

Health Canada's recommendation is that maximum dosage be at 3g/day.

As with many other medications, prescribing contraindications exist with concurrent medications and existing medical conditions. Health Canada's detailed document for professionals clearly outlines them. Employers bound by privacy laws will not have access to this information and may need to partner with their insurance carrier or claims management provider to obtain confirmation that treatment is appropriate and safety is ensured.

Recommendations

Whether you are an employer, an insurer or a third party service provider, it will be important to ensure the employee/client is obtaining the medical cannabis prescription from a licensed producer registered with Health Canada.

Consider stay-at-work initiatives that will allow a third party provider to work with employees and their treatment provider to ensure a work-friendly form of medical cannabis is prescribed; ensure the employee is registered and obtaining the medical cannabis from one of the 52 licensed producers registered with Health Canada; and work with the employee and employer to find suitable accommodations and ensure work safety.

As more physicians prescribe medical cannabis and as cases of workplace accommodation become more prevalent – coupled with proper workplace policy implementation – the current unease with medical cannabis could subside over time and be managed as any other opioid medication and accommodation need.

For more information or to attend a webinar, please contact the author.

Considerations for establishing the minimum age to purchase and consume marijuana

By Paula Roy

While there are many contentious aspects to the legalization of marijuana, one of the most hotly-debated topics is establishing the minimum age for legal purchase and consumption. Some lobby groups feel it should be 18, similar to the voting age, while others argue that it should be aligned with the legal age for purchasing alcohol in Canada (19 in most provinces, 18 in Quebec, Manitoba and Alberta). A third voice is that of the Canadian Paediatric Society, which is urging the federal government to strongly consider a higher age limit and/or limiting the concentration of THC (tetrahydrocannabinol, the main psychoactive component) in cannabis that 18- to 25-year-olds can purchase legally. Joining the chorus is the Canadian Psychiatric Association which has warned about the mental health implications of cannabis for young people, and recommended an age limit of 21, as well as quantity and potency limits for those under 25.

The principal reasons for these cautionary recommendations are the increased risks associated with recreational marijuana use by younger people. Doctors and scientists confirm that brain development is not complete until we reach our mid-20s and that cannabis can have both structural and functional effects on the brain during this critical time of development. It is believed that lower concentrations of THC may mitigate this risk.

Research has shown that sixteen percent of youth who regularly use marijuana are at risk of developing clinically-diagnosed cannabis-use dependency, despite pro-pot advocates' claims that the drug is not addictive. Young people with this dependency typically find the patterns of their lives become severely disrupted, with negative impacts on academic performance, relationships and social life. Those who become dependent on marijuana also find it difficult to reduce or eliminate their consumption thanks to withdrawal symptoms including anger, agitation, sleep disruption, digestive upset and severe headaches. Of even greater concern is that heavy consumption of marijuana can also lead to psychotic events including hallucinations, depersonalization and more.

Doctors – including addiction experts – argue that the combination of the dangers to the developing brain and the mental health risks are compelling reasons why legislation should be structured to protect young people from cannabis exposure. In addition, legislation similar to what has been enacted for tobacco usage should also be developed for marijuana, to protect children from second-hand pot smoke.

Of equal concern are the implications of marijuana use among young drivers. Many people erroneously believe there is no danger to driving when 'high', however this is not true. Young drivers, some of whom may overestimate their own proficiency behind the wheel under many circumstances, are particularly vulnerable to making driving errors. If they are impaired by marijuana consumption or, even worse, a combination of marijuana and alcohol, they may not realize the risk they pose to themselves or others should they choose to get behind the wheel.

Finally, doctors warn that another potential consequence of marijuana legalization could be that young children can unintentionally access cannabis products. In Washington and Colorado, two jurisdictions in the United States where recreational marijuana has already been legalized, the number of young children being brought to hospital emergency departments due to cannabis overdoes has tripled, primarily due to kids eating marijuana-laced baked good or candies intended for adult consumption. Some suggest that the government should ban the sale of such products because of the danger they pose to young children, who have no way to distinguish them from non-cannabis based treats.

As the federal government develops a framework to legalize marijuana, experts from many fields confirm that it is crucial that restricting youth access and usage be fundamental parts of the legislation.

Pros and cons of legalizing marijuana

By Paula Roy

Proponents of the legalization of marijuana put forth a number of arguments in support of this legislative change. Here are a few of their key points:

PROS

1 Tax revenue – New taxes applied to the sale and distribution of marijuana could raise many millions of dollars each year, making the legalization a much-valued revenue generator for federal or provincial governments.

2 Decreased revenue for organized crime – Advocates say that legalizing marijuana will significantly cut into the profits of those currently supplying drugs illegally. Secondary benefits would include decreased costs to police and prosecute illegal drug traders, as well as decreased violence as a result of organized crime activity.

3 Reallocation of resources for law enforcement and criminal justice – Some groups who are pro-legalization of cannabis feel that decriminalization will enable police and the legal system to focus more on violent crimes, making our communities safer while also reducing court backlogs and prison overcrowding.

4 Better assurance of safety controls – As the current opioid crisis proves, when drugs are purchased off the street, there is no assurance of quality or safety. Legalization is intended to create a safety control system that protects consumers.

5 Improved access for medicinal use – Some medical experts and advocates agree that marijuana is effective in treating a range of health conditions, including cancer pain, glaucoma, epilepsy, multiple sclerosis (MS), posttraumatic stress disorder and more. Making it easier for patients to access marijuana for medicinal use will benefit those who wish to use it to ease symptoms.

6 Respect for personal choice – some people feel that limiting access to and use of marijuana intrudes on personal freedom, therefore they believe marijuana use should be a matter of individual choice rather than a regulated act.

7 Parity with other substances – proponents argue that marijuana is no more harmful to a person's health than alcohol or tobacco, which are both legal and widely used, and have controlled access which is regulated by current legislation.

8 Support for new businesses – legalization would enable licensed industrial growers in Canada to develop and establish reputable, profitable companies which will employ many workers and contribute tax revenue and other financial benefits as good corporate citizens.

Those who are opposed to legalizing marijuana have their own compelling reasons for doing so. These include:

CONS

1 Risk of addiction – researchers and addiction treatment specialists agree that long term, habitual use of marijuana does lead to addiction, with as many as ten per cent of users developing dependence on the drug over time. As with any form of substance abuse, quitting the habit can lead to withdrawal symptoms ranging from mild to severe.

