

CARE THROUGH CONNECTION

# Cannabis Use Across the Lifespan



First Nations Health Authority  
Health through wellness



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First Nations Health Authority  
Health through wellness

The First Nations Health Authority (FNHA) is the health and wellness partner to over 200 diverse First Nations communities and citizens across British Columbia (BC). In 2013, the FNHA began a new era in BC First Nations health governance and health care delivery by taking responsibility for the programs and services formerly delivered by Health Canada. Since then the FNHA has been working to address service gaps through new partnerships, closer collaboration, health systems innovation, reform and redesign of health programs and services for individuals, families, communities and Nations.

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## Preface

The health and wellness of First Nations people was disrupted by colonialism, leading to the historical and current state of disproportionate social, economic, political and cultural harms. With the history of residential schools, the Sixties Scoop, the *Indian Act* and assimilation policies, First Nations people lost important aspects of their culture, including traditions, language and ceremony.

Colonialism has resulted in poorer physical, mental, spiritual and emotional health for First Nations people compared to other residents of Canada. First Nations people face increased challenges such as food insecurity, lower education and employment rates, chronic illness, mental health crisis and substance use.

As revealed in the historic report by the Truth and Reconciliation Commission of Canada in 2015, the *Murdered and Missing Indigenous Women and Girls Reclaiming Power and Place* report in 2019, and the *In Plain Sight* report in 2020, it is evident that First Nations people continue to face health inequities across their lifespans. These reports brought to light the current trauma that First Nations people continue to experience as a result of racism, discrimination, social exclusion and repression of self-determination, in addition to the effects of intergenerational trauma.

The United Nations Declaration of the Rights of Indigenous Peoples' (UNDRIP) report, the Canadian federal government's UNDRIP Act, and the Government of British Columbia's (BC) *Declaration on the Rights of Indigenous Peoples Act* provide a path forward to improving health equity for First Nations, Metis and Inuit people in Canada. Health care providers play a crucial role in improving health equity by providing culturally safe care.

## About this resource

**This resource supports health care providers who want to facilitate conversations with their clients about cannabis use. Following wise practice, health care providers can use a harm reduction approach that is person-centred, trauma-informed and culturally safe when providing care.**

While this resource has reviewed some of the available research and expert consensus on cannabis, research is ongoing and knowledge is expected to evolve as new data on this topic emerges.

It's important to make clients aware that current evidence regarding the short- and long-term health effects of cannabis use remains inconclusive. Although there have been a variety of studies that have reviewed cannabis use in all its various forms, these research conclusions are often not appropriately synthesized, translated for or communicated to health care providers. "Unlike other controlled substances such as alcohol or tobacco, no accepted standards for safe use or appropriate dose are available to help guide individuals as they make choices regarding the issues of if, when, where, and how to use cannabis safely and, in regard to therapeutic uses, effectively." [01]

This resource focuses on supporting:

- Women who are looking to conceive, or who are pregnant or breastfeeding;
- Youth; and,
- Older adults (55+).

These three groups were identified as focus areas because of the potentially greater health impacts of cannabis use for people within these groups.

This resource includes:

- Definitions of some common terms and approaches;
- Approaches to care using trauma-informed, culturally safe and harm reduction principles;
- For each population group, a review of some of the potential impacts of cannabis;
- Case studies that help provide context to the content; and,
- Ideas and questions to consider when providing care to First Nations people.

While this resource aims to offer health care providers with information on how to have respectful and strengths-based conversations on cannabis use with the specific populations identified, the guidance and advice can certainly be used with those who don't fall within the three groups reviewed.

There are also other resources you may want to review. The First Nations Health Authority's (FNHA) [Cannabis Resources](#) webpage includes recorded webinars and fact sheets, and it offers information on the effects of cannabis on the body, a review of the human endocannabinoid system, the different forms of cannabis and consumption methods, among other topics. We encourage you to review these resources to help you prepare for conversations with clients on cannabis.

**When supporting individuals who use cannabis, it is crucial to focus on building relationships based on mutual respect and trust from a strengths-based, culturally safe, trauma-informed approach. This resource provides a framework for building these relationships with the hope that every interaction moves us forward in our path to reconciliation and decolonization.**

## Definitions

**Cultural safety** is an approach to providing safe and equitable health care to First Nations people. The relationship between the health care provider and client is built on a foundation of trust and respect, is free of judgement and considers the client's unique cultural practices, beliefs and traditional approaches to healing. Cultural safety is based on a journey towards respectful engagement that recognizes and strives to improve power imbalances that are inherent within the health care system. Incorporating this into one's practice creates an environment that is free of racism and discrimination and allows the client to determine whether the care was culturally safe. [02]

**Cultural humility** is a process of self-reflection to understand personal and systemic biases and to develop and maintain respectful relationships based on mutual trust. Cultural humility involves humbly acknowledging oneself as a learner when it comes to understanding another's experience. [02]

**Trauma-informed care**, regardless of disclosure, recognizes that many people have experienced trauma and recommends a "universal precaution" amongst health care providers as best practice. [03]. There are four principles and practices of trauma-informed approaches [04]:

- Trauma awareness;
- Emphasis on safety and trustworthiness;
- Opportunities for choice, collaboration and connection; and,
- Strength and skill building.

To learn more, visit the [Trauma-Informed Practice Guide](#).

**Harm reduction**, as viewed by the FNHA, is an approach deeply embedded in culture – as well as in public health and human rights – that seeks to minimize harms associated with substance use and supports people who use substances wherever they are on their healing journey. A First Nations approach strengthens conventional harm reduction by weaving in culture, teachings, community and connections to the land and each other. [05]

**Gender-affirming care** means making space for and validating the language clients wish to use to identify their gender (e.g., use of name or pronouns). It is important that we practice relationally and respectfully with all people, from all backgrounds, genders and identities so they are receiving culturally safe and trauma-informed care.

**Decolonizing practice** is a "social and political process aimed at resisting and undoing the multi-faceted impacts of colonization and re-establishing strong contemporary First Nations people, Nations, and institutions based on traditional values, philosophies, and knowledge systems." [06]

**Person-centred care** focuses on what your client needs for their wellness. By taking the time and having a respectful dialogue with each client, you can learn about what they need, what they want, what will work for them, what health means to them and what their health care goals are. [07]

The government of BC developed a person-centred framework in 2015 that states [08]:

*"Patient-centred care puts patients at the forefront of their health and care, ensures they retain control over their own choices, helps them make informed decisions and supports a partnership between individuals, families, and health care services providers. Patient-centred care incorporates the following key components:*

- self-management;
- shared and informed decision-making;
- an enhanced experience of health care;
- improved information and understanding; and,
- the advancement of prevention and health promotion activities."

