IN THE MATTER OF AN ARBITRATION
UNDER THE *LABOUR RELATIONS CODE*, RSBC 1996 c. 244

Between

INTERIOR HEALTH AUTHORITY

("IHA" or the "Employer")

-and-

HOSPITAL EMPLOYEES' UNION

(the "Union")

(Substance Use Disorder Policy Grievance)

ARBITRATOR:	John B. Hall
APPEARANCES:	Sari A. Wiens and Ilan B. Burkes, for the Employer Lindsay A. Waddell, Heather D. Hoiness, Jonathan Chapnick and Daniel McBain (Articled Student), for the Union
HEARING:	January 30, 31; February 1, 2, 3, 22, 23, 24; March 1, 2; April 3, 4, 5, 6, 7, 13 & 26; and June 22 & 23, 2017 Vancouver, BC
AWARD:	November 13, 2018

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AWARD

I. INTRODUCTION

This proceeding results from a Union grievance challenging a policy implemented unilaterally by the Employer. The policy is titled "Substance Use Disorder". The Union alleges it targets employees with substance use disorders, and singles them out for differential treatment based on stereotypical and highly stigmatizing assumptions. It additionally argues that the policy reflects a fundamentally disciplinary approach to employees with substance use disorders, and treats them as a group without considering their individual circumstances. Moreover, it is said to reach beyond the confines of the workplace and intrude upon the private, personal and medical lives of employees.

For these and other reasons, the Union submits the policy systematically discriminates against employees with substance use disorders and is therefore contrary to the Facilities Subsection Collective Agreement (the "Collective Agreement"). As a consequence, the policy is unreasonable, and represents an arbitrary and harmful exercise of management rights. The Union submits as well that the policy discriminates against employees contrary to Section 13 of the *Human Rights Code* (the "Code") and is unreasonable because:

(a) it singles out employees with substance use disorders or perceived substance use disorders based on the stereotypical assumption that they pose an extraordinary risk to workplace safety while other employees do not;

(b) subjects employees with substance use disorders or perceived substance use disorders to mandatory and/or random invasive testing;

(c) compels employees with substance use disorders or perceived substance use disorders to submit to medical examination by a doctor of the employer's choosing;

(d) compels employees with substance use disorders or perceived substance use disorders to disclose an unnecessary and inappropriate amount of private medical information;

(e) subjects employees with substance use disorders or perceived substance use disorders to searches of their person or personal effects;

(f) subjects employees with substance use disorders or perceived substance use disorders to mandatory and specific forms of treatment; and

(g) imposes financial burdens and negative consequences on employees with substance use disorders or perceived substance use disorders. (Closing Argument, at para. 7)

The Union seeks a declaration that the policy is void *ab initio*, together with a series of declarations specific to the aspects of the policy which it maintains are discriminatory. It additionally seeks an order directing the parties to negotiate a replacement policy, with a reservation of arbitral jurisdiction should the parties be unable to agree on new provisions.

The Employer maintains that the policy complies with current Canadian jurisprudence. It says the components challenged by the Union are not unique and, indeed, are common to virtually all drug and alcohol policies in safety sensitive workplaces (those components such as disclosure obligations, independent assessment by an addictions specialist, abstinence, monitoring and drug tests will all be explored in the course of this award). Based on the recognition that IHA is a safety sensitive workplace, the Employer submits there is no basis to find a violation of the Code or an unlawful exercise of management discretion. In short, it maintains that what the Union seeks through its grievance is nothing short of a fundamental change in Canadian law.

The foregoing introduction is intended to merely frame the broad parameters of the extensive discussion which follows in this award. The Union's allegations and the parties' respective positions in relation to each will be examined more completely below. But before doing so, the factual context must be explained.

II. THE POLICY

The Employer's policy AU0200 is headed "Substance Use Disorder". Various elements will be reproduced in full at the appropriate junctures. For the time being, a summary of the contents will suffice:

- Section 1.0 sets out the Purpose;
- Section 2.0 contains several definitions, including "Substance Dependence" and "Safety Sensitive Positions";
- Section 3.0 describes IHA's policy regarding substance dependence and its belief that "substance dependence is a treatable disease and [IHA] will promote self awareness and voluntary referral for assistance";
- Section 3.1 addresses "Substance Free Workplaces", including the expectation that "all individuals who are employed by or carry out business on behalf of [IHA will] arrive at work fit for duty and perform their assigned duties safely and responsibly without any limitations due to inappropriate use or after-effects of use of alcohol, illegal drugs, medications or other mood altering substances …";
- Section 3.2 is directed to Employee Support and Assistance;
- Section 3.3 is headed Reporting Substance Use and Unsafe Acts, and includes reporting obligations and both reasonable cause testing and post-incident testing for substance use (the latter are not in issue for purposes of the present grievance);
- Section 3.4 concerns Compliance, and advises that violation of the policy and the related guidelines may result in disciplinary action up to and including termination of employment;
- Section 4.0 is a lengthy segment headed Procedures, and lists in turn various Specific Responsibilities for Senior Executives; Directors, Managers, Supervisors and Physician Leaders; Disability Management Specialist (DMS); and Human Resources Business Partner (HRBP); and
- Section 5.0 headed References lists the *Health Professionals Act*, the WorkSafeBC Occupational Health & Safety Regulations and the Procedural Guidelines for the policy.

As just indicated, the Procedural Guidelines for Policy AU0200 are found in a separate document. It is just over 10 pages in length and covers these subjects:

- Purpose
- Definitions
- Procedures
- Signs which may indicate substance abuse
- Action to be taken if a manager or designate suspects an employee at work is impaired or unfit to work
- Subsequent meeting
- Conditions of returning to work for employees with substance dependency diagnosis
- Return to work or last chance agreement
- Resources for assistance
- Self disclosure
- Safety sensitive positions
- Evaluation for substance use/abuse/dependence: safety sensitive positions
- Guidelines for contractors
- Guidelines for medical staff
- Guidelines for volunteers
- Guidelines for students
- Searches

The two agreements referred to in the Guidelines are headed "Return to Work Agreement" and "Return to Work Agreement/Last Chance Agreement". The Employer has a separate template for each, although they are virtually identical. The Return to Work Agreement is to be used for self-disclosure; that is, when employees voluntarily advise the Employer of their substance dependence without any triggering investigation, allegation or concern regarding their conduct. The Last Chance Agreement is to be used

"in all scenarios" except self-disclosure. The only material difference is paragraph 20 dealing with compliance. Under the Return to Work Agreement, breaching any term "will result in disciplinary action up to and including termination of employment". Under the Last Chance Agreement, the same violation "shall result in the employee's termination of employment".

For the balance of this award, I will refer to all of the foregoing documents collectively as "the Policy". Where required by the context, they will be indentified by their individual descriptions.

III. GENERAL BACKGROUND

The Employer is one of the established health authorities in British Columbia and provides a wide range of health care services throughout the Interior of the Province. Its various facilities and worksites range from purely administrative operations to acute care and tertiary hospitals, and include community health services and residential care homes.

The Union has about 8000 members in the Interior region. Of this number, approximately 85% are female and the majority are full-time. They work in a wide range of non-clinical occupations, including clerical, housekeeping, laundry and food services.

The Employer's current organizational structure identifies a Vice-President of Human Resources who is responsible for four departments, two of which are Human Resources Operations and Workplace Health & Safety. Mr. John Bevanda is the Director of Labour and Employee Relations and is responsible for those two departments.

One of the positions within Human Resources Operations is known as Human Resources Business Partner ("HRBP"). The duties of the HSBPs include guiding and advising managers regarding human resources concepts such as the investigation of workplace incidents, interpretation of the Collective Agreement and workplace

accommodations. Grievances which cannot be resolved by HSBPs and proceed to Step 3 under the Collective Agreement are referred to the Labour Relations Centre where there are a number of Labour Relations Specialists supervised by a Labour Relations Team Leader.

The functions of Workplace Health & Safety include disability management, and the department is intended as a confidential link for purposes of receiving employee medical information. Among other duties, Disability Management Advisors ("DMAs") work with employees to ensure they obtain any necessary treatment and facilitate their return to work arrangements.

