



Cannabis and the Workplace

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As of November 2020, 36 states, the District of Columbiaⁱ and four territories have approved medical cannabis laws, and 15 states, the District of Columbiaⁱⁱ and three territories have approved recreational cannabis use. The federal government, however, classifies cannabis as a Schedule I drug under the Controlled Substances Act. Schedule I drugs are defined as drugs with no currently accepted medical use and a high potential for misuse. Regardless of whether cannabis is considered legal by a state government, it remains an illegal drug under federal law in all circumstances – a medical cannabis card is not classified as a legitimate medical explanation for a positive drug test under federal drug testing regulations.

Cannabis can have a major impact on the safety of your workers and people with whom they interact, and cannabis legalization is creating new challenges. According to a [survey by American Addiction Centers](#), over 20% of respondents said they use cannabis recreationally at work during work hours, nearly 5% admitted to daily use and over 13% use it more than once a month. Furthermore, Quest Diagnostics reports that cannabis continues to be the most commonly detected illicit substance in workforce drug tests.ⁱⁱⁱ

Characteristics of Workers who use Cannabis

Cannabis is the most frequently used illicit drug in the U.S., with an estimated 43.5 million past-year users age 12 or older in 2018. Nearly 18% of adults employed full-time and 21% of adults employed part-time reported using cannabis during the previous year. Of working adults, 1.5% met criteria for a cannabis use disorder (CUD).^{iv}

According to data from the 2015-2018 NSDUH^v, workers with a CUD are disproportionately young (80% are 18-34 years old), a much larger cohort than their peers with no SUD (36% are 18-34 years old). They miss work more than twice as often as their fellow workers (35.7 days/year vs. 15 days/year) and are more likely to report having more than one employer in the prior year (49% vs. 22%). Additionally, they are more likely than their peers to report engaging in risky behaviors (45% vs. 16%) and driving under the influence of alcohol or other drugs (73% vs. 10%). Workers with CUDs use about the same amount of hospital and emergency care as their peers with no substance use disorder (SUD). Workers with CUDs are over five times more likely to report experiencing psychological distress in the previous year than their peers with no SUDs (45% vs. 9%). They are also more likely to report experiencing a major depressive episode in the prior year (26% vs. 6%).

Workers with CUDs are concentrated in industries that disproportionately employ young and male workers: construction, retail, entertainment and food service. Industries with

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an older and more female workforce have substantially lower rates of use and CUDs: durable goods manufacturing, public administration, transportation^{vi} and utilities. States that were among the first to legalize medical use of cannabis have higher rates of CUD than states that legalized medical use more recently or have not passed medical cannabis laws.^{vii}

Why Cannabis in the Workplace Matters

Cannabis use is impairing, regardless of the reason for use. The acute effects of cannabis use are well known: sedation, disorientation, impaired judgment, lack of concentration and slowed fine motor skills, all of which can contribute to delayed decision-making, impaired learning, and memory and attention deficits.^{viii} Recent research indicates that there are longer term effects of cannabis use on cognition.^{ix} These effects can present especially unsafe situations for those working in safety-sensitive environments. This presents a unique challenge to employers, as there is no scientific test to prove cannabis impairment.

Research demonstrates that cannabis intoxication is associated with an increased risk of a motor vehicle crash, especially for fatal collisions.^{x xi} Driving under the influence is a behavior that tends to be concentrated in populations with raised risks of crashes irrespective of cannabis use, such as being a young adult, male, holding 'high-risk' attitudes towards driving and higher rates of driving under the influence of alcohol. There is clearly an association between recent use of cannabis and crashes, but not nearly as great as the association between alcohol and crashes.^{xii} However, initial research has shown that when alcohol and cannabis are combined, impaired driving risk may increase more compared to use of either substance alone.^{xiii xiv}

Research exists that shows both positive and negative potential correlations between cannabis use and occupational safety. However, additional research and study are needed in order to have consensus. NSC echoes and supports the CDC and NIOSH's call for more research in the following topic areas:^{xv}

- Data about industries and occupations where cannabis consumption among workers is most prevalent
- Adverse health consequences of cannabis consumption among workers
- Relationship between cannabis consumption and occupational injuries
- Hazards to workers in the emerging cannabis industry
- Cannabis consumption and its effect on occupational driving

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- Ways to assess performance deficits and impairment from cannabis consumption
- Workplace supported recovery programs
- Ways to craft workplace policies and practices that take into consideration conflicting state and federal laws pertaining to cannabis

Costs to Employers

Employee cannabis use can cost employers on several fronts. For example, employers may:

- Experience complications of legalization of medical or recreational use, which may complicate workplace drug-free policies, and could result in confusion, mixed signals and possible legal issues
- Be required to pay workers' compensation to workers let go for positive drug tests^{xvi}, depending on the state
- Be potentially liable if a cannabis-impaired worker is involved in the injury or death of fellow workers or the public

Emerging Issues Surrounding Legalization and Commercialization

NSC supports the right of employers to [maintain drug-free workplaces](#), regardless of the legal status of the impairing substance. Employers must articulate and enforce a consistent policy toward cannabis use. This policy must be in compliance with all relevant federal, state, local and industry regulations. These include but are not limited to the Americans with Disabilities Act (ADA), the Health Insurance Portability and Accountability Act (HIPAA), and other laws and regulatory considerations such as the National Labor Relations Act, the Occupational Safety and Health Act and the Controlled Substances Act. All policies should be reviewed by an attorney or legal counsel who has expertise in these specific areas.