**Intergenerational trauma** describes the psychological or emotional effects that can be experienced by people who live with trauma survivors. Coping and adaptation patterns developed in response to trauma can be passed from one generation to the next. [04]

**Cannabis** (or marijuana) is a broad term that refers to the dried, harvested flowers of a group of three plants: Cannabis Sativa, Indica and Ruderalis. It includes 400+ different compounds including 140+ cannabinoids. [09]

**THC (delta-9-tetrahydrocannabinol)** is the most common (and most studied) cannabinoid and is the psychoactive component of cannabis. It is demonstrated to have some pain modulation, but also the potential for dependence due to its “euphoria” inducing properties. [09]

**CBD (cannabidiol)** is the non-intoxicating component being studied for its anti-inflammatory properties. [09]







## Approaches to care

When providing care to clients, you can invite them to consider what makes them strong, what makes them thrive and what their goals are for leading a healthy and fulfilling life. For clients to become strong and self-determining individuals, it is helpful for them to weave mind, body, heart and spiritual aspects into their care plan.

Len Pierre (an Indigenous cultural safety and humility, decolonization and reconciliation consultant) has developed a model called Four Relationships with Substances that is used as part of the Not Just Naloxone training program provided by the FNHA. Health care providers may find it useful to review this model together with their clients to support them in identifying their wellness goals.

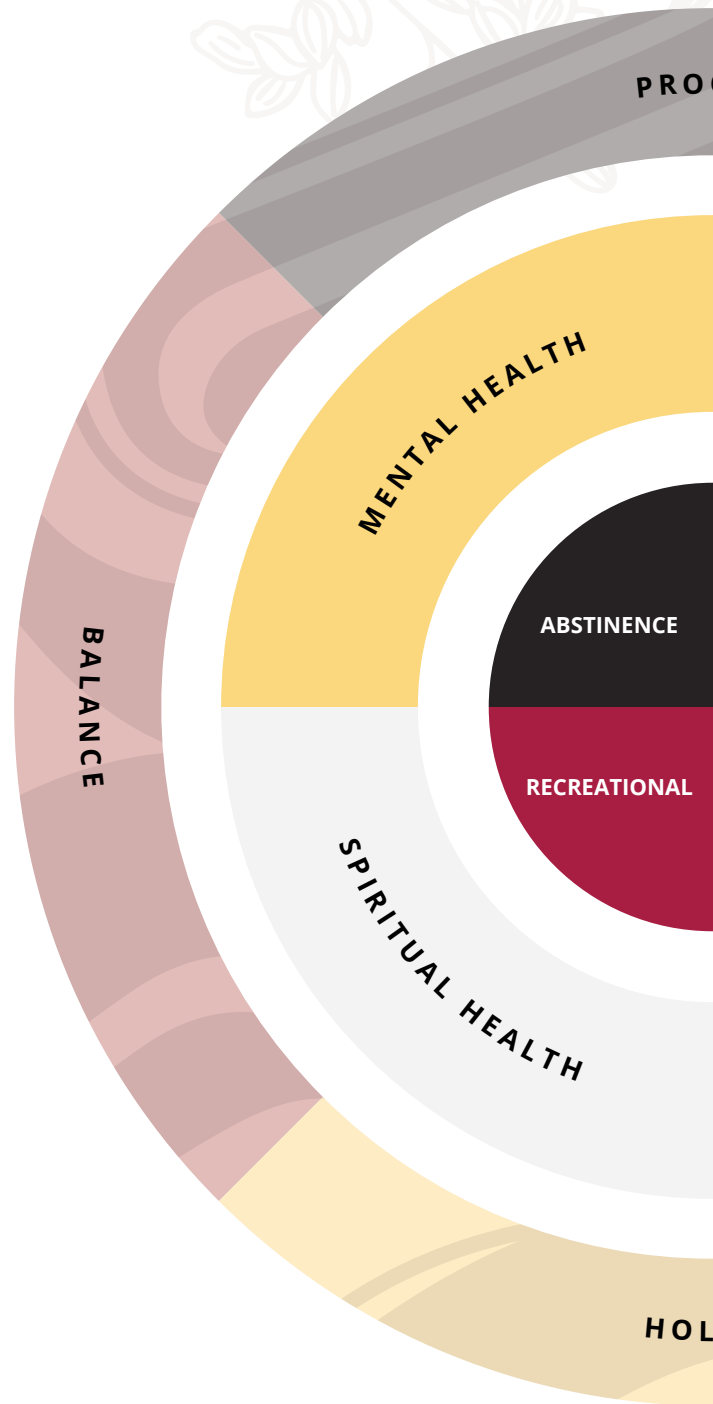
# Four relationships with substances

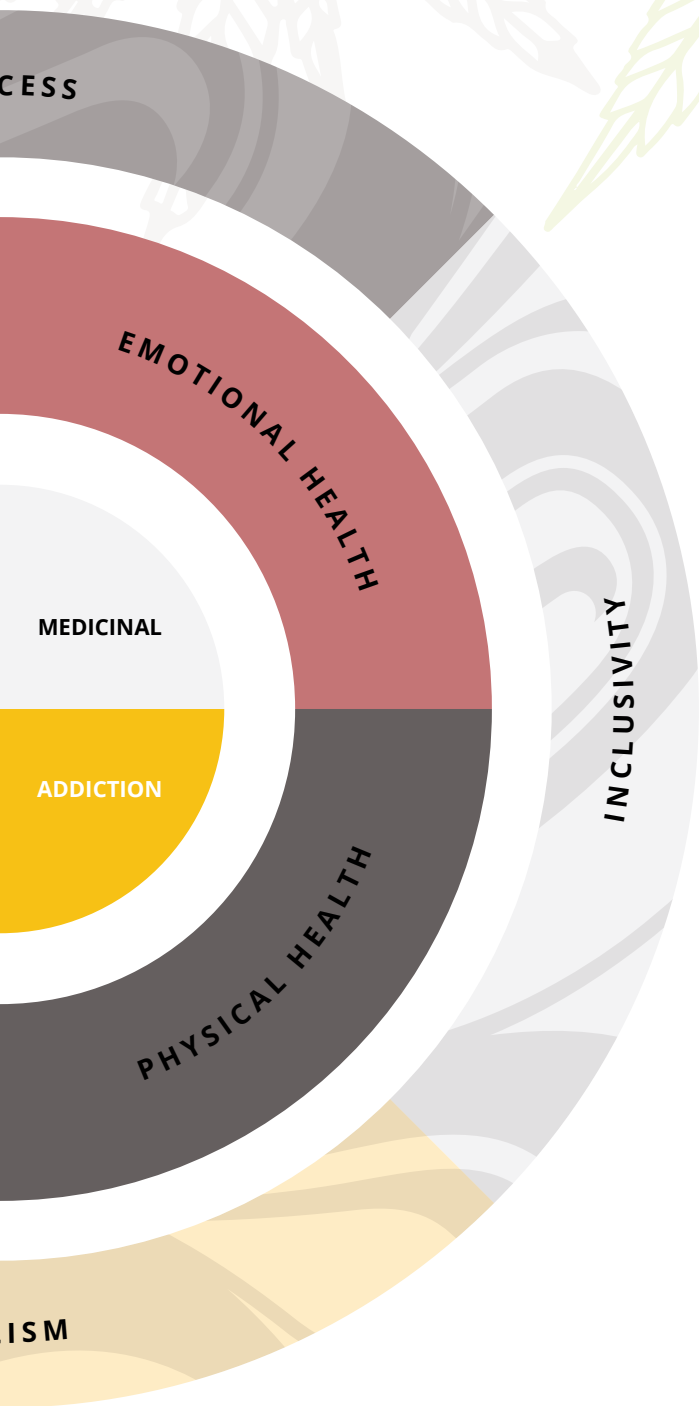
Len Pierre's model (2018) [10] incorporates three different layers of meaning:

- **First layer:** The outer wheel itself represents Indigenous knowledge and values, as well as the teachings of balance, process, inclusivity and holism.
- **Second layer:** This layer of meaning represents four directions and the four aspects of health (mental, emotional, physical and spiritual).
- **Third layer:** The third layer shows the four relationships one can have with substances: abstinence, medicinal, recreational and addiction.

This model can be a useful way to:

- Reflect Indigenous knowledge, values, ways of being, ways of doing and ways of knowing.
- Decolonize perspectives when talking with communities and families about substance use.
- Promote a less pathologizing, clinical, divisive, binary or colonial perspective to better understand relationships with substances in the Indigenous context.
- Support First Nations people to reclaim their power when describing their experiences without using a traditional substance use spectrum that reinforces the good-bad binary discourse, which can be further stigmatizing and detrimental to First Nations people who are already experiencing stigma and social exclusion.





The four relationships with substances model can be applied to cannabis use, just as it can be used to talk about alcohol, tobacco, prescription medications or unregulated substance use. For example:

1. **Abstinence:** People can choose to be abstinent from cannabis.
2. **Recreational:** People can develop a recreational relationship to cannabis by consuming only during evenings or weekends after school or work.
3. **Medicinal:** People can use cannabis medicinally to manage chronic pain or comfort a loved one who is terminally ill.
4. **Addiction:** People can be in an addictive relationship with cannabis whereby they develop problematic behaviours associated with addiction.

#### Cultural teaching in relation to cannabis

Whatever our own personal relationship is with cannabis, we may have relatives, friends or coworkers we care about who fall into one of the other quadrants. We want to ensure we care for everyone regardless of where they are on their journey.

Just because someone is in a specific quadrant, such as addiction, it does not mean they will always be there. However, they are deserving of care, compassion and dignity as this relates to First Nations cultural teachings. Like the seasons, people transform, change and grow throughout their lives.

When reviewing this model, what are some of the ways in which you can provide a safe and trusting environment to your clients?

# Culturally safe and trauma-informed approaches to care

Decolonizing practice involves dismantling structures that perpetuate the status quo, addressing unbalanced power dynamics and acknowledging settler biases and assumptions while honouring and valuing First Nations knowledge and approaches.

## Considerations and tips for providing safe care

**Biases:** Be aware of your biases, values and judgements when working with clients who use cannabis. As a health care provider, you hold considerable power in the clinical setting.

**Needs:** Attend to a client's immediate needs. For example, if they are in pain, try to determine the source of their pain.

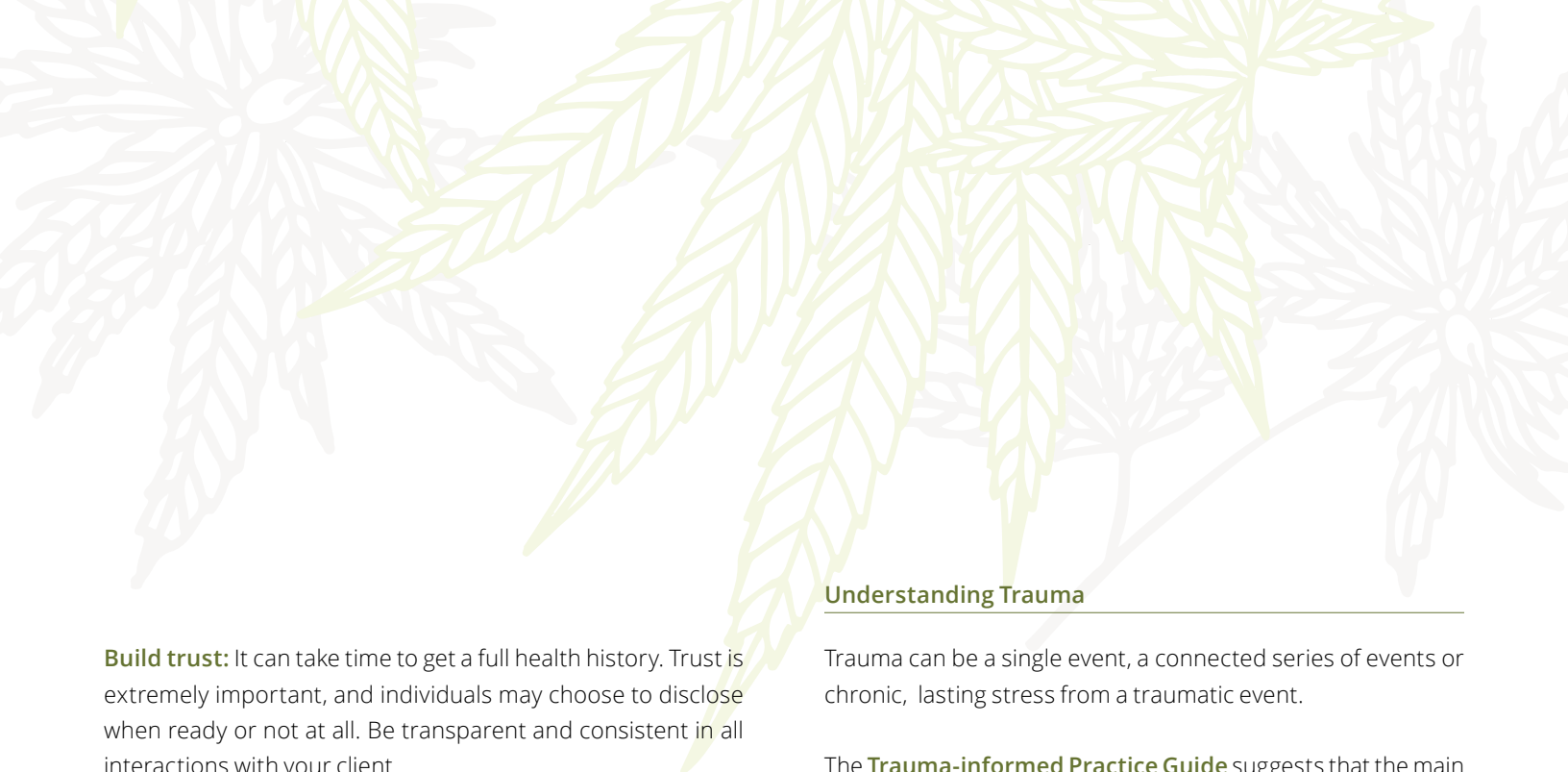
**Choice:** Consider acknowledging that it is the client's choice to use cannabis.