IV. DEVELOPMENT OF THE POLICY

Ms. Norma Janes has been employed by IHA's Human Resources area for over 17 years and is presently a Labour Relations Specialist. She gave evidence regarding development of the Policy. Although not involved directly at the time, she was asked to assist with its subsequent "roll-out" in June 2013.

It is common ground that the Policy was not promulgated because of any workplace health or safety issues being experienced by the Employer related to employees with substance use disorders. The impetus came instead from an outside consultant, Dr. Paul Farnan, who proposed a "more efficient and proactive approach to [IHA's] addicted employee situations" (this terminology was used by a now retired Labour Relations Specialist who was assigned to lead the initiative). The Employer's representatives met with Dr. Farnan in or around May 2010. By that point, the decision had been made to draft procedures for "dealing with employees with substance abuse" which could later be incorporated into a formal policy.

Various individuals and bodies were consulted in the course of developing the Policy, although the Union was not part of the process. One of the resources was a

labour lawyer who, according to Ms. Janes, gave legal advice "to ensure the policy was consistent with case law". A recommendation to adopt "the *Substance Use Disorder Policy* for use across Interior Health" was presented to the Senior Management Team in a briefing dated September 2012. Portions of the briefing will be reproduced and examined later in this award.

The Policy was approved in May 2013 and, as noted already, implemented in June of that year. The roll-out included training sessions with managers (a transcript was entered into evidence); an email to all employees providing links to AU0200 and the Guidelines (but not to the agreement templates which the Employer says are meant to be individualized); and, an email newsletter to employees providing the same links. Ms. Janes testified that IHA's new hire package includes a policies and procedures booklet; further, all policies are available on its website.

V. APPLICATION OF THE POLICY

A. The Employer's Evidence

Ms. Janes testified about several aspects of the Policy as it pertains to its practical application in the workplace. One area canvassed extensively by the Union in her cross-examination concerned the extent to which positions at IHA are regarded as safety sensitive. Ms. Janes acknowledged the Employer's job descriptions do not indicate whether positions fall within that category; nor is anything mentioned in offer letters sent to employees. While Ms. Janes said it was "not safe" to say all positions are safety sensitive and IHA would not make "a blanket statement", she was not able to identify any situation where the Employer has made a specific or individual determination. The only resource available to assess whether a position is safety sensitive is the Guidelines.

Ms. Janes explained the role of Human Resources when an employee has a potential substance use disorder. If there has been an incident or concern in the

workplace, the HRBP and the manager would be required to investigate, and a Union shop steward would be informed. If there is reason to believe there could be a substance use disorder, the investigation is put on hold and IHA "asks for the employee's agreement to attend an IME with an addictions specialist". If the resulting report advises there is no addiction disorder, then the Employer regards the behaviour as culpable and disciplines accordingly. Where there is a diagnosis of substance use disorder, the investigation remains in abeyance and the focus in placed on the employee taking time away from the workplace doing whatever is recommended for treatment. The time off may be paid if a regular employee has sufficient accrued sick benefits but is otherwise unpaid. Employees who self-disclose are likewise placed on sick leave while they are assessed. In those circumstances, Disability Management will typically advise a Union EDMP steward.

Ms. Janes testified that Human Resources is provided with the information from an IME once the report is received by Disability Management. This includes any diagnosis and treatment recommendations. Before employees are permitted to return to the workplace, there must also be a reassessment by the same addictions specialist. Once those results are received, and assuming clearance to return, the monitoring physician's report and recommendations are incorporated into whichever of the Employer's return to work agreements applies. The HRBPs are responsible for drafting those agreements and they "call a meeting" with the Union and the employee to "ensure everybody understands the terms". It was Ms. Janes' understanding that the employee has the monitoring agreement prior to the meeting and may have the report of the addictions specialist. The Employer does not provide that documentation to the Union but employees "are free" to share the information with their bargaining representative.

Ms. Janes identified the Return to Work and Last Chance Agreements developed by the Employer and explained their use. The former applies where employees self-disclose and there has been no previous discipline or performance issues linked to the workplace. The Last Chance Agreement applies to other circumstances, including where employees have relapsed. Where there has been an apparent breach, the Employer will

investigate to determine “if there was a breach and any mitigating factors”. However, the Last Chance Agreement provides for termination in the event of a breach “and that will occur” subject to the employee’s right to grieve under the Collective Agreement.

Both the Return to Work and Last Chance Agreements provide for regular meetings between employees and their managers, as well as with Disability Management. Ms. Janes stated the purpose of the department meetings is to ensure the employees are “set up for success” and can be supported if there are any difficulties in the workplace or barriers to be removed (I note in passing that this purpose is not recorded in the agreements themselves). She said there is no script for managers to follow as the meetings are intended to be individual and “respectful to the employee”.

At the end of her direct examination, Ms. Janes commented on the feedback she has received from employees who have been diagnosed with substance use disorders and subject to the Policy. She stated she has seen employees who were very angry and in denial go off work for treatment. When they return, they have been “very appreciative” for IHA’s support and proud of their recovery (e.g., advising the Employer on their anniversary of being drug or alcohol free).

Ms. Joan Meidl is one of the Employer’s Disability Management Advisors and has been employed with IHA since 2011. She is a Certified Disability Management Professional and, among other qualifications, has a broad range of experiences in nursing and occupational health. Her prior employment includes roles in a number of safety sensitive workplaces. She has had various assignments within Disability Management depending on the organizational structure in place at the time. For instance, she was at one point responsible for all workplace accommodations under a centralized system and was subsequently assigned in 2016 to a “desk” created to deal with all substance use disorders within IHA.

Ms. Meidl testified in considerable detail regarding the Employer’s procedures for dealing with employees who have, or are suspected of having, substance use disorders.

Permanent employees have benefits (including LTD coverage) provided through the Health Care Benefits Trust which are administered or managed by Great West Life. Where assessment by an addictions specialists is required, the referral is made internally and paid for by GWL. According to Ms. Meidl, GWL typically uses the same five specialists located in the Lower Mainland who are also used by IHA. For employees without benefits (i.e., casuals and those on probation), IHA makes the referral. The cost of an assessment is about $3000 and the Employer looks for funding from the department where the employee was working.

Ms. Meidl stated IHA uses an addictions specialist to assess employees because it wants the "best quality of information" including a detailed report with a clear diagnostic direction for treatment. She added the Employer is seeking a "very specialized assessment" and adopted the characterization of Dr. Els that assessment is "an art". In her view, a general practitioner is not equipped to fulfill this role. In cross-examination, Ms. Meidl agreed the Employer does not speak with a GP in cases of suspected substance use disorder and goes "straight to an IME". This contrasts with other medical situations such as a back injury where the Employer will go back to the person (e.g., the GP or other healthcare provider) who initially sent in the information. In those other situations, the Employer also accepts a GP's recommendations for treatment.

Ms. Meidl described the various steps where Disability Management makes arrangements for an employee to be assessed by an addictions specialist. She said there might sometimes be EDMP involvement but that is often not the case. She goes over the process with the employee to make sure the individual wants to proceed. In her experience, appointments are hard to obtain and she wants to book as soon as possible. The Employer has a list of six specialists who are used based on past experience, including reports received through GWL or the LEAP program applicable to another bargaining unit. Some of the specialists work with the same agency. Ms. Meidl stated she books the appointment with "whoever calls back first with the appropriate time and date" for the employee concerned. Ms. Meidl confirmed in cross-examination that she looks for the first available specialist. She does not communicate to employees that they

have a choice regarding who performs the assessment, although she tells them how she is making the selection.

Some, if not all, of the addictions specialists used by both the Employer and GWL have associated monitoring agencies. For example, Ms. Meidl testified Dr. Baker in Kamloops is affiliated with an entity known as Arbutus although she was not sure of the relationship. Those affiliated agencies may be used for purposes of monitoring under the treatment plans recommended by the specialists where there has been a diagnosis of substance use disorder, although employees apparently have a choice once any benefit coverage comes to an end.

