



Report on

Substance Abuse, Marijuana, Medical Marijuana, and the Maine Employer Substance Abuse Testing Law (26 MRSA Subchapter 3-A)

Maine Department of Labor, Bureau of Labor Standards

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Executive Summary

From May through September of 2015, the Maine Department of Labor, Bureau of Labor Standards convened a diverse workgroup to gather information on issues relating to substance use and abuse in the workplace, legalization of medical marijuana, the potential statewide legalization of recreational use of marijuana, and other matters as they relate to the administration of the Maine Substance Abuse Testing Law (26 MRSA Subchapter 3-A). This four-part report stems from presentations and discussions of that workgroup, and from our review of an abundance of related studies and reports. Recent headlines regarding opiate use and addiction also underscore the importance of addressing substance use and abuse in daily life, especially the workplace, where safety is an important concern.

Workgroup members were invited from the field of the stakeholders associated with medical marijuana treatment and distribution, workplace substance impairment testing, and employer substance abuse testing. They included representatives of such state agencies as the Maine Department of Health and Human Services, the Center for Disease Control, and the Workers Compensation Board, as well as groups and individuals representing employees, employers, medical caregivers, substance abuse testing companies, medical marijuana patients, and labor organizations. In addition, all of the groups that have testified on recent employer drug testing bills were invited to be members of the workgroup. The workgroup provided an expansive base of expertise and perspective relating to the nature, uses, and effects of marijuana and other substances of abuse; the physical, physiological, and institutional constraints to monitoring and controlling their use; and how programs might be designed to fairly and effectively deal with substance impairment in the workplace.

The Department of Labor, based on the contributions of this workgroup, recommends two fundamental changes to the 25-year-old Maine Substance Abuse Testing Law so that it can better meet today's conditions and challenges. The goal of these changes is to be corrective of behaviors that endanger the individual, coworkers or clients, not to be punitive; we want to keep workers, when possible, connected to the community of support that employment represents. The first of these changes is to streamline the policy approval process to assure: 1) that substance abuse testing is administered consistently and more efficiently by employers; 2) that the regulatory process is more responsive to changes and trends in substances and practices of abuse; and 3) that the administrative delays, inequities, and unnecessary burdens happening under the current law are eliminated. Instead of requiring employers to submit their own drug testing policies for the Department's review and approval, and then to resubmit policy amendments for approval whenever they make changes, the new procedure would be a uniform substance abuse testing policy prepared by the Department and applied to all employers and all monitoring and testing scenarios. Employers would only have to submit a one-page notification form indicating they want to conduct substance abuse testing in accordance with the uniform policy and includes appropriate contact and other information data. Once the Department receives a completed notification form, they would officially confirm that employer's adoption of the uniform policy to validate their future drug testing.

The second change responds to the evolving nature of substance impairment in the workplace, including new or newly legalized substances of abuse and new trends in how existing substances like opioids and prescription drugs are abused. Under the current law, employers that have

approved “probable cause” drug testing policies can test an employee for marijuana and a handful of other substances, but only after they have established probable cause that the employee has taken the illicit drugs. However, we know there are many substances that cause impairment in the workplace and are not tested under the current law, including some prescription drugs and opioids. Accordingly, we recommend replacing the “probable cause testing” provisions with a new program providing training for supervisors and managers to effectively detect employee impairment, regardless of its cause, so they can quickly act to avoid worker injuries. Under the proposed change, employers would be provided training to initially detect impairment, but it would be the role of a professional medical review officer (MRO) to actually confirm the impairment, determine its actual cause, and make any recommendations to employee and employer going forward. Having the MRO rather than the employer make the impairment determination means the employee would be able to provide personal, medical, and other private information to the MRO in response to the allegation in doctor/patient confidentiality.

The above changes will help both employers and employees deal more effectively with their particular issues of substance abuse in the workplace. It will also allow the Department to focus less on administering the intricacies of the employer drug testing rules and more on helping employers and employees recognize and respond to substance impairment. The result: workplaces will be safer, more of them will be drug-free, and fewer Maine workers will be injured on the job.

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Introduction

On September 18, 2015, the Bureau of Labor Standards received a call from Brydie Armstrong ¹ of Ernest R. Palmer Lumber Company in Sangerville, Maine. Her company had recently received the bureau's approval to implement applicant and employee random substance abuse testing. Now, she wanted to know if she could also do some post-accident testing.

The company had never had an injury that rose to the level of OSHA reporting. Then, in 2014, in spite of the work they had done with OSHA and other agencies to assure the sawmill had state-of-the-art machine guarding, an employee had his fingers amputated. Now, less than a year later, it had happened again to another employee.

The factor common to both amputations: the employees were impaired. One had smoked marijuana prior to his accident and the other had taken 40 milligrams of Valium.

Initially, a bill (LD 1201) was introduced during the First Regular Session of the 127th Maine Legislature to the Standing Committee on Labor, Commerce, Research and Economic Development (LCRED). This bill included a recommendation that a workgroup convene to discuss medical marijuana in the workplace and Maine's Substance Abuse Testing Law. Another bill (LD 1384) was also introduced to LCRED during the First Regular Session regarding workplace safety and Maine's substance abuse testing law. The committee eventually voted LD 1201 "ought not to pass," while LD 1384 was carried over into the Second Regular Session. The Department of Labor, Bureau of Labor Standards (BLS) offered to convene a workgroup to study workplace drug testing issues relating to legalization of medical marijuana, the potential statewide legalization of recreational use of marijuana, and other matters pertaining to the administration of the Maine Substance Abuse Testing Law (26 MRSA Subchapter 3-A). BLS regularly conducts research and issues reports relating to workplace safety in Maine. This four-part report stems from the meetings and activities of that workgroup over the summer and fall of 2015.

The mission of the study group was to explore the Maine substance abuse testing law and the emergence of medical marijuana, recreational marijuana, and other substances as they relate to the workplace. From many presentations, examples, and discussions, the group learned that cases like Palmer Lumber's are common in Maine, and though they may seem straight-forward, each case is not as easily judged, remedied, or prevented as one might think. From lessons learned via the workgroup, this publication offers a strategy for Maine to address the inconsistencies in current law with the goal of making workplaces safer and the process simpler, clearer, and more effective for both employers and employees.

Part One sets forth a strategy to address substance abuse and administrative issues by changing the Maine Employer Substance Abuse Testing law. This strategy does not apply to all of Maine government; rather it focuses on what the Department of Labor can change within the law it administers to more efficiently regulate employer drug testing and to better address substance impairment so injuries to Maine workers can be avoided. The strategy would shift the

¹ Used with permission

Department's role of interpreting, implementing, and enforcing the detailed and intricate requirements of the current employer drug testing law, to one of guiding and training employers to recognize workplace impairment, to help their employees to avoid substance abuse problems, and, in concert with DHHS and other agencies, to foster new and more affordable approaches to substance impairment prevention and intervention.

Some may argue drug testing and other such interventions are unwarranted, but experience suggests the impositions they cause are far outweighed by the protection they afford, particularly from the viewpoint of those placed in harm's way. We do not know how many of the thousands of worker injuries and illnesses recorded each year are actually due to substance impairment because it is not required to be reported, but newspaper accounts of worker accidents and fatalities, accounts documented in some workers' compensation claims, and verbal reports received by the Bureau clearly show substance impairment is a significant cause of workplace accidents, and many employees are injured each year because of somebody's impairment on the job.

Part Two provides observations from the workgroup meetings and from other publications relating to marijuana, medical marijuana, and substance abuse generally in Maine today. It includes information from the workgroup's many presentations and discussions. Although it is by no means all-inclusive, it provides a solid context for the strategy in *Part One*.

Part Three identifies and discusses some problematic sections of the current law. While these sections are not just about marijuana, medical marijuana, or substances of abuse, they need to be simplified and improved so the law can be administered fairly and more commensurate to today's substance abuse trends and conditions.

Part Four provides background and supporting documents for the report including a bibliography that cites the papers and articles reviewed for this study; the text of proposed changes to the drug testing law; information about the participation; and reports to the work group.

PART ONE:

**RECOMMENDATION: A Strategy to Reduce
Worker Injuries and Illnesses Caused by
Workplace Impairment**

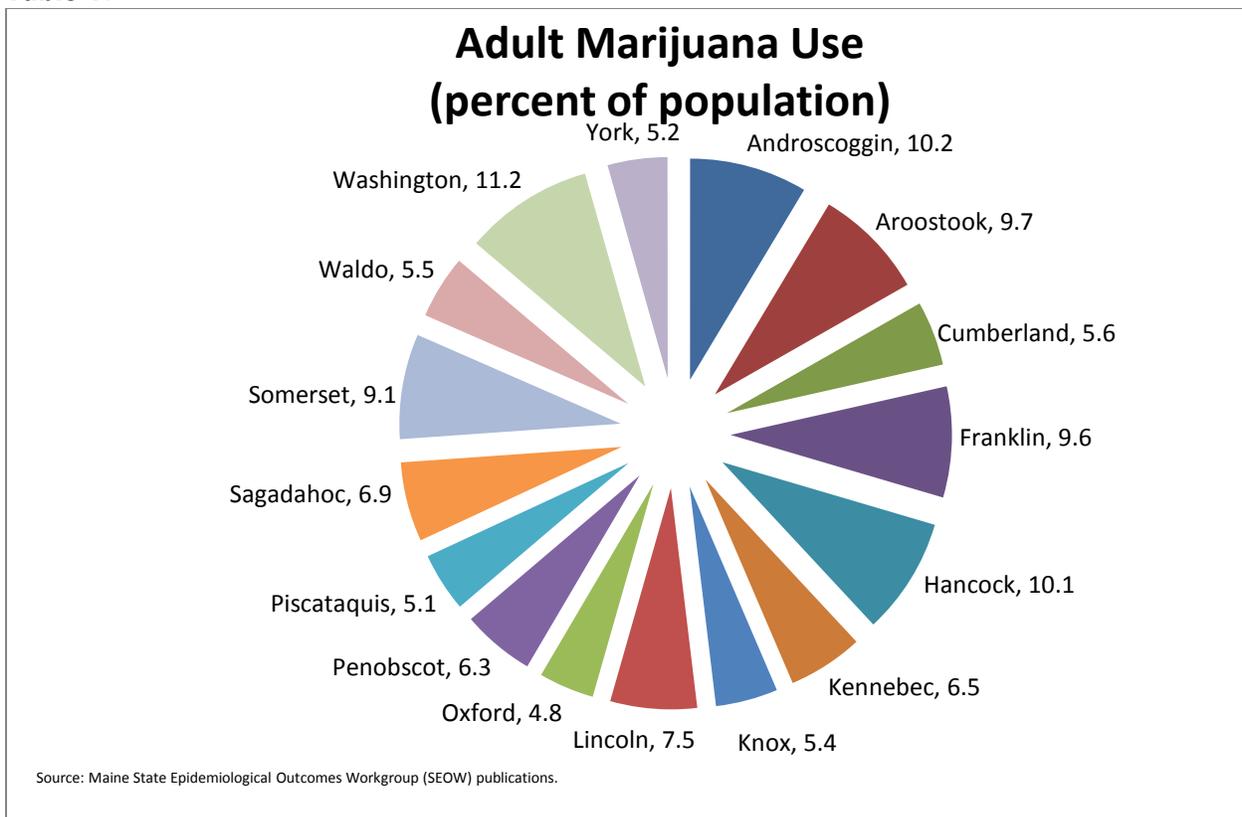
A Strategy to Reduce Injuries and Illnesses Caused by Workplace Impairment

Background

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), there are five components to a successful drug-free workplace program. They include, a written policy, an employee assistance program, a drug testing component, employee education, and supervisor training.² Some states, such as Alabama and Ohio already require some form of employee education and supervisor training as part of their drug-free workplace policies.³ We are recommending changes to the Substance Abuse Testing Law to bring about something similar for our state.

Substance abuse in Maine is serious and widespread. As shown in Table 1, general marijuana use among adults is significant in every geographic part of Maine.

Table 1.

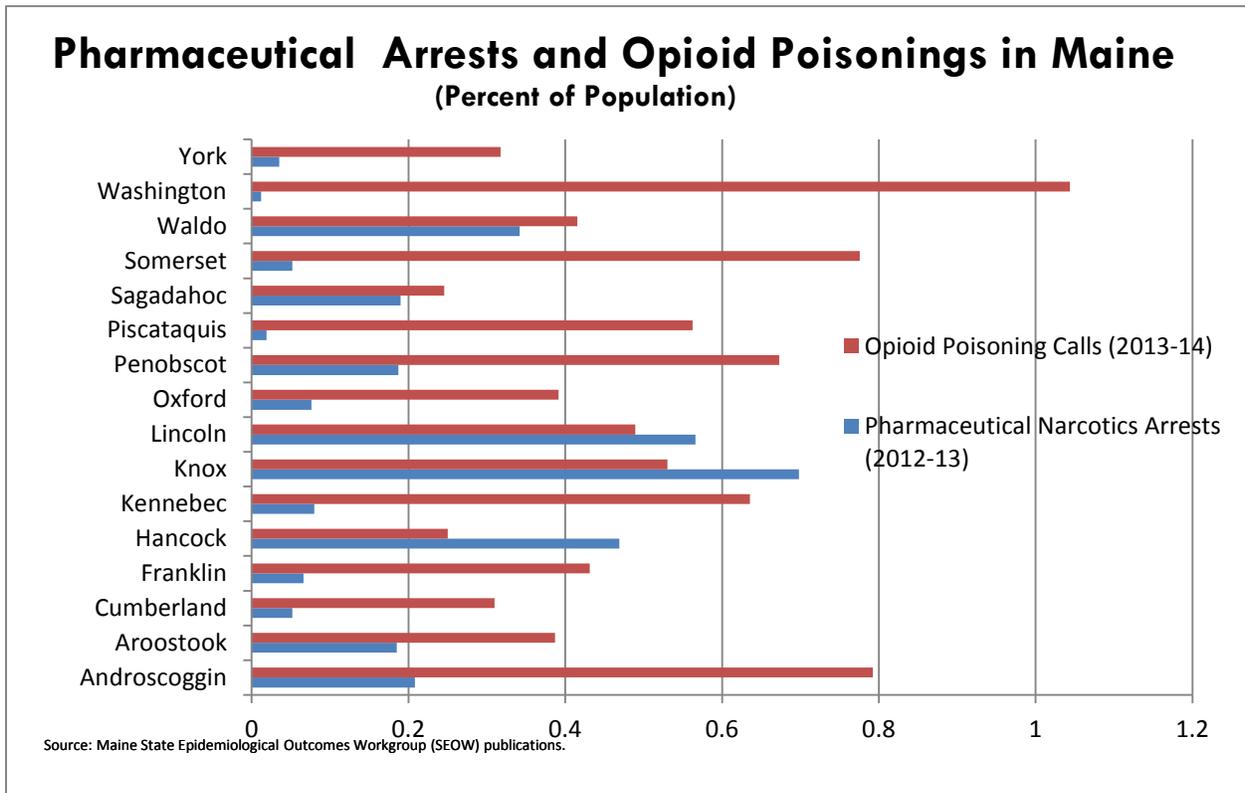


² <http://www.samhsa.gov/workplace/toolkit>

³ <https://www.shrm.org/LegalIssues/StateandLocalResources/StateandLocalStatutesandRegulations/Documents/State%20Drug%20Testing%20Laws.pdf>. Accessed October 29, 2015.

The United States has also seen a significant rise in the amount of prescription painkillers being dispensed. Since 1999, that number has quadrupled in the U.S., along with the number of deaths from prescription painkillers.⁴ Maine, in particular, has seen the effects of this trend and current reports point to serious implications of not updating our laws to address the issue. As shown in Table 2, prescription drug and opioid abuse is distributed throughout the state.

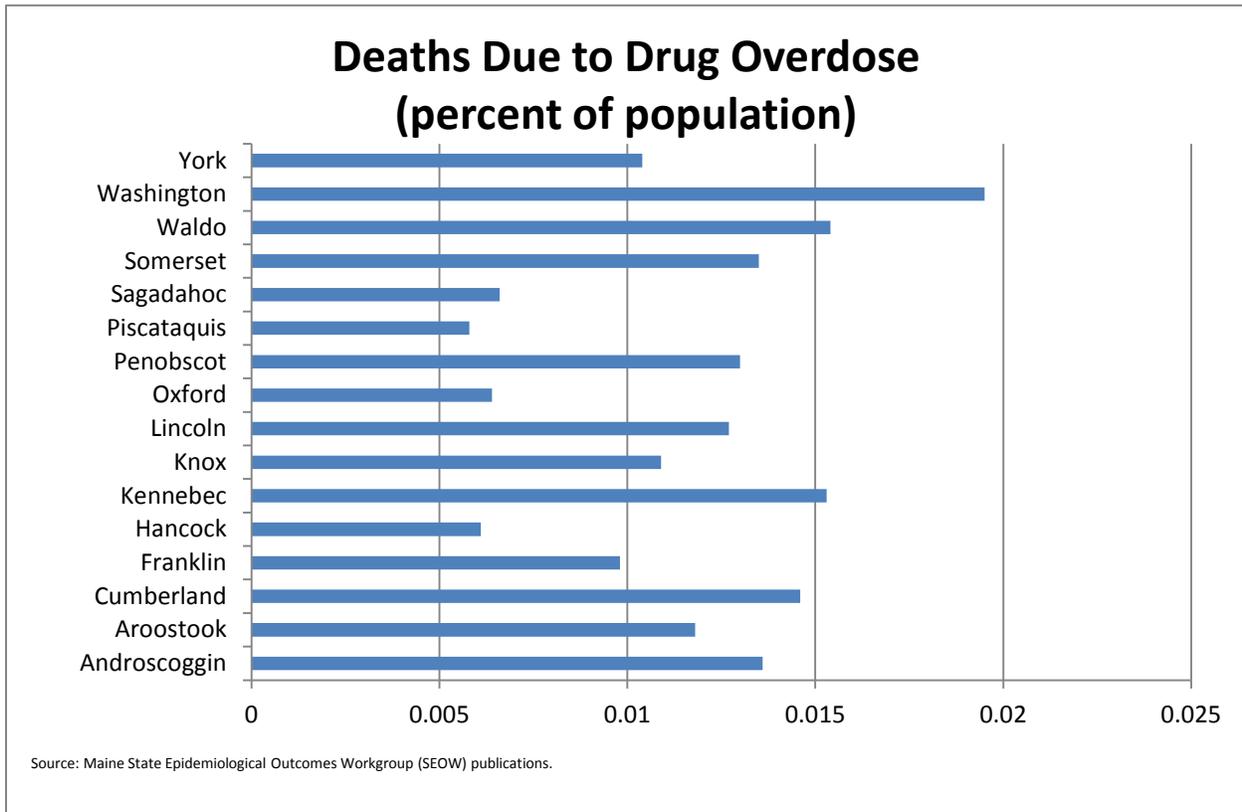
Table 2.



As shown in Table 3, no geographic area in Maine escapes the terrible consequences of drug abuse. It is quite doubtful that the workplaces within these geographic areas are free from these effects either.

⁴ <http://www.cdc.gov/drugoverdose/data/index.html>

Table 3.



Many employees who use opioids have legal prescriptions for them and would have a valid medical argument for ignoring any workplace screening result. Many prescription opioids and other drugs can cause significant impairment when patients overmedicate and sometimes even when they follow the correct dosages.

As relates to marijuana in the workplace, its widespread medical use and its recreational use can both be detected by workplace screenings, however, as this report will later discuss, testing results do not always indicate impairment. For example, qualified patients who use medical marijuana do so regularly, which means the residuals will stay in their bodies well after their return to work; likewise recreational marijuana users may have marijuana metabolites in their systems long afterwards. If employers rely only on drug tests as a way to keep or justify termination of their employees, they will likely be letting many valuable employees go who, although testing positive, have never come to work impaired.

As Maine faces a shrinking workforce due to the waves of retiring Baby Boomers and fewer younger workers to replace them, employers may want to retain workers who test positive for substances. Educating employers to assess impairment may give them a means to retain workers and use drug testing to set boundaries rather than an automatic termination trigger.

Purpose

The purpose of this section is to outline the recommended strategy to reduce potential injuries and illnesses caused by substance impairment in Maine workplaces.