2 Gateway to harder drugs – Addiction specialists believe that marijuana use can lead users towards more serious drugs, including the use and abuse of prescription drugs, hash, cocaine, heroin and more. Marijuana legalization could therefore increase societal and financial costs for treating individuals who move on to harder drugs.

3 Increased impaired driving – In Colorado and Washington, two of the first states to legalize recreational marijuana, statistics show that the rate of serious highway crashes due to marijuana-induced impairment has increased. Experts recommend Canada combat this risk by setting legal bloodstream limits for THC, as has been done for alcohol, but more reliable roadside testing methods also need to be developed.

4 Altered perception – Marijuana is a drug, which by definition changes the way the human body functions. A primary effect altered perception, which some believe can lead to lapses in judgement as well as aberrant and illegal behaviour including crimes such as robbery and rape.

5 Physiological effects –The lungs, cardiovascular system and brain are all adversely affected by marijuana use. Marijuana is estimated to have almost double the levels of carcinogens than tobacco smoke. Marijuana use raises the heart rate from 20 to 100 percent for up to three hours after it has been smoked, increasing the risk of problems, such as arrhythmia, heart palpitations and heart attack.

6 Psychological effects – Research has discovered a link between marijuana use and mental illnesses such as schizophrenia and depression.

7 Increased access by children and youth – Harmful substances like alcohol and cigarettes are prohibited from being sold to children, who typically do not have the same judgement, reasoning and sense of responsibility as adults. Plus, their still-developing bodies suffer more ill-effects from the intake of such substances, as well as marijuana. There is also a risk of accidental ingestion of marijuana by children, particularly in edible products, which children may not realize are not intended for them.

8 Second-hand smoke – Science has proven the danger of second-hand smoke from cigarettes; those same dangers apply to smoking marijuana. While people can no longer smoke in public spaces and workplaces will extend to marijuana use, smoking cigarettes or marijuana in private homes, yards and balconies is not regulated and is often a point of contention in townhouse complexes, apartment buildings, etc.

Impact on provinces and municipalities of legalization of marijuana

By Paula Roy

On April 13, 2017, the Canadian federal government announced that it intends to enact legislation to legalize marijuana, fulfilling a campaign promise made during the 2015 election campaign. There are broad implications to this significant change in public policy, including in the areas of health, safety, security, international relations and even Canadian culture. The government indicated that one of the prime reasons it is pursuing this new legislation is as a means to address very high percentages of young people using cannabis in Canada; our country actually has one of the highest rates in the world and criminalization has not historically served as a deterrent.

Two bills were introduced in the House of Commons in April by Justice Minister Jody Wilson-Raybould, Public Safety Minister Ralph Goodale, Health Minister Jane Philpott and Foreign Affairs Minister Chrystia Freeland. Canada is now the largest federal jurisdiction in the world to embark on the process of legalizing cannabis consumption, in an attempt to replace the current law, which bans the recreational use of marijuana but has long been deemed an ineffective piece of legislation. The foundations of the new legislation are that marijuana should remain strictly controlled, not be consumed by drivers and not made available to children.

If passed, the new laws would allow adults 18 and over to possess up to 30 grams of dried cannabis or its equivalent in public, share up to 30 grams of dried marijuana with other adults and buy cannabis or cannabis oil from a provincially-regulated retailer. It would also be legal for adults to grow up to four plants at home for personal use and make products containing cannabis at home. There will be significant penalties for those who assist young Canadians in committing cannabis-related offences as well as zero-tolerance for drug-impaired driving. Police would be able to issue tickets for possession of small amounts above the legal limit, while illegal possession of larger amounts could bring a maximum penalty of up to five years in jail. There will also be strict controls imposed on the branding, marketing and advertising of legal marijuana.

Under the proposed legislation, Health Canada would continue to regulate such areas as pesticide use, product safety and quality standards. In terms of impaired driving, there would be a regulated limit – the first such imposition in Canadian law – for THC (cannabis' psychoactive ingredient) levels in a driver's blood. If a police officer has reason to suspect that a driver is impaired, the officer can demand the driver take a roadside saliva test, the results of which could lead to the officer requesting a blood sample or evaluation by a drug impairment expert. Failure to comply would be a criminal offence and the penalties would be harsher if the driver was impaired by both alcohol and marijuana.

Despite these details, there are still many grey areas. We do not know yet, for example, how cannabis will be priced, how it will be taxed or what amount of revenue the government expects because of legalization (experts suggest it could be anywhere from $600 million to $5 billion or more). Of course, higher prices and/or higher taxes are perilous because they may cause consumers to continue to support unlicensed marijuana dealers rather than licensed channels.

Much debate has ensued about the proposed legislation, particularly its impact on provincial and territorial governments, upon whom the federal government is downloading responsibility for distribution and enforcement. As mentioned, the new bills have set the legal age for marijuana consumption at 18, although the current wording says that provincial and territorial governments would be free to impose a higher legal age limit. Whether cannabis will be sold in standalone retail locations or via provincially-licensed liquor outlets is unclear, as is whether or not its consumption in public spaces (i.e., places where alcohol is served) will be permitted. Even though distribution will be handled at a provincial level, retailers must obtain federal licenses to sell marijuana, yet the inspection of production and distribution facilities will conversely fall under the provincial rather than federal umbrella. From an international perspective, it is also not known how Canadians will be treated abroad if travelling from a country where marijuana has been legalized to one which has not.

In April, Yasir Naqvi, then-Minister of Community Safety and Correctional Services (and now Ontario's Attorney General) likened the scope and impact of the new marijuana legislation to the end of prohibition in the 1930s. In advance of the unveiling of the new bills this year, in 2016 the Ontario government established a cannabis legalization secretariat to proactively start exploring various options – focusing especially on youth, public health and road safety, as well as prevention and harm reduction – so as to be better prepared to respond to the proposed federal legislation.

Also at the time of the proposed legislation's unveiling, Manitoba Justice

Minister Heather Stefanson warned that the provinces could incur significant costs to enforce new marijuana laws, including officer training to combat impaired driving, and suggested that the federal government should help pay some of these costs. She indicated that while the Manitoba government is pleased their federal counterparts are following in the footsteps of their province's Cannabis Harm Prevention Act, there needs to be clarity over who will pay for both training and the technology to test for THC levels in drivers. The lack of a reliable roadside testing methodology is particularly problematic, she emphasized. Some jurisdictions use a saliva test but measuring THC levels in nanograms is not reliable, since individuals all metabolize drugs differently.