Ms. Meidl was asked in direct examination whether employees have an opportunity to consult with EDMP or the Union before being sent for assessment. She replied EDMP would know if it had been involved, and the Union would be aware if the referral came out of a meeting held to investigate a workplace incident. Ms. Meidl later clarified that she does not contact shop stewards directly and assumed this was done by Human Resources. If she knows a particular shop steward is involved, she will copy the representative on the referral letter. She agreed in cross-examination that EDMP becomes involved after the IME appointment is made and has been copied on the referral letter. Other “stakeholders” are also copied, including Human Resources and the department paying for the assessment.

Travel to and from assessments arranged by IHA is paid for by Human Resources. Employees are not allowed to drive themselves so they must either have a friend or spouse drive, or take public transportation. Many of the assessments are carried out in the Lower Mainland.

Ms. Meidl recounted the typical contents of the resulting IME report. It usually contains a detailed and personal family history based on a verbal interview, along with test results and observations. The summary page sets out any diagnosis and treatment recommendations. If the Employer has asked specific questions in the referral letter, they

are usually answered as well. The report does not ordinarily go to the employee who has been assessed.

Ms. Meidl was asked in both her direct testimony and cross-examination about the types of treatment recommendations she sees flowing for the assessments. Among other things, residential treatment is commonly recommended for employees who have been diagnosed with a substance use disorder, although she knows of situations where the addictions specialist has recommended a dayprogram where the employee is unable to attend residential treatment due to personal circumstances. The Union ultimately elicited admissions that the addictions specialists selected by IHA to perform assessments almost always prescribe residential treatment; always prescribe AA/NA mutual support; usually prescribe complete abstinence; and, always require "robust biological monitoring" for at least two years.

Once employees have completed the period of recommended treatment, they must be reassessed before being allowed by the Employer to return to active employment. This is done by the original IME physician unless that proves impossible.

According to Ms. Meidl, the physicians generally will not do a reassessment until there has been one or two months of compliance (i.e., random testing, attendance at AA and so forth). A copy of the reassessment report is provided to the Employer (including reports from reassessments carried out at the direction of GWL). The employee does not receive a copy unless it is sent to their GP and relayed through that avenue, or a copy is requested under prevailing privacy legislation. Ms. Meidl reiterated that reassessment by an addictions specialist is "absolutely" required in all cases, and made reference to language in the Policy. The recommendations in the reassessment report are sent to various "stakeholders" including an HRBP and an EDMP steward.

The recommendations in a reassessment report typically require an employee to enter into a monitoring agreement with an agency providing the required services (including sending the employee for random drug testing). Ms. Meidl testified she is

only aware of three options in British Columbia, although IHA is not involved in the selection process as it is a contract between the employee and the agency. If an employee wishes to change agencies, Ms. Meidl can provide the contact information. The monitoring agency will have scheduled discussions with the employee to ensure ongoing compliance and to look for "clues" of relapse.

Once the reassessment report is received by the Employer, Ms. Meidl will speak with the employee about the various requirements for returning to the workplace. In some situations, a graduated return to work plan will be put in place and, according to Ms. Meidl, the EDMP steward would be aware of the applicable recommendations. She will draft any return to work plan but the formal return to work agreement under the Policy is drafted by Human Resources. Ms. Meidl attends the return to work meeting called by Human Resources to sign the agreement. She attends by conference call, while a Human Resources representative, a manager, a Labour Relations Officer from the Union and the employee meet in person. Others may attend as well. Ms. Meidl stated that "everyone in the room" has a copy of the return to work agreement (which may be either a Return to Work Agreement or a Last Chance Agreement depending on the circumstances). She said as well that a copy goes to "staffing and payroll". The Human Resources representative goes through all the terms in the agreement and provides an opportunity for questions before it is signed.

The return to work agreements contain a term requiring the employee to "check in" with Disability Management. Ms. Meidl connects with the employee by email and presets meetings one month at a time according to their respective calendars. The employee is responsible for contacting her by telephone. Ms. Meidl stated she has a "template" to use for those calls, but they are not "script[ed] in stone". She elaborated that there are about four or five "superficial" questions such as whether the employee has attended support meetings and other subjects. She asks as well how things are going in the workplace because occupational health is about "removing boundaries" and the meetings are intended to be supportive. The meetings also celebrate achievements (e.g., one year of sobriety) and, in Ms. Meidl's view, are "less policing and more problem

solving". Where a scheduled call is missed, she gives employees about 15 minutes before sending an email with an opportunity to reschedule the session. Ms. Meidl recognizes that "things happen in health care" and so allows this "wiggle room".

Ms. Meidl agreed in cross-examination that part of the monitoring agency's role is to ensure compliance with the recommendations of the addictions specialist. She agreed further that employees are also being "monitored" for compliance through the meetings with Disability Management, as well as through the meetings with their managers (which she agreed "is intended"). When asked whether all of this is necessary, she replied"[It] is not mine to judge". She later sought to differentiate the sessions by explaining the session with the monitor is "more nuts and bolts"; the meeting with the manager is "more department purview"; and, her discussion is "not policing [but] more how are things going".

Ms. Meidl was taken later in cross-examination to a template used by another Disability Management Advisor for a session with one of the Union's members who testified at arbitration. She acknowledged the template contained questions about: whether the employee had abstained from using various substances; the date of the last meeting with an addictions specialist or family physician; the date(s) and results of random testing; and, attendance at support programs such as AA. When it was suggested the meeting with Disability Management serves the same function as the monitor, she steadfastly maintained "they have a different role".

Ms. Meidl was asked a number of questions related to whether IHA is a "safety sensitive" workplace. In direct examination, she recounted receiving calls from IME physicians who have asked or assumed a position is safety sensitive, and her answer has been "yes". She added in cross-examination that she "just refers them to the Policy", having earlier testified that whether a position is "safety sensitive "… is not my determination [and] it is a policy I'm bound to follow in my role". She was unaware of anyone with a substance use disorder who she has been involved with and was not covered by the Policy, and said "it applies in my mind".

B. The Union's Evidence

The Union called four lay witnesses to give evidence regarding application of the Policy. Three of the witnesses were bargaining unit members, and the fourth was the Director of Member Services for Interior Health. By agreement, the names of the employees have been anonymized (the identifiers used do not reflect their last names).

(i) Ms. A

Ms. A has been employed by IHA since 2005 and was a full time Lab Assistant at the time of the arbitration. She has four school-aged children.

Ms. A began a long term disability (LTD) claim in 2013 due to a diagnosed health issue caused by her domestic situation and unrelated to substance use. She had not been disciplined prior to the leave; however, the Employer had documented problems with her attendance beginning in mid-2012 and had issued a fourth "intervention letter" under its Attendance Enhancement Program in late June 2013 shortly before she went off work.

Ms. A was sent for an IME in July 2014 by Great West Life ("GWL") because it perceived she might have a substance use disorder. Ms. A had previously self-referred in 2013 to see a drug and alcohol counselor in her community, and had been charged with driving under the influence in September and November of that year. The doctor performing the IME diagnosed alcohol dependence and recommended "comprehensive primary addiction treatment" including residential treatment followed by a rigorous medical monitoring program. GWL developed a rehabilitation plan based on the doctor's report.

Ms. A's family doctor disagreed with the IME and wrote to GWL. Among other points, the family doctor "strongly" disagreed with the recommendation for residential treatment. At GWL's request, the doctor provided additional information and this resulted in a letter from GWL advising that Ms. A no longer satisfied the definition of

total disability. Further, she did not need any additional treatment, and there were no restrictions or limitations preventing her from returning to work.

After receiving this letter from GWL, Ms. A contacted one of the Employer's Disability Management Advisors. She was subsequently advised that she had to be reassessed by another doctor (the doctor who had completed the first IME was not available) before returning to work. This second IME was paid for by the Employer. Ms. A was not given any choice in the selection of the doctor, and she was assessed by a Dr. Yang in mid-January 2015. According to Ms. A's largely unchallenged testimony, Dr. Yang relied extensively on the original IME and did not perform several of the "Components of the Assessment" identified in the letter she had received confirming the appointment. Ms. A later learned that none of her healthcare providers had been contacted.