In a medical setting, “*impairment*” is defined as “any loss or abnormality of psychological, physiologic, or anatomic structure or function.”⁵ Given that definition, any number or combination of factors besides substance abuse may cause impairment, including extant illnesses and injuries, stress, intoxication, domestic violence, or other personal events.

Throughout the summer, workgroup sessions examined the use of marijuana and its effect on impairment in the workplace. Marijuana affects people in different ways since it has no standard “dose”, the drug and its metabolites stay in a person’s body for long periods, and retention varies from person to person.

Likewise, impairment is not correlated with dosage or system levels of some substances of abuse, including marijuana. There is no “impairment level” for THC as there is for blood alcohol, and testing for levels of cannabinoids in one’s bloodstream or urine is not effective in determining how much the person is impaired. Impairment is also as likely to be caused by other substances and, at times, by the proper dosages of prescribed drugs.

While these may be formidable constraints in determining impairment by selected substances of abuse using traditional testing, it is clear from the group’s discussions that employers are generally less concerned about determining whether an employee has a threshold concentration of certain drugs in his or her system, or if those concentrations are onset or residual. Employers desire instead to know *how to determine when their employees are impaired regardless of the cause*. Having the ability to determine impairment when it happens can mean fewer accidents, a smaller decrease in job performance or output, and, ultimately, safer workplaces for all employees. Many employers would like to have managers and supervisors trained in the following: the ability to recognize behaviors consistent with impairment and to documenting those observations; the ability to respond to threats, and the ability to follow through by understanding and resolving problems.

This strategy the Department recommends incorporates these objectives; it transcends the discussions and recommendations in other sections of this report, and takes into account the trends in medical and recreational marijuana use, opioid and other prescription drugs, and other uses or misuses of drugs and alcohol that can lead to impairment on the job. Importantly, it sets out a number of affirmative changes at both the policy level, e.g., recommended changes to the Maine Substance Abuse Testing Law itself, and at the program level, e.g. changes to the way the Maine Department of Labor administers the drug testing law, to promote workplace safety.

This strategy is also accompanied by recommendations to streamline and clarify certain provisions of the substance abuse testing law. These changes are meant to go hand-in-hand: removing unnecessary administrative burdens and obstacles from the current law means more resources can be directed toward more current needs and objectives, particularly reducing injuries and illnesses to Maine workers and enabling employers to retain a quality workforce while encouraging workers to avoid substance abuse. We want to be clear, however, that these recommendations

⁵ Impairment; <http://medical-dictionary.thefreedictionary.com/impairment> Accessed 10/21/2015

and the statutory changes, which implement them, are designed to honor the other goals of the Maine Substance Abuse Testing Law as well, including protection of the privacy rights of employees and protection from undue invasion.

The Five-Part Strategy

The steps identified below provide a five-part blueprint for a comprehensive strategy to eliminate injuries due to substance impairment in the workplace. This strategy acknowledges that it is the employers choice whether to enact a drug testing and impairment assessment program, but recognizes that such a program is in the best interest of both Maine's employers and workforce, and state policy should encourage such choices.

1. Establish and Clearly Communicate A Drug-Free Workplace Policy.

Any employer who conducts or wishes to conduct applicant or employee drug testing in Maine should first adopt a drug-free workplace policy. Such a policy would allow managers, supervisors, and employees to know and understand what is and what is not accepted behavior relating to substance use and abuse in that specific place of employment.

An effective drug-free work place strategy must involve both employers and employees as participants and partners. Employers must clearly, unambiguously and persistently communicate their drug-free expectations to their employees so they have no misunderstanding about what is or is not acceptable to do. Employers should regularly reiterate those expectations and requirements so that employees maintain focus and not begin thinking it is less important as time passes. Where there is ambiguity in an employer's written policy, or the way it is sustained over time, there will likely be deviations.

It is important employers' policies clearly spell out any prohibitions or restrictions relating to opiates, marijuana, alcohol, and other drugs the employer wishes to include. The Department's staff has reviewed many written drug-free workplace policies in the past and has developed policy templates that can be used today, which differ depending upon whether employers wish to accommodate medical marijuana, prescription drugs or other medical necessities with or without employee non-impairment agreements (see templates in *Part Four*).

2. Maintain a Maine Substance Abuse Testing Policy

Many employers in Maine prefer to not conduct substance abuse testing even though many of them develop and embrace drug-free workplace policies. Indeed, an employer can implement and enforce a drug free workplace policy without drug testing, but based on the Department's experience, it seems more advisable for employers to have that tool in their toolbox in the event they ever want to use it.

As part of the recommended strategy, substance abuse testing would still be done at the discretion of the employer. However, having a uniform policy would allow each employer to do any type of applicant or employee substance abuse testing as individual cases may necessitate. Many times, the Bureau has denied employer requests to do immediate drug testing because it

did not have approved drug testing policies in hand when some new or unexpected drug-abuse issue showed up in the workplace.

3. *Identify and focus upon safety-sensitive positions and tasks.*

From the Department's standpoint, the principal policy goal associated with impairment detection and response is to make workplaces safer by protecting workers from injuries and illnesses recognizing these procedures will also help employers avoid other such effects as poor performance and absenteeism. Therefore the Department recommends that the strategy of impairment detection and response be best targeted to employees who work in certain environments or perform certain "safety-sensitive" tasks where impairment could pose a safety threat. These include positions where an employee's work can affect for his/her own safety or the safety of nearby co-workers; where the employee performs tasks or works in an environment that would be dangerous if that employee is impaired; or the employee performs tasks that if done incorrectly could result in hazardous conditions to employees and others elsewhere, including patients or clients.

Safety-sensitive occupations may range from the obvious, such as firemen, policemen and skyscraper window washers, to the less obvious, such as procurement clerks who place orders for hazardous chemicals, or custodians who maintain walking/standing surfaces so they do not become slip/fall hazards. Tasks on a given job or at a given jobsite may vary in safety sensitivity, so it is appropriate for each employer to designate up front which jobs are safety-sensitive and then target impairment detection programs to them.

The current substance-abuse testing law does not allow employer to test temporary employees provided by other employment agencies, and thus, they are not included in employers' random or probable-cause testing. However, even temporary employees may be directed to work in hazardous environments or perform safety-sensitive tasks. If so, it makes sense that employer impairment detection activities be applied to them as well. The Department recommends that, for the purposes of impairment detection, the statute's definition of employee be expanded to include temporary employees under the direct supervision of the employer. This is similar to federal OSHA rules [Section 1904.31(b)(2)] that require injury/illness recordkeeping for temporary employees who are under the direct supervision of the employer.

4. *Impairment Detection*

The study group reviewed extensive reports and publications on impairment detection strategies. They range from hands-on impairment detection techniques used by the law enforcement community to simple computer software applications requiring certain concentration or motor control skills to pass. On the one extreme, the law enforcement techniques require months of hands-on individual training for impairment detection; on the other extreme, the once viable software applications fell out of use, and have not been further developed since the mid-1990s.

While the scope of impairment detection is broad, a good starting point is a process similar to what employers now use to determine probable cause for substance abuse testing. It generally starts with observation of one's behavior or performance. If some signs of impairment are seen, the observer would then look for further signs to confirm the impairment.

Consequently, the central proposition of this strategy is for supervisors and managers to be trained to recognize when workers who carry out safety-sensitive tasks or work in risky environments are

impaired on the job, regardless of the source of the impairment. That training should also allow employers to understand and identify the best way to handle impairment incidents when they occur.

The Department is now working with DHHS staff and others to develop an “Impairment Detection” training program for employers. This will provide the skills necessary for managers and supervisors to detect when a safety-sensitive employee may be impaired, regardless of the cause. Under the proposed strategy, once supervisors or managers are certified to perform impairment determinations, employers may implement an ongoing impairment detection strategy that relies upon those individuals to detect impairment when it occurs to employees and co-workers.

5. Response to impairment

Once an employer detects that an employee may be impaired, a three-part response should be triggered to protect worker safety, both immediately and long term.

The first step is ***immediate removal of the safety hazard.*** This may mean removing the employee temporarily from a safety-sensitive job or task, or from an environment where his or her impairment could result in an accident or serious harm to themselves or to others, and reassigning that employee until the impairment threat is passed.

The second step is to activate a ***medical investigation of the impairment and its cause*** by a medical review officer (MRO) to confirm the impairment, identify its cause, and recommend any actions necessary to keep the problem from recurring. In this process, the MRO or the employer may require the employee to submit to substance abuse testing to further identify the cause, and the MRO may direct the employee to obtain further medical evaluation by either the employee’s physician or other licensed physician as acceptable to the MRO. The MRO may request the referral physician to evaluate the employee, consider all evidence and make further recommendations regarding the employee’s ability to perform assigned tasks safely. The referral physician may also suggest a remedial program to assure the employer that the employee will schedule any necessary medications in a manner that will not cause impairment on the job.

Following discussions with the employee and/or referral physician, the MRO will make the final determination whether the employee was impaired, identify the cause of any impairment, and determine whether the employee can continue to perform safety-sensitive tasks. If the employee has not violated the employer’s drug-free workplace policy and can continue the job without presenting a threat to worker safety, the MRO should so indicate to the employer and identify any remediation steps or restrictions to assure that the safety risk will not recur.

The third step is to decide whether or not to ***implement the remedy recommended by the MRO or employer’s physician.*** If the recommendation is for the employee to seek treatment for substance abuse, then at the time the employee has completed treatment the employer and employee may want to initiate a “Return to Work Agreement” that would set forth the expectations of the employee for continuing employment, and the consequences if those expectations are not met.

Under some circumstances, an employee may be able to keep doing that work if certain remedial or preventative measures are in place. For example, if an individual is legitimately taking prescription opioids or medical marijuana to treat a medical condition, the employer and employee may be able to make an arrangement or agreement that the employee will not take

any impairing medications or treatments prior to work; or may not work on certain safety-sensitive tasks within a certain period of time after taking a medication. Such remedial or preventative arrangements should be pursued and evaluated by the medical review officer and, if appropriate, recommended to the employer. Whether it is an opioid agreement, a medical marijuana agreement, or other formal arrangement, the ideal strategy allows the employee to continue to work productively while the employer is assured any impairment problems or safety issues will not recur. Thus the primary goal of such a policy is to maintain the employment relationship to the extent possible. A worker who feels supported by the employer will more likely remain employed. However, at times the only option to assure that the safety threat does not recur will be to remove the worker from the safety-sensitive task or environment or to reassign that worker to a less sensitive post.

Other than temporary removal of a potential safety hazard when impairment is detected, no employer should take action against the employee, unless the medical review officer confirms the employee's impairment or impairment condition or the employee has violated the employer's drug-free workplace policies. If the medical review officer or employee's physician otherwise finds that the employee was not impaired on the job or that any detected impairment posed no safety risks, the employee should be entitled to full reinstatement to their position without any lost wages or benefits.

PART TWO:

Medical Marijuana and Other Substances of Abuse

Concepts from the Studies and Discussions

The purpose of this section is to report the results of the workgroup's investigation and analysis of medical marijuana and other potential substances of abuse. These include relevant lessons and points that relate or form the appropriate backdrop to the recommendations in *Part One* of this report. Those policy changes are in large part linked to six general themes that emerged and re-emerged throughout the work of the workgroup.

1. *People have earnest, but very different, perspectives.* The issue of legalizing marijuana for any use is clearly polarized in our society and has been for a long time. Biases work their way into studies, reports, debates and rhetoric, both past and present and at times quash discussions. One person may perceive the medical use of marijuana as a patient's alternative for chronic pain, while another may see it as a gambit by "pot heads" to legally smoke "dope." One's first impression of a teenager receiving a medical marijuana card is so they could treat their lifelong epilepsy or Crohn's disease, whereas another's may be that the parents just found a way to get more "weed" to smoke. To one, the person addicted to opioids simply lacks the fortitude to pick themselves up; to another, that person was likely set upon that tragic slope by nothing more than a common injury or illness. Some may deem the doctor who issues medical marijuana cards a charlatan, or the dispensaries or individuals that grow and sell medical marijuana as profiteers; to others they are just providing help to the helpless. No doubt, all these things occur to some degree, but the goal of the group was to set aside biases to identify areas of potential consensus. The real questions are hard because there is no poll or study that quantifies how much the desirable outcomes may outweigh the undesired.

Overall, the workgroup took care to avoid from the pushes and pulls of one advocacy group or another and the perspectives of individual stakeholders to garner a core set of facts, draw reasonable conclusions, identify options, and develop recommendations. Each stakeholder was encouraged to share its unique perspective and experience, participants respected the differing points of view, and the group as a whole was willing to consider and discuss others' ideas and arguments. These working relationships and respect for differing opinions allowed for frank, balanced, and deep analysis.

2. *Medical and behavioral knowledge about marijuana is underdeveloped.* Although matters of marijuana use and legalization have been squarely in the public eye for decades, there is a conspicuous absence of the research typically conducted by or for the federal agencies. Due largely to marijuana's illegal status at the federal level, agencies have not completed the same empirical analysis and study that would usually accompany the introduction of a medicine or consumable product to our society. Some suggest at this point that this research will lag far behind the eventual legalization of marijuana. Thus, if the group was to summarize its findings about marijuana in a single statement, it would be: "*We have learned new and important things, and yet there are quite a few things we still do not know.*" As demonstrated throughout the presentations and literature (see *Part Four*), the group learned about a variety of marijuana and drug testing matters, experiences, and perspectives that, taken as a whole, provided helpful findings and led to a better approach to combat workplace impairment. At the same time, there is still much more to learn, such as how to determine the dose effects of marijuana so that doctors can understand and control medical dosages to optimize treatment. Policy makers should be encouraged to favor further research to further identify and fill those kinds of gaps.

3. Recreational marijuana issues and medical marijuana issues are different. There is a difference between the cost, benefit, social, and other risk factors involved with refining the use of *medical* marijuana versus those involved with legalizing its general recreational use. Policy makers must take care to differentiate the two. Recreational marijuana use and medical marijuana use share the media spotlight at the same time, but there are critical differences that need to be understood before making any decisions. Both recreational and medicinal uses of marijuana deserve careful and articulate policy development and regulatory structure, and, unfortunately, in some policies these specifications have been left out. For example, Maine's medical marijuana law today carefully articulates the specific medical conditions that qualify to be treated by medical marijuana, and while it outlines some guidelines requiring patient education and does set limits for dispensing, the law lacks prescriptive language for dosage and methods of administration, and it does not require these to be directed by a medical professional. Essentially, a patient may interpret the law as saying "Go get your 2.5-ounce bag of marijuana and figure out how to make yourself better."

4. Other substances and abuse behaviors need to be considered. Today's discussion about legal uses of marijuana comes amid growing abuse of opioids and other drugs in our society. Abuse of prescription painkillers is common in Maine, and deaths due to opioid misuse are at an all-time high in our nation. Dr. Marcella Sorg, a research professor at the University of Maine in Orono has been reviewing overdose data since 1997. In an August 2015 study, she found drug-induced deaths in Maine rose from 176 in 2013 to 208 in 2014, an increase of 18 percent. The increase was due largely to a rise in deaths from heroin/morphine and fentanyl, a synthetic opiate that is 40 to 50 times stronger than heroin.⁶

Going forward, policies to address substance impairment in the workplace should not be limited to marijuana or medical marijuana. Other substance impairment is equally important, and setting workplace expectations around substance abuse may serve as a deterrent or as a support for a worker.

5. Marijuana is a medicine. Despite federal obfuscation to the contrary and ongoing debate from some medical professionals, empirical studies and reputable scientific evidence document the medicinal value of marijuana, and studies suggest marijuana has a much higher therapeutic ceiling than we have yet attained. Policymakers should support further research to better understand, control, and maximize its medical uses; allow and encourage the medical community to further develop medicinal strains; and develop dosages tailored to patient needs and conditions instead of the whims of self-medication. Maine should prepare the table now for prudent management and administration of medical marijuana and continue to learn as much as possible about related, important health, impairment, and social issues. There are countless substances in the world with clear and vital medical properties and crucial healthcare applications, yet they are *regulated and controlled* by medical oversight agencies because such control allows them to be used to their highest medical potential *and because their unfettered use means sometimes drastic risks to the population.* Marijuana appears to be in this category.

6. We can do more to protect Maine workers and workplaces from substance impairment. Based on the cases and examples provided to the workgroup, policymakers can and should establish more effective strategies to combat substance impairment in our workplaces. Much can be done now

⁶ Margaret Chase Smith Policy Center. N.p., n.d. Web. 08 Dec. 2015. <<https://mcspolicycenter.umaine.edu/tag/sorg/>>.

to assure that employers can keep workplaces and employees safe from the adverse effects of substance impairment, and much can be done to help employers determine under what circumstances they can accommodate medical marijuana, prescription drugs, and other legitimate uses.

In Part One, this report offers recommendations to streamline and update the current Maine Substance Abuse Testing Law. This is not proposed simply to make the process easier for employers; it is proposed to help employers more effectively recognize and handle drug use in their workplaces; protect their assets from damage and destruction, protect their employees from injuries and illnesses; and assure that employees know up front about their substance abuse policies and how they are implemented and enforced. Drug testing would continue to play a central role, particularly in deterring drug use at work and in confirming and defining impairment when it occurs, but it would no longer be the sole tool for keeping drug impairment injuries out of the workplace. The updated program would allow employers to focus on detecting impairment and keeping it from threatening worker safety, regardless of its cause.

History and Nature of Marijuana

*Brief History*⁷

Archaeological evidence of marijuana in Taiwan dates back to 8,000 B.C. and it was used medicinally in China as far back as 2,900 B.C. The botanist, Karl Linnaeus, labeled the plant “*Cannabis sativa*” in 1753 and through the centuries, many notable groups in western culture either grew hemp or used it medicinally. In 1850, marijuana was added to U.S. Pharmacopeia (an official public standards-setting authority for all prescription and over-the-counter medications) and patented marijuana tinctures were sold commercially as medicines. Socially acceptable medicinal and recreational use of marijuana continued until the early 1900’s when it was fetched under the far-reaching scope of the prohibitionists. Abruptly it became a social pariah, outlawed by many states, including Massachusetts in 1911 and Maine in 1913, and finally as part of the nationwide prohibition laws from 1915 through 1927. In the United States and worldwide, marijuana was limited to medicinal uses. Then in 1930s, it came to be regarded by leaders as a malevolent public enemy. In 1942, it was removed from U.S. Pharmacopeia.

The LaGuardia Report in 1944 concluded that marijuana is less dangerous than commonly thought; the 1968 Wooten report in the United Kingdom concluded that marijuana is less dangerous than alcohol and other drugs; and later the US 1972 Shafer Commission report recommended that it be decriminalized. Nevertheless, marijuana continued to be treated as a pariah by government leaders and federal policymakers. In 1970, it was classified under the Controlled Substances Act as a *Schedule 1* substance, which put it among the drugs “classified as having high potential for abuse, no currently accepted medical use in treatment in the United States and a lack of accepted safety for use of the drug or other substance under medical supervision.”⁸

Although handicapped by its *Schedule 1* status, starting in the mid-1970s, medical use of marijuana began to regain some of its credibility. The federal judge in *United States v Randall* (1976) ruled that Robert Randall’s use of marijuana for treatment of glaucoma constituted a medical necessity, and the government instituted the “Compassionate Use Program” that supplied cannabis to qualified patients. From that time, the issue of medical use seems to have volleyed back and forth with courts, medical providers, and some states advancing its use, legalizing medical marijuana⁹ and even developing synthetic THC for medical treatments, while at the same time the federal agencies continued to classify it as a *Schedule 1* drug.

⁷ A more detailed history and timeline can be found in the April 2015 report by Maine Department of Health and Human Services entitled, “*Comprehensive Narrative on Marijuana and its Impact Across the Life Spectrum*”. That paper is found in Appendix X to this report.

⁸ For additional information see <https://en.wikipedia.org/wiki/Cannabis>

⁹ In reports and other literature readers will note the labels “*medical marijuana*” and “*medical cannabis*”. Both mean the same thing. The former has been traditionally applied to the medical use of cannabinoids, whereas the latter seems to have emerged more recently among the medical community and others to provide a distinct medical identity. This report uses the term *medical marijuana* because we think at this time it is less apt to be misunderstood by the general public.