**Privilege:** Recognize how your own privilege, unconscious bias and experiences play a role in how you provide care.

**Listen:** Be an active listener, ask open-ended questions, focus on understanding, reflect back what you are hearing, be open-minded, avoid expressions of approval or disapproval and maintain a calm approach, using clear communication free of jargon. There are a few **Motivational Interviewing frameworks** that you may find useful in preparing for your conversation, for example PACE [11]:

- P** = partnership, person centred
- A** = acceptance, active listening
- C** = compassionate, calm, connecting
- E** = empathy, evoking

**Reflect:** Be self-reflective of your position of power and privilege as a health professional when asking questions regarding cannabis use. Try to limit the number of questions asked to reduce any power dynamics. [03]



**Build trust:** It can take time to get a full health history. Trust is extremely important, and individuals may choose to disclose when ready or not at all. Be transparent and consistent in all interactions with your client.

**Culture:** Recognize that healing is embedded in First Nations culture and traditions and the more we understand, the better we can foster trusting relationships.

**Trauma:** Develop an understanding of how trauma can impact an individual and how substance use is often used as a coping strategy.

## Understanding Trauma

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Trauma can be a single event, a connected series of events or chronic, lasting stress from a traumatic event.

The **Trauma-informed Practice Guide** suggests that the main areas for trauma-informed practice include:

- *Trauma awareness* of how the impact of trauma can affect development; adaptations to cope with trauma; as well as the interaction between trauma, substance use and mental health concerns.
- *An emphasis on safety* to provide a physically, emotionally and culturally safe environment.
- *Opportunities for choice, collaboration and connection*, such as identifying the goals of the individual, meeting them where they are, and exploring their choices about family involvement, treatment options, risk reduction strategies, etc.
- *Strength and skill building* to develop resilience and coping skills. Keep the conversation open, so the client feels safe to bring up the topic when they are ready to further discuss their cannabis use. [04]

**Review the webpage on [Trauma-Informed practice \(TIP\) resources and guides to learn more.](#)**

# Harm reduction approaches to care

**Harm reduction approaches to care are similar to trauma-informed approaches, as both focus on safety and engagement.<sup>[12]</sup> The FNHA's overarching vision for harm reduction is to work as a health and wellness partner by <sup>[05]</sup>:**

- Meeting individuals, families and communities where they are at and work alongside them as they travel along their health and wellness journeys.
- Promoting a First Nations, strengths-based, people-centred, destigmatized harm reduction approach based on dignity, self-determination, empathy, love, compassion, lateral kindness, culture and traditions and relationships.
- Facilitating, promoting and sustaining the availability of culturally safe and trauma-informed harm reduction strategies, practices and services, in the context of a continuum of mental health and wellness programs and services.
- Recognizing the self-determination of individuals, communities and Nations by supporting them to develop or access the harm reduction strategies, practices and services that work for them.
- Implementing the FNHA policy on First Nations Harm Reduction.

**Keep in mind that people who struggle with addiction need to be supported without judgement. Stigma around substance use can contribute to harm. Shame can increase a person's reluctance to discuss their ambivalence about or challenges with substance use, thereby potentially reducing their openness to seek help. <sup>[05]</sup>**



## Screening for cannabis use

Screening for substance use is a wellness approach aimed at identifying and reducing the risks of preventable disease and injury. With client consent and as part of collaborative and person-centred care planning, screening for cannabis use may be appropriate. Consider screening for cannabis use the same way you would for tobacco or alcohol.

**Avoid making assumptions about a person’s lifestyle or personal choices. Safe care is about providing education and resources while supporting a client’s autonomy to make the best choices for themselves.**

Once you have established a safe and trusting relationship with the client, the next step is to understand what the individual’s goals are and to support them in the best way possible with the resources at hand.

Consider using the **Cannabis Use Disorder Identification Test** as a cannabis specific screening tool to identify what the client wants and needs.

#### Other considerations

- What does your agency’s intake process look like?
- Are you using a form? Is it trauma-informed and culturally safe? If not, could some of the wording be changed to make it trauma-informed and culturally safe?
- Can your client fill it in on their own time? Offer options for the intake process.





## The potential impacts of cannabis use

This section of the resource describes the potential impacts of using cannabis for three specific population groups:

- **Women who are planning to conceive, or who are pregnant or breastfeeding**
- **Youth**
- **Older adults (55+)**

For each group, the resource summarizes current research and understanding of the short- and long-term effects of cannabis use. Before meeting with a client who may share that they are using cannabis, review and reflect on the information provided in this resource to prepare for the conversation.

What we know about the effects of cannabis is still emerging, and in some studies is inconclusive. There is a large gap in the literature on cannabis studies focusing on minorities, including First Nations people. However, as summarized below, there is reasonable consensus on some of the points presented in the following section of this resource.

# Cannabis use during prenatal, perinatal and breastfeeding periods

People who are planning to become pregnant, are pregnant or who are breastfeeding may have questions about the safety of using cannabis during these periods. There is no known safe amount of cannabis use in these periods and abstinence is a preferred option. Clients can also be supported with harm reduction strategies.

A discussion with a client is required to:

- Assess their consumption of cannabis and other substances (e.g., alcohol, tobacco or illicit drugs);
- Identify possible harms; and,
- Explore if stopping cannabis use is an option. If not, harm reduction strategies can be used.