Similarly, Alberta premier Rachel Notley expressed concern months ago that meeting the July 1, 2018 deadline could be difficult. She said the provinces may need more time because administering the new legislation is very complex. She reiterated this position in mid-July at the annual meeting of Canada's provincial and territorial leaders, where she and her counterparts urged the federal government to consider delaying marijuana legalization past July 2018 until issues such as distribution, public and traffic safety, measuring cannabis impairment and protecting the health of youth are fully addressed. They also expressed concern that they do not wish a patchwork of legislation as exists across the country for beer, wine and spirits. The premiers and territorial leaders have decided to establish a working group to examine the issues that surround legalization of marijuana; it is expected to deliver a preliminary report by November 1st.

Meanwhile, individual provinces will continue to grapple with the issues surrounding legalization in their own ways. In mid-July, Ontario embarked on a series of public consultations to gather feedback on the legal age to buy pot and the appropriate vendor structure for marijuana sales. Despite the fact that the public consultations have just begun, Premier Kathleen Wynne has already said that consumers will have to be 19 years old to legally purchase marijuana in Ontario, to align with the age limit for the purchase of alcohol. She also emphasized that as Ontario makes plans for the legalization of marijuana, the province will also be working diligently to align its policies and practices with Quebec, given that two of the country's two most populous provinces share a lengthy border and differing rules could drive traffic across the border in either direction. British Columbia's politicians have similarly pointed out that harmonizing the tax rates between provinces are an important consideration because if they are not standardized, Canadians may choose to travel to another province where the tax rate is lower to purchase marijuana.

The bills put forward by the government in April must now be studied by Commons and Senate committees before being voted into law. In announcing the proposed new legislation, the federal government promised a comprehensive public awareness campaign to educate people about the dangers of both early and long-term marijuana use, the risks of high-potency products, and the fact that marijuana impairs judgment, especially when combined with alcohol or other drug use. We can be certain that in the months ahead, impaired driving will be an area of intense focus for federal law makers, the RCMP and provincial and municipal law enforcement agencies. Much work remains to be done before the target legalization date of July 1, 2018, and much of that work rests on the shoulders of provincial and territorial politicians.

Timeline of marijuana's political and legal journey

By Paula Roy

As Canada prepares for the legalization of marijuana, widely anticipated to happen in mid-2018, it is interesting to take a look at marijuana's history in North America.

1700s: Early American colonists grew hemp, but it was low in THC ((tetrahydrocannabinol, the main psychoactive component). The plant's commercial value was for making rope, paper and clothing.

1800s: The British grew cannabis in their colonies of Bengal and India, exporting it to Jamaica where it was given to slaves to pacify them. This practice continued into the early 1900s. Smoking marijuana became an entrenched part of Jamaican culture and spread to other Caribbean islands.

Early 1900s: at the end of the Mexican Revolution of 1910-1911, refugees fleeing violence brought cannabis with them into the United States. Sailors who plied routes from the Caribbean also brought it to New Orleans and a stereotype developed that it was brown and black people who smoked marijuana.

1922: Pioneering Canadian feminist Emily Murphy publishesda strident anti-cannabis book called The Black Candle, in which she claims that marijuana use turns people into homicidal maniacs.

1923: Cannabis is added to Canada's Schedule of the Opium and Narcotic Control Act.

1930: The aforementioned racial stereotyping in the U.S. fuelled activists to pursue anti-marijuana legislation. As marijuana use increases, partially as a response to Prohibition, The Federal Bureau of Narcotics is established.

1937: The U.S. Marijuana Tax Act is passed; this statute effectively criminalized marijuana, restricting possession to people who paid an excise tax for authorized medical uses of the drug.

1960s: The perception of marijuana as primarily a 'coloured-people's drug' changed when baby boomers and white college kids embraced it. Studies commissioned by Presidents Kennedy and Johnson concluded that marijuana use did not induce violence.

1969: The Canadian government establishes a Commission of Inquiry Into the Non-Medical Use of Drugs (called the LeDain Commission after its chairperson). In 1972 the commission recommends decriminalizing simple cannabis possession and cultivation for personal purposes.

1976: American conservative Christian groups lobbied for stricter marijuana laws. The power of this vocal coalition eventually led to the 1980s "War on Drugs".

1977: Reflective of changing attitudes, Prime Minister Pierre Trudeau told a group of students: "If you have a joint and you're smoking it for your private pleasure, you shouldn't be hassled."

1986: President Regan implemented the Anti-Drug Abuse Act which increased penalties for marijuana offences, and establishes harsh mandatory "three strikes" sentencing laws.

1989: President George H.W. Bush declared a new "War on Drugs".

1996: California became the first state to legalize medical marijuana. Within the next 12 years, twelve other states followed suit, though restrictions varied widely.

1999: Two Canadians received federal permission to use marijuana for medicinal purposes.

2000: The Ontario Court of Appeal ruled that Canadians have a constitutional right to use cannabis as a medicine.

2001: New Canadian medical marijuana access regulations granted legal access to cannabis for individuals with HIV/AIDS and other illnesses. Authorized patients can grow their own pot or obtain it from authorized producers or Health Canada.

2012: The Conservative majority government passed the *Safe Streets and Communities Act*, which amends the *Controlled Drugs and Substances Act* to provide for minimum penalties for serious drug offences and increase the maximum penalty for cannabis production.

2013: New federal regulations further changed Canadian medical marijuana access rules, shifting from homegrown to licensed commercial growers. Some 37,800 peopled receive authorization authorized to possess marijuana, up from fewer than 100 in 2001.

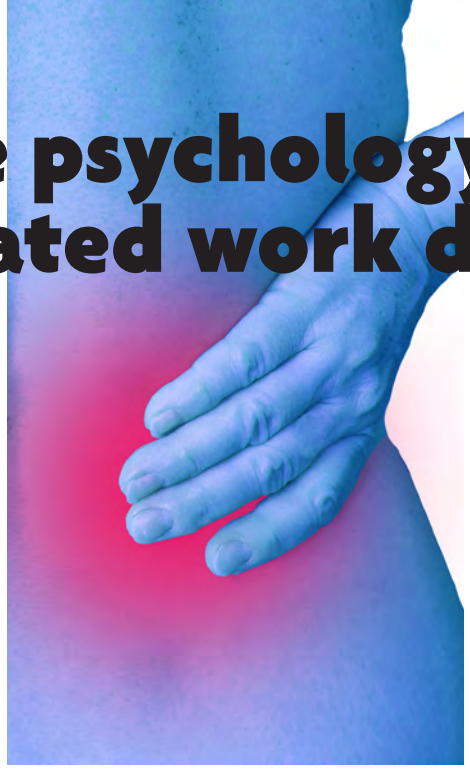
2014: As the result of referendums held in 2012, Colorado and Washington are among the first states to legalize the recreational use of small quantities of marijuana.