Physical Properties and Effects

Marijuana is commonly evaluated based on its content of the cannabinoid THC (Δ^9 tetrahydrocannabinol), yet the plant has almost 500 bioactive chemical components including more than 70 other cannabinoids. There is agreement that many of these cannabinoids exert therapeutic effects like fighting tumors and cancer cells; however, the effects of most are not yet understood. THC and *cannabidiol* (CBD) are the notable exceptions; taken together they are believed to be the primary providers of the therapeutic benefits of marijuana and are the focus of expanding medical research.

Cannabinoids are not unique to the marijuana plant; actually, they are found in human and other animal systems (endocannabinoids) and play an important role in regulating feelings, tranquility and behavior. The nervous system as well as the immune system contains receptors for cannabinoids including areas that effect memory, motor reaction time, time awareness, motor functions, and cognition. When cannabinoid receptors are blocked (taken up) by certain cannabinoids called “CB agonists,” they create the outward symptoms associated with their use such as mild euphoria and “the munchies.”

The best-known agonistic cannabinoid is THC. When one smokes marijuana, THC rapidly passes from the lungs into the bloodstream, which carries the chemical to the brain. THC acts on specific sites in the brain, called cannabinoid receptors, producing a series of cellular reactions that ultimately lead to the high that users seek.

Some brain areas have many cannabinoid receptors that are affected by various cannabinoids; others have few or none. Taken as a whole, these receptors in the body are called the *endocannabinoid system*. The highest density of THC receptors are found in parts of the brain that influence pleasure, memory, thoughts, concentration, sensory and time perception, and coordinated movement. THC has positive medicinal values, including the suppression of nausea and pain, but also carries the psychoactive side effects usually associated with marijuana.

CBD is, so far, the best-known non-psychoactive cannabinoid. It has been found to have a number of medical and therapeutic values, including the suppression of lung, cervical and breast cancer cells,¹⁰ and provides the promise of therapeutic qualities from marijuana. Yet it produces no psychoactive side effects.

Therapeutic effects of medical marijuana

Some typical treatment applications of medical marijuana include:

- Treatment of glaucoma. Smoking marijuana is known to reduce pressure inside the eye in people with glaucoma. However, it also is known to decrease blood flow to the optic nerve. So far, it is not known if marijuana can improve sight.
- Treatment of HIV/AIDS-related weight loss. Smoking marijuana is known to stimulate the appetite of people with AIDS. Marijuana cigarettes can also cause weight gain in people with HIV who are also taking indinavir (Crixivan) or nelfinavir (Viracept).

¹⁰ Americans for Safe Access Medical Cannabis Research found at http://www.safeaccessnow.org/medical_cannibis_research_what_does_the_evidence_say

- Treatment of multiple sclerosis (MS). When smoked or when used as a mouth spray, marijuana is known to be effective for the treatment of muscle tightness and shakiness in people with MS. However, taking marijuana extract by mouth does not seem to consistently reduce shakiness in patients with MS.
- Treatment of nerve pain. Early research shows that smoking marijuana three times a day may reduce nerve pain caused by HIV and other conditions.
- Treatment of long-term pain. Research shows that taking marijuana or certain marijuana components, called cannabinoids, by mouth can decrease pain in people experiencing long-term pain.¹¹

Deleterious effects of medical marijuana use (Maine CDC/DHHS, 2013)

The use of marijuana also involves less-wanted side effects (although some of them are sought by recreational marijuana users). Short-term effects include:

- Sensory distortion
- Panic
- Anxiety
- Poor coordination of movement
- Lowered reaction time
- After an initial “up,” the user feels sleepy or depressed
- Increased heartbeat (and risk of heart attack)

Known long-term effects of marijuana include:

- Reduced resistance to common illnesses (colds, bronchitis, etc.)
- Suppression of the immune system
- Growth disorders
- Increase of abnormally structured cells in the body
- Reduction of male sex hormones
- Rapid destruction of lung fibers and lesions (injuries) to the brain that could be permanent
- Reduced sexual capacity
- Study difficulties: reduced ability to learn and retain information
- Apathy, drowsiness, lack of motivation
- Personality and mood changes
- Inability to understand things clearly

Some of the more common antisocial side effects with marijuana use include reduced motivation, short-term memory loss and withdrawal from relationships. Some health care providers have observed that people who smoke on a daily basis get out of touch with reality, have memory problems and cannot see the destruction they are causing themselves and their families. Some therapists noted, “I’ve seen it again and again. Really bright people, but they just never get around to doing the things they want to do” (Poole, 2012).

¹¹ Ibid.

Marijuana as a Medicine

(CNN) Dr. Sue Sisley noticed an unexpected trend among her patients. The psychiatrist works with veterans who struggle with post-traumatic stress disorder, also known as PTSD. Many don't like how they feel on all the meds they take to manage their anxiety, sleeplessness, depression and the flashbacks.

"There's just a few medications on the market that work, and even these can be inadequate," Sisley said. "They end up getting stuck on eight, ten, twelve different medications, and after taking so many, suddenly they're like zombies."

Some of these patients though were starting to feel better. They also seemed much more present. She wanted to know what was making a difference. They told her they found an alternative to all those medicines. They were self-medicating with marijuana. (Christensen, 2015).

In 1970, Congress placed marijuana in Schedule I of the Controlled Substances Act because they considered it to have "no accepted medical use." Since then, 23 of the 50 US states and the District of Columbia have legalized the medical use of marijuana.

Proponents of medical marijuana argue that it can be a safe and effective treatment for the symptoms of cancer, AIDS, multiple sclerosis, pain, glaucoma, epilepsy, and other conditions. They cite dozens of peer-reviewed studies, prominent medical organizations, major government reports, and the use of marijuana as medicine throughout world history.

Opponents of medical marijuana argue that it is too dangerous to use, lacks FDA approval, and that various legal drugs make marijuana use unnecessary. They argue marijuana is addictive, leads to harder drug use, interferes with fertility, impairs driving ability, and injures the lungs, immune system, and brain. They also argue medical marijuana is a front for drug legalization and recreational use.¹²

However, at this point, evidence supporting the medical efficacy of marijuana is convincing. The workgroup and DOL staff reviewed many research papers and reports, and heard hours of presentations by qualified physicians, caregivers, patients, and others that demonstrate marijuana has a variety of real and important medicinal uses. Some have been known for centuries, others are known through applied research, while others stem from solid anecdotal evidence. While there is room for debate about the effectiveness of marijuana in treating some illnesses, there is ample evidence that it treats many illnesses and symptoms effectively.

Medical Applications of Marijuana

Table 1, provides a list of medical conditions that have been treated with medical marijuana in the United States, and those that Maine allows to be treated under its medical marijuana laws. While medical marijuana is not seen as a cure for significant illnesses it is effective in treating and

¹² *Should Marijuana Be a Medical Option?* ProCon.org, found at <http://medicalmarijuana.procon.org/>

alleviating the symptoms of many debilitating illnesses and injury conditions including pain, muscle spasms, nausea, food intake, PTSD and seizures.

Medical marijuana is regulated under the Maine Medical Use of Marijuana Program (MMMP) that is set forth in Maine regulations, 10-144 CMR Chapter 122 effective September 17, 2013. Under that program a person who has been diagnosed by a physician as having a debilitating medical condition may receive from that physician a “written certification” stating that person is likely to benefit from the medical use of marijuana to treat the debilitating condition or its symptoms. That “qualified patient” is then allowed to possess up to 2.5-ounces of prepared marijuana during a 15-day period, to cultivate or designate a caregiver or dispensary to cultivate up to 6 mature plants to supply their use, to possess marijuana paraphernalia, and to furnish marijuana to another qualifying patient.

Medical marijuana is ingested in several different ways:

1. *Smoking Medical Marijuana*

The traditional and most common form of intake is smoking the dried flowers or leaves of the marijuana plant. It can be smoked through a pipe, rolled into a cigarette (joint or blunt), or smoked using a glass pipe or a water pipe (bong). The effects of smoking begin almost immediately, but soon peak and diminish. Depending on the patient, and potency of the particular plant, effects wear off within a few hours.

2. *Vaporizing Medical Marijuana*

A vaporizer is a device that is able to extract the therapeutic ingredients in the marijuana plant (cannabinoids) in a gas form at much lower than combustion temperatures (also called volatilization). Using a vaporizer, patients inhale the active ingredients as a vapor instead of as smoke which reduces or eliminates the harmful byproducts of combustion, and reduces irritation and burning sensations. With no combustion the tars, hydrocarbons, benzene, carbon monoxide, and other toxic byproducts of smoking are avoided. Vaporizing also reduces the typical odor of marijuana combustion.

3. *Oral Ingestion of Medical Marijuana*

In a variety of ways, marijuana can be worked into edible materials like cookies, brownies and so forth where the ingredients mask the taste of the pure marijuana. The marijuana plants and flowers may be blended in with solid food products, or absorbed into the liquid ingredients like butter or oil used to cook the food. The therapeutic effects of edibles usually take more time to manifest than they do via smoking or vaporizing, but because of their conversion to 11-hydroxy-THC via the liver, tend to be effective much longer, often more than four hours after the onset, and tend to wear off more gradually. Edibles also eliminate the irritations to the upper respiratory system associated with inhalation of smoke or vapors. However, it is difficult to determine the strength and effective dosages for edibles because of variables in THC levels and the inevitable time delay in the digestive processes; so impatient patients are more likely to consume more edibles than necessary to achieve the desired therapeutic effects. Edibles are also more likely to be used accidentally by children and other non-patients.

Table 1. Conditions that have been treated with medical marijuana.

Acquired Hypothyroidism	Cervicobrachial Syndrome	Hemophilia A	Schizophrenia
Acute Gastritis	Chemotherapy	Henoch-Schonlein Purpura	Scoliosis
Agoraphobia	Chronic Fatigue Syndrome	HEPATITIS C*	Sedative Dependence
AIDS RELATED ILLNESS*	Chronic renal failure	HIV/AIDS *	SEIZURES *
Alcohol Abuse	Cocaine Dependence	Hospice Patients	Senile Dementia
Alcoholism	Colitis	Huntington's Disease	SEVERE NAUSEA*
Alopecia Areata	Constipation	Hypoglycemia	Shingles (Herpes Zoster)
ALZHEIMER'S DISEASE*	CROHN'S DISEASE *	Impotence	Sinusitis
Amphetamine Dependency	Cystic Fibrosis	Inflammatory Autoimmune-	Skeletal Muscular Spasticity
Amyloidosis	Damage to Spinal Cord	INFLAMMATORY BOWEL DISEASE	Sleep Apnea
AMYOTROPHIC LATERAL SCLEROSIS (ALS)*	Darier's Disease	Insomnia	Sleep Disorders
Angina Pectoris	Degenerative Arthritis	Intermittent Explosive Disorder	Spasticity
Ankylosis	Degenerative Arthropathy	INTRACTABLE PAIN*	PARKINSON'S DISEASE*
Anorexia	Delirium Tremens	Intractable Vomiting	Peripheral Neuropathy
Anorexia Nervosa	Dermatomyositis	Lipomatosis	Peritoneal Pain
Anxiety Disorders	Diabetes, Adult Onset	LOU GEHRIG'S DISEASE (ALS) *	Persistent Insomnia
Any Chronic Medical Symptom that	Diabetes, Insulin Dependent	Lyme Disease	Porphyria
Arteriosclerotic Heart Disease	Diabetic Neuropathy	Lymphoma	Post-Polio Syndrome (PPS)
Arthritis	Diabetic Peripheral Vascular	Major Depression	Post-traumatic Arthritis
Arthritis (Rheumatoid)	Diarrhea	Malignant Melanoma	POST-TRAUMATIC STRESS DISORDER (PTSD)*
Arthropathy, Gout	Diverticulitis	Mania	Premenstrual Syndrome (PMS)
Asperger's	Dysthymic Disorder	Melorheostosis	Prostatitis
Asthma	Eczema	Meniere's Disease	Psoriasis
Attention Deficit Hyperactivity Disorder	Emphysema	Motion Sickness	Pulmonary Fibrosis
Autism	Emphysema	Mucopolysaccharidosis (MPS)	Quadriplegia
Autoimmune Disease	Endometriosis	MUSCLE SPASMS*(severe and persistent)	Spinal Stenosis
Back Pain	Epidermolysis Bullosa	Muscular Dystrophy	Sturge-Weber Syndrome (SWS)
Back Sprain	Epididymitis	Myeloid Leukemia	Stuttering
Bell's Palsy	Felty's Syndrome	NAIL-PATELLA SYNDROME*	Tardive Dyskinesia (TD)
Bipolar Disorder	Fibromyalgia	Nightmares	Temporomandibular Joint Disorder (TMJ)
Brain Tumor, Malignant	Friedreich's Ataxia	Obesity	Tenosynovitis
Bruxism	Gastritis	Obsessive Compulsive Disorder	Terminal Illness
Bulimia	Genital Herpes	Opiate Dependence	Thyroiditis
CACHEXIA *	GLAUCOMA*	Osteoarthritis	Tic Douloureux
CANCER *	Glioblastoma Multiforme	Panic Disorder	Tietze's Syndrome
CANCER, ADRENAL CORTICAL *	Hypertension	Radiation Therapy (Learn more)	Tinnitus
CANCER, ENDOMETRIAL *	Hyperventilation	Raynaud's Disease	Tobacco Dependence
CANCER, PROSTATE*	Graves' Disease	Reiter's Syndrome	Tourette's Syndrome
CANCER, TESTICULAR*	Headaches, Cluster	Restless Legs Syndrome (RLS)	Trichotillomania
CANCER, UTERINE *	Headaches, Migraine	Rheumatoid Arthritis	Viral Hepatitis
Carpal Tunnel Syndrome	Headaches, Tension	Rheumatoid Arthritis	WASTING SYNDROME*
Cerebral Palsy		Rosacea	Whiplash
Cervical Disk Disease		Schizoaffective Disorder	Wittmaack-Ekbom's Syndrome
			Writers' Cramp

* Maine Qualifying Conditions

4. Topical Application of Medical Marijuana

Topical marijuana extracts include lotions, salves, balms, sprays, oils, and creams infused with decarboxylated (activated) cannabis oils extracted from medical marijuana plants. They are applied directly to the skin, through which they are absorbed.

5. Tinctures (Cannabinoid Concentrates from Medical Marijuana)

A tincture is a concentrated form of medical marijuana in an alcohol solution that can be taken by direct absorption into the bloodstream from underneath the tongue, or mixed into beverages and ingested. Because tinctures are very concentrated dosages, it is very important to calculate dosages cautiously and monitor use in order to evaluate whether the dosage is effective or needs to be altered.

6. Other Special Applications

Some cannabis oils or extracts can be placed in a capsule for oral ingestion. In addition, medical marijuana oils or extracts can be administered via suppositories for patients who would have difficulties with the other forms of ingestion or inhalation.

Regulating Medical Marijuana Dosage

One important issue that recurred throughout the discussions was that, for a number of reasons, there is a lack of control over dosages of medical marijuana:

Dr. Nelson Haas, Director of MaineGeneral Workplace Health, states in his report to the study group (see Part Four) *“There is no way to monitor marijuana use as can be done with prescription medications that have potential for abuse. For example, benzodiazepines, opiates and amphetamines are obtained in exact doses and quantities; unless obtained illegally, prescriptions must be renewed for many of these medications monthly; and there is a tracking system that shows when and where prescriptions are filled and who provided the prescription. Almost none of these features are available with medical marijuana. A medical marijuana patient may see the certifying practitioner once annually, grow his or her own marijuana, and consume marijuana without characterized doses of the active ingredients.”*

This is not a problem caused by the health care community; it is a political feature of the current medical marijuana law. The program allows the medical community to determine which patients qualify for the use of medical marijuana and regulates who can cultivate and provide the marijuana to patients and how much, but unlike what happens with prescription drugs, the medical marijuana program does not enable health care providers to manage a patient’s medical marijuana treatment, nor does it require patients to work with or defer to dosage and treatment recommendations of their providers. Instead, it permits a qualified patient to possess 2.5-ounces of prepared marijuana every two weeks, with which they are left to work with the designated caregiver or dispensary staff who are not required to have any medical training to determine which strain and how much to “medicate” themselves. Fortunately, the risk of overdose toxicity with medical marijuana is rare and symptoms are minimal when compared to other controlled substances, and has not been reported to result in death.

Dosages and strains of marijuana may be hard to control, yet they are much more important to the successful treatment of the patients than have been thought. Responsible physicians and

health care providers have come to realize that medical marijuana patients can benefit from greater control of their medications for a number of reasons.

First, while there are many valuable studies that provide guidance in taking or administering medical marijuana, there are few “FDA Type” clinical studies, e.g., double blind studies, aimed at refining applications and dosages other than for the synthetics (Marinol) that have been FDA approved.

Second, there is no control over the concentrations of THC and other important constituents among the myriad strains of marijuana available to qualified patients, and notwithstanding efforts by medical marijuana dispensaries, no true quality control of the medical product. Currently, there are no regulations addressing testing requirements, or labeling accuracy of medical marijuana products (Vandry, 2015).

Consequently, most medical marijuana patients really don’t know how many “active ingredients” they are getting or how a particular batch is going to work for them. Imagine a person being given prescription pain medication and instead of saying that each pill contains, for example, 10 or 15 mg of oxycodone, the prescription label just says “*Contains a worthwhile amount of active ingredients.*”

Third, the amounts of “active ingredient” in medical marijuana that actually create the desired therapeutic effect vary with each patient and method of delivery (inhalation, ingestion, etc.). Inhalation of medical marijuana vapor or smoke produces a more immediate result but the effect does not last as long; as ingestion, which takes much longer to start but lasts a significantly longer time. In both cases, THC is absorbed and transferred at different rates depending upon each patient’s physical and physiologic traits and their particular condition at the time. For example, marijuana ingested via brownie will take effect and probably diminish much sooner if taken on an empty stomach. For medications with similar uncertainties, physicians typically work with patients over time to manage that patient’s tolerances and side effects and to refine and eventually achieve the optimum dosages. This should be an objective for medicinal marijuana.

Fourth, research and medical experience over time shows that, for medical marijuana, smaller doses often provide the most effective treatment for the typical symptoms and conditions, and, in many of those cases, higher doses have a counterproductive effect (Shortsleeve, 2013). In a recent internet article, one Maine health care provider who has worked with many medical marijuana patients noted that, “When I started my practice, I was surprised to see that some patients were using very low dosages (e.g., 1 puff), while other patients require much higher dosages (e.g., 1 joint or a potent edible) to achieve optimal benefits. Over time, I began to notice that most patients using small amounts of cannabis were getting better and more sustainable results than their high-dosage counterparts with similar conditions. Eventually I discovered that most people have a certain threshold dosage of cannabis, below which they’ll actually experience a gradual increase in health benefits over time, and above which they’ll start building tolerance, experiencing diminishing benefits, and more side effects” (Malanca, 2015). This suggests that a good share of self-medicating medical marijuana patients actually defeat their healing objectives. Smoking a whole marijuana cigarette ends up having less therapeutic effect, than the optimum medication that would have been just one puff.

Few if any medicines are dispensed with less regulatory guidance than is medical marijuana. Given the uncertainties involved in administering optimum or correct dosages, there should be a focus on encouraging health care providers to be trained and better educated on administering

marijuana as a medicine and then following up with their patients on a regular basis as they would with patients who are prescribed other medications.

Opioids and Medical Marijuana

“Opiate dependence and addiction is a widespread problem in today's society. It often begins with painkiller use, whether legal or illegal, and it leads to serious consequences, including death by overdose. Prescription opiates are not safer than street drugs!”¹³ - Addictions.com

Opioids and the Workplace

In 2009, over 256 million prescriptions for opioids were filled in the United States alone and the painkiller market exceeded \$9 billion.¹⁴ Opioids are the analgesic drugs derived from the opium poppy (opiates) such as morphine and the opiate-like synthetics such as oxycodone. Opioids comprise the popular and revolutionary prescription painkillers for severe acute pain and/or chronic pain that other traditional medications cannot alleviate. They are the preferred pain treatment for ailments such as cancer, back injuries, and other musculoskeletal problems.