Up-to-date, evidence-based information as well as the gaps and or limitations of the available evidence should be shared with people who are pregnant or breastfeeding. As stated by BC Perinatal Services:

*"It is recommended that health care providers start having regular conversations about cannabis use with women and individuals contemplating pregnancy during routine health visits."*[13 pg.3]

## Gender-Affirming Care in the Perinatal Period

*This resource has made every attempt to use gender-inclusive language that is representative of parents, women, girls and 2SLGBTQQIA individuals/communities, recognizing that not every person who is lactating, feeding directly at the breast/chest or providing expressed milk via another route identifies as "mother," "woman" or "she". Throughout this resource, you may see the terms "mother," "father," "women/woman," "men," "she," "parent" and "breastfeeding". It is important to recognize that there are individuals in a parenting, pregnancy or human-milk-feeding relationship with a child who may not self-identify as female.*

## Resources to support discussions

### **Society of Obstetricians and Gynaecologists of Canada -**

This [webpage](#) contains information on cannabis use during pregnancy and while breastfeeding that may be beneficial to share with your client. Areas of focus include: effects on your baby; fast facts about cannabis; and alternative options.

**Centre of Excellence for Women's Health** - The two guides below are aimed at breastfeeding mothers. They provide useful information and activities related to breastfeeding, substance use, harm reduction and cannabis

- [Taking Care. A Short Guide to Breastfeeding and Substance Use](#)

- [Breastfeeding and Cannabis: A Harm Reduction Resource for Health Care and Social Service Providers](#)

**Champlain Maternal Newborn Regional Program** - This [webpage](#) contains a variety of resources on substance use, aimed at both health care providers and clients. Two resources that may be of particular use are:

- [Lactation and cannabis use: A harm reduction approach](#)

- [Perinatal substance use and cannabis resource](#)

## Cannabis and fertility

The human endocannabinoid system has a critical role in controlling hormones and human reproduction. THC (the main psychoactive compound in cannabis) acts on the endocannabinoid receptors, interfering with the functioning of this communication process, and may therefore disturb the body's reproductive function. [14,15]

Cannabinoids (THC or CBD) can potentially have adverse effects on human reproduction, although the evidence on this is inconclusive. Moreover, cannabis use is frequently associated with alcohol, tobacco and other substance use, which may also contribute to and increase the risk of detrimental effects. [16]

There is currently little or inconclusive evidence on the clinical effects cannabis has on the reproductive system. Parents who are trying to get pregnant should follow current recommendations to avoid or reduce the use of cannabis where possible. [14,15]

### **Female fertility**

Studies have revealed reduced hormonal levels in women who use cannabis, which may disrupt ovulation, tubal transportation and embryo implantation. [16] Despite this, large-scale cohort studies have failed to demonstrate reduced fertility in women who use cannabis. [16]

### **Sperm function**

THC, as well as its major metabolites, is present in the semen of men who are heavy or long-term cannabis users. [16] Although contradictory data persists regarding hormone plasma levels in cannabis users, numerous in vitro and animal studies demonstrate reduced sperm quality with cannabis use. [16]

Overall, the effects on both female fertility and sperm function need further studies to validate the findings in pre-clinical studies about the impact that cannabis has on human fertility. [16]

## Cannabis and pregnancy

More research is needed to fully understand the effects of cannabis on pregnant individuals and their fetuses. Further research is also needed to determine if cannabinoids, like THC, affect neurodevelopment, or whether this link is accounted for by other factors (e.g., pre-existing traits of the parent or social determinants of health, particularly considering Indigenous determinants of health such as the experience of colonialism, racism, intergenerational trauma or self-determination.) [17]

### What we know so far

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**Use:** Cannabis is the most commonly used substance after alcohol during pregnancy. [17] There is no known safe amount of cannabis use in pregnancy. [18]

**Safety:** The Society of Gynecologist and Obstetricians of Canada states:

*“Until we have more definitive answers, not using THC or CBD during pregnancy or when breastfeeding is the safest option for you and your baby.”* [19]

**Breast milk:** During pregnancy, chemicals found in cannabis, such as THC, are carried through the bloodstream to the fetus. [14] Studies have demonstrated that cannabinoids readily cross the placenta and appear in human breast milk, resulting in fetal and neonatal exposure. [20]

**Birth weight:** Frequent cannabis use during pregnancy is associated with low birth weight and other risk factors correlated with other adverse birth outcomes. [17,21]

**Fetal growth:** During the Generation R study (quoted by the Canadian Centre on Substance Abuse (CCSA [21]) maternal cannabis use during pregnancy was associated with reduced fetal growth in mid and late pregnancy. These findings were independent of socio-economic factors. [21]

**Cannabis and tobacco use:** Negative perinatal outcomes appear to be greater when pregnant women smoked both cannabis and tobacco in comparison to use of either substance alone.

**Inconclusive data:** Although there is inconclusive data on the effects that cannabis has on pregnancy and fetal development, according to the National Academies of Sciences, Engineering and Medicine report [22]:

- There is substantial evidence of a statistical association between maternal cannabis smoking and lower birth weight of the offspring
- There is limited evidence of a statistical association between maternal cannabis smoking and:
  - Pregnancy complications for the mother
  - Admission of the infant to the neonatal intensive care unit
- There is insufficient evidence to support or refute a statistical association between maternal cannabis smoking and later outcomes in the baby (e.g., sudden infant death syndrome, cognition/academic achievement and later substance use).

**THC in the bloodstream:** In heavy users (consuming cannabis daily) it can take up to 30 days or longer after stopping cannabis for THC levels to be undetectable in the blood. [23]

**Anemia:** Individuals who use cannabis during pregnancy may also be at greater risk of anemia. [14]

**CBD:** There is little evidence currently to demonstrate the effects of CBD on its own during pregnancy and breastfeeding. [13]

*Monica, aged 19, has been brought in by her aunt to your community health centre. She shares with you that she is 13 weeks pregnant. She states that she and her partner Sam “stopped partying” when she found out about her pregnancy. Monica says that she and her partner have “cut back on smoking weed” and she no longer drinks alcohol. Monica tells you she has been vomiting and having nausea. A friend of Monica’s told her that smoking weed helps with nausea. Monica is concerned about using weed to reduce nausea and she shares with you that she does not want to hurt the baby.*

### Things to consider when providing care

See this as an opportunity to build a relationship and develop a circle of care as determined by Monica’s goals.

Consider what support or connection might look like to Monica. How can you develop a trusting relationship? Some ideas to consider:

- In Monica’s case, is she open to sharing her goals for care today or in the future?
- Ask open-ended questions when appropriate.
- Offer room for silence to give Monica time to think, reflect and decide what she is comfortable sharing with you.
- Show interest and curiosity in Monica’s health goals. Explore what Monica’s priorities are and work at her pace.
- What does Monica consider to be her strengths?
- How does she take care of herself?
- Does she connect with culture? What does that look like for her?

Let Monica know that you are available anytime to discuss anything that is important to her.