2015: The Liberal Party won the Canadian federal election and Justin Trudeau became Prime Minister. The party had including legalizing marijuana as part of its election platform.

2017: In April, the Canadian government announced it will decriminalize marijuana by July 2018.

At the annual meeting of Canada's provincial and territorial leaders in July, the group urged the federal government to consider delaying marijuana legalization past July 2018 until issues such as distribution, public and traffic safety, measuring cannabis impairment and protecting the health of youth are fully addressed. They also expressed concern that they do not wish a patchwork of legislation as exists across the country for beer, wine and spirits.

The psychology of pain-related work disability



By Dr. Michael Sullivan

In North America, work-related musculoskeletal conditions are the most expensive non-malignant health condition affecting the working-age population [1]. Musculoskeletal disorders can arise from activities or incidents involving muscular strain, falls, repetitive movements or physical impact. Although the majority of musculoskeletal conditions recover within weeks of injury, a significant proportion of individuals will remain permanently disabled. The prevalence of work disability associated with musculoskeletal conditions has been increasing steadily in spite of numerous policy, prevention and intervention initiatives launched to date.

By the mid-1960s, mounting clinical and scientific evidence was suggesting that traditional medical approaches to understanding (and treating) pain-related disability were inadequate. Research was accumulating indicating that medical status variables alone could not fully account for presenting symptoms of pain and disability that arose consequent to injury [1, 2]. Biopsychosocial models have been slowly replacing traditional medical models as the dominant conceptual frameworks guiding research and practice on pain-related disability. These models suggest that a complete understanding of pain experience and pain-related disability consequent to injury will require consideration of physical, psychological and social factors [3, 4].

As intuitive as the premise might be, pain severity is not the primary determinant of prolonged work disability following injury. Overwhelmingly, research suggests that pain severity accounts for only approximately 10% of the variance in the disability associated with musculoskeletal conditions [5]. Still, pain reduction remains the major focus of interventions offered to individuals who have sustained musculoskeletal injuries. In light of the weak relation between pain and disability, it is perhaps not surprising that pain-focused interventions have not been shown to be effective in reducing the magnitude or duration of work-disability. Indeed, certain pain-focused interventions, such as the prescription of opiates, have been shown to increase rather than decrease disability [6].

Our work over the past two decades has examined the role of pain-related psychosocial factors as determinants of work-disability following musculoskeletal injury. Numerous investigations have shown that individuals who engage in catastrophic or alarmist thinking about their symptoms, and who feel that they are suffering unjustly, are individuals at high risk for prolonged disability following musculoskeletal injury [7, 8]. The predictive value of catastrophizing, and perceived injustice for prolonged work-disability has been so robust, that these psychosocial variables have risen to the status of 'risk factors' for problematic recovery [1].

Over the past two decades, great strides have been made in alerting clinicians to the importance of assessing psychosocial risk factors in their evaluations of individuals suffering from debilitating pain conditions. Measures of pain-related psychosocial risk, such as the Pain Catastrophizing Scale (PCS) [8] and the Injustice Experiences Questioannire (IEQ) [7] have been incorporated into the assessment protocols of pain clinics and rehabilitation centers around the world.

Although psychosocial risk measures such as the PCS and the IEQ have been readily adopted, the clinical community has lagged in the implementation of interventions specifically designed to target these psychosocial risk factors. While speaking at a recent rehabilitation conference, I asked members of an audience of approximately 1000 clinicians to raise their hand if they used a measure of pain catastrophizing as part of their assessment protocol. Nearly every hand in the audience was raised. I then asked what clinicians did differently when one of their clients obtained a high score on the measure of catastrophizing. Not one hand was raised to offer a response.

The assessment of psychosocial risk factors is only worthwhile if there are plans to institute an intervention specifically designed to target psychosocial risk factors. Unfortunately, in many settings, the assessment of pain catastrophizing and perceived injustice (and other psychosocial risk factors) is more likely to be used to blame the client for failing to respond to treatment, as opposed to being used to tailor treatment to the client's needs.

When measures of psychosocial risk are used only for assessment purposes, as opposed to treatment planning, their use can actually be potentially harmful to the client. I have witnessed many occasions where psychosocial risk measures were included as part of a functional capacity evaluation. When results fail to reveal a consistent picture of physical limitations, and the patient obtains high scores on pain-related psychosocial risk factors, the conclusion is drawn that the patient's problem is psychological as opposed to physical. This erroneous conclusion can have disastrous consequences for the client's eligibility for compensation.

Can the current situation be improved? One significant challenge is that primary care services are not well suited for targeting psychosocial risk factors in the early stages of recovery. Primary care practitioners, such as physicians and most physical therapists, have neither the time nor the skill set necessary to effectively manage psychosocial risk factors for work-disability. Additionally, there are indications that primary care

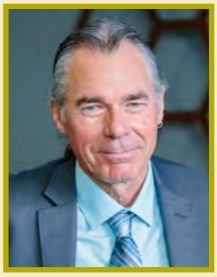
practitioners do not necessarily consider their role to include involvement in the return-to-work process [9].

It is unrealistic to propose that referral for psychological services should be considered earlier in the recovery process following injury. While, psychological services are an important component of the management of chronic pain, psychological services are under-represented in the management of acute injury. Perhaps, based more on experience than empirical data, many injury insurers are weary that an early referral to a psychologist will prolong rather than decrease the period of work-disability. Indeed, the majority of clinical psychologists are ill-equipped to function as a 'return-to-work' interventionists. The processes of work-disability and pathways to occupational re-integration are not core elements in the curricula of clinical training programs in psychology.

Our recent work suggests that, unless successful return to work is the outcome of rehabilitation interventions for musculoskeletal pain, the majority of treatment gains are lost shortly following termination of treatment [10]. From this perspective, neglecting to place return-to-work as a central treatment objective in the treatment of musculoskeletal injury could be associated with high costs. However, the issue is more than simply economic. Return-to-work represents the highest level of independence that can be offered to a work-disabled individual with a musculoskeletal condition. Our clients are unlikely to realise this outcome, unless we are prepared to make return to work part of our treatment plan [11].