There are many forms of opioids including:

- codeine (only available in generic form)
- fentanyl (Actiq, Duragesic, Fentora)
- hydrocodone (Hysingla ER, Zohydro ER)
- hydrocodone/acetaminophen (Lorcet, Lortab, Norco, Vicodin)
- hydromorphone (Dilaudid, Exalgo)
- meperidine (Demerol)
- methadone (Dolophine, Methadose)
- morphine (Astramorph, Avinza, Kadian, MS Contin, Ora-Morph SR)
- oxycodone (OxyContin, Oxecta, Roxicodone)
- oxycodone and acetaminophen (Percocet, Endocet, Roxicet)
- oxycodone and naloxone (Targiniq ER)

Opioids work by binding opioid receptors in the brain, spinal cord and other areas of the body such that pain messages are not sent to the brain, and so feelings of pain are reduced. Some of them serve as “agonists,” initiating a positive physiological response when combined with a receptor, while others act as antagonists interfering with or inhibiting a physiological action.

The most significant side effects associated with opioids are: 1) increased tolerance to opioid dosages; 2) increased dependence on opioids; and 3) addiction to them. Addiction is a chronic, neurological disease resulting from the use of opiates. It leads to psychological, environmental, and physical factors characterized by an impaired control over the drug, impaired behavior

¹³ Found at <http://www.addictions.com/opiate/>

¹⁴ Web MD: “Opiate (Narcotic) Pain Medications: Dosage, Side Effects and More” <http://www.webmd.com/pain-management/guide/narcotic-pain-medications>

revolving around the use of the drug or a craving for the drug, despite known consequences of drug use. Other side effects include:

- constipation
- drowsiness
- nausea and vomiting
- convulsions
- euphoria
- mental clouding
- respiratory depression
- suppressed cough reflex
- pupil constriction

Because of their side effects, opioid treatments carry a high risk of impairment and long-term health problems. In 2010, opioid overdose fatalities (16,651) outnumbered fatalities from heroin and cocaine combined, and exceeded car crashes as the leading unintentional cause of death (Teater, 2015). Opioid tolerance, dependence, and addiction are all manifestations of brain changes resulting from chronic opioid abuse.¹⁵

Even when taken as directed, opioids can lead to significant problems in the workplace including the potential for accidents due to mistakes, and unsafe behaviors involving motor vehicles, forklifts, cranes, or other heavy machinery. There is also an increased risk of injury from workplace violence that stems from the side effects.

Opioids are also very costly to employers and employees. A 2012 study reported that workplace insurers were spending approximately \$1.4 billion annually on direct purchases of opioid medications. They also incur significant indirect expense in the form of long-term health care costs due to side effects, increased employee turnover, absenteeism, and subpar productivity. These effects are further magnified when employees increase their dosages due to dosage tolerance, addiction, or just prescription abuse (Kuhl, 2015).

Due to successful marketing and popularity among the medical community, opioids have been prescribed for many ailments, some of which can be treated through other alternatives.^{16,17} This suggests that in many cases, opioids can be avoided through substitution and perhaps many cases of dependence and addiction can be reversed. While feasibility may vary from patient to patient, and depend largely on the root cause of the pain, safer and less expensive alternative medications/treatments include:

- analgesics such as aspirin and acetaminophen

¹⁵ Found at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2851054/>

¹⁶ "Avoiding Opioid Abuse and Finding Alternatives" Colorado Pain Co. found at <http://coloradopain.co/inside-pain/avoiding-opioid-abuse-finding-alternatives/>

¹⁷ Opioid-Free Ways to Live Well With Chronic Pain, Everyday Health, found at <http://www.everydayhealth.com/pain-management/opioid-free-ways-to-live-well-with-chronic-pain.aspx>

- non-steroidal anti-inflammatory drugs such as ibuprofen and naproxen where organ failure is a low risk
- Antidepressants that suppress reuptake of serotonin and norepinephrine, e.g., Cymbalta
- Corticosteroids such as prednisone where side effects do not present
- Topical medications such as lidocaine and capsaicin
- Neurostimulators
- Anticonvulsants
- Massage, acupuncture and other alternative therapies
- Hot and cold applications
- Stress-relieving techniques
- Losing weight
- Healthy diet with supplements like glucosamine chondroitin and/or Omega 3 fatty acids
- Exercise and physical therapy
- Laughter
- Getting enough sleep
- Meditation and music

For some conditions or illnesses there may be no effective substitutions. Moreover, when opioid addiction or dependence is involved, even proven alternatives, treatments, or interventions may be strongly resisted by patients. Circumstances may cause them to abandon those alternatives and revert back to their opioids even after they have had some success with them.

Reducing the impacts of opioids through the use of medical marijuana

Recent studies and articles, as well as statements presented by Maine employees who have chronic pain issues, support the use of medical marijuana as a way to replace or augment opioids, particularly in treating chronic pain. In clinical studies, the use of medical marijuana along with opioid prescription drugs has been shown to promote a greater cumulative relief of pain, and a reduction in the use of opioids and their side effects. Additionally, cannabinoids have been shown to prevent the development of tolerance to opioids and even restore opiate pain relief after a prior dosage became ineffective.

One employee told the workgroup he had been able to eliminate his opioid prescription by using medical marijuana to manage pain and other ailments, until his employer started testing for marijuana and he had to go back on his opioid painkillers. In the past several others have made similar statements to the Bureau's staff.

Recent articles also suggest that expanding access to medical marijuana reduces opioid dependence and addiction. Studies indicate that in parts of the United States and Canada, availability of medical marijuana is reducing the use of opioids.¹⁸ While marijuana will never be able to replace opioids for certain ailments or for the most severe pain, it carries minimal overdose risks and a far lower risk of addiction than prescription painkillers do (Szalavitz, 2011).

¹⁸ J Psychoactive Drugs, 2012 Apr-Jun;44(2):125-33

One study published in *JAMA Internal Medicine*, found states which implemented medical marijuana laws saw a reduction in average opioid analgesic overdoses and deaths, both from prescription painkillers and illicit drugs like heroin. Their study went as far back as 1999, when only three states had legalized medical marijuana. In all, states with medical marijuana laws had a 24.8 percent lower average of annual overdose death rates when compared to states that had not legalized the drug (Bachhuber, 2014). Opioid overdose death rates have decreased at the same time medical marijuana has become more widely used. Whereas the first year of significant medical marijuana legalization (1999) saw an average decrease in overdose deaths of about 20 percent, by 2005 the average reduction was 33.3 percent. By 2010, which was the end of the study period, there were about 1,729 fewer deaths from opioids (Rivas, 2014). While this may or may not show promise in fighting the reported “heroin epidemic” in Maine, it does suggest that medical marijuana use can lead to some level of reduced opioid abuse.

There can be effective alternatives to opioids in many cases, including the use of medical marijuana, THC synthetics like dronabinol, and a host of other treatments and interventions. Inasmuch as opioid use and misuse present the same array of safety and other potential problems in the workplace as other substances of abuse, they should be included in any comprehensive strategy to reduce substance abuse and impairment problems in the workplace. This presents further argument in favor of redirecting the focus of employer substance abuse program less towards testing for selected substances of abuse and more towards detecting employee impairment and responding to it, regardless of its causal substance or other trigger.

PART THREE:

**Administrative/enforcement issues with
current provisions of the employer
substance abuse testing law**

Federal/Non-Federal Employee Testing

Section 681 of the Maine Substance Abuse Testing Law includes broad exemption (“federal exemption”) for employers “subject to federal drug testing programs.” Prior to 2011, Section 681 included an exemption provision for employees subject to federal testing requirements but it required that if a federally regulated Maine employee tested positive, that the Maine provisions relating to disciplinary actions, opportunity for treatment or rehabilitation, employee confidentiality and consequences of enforcement would be followed:

“This subchapter, except for section 685 subsection 2 and section 689 subsections 1 and 4, does not apply to employees subject to substance abuse testing under any federal law or regulation ...” MRSA 26 § 681.8.B. (2011).

In 2011, the 125th Maine Legislature changed Section 681, Subsection 8 paragraph c. of the law by repealing the employee exemption and by adding the following paragraph:

“This subchapter does not apply to any employer subject to a federally mandated drug and alcohol testing program, including, but not limited to, testing mandated by the federal Omnibus Transportation Employee Testing Act of 1991, Public Law 102-143, Title V, and its employees, including independent contractors and employees of independent contractors who are working for or at the facilities of an employer who is subject to such a federally mandated drug and alcohol testing program.”

No such exemption is found anywhere else in the United States and the Bureau of Labor Standards (BLS) has received many inquiries from employers and others since 2011 about the provision and what it means. Because of its wording, and because the federal drug testing law is based on the job activities of *employees* rather than *employers*, many have had differing thoughts about what it means and how to apply it.

The BLS interpretation is that an employer would be subject to a federally mandated program, and thus exempt from the Maine drug testing law, by virtue of having at least one employee whose job is on the federal (DOT) list that makes the employee subject to federal testing requirements. That interpretation stems from the plain language of the provision, but based on the written statement of purpose at the time the committee enacted it; and on the problems and questions that have arisen from it, the legislative committee probably did not intend such a broad exemption. From all accounts, the committee proposed this change simply to allow employers - who must do federal drug testing - to not have to administer both state and federal drug testing programs if they apply the federal procedures and protocols to their non-federal employees, because the two programs were assumed to be fairly redundant.

Problems with the federal exemption

Since the adoption of the federal exemption in 2011 there have been incidents where Maine workers not otherwise subject to federal testing have not been afforded the privacy protections, the notice that they would be subjected to drug testing, the opportunity for appeal of the results, or the treatment options under the state or even under federal law. BLS has received very few complaints over the years about heavy-handedness by Maine employers involved with substance abuse testing, but since 2011 it has received several involving employers who were exempt under

Section 681 8.B. All recent complaints involve drug testing invoked by multi-state companies headquartered outside of Maine (See *Part Four* for specific cases).

These complaints are not widespread among the Maine employers who would be exempt under §681.8.B. In fact, more than 100 Maine companies that are exempt under this provision still maintain approved drug testing policies, carry them out in accordance with the Maine law, and report their testing to BLS each year. In last year's employer drug testing survey, almost half of the employers who were subject to the federal exemption indicated they would continue to follow their Maine-approved testing policies. Several reported they felt there were greater advantages to administering their programs in accordance with the Maine law. When asked for preferences, almost half (41%) of the participants indicated they would continue to follow their Maine approved policy for testing non-federally regulated employees, and a little more than half (52%) would prefer to extend their federal drug testing activities to their non-federally regulated employees. A smaller number (7%) indicated that they would not abide by federal or state substance abuse testing procedures with their non-federally regulated employees.

Although almost half the participants prefer operating under their state-approved drug testing policies for non-federally regulated employees, many written comments argued for a single set of procedures when federally regulated and non-federally regulated employees are tested. Many also stated that they were looking to the Department to reduce confusion over this part of the law. One pointed out that some provisions of the federal programs ought not to be applied to non-federally regulated employees, including observed urine sample collection, which is allowed and, in some cases, required under the federal program. Another noted that employers should continue to report testing of non-federally regulated employees to the Department so that it will know the full extent of employee drug testing that occurs in Maine.

Nevertheless, the few complaints received by BLS are troubling in that they show an indifference towards fair and consistent administration of drug testing activities for non-federally regulated Maine employees. Four factors seem to contribute to this.

First, despite its appearance, the federal exemption does not really simplify things for employers. Some may argue that Maine's drug testing law is excessive, but it is far less proscriptive and complex than its federal counterpart. For example, while testing for any particular substance is optional under the Maine law, the federal law requires that five substances (and five only) along with alcohol must be measured for each test. If an employer wanted to test for another substance like bath salts, that employer would be required to work outside of any federal regulation and guidance and keep the testing results separate from the rest of the process. Likewise, while any kind of testing of any employee under the Maine law is optional, the federal law requires pre-employment, random, probable cause, return to duty, follow-up, and post-accident testing for all employees who are subject to testing. Employers who do apply the federal program to non-federal employees will spend much more on testing than if they follow the Maine program.

Below are some further examples of how the federal substance abuse testing program is more proscriptive for employers and employees:

1. When any employee returns to duty having violated drug and alcohol rules, employers are required by the federal regulations to conduct unannounced follow-up testing on that

employee at least 6 times in the first year and continue the follow-up testing for up to five years as required by a substance abuse professional.

2. Under the federal program, an employee fails a drug test (and is subject to disciplinary action) if he or she refuses to take the test. While this is considered by most a logical and appropriate practice, the federal law makes its definition of “refusal” more rigid and intrusive than one might expect. Among other actions, a “refusal” would include:
 - a. Failure of an employee to appear for a test if directed to do so;
 - b. Failure of the individual providing a urine sample to permit observation or monitoring when required;
 - c. Failure of an employee to provide enough urine for a test unless there is a medical explanation for the shortage;
 - d. Failure of an employee to cooperate with any part of the testing process including refusal to empty pockets when directed to do so; behaving in a confrontational manner that disrupts; and failure to wash hands when directed to do so.
 - e. Failure of an employee to follow an observer’s instructions during a direct observation test to raise clothing above the waist, to lower clothing and underpants sufficiently and turn around to permit observation.

The federal program also does not allow an employer any latitude with regard to outcomes that may be lawful in the state but not so under federal law. So, for example, the employer is required to treat any employee who tests positive for marijuana, whether or not it is from “legally established” medical or recreational use in the local jurisdiction, as having violated the substance abuse policy and subject to disciplinary action.

The second contributing factor is that without the structure of a Maine drug testing policy, some exempt employers do not develop a coherent approach to applying the federal protocols to their non-federal Maine employees. Problems occur especially when drug testing programs and procedures for those employees are developed and implemented on the fly by local supervisors.¹⁹ Employees who had not previously been subject to drug testing have found themselves blindsided by new corporate requirements mandating they be tested for drugs and, to make matters worse, local administrators and supervisors sometimes lack the training or preparation necessary to explain or apply the testing requirements consistently and in a non-threatening/non-invasive fashion. BLS has heard several variations of the same story: an employee is told one day that “corporate” requires he or she to sign an agreement to provide a urine sample, and if they don’t sign or if they don’t cooperate with the program they will be terminated, while at the same time their questions and concerns about “how and why” go unanswered by their superiors.

The third contributing factor is that although the federal program allows employers to conduct substance abuse testing beyond what it proscribes, it also requires that such testing not be done in a way that interferes with or takes precedence over the federal employee testing. Moreover, employers are not allowed to use the federal forms for reporting, recordkeeping, chain of custody, etc. for anything other than the federally proscribed testing. To conduct substance abuse testing of non-federally regulated employees, the employers must keep the testing processes and

¹⁹ All recent complaints involve drug testing invoked by multi-state companies headquartered outside of Maine.

paperwork separate from those used for their federally regulated employees. They must maintain separate testing rosters, separate random testing pools, separate chain of custody and other tabulation forms, and so forth. Exempting an employer from the Maine drug testing simply does not reduce duplication for the employer when the federal law is involved, and may often be where shortcuts are taken.

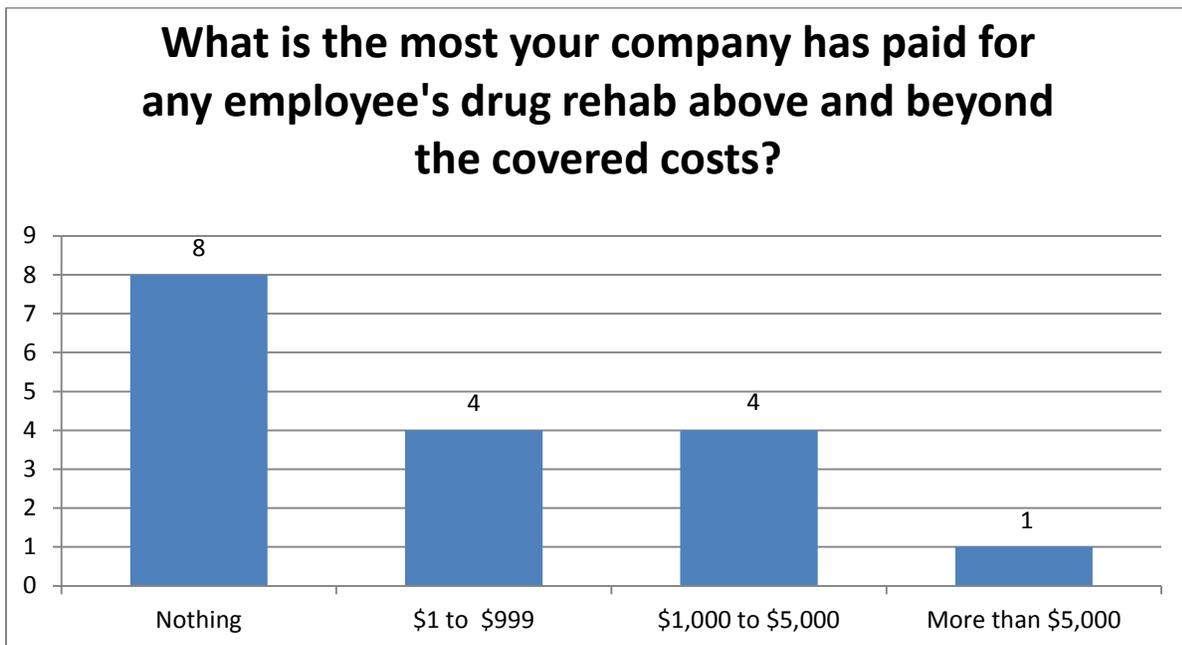
The fourth contributing factor is that the federal laws and programs do not contemplate or provide reference for compliance or enforcement involving substance abuse testing of nonfederal-designated employees. Given that the employers are exempt under the Maine law, they are, in effect, not held accountable by any agency, state or federal, for their treatment of non-federally regulated employees, and those employees have nowhere to go with their questions and concerns, or to appeal any actions by their employer. Under those circumstances, too, employers are given no guidance or validation as to how they should test their non-federal employees, which non-federal employees they should test, which protocols they should follow, or how they should mete out the consequences of testing. No agency even asks them to record or report their non-federal testing results.

Based on the discussion above, the workgroup concludes there ought to be a change to the Section 681.8.B. (see Part One for all recommendations). The workgroup considered repealing the exemption entirely, but is more inclined to amend it in a way that would allow employers to continue to overlay their federal testing programs while providing appropriate protection for employees.

Employee Assistance Programs and Substance Abuse Treatment

Maine substance abuse testing law requires any employer with more than 20 full-time employees who conducts employee drug testing to have a functioning employee assistance program (EAP) certified by the Maine Department of Health and Human Services. In addition, employers with over 20 full-time employees must also pay for up to six months of treatment through their EAPs. If the employer provides health insurance covering substance abuse treatment, the employer is required to pay half of the cost not covered by insurance. In comparison, employers with fewer than 20 full-time employees are required to offer their employees an opportunity for treatment, but are not required to have a functioning EAP, and are not responsible for paying costs associated with that treatment. While most employers are willing to support their EAPs, and very few Maine employers have actually had to pay any significant fees above coverage (Table 3), to some it seems inequitable to require employers to additionally pay for treatment of an employee's drug abuse problem or to pay for uncovered treatments.

Table 3



Source: BLS, Employer Drug Testing Survey Report – 2014

While the policy issue is whether to continue to require larger companies that conduct drug testing to have EAPs, it is important to understand how EAPs fit in to the broader employee relations environment in responding to or preventing substance abuse, and implementing employer workplace drug free policies.

What are EAPs?

An EAP is a voluntary, confidential program that helps employees (including management) work through various life challenges that may adversely affect job performance, health, and personal

well-being to optimize an organization's success.²⁰ There is no more specific definition of an EAP largely because most EAPs are multi-faceted, and their roles vary depending on the needs and preferences of the employer.