Dr. Yang concluded in his report dated January 17, 2015 that Ms. A needed to demonstrate she could sustain abstinence from alcohol and recommended "robust medical monitoring", the components of which were identified in his report. If the monitor confirmed Ms. A had been compliant for an initial four weeks, he advised she could then begin a return to work process.

As a result of the second IME, the Disability Management Advisor arranged an appointment for Ms. A to meet with Dr. Robert Baker who would act as her monitor. She was not told she had any choice in the selection of a monitor. The ensuing Recovery Management Agreement - Distance was signed on February 13, 2015 and reflected Dr. Yang's recommendations along with additional terms. The monitoring agreement was, in turn, incorporated into a Last Chance Agreement which was signed on March 24, 2015. Ms. A testified that neither she nor her family doctor agreed with Dr. Yang's recommendations. However, she signed the Last Chance Agreement because she would otherwise not be allowed to work.

Ms. A gave detailed evidence regarding the terms and impacts of the monitoring agreement. They were accurately summarized by the Union as follows:

> … attend 3 AA meetings per week; counseling twice a week; check-in with Dr. Baker's office once per week; meet with her family physician regularly; keep track of all her appointments; not take any medications except Advil and Tylenol for two years; not eat certain foods, including anything containing poppy seeds, and; submit to random biological testing twice per month. (Closing Argument, at para. 123)

The cost of the medical monitoring was borne by Ms. A and was raised at one point to $150 per month. She stated this is "a lot for me" given her income. There were times she could not afford to pay the amount; at other times, the money would have been used to put her kids in swimming lessons. In addition to the "financial burden", Ms. A spoke to the "extra stress" caused by attending to monitoring requirements on her own time. She has needed to arrange daycare for her children and has missed some of their appointments. Her family doctor wrote the Employer and Dr. Baker in June 2016 requesting they "cease and desist in the enforced medical monitoring" because of the increased stress. There is no evidence of a reply from the Employer and Dr. Baker advised his role was to "implement [Dr. Yang's] recommendations not to develop them".

At the time of her testimony, Ms. A had been fully compliant with the Last Chance Agreement and there was about one month remaining until it ended.

(ii) Ms. B

Ms. B was hired by IHA in late 2013 and worked as a casual employee in various positions. She has not been called for work since May 2015 because she has not satisfied the Employer's conditions for returning to work following an IME by Dr. Baker.

Ms. B was off work in April 2015 while she attended a detox centre in Kamloops (she lives in another British Columbia community). She testified that she had been drinking due to "a very personal breakdown" and went to see her family physician for

help. She also saw a local counselor who directed her to the detox centre. At the time, Ms. B's physician provided medical notes indicating she was "unavailable to work for an undetermined amount of time due to medical reasons". When pressed in cross-examination, Ms. B acknowledged she had been missing shifts at work due to being hung over. However, she had not been directed or placed on the IHA attendance management program. Ms. B admitted she had not disclosed her alcohol problem to the Employer, explaining: "You don't want to tell anyone that - it's embarrassing".

Ms. B did, however, disclose her attendance at the detox centre when contacted by a Disability Management Advisor about her absence after she returned to work in mid-May. She also disclosed that she had previously been drinking between 13 and 26 ounces of liquor per day but said she had not consumed any alcohol since April 26. The Disability Management Advisor said that she would need to speak with a supervisor. Ms. B was by this point attending AA; she was also continuing to see the counselor and her family doctor who had cleared her return to work.

Ms. B next heard from another Disability Management representative who said she was being placed on administrative leave and would need to see an addictions specialist according to the Policy. The Employer made an appointment for Ms. B to see Dr. Baker on May 29. She was notified of the appointment by two Disability Management representatives via telephone call and was not given the opportunity for Union representation. However, she did speak the next day with a Union representative who sent an email to IHA advocating that the referral be "rescinded" and Ms. B be returned to work without loss of pay. The request was discussed by the Employer internally and it was agreed Ms. B should attend the assessment "in accordance with policy".

Ms. B and her husband drove to Kamloops for the assessment which Ms. B described at arbitration as "terrible". She testified that she felt really "bullied" and was asked "uncomfortable questions" such as whether she had ever cheated on her husband. At the end of the session, Dr. Baker asked her to sign a monitoring agreement. Ms. B

stated she did so under "duress". If she did not sign at that point, she would either have to return to Kamloops at a later date to sign or Dr. Baker would tell IHA not to let her return to work.

When Ms. B returned from Kamloops she spoke again with the Union representative and asked to use her own doctor for the monitoring because she felt so "violated" by Dr. Baker. She made the same request directly to Disability Management in early June. According to a record of the telephone discussion, she felt the monitoring program was degrading; did not like Dr. Baker; and, did not want to pay him for the monitoring (he was charging $250 per month).

Dr. Baker's report was received towards the middle of June. He diagnosed Ms. B with "severe substance use disorder, alcohol dependence", and would have referred her for "extensive residential treatment followed by a comprehensive aftercare plan" in an "ideal world". However, he recognized she did not have benefits as a casual employee and proposed a plan with three components: regular attendance at 12 step recovery meetings; regular continued involvement with the counselor; and, regular weekly involvement with a relapse prevention group. He regarded Ms. B as "medically unfit to return to work at this time".

Ms. B did comply with the monitoring requirements for about one month. This consisted of telephoning Dr. Baker's office and speaking with the receptionist who asked "what she had done during the week, how many AA and mental health meetings she had been to, if she was getting exercise, and if she had found a sponsor". She also submitted to random biological tests which were all negative. At the end of the first month, Ms. B decided she did not want to continue with the monitoring (although she was prepared to be monitored by her own doctor) and telephoned Dr. Baker's office to advise of this decision. She has since found other employment, although at lower wages than her position with IHA.

(iii) Ms. C

Ms. C was hired by IHA in 2013 and was employed as a permanent part-time Food Service Worker at the time she testified. She had never been disciplined by the Employer or received anything other than positive feedback for her job performance.

Ms. C telephoned her supervisor in February 2016 to request time off because she was struggling with alcohol and felt she needed assistance; i.e., she self-disclosed. The supervisor said she would convey the information to the manager who called Ms. C the next day. The manager advised that Ms. C was to see an assessment doctor in Kamloops, and that she was to stay off work with pay for the three days left on her rotation.

Ms. C spoke with Ms. Meidl the following week. After receiving additional information from Ms. C, Ms. Meidl explained the role of Disability Management in assisting with treatment and recovery, and advised of "next steps" starting with an IME and treatment recommendations. Ms. Meidl also advised of IHA policy regarding substance use and the need to have a recovery and monitoring plan, likely for a period of two years.

Although eligible, Ms. C was not enrolled in the Employer's health benefits because she was on her former husband's plan. As a result, and in order to expedite the process, Ms. Meidl did not follow the ordinary practice of having Great West Life arrange an assessment with an addictions specialist and, instead, arranged an appointment for Ms. C on her own. The appointment was made with Dr. Baker in Kamloops because he had openings about 10 days later. One of the Union's EDMP representatives where Ms. C worked was copied on the referral letter but there was otherwise no Union representation. The assessment was paid for by the department at IHA where Ms. C was working.

Ms. C gave evidence regarding what transpired during her assessment by Dr. Baker which she said lasted 1 ½ hours (the referral letter estimated the session would take

3-4 hours to complete). Dr. Baker's ensuing report bears the same date as the assessment, although it was apparently not forwarded to the Employer until about two weeks later. A short letter conveying a diagnosis of "substance use disorder - alcohol" was sent to Ms. Meidl three days after the appointment, along with the opinion that Ms. C was not fit to return to work and required "intensive residential intervention". The only documentation reviewed for purposes of the IME was the letter of instruction prepared by Ms. Meidl and it did little more than indicate Ms. C had self-disclosed her struggle with alcohol. Although Ms. C additionally told Dr. Baker about her feelings of depression and anxiety (and diagnoses were made regarding depressive disorder and anxiety disorder), no treatment reconsiderations were made in relation to those issues. The recommendations in the final assessment report included attendance at a suitable residential treatment facility which "stress[es] abstinence and a 12-step program of recovery" for a minimum of 28 to 42 days. The report also attached an example of "an acceptable contract" for an after-care period of not less than 36 months, and stated that a "re-evaluation prior to return to a Safety Sensitive/Critical position *may* be indicated" (italics added).