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*Monica has told you that she stopped partying.*

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You may want to explore what “partying” means to her. As a practitioner, some suggestions for opening up this conversation could include:

- “I hear that you and your partner made a change around your partying – what was that like?”
- “It sounds like it’s important to you to make changes around smoking weed and drinking. How are those changes going for you? What has helped you with this?”
- “Do you need any other support or help with these changes?”

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*Monica has also shared that she has had some nausea and has been vomiting, but she doesn’t want to consume anything to alleviate her nausea that would hurt the baby.*

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You may want to check in with Monica to make sure you are interpreting her words correctly. Some suggestions include:

- “It sounds like doing what’s best for your baby really matters to you. You said that you have been experiencing some nausea and vomiting, what have you tried?”
- You could let Monica know to eat whatever pregnancy-safe food appeals to her, and to try choosing smaller more frequent meals and to reduce greasy, processed foods.
- Other remedies may be helpful for nausea and vomiting, such as ginger. However, it is best for Monica to consult with her physician to discuss whether other medications may be helpful.
- Ask for permission to share what you know about cannabis use for nausea and vomiting

## Cannabis and breastfeeding

**“There is some variance in messaging from various health professional and clinical practice standards. The general consensus, however, is that in the absence of evidence, abstinence is suggested as the preferable option. If this is not possible, breastfeeding should continue (if it is the parent’s goal), while minimizing cannabis use and infant exposure, recognizing the significant known positive effects of breastmilk and breastmilk feeding for both parent and child.” [24]**

There is limited evidence-based information on the short and long-term effects cannabis has on breast milk and the baby’s health outcomes. [13] Some consensus has been found in the following:

- When breastfeeding, THC (and other chemicals) passes from the parent’s blood into breastmilk. When the infant ingests the milk, it is circulated in the infant’s blood where it eventually accumulates in fatty organs and tissues, such as the brain. [14]
- A study in 2018 by Baker, et al. found that breastmilk concentrations of THC peaked at one hour and receded slowly after four hours. [25]
- Some studies have shown that babies who are exposed to THC through breast milk had slower motor development. [18]
- The developing baby may be affected by all methods of cannabis consumed (i.e., smoked, vaped, or eaten as edibles), and each method of consumption may pose its own risks. [26] For example, edibles have slower onset, but can have longer and more intense effects. [26]
- “Pumping and dumping involves expressing human milk and discarding it; it is not recommended to eliminate levels of THC from human milk as there is a lack of evidence on the length of time required for THC levels to decrease in human milk. It is not yet known whether CBD is transferred into human milk or its potential effects on human milk.” [03]

**If needed, with consent, you can review ways to minimize harm when using cannabis:**

Ask for permission to share what you know about cannabis and breastfeeding. If your client is open to learning more, this can be an opportunity to provide some harm reduction ideas to consider, such as:

- Having a caregiver available to take care of the child when clients would like to use cannabis.
- Using less potent THC products.
- Getting products from reliable sources.
- Reducing second-hand smoke by smoking or vaping cannabis outside of the house and car, away from the baby, and considering changing clothes before breastfeeding or holding the baby. [14]
- Have a smoking jacket that they only wear when smoking and that they remove before going back into the house.
- Wash hands after smoking.
- Clients can consider breastfeeding before consumption to avoid breastfeeding at peak levels after consumption (one hour after cannabis use). [27] However, note that there is still limited information on how long THC stays in human milk and whether this is influenced by regular or heavy using as opposed to occasionally using. [03]

**Additionally, some families might find the following self-reflection questions helpful: [18]**

- What are my reasons for use? Are there other ways to address those needs that reduce risk?
- Are there ways to cut down my use (frequency, amount, THC content)?
- If I decide to use, how can I reduce exposure to my infant and/or child?
- How can I ensure that caregiving for my infant remains responsive and safe?
- Are there risks of exposure to my infant from our family environment? If so, how might I reduce those risks?

**For general information about cannabis use while parenting, families may find the “Thinking about using cannabis while parenting?” section of the Government of Canada website useful: <https://www.canada.ca/en/health-canada/services/drugs-medication/cannabis/health-effects/parents.html>**

## Reportability to Ministry of Children and Family Development (MCFD)

From an ethical standpoint, with the current state of evidence, unless the assessed level of risk posed by cannabis (and possibly other substances) use is unacceptably high, health care providers are generally not in a position to override parental autonomy in making decisions about their use of cannabis. [14 & 28]

The topic of reportability requirements to MCFD can be very real, hard and scary for Indigenous People, based on previous negative experiences they have endured in health care settings. If your client fears that they may get reported to MCFD, they may not want to continue with their care and you will not be in a position to build a relationship with them as their health care partner.

Consider: Are there supports in the community to ensure the client's safety and the safety of other children? Are family and/or friends actively involved in supporting them? Are they connected to a counsellor or addictions specialist? Do they have a safety plan if they plan to use and have other children in the house? Ensuring there are people to support them and plans in place may avoid the need to report. It's important to understand what can and what shouldn't be reported.

The [Collaborative Practice for Providing Services for Families with Vulnerabilities: Roles and Responsibilities of the Director \(Child, Family and Community Service Act \(CFCSA\)\) and the Ministry of Health \(Protocol Agreement, 2019\)](#) states that health care providers understand the *Freedom of Information and Protection of Privacy Act* (FOIPPA) respecting their collection, use or disclosure of personal information and the duty to report a child in need of protection under section 14 of the CFCSA.

### Guidance on information sharing from the Ministry of Health states:

#### "Where the client is a pregnant person without children in the home:

- When offering or providing services, information can only be obtained and shared about a pregnant person with their written consent."

#### "Fetus:

- Any information that MCFD/Delegated Aboriginal Agency (DAA) receives about a fetus from any source cannot legally be considered a child protection report under the CFCSA (as there is no child)."

#### "Where the client is a pregnant person with children in the home:

- Information can be disclosed by the MCFD/DAA worker without the pregnant person's consent if the concerns identified relate to the safety and well-being of the children in their care pursuant to s.79(a) of the CFCSA." [28 pg. 6]

Flow charts are also provided to provide guidance on information sharing and disclosure. See pages 16 and 17 of the [Collaborative Practice for Providing Services for Families with Vulnerabilities: Roles and Responsibilities of the Director \(CFCSA\) and the Ministry of Health \(Protocol Agreement, 2019\)](#).

Another point to note is that "Birth Alerts" are no longer allowed. To learn more, please review the statement released in November 2019 by MCFD at: <https://news.gov.bc.ca/releases/2019CFD0090-001775>.