Historically, EAPs began in the 1940s with services to help employers deal with the effects of alcohol abuse and job performance. Over time, their scope broadened to approach a variety of employee issues that affect job performance. As these services expanded to cover subject matter that was more confidential in nature, external EAP providers started to replace the internal services once provided by employers. EAP providers and services have grown substantially since the early 1970s; such that most of the large companies offer them and they deliver a variety of health and productivity services. Not only do EAPs provide preventative, triage, intervention, and problem solving services to employees and their families, but they also provide consulting and training services to employers and their managers relating to employee performance issues (SAMSHA, 2008). They also provide professional guidance and consultation on financial, legal, eldercare, childcare, and other such matters.²¹

EAPs offer value to employers in three ways. First, they protect and support the employer's investment in their workforce by helping employees respond to problems and challenges that affect their ability to work productively by referring them to appropriate organizations to help address their particular problems, and by helping both managers and employees improve team performance and handle workplace stress. Second, EAPs reduce business costs by helping decrease workplace absenteeism and "presenteeism," improving productivity and morale, decreasing unplanned absences, workplace accidents, and insurance premiums, lowering turnover, facilitating smooth employee returns to work, reducing healthcare costs by providing for earlier identification and intervention of health care problems. Third, EAPs help businesses mitigate risks by reducing avoidable accidents and workplace violence, helping employees adjust to significant changes in the organization and workplace, reducing legal costs from problems that were not otherwise handled and promoting workplace safety, and drug- and alcohol-free workplace policies.

Second, EAPs should be proactive as well as reactive and should be set up to enable employers and encourage employees to identify problems as they emerge so that they can be addressed before their undesired effects occur. Several federal agencies believe that EAPs are essential components of a successful drug-free workplace program, including the Substance Abuse and Mental Health Services Administration²² and the National Safety Council (Teater, 2015).

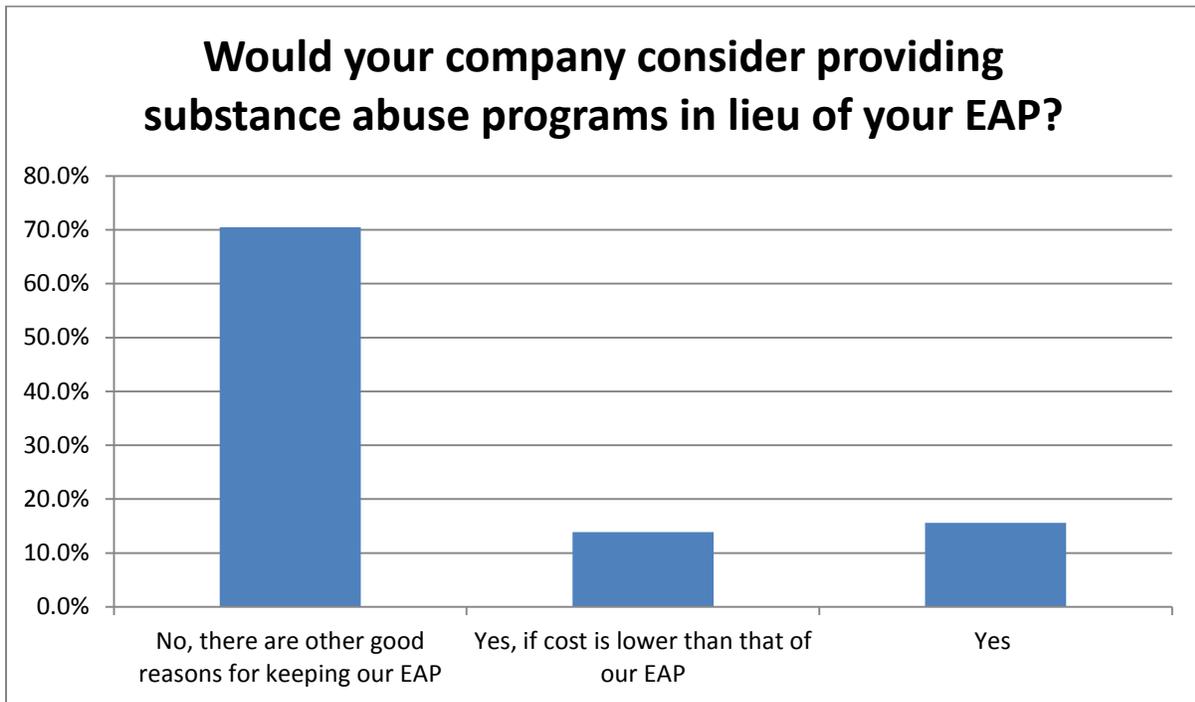
Third, EAPs lend themselves well to integration with wellness, safety, drug free workplace and other programs, and can be used to promote and enhance them. For example, EAP programs can be the principle source of fitness-for-duty and return-to-work analyses. More than 70 percent of the employers that participated in the 2014 Maine Employer Drug Testing Survey indicated they would not consider other treatment or prevention programs in lieu of their EAPs because there were other good reasons for keeping them (Dawson, 2014).

²⁰ <https://www.opm.gov/policy-data-oversight/worklife/employee-assistance-programs/#url=Overview>

²¹ *Employee Assistance Programs and Substance Abuse Rehabilitation Treatment*. Cheryl Cichowski, DHHS Office of Substance Abuse and Mental Health Services; Presentation to the Workgroup, August 18, 2015.

²² <http://www.samhsa.gov/workplace/toolkit>

Table 4

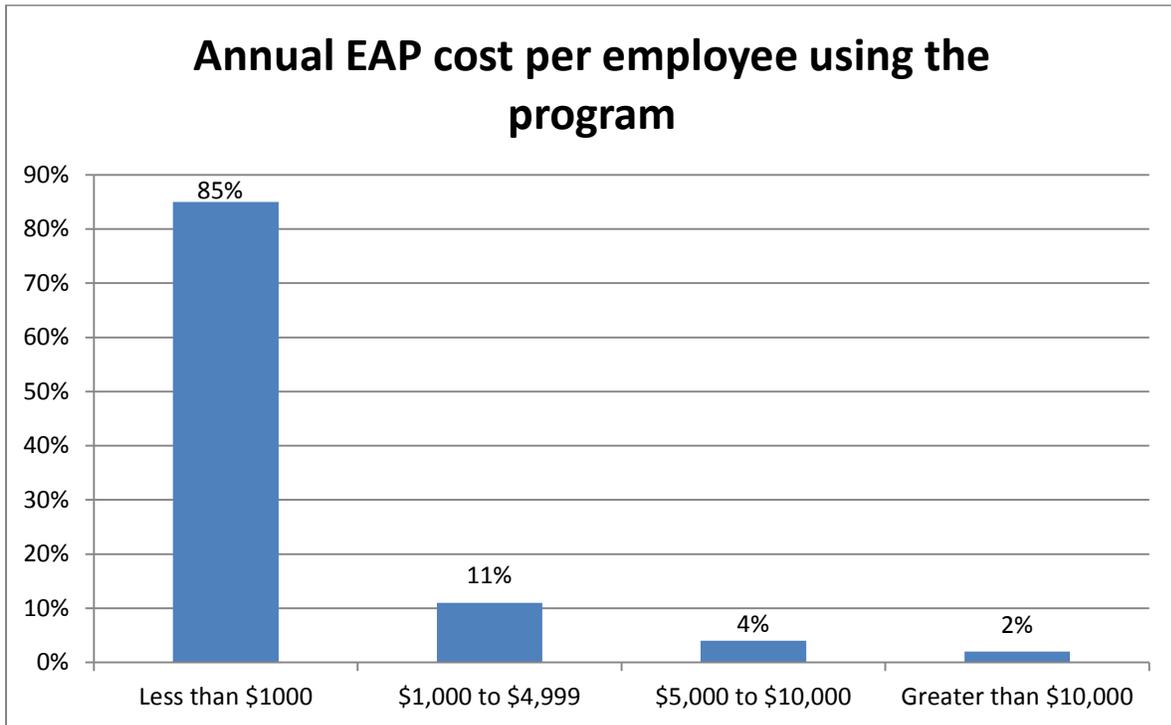


Source: BLS, Employer Drug Testing Survey Report - 2014

Employee Assistance Program Costs

There was sentiment among the workgroup that EAPs are too costly and the services are not worth their cost; in other words, EAPs do not provide a positive return on investments (ROI). While each employer's economics are unique, each may have varying EAP requirements, and some benefits are not readily quantified, e.g., the value of productivity gained or absenteeism averted by avoiding a crisis or escalation. However, based on the group's research, most employers who have evaluated EAP costs and benefits and who place a positive value on retaining and supporting their current employees find that their EAPs provide sufficient ROIs and added value beyond substance abuse treatment. Studies by several large U.S. companies support this, and report an ROI of 3 to 10 dollars saved for each EAP dollar invested (Dawson, 2014). The cost of EAP programs nationwide account for less than one third of 1 percent of the average cost spent on employee health benefits, putting them among the lowest-cost tools in any employee benefit package. Over the last decade EAP fees nationwide have been in the range of \$12 to \$40 per employee annually depending largely on company size and program components (Attridge, 2009).

Table 5



Source: BLS, Employer Drug Testing Survey Report - 2014

Exemption of Single Work-Related Accident in Probable Cause Testing and why employers should be testing for impairment

The problem with the first accident exemption

Section 682 of the Maine Substance Abuse Testing Law includes an exemption that employers cannot base their determination for probable cause testing on a single work-related accident or “first accident.” Courts in other states generally agree that companies may test employees after an accident, regardless of whether it is the first or subsequent incident. In fact, for most of the states that permit probable cause testing, the determination to test is based solely on the occurrence of an accident.²³ Maine is the only state in the United States that has a provision for exempting the first accident, and BLS has had countless inquiries as to why this particular exemption is included within the statute.

During the summer, workgroup sessions were held with BLS staff, employers, and employer-representatives, employees, and other key stakeholders where it was noted that the single accident exemption is one of the more frustrating rules that employers are required to follow in regards to drug testing their employees. Keeping a safe work environment for their employees is a huge concern for employers, so when an accident occurs, that is exactly the time when employers want to know if an employee is impaired or not.

Currently, an employer can require an employee be tested for a substance of abuse based on a reasonable suspicion that the employee was impaired. While many employers use this method of drug testing, it does not adequately address the issue of being impaired at the workplace. Even though a supervisor or manager may have probable cause to believe an individual was impaired due to an incident, with the first accident exemption, an employer cannot require that the employee be subjected to drug testing. Accidents are often the only time when “suspicious behavior” is presented, and, if it happens to be an employee’s first accident, it could potentially lead to another more serious incident in the future.

Another issue occurs when employers may not be willing to make a probable cause determination without an accident occurring due to being uncomfortable with the practice of determining impairment because they have not been trained to do so. Not having the necessary skills to recognize signs and symptoms of impairment can be problematic if a supervisor is unsure about his suspicion. These fears could be alleviated if employers keep in mind that in making an impairment determination, they are not accusing or attempting to diagnose a substance abuse or addiction; they are trying to rule out a possible reason or explanation that is a cause for concern.

One of the biggest concerns regarding reasonable suspicion testing is whether the employer’s suspicion was objectively reasonable under the circumstances.²⁴ In the event of an accident, this

²³ <http://www.testcountry.com/StateLaws/>

²⁴ <http://www.rendermagazine.com/articles/2014-issues/june-2014/post-accident/>

would normally not be a concern; however, when action cannot be taken based on the first accident, it can become a problem because at that point the employer would need another reason to corroborate his or her suspicion. When employers are met with such roadblocks as the first accident exemption, they may feel they are enabling bad behavior, and that all employees will receive a one-time “free pass” should they have an accident while at work regardless of the damage caused.

If employers were to test solely on observed behaviors that lead to a determination of impairment by a trained or certified supervisor instead of based on reasonable suspicion it would create a better mechanism for employers to keep their workplace safe while keeping the rights of their employees protected. Well-trained supervisors will not only be able to detect impairment at the workplace, but will also be better prepared to discuss their observations with the employee, and determine the root cause of the noticed behavior, whether it is truly an impairment concern or a separate personal matter.

With the rise of prescription medication use and abuse in Maine, being able to determine whether an employee is impaired while at work is going to be extremely important. In addition to the prescription drug problems we are facing, there is also the rising use of medical marijuana as treatment for many disorders. In the future, Maine may also see a rise in recreational use and abuse of marijuana, so having a policy set up to handle impairment in the workplace now will prepare employers for those issues and any others that may arise in the future.

PART FOUR:

Supporting Documents

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Background Publications and Literature Cited

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*PROPOSED MODIFICATIONS TO THE MAINE EMPLOYER
SUBSTANCE ABUSE TESTING LAW
(26 MRSA Subchapter 3-A).*

Be it enacted by the people of the State of Maine as follows:

Sec. 1. 26 MRSA §681, sub-§1, ¶E is enacted to read:

E. Protect Maine workers from injuries and illnesses caused by impairment in the workplace.

Sec. 2. 26 MRSA §681, sub-§8, as enacted by PL1989, c. 536, §§1 and 2 and affected by c. 604 §§2 and 3, is amended to read:

8. Nuclear power plants; federal law. Federally mandated drug and alcohol testing programs. The following limitations apply to the application of this subchapter.

A. This subchapter does not apply to ~~nuclear electrical generating facilities and their employees, including independent contractors and employees of independent contractors who are working at nuclear electrical generating facilities.~~ an employee, including independent contractor and or employee of an independent contractor who is working for or at the facilities of an employer who is subject to a federally mandated drug and alcohol testing program.

B. An employer with Maine employees subject to a federally mandated drug and alcohol testing program may either follow a Maine substance abuse testing policy in accordance with this subchapter; or may choose to not follow this subchapter for substance abuse testing of employees who are not subject to federal testing requirements, provided that:

1. The employer prepares a substance abuse testing plan for non-federally regulated employees and provides a copy of that plan to employees and the Bureau of Labor Standards prior to testing. The plan shall identify the kinds of testing to be administered, notification and administration procedures and how confirmed positive test results that may be allowable under state law but not federal law will be handled for the non-federally regulated employees.
2. The employer otherwise follows corresponding federal notification provisions, and procedural protocols, for any non-federally regulated employees, and follows section 685 subsection 2 for non-federally regulated employees who receive a confirmed positive test result for any substance of abuse and section 689 subsections 1 and 4 for non-federal employee testing.

C. This subchapter does not apply to any employer subject to a federally mandated drug and alcohol testing program, including, but not limited to, testing mandated by the federal Omnibus Transportation Employee Testing Act of 1991, Public Law 102-143, Title V, and its employees, including independent contractors and independent contractors who are working for or at the

facilities of an employer who is subject to such a federally mandated drug and alcohol testing program.

Sec. 3. 26 MRSA §682, sub-§1-A is enacted to read:

1-A. Arbitrary. “Arbitrary” means that the frequency of testing and the selection of those being tested is based on a set event, such as an employment anniversary, promotion, etc. Arbitrary testing can only be conducted on employees whose job is of a nature which could pose a potential threat to the health or safety of the public or co-workers if the employee were under the influence of a substance of abuse. Arbitrary testing events also include client-required or site-specific: testing based on criteria unrelated to substance abuse such as when a client requires testing prior to work on a project or specific site.

Sec. 4. 26 MRSA §682, sub-§3, as enacted by PL1989, c. 536, §§1 and 2 and affected by c. 604 §§2 and 3, is amended to read:

3. Employer. “Employer” means any person, partnership, corporation, association or other legal entity, public or private, that employs one or more employees or temporary employees under their direct supervision. The term also includes an employment agency.

Sec. 5. 26 MRSA §682, sub-§3-A, as enacted by PL1989, c. 832, §§4 is amended to read:

~~**3-A. Medically disqualified.** “Medically disqualified” means that an employee is prohibited by a federal law or regulation, or any rules adopted by the State's Department of Public Safety that incorporate any federal laws or regulations related to substance abuse testing for motor carriers, from continuing in the employee's former employment position due to the result of a substance abuse test conducted under the federal law or regulation or the Department of Public Safety rule.~~ **Impairment.** “Impairment” means a physical or mental defect in a body system or organ; any loss or abnormality of psychological, physiologic, or anatomic structure or function. Impairment may be caused by any number or combination of factors including extant illnesses, injuries, stress, intoxication, domestic violence and other personal causes. For purposes of this chapter, “impairment” or “impaired” means any abnormality or change in an employee’s physical, psychological or physiological condition present in the workplace and regardless of source, which could cause that employee to behave or perform tasks in a manner that threatens the safety of the employee, his/her coworkers, or any others.

Sec. 6. 26 MRSA §682, sub-§3-B, is enacted to read:

3-B. Medical Review Officer. “Medical Review Officer” or “MRO” means a person who is a licensed physician and who is responsible for receiving and reviewing laboratory results generated by an employer’s drug testing program and evaluating medical explanations for certain drug test results. An MRO may be an employee or a contractor for an employer; however, the following restrictions apply:

- A. The MRO must not be an employee or agent of or have any financial interest in a laboratory for which the MRO is reviewing drug test results, and
- B. The MRO must not derive any financial benefit by having an employer use a laboratory that may be construed as a potential conflict of interest.

Sec. 7. 26 MRSA §682, sub-§6, as enacted by PL1989, c. 536, §§1 and 2 and affected by c. 604 §§2 and 3, is repealed.

Sec. 8. 26 MRSA §682, sub-§6-A, is enacted to read:

6-A. Random. “Random” means a method of selecting those to be tested where all potential testees have an equal probability of selection by chance.

Sec. 9. 26 MRSA §682, sub-§6-B, is enacted to read:

6-B. Return to Work Agreement – a written document that sets forth the expectations that the employer and the employee assistance/medical professional have of an employee who has completed mandated treatment for alcohol and/or drug problems. It also sets forth the consequences if the expectations are not met. This agreement should be used if an employee has violated the drug-free workplace policy and has been provided the opportunity to participate in treatment as a condition of continued or re-employment.

Sec. 10. 26 MRSA §682, sub-§6-C, is enacted to read:

6-C. Safety-Sensitive task or occupation. “Safety-sensitive task or occupation” means a work task or an employee occupation that based on its nature, machinery, location, surroundings, or its influence upon other operations could potentially pose a threat to the safety of that worker, a co-worker, or others.

Sec. 11. 26 MRSA §682, sub-§7¶ C, as enacted by PL2009, c. 133, §1 is amended to read:

C. "Federally recognized substance abuse test" means any substance abuse test recognized by the federal Food and Drug Administration as accurate and reliable through the administration's clearance or approval process or a substance abuse test conducted in accordance with mandated guidelines for federal workplace drug testing programs, or with protocols and levels established by the Federal Department of Health and Human Services, Substance Abuse and Mental Health Services.

Sec. 12. 26 MRSA §683, sub-§2, first ¶ as enacted by PL1989, c. 536, §§1 and 2 and affected by c. 604 §§2 and 3, is amended to read.

1. Employee assistance program required. Before establishing any substance abuse testing program for employees, an employer with over ~~20~~50 full-time employees must have a functioning employee assistance program.

2. ~~Written Model~~ Uniform Substance Abuse Testing Policy. On or before January 1, 2017, the Department shall promulgate a Uniform Substance Abuse Testing Policy for adoption by employers. Before establishing any new substance abuse testing program or reactivating an inactive substance abuse testing policy after January 1, 2017, an employer must notify to the Maine Department of Labor that it has adopted the Uniform Substance Abuse Testing Policy as set forth in Department regulations and certify that it will carry out all non-federally regulated substance abuse testing activities in accordance with that policy. Any employer with active Maine substance abuse testing policies approved prior to January 1, 2017 must certify to the Department by no later than January 1, 2018 that it has adopted the Uniform Substance Abuse Testing Policy. The Uniform Substance Abuse Testing Policy shall provide an employer must develop or, as required in section 684, subsection 3, paragraph C, must appoint an employee committee to develop a written policy in compliance with this subchapter providing for, at a minimum:

Sec. 13. 26 MRSA §683, sub-§2, ¶ C.2(b) as enacted by PL1989, c. 536, §§1 and 2 and affected by c. 604 §§2 and 3 and amended by PL2001, c. 556, §2 is repealed.

Sec. 14. 26 MRSA §683, sub-§2, ¶ G as enacted by PL1989, c. 536, §§1 and 2 and affected by c. 604 §§2 and 3 and amended by PL2009, c. 133, §2 is amended to read:

G. The cutoff levels for ~~both screening and~~ confirmation tests at which the presence of a substance of abuse in a sample is considered a confirmed positive test result.

(1) Cutoff levels for confirmation tests for marijuana may not be lower than 15 nanograms of delta-9-tetrahydrocannabinol-9-carboxylic acid per milliliter for urine samples.