The management of psychosocial risk factors for delayed recovery has been a major focus of our work for many years. Part of this work has involved the development of psychosocial risk measures such as the PCS and the IEQ. More recently, we have modified these measures to make them suitable for individuals who are work-disabled due to mental health conditions as opposed to being restricted to individuals who are work-disabled due to a pain condition. We have also been involved in the development and implementation of risk-targeted interventions aimed at reducing psychosocial barriers to rehabilitation progress. One such intervention, the Progressive Goal Attainment Program (PGAP), has become the most widely applied standardized risk-targeted intervention aimed at reducing psychosocial risk factors for delayed recovery. PGAP was conceived as a psychosocial intervention that could be delivered by a wide range of rehabilitation professionals. PGAP training workshops have been held in several countries including Australia, Canada, France, Ireland, New Zealand, South Africa, Sweden, and the United States. In 2013, the Official Disability Guidelines (ODG) for Workers' Compensation Boards of the United States listed the PGAP as an evidence-based intervention for the treatment of work-disability.

Future research is likely to continue to reveal that psychological processes are critical determinants of recovery trajectories following illness or injury. The accumulating evidence base will call for the incorporation of risk-targeted psychosocial services earlier in the management of disabling illness or injury. In order to respond effectively to this call, our rehabilitation training programs will need to incorporate training on the psychological management of work-disability, and rehabilitation clinicians, regardless of their specific discipline, will need to consider placing return to work as a central objective of the treatments they offer to work-disabled clients.



Dr. Michael Sullivan is a clinical psychologist who is currently Professor of Psychology, Medicine, Neurology, Neuroscience, Physical and Occupational Therapy at McGill University (Montreal, Canada), and Honorary Professor in the Faculty of Health and Behavioural Sciences at The University of Queensland (Brisbane, Australia).

Over the past 25 years, Dr. Sullivan has worked as an educator, director, clinician, and department chair. He has served as a consultant to numerous health and safety organizations, veterans' administration organizations, insurance groups as well as social policy and research institutes. In 2011, he received the Award for Distinguished Contributions to Psychology as a Profession by Canadian Psychological Association.

He is best known for his research on psychosocial risk factors for pain-related disability, and for the development of risk-targeted interventions designed to foster occupational re-engagement following injury. One such intervention, the Progressive Goal Attainment Program (PGAP), was included in the 18th edition of the Official Disability Guidelines (Work Loss Data Institute, 2013) as an evidenced-based approach to the management of work-disability. Dr. Sullivan developed the Pain Catastrophizing Scale (PCS) and the Injustice Experiences Questionnaire (IEQ). Dr. Sullivan has published more than 190 peer reviewed scientific articles, 2 books and 23 book chapters.

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Ethics in governance

The good, the bad and the ugly

By Betty Thompson, FCPA, FCGA,
Partner, Calvista LLP

You would rarely think of a not for profit organization as having ethical issues to deal with at the Board table or elsewhere within the organization. Board members are usually volunteers, working in the best interest of their organization, its members and any beneficiaries of their supports and services. However, unethical behavior can occur in the smallest not for profit just as readily as it can in the biggest multi-national for-profit company. Boards of directors, as a rule, don't discuss ethics as an agenda item. There is an assumption that if they have volunteered, you are lucky to have them.

Individuals' ethics are looked at through a lens that includes cultural beliefs, religious beliefs, personal experiences, current issues in society, and what ethical behavior has been demonstrated in other organizations. Ethics are considered standards of right and wrong to be applied overall or in particular situations. As individuals, we need to consider our own moral beliefs and moral conduct. The ethics discussions need to include integrity, credibility and values.

Fiduciary duties of a Board

Fiduciary duty requires Board members to act honestly and in good faith, with a view to the best interests of the organization. This duty requires they stay objective, honest, and be trustworthy. They are stewards of the public trust and must:

- always act for the good of the organization rather than incurring a benefit to themselves;
- avoid conflicts of interest with the organization and with others within the organization;
- maintain the confidentiality of information they acquire by virtue of their position and not use it for personal gain; and
- serve the organization selflessly and with honesty.

Unethical behavior may not be illegal, but still impacts the Board members' fiduciary duty to think and behave in the best interests of the organization.

The Board assumes responsibility for liability related to non-management, negligence or willful mismanagement, as well as for conflict of interest or self-dealing. You can see the potential application in the examples below; some are blatant and some are less identifiable. The Board sets the tone at the top and, as a group and individually, its members have a responsibility to build a culture of ethical leadership.

Good ethical behavior in decision-making

Good ethical behavior shows a Board understands their mandate to act in the best interest of their organization. Some examples of good ethical behaviour include:

- A not for profit organization included in their code of ethics a policy that no remuneration is given to any Board member, other than reimbursement for out of pocket expenses following financial management policies. This includes any of the work they may do outside their role as a Board member as well as any business relationships they may have that could be leveraged to do work for the organization at a discount. This decision protects the integrity of the Board and the organization by recognizing appearances matter. All Board members sign off on this code before becoming a Board member.
- Organizations with a strong set of values shared openly and relevant to their mission use a checklist to monitor whether they are onside with their values in difficult decision-making situations. This openness to discussion creates a strong culture of ethical behavior in decision-making by Board members and staff.
- Board members formally approved a more modern mission going forward to help their organization be more relevant. This would involve a rebranding and probable name change. One Board member was not in favor of the change and with support of some other Board members put forth a motion for a name change to entrench the old direction. The motion also included a promise from this Board member to provide a significant donation to the organization if it were to pass. This situation might be considered bad or ugly, but turned out well. The Board members outside of this small group defeated the motion and the discussion included a debate on ethics, resulting in making the Board much stronger.

Bad ethical behavior in decision-making

Bad ethical behavior may not be illegal but it can still have a detrimental impact on the organization, the Board itself, its stakeholders and staff. It tests the moral fibre of an organization and may take years to recover. Some examples of bad ethical behaviour include:

- An organization had no clear guidance or policies on what was expected of Board members. This led the group to 'making up rules on the fly' and a tendency for 'group think' to prevail, meaning Board members 'went along with it' even though some struggled with the ethics of the decisions. This resulted in poor financial management and actions such as over-inflating expense reports, not matching Board costs against criteria in line with financial resources and other activities which impacted the reputation of the organization.
- A lack of transparency from the Board to the members and others about the strategic direction of the organization, financial information, and organizational management leads to major disruptions benefiting no one, especially the members. There have been many takeovers attempted by groups of Board mem-

BETTY THOMPSON

bers and others at AGMs, intended to further agendas that may not be in the best interest of the organization. In some cases, the organization never recovers.

- Stretching the truth about the financial health of an organization in a funding application or to members of the organization can border on fraud if the organization is, in fact, barely hanging on. This behaviour usually doesn't turn out well.