The 45-day residential treatment was arranged by GWL and completed successfully by Ms. C. Prior to being discharged, she was told that she would need to enter into a monitoring agreement with Alliance Medical Monitoring. The comprehensive agreement was signed in the middle of June. Ms. C inquired immediately of Ms. Meidl whether she could return to work, and was told there must first be a re-assessment by Dr. Baker. The appointment was arranged for mid-July and, after receiving clearance. Ms. C again contacted Ms. Meidl as she was eager to return to work. She was told in early August that the next step was "drawing up a Return to Work Agreement and having all the parties meeting to sign off on it". This was eventually arranged for the third week of August.

Ms. C had expressed a concern to Ms. Meidl in early August about the cost of monitoring through Alliance (about $800). This was being paid at the time by GWL but her claim would be closed at the end of August. Ms. Meidl provided her with the

telephone numbers for two alternate monitoring agencies, and she ultimately selected Arbutus Work Solutions which charged $150 per month. She began paying that amount after her coverage with GWL ended.

The Return to Work Agreement prepared by the Employer was reviewed at a meeting on August 24. Ms. C learned for the first time that the monitoring period would be 36 months, and not 24 months as she had previously been led to believe. A Union shop steward and EDMP representative were at the meeting; there were three management representatives, including her direct supervisor, as well as representatives from Disability Management and Human Resources.

Ms. C identified some of the terms in the Return to Work Agreement and described their impact. Among other requirements, she finds the testing "embarrassing" and "shameful" because it is done at a lab run by IHA and she knows the women who work there. This and other requirements must be completed on her own time. She "checks in" with her supervisor regularly -- something which is required by the Return to Work Agreement but not the monitoring agreement. She also calls a Disability Management Advisor at specified times (initially bi-weekly and then monthly) to canvass a number of subjects such as her AA attendance.

Ms. C elaborated on the impacts of being subject to the IHA Policy. They include being "super stress[ed]" and "so scared" of being non-compliant over things such as the timing of check in telephone calls, to the point where she could not sleep and her hair was falling out. There were also significant financial costs due to the loss of income while she was off work and later having to pay for the on-going monitoring. She was unable to get a second job to help cover the monitoring and had to access the local food bank. In terms of emotional impacts, Ms. C characterized her anxiety as "through the roof" and said her relationship with a boyfriend could not be sustained because of travel limitations imposed by the testing through Arbutus (all of which had been negative). The record indicates that some, but not the majority, of these impacts were conveyed to Disability Management.

Before the arbitration concluded, an Employee witness confirmed that Ms. C had decided to resign from her position with IHA. The resignation was due to the demands of the Return to Work Agreement and, more specifically, the monitoring.

(iv) Barb Lemky

As indicated, Ms. Lemky is the Director of Member Services for the IHA. She testified that over 30 of the Union's members have been subject to the Policy since it was implemented. A number of individual grievances have been filed which are being held in abeyance pending the outcome of this arbitration.

Ms. Lemky compiled the data which was used to prepare documents tendered by the Union showing the prevalence of various terms in Return to Work Agreements and Return to Work/Last Chance Agreements which members have been required to sign before returning to the workplace after being diagnosed with a substance use disorder. She testified in direct examination that all of those Agreements have required: abstinence; monitoring (most for a period of 24 months) based on the same specific requirements; attendance at AA or NA meetings through incorporation of monitoring agreements; and, regular meetings with department managers and a Disability Management Advisor. Further, employees subject to those Agreements must report unscheduled and unanticipated absences directly to their manager (as opposed to dialing an automated line used by other employees to report absences), and must stop working immediately if there is evidence of a relapse.

Ms. Lemky was challenged in cross-examination regarding the universality of terms in the Return to Work and Last Chance Agreements. There were admittedly some differences. For instance, some abstinence clauses made allowance for over-the-counter medications and there were differences in language resulting from the agreement with the applicable monitoring agency. By way of another example, a few Agreements did not refer specifically to AA or NA; however, such could be inferred based on requirements in

the monitoring agreements to keep a meeting log and have a same-sex sponsor. Ms. Lemky also conceded that not everything in the two templates was included in all of the Return to Work and Last Chance Agreements which she had reviewed.

That said, there is a striking commonality between all of the 21 Agreements placed in evidence. To the extent there are variations, they relate more to the wording (i.e., the language may not be identical) than to the substance and effect of the clauses. The cumulative effect is that the templates are in practice an almost invariable checklist of the substantive terms and conditions found in the Agreements prepared by the Employer.

This leads to another important area of Ms. Lemky's testimony. She stated that the first time the Union sees an Agreement is when it is called to attend a meeting with Employer representatives and the affected member in order to sign the document. According to Ms. Lemky, "it's not a draft and we don't get any medical information". The Union is handed the Agreement and told to sign in the space provided. If it does not sign (or, on some occasions, when the Union has purported to sign "without prejudice" to its position regarding the Policy), the member will not be returned to work. Contrary to directions found at three places in AU0200, Ms. Lemky testified there is no "collaboration" with the Union to develop Return to Work and Last Chance Agreements.

It was suggested to Ms. Lemky in cross-examination that the meeting called by the Employer was an opportunity to raise any specific areas of disagreement with provisions in an Agreement. She replied in part by indicating that the Union disagrees with the Policy from which the Agreements are derived, and that is why it has grieved. In response to the more specific suggestion that the Union could object if there was a discrepancy with the terms of a monitoring agreement, she stated those agreements are not provided to the Union; nor does the Employer provide details beyond saying the member has a substance use disorder and there is no "exchange of information". Ms. Lemky ultimately explained that the Union signs (and tells its members they can grieve)

because "the member needs to go to work" and it is "more harmful if the member does not return to work".

It was Ms. Lemky's further evidence that the Union is not notified when a member is placed on administrative leave because of a substance use disorder or a suspected problem in that regard; nor is it notified when a member is sent to an addictions specialist. Rather, as indicated, the Union only becomes aware a member is engaged in the Policy process at the point when the Employer wants the Return to Work or Last Chance Agreement signed.

The Employer does, however, provide notice to an individual known as the EDMP Steward when an employee is referred for an IME (and, this occurred in the circumstances of the three employees canvassed above). Ms. Lemky referred to a Memorandum of Agreement between HEABC and the Facilities Bargaining Association in their Collective Agreement concerning the Enhanced Disability Management Program ("EDMP") and its associated Policies and Procedures. The Union has EDMP Stewards who are recruited from its membership for 24 month terms. It is clear from the documentation that their role is to represent and assist members who have accessed that program. Ms. Lemky was emphatic that they are restricted from labour relations by both the Union and HEABC; that is, they are not to represent members in labour relations issues at the worksite. She elaborated in cross-examination that EDMP Stewards are not Union-designated representatives for purposes of the Collective Agreement. Further, they are not permitted to share medical information with Shop Stewards or other Union representatives as that would be a "gross breach of confidentiality".

VI. EXPERT EVIDENCE

The parties called a total of six witnesses as experts. The individuals called by the Union were, in order:

Dr. Christy Sutherland - Dr. Sutherland is a family doctor who specializes in addictions medicine. She is certified by the American Board of Addiction Medicine (ABAM) and is a clinical professor in the Faculty of Medicine at the University of British Columbia. Her principal employment is Medical Director of the Portland Hotel Society. Dr. Sutherland was called to provide evidence on the role of family physicians in diagnosing and treating substance use disorders, as well as alternatives to abstinence-based treatment approaches.

Dr. Karen Urbanoski - Dr. Urbanoski is employed by the Centre for Addiction Research of British Columbia, and has a doctorate degree from the Dalla Lana School of Public Health at the University of Toronto. She is an epidemiologist who specializes in the study of alcohol and drug use and addictions, with specific emphasis on the study of coercion and mandated treatment. She was called by the Union to opine on the effectiveness and appropriateness of the Policy; the potential negative consequences of the Policy; and, potential alternatives to the Policy.