(2) The Department of Health and Human Services shall adopt rules under section 687 regulating ~~screening and~~ confirmation cutoff levels for other substances of abuse, including those substances tested for in blood samples under subsection 5, paragraph B, to ensure that levels are set within known tolerances of test methods and above mere trace amounts. An employer may

request that the Department of Health and Human Services establish a cutoff level for any substance of abuse for which the department has not established a cutoff level.

(3) Notwithstanding subparagraphs (1) and (2), if the Department of Health and Human Services does not have established cutoff levels or procedures for any specific federally recognized substance abuse test, the minimum cutoff levels and procedures that apply are those set forth in the Federal Register, Volume 69, No. 71, sections 3.4 to 3.7 on pages 19697 and 19698, or in mandated guidelines for federal workplace drug testing programs, or protocols and levels established by the Federal Department of Health and Human Services, Substance Abuse and Mental Health Services

Sec. 15. 26 MRSA §683, sub-§2, ¶ K) as enacted by PL1989, c. 536, §§1 and 2 and affected by c. 604 §§2 and 3 and amended by PL1995, c. 324, §4 is amended to read:

K. A procedure under which an employee or applicant who receives a confirmed positive result may appeal and contest the accuracy of that result or, in the case of alleged impairment obtain a confidential medical review to determine appropriate response and remedial action. The policy must include a mechanism that provides an opportunity to appeal at no cost to the appellant; and

Sec. 16. 26 MRSA §683, sub-§2, final ¶ as enacted by PL1989, c. 536, §§1 and 2 and affected by c. 604 §§2 and 3 and amended by PL2009, c. 133, §2 is repealed.

Sec. 17. 26 MRSA §683, sub-§3, as enacted by PL1995, c. 324, §5 is amended to read:

3. Copies to employees and applicants. The employer shall provide each employee with a copy of the written policy approved by the Department of Labor under section 686 or the adopted Uniform Substance Abuse Testing Policy at least 30 days before any portion of the written policy applicable to employees takes effect. ~~The employer shall provide each employee with a copy of any change in a written policy approved by the Department of Labor under section 686 at least 60 days before any portion of the change applicable to employees takes effect. The Department of Labor may waive the 60 day notice for the implementation of an amendment covering employees if the amendment was necessary to comply with the law or if, in the judgment of the department, the amendment promotes the purpose of the law and does not lessen the protection of an individual employee.~~ If an employer intends to test an applicant, the employer shall provide the applicant with a copy of the uniform or written policy ~~under subsection 2~~ before administering a substance abuse test to the applicant. The 30-day ~~and 60 day~~ notice periods provided for employees under this subsection does not apply to applicants.

Sec. 18. 26 MRSA §683, sub-§8, ¶E is enacted to read:

E. Medical Review Officer. No confirmed positive substance abuse test results shall be reported to the employer except by a Medical Review Officer (MRO).

(1) The MRO shall be a licensed physician knowledgeable and with clinical experience in controlled substance abuse disorders and knowledgeable in deviations of substance abuse testing specimens and causes of invalid testing results. The medical review officer may or may not be qualified to serve as a medical review officer under federal drug testing laws.

(2) The MRO may be directly or indirectly retained by the employer, but shall act independently in carrying out any testing reviews or recommendations. The functions of the MRO may also be provided by qualified personnel in the employer's sampling and screening organization.

(3) The MRO will contact the employee and, if necessary, the employee's physician to review each confirmed positive substance abuse test or any test found to be adulterated, substituted or otherwise invalid to determine whether or not there is a legitimate medical explanation for the result. Any exchange between the employee and the MRO is not subject to doctor patient relationship although the MRO must protect the confidentiality of the drug testing information as otherwise provided in this chapter. The MRO shall not disclose the presence or absence of any physical or mental condition of the employee nor the presence or absence of any substances other than those allowed to be tested under Department of Human Services laboratory testing rules.

(4) The MRO may direct the employee to obtain further medical evaluation by either the employee's physician or other licensed physician as acceptable to the MRO. The MRO may request the referral physician to evaluate the employee and consider all evidence regarding the medical explanation and make further findings regarding the employee's ability to safely perform all assigned tasks and any remedial measures necessary to assure that outcome, including but not limited to formal agreement by the employee to assure the employee will schedule any necessary medication in a manner that will not lead to impairment on the job. The MRO will make a final determination that the employee was or was not impaired and, if so, what future measures if any are necessary to ensure the safety of the employee, coworkers and anyone else who may be affected by the employee's performance.

Sec. 19. 26 MRSA §684, sub-§2, as enacted by PL1989, c. 536, §§1 and 2 and affected by PL1989 c. 604 §§2 and 3 is repealed.

Sec. 20. 26 MRSA §684, sub-§2-A, is enacted to read:

2-A. Impairment determination for safety sensitive tasks or occupations and testing of employees. Prior to January 1 2017, the department shall provide a training program for employers, managers and supervisors to be trained and certified in the identification of employee impairment in the workplace.

A. Prior to certification for impairment detection by the Maine Department of Labor, an employer must have submitted a list of safety sensitive positions and/or personnel that could be subject to impairment detection testing, including sufficient information to identify the position or position tasks as safety-sensitive, on a form provided for department review and approval. The employer must provide the department approved list to its employees and post it in a location accessible to employees. The employer may amend the list from time to time provided

the amended list is posted in a location accessed by employees, a copy is provided to each affected employee and the amended list is submitted to the Department for approval.

B. An immediate supervisor, other supervisory personnel, human resources personnel or security personnel, if certified for impairment detection by the Maine Department of Labor may make an impairment determination regarding an individual employee. A licensed physician or nurse may also make an impairment determination. An employer may require, request or suggest that an employee involved with a safety sensitive occupation or task submit to a substance abuse test if the employer has determined that the employee is impaired.

C. The person making the impairment determination must state, in writing, the facts upon which this determination is based and provide a copy of the statement to the employee.

D. Prescription medications may be tested when only an impairment determination has been made, and only for the purpose of assisting the MRO in evaluating whether an employee or applicant is impaired and the cause of the impairment.

E. There shall be no cause of action against an employer for making and acting upon an impairment determination in accordance with this section as long as the determination is provided to the employee in writing and is based on the employer's good faith belief that the employee was impaired at work.

Sec. 21. 26 MRSA §684, sub-§2-B, is enacted to read:

2-B. Temporary Removal and Medical Review following an Impairment

Determination. If an impairment determination has been made, the employer may immediately remove the employee from the safety sensitive task or location, or make changes as necessary to eliminate any safety or property damage risk caused by the impairment.

A. Any impairment determination must be confirmed through a medical review by the MRO. The employer or MRO may require that the employee submit to testing for any substances of abuse, including prescription medications, to assist the MRO in investigating the impairment determination. All impairment testing shall be done by an independent testing facility and all screening and confirmatory test results shall be delivered only to the MRO and to the employee's primary or prescribing physician, if requested by the employee.

B. The MRO may direct the employee to obtain further medical evaluation either by the employee's physician or other licensed physician as acceptable to the MRO. The MRO may request the referral physician to evaluate the employee, consider all evidence and make further recommendations regarding the employee's ability to safely perform all assigned tasks, including any remedial measures, including but not limited to, written agreement by the employee to schedule any necessary medications in a manner that will not lead to impairment on the job.

C. The MRO will make the final determination on whether or not employee was or is impaired; identify the cause of any impairment; determine whether or not the employee can

continue to perform any safety-sensitive tasks and, the impairment remediation program, if any, necessary to assure that the impairment will not recur or will not adversely affect the safety of the employee, coworkers and anyone else in the future.

D. If, the medical review officer or employee's physician finds that the employee was not impaired on the job or that any such impairment posed no safety risks and the employee did not violate the employer's drug free workplace policy, the employee is entitled to full reinstatement to his/her position without any lost wages or benefits.

Sec. 22. 26 MRSA §684, sub-§3, as enacted by PL2003, c. 547, §2 is amended to read:

3. Random or arbitrary testing of employees. ~~In addition to testing employees on a probable cause basis under subsection 2,~~ An employer may require, request or suggest that an employee submit to a substance abuse test on a random or arbitrary basis if:

A. The employer and the employee have bargained for provisions in a collective bargaining agreement, either before or after the effective date of this subchapter, that provide for random or arbitrary testing of employees. A random or arbitrary testing program that would result from implementation of an employer's last best offer is not considered a provision bargained for in a collective bargaining agreement for purposes of this section.

B. The employee works in a position the nature of which ~~would create an unreasonable~~ could pose a potential threat to the health or safety of the public or the employee's coworkers if the employee were under the influence of a substance of abuse. It is the intent of the Legislature that the requirements of this paragraph be narrowly construed; or

C. The employer has established a random or arbitrary testing program under this paragraph that applies to all employees, except as provided in subparagraph (4), regardless of position.

(1) An employer may establish a testing program under this paragraph only if the employer has ~~50~~ 10 or more employees who are not covered by a collective bargaining agreement.

~~(2) The written policy required by section 683, subsection 2 with respect to a testing program under this paragraph must be developed by a committee of at least 10 of the employer's employees. The employer shall appoint members to the committee from a cross-section of employees who are eligible to be tested. The committee must include a medical professional who is trained in procedures for testing for substances of abuse. If no such person is employed by the employer, the employer shall obtain the services of such a person to serve as a member of the committee created under this subparagraph.~~

~~(3) The written policy developed under subparagraph (2) must also require that selection of employees for testing be performed by a person or entity not subject to the employer's influence, such as a medical review officer. Selection must be made from a list, provided by the employer, of all employees subject to testing under this paragraph. The list may not contain information that would identify the employee to the person or entity making the selection.~~

(2) An employer may establish a testing program under this paragraph if the employer is required to test employees to retain a contract.

A. An employee will be allowed to sign a waiver exempting them from testing when required for a contract and the employee acknowledges that they will not have an opportunity to work under the contract for which testing is required.

(3) Employees who are covered by a collective bargaining agreement are not included in testing programs pursuant to this paragraph unless they agree to be included pursuant to a collective bargaining agreement as described under paragraph A.

~~(5) Before initiating a testing program under this paragraph, the employer must obtain from the Department of Labor approval of the policy developed by the employee committee, as required in section 686. If the employer does not approve of the written policy developed by the employee committee, the employer may decide not to submit the policy to the department and not to establish the testing program. The employer may not change the written policy without approval of the employee committee.~~

~~(6) The employer may not discharge, suspend, demote, discipline or otherwise discriminate with regard to compensation or working conditions against an employee for participating or refusing to participate in an employee committee created pursuant to this paragraph.~~

Sec. 23. 26 MRSA §685, sub-§2, ¶A as enacted by PL1995, c. 324, §7 is amended to read:

A. Subject to any limitation of the Maine Human Rights Act or any other state law or federal law, an employer may use a confirmed positive result for a substance of abuse or, refusal to submit to a test, ~~or a confirmed impairment that poses a safety risk that cannot be mitigated, or an employee's second confirmed impairment determination~~ as a factor in any of the following decisions:

- (1) Refusal to hire an applicant for employment or refusal to place an applicant on a roster of eligibility;
- (2) Discharge of an employee;
- (3) Discipline of an employee; or
- (4) Change in the employee's work assignment.

Sec. 24. 26 MRSA §685, sub-§2, ¶C, sub-¶(1)(a) as enacted by PL1995, c. 344, §1 is amended to read:

(a) Except to the extent that costs are covered by a group health insurance plan, the costs of the public or private ~~rehabilitation treatment~~ program not required or agreed upon by the employer must be paid by the employee. Uncovered costs that are not covered by a group health insurance plan and are required or agreed upon by the employer shall be equally divided between the employer and employee if the employer has more than 20 full-time employees. This requirement does not apply to municipalities or other political subdivisions of the State or to any employer when the employee is tested because of the alcohol and controlled substance testing mandated by the federal Omnibus Transportation Employee Testing Act of 1991, Public Law 102-143, Title V. ~~If necessary, The employer shall~~ may assist in financing the cost share of the employee through a payroll deduction plan.

Sec. 25. 26 MRS §686, sub-§1, as enacted by PL1989, c. 536, §1 and 2 and affected by c. 604 §§2 and 3, is amended to read:

§686. Review of ~~written policies~~ uniform policy notifications

1. Review required. The Department of Labor shall review each ~~written policy or change to an approved policy~~ uniform policy notification submitted to the department by an employer under section 683, subsection 2. The department will use the data from the submitted uniform policy notification to create the Uniform Substance Abuse Testing Policy for the employer.

A. The department shall determine if the employer's ~~written policy or change~~ complies with this subchapter and shall immediately notify the employer who submitted the policy or change of ~~that determination~~ uniform policy notification is complete. If the department finds that the ~~policy or change does not comply with this subchapter~~ uniform policy notification is incomplete the department shall also notify the employer of the specific areas in which the ~~policy or change is defective~~ defects.

B. ~~The department may request additional information from an employer when necessary to determine whether an employment position meets the requirements of section 684, subsection 3. The department shall not approve any written policy that provides for random or arbitrary testing of any employment position that the employer has failed to demonstrate meets the requirements of section 684, subsection 3. An employer shall notify the department in writing if it chooses to discontinue an approved substance abuse testing policy. The notice must include the effective date and once approved by the department, the employer will be put into an inactive status and will not be allowed to conduct substance abuse testing. An employer that has discontinued their approved substance abuse testing policy must notify the department in writing if they choose to reinstate their prior approved substance abuse testing policy.~~

C. The department shall allow for the use of any federally recognized substance abuse test.

Sec. 26. 26 MRS §685, sub-§2, ¶D as enacted by PL 1997 c.49, §1 is amended to read:

D. ~~The rules may establish model applicant policies and employee probable cause policies and provide for expedited approval and registration for employers adopting such model policies~~ the uniform substance abuse testing policy. The rules adopted under this paragraph are routine technical rules pursuant to Title 5, chapter 375, subchapter II-A.

SUMMARY

These changes stem from the study group convened by the Department of Labor to address the emergence of legalized medical marijuana, increased use of various substances of abuse; the prospect of future legalization of general marijuana use as they relate to the workplace; and other issues relating to the administration of the drug testing law. The changes will make the drug

testing law more responsive to emerging trends and substances of abuse. Through streamlining of the approval process, employers will be better able to address substance abuse problems as they occur. While drug testing remains an integral tool, these changes will allow employers to detect and address impairment and keep Maine workers out of harm's way even before they receive the test results. With these changes the law will continue to protect the privacy of employees and assure they are informed up front about their employer's drug free policies and testing activities.

This bill modifies the section relating to employers that conduct drug testing under federal requirements in order to lessen confusion about the interface between federal and non-federal programs and eliminate inconsistent and unfair treatment of non-federally regulated employees. While employers may still extend their federal testing protocols to their non-federal employees, these changes will assure that those employees are given the privacy and notification protections, and their testing is reported just as the law provides for all other Maine employees. The bill also establishes the role of the Medical Review Officer (MRO), parallels to that in the federal testing programs, which eliminates confusion between the two.

This bill streamlines the drug testing policy approvals by providing a one-time uniform employer drug testing policy applicable to all employers. Each employer who wishes to conduct any drug testing simply completes a notification form and submits it to the Department of Labor. Upon review of the notification the department confirms that the employer will be operating under the uniform policy and presents a copy of the policy to that employer. The purposes of the uniform policy are: 1) to assure that employer substance abuse testing is implemented fairly, accurately and consistently; 2) to allow employers the tools and flexibility necessary to respond to substance abuse trends and issues as they emerge without undue administrative delays; and 3) to assure that employees know about, and have an opportunity to understand, their employer's substance abuse testing activities before they are carried out. It will also reduce the employers' burden of writing their own policies; convening special committees to maintain them, and having to wait for procedural delays when changing them.

This bill clarifies how any uninsured treatment costs are distributed between employee and employer. It continues to require that employers share in any uncovered treatment costs that they require or agree to, but not in costs incurred independently by employees.

This bill replaces probable cause testing with a broader impairment detection and response program so employers can more quickly and effectively neutralize safety hazards from impairment. The Department of Labor would facilitate a training/certification program for supervisors to detect impairment. Then, if a trained and certified supervisor determines that an employee is impaired, that supervisor may immediately reassign the employee to eliminate the safety hazard; require the employee to submit to substance abuse testing to help determine the cause; and request an impairment investigation by the MRO to confirm the alleged impairment, and its cause, and make any appropriate recommendations to assure that it will not present any further safety risks. Discussions and information between the MRO and the employee, the employee's health care provider(s) or others relating to the employee's physical, psychological, emotional or medical condition would be confidential and not included in any report or recommendations to the employer. Moreover, if the MRO or the employee's health care provider

determines there was/ is no impairment or no additional safety risk, and the employee had not violated provisions of the employer's drug free workplace policy, the employee would be restored to his/her job and fully compensated for any lost time or earnings.

Federal Exemption Cases presented to BLS

Since 2011, several complaints about incidents involving employers operating under the federal exemption provision have been reported to BLS via phone or email. Most were dismissed without much discussion once information from the caller or writer indicated that the employer exemption applied. Below are four cases documented by BLS.

Case I

Two employees of a multi-state corporation based in Massachusetts addressed the work group in September. This past spring, their company decided to conduct drug testing on certain non-federally regulated positions that they deemed as safety-sensitive, and those employees were notified they would immediately be subjected to random and probable cause testing. They were told to sign a waiver to allow the testing, or they would be terminated from their employment. They were given no information about how the testing results would be applied, or if they had any means to appeal or contest any testing results. They indicated the employers' representatives did not seem to have a protocol to follow, and were not always mindful of privacy issues. They had no procedure or answers for dealing with an employee who is a certified medical marijuana patient and as a result, the employee decided to start taking prescription opiates and other painkillers again instead of the medical marijuana he had been using in order to keep his job.

Based on the information provided by the employees, BLS sent a letter of inquiry to the employer noting that the company had recently conducted substance abuse tests on Maine employees who were not previously subject to federal substance abuse testing requirements and that the company did not have an approved Maine drug testing policy. The following is the company's response:

"... the company has employees in Maine who are subject to a U.S. Department of Transportation ('DOT') drug and alcohol testing program... it is our understanding the company need not provide any additional information in response to your letter."

Case II

In early 2015, a national company purchased a local service franchise and immediately administered pre-employment and employee drug testing, including testing any existing employees who wanted to keep their previous job at the establishment.

BLS received complaints from several of the former employees and issued a letter of inquiry to the employer because:

- One employee was served a Termination Notice in May 2015, based on the results of that person's drug test, and Termination Notices were served to others thereafter.
- The company did not have an approved Maine Substance Abuse Testing Policy for employees or job applicants.
- None of the positions were safety-sensitive or otherwise subject to federal substance abuse testing requirements.

Response to the BLS letter of inquiry was provided verbally over the phone by the company's attorney in Atlanta:

“While none of our Maine employees are subject to federal testing requirements, we have CDL drivers in some other states. Therefore based on my reading of Section 681 of your law, our company does not need your approval to do drug testing or to not re-hire those employees”.

Case III

A large multi-state company’s response to the BLS request for its annual substance abuse testing information:

“Some of our employees are subject to DOT drug testing, so in accordance with your statute our company is not required report any drug testing activities to your state.”

Case IV

In January 2014, BLS received several calls about drug testing incidents in central Maine. A multi-state construction-related company had rounded up its 100 or so employees into a double-wide construction trailer for the usual morning safety talk. Afterwards, supervisors blocked the doors and informed everyone that they all were going to be tested for drugs that morning. They were told that if anyone went to their cars, back to their work stations or even if they left the trailer they would be fired. They were told they could not go to the bathroom and were forced to stay in the trailer through the morning.

It took almost six hours for supervisors to take them one by one to the drug testing station to leave their urine sample. During the wait, the company monitored what employees were saying and how they were acting; at least one employee was fired because he had acted “nervous” prior to the testing, an action that was not reversed when that employee subsequently passed his drug test.

The company did not have a state-approved employee drug testing policy. The employees who spoke to BLS had not had any prior notice that they would be subject to any testing, and from what they described they were not given any of the processing and other protections that employees in Maine are thought to receive under Maine’s drug testing law. BLS investigation was suspended after the Bureau learned from the employees that some of their coworkers were subject to federal drug testing.

Papers and Presentations to the Work Group

Executive Summary

Marijuana and Workplace Safety

Nelson S. Haas, MD, MPH, FACOEM September Medical Director, MaineGeneral Workplace Health

The summary of and recommendations from a report prepared for the Maine Department of Labor Employer Drug Testing and Marijuana in the Workplace Work Group, finalized on September 16, 2015.