# Cannabis and youth

Many people start using cannabis as early as elementary school. [29] Effects of cannabis in youth can vary based on when they start, and how much and how often they consume. [29]

## Quick facts

- **Legal age:** Must be 19 years or older to buy, use, possess or grow non-medical cannabis in BC. [29]
- **Amount allowed for personal consumption:** Adults 19+ can carry up to 30 grams of dried non-medical cannabis, or its equivalent, in a public place. [30]

## Cannabis and the developing brain

Some of the associated effects of adolescent cannabis use are listed below. Although most of the research suggests that cannabis use mainly has negative outcomes during adolescence, further research is required to validate these initial findings.

Some studies reveal that regular heavy use during adolescence is associated with negative outcomes, including cognitive impairment (attention, memory and verbal learning) and increased risk of psychosis. [31,32]

Regular cannabis use during this period is associated with the experience of psychotic symptoms for those who are predisposed to psychotic episodes. [31] However, it is important to consider that these results have been inconclusive, with many studies stating that there is limited consensus as to whether cannabis directly causes long-term harmful health effects, whether it is one of a number of risk factors or if it correlates with other root causes. [32]

The potential for dependency has been estimated at 16 per cent, based on individuals who started using cannabis during adolescence; for those who used daily during this time, dependency rises to 33-50 per cent. [33]

Functional brain imaging has shown that cannabis has a negative impact on processes such as executive functioning, motivation and risk-taking behaviour. [29]

According to the Canadian Centre on Substance Abuse (CCSA) 2015 report on *The Effects of Cannabis Use during Adolescence*, evidence from a few studies shows that cognitive ability and academic performance are impacted by those who use cannabis early on in their life. [29] CCSA's report also states that further research is needed in this area, as consistent results have been difficult to ascertain. [29]

When compared to alcohol or tobacco, cannabis use has the highest rate of transition to substance use disorder. [29] The risk of developing dependency is one in six among those who start using cannabis frequently during their youth. [31]

Youth who use cannabis are more likely to drop out of school, and less likely to pursue post-secondary schooling. [31]

Youth have a higher rate of polysubstance use, and reduced tendency to seek treatment (related to shorter history of using substances, substances use among their peers, normalization of substance use and lower ability to recognize a problem owing to lower levels of maturity than adults). [34]

Despite adverse effects, some youth use cannabis as a harm reduction approach for other substance use. [35] Semi-structured, in-depth qualitative interviews conducted between 2017 and 2019 with 56 young people recruited from a cohort of street-involved youth in Vancouver, Canada, found that, in the context of broader substance use trajectories that included the intensive use of opioids, meth and alcohol, many young people described using cannabis as a way of intermittently reducing their use of or eliminating other forms of substance use. [35]

## Why youth use cannabis

The CCSA [36] conducted a series of focus group interviews, where 77 participants\* were asked why they believed youth consumed cannabis. Below is a high-level summary of their findings:

**Influence from important others:** Peer pressure to “fit in” among friends was one of the most common reasons for using. Boredom while with friends was also noted as a reason to participate in cannabis consumption, especially for those who lived in rural areas. Those whose parents used cannabis were more likely to use themselves.

**Availability and acceptability:** Youth mentioned that the availability of cannabis, such as at parties and other social events, made it much easier to end up consuming.

**Positive effects on the body and mind:** Youth classified cannabis as the safest of all substances to use and said the side effects were lower when compared to other substances. Youth mentioned that the effects of cannabis, in comparison to heroin, for example, were considerably milder.

*\*Note: Participants ranged from the ages of 14 to 19, with 47 per cent of the participants being male and 53 per cent female.*

## CASE STUDY

Jason, age 16

*While reviewing the immunization records for youth in your community, you invite Jason, 16, to get up to date on his Hepatitis A vaccination. While at the appointment, Jason brings up the fact that he has been having trouble sleeping at night and has been using cannabis to help him sleep. He shares with you that his uncle recently passed away from lung cancer related to complications of a lifetime of smoking cigarettes. Jason states, "I saw on Tik Tok that smoking weed is just as bad as smoking cigarettes. I don't want to die like my uncle did. Do you think eating edibles is safer for me?"*

### Things to consider when providing care:

#### Show appreciation for Jason coming in and asking great questions.

- Acknowledge the passing of Jason's uncle and leave space for discussion if he wishes to discuss this further.
- Similarly, as with Monica, see this as an opportunity to build a relationship and develop a circle of care as determined by the client's goals. Is Jason open to sharing his goals for care today or in the future?

#### Ask Jason if he feels comfortable talking with you about the troubles he is having with sleep. Some things you can ask:

- "How long have you been having trouble sleeping?"
- "Is there anything that keeps you up at night? Something you are worried about?"
- Explore Jason's sleep concerns as much as he feels comfortable sharing.

#### Ask Jason if you can share information with him about youth using cannabis and how this information varies whether it is smoked or consumed through an edible.

- Offer space for Jason to ask questions.
- If he wants to think about his options, offer him the option to come back anytime to discuss this with you.

#### Should Jason come back at a later date, keep in mind to:

- Consider factors specific to youth when discussing cannabis use, which include options that are youth-oriented, relevant, interesting, accessible, confidential and family-inclusive. [34]
- Explore with Jason various therapies available, such as CBT (cognitive behavioural therapy) and family therapy. CBT and family therapy approaches are efficacious in treating adolescents with problematic substance use. [34]
- Acknowledge that vocational support, family intervention approaches and other behavioural interventions have also been found to be beneficial. [34]



## Cannabis use in older adults (55+)

Older adults are the fastest-growing group of cannabis users in Canada. There is some clinical evidence that indicates that cannabis may be helpful for select medical purposes for older adults. However, there is limited research about older adults' experiences and the effects of using cannabis later in life. [37]

### Reasons for use

Based on a recent study that interviewed 12 older adults (65+) about their cannabis use, the main reasons for use were:

- Pain management;
- Alternative to prescription or over the counter medication; and,
- Sleep aid [37].