Examples of ugly ethical behavior in decision-making

Ugly ethical behavior usually involves fraud at some level and the organization always loses. Some examples of this behaviour include:

- An organization received a grant for expanding their space. They were also fundraising for operational funds for the increased capacity of service to be provided. The fundraising did not raise the funds expected but the expansion proceeded. The organization started to use the grant dollars for operations with the intent of increasing their fundraising efforts. The contractors completing the space expansion did not get paid and complained to the funder. The funder initiated an investigation resulting in individual Board members with potential financial liabilities having to pay the funder back. In addition, the executive director was convicted of fraud and the organization was ultimately dissolved.
- One charitable organization faced significant controversy and suffered a blow to their reputation around decision-making in the use of funds donated following a tragedy of global significance. The donors had anticipated that the organization would use all the donated funds to assist affected individuals directly impacted by this specific tragedy. The charitable organization had, in fact, followed their established policy of putting a significant amount of the funds into a fund for future catastrophes. They amended their policy but suffered reputational damage.
- A Board delegated all decisions, including financial oversight, to their CEO as they believed this would be more efficient. The CEO took advantage of this approach and provided preferential treatment to herself, 'borrowed' organizational assets, went unsanctioned trips to other parts of the world, and garnered additional perks. The CEO was charged with fraud and the organization dissolved.

In considering the examples above, we can see where unethical behavior leads. So what are the best practices for ethical decision-making? Suggestions include:

- Related policies (approved by the Board) for ethical behavior:
  - Creating a clearly articulated mission, unambiguous roles and responsibilities for Board, individual Board members and committees;
  - A policy of robust Board recruitment and orientation processes with a focus on ethical behavior;
  - Establishing and adhering to policies providing credible and effective oversight of all aspects of the organization;
  - Developing and following a stringent code of ethics/code of conduct, including values with guidelines for ethical discussion processes to make choices and be accountable for those choices. This code should be fully transparent and available to everyone, with each Board member to sign off annually to confirm their commitment to the code;
  - Creating a conflict of interest policy that is transparent with clear processes to include sanctions for non-compliance and is signed off by individual Board members;
  - Establishing sound financial management policies to enhance organizational management, transparency, and financial accountability;
  - Developing whistleblower policies and processes to provide an avenue for discussion with relevant party(ies) without recrimination; and
  - Preparing a confidentiality policy that defines what information is private and what should be provided to members and other stakeholders.
- Have members and other stakeholders present for discussions of importance to them so effective planning can occur;
- Demonstrating outcomes and effectiveness (impact) to the members and other stakeholders of the organization.

In making decisions, ask yourself:

- Is it legal?
- Is it ethical?
- Is it fair and honest?
- Does it follow organizational policy?
- Does it advance the cause or the organization?
- Does it make sense?
- Does it identify the risks?

The VRA Code of Ethics provides an ethical decision-making model outlining ethical decision- making steps to assist in the process of choosing the action that is most consistent with the ethical principles of VRA. The VRA Code of Ethics is available on the VRA website.

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On developing the Career Handbook's third edition

By Francois Paradis, M.A., CVE, CCVE,
Career Options

The *Career Handbook* is the counseling component of the National Occupational Classification (NOC), first published in 1996 as a companion volume to the 1992 version of the NOC. The NOC itself is a replacement for the Canadian Classification Dictionary of Occupations (CCDO) first published by the Department of Manpower & Immigration and the Dominion Bureau of Statistics in 1971. The *Career Handbook*, now in its second edition, was last updated in 2003, based on the 2001 edition of the NOC. It has been for more than 20 years a valuable resource to a variety of professionals, including those in career counseling and vocational rehabilitation.

Over the years, there have been numerous requests to update the *Career Handbook*[1]. Employment and Social Development Canada (ESDC) is now undergoing the process of updating the *Career Handbook* and aligning it with the 2011 structure of the NOC. The aim of this article is to inform you on what shape the next *Career Handbook* may take. An overview of preliminary results of a survey of VRA members conducted this year by VRA on the use of the *Career Handbook* will also be included.

The Context

On May 19, 2017, I had the pleasure of interviewing Ms. Laura Sauer, Research Advisor, and Ms. Christine Beeraj, Manager, both with the Labour Market Information Directorate at ESDC. The meeting took place at ESDC's offices in Gatineau, Quebec. This was an opportunity to ask some key questions regarding the development of the third edition of the *Career Handbook*. The information gathered will be summarized and commented upon in this article.

In partnership with Statistics Canada, ESDC has decided to increase the frequency at which it updates the NOC occupational descriptions to improve its relevancy and timeliness with regard to the Canadian labour market. Until now, non-structural (descriptive content) updates to the NOC have taken place alongside with national census data on a five-year cycle. NOC structural revisions, which include changes to the NOC codes, have taken place and will continue to take place every 10 years. The most recent non-structural update to the NOC took place in 2016 and the next structural revision is scheduled for 2021.

ESDC understands the crucial role the *Career Handbook* plays in making informed educational and career decisions but that its data has become increasingly obsolete. Their primary objective is to ensure the next edition of the *Career Handbook* meets users' needs and reflects the changes that have occurred in the labour market over the past 15 years as well as those that will occur in the future.

On December 20, 2016, ESDC launched consultations to get input from *Career Handbook* users and stakeholders on its relevance and utility. Ongoing consultations, which has included the VRAC, have been taking place to seek comments and suggestions on how to improve the NOC and *Career Handbook* content. This phase concluded in August 2017, although ESDC indicated there will be ongoing consultations and feedback analysis. ESDC is now working on designing the appropriate methodology to collect occupational data to update the *Career Handbook* and data collection is expected to begin in 2018.

Survey Results & Feedback

Feedback[2] received highlights the need to align the *Career Handbook*'s content and terminology and make it more consistent with the NOC and other sources of career information. Requests for clearer language in a more user-friendly format have been made, as some have found the current code system of the *Career Handbook* non-intuitive. There have also been requests to better define and more clearly communicate the research methodology used in updating the *Career Handbook*, to foster confidence in its validity and reliability.

Survey data[3] collected from VRA members suggests the *Career Handbook* is used more or less regularly (weekly to monthly or less) by case managers, career counselors and program managers. In this group, respondents indicated they tend to rely more on other sources of occupational data, such as the NOC, job sites, job postings, employers or provincial occupational profiles. A common observation is that the *Career Handbook* is not an easy tool to use.