Marijuana use causes deficits in judgment of time and speed; coordination; attentiveness; vigilance; ability to plan, organize, solve problems, and make decisions; memory; and control of behavior. There is a positive relationship between motor vehicle accidents and marijuana use. Studies of marijuana use and motor vehicle accidents, and marijuana use and neuropsychological performance show a positive, dose-dependent relationship between blood THC concentration on the one hand, and involvement in motor vehicle accidents or decrements in performance on the other hand. Long-term marijuana users are at risk for performance problems in a period of up to 24 hours after use and during periods of withdrawal, which may last for weeks after cessation of use.

Monitoring for marijuana use and impairment is difficult. Much impairment caused by marijuana is subtle and testing for performance problems due to marijuana use can take hours. There is no way to monitor marijuana use as can be done with prescription medications that have potential for abuse. For example, benzodiazepines, opiates, and amphetamines are obtained in exact doses and quantities; unless obtained illegally, prescriptions must be renewed for many of these medications monthly; and there is a tracking system that shows when and where prescriptions are filled, and who provided the prescription. Almost none of these features are available with medical marijuana. A medical marijuana patient may see the certifying practitioner once annually, grow his or her own marijuana, and consume marijuana without characterized doses of the active ingredients.

Standard urine testing for marijuana metabolites, when positive, shows that the urine donor has used marijuana in some undeterminable quantity at sometime within weeks of the test. Blood testing for THC may be unlawful, invasive, and expensive; and only gives a rough indication of time of use and level of impairment. As drug levels in blood change with respect to THC content in marijuana and time of use, and THC content in marijuana and ingested marijuana preparations is not standardized, tracking marijuana use and impairment from marijuana on a regular basis is unrealistic. Trying to characterized blood THC levels after use and set some safe-use time window is unrealistic.

To wait for a marijuana user to demonstrate observable impairment is likely only catch the worst cases, and is not likely to address the bulk of the safety problems created by marijuana use.

The medical marijuana user is supposed to have a chronic and/or debilitating medical condition according to Maine law. As with any drug, evaluation of medical marijuana users for workplace safety risk must include not only safety risks from the drug, but safety risks from the condition that the drug is meant to treat.

Recommendations from this review of marijuana impairment literature and workplace safety standards include the following.

- Workplace drug testing for marijuana use continue in its current form without alteration.
- Workplace blood testing for THC, OH-THC, or other cannabinoids or cannabinoid metabolites should not be performed.
- When marijuana metabolites are detected in urine, the donor should undergo review of legitimate reasons for use of medical marijuana by a medical review officer as is currently done for other drugs detected in workplace urine drug testing.
- Users of medical marijuana may be excluded from performance of safety sensitive tasks based on increased risk of harm to themselves, coworkers, and the public, and based on increased risk of property damage. Assessment for safety risk should include debility from the health condition that medical marijuana is meant to treat. The recommendation for removal from safety-sensitive activities should come from a licensed health care provider familiar with safety risks posed by medication use, including use of marijuana.
- Exclusion of medical marijuana users should not require elaborate or invasive testing, regular monitoring, or examination for frank impairment before exclusion from safety-sensitive activities.
- Employers should designate safety-sensitive activities in their workplaces based on known risks and safety precautions implemented in their workplaces.
- Employers should remove employees who are designated as safety risks from performance of safety-sensitive tasks after recommendation to do so by a qualified health care provider and not undertake implementation of medical risk assessment themselves.

The need for Supervisor Impairment Determination Training and Employee Education

Throughout the summer, the Department of Labor has facilitated workgroup sessions focused around medical marijuana in the workplace. With all of the presentations and research provided during these sessions it is known that medical marijuana is going to affect people in different ways, there are no standard 'doses' to be taken and the drug and its metabolites stay in a person's body for long periods and differ per person. What we have discovered is this – employers want to know how to determine whether their employees are impaired while at work. Having the ability to determine impairment as it occurs could possibly reduce accidents, increase job performance or output, and ultimately make their workplace safer for all their employees.

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), there are five components necessary to have a successful drug-free workplace program. They include, a written policy, an employee assistance program, a drug testing component, employee education and supervisor training.²⁵ There are some states, like Alabama and Ohio that already require some form of employee education and supervisor training as part of their drug-free workplace policies.²⁶

The United States has seen a significant rise in the amount of prescription painkillers being dispensed, since 1999 that number has quadrupled along with the number of deaths from prescription painkillers.²⁷ Maine, in particular, has seen the effects of this trend and recognizes the serious implications of not updating our laws to address the issue. The majority of employees who use prescription opioids are prescribed these types of medications legally. If one of these employees was drug tested, they might not test positive but even if they did, the employee would be able to plead their case since the substance is a valid medication prescribed by their physician. One big problem with this issue is that many opioid prescriptions can cause significant impairment and these employees take them throughout the day, many of them while they are at work. An additional problem arises when employees are taking prescriptions illegally (without a valid prescription) while at work.

Medical marijuana use is another trend that points us toward impairment detection rather than just relying on drug testing. Most qualified patients that use medical marijuana do so daily, which means, the substance is going to stay in their bodies for long periods as research shows. These employees will consistently produce a positive test result even when they are not impaired. In this case, employers could lose valuable employees just because they test positive, if that is what their policy dictates.

The bottom line is that employers need to provide training in determining impairment for supervisory positions and need to provide basic education for all of their employees on the

²⁵ <http://www.samhsa.gov/workplace/toolkit>

²⁶ <https://www.shrm.org/LegalIssues/StateandLocalResources/StateandLocalStatutesandRegulations/Documents/State%20Drug%20Testing%20Laws.pdf>. Accessed October 29, 2015.

²⁷ <http://www.cdc.gov/drugoverdose/data/index.html>

dangers of substance abuse. The content of the supervisor training will differ from the basic employee education in that the major focus will be on recognizing behaviors that are consistent with impairment. Supervisory training will also give supervisors the tools they will need to write their determinations, discuss the determination with the affected employee and how to refer employees to an EAP for assistance.

Implementation of training and education

1. Department of Labor:

- a. Will work with DHHS/SAMHS and other agencies to develop a training program for supervisors to determine impairment in the workplace.
- b. Requires all employers seeking to conduct substance abuse testing to adopt the Uniform Policy, a comprehensive policy consisting of a Drug-Free Workplace policy and a substance abuse testing policy in one.
- c. In order to successfully conduct impairment determination testing on employees, employers will be required to have supervisors trained and certified to determine impairment in the workplace.

2. Employers:

- a. Will fulfill the requirement for supervisor training prior to adopting the Uniform Policy by doing the following:
 - i. At least one supervisor per shift will be trained and certified by DHHS/SAMHS trainers²⁸
- b. Once the Uniform Policy has been adopted, the employer will be required to have all supervisory staff trained and certified within the first two years of policy adoption with retraining performed every two years thereafter.
- c. Will fulfill basic employee education by doing any of the following:
 - i. Add education to New-hire orientation
 - ii. Provide brochures and resources for substance abuse education at workplace
 - iii. Send employees (or have someone go there) to a formal education program provided by DHHS/SAMHS

²⁸ DHHS/SAMHS will work with BLS staff to develop a training program suitable for impairment detection

Workgroup Minutes and Participation

Employer Drug Testing and Marijuana Work Group

June 16th Meeting held at Department of Labor

Attendees: Please see attached list with contact information

Overview of Work Group Focus - Pam Megathlin

While the Department of Labor does not take a stance for or against the issues that will be presented here, it is facilitating this work group in the hopes to get all participants to a common ground regarding drug testing and medical marijuana in the workplace. This will give us meaningful and relevant information to use when reporting to Legislature. The major focus areas for this work group will be:

- Impairment Testing
 - Defining and determining impairment
 - Testing options
- Educational Opportunities
 - Properties of medicinal marijuana
 - Adverse effects of medicinal marijuana
 - Overview of Employee Assistance Program (EAP)
 - Other educational opportunities

Schedule of Topics and Presenters

Please review the schedule and submit all questions and/or concerns to the presenters listed at least a week before that topic is presented. This will allow the presenter time to incorporate responses into their respective presentations. The email list is attached and will be updated after each meeting.

Meeting times: 9-12pm

Meeting locations: Safety Works Institute – Department of Labor (the 9/9 meeting is the only exception and will be in the Frances Perkins room at DOL)

Requests for presentation aids (projector, TV, etc.) should be submitted at least a week prior to presentation date.

Date	Topic	Notes	Presenting (subject to change)
July 1	The different properties of marijuana (medicinal and non-medicinal)	Opportunity to learn more about the plant's therapeutic properties as well as adverse effects.	Becky Dekeuster Cathy Cobb Others to be determined
July 14	Exemption for employers with federal testing program	Discussion around this section of the statute. Why this is an issue and what the implications are	DOL Staff

July 29	Employers' concerns/issues with medical marijuana in the workplace	Opportunity to hear from employers and MROs	Bill Judge, Dr. Catlett, Workplace Health MROs, and others to be determined
August 11	How to gauge "impairment"	Defining impairment, determining impairment, testing options	Workplace Health representatives
August 18	EAPs, substance abuse rehab programs, costs and options.	Overview of EAPs, rehab/treatment, etc.	DHHS Staff
September 3	What is a significant first accident to determine probable cause	Defining 'first accident', discuss exemption of 'first accident' in statute	ALL
September 9	Wrap-up	Final thoughts	ALL

Additional feedback to consider:

- Discussion around impairment
 - Priorities should be around Job Performance and Safety
 - No reliable way to test impairment
 - Federal vs. State laws
- Define 'adverse effects'
- Concerns with the use of the phrase 'substance abuse' vs. 'substance use'
- Fitness for duty vs. impairment and the issues that may arise around that language (ex. ADA implications)

June 16th Attendees:

Name	Representing	Phone	Email
Danielle Porter	Wellness Connection of Maine	553-9009	dporter@mainewellness.org
Cheryl Cichowski	DHHS –SAMHS (Office of Substance Abuse and Mental Health Services)	287-4391	Cheryl.cichowski@maine.gov
Jan Bielau-Nivus	Interested party		Jmbn2008@gmail.com
John Bielecki	MGMC – Workplace Health	621-7550	jbielecki@mainegeneral.org
Kevin Ward	MGMC – Workplace Health	621-7550	Kevin.ward@mainegeneral.org
Neil Haas	MGMC – Workplace Health	621-7550	Nelson.haas@mainegeneral.org
Catherine Cobb	Wellness Connection of Maine	622-4561	outreach@mainewellness.org
Meghan Wells, MROA	OMC (Occupational Medical Consulting, LLC)	800-575-6537	mwells@omcwellness.com
Dr. Larry Catlett	OMC (Occupational Medical Consulting, LLC)	800-575-6537	drclatlett@omcwellness.com
Laura Harper	Maine Association of Dispensary Operators	462-4067	laura@mooseridgeassociates.com
Bill Judge, JD, LLM (via conference call)	Encompass Compliance Corp.	866-328-7487	bjudge@encompinc.com
Mark Dawson	Dept. of Labor, Bureau of Labor Standards	623-7904	Mark.dawson@maine.gov
Amanda O’Leary	Dept. of Labor, Bureau of Labor Standards	623-7902	Amanda.oleary@maine.gov
Pam Megathlin	Dept. of Labor, Bureau of Labor Standards	623-7900	Pamela.megathlin@maine.gov

Employer Drug Testing and Marijuana Work Group

July 1st Meeting held at Department of Labor

Attendees: Please see attached list with contact information

Meeting times: 9-12pm

Meeting locations: Safety Works Institute – Department of Labor (the 9/9 meeting is the only exception and will be in the Frances Perkins room at DOL)

PLEASE NOTE: the next meeting will be held on July 29th

Topic of Discussion: Medical and ‘Narcotic’ Properties of Marijuana

Presenters: Brian Piper, Ph.D., M.S. and Becky DeKeuster, M.Ed

Items of consideration and additional resources:

- *If there are any cases that you know about regarding medical marijuana, whether being tried in Maine or elsewhere, please share with the group.*
- When trying to develop a test for marijuana impairment there are several issues that are important to contemplate:
 - The effects of marijuana on ‘new’ users as opposed to ‘experienced’ users.
 - Individuals metabolize the components of marijuana differently and what is considered to be ‘under the influence’ for one person may not necessarily be for the next.
 - Even if someone tests positive for marijuana does not necessarily mean they are under the influence at that time – marijuana components stay in the body for some time.
- Marijuana is not prescribed – a doctor (MD, DO, NP) can only *certify a qualifying condition or symptom of that condition* but DO NOT recommend or prescribe marijuana for treatment.
- Should employers be more focused on job performance and safety rather than what the employee may or may not be taking for medication? What issues could arise from doing so?
- The Compassionate Access, Research Expansion and Respect States (CARERS) Act – a senate bill introduced could mean the reclassification of marijuana from a Schedule I drug to a Schedule II drug. For more information on the bill and what it could mean for medical marijuana patients: <https://www.congress.gov/bill/114th-congress/senate-bill/683>
- NSDUH (National Survey on Drug Use and Health) is the primary source of information on the prevalence, patterns, and consequences of alcohol, tobacco, and illegal drug use and abuse and mental disorders in the U.S. civilian, non-institutionalized population, age 12 and older. <http://www.samhsa.gov/data/population-data-nsduh>

Schedule of Topics and Presenters (subject to change)

Please review the schedule and submit all questions and/or concerns to the presenters listed at least a week before that topic is presented. This will allow the presenter time to incorporate responses into their respective presentations. The email list is attached and will be updated after each meeting. Presenters: please contact either Mark Dawson or Amanda O’Leary should you need any audio/visual assistance.

Date	Topic	Notes	Presenting (subject to change)
July 1	The different properties of Marijuana (medicinal and non-medicinal)	Opportunity to learn more about the plant’s therapeutic properties as well as adverse effects.	Becky Dekeuster Cathy Cobb Others to be determined
July 14 This topic will be added to the September 3rd meeting	Exemption for employers with federal testing program	Discussion around this section of the statute. Why this is an issue and what the implications are	DOL Staff
July 29	Employers’ concerns/issues with medical marijuana in the workplace	Opportunity to hear from employers and MROs	Presentation provided by Bill Judge (will not be in attendance) Others to be determined
August 11	How to gauge impairment	Defining impairment, determining impairment, testing options	Workplace Health representatives
August 18	EAPs, substance abuse rehab programs, costs and options.	Overview of EAPs etc	DHHS Staff
September 3	What is a significant first accident to determine probable cause / Exemption for employers with federal testing program	Discussion around this section of the statute. / Why this is an issue and what the implications are	ALL / DOL Staff
September 9	Wrap-up	Final thoughts	ALL

July 1st Attendees:

Name	Agency	Email
Janie Miller	Maine Staffing Group	jmiller@mainestaff.com
Cheryl Cichowski	DHHS – ME SAMHS (Maine Substance Abuse and Mental Health Services)	Cheryl.cichowski@maine.gov
Jan Bielau-Nivus	Interested party	Jmbn2008@gmail.com
Heather Pinkham	Backyard Farms	heather.pinkham@backyardfarms.com
Tawyna Brown	Central Maine Partners in Health (CMPH)	Tawnyambrown@cmph1.com
Kevin Ward	MGMC – Workplace Health	Kevin.ward@mainegeneral.org
Neil Haas, MD	MGMC – Workplace Health	Nelson.haas@mainegeneral.org
Catherine Cobb	Wellness Connection of Maine	outreach@mainewellness.org
Meghan Wells, MROA	OMC (Occupational Medical Consulting, LLC)	mwells@omcwellness.com
Dr. Larry Catlett, MD	OMC (Occupational Medical Consulting, LLC)	drcatlett@omcwellness.com
Laura Harper	Maine Association of Dispensary Operators	laura@moosridgeassociates.com
Peter Crockett	MLGH (Maine Labor Group on Health, Inc.)	mlgh@gwi.net
Becky DeKeuster, M.Ed	Maine Wellness Connection	becky@mainewellness.org
Brian Piper, Ph.D., M.S.	Husson University and University of Maine, Orono	piperbj@husson.edu
Jeff Austin	MHA (Maine Hospital Association)	Jaustin@themha.org
Scott Gagnon	Healthy Androscoggin/Smart Approaches to Marijuana	gagnons@cmhc.org
Atoka Dumont	Volk Pkg Corp.	atoka@volkboxes.com
Kim Robitaille	Rose’s Commercial Cleaning	kimr@rosescommercialcleaning.com
Rebecca Webber (via conference call)	Attorney	rwebber@sta-law.com
Mark Dawson	Dept. of Labor	Mark.dawson@maine.gov
Amanda O’Leary	Dept. of Labor	Amanda.oleary@maine.gov

Pam Megathlin	Dept. of Labor	Pamela.megathlin@maine.gov
Kara Littlefield	Dept. of Labor	Kara.littlefield@maine.gov
Paul Sighinolfi	Workers' Compensation Board	Paul.sighinolfi@maine.gov

Employer Drug Testing and Marijuana Work Group

July 29th Meeting held at Department of Labor

Attendees: Please see attached list with contact information

Meeting times: 9-12pm

Meeting locations: Safety Works Institute – Department of Labor (the 9/9 meeting is the only exception and will be in the Frances Perkins room at DOL)

PLEASE NOTE: the next meeting will be held on August 11th

Topic of Discussion: Employers' concerns/issues with Medical Marijuana in the workplace

Presenter: Dr. Nelson S. Haas, MD, MPH, FACOEM

Items of consideration and additional resources:

- If there are any cases that you know about regarding medical marijuana, whether being tried in Maine or elsewhere, please share with the group. Here are a few such cases:
 - U.S. Supreme Court decision of *Gonzales v. Raich*, an employer may safely refuse to accept medical marijuana as a reasonable medical explanation for a positive drug test result in states with medical marijuana laws.
 - California Court of Appeal, *Ross v. Ragingwire Telecommunications, Inc.*, which determined that employers have legitimate reasons for not employing individuals who use illegal drugs.
 - Oregon Appeals Court Decision of *Washburn v. Columbia Forest Products, Inc.*, the Court ruled that Oregon employers might have to make reasonable accommodation for disabled workers invoking the protection of Oregon's Medical Marijuana Statute due to the requirements of the Oregonians with Disabilities Law. The Court also ruled that Washburn's medical use marijuana does not automatically entitle him to accommodations. Rather, an employer could argue that certain accommodations might be unreasonable or create "undue hardship".
- If there are any definitions that you feel may need more
- Should employers be more focused on job performance and safety rather than what the employee may or may not be taking for medication? What issues could arise from doing so?
 - There are several standards set for employers to follow for safety-sensitive occupations (commercial motor vehicle operator, airplane pilot, etc.) but what about other safety-sensitive occupations (healthcare workers, teachers, hazardous waste and environmental cleaners, etc.) and the non safety-sensitive occupations.