Dr. Scott Macdonald - Dr. Macdonald is a social epidemiologist and biostatistician, and is presently the Assistant Director with the Centre for Addictions Research at the University of Victoria. He has published and taught extensively regarding substance use and various types of outcomes, and is an experienced expert witness. Dr. Macdonald was called to give evidence in this proceeding on, among other subjects: the relationship between employee substance use disorders and workplace injuries; the distinction between substance use and substance-related impairment; and, the relationship between substance dependence and on-the-job use, impairment and safety outcomes.

Dr. Jamie Livingston - Dr. Livingston is an Assistant Professor in the Sociology and Criminology Department at Saint Mary's University in Nova Scotia, as well as an Adjunct Professor in the School of Criminology at Simon Fraser University in British Columbia. His doctorate from the latter institution is in the fields of philosophy and criminology. The Union called Dr. Livingston as an expert in stigma as it relates to mental health and substance use problems. He was asked to opine on whether the Policy promotes stigma against employees with substance use disorders.

The two expert witnesses called by the Employer were, in turn:

Dr. Mace Beckson - Dr. Beckson is a psychiatrist and is certified as an addictions specialist by ABAM. He is currently the staff psychiatrist for the Substance Abuse Treatment Programs of Veterans Affairs in the Greater Los Angeles Healthcare System and additionally has a private practice in addiction psychiatry. He has authored and co-authored chapters in various textbooks concerning substance abuse, as well as risk assessment and management. Broadly speaking, Dr. Beckson's testimony was directed to his opinion on impairments caused by the use of alcohol and other drugs, as well as the risks associated with substance use in a safety sensitive workplace.

Dr. Charl Els - Dr. Els is a psychologist who holds various credentials, including certifications as an addictions specialist by ABAM as a Medical Review Officer by the MRO Certification Council. Current appointments include that of Associate (Clinical) Professor in both the Departments of Psychiatry and Medicine at the University of Alberta. His testimony addressed a number of subjects, including: what constitutes a "safety sensitive" workplace; the diagnostic criteria in the former DSM-IV and the current DSM-5; diagnosing substance dependency and comprehensive independent assessments (which also addressed "dual agency" concerns); medical treatment plans; and, the components of return to work agreements.

I do not intend at this stage to recount the expert testimony, primarily because substantial portions were eventually not relied on in final argument by either party; even less has factored into the various determinations required to address the issues raised by the grievance. Those portions of the expert testimony which have been of assistance during my deliberations will be recounted where relevant to the analysis.

That said, I have determined that none of the expert testimony should be rejected outright as was argued by both parties in respect of at least some of the other's witnesses. At the same time, there are plainly questions of weight to be afforded the evidence given

the respective fields of expertise and relative experience of the witnesses regarding the matters at issue in this proceeding. Where relevant, I have been most comfortable relying on the testimony of Dr. Els, although the Union's submissions raised a potential obstacle based on certain events which occurred prior to completion of his Final Report. An exploration of those arguments can fortunately be avoided by relying on his Draft Report which was also placed on the record and is not subject to the same challenges.

VII. THE GENERAL LEGAL FRAMEWORK

It has been authoritatively determined that arbitrators have "not only the power but the responsibility" to apply human rights legislation: *Parry Sound (District) Social Services Administration Board v. O.P.S.E.U., Local 324,* 2003 SCC 42, at para. 40. Under Article 4.01 of the present Collective Agreement, the parties have expressly subscribed to the principles of the Code. Section 13 of the statute provides:

> 13 (1) A person must not
>
> (a) refuse to employ or refuse to continue to employ a person, or
>
> (b) discriminate against a person regarding employment or any term or condition of employment
>
> because of the … physical or mental disability … of that person[.]
>
> *   *   *
>
> (4) Subsections (1) and (2) do not apply with respect to a refusal, limitation, specification or preference based on a bona fide occupational requirement.

In order to make out a violation of Section 13, the Union must first establish a case of *prima facie* discrimination. That threshold will be met if persons with a characteristic protected from discrimination under the Code experience an adverse impact with respect to their employment, and the protected characteristic is a factor in the

adverse impact: *Moore v. British Columbia (Education),* 2012 SCC 61, [2012] 3 SCR 360 ("*Moore*"), at para 33.

Once a *prima facie* case of discrimination has been established, the onus shifts to the Employer to demonstrate that the standard constitutes a *bona fide* occupational requirement ("BFOR"). This requires the Employer to justify the impugned standard by satisfying the three-step test in *British Columbia (Public Service Employee Relations Commission) v. BCGSEU*, [1999] 3 SCR 3 ("*Meiorin*"), on the balance of probabilities. Namely:

> 1. That the employer adopted the standard for a purpose rationally connected to the performance of the job;
>
> 2. That the employer adopted the particular standard in an honest and good faith belief that it was necessary to the fulfillment of that legitimate work-related purpose; and
>
> 3. That the standard is reasonably necessary to the accomplishment of that legitimate work-related purpose. To show that the standard is reasonably necessary, it must be demonstrated that it is impossible to accommodate individuals sharing the characteristics of the claimant without imposing undue hardship. (para. 54)

With respect to the first step, the Court explained in *Meiorin* that the focus is not on the validity of the particular standard in issue, but rather on the validity of its more general purpose:

> The focus at the first step is not on the validity of the particular standard that is at issue, but rather on the validity of its more general purpose. This inquiry is necessarily more general than determining whether there is a rational connection between the performance of the job and the particular standard that has been selected, as may have been the case on the conventional approach. The distinction is important. If there is no rational relationship between the general purpose of the standard and the tasks properly required of the employee, then there is of course no need to continue to assess the legitimacy of the particular standard itself. Without a legitimate general purpose underlying it, the standard cannot be a BFOR. In my view, it is helpful to keep the two levels of inquiry distinct. (para. 59)

The first step assesses objectively whether there is a rational connection between the general purpose of the standard and performance of the job. As stated in *Meiorin*, where the general purpose is to ensure safe and efficient performance of the job, it will likely not be necessary to spend much time at this stage (para. 58). The second step addresses the subjective element of the test “which, although not essential to a finding that the standard is not a BFOR, is one basis by which the standard may be struck down” (*Meiorin*, at para. 60). If the standard was not thought to be reasonably necessary or was motivated by discriminatory animus, then it cannot be a BFOR. At that point, the analysis shifts from the general purpose of the standard to the particular standard itself under the third step of the test. In this regard, the relevant considerations “should be applied with common sense and flexibility in the context of the factual situation presented in each case” (*Meiorin*, at para. 63).

The Union also invokes the *KVP* test which limits the unilateral exercise of management rights: see *Re Lumber and Sawmill Workers’ Union, Local 2537 and K.V.P. Co. Ltd.* (1965), 16 LAC 73 (Robinson). This seminal authority holds that a rule introduced by an employer without the union’s agreement must satisfy the following requisites:

> 1. It must not be inconsistent with the collective agreement.
>
> 2. It must not be unreasonable.
>
> 3. It must be clear and unequivocal.
>
> 4. It must be brought to the attention of the employee affected before the company can act on it.
>
> 5. The employee concerned must have been notified that a breach of such rule could result in his discharge if the rule is used as a foundation for discharge.
>
> 6. Such rule should have been consistently enforced by the company from the time it was introduced. (para. 34)

The only *KVP* requirement raised by the Union's grievance concerns the reasonableness of the Policy.