In contrast, the *Career Handbook* appears to be an essential tool among vocational rehabilitation evaluators, many using it daily for services such as transferrable skills analysis or vocational assessment with clients having sustained injuries. In this group, several respondents stated that occupational aptitude profiles, physical demands and educational requirements are crucial elements in determining the suitability of alternate employment for their clients. However, many users also consult other sources for information that is more up to date or missing in the *Career Handbook*, such as essential skills profiles or for more detailed information on cognitive, physical or educational requirements. Popular sources include provincial occupational profiles, physical demands analysis reports and job postings. The American O*NET (Occupational Information

Network) is also popular and its predecessor, the Dictionary of Occupational Titles (DOT), still consulted by several for its wealth of quantitative data. Overall, the survey highlights the need to update and expand the information found in the *Career Handbook*.

In response, ESDC has expressed its intent to not only redesign and expand the *Career Handbook* but to also make it more accessible. This will involve a thorough review of its descriptors and scales to make them easier to understand and improving the user interface so that information can be found more easily. To improve ease of access, ESDC is considering integrating data from the NOC, *Career Handbook*, Skills and Knowledge checklist and Essential Skills Profiles into one portal. The Job Bank portal[4] has been used by many Canadians to access a variety of career and labour market information by geographic area, occupation, education program, skills and knowledge, etc. So far however, the *Career Handbook* information is not accessible through Job Bank but once updated, the user experience will likely be enhanced to improve the navigation and accessibility[5].

During the consulting phase, ESDC gathered the views of various stakeholders and users on the relevance and importance of the wide array of possible occupational descriptors. It also looked at other sources of occupational information within Canada and abroad. Canadian sources included Essential Skills profiles, the Skills and Knowledge checklist, the National Occupational Standards and the National Occupational Analyses (Red Seal) for trade occupations. European and Australian occupational Classifications were also reviewed to identify any additional occupational descriptors. Closer to home, the typology, terminology and definitions of the U.S. O*NET occupational classification were also reviewed. The goal is not only to update the *Career Handbook* but also to make its language more consistent in the wider environment of career information.

Some Possible Features of the Next Career Handbook

Some key elements[6] of the *Career Handbook* being considered for change or addition include:

- Integration and expansion of the Competencies category to include foundational/essential skills as well as analytical, technical, social and management competencies.
- Transition from the CWPI interest codes to Holland codes.
- Integration and expansion of the Abilities category, divided into the sub-categories of: cognitive abilities, physical abilities, psycho-motor abilities, sensory abilities and personal attributes.
- Addition of information on the work activities and work context to occupational profiles.

ESDC is now designing a research methodology for the occupations and descriptors to be included in the third edition of the *Career Handbook*. There are several possible sources of information that will be considered, including job incumbents, vocational experts, career counselors, professional and educational associations as well as any stakeholders having an interest in updating the *Career Handbook*. To facilitate this influx of information, ESDC is currently building a web based collaborative platform that will be used to get feedback and suggestions on the content of the NOC and *Career Handbook*.

My View on This Project

In my opinion, updating and expanding the *Career Handbook* is an ambitious project faced with several challenges. What follows are some factors and resources I think ESDC should consider in updating the *Career Handbook*:

Currently, it is not easy to assess how quickly skills for any given occupations become obsolete[7]. This is especially important when trying to determine if a person's skills are still relevant in the current job market after a prolonged absence. While we know that some sectors such as Technology or Health Care are more sensitive to skill obsolescence, it is less obvious for other sectors and a more systematic method would be beneficial.

FRANCOIS PARADIS

The current structure of the *Career Handbook* allows assessing skills transferability and inter-occupational mobility to a certain degree but while the *Career Handbook* makes it clear there is transferability within the same unit group, it is less obvious between different unit groups or across different industries[8]. Transferability of skills is particularly important to assess employability from one sector to another. It is worth noting that this issue has been tackled in the United States and the work of Dr. Billy J. McCroskey[9]. Dr. McCroskey has designed a statistical method, the McCroskey Vocational Quotient System (MVQS), to assess the closeness of relationship on a percentage scale between various occupations of the DOT. Such a system would be a valuable source of inspiration for the next *Career Handbook*.

Assessing if a person has spent sufficient time learning a job to be considered qualified in terms of skills and aptitudes is problematic with the current version of the *Career Handbook*. According to the Revised Handbook for Analyzing Jobs[10] (RHAJ), the concept of Specific Vocational Preparation (SVP) is defined as the amount of lapsed time required by a typical worker to learn the techniques, acquire the information and develop the facility needed for average performance in a specific job-worker situation. The SVP component was included in the DOT and CCDO on a scale that varied from a short demonstration to over 10 years of preparation. This component has been adapted for the O*NET under the category of Job Zones. It would be a valuable addition to the next *Career Handbook*.

Regarding data collection methodology, I would also suggest ESDC looks at what the Social Security Agency

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(SSA) in the United States. The SSA has over the past several years been working on a new Occupational Information System[11] (OIS) to replace the DOT, as the O*NET does not provide sufficiently detailed information on physical demands of occupations to meet their needs in adjudicating disability applications. The SSA has designed, in partnership with the US Bureau of Labor Statistics a data collection methodology. Collection began in November 2012, with the first complete set of occupational data expected in 2019. The OIS is likely to become a major source of occupational information in North America within the next few years and ESDC would benefit from having a look at the SSA's methodology, at the very least.

Aside from designing an effective data collection methodology, ESDC will have to collaborate with stakeholders that have a vested interest in the *Career Handbook*. I can think of 3 major sources: Workers compensation boards, auto insurers and employers. The first two, in my experience, have accumulated over the years a vast amount of occupational data through Job Site Analyses and Physical Demands Assessments for adjudication purposes. Many employers also have detailed job descriptions outlining tasks, environmental conditions and physical demands. Harnessing such rich sources of occupational data would support a successful update to the *Career Handbook* and help keeping it up to date more effectively.

If ESDC wants to maximise the use of the *Career Handbook*, it will have to consider the availability of reliable tools to assess people against its descriptors, such as essential skills and aptitudes. In the case of aptitude testing, the English version of the GATB, a popular aptitude test, in spite of its age, is now being phased out by its publisher, Nelson Assessment, and will no longer be available once existing stocks are depleted. The French version of the GATB, last re-normed in 2012, remains available through web-based delivery with the Institute of Psychological Research. The *Career Handbook* is poised to become the only occupational classification (aside from the increasingly obsolete DOT) in the G7 countries to include aptitude profiles, invaluable in assessing work potential and future outcome. Having reliable assessing tools will be key to the success and popularity of the *Career Handbook*.