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Heather Pinkham	Backyard Farms	heather.pinkham@backyardfarms.com
Tawyna Brown	Central Maine Partners in Health (CMPH)	Tawnyambrown@cmph1.com
Kevin Ward	MGMC – Workplace Health	Kevin.ward@mainegeneral.org
Neil Haas, MD	MGMC – Workplace Health	Nelson.haas@mainegeneral.org
Catherine Cobb	Wellness Connection of Maine	outreach@mainewellness.org
Meghan Wells, MROA	OMC (Occupational Medical Consulting, LLC)	mwells@omcwellness.com
Dr. Larry Catlett, MD	OMC (Occupational Medical Consulting, LLC)	drcatlett@omcwellness.com
Laura Harper	Maine Association of Dispensary Operators	laura@moosridgeassociates.com
Peter Crockett	MLGH (Maine Labor Group on Health, Inc.)	mlgh@gwi.net
Becky DeKeuster, M.Ed	Maine Wellness Connection	becky@mainewellness.org
Brian Piper, Ph.D., M.S.	Husson University and University of Maine, Orono	piperbj@husson.edu
Jeff Austin	MHA (Maine Hospital Association)	Jaustin@themha.org
Scott Gagnon	Healthy Androscoggin/Smart Approaches to Marijuana	gagnons@cmhc.org
Atoka Dumont	Volk Pkg Corp.	atoka@volkboxes.com
Kim Robitaille	Rose's Commercial Cleaning	kimr@rosescommercialcleaning.com
Rebecca Webber (via conference call)	Attorney	rwebber@sta-law.com
Mark Dawson	Dept. of Labor	Mark.dawson@maine.gov
Amanda O'Leary	Dept. of Labor	Amanda.oleary@maine.gov

Pam Megathlin	Dept. of Labor	Pamela.megathlin@maine.gov
Kara Littlefield	Dept. of Labor	Kara.littlefield@maine.gov
Paul Sighinolfi	Workers' Compensation Board	Paul.sighinolfi@maine.gov

Employer Drug Testing and Marijuana Work Group

August 11th Meeting held at Department of Labor

Attendees: Please see attached list with contact information

Meeting times: 9-12pm

Meeting locations: Safety Works Institute – Department of Labor (the 9/9 meeting is the only exception and will be in the Frances Perkins room at DOL)

PLEASE NOTE: the next meeting will be held on August 18th

Topic of Discussion: How to gauge ‘impairment’

Presenter: Dr. Larry Catlett, MD

Items of consideration and additional resources:

- Should employers develop company policies that address safety and performance as well as substance abuse testing – an ‘all-inclusive’ policy that clearly states the expectations of employees and the employer? Here are a few areas to consider:
 - Employee performance measuring (evaluations) which might include a ‘fit for duty’ or ‘observed behavior’ section
 - Safety sensitive job list with current job descriptions
 - Drug-free workplace and Smoke-free workplace –
 - Include section regarding not allowing substances to be used during work hours (including lunches and breaks), on work premises, in company vehicles, etc.
 - Include section regarding prescription drug use (keep confidentiality in mind with this one)
 - Include section specific to medical marijuana
 - Example of language from an existing policy when there is a confirmed positive: “if an employee demonstrates that he is certified under the Maine Medical Use of Marijuana Program, he or she shall be required to be evaluated for fitness for duty before returning to work. No employee may be in physical control of any motor vehicle while under the influence of marijuana, and no employee shall work while under the influence of marijuana.”
 - Remember to include consequences of violating parts of the policy – and be consistent when following up
- Role of MROs:
 - Consult/interview employee (find out whether there is a legitimate reason for non-negative or positive result) – they CAN ask the employee why they are taking the medication while employers cannot
 - May consult with employee’s healthcare provider for more information
 - Ultimately will make the determination whether to report as non-negative or positive based on gathered information

- If there are any cases that you know about regarding medical marijuana, whether being tried in Maine or elsewhere, please share with the group.
- If there are any definitions that you feel may need more clarification (whether within Maine Statute or DOL rules) please let us know. This may assist us when making our recommendations to Legislature.

Schedule of Topics and Presenters (subject to change)

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September 3	What is a significant first accident to determine probable cause / Exemption for employers with federal testing program	Discussion around this section of the statute. / Why this is an issue and what the implications are	ALL / DOL Staff
September 9	Employers’ experiences with drug testing		Peter Lowe
September 22	When an employee tests positive but has a medical marijuana card – what happens then?		Josephine Kenney

August 11th Attendees:

Heather Pinkham (Backyard Farms) and John Rioux (DOL) attended via conference line

SIGN-IN SHEET			
Project:	Employer Drug Testing and Medical Marijuana in the Workplace - Work Group	Meeting Date:	August 11, 2015
Facilitator:	Department of Labor, Bureau of Labor Standards	Place/Room:	Safety Works Institute, DOL

Name	Company/Agency	E-Mail
Meghan Wells	OMC	mwells@omcwellness.com
Dr. Larry Catlett	OMC	
Danielle Porter	Wellness Connection of ME	dporter@mainewellness.org
Sgt. Bruce Scott	MSP	bruce.g.scott@maine.gov
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Josephine Elizabeth Kenney	First Advantage	Josephine.Kenney@fad.com
James Peter Kenney	Unity	Railnut248@aol.com
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PAM MEGATHLIN	MDOL	pamela.megathlin@maine.gov
Corenna O'Brien	Core Consulting	Corennaconsulting.com
Cheryl Ackowicki	MESAMHS	cheryl.ackowicki@maine.gov
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K. Roberts	Rose's Com. Cleaning	Kim@rosescommercialcleaning.com

Employer Drug Testing and Marijuana Work Group

August 18th Meeting held at Department of Labor

Attendees: Please see attached list with contact information

Meeting times: 9-12pm

Meeting locations: Safety Works Institute – Department of Labor (the 9/9 meeting is the only exception and will be in the Frances Perkins room at DOL)

PLEASE NOTE: the next meeting will be held on September 3rd

Topic of Discussion: Overview of Employee Assistance Programs (EAPs)

Presented by: Cheryl Cichowski (DHHS/SAMHS) and Marietta D'Agostino (DHHS/DLRS)

Items of consideration and additional resources:

- EAPs are not only for employees who test positive for drugs or alcohol, they are for all employees who need assistance for a variety of reasons (marriage counseling, domestic violence issues, financial issues, mental health issues: whether work-related or not, substance abuse, etc.).
- While DHHS has a requirement to verify an EAP agency's licensure (or individuals who perform EAP services) they are not required to check into the effectiveness or success of the agency/individual providing services. *It is a good idea for a company to do some research when deciding on an EAP agency/provider.*
- Employers may have concerns regarding the cost of an EAP but the price can vary depending on company size and components of the program selected.
- Another concern is regarding the reintegration of employees who have completed a treatment program (rehab) back into the workplace. Issues with not knowing if the employee will relapse, (which cannot be predicted) are important concerns. There are programs available for assisting with risk-assessment and prevention. (Prime for Life is one example and is the basis for the DHHS DEEP program <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=12>)
- If there are any cases that you know about regarding medical marijuana, whether being tried in Maine or elsewhere, please share with the group.
- If there are any definitions that you feel may need more clarification (whether within Maine Statute or DOL rules) please let us know. This may assist us when making our recommendations to Legislature.

Schedule of Topics and Presenters (subject to change)

Please review the schedule and submit all questions and/or concerns to the presenters listed at least a week before that topic is presented. This will allow the presenter time to incorporate responses into their respective presentations. The email list is attached and will be updated after each meeting.

Presenters: please contact either Mark Dawson or Amanda O’Leary should you need any audio/visual assistance.

Date	Topic	Notes	Presenting (subject to change)
September 3	What is a significant first accident to determine probable cause / Exemption for employers with federal testing program	Discussion around this section of the statute. / Why this is an issue and what the implications are	ALL / DOL Staff
September 9	Employers’ experiences with drug testing		Peter Lowe
September 22	When an employee tests positive but has a medical marijuana card – what happens then?		Josephine Kenney

August 18th Attendees:

Via conference line:

John Rioux – DOL

Atoka Dumont – Volk Packaging

Diane Clairmont – Community Concepts

SIGN-IN SHEET			
Project:	Employer Drug Testing and Medical Marijuana in the Workplace – Work Group	Meeting Date:	August 18, 2015
Facilitator:	Department of Labor, Bureau of Labor Standards	Place/Room:	Safety Works Institute, DOL

Name	Company/Agency	E-Mail
Heather Pinham	Backyard Farms	heather.pinham@backyardfarms.com
Tawnya Brown	CMPH	Tawnyabrown@cmph1.com
Danielle Porter	Wellness Connection of Maine	dporter@mainewellness.org
Bekky Dellenator	wcm	bekky@mainewellness.org
Catherine Cobb	wcm	outreach@mainewellness.org
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Jim Kenney	Unity	rainnet248@aol.com
Cheryl Aichowicz	SAMHS	cheryl.aichowicz@maine.gov
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Karin O'Leary	ALCOM LLC	kalesy.alcomllc@gmail.com
Pam Megathlin	MDUL	pamela.megathlin@maine.gov
Nevia Warren	MGM	
Nep Haag	Maine Sen WPA	
Meghan Wells	OMC	
Jeff Aush	MMA	
Barb Gabri	Motivational Services	bgabri@macomaine.com

Employer Drug Testing and Marijuana Work Group

September 3rd Meeting held at Department of Labor

Attendees: Please see attached list with contact information

Meeting times: 9-12pm

Meeting locations: Safety Works Institute – Department of Labor

PLEASE NOTE: the next meeting will be held on September 9th and will be held in the Frances Perkins Room at DOL

Topics of Discussion: Federal exemption and 1st accident for probable cause

Presented by: Mark Dawson

Items of consideration and additional resources:

- Employers that are federally required to test their employees (DOT, safety-sensitive etc.) may test all of their employees even if they are not in positions that require it (non-DOT). The employers need to remember that if they follow the federal guidelines that they cannot add the non-DOT employees in the same random testing pool as the DOT employees and they cannot use the federal forms. They can however, create similar forms to use for the other employees.
 - Concerns may arise when employers are not upfront with all employees as to their testing policies or do not have a mechanism in place for employees to ask questions and receive valid answers regarding testing policies and procedures.
- **Feedback regarding federal exemption options:**
 - Another option would be to give BLS the ability to amend rules as needed.
 - Even if following the federal standards employers would still need to have two separate programs, as the federal consortiums will not allow those who are not covered under the federal regulations to be in the federal programs.
 - If the Federal regulations were to be applied, why not divide them into applicant and employee testing? That way employers could have a choice to do one or the other or both.
 - What would you do for employers who wish to test for more than the five substances that DOT allows? **Maine law does allow for testing of more than the standard five substances. If employers decide to follow federal regulations for all employees they would need to keep the two programs separated. Then they would want to make sure that any additional substances being tested for are listed in the policy(ies). For specific questions relating to federal drug testing rules for commercial motor carriers and other DOT-related positions call: 1-800-832-5660**
- **Feedback regarding first accident exemption options:**
 - Consensus seems to be that the language be amended to include 'significant damage-personal or property'. This would give employers the authority to determine a value for significant damage that fits for their company.
- **Here is a great question that MDOL will be looking into:**
 - What about employers who may or may not have a State and/or federal program and who are subcontractors to companies that require testing. For example an electrical contractor who is sending people to work at a nuclear power plant (an extreme example but you get my point.) The subcontract may

need to show proof of a drug test for a specific list of drugs within a certain timeframe. Standard applicant or random testing may not cover these requirements. I know of at least 2 employers who face this dilemma. They want to be in compliance with all regulations and at the same time must provide drug testing that meets the requirements of each specific job.

- If there are any other options for the federal exemption amendment or the first accident amendment, please share with the group.
- If there are any cases that you know about regarding medical marijuana, whether being tried in Maine or elsewhere, please share with the group.
- If there are any definitions that you feel may need more clarification (whether within Maine Statute or DOL rules) please let us know. This may assist us when making our recommendations to Legislature.
 - Definitions:
 - Substance of Abuse – means any scheduled drug, alcohol or other drug, or any of their metabolites.

Schedule of Topics and Presenters (subject to change)

Please review the schedule and submit all questions and/or concerns to the presenters listed at least a week before that topic is presented. This will allow the presenter time to incorporate responses into their respective presentations. The email list is attached and will be updated after each meeting.

Presenters: please contact either Mark Dawson or Amanda O’Leary should you need any audio/visual assistance.

Date	Topic	Notes	Presenting (subject to change)
September 9	Employers’ experiences with drug testing		Peter Lowe
September 22	When an employee tests positive but has a medical marijuana card – what happens then?		Josephine Kenney

September 3rd Attendees:

Via conference line:

John Rioux – DOL

Kara Littlefield – DOL

Sharon Crowe – Workplace Health, MGMC

Heather Pinkham – Backyard Farms

Corenna O'Brien – Core Consulting

Denise

SIGN-IN SHEET		
Project:	Employer Drug Testing and Medical Marijuana in the Workplace – Work Group	Meeting Date: September 3, 2015
Facilitator:	Department of Labor, Bureau of Labor Standards	Place/Room: Safety Works Institute, DOL
Name	Company/Agency	E-Mail
Kevin Olenny	Alcom LLC	kolenny@alcominc.com
Aaron Turcotte	MSP	Aaron.M.Turcotte@maine.gov
Sodi Stebbins	maine matters	Hmained@fmaill.com
Tawny Brown	EMPH	Tawnyabrown@emph1.com
LARRY CROST	JMC	—
CATHY CORSE	wcm	outreach@mainewdness.org
Cheryl Cichowski	SAMHS	
Glenn Burroughs	WC Board	lsbgmb@hotmail.com
Peter Lowe	Bran & Isaacson	plowe@brannlaw.com
R. Scott Guimont		—
Barb Gabri	Motivational Services Mental Health	bgabri@mcocomaine.com
Mag Anne Wenzli	MSEA	
J		

Employer Drug Testing and Marijuana Work Group

September 22nd meeting held at Department of Labor

Attendees: Please see attached list with contact information

Please note: There are no more scheduled meetings at this time; however, we will be reaching out to the group to reconvene later once we have had an opportunity to put together some material for further review. Some of the items we will be working on will be medical marijuana in the workplace, policy and law changes, and model policy development.

Topics of Discussion: What to do when an applicant or employee tests positive for marijuana and presents a medical marijuana card or certificate?

Presented by: Josephine E. Kenney, J.D.

Discussion items:

- When dealing with accidents or near misses, should the unsafe act be the focus of the employer and not the type of substance that was used. Would the employee have performed the unsafe act regardless of substance abuse?
- Random testing seems to be the 'biggest hurdle' for some employees, especially in regards to medical marijuana. For instance, if an employee is selected for testing and that employee is a certified medical marijuana patient than he/she is always going to test positive no matter when the test is conducted. It is also a problem if an employee uses recreational marijuana during the weekend and is tested during the week – he/she will test positive but will that actually determine impairment at work?
- Just having policies is not enough for employers; they need to enforce them consistently as well. Another important piece is communicating the policy with employees so they know what is expected and what the outcome is should they violate the policy.
- Case: an employer has had two employees involved in amputation incidents and both admitted to using marijuana prior to their accident. One of the employees used it during the weekend before the accident. Questions arise as to whether the employee who used over the weekend would have still been impaired when the accident occurred. Was impairment the issue or was it something else that caused the accident? This relates to assessing the unsafe actions being performed.
- Question: can an employee volunteer to take a substance abuse test? Can the employer allow them to be tested (with or without a testing policy?) and what happens if they are tested and the result is positive? MDOL will need to look into this more and it may need to be addressed in our report.
- Question: should medical marijuana be treated differently than any other prescription medications?

Items of consideration and additional resources:

- If you have any suggestions for law changes, policy language changes, etc. please send them to Mark or Amanda.

- If there are any other options for the federal exemption amendment or the first accident amendment, please share with the group.
- If there are any definitions that you feel may need more clarification (whether within Maine Statute or DOL rules) please let us know. This may assist us when making our recommendations to Legislature.
- Interesting reading:
 - *Going to Pot: Why the Rush to Legalize Marijuana is Harming America* by William J. Bennett and Robert A. White
 - *Weed the People: The Future of Legal Marijuana in America* by Bruce Barcott
 - *Marijuana in the Workplace: Guidance for Occupational Health Professionals and Employers* (joint guidance statement of the American Association of Occupational Health Nurses and the American College of Occupational and Environmental Medicine)

September 22nd Attendees:

Via conference line:

Heather Pinkham – Backyard Farms

Matt Nieman – Jackson Lewis

SIGN-IN SHEET		
Project:	Employer Drug Testing and Medical Marijuana in the Workplace – Work Group	Meeting Date: September 22, 2015
Facilitator:	Department of Labor, Bureau of Labor Standards	Place/Room: Safety Works Institute, DOL

Name	Company/Agency	E-Mail
<i>Josephine Elizabeth Kenney</i>	<i>First Alternatives</i>	<i>Josephine.Kenney@firstalternatives.com</i>
<i>Jim Kenney</i>		<i>mail mt 248@aol.com</i>
<i>Amanda O'Leary</i>	<i>DOL</i>	
<i>Mark Dawson</i>	<i>DOL</i>	
<i>Tawnya Brown</i>	<i>EMPH</i>	
<i>Meghan Wells</i>	<i>OMC</i>	
<i>Danielle Porter</i>	<i>Wellness Connection of Maine</i>	
<i>Alicia Burroughs</i>	<i>WCB Local 56</i>	
<i>LARRY CARTER</i>	<i>OMC</i>	
<i>Hillary Lister</i>	<i>WCB</i>	
<i>Paul H. Gil</i>	<i>McWCB</i>	
<i>Cathy Cobb</i>	<i>WCM</i>	

if I have it already, no need to fill in

Name	Representing	May 8	May 15	Jun 16	Jul 1	Jul 29	Aug 11	Aug 18	Sep 3	Sep 9	Sep 22
Jeff Austin	Association	X			X	X	X	X			
Diane Clairmont	Association					X	X	X			
Jodi Stebbins	Association					X			X		
Laura Harper	Association	X	X	X	X						
Peter Crockett	Association				X						
Scott Gagnon	Association				X						
Paul McCarrier	Association		X								
Barb Gabri	Association						X	X	X	X	
Hillary Lister	Association									X	X
Oamshri Amarasingham	Association		X								
Bill Judge	Attorney			X							
Kevin Haskins	Attorney	X	X								
Josephine Kenney	Attorney						X	X		X	
Jim Kenney	Retired Engineer						X	X		X	
Lynne Williams	Attorney										
Peter Lowe	Attorney						X		X	X	
Robert Bower	Attorney										
Rebecca Webber	Attorney / Association				X	X					
Catherine Cobb	Dispensaries	X	X	X	X	X	X	X	X	X	X
Becky DeKeuster	Dispensaries	X	X		X	X	X	X		X	
Danielle Porter	Dispensaries			X		X	X	X		X	X
John Rioux	DOL				X	X	X	X			
Pam Megathlin	DOL	X		X	X		X	X		X	
Jan Bielau-Nivus	DOL			X	X						
Julie Rabinowitz	DOL	X									
Mike LaPlante	DOL	X									
Anne Ryerson	DOL					X					
Steve Greeley	DOL										
Mark Dawson	DOL	X	X	X	X	X	X	X	X	X	X
Amanda O'Leary	DOL	X	X	X	X	X	X	X	X	X	X
Kara Littlefield	DOL	X			X	X		X			
Chris Hopkins	Employees					X					
Dan Dumais	Employees					X					
Kevin O'Leary	Employees					X		X	X		
Scott Guimont	Employees								X		
Glenn Burroughs	Employees / Association					X	X		X	X	X
Heather Pinkham	Employers				X	X	X	X		X	
Kim Robitaille	Employers				X	X	X				
Tim Walton	Employers	X	X			X	X				
Karen Gallup	Employers					X		X			
Kristy Gould	Employers					X					
Mark Hovey	Employers					X	X				
Pearl Ivey	Employers					X					
Sharon Crowe	Employers					X					
Derek Volk	Employers										
Donna McEachern	Employers										
Jennifer Andrews	Employers										
Michael Bourque	Employers										
Atoka Dumont	Employers				X		X	X			
Tawnya Brown	Employers / Assn.	X			X	X	X	X	X	X	X
Janie Miller	Employers/Assn				X						
Peter Gore	Employers/Assn		X							X	
Corenna O'Brien	Employers/Assn						X				
Curtis Picard	Employers/Assn										
Ed MacDonald	Employers/Assn										

Name	Representing	May 8	May 15	Jun 16	Jul 1	Jul 29	Aug 11	Aug 18	Sep 3	Sep 9	Sep 22
Cheryl Cichowski	State Agency			X	X	X	X	X	X		
Anna Black	State Agency					X					
Paul Sighinolfi	State Agency				X			X		X	X
Rebecca Morris	State Agency	X	X								
Aaron Turcotte	State Agency								X		
Andre Cushing	State Agency										
Bruce Scott	State Agency						X				
Chris Montagna	State Agency										
Marietta D'Agostino	State Agency						X	X			
Dr. Larry Catlett	Physicians			X	X	X	X		X	X	X
Dr. Nelson Haas	Physicians			X	X	X	X	X		X	
Kevin Ward	Physicians			X	X	X		X			
Meghan Wells	Physicians			X	X	X	X	X		X	X
John Bielecki	Physicians			X							
Dr. Dan Morin	Physicians										
Dr. Howard Jones	Physicians										
Anne Macri	Union		X								
Mary Ann Turowski	Union								X		
Matt Schlobohm	Union										

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