In dealing with unilaterally imposed rules or policies which negatively impact on employee privacy, arbitrators have used a "balancing of interests" approach. It was explained by one of Canada's leading arbitrators in *Canadian National Railway and CAW-Canada* (2000), 95 LAC (4th) 341 (M. G. Picher), where he wrote in part:

> … Without exception, boards of arbitration, striving to be responsive and pragmatic in the face of workplace realities and genuine concerns for safety, have opted for the balancing of interests approach. In this Arbitrator's view that is the preferable framework for a fair and realistic consideration of the issue of drug and alcohol testing in the workplace generally, most especially in an enterprise which is highly safety-sensitive. While the time-honoured concept of the sovereignty of an individual over his or her own body endures as a vital first principle, there can be circumstances in which the interests of the individual must yield to competing interests, albeit only to the degree that is necessary. The balancing of interests has become an imperative of modern society: it is difficult to see upon what basis any individual charged with the responsibilities of monitoring a nuclear plant, piloting a commercial aircraft or operating a train carrying hazardous goods through densely populated areas can challenge the legitimate business interests of his or her employer in verifying the mental and physical fitness of the individual to perform the work assigned. Societal expectations and common sense demand nothing less. (para. 185)

The balancing of interests approach was affirmed more recently by the Supreme Court of Canada in *Communications, Energy, and Paperworks Union of Canada, Local 30 v. Irving Pulp & Paper Ltd.,* 2013, SCC 34 ("*Irving*"), where the issue was random drug and alcohol testing in a safety sensitive workplace.

A substantial body of case law has been developed over the years by arbitrators, tribunals and the courts regarding the components of drug and alcohol policies, as well as an employer's obligation to accommodate employees with what are now referred to under DSM-5 as substance use disorders. In a safety sensitive or dangerous environment, the underlying premise of such policies is that employees with untreated substance

dependency problems, or those who have relapsed, present a risk to the workplace. Therefore, and in contrast to the threshold for implementing random drug and alcohol testing, Arbitrator Taylor held in *IWA-Canada and Weyerhaeuser Co.* (2004), 127 LAC (4th) 73 ("*Weyerhaeuser*"):

> I also accept the Company's submission that an industry such as this where safety is clearly a justifiable concern, requiring proof of a substance abuse problem in the workplace as a pre-condition to the introduction of a substance abuse policy, could have the effect of denying to the Company the utility and effectiveness of any safety improvement, deterrence or information that could be obtained from a testing policy for drugs and alcohol. The practical fact is that such evidence is difficult to adduce. Substance users and abusers are secretive, many are in denial. The natural tendency is to enable it, not to report it. (para. 130)

In general terms, drug and alcohol policies are designed to address substance use and/or impairment in the workplace. They are additionally intended to ameliorate the risks occasioned by having employees with substance dependency problems work in safety sensitive positions. The typical features of policies such as that found in *Weyerhaeuser* (see especially paragraphs 13 & 14) are now widely regarded as satisfying scrutiny under the *Meiorin* human rights analysis. The consequence is that grievances within the usual framework are more often advanced under the *KVP* analysis (e.g., whether a particular facet of a policy is a reasonable infringement on privacy rights under the balancing of interests approach).

As recorded already, the Union advances a far more fundamental challenge in this proceeding. It maintains the Policy is targeted at a specific group (i.e., persons with substance use disorders which is a mental disability protected under the Code) instead of being directed at "alcohol or drug use or impairment in the workplace, more broadly" (Closing Argument, at para. 375). It says this distinguishes the Policy from other workplace regimes which properly address operational safety concerns related to substance use. Given the Union's position and the Employer's countervailing arguments in support of the Policy, it will be necessary to consider the various provisions at issue from both the human rights and the *KVP* perspectives. That said, at the end of the day,

the common element to both avenues of inquiry is a variant of the reasonableness standard.

VIII. APPLICATION OF THE LAW AND ANALYSIS

In this case, several elements of the human rights analysis can be addressed in relatively brief terms.

I am satisfied that the Union has made out a case of *prima facie* discrimination. Employees with substance use disorders (a protected characteristic) are affected by the Policy; they suffer an adverse impact such as the intrusive invasion of personal privacy through biological testing; and, the protected characteristic is a factor in the adverse impact. Nor do I understand the Employer to be disputing seriously (if at all) these threshold elements.

The inquiry thus moves quickly to the *Meiorin* requirements. The Union submits the Employer must lead evidence capable of satisfying each aspect of the test, and that impressionistic or anecdotal evidence will not suffice: *Willoughby v. Canada Post*, 2007 CHRT 45, at para. 64; and *Meiorin*, at para. 79. In terms of the evidentiary burden, the Union asserts in its written argument that the Employer has provided no evidentiary basis to establish that health care is an inherently safety sensitive industry, and the Union makes no such concession (Closing Argument, at para. 361).

The difficulty faced by the Union with this and related submissions is the "clarification" of its position provided on the second day of the hearing after opening statements and before any evidence was called. In response to the Employer's opening position that health care is safety sensitive, the Union acknowledged there are safety sensitive aspects to the industry, although it did not concede that "everything" is safety sensitive. The Employer was understandably surprised by the Union's change of position in final argument and I find it came too late in the day. In any event, there is sufficient

material on the record before me to establish the safety sensitive nature of health care generally. The Employer points to, among other sources: the testimony of Dr. Els (see also his Draft Report at pages 9-10 of 54); the ASAM Criteria for safety sensitive occupations (which refer to "health care professional"); and, the decision of the Labour Relations Board in *HEABC -and- HEU et al* (2002), 87 CLRBR (2d) 70 (see, in particular, paragraph 48). No evidence to the contrary was proffered by the Union and, regardless, it cannot resile from its initial acknowledgement regarding the nature of health care generally.

Therefore, the remaining analysis will proceed on the basis that aspects of the Employer's operations covered by the Policy are safety sensitive. It necessarily follows that my determinations with respect to the allegations made by the Union under the grievance apply only to employees who occupy safety sensitive positions. However, in accordance with a preliminary ruling, I am not making any determination as to whether specific positions are safety sensitive. And, while the exact parameters have not been identified, the Employer does not claim that all positions are safety sensitive.

My preliminary ruling of January 18 proceeded to indicate that the definition of what constitutes a "safety sensitive position" had not previously been placed in issue through the Union's particulars. This question was nonetheless addressed squarely by counsel in final argument and it is appropriate to provide an answer. The definition of "Safety Sensitive Positions" in AU0200 reads:

> Positions that Interior Health determines have a role in the operation where impaired performance could result in: i) a significant incident affecting the health and safety of employees, patients, public, medical staff, volunteers, students, contractors or their employees; ii) damage affecting the reputation of Interior Health, property or the environment. This includes all employees who are required to rotate through or regularly relieve in safety sensitive positions. Supervisors and Managers who directly supervise employees in safety sensitive positions or who may perform the same duties or exercise the same responsibilities are considered to be in safety sensitive positions.

The Guidelines contain the same definition at page 2, and list various examples on pages 7-8 of occupations which "are determined to be safety sensitive under this policy and guidelines". The list is not exhaustive. The evidence indicates that the Employer does not have a process to determine what is, or is not, a safety sensitive position. Ms. Janes testified that she was not personally aware of any determination under the Policy as to what position(s) are safety sensitive. The overall impression is that the Employer effectively treats all positions as being safety sensitive.

The Union submits a safety sensitive position at law is one in which an employee's performance limitations "could result in a significant incident or accident causing fatalities or serious injury, significant property damage or significant environmental damage", and cites various authorities, beginning with *Milazzo v. Autocar Connaisseur Inc.*, 2005 CHRT 5, at para. 36. It submits that, by extending the definition of safety sensitive beyond the scope of what is recognized in the case law, the Employer extends the Policy's most burdensome provisions to all employees with substance use disorders. In this regard, it points to, among other things, paragraph 3.1.4 of AU0200 which requires the disclosure of problems within the past six years. The Union submits the Employer's definition of what it considers to be safety sensitive positions is overly broad on its face, and encompasses every position regardless of the specific job duties or the particular work environment (Closing Argument, at para. 388). (In fact, the disclosure obligation is narrower, and is directed to "*dependency* problems involving alcohol or drugs within the past six years" and further defines "past dependency problems" as meaning "problems that have been diagnosed by qualified persons and have triggered a treatment program that has been successful to the point that the dependency problem has gone into remission").