Conclusion

In summary, surveys have shown the *Career Handbook* remains an important source of occupational information and that there is pent up demand for an update. ESDC is taking steps to update and expand it. The consultation phase was critical in assessing the level of interest for an update and feedback collected will guide ESDC in identifying an appropriate research methodology and establishing priorities.

Updating and expanding the *Career Handbook* with available resources and aligning it in a timely manner with the NOC 2011 structure will be challenging. It will certainly take several years to do so and by the time it is complete, we will be on the cusp of another restructuring of the NOC (due for 2021). It is ESDC's hope that a more efficient collaborative structure will help ensure that future updates of the *Career Handbook* continue to be aligned with the NOC updates and meet the needs of its users.

There is currently no timetable on the release of the next *Career Handbook* but one will be determined once the research design and methodology for the update is in place. This is therefore a work in progress and its success will depend in part on the level of interest and contribution from stakeholders and the professional community. Although initial consultations are now complete, ESDC has expressed a desire for ongoing input from users. You therefore have an opportunity to take active part in this project and help ESDC bring it to fruition by submitting your comments and suggestions to NC-ICSE-CIES-GD@hrsdc-rhdcc.gc.ca.

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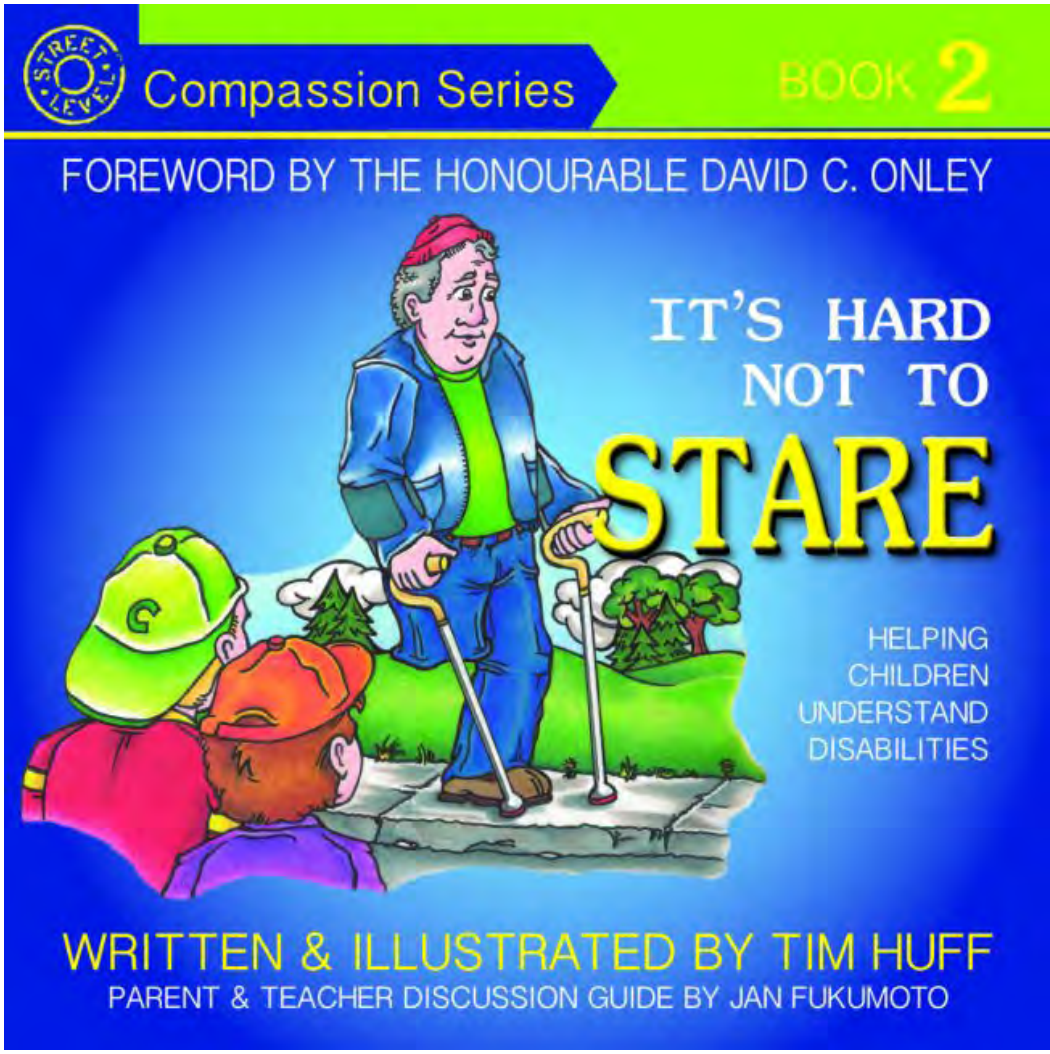
March of Dimes Canada

It's Hard Not to Stare: Helping Children Understand Disabilities
Written and Illustrated by Tim Huff. Includes a Parent & Teacher Discussion Guide by Jan Fukumoto Forward by the Honourable David C. Onley
Published by Castle Quay Books 2013.
40 pages



This children's book is written with simple prose and beautiful illustrations used to help children understand that people are different. It is a book that parents and educators can utilize to teach children about disabilities and how to interact with people that are differently abled. This book gently encourages children to learn more about disabilities and to see the person first, not the disability. Children can learn to accept, not fear, a disabilities and to learn how to compassionately interact with people who are different.

A discussion guide is included with questions and tips that can be used to promote discussion with children and assist in the comprehension of the issues.

This is the second book in the author's Compassion Series, the first being The Cardboard Shack: Beneath the Bridge – Helping Children Understand Homelessness.

The foreword by the Honourable David C. Onley discusses the former Lieutenant Governor's personal struggles to break down barriers both physical and perceptual within Canadian society. He discusses how this book can guide "children forward from staring to caring".

The book is beautifully illustrated by the author, creating engaging pictures that will capture the children's' imaginations and help them to comprehend the meaning of the book.

As noted on the back of the book: Tim Huff is a Toronto native who has lived a life of service to his community. Including; staff director at the Ontario Camp of the Deaf, founding director of Frontlines Youth Centre, founding director of Youth Unlimited Light Patrol street outreach and Operation Good Thing, member of the boards of directors for Hockey Helps the Homeless and the Daily Bread Food Bank, and chairperson for several national social-justice conferences and campaigns. Tim is also the co-founder of The Hope Exchange Street Level Network, currently serving as the director of community engagement.

Children can learn to accept, not fear, a disabilities and to learn how to compassionately interact with people who are different.

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