This study concluded that most older adults were using cannabis for what they perceived to be medical purposes for a range of issues, and primarily obtained information on cannabis use from non-clinician sources like friends, cannabis store staff and the media. [37]

### Potential adverse effects of cannabis in older adults

A 2014 review on cannabis and older adults shared that drowsiness and dizziness were two known side effects of cannabis that could contribute to falling in older people. It also pointed to an increased risk of arrhythmia. [38]

Other studies have shown that cannabis could trigger a stroke in people with coronary artery disease. [38]

For those who are already struggling cognitively, cannabis could have further negative impacts on their cognition. [39]

Cannabis can cause side effects when mixed with other medications, such as increasing the risk of bleeding, lowering blood pressure and affecting blood sugar levels. [40]

## Cannabis use for symptom management:

Most studies on cannabis use have reviewed the effects on people in young adulthood or middle adulthood, and very little research has been done with a focus on older adults, particularly research on how aging impacts the pharmacology of cannabis use. [41]

Based on their known and theorized properties, THC and CBD have been proposed as remedies to modulate symptoms of stress, insomnia, pain, inflammation and cognitive impairment, particularly in older individuals. [42] There have been mostly unsubstantiated claims that THC and or CBD could treat Alzheimer's disease, Parkinson's disease, schizophrenia, anxiety and mood disorders. [42] Although further research is still needed in this area, findings from a few robust randomized controlled trials suggest that nabilone\* might be useful for treating agitation in patients with dementia, but there is no convincing evidence for THC. [43]

*\*Nabilone is a synthetic cannabinoid that mimics THC. [44] It's primarily used for cancer patients going through chemotherapy to help with nausea and vomiting.*

## Summary of findings on the use of cannabis for symptom management:

Few randomized controlled trials have focused on medical cannabis for the older adult population. Existing studies have small sample sizes (N <100) and indicate a lack of high-quality evidence for the efficacy and safety of medical cannabis for older adults. In total, fewer than 250 older adults have been included in these studies. These studies usually include healthy older adults and it is rare that the studies include frail older adults with multiple chronic conditions.

Mixed evidence suggests no strong indication that medical cannabis effectively reduces neuropsychiatric symptoms associated with dementia or cancer-related pain and its side effects.

Low to moderate evidence suggests medical cannabis effectively reduces pain, particularly at the 30 per cent level relative to pre-intervention pain.

Studies assessing tolerability and safety report higher rates of mild adverse events and study withdrawal due to treatment-related side effects in participants receiving cannabinoids.

There is no clear recommendation of use of medical cannabis for most indications relevant to palliative care.

*Content obtained and adapted from [45]*

**It's important to share with your client the limitations of the associated benefits and risks of cannabis use in later years.**

*You receive a referral from the local physician to see Sheila, an Indigenous woman, 67, twice a week for blood pressure monitoring. Sheila has now come in for a few visits and has started to build a relationship with you. On Sheila's fourth visit she shares that her grandson has been giving her some weed to smoke to help her with her pain and insomnia. She has been struggling over the last few months with pain from her right hip, which is also preventing her from getting enough sleep.*

**Things to consider when providing care:**

**How can you approach this conversation with Sheila in a way that makes her feel safe?**

- Be aware of your biases and use words and a tone of voice that conveys respect, compassion and is judgement free.
- Show appreciation and gratitude for her trusting and sharing with you that she has been smoking weed, as some people may not feel comfortable sharing information about their substance use based on the associated stigma or from previous negative experiences in health care settings.

**Ask for permission to explore the concerns she would like to focus on. For example, you can say “Thank you for sharing this with me Sheila. Would you be willing to chat about this more?”**

- If your client is happy to explore this in more detail, you could ask if they would like to learn more about cannabis and to ask what their goals are when using cannabis for sleep and pain.

**Offer space and time for your clients to think through the information given and allow space for any questions they may have.**

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## Conclusion

When we are supporting individuals who use cannabis, it is crucial to focus on building relationships based on mutual respect and trust from a strengths-based, culturally safe, trauma-informed approach:

- Show appreciation;
- Confirm concerns; and,
- Acknowledge challenges.

See all interactions with clients as an opportunity to build relationships and develop a circle of care as determined by the person's goals.

Show your sincere interest in and curiosity about their goals. Offer space and time for them to share with you what is important for them and what priorities they want to work on.

Work at their pace and alongside them; ask for permission to share any information you know on cannabis use.

And finally, with consent, make clients aware that evidence regarding the short- and long-term health effects of cannabis use remains inconclusive and new evidence is constantly emerging in this field.

# Helpline numbers



## **Tsow Tun Le Lum**

Call toll-free 1-888-403-3123 or visit [www.tsowtunlelum.org](http://www.tsowtunlelum.org)

## **KUU-US Crisis Line Society**

A 24-hour provincial Indigenous crisis line. Adults and Elders call 250-723-4050; Children and Youth call 250-723-2040. Toll-free 1-800-588-8717. Learn more at [www.kuu-uscrisisline.com](http://www.kuu-uscrisisline.com)

## **Indian Residential School Survivors Society (IRSSS)**

Call toll-free 1-800-721-0066 or visit [www.irsss.ca](http://www.irsss.ca)

## **First Nations and Inuit Hope for Wellness Help Line**

Phone toll-free 1-855-242-3310 or chat online at [hopeforwellness.ca](http://hopeforwellness.ca).

## **The Métis Crisis Line**

Available 24 hours a day at 1-833-MétisBC, 1-833-638-4722.



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## Further reading

- FNHA Cannabis Resources - <https://www.fnha.ca/what-we-do/mental-wellness-and-substance-use/non-medical-cannabis/downloadable-resources>
- Trauma-Informed Practice Guide - [https://cewh.ca/wp-content/uploads/2012/05/2013\\_TIP-Guide.pdf](https://cewh.ca/wp-content/uploads/2012/05/2013_TIP-Guide.pdf)
- Motivational Interviewing Frameworks - <https://go.gale.com/ps/i.do?p=HR-CA&u=google scholar&id=GALE%7CA572716209&v=2.1&it=r&sid=HRCA&asid=3459fb36>
- Trauma-Informed Practice Resources - [https://cewh.ca/wp-content/uploads/2017/03/TGS-TIP-Resource-list\\_2017.pdf](https://cewh.ca/wp-content/uploads/2017/03/TGS-TIP-Resource-list_2017.pdf)
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- Perinatal Substance Use and Cannabis Resource - [http://www.cmnrp.ca/uploads/documents/Perinatal\\_Substance\\_Use\\_and\\_Cannabis\\_Resources\\_CMNRP\\_2020\\_01.pdf](http://www.cmnrp.ca/uploads/documents/Perinatal_Substance_Use_and_Cannabis_Resources_CMNRP_2020_01.pdf)
- Human Endocannabinoid System - <https://www.fnha.ca/Documents/FNHA-nursing-human-endocannabinoid-system.pdf>
- Thinking about using cannabis while parenting? - <https://www.canada.ca/en/health-canada/services/drugs-medication/cannabis/health-effects/parents.html>
- Collaborative Practice for Providing Services for Families with Vulnerabilities: Roles and Responsibilities of the Director (Child, Family and Community Service Act) and the Ministry of Health (Protocol Agreement, 2019) - <https://www2.gov.bc.ca/assets/gov/birth-adoption-death-marriage-and-divorce/deaths/coroners-service/child-death-review-unit/reports-publications/collaborative-practice-protocol-for-providing-services-for-families.pdf>



**CANNABIS USE ACROSS THE LIFESPAN:**

**Care Through Connection**

*Supporting First Nations People*



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Health through wellness

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