What Employers Can Do

- Remain up to date on changing laws and the cannabis landscape
- Know the risks associated with cannabis use, and develop and enforce consistent workplace policies to control those risks
- Work with legal counsel to revise and adapt drug-free workplace policies according to changing laws and circumstances

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- Ensure workers in [safety-sensitive positions remain impairment-free](#)
- Educate managers and workers on cannabis issues and harms to minimize misinformation in the workplace
- Train supervisors to recognize the signs of impairment and act upon any next steps as dictated by company policies

Employers can learn more about cannabis and the workplace at nsc.org/highatwork.

ⁱ Alaska (1998), Arizona (2010), Arkansas (2016), California (1996), Colorado (2000), Connecticut (2012), Delaware (2011), Florida (2016), Hawaii (2000), Illinois (2013), Louisiana (2015), Maine (1999), Maryland (2014), Massachusetts (2012), Michigan (2008), Minnesota (2014), Mississippi (2020), Missouri (2018), Montana (2004), Nevada (2000), New Hampshire (2013), New Jersey (2010), New Mexico (2007), New York (2014), North Dakota (2016), Ohio (2016), Oklahoma (2018), Oregon (1998), Pennsylvania (2016), Rhode Island (2006), South Dakota (2020), Utah (2018), Vermont (2004), Washington (1998), West Virginia (2017), Washington, D.C. (2010),

ⁱⁱ Alaska (2014), Arizona (2020), California (2016), Colorado (2012), Illinois (2019), Maine (2016), Massachusetts (2016), Michigan (2018), Montana (2020), Nevada (2016), New Jersey (2020), Oregon (2014), South Dakota (2020), Vermont (2018), Washington (2012), Washington, D.C. (2014)

ⁱⁱⁱ <https://www.questdiagnostics.com/home/physicians/health-trends/drug-testing/>

^{iv} NORC analyses of 2015-2018 NSDUH.

^v NORC analyses of 2015-2018 NSDUH.

^{vi} A systematic review of the literature on drug use among truck drivers found illicit CNS-stimulants (amphetamine, 21% and cocaine 2%) the predominant substances used. The authors conclude that truck-drivers choose stimulants as a form of performance enhancing drug, in order to increase productivity. Dini G, Bragazzi NL, Montecucco A, Rahmani A, Durando P. Psychoactive drug consumption among truck-drivers: A systematic review of the literature with meta-analysis and meta-regression. *Journal of preventive medicine and hygiene*. 2019 Jun;60(2):E124.

^{vii} The earlier a state legalized medical marijuana, the greater is the CUD rate ($r=-.69$). Among the 10 states with the highest rates, the average date they passed MML was 2000. Among the 10 states passing MML with the lowest CUD rates, the average date of their MML was 2016. Of the 25 states with the highest rate of CUD among employed populations, 21 passed MML. The 25 states with the lowest CUD rates, only 10 have MMLs.

^{viii} [NIDA Report: Marijuana](https://www.drugabuse.gov/publications/research-reports/marijuana) <https://www.drugabuse.gov/publications/research-reports/marijuana>

^{ix} <https://pubmed.ncbi.nlm.nih.gov/31670548/>

^x Asbridge M, Hayden JA, Cartwright JL. Acute cannabis consumption and motor vehicle collision risk: systematic review of observational studies and meta-analysis. *Brit Med J*. 2012;344.

^{xi} Bonar, E. E., Cranford, J. A., Arterberry, B. J., Walton, M. A., Bohnert, K. M., & Ilgen, M. A. (2019). Driving under the influence of cannabis among medical cannabis patients with chronic pain. *Drug and Alcohol Dependence*, 195, 193-197. doi:10.1016/j.drugalcdep.2018.11.016

^{xii} Asbridge M, Hayden JA, Cartwright JL. Acute cannabis consumption and motor vehicle collision risk: systematic review of observational studies and meta-analysis. *Brit Med J*. 2012;344.

^{xiii} Hartman, R., & Huestis, M. (2013, March). Cannabis Effects on Driving Skills. Retrieved November 12, 2020, from <https://academic.oup.com/clinchem/article/59/3/478/5621997>

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^{xiv} Hartman RL;Brown TL;Milavetz G;Spurgin A;Pierce RS;Gorelick DA;Gaffney G;Huestis MA;. (2015, June 23). Cannabis effects on driving lateral control with and without alcohol. Retrieved November 12, 2020, from <https://pubmed.ncbi.nlm.nih.gov/26144593/>

^{xv} https://blogs.cdc.gov/niosh-science-blog/2020/08/20/cannabis-work-research/?deliveryName=USCDC_170-DM35851

^{xvi} Rusche, S. & Sabet, K. (2015). *What Will Legal Marijuana Cost Employers?*

http://www.nationalfamilies.org/reports/What_Will_Legal_Marijuana_Cost_Employers--Complete.pdf. 15 states provide legal employment protections for MM, including 10 since 2010 that have anti-discrimination provisions. MML in 7 states have positive statements that MM offers NO employment protections. MML in a n additional 11 states and DC are silent or vague, and there have been no state supreme court decisions or courts that have found possible protection under other state law (i.e., disability discrimination law). Caldwell, F. Emerging Issues with Marijuana Legislation.

https://www.samhsa.gov/sites/default/files/meeting/documents/dtab_rti_fayecaldwell_marijuanalegalization.pdf