The Employer maintains the authorities cited by the Union do not stand for the proposition that safety sensitive must be defined in the same manner. In any event, it notes the Policy definition resembles closely that advocated by the Union, and differs in only two substantive respects: it refers to a potential impact on "health and safety" instead of "fatalities or serious injury"; and, it includes positions that could cause

potential damage to the "reputation" of IHA. The Employer submits both of these differences arise from its responsibilities as a health care provider to the public and the associated public trust. The latter was addressed in *Baptist Housing Society (Grandview Towers) and HEU, Local 18*0, [1982] BCCAAA No. 497 (Greyell):

> ... In this industry arbitrators are required to have regard not only to the interests of the grievor and of the employer but also must have regard to the public interest. *Both employer and employee are reposed with a public trust for which they are held accountable*.
>
> *The public trust is onerous. In broad terms it is a charge of responsibility for the physical and emotional comfort of a member of our society who is unable to live independently*. The institution and no less its employees, in addition to regular duties assume a role which may best be described as similar to that of a "surrogate" family. This is particularly so in a facility such as Grandview which strives to be a "home" for elderly residents. ... (paras. 24-25; italics added)

I agree with the Employer's submissions regarding the definition in the Policy. The authorities cited by the Union do not establish a definitive formula for what constitutes a safety sensitive position, and any definition must be tailored to the context. I find the definition in question is reasonable. In this regard, and independent of my decision, I note the definition of "Risk Sensitive Positions" in the Alcohol and Drug Use policy at Fraser Health Authority is virtually identical to the Policy definition. The Union introduced this document (it was marked for identification) and explained it had been obtained from the FHA website. Whether the definition in the Policy has been applied properly by the Employer to the designation of specific positions is not, as indicated, a matter being addressed in this award.

In light of the Union's concession on the second day of the hearing (i.e., that aspects of the health care industry are safety sensitive) it is not necessary to address a number of its submissions, particularly as they relate to the first and second steps of the *Meiorin* analysis. Moreover, as stated by the Supreme Court, where the general purpose of the standard is to ensure the safe performance of the job, it is not necessary to spend much time at the first stage. While the impetus for the immediate Policy may well have

come from an outside consultant, the primary document on its face demonstrates the required rational connection:

> 1.0 PURPOSE
>
> To assist in protecting patients/residents/clients, employees, medical staff, volunteers, students and the public from the potential adverse effects of the inappropriate use of alcohol and drugs.
>
> To encourage and support employees to take steps to resolve their medical or health conditions that might put those in the workplace at risk.
>
> To enable employees with substance use disorders to get well. Interior Health will support the rehabilitation and return to work of employees and medical staff who are experiencing difficulties with substance dependence.

These purposes were confirmed by Ms. Janes in her testimony. Additionally, and as is often the case in a safety sensitive workplace, the Policy is directed in part to risk management. The Executive Summary seeking approval to adopt the Policy provided:

> Purpose To protect patients/residents/clients, employees, medical staff, volunteers, students and the public from the adverse effects of the inappropriate use of alcohol and drugs. To ensure that the workplace remains free from adverse health effects. To provide education and direction on early detection, intervention and rehabilitation initiatives.
>
> * * *
>
> 1. If a Substance Use Disorder policy is not in place giving clear direction to employees, IH could be held responsible and liable for the adverse effects on patients and others due to the actions of individuals employed by, or carrying out business for, IH who are inappropriately using alcohol or drugs.
>
> 2. Patient safety, as well as the safety of those in the workplace, is at risk if employees and medical staff who inappropriately use alcohol and drugs are permitted to continue working without addressing their

> condition and actions. The policy and subsequent guidelines provide direction on how to address their health condition.
>
> 3. Under the above process, if the employee or medical staff breaches the safeguards that the employer has put in place, the employer is better able to prove to an arbitrator and/or third party tribunal that the resulting disciplinary action, including termination, was warranted. In this way, terminations and other disciplinary actions due to substance misuse are more likely to be upheld, and the arbitral consequences are less costly.

I note in passing that the third-numbered paragraph potentially lends support to the Union's complaint that the overall thrust of the Policy is "disciplinary" in nature, and will return to that concern below. I am otherwise satisfied that there is a rational connection between elements of the Policy in issue (such as medical assessment and random testing in certain circumstances) and the legitimate objective of protecting workplace safety.

The Executive Summary also provides evidence that the Policy was adopted in good faith in order to address substance use disorders in the workplace. The background section explains in part:

> With the centralization of Labour Relations Services, the department has observed an increase in the number of employees who present with Substance Use Disorder behaviour. In many cases, employees are being, or have been, terminated for disciplinary action, such as theft of drugs, when they or their union disclose a substance use addiction and request an accommodation due to this disability.
>
> BC Human Rights legislation has identified these addictions as a disability. The impact the disability has on the disciplinary action taken by the employer depends on the circumstances of the case. The approach taken in accommodating this disability depends on the circumstances and past history, as well as the Human Rights jurisprudence.
>
> At the same time, it was pointed out by an Addiction Specialist that there may not be a standard IH approach to supporting employees who

> voluntarily seek assistance in dealing with their substance dependency from IH Disability Management Specialists.
>
> These cases are becoming more and more complex. As a result, Managers have requested guidance from HR when dealing with these difficult cases. To date, the approaches taken throughout IH have varied and a need for standardization has been identified.
>
> * * *
>
> Without this policy, there is no consistent, comprehensive, risk-adverse approach to these potentially dangerous situations throughout Interior Health.

In short, I am satisfied that the Policy -- including the specific aspects challenged by the Union -- meet the first and second *Meiorin* requirements. The real debate lies at the third step; that is, whether the impugned elements can be justified by the Employer as *bona fide* occupational requirements.

Aside from the sheer breadth of the Union's assault on the Policy, one difficulty in addressing the parties' arguments lies in the practical reality that they have, from the outset, taken non-aligning approaches to the issues. To oversimplify, the Employer places considerable reliance on existing case law which has examined drug and alcohol policies under the *KVP* test. In contrast, the Union places primary reliance on human rights principles, and adopts a much more evidence-based approach to submit the Employer has not met the applicable tests. To further compound the adjudicative challenges, the Employer did not respond directly in argument to some of the specific "allegations" advanced by the Union. There is additionally considerable duplication across the evidentiary grounds for the Union's allegations as framed in its comprehensive Closing Argument. Faced with all of these variables, I have endeavoured to distill the essential features of the Union's complaints about the Policy, and they will be addressed under the headings set out below.

A. <u>The Requirement for Individualized Assessment</u>

A fundamental premise of the duty to accommodate is that employees will be considered on an individualized basis and within the particular circumstances of their employment. As stated in one of the Employer's cases, *Teamsters Local 879 and Holtz Environmental (Environsystems)* (2016), 264 LAC (4th) 131 (Knopf), ("*Holtz*"):

> … *In all issues involving the application of Human Rights protections to workplace rules and policies, it is imperative that individuals be given individualized consideration*. … Therefore, where drug or alcohol addiction issues are at play and the *Human Rights Code* must be respected, any consideration about the reasonableness of Return-to-Work Follow-up Testing must allow for the individualized treatment of each employee. (para. 44; italics added)

The Union quotes at paragraph 419 of its Closing Argument a passage found in *McGill University Health Centre (Montreal General Hospital) v. Syndicat des employés de l'Hôpital général de Montréal*, 2007 SCC 4:

> The importance of the individualized nature of the accommodation process cannot be minimized. The scope of the duty to accommodate varies according to the characteristics of each enterprise, the specific needs of each employee and the specific circumstances in which the decision is to be made. Throughout the employment relationship, the employer must make an effort to accommodate the employee. … Reasonable accommodation is thus incompatible with the mechanical application of a general standard. (at para. 22)

This careful, individualized approach must be borne in mind when examining any aspect of the Employer's Policy and a "one size fits all" formula will not withstand scrutiny: *Holtz,* at para. 47.

When the Employer becomes aware that an employee has a substance use disorder, the employee is placed on leave pending the results of an IME. This step is taken regardless of how the knowledge came to the Employer's attention and irrespective of whether there has been a workplace incident. There is no evidence to suggest the

Employer considers the specific tasks or responsibilities of the employee, or whether the position does indeed fall within the definition of safety sensitive in the Policy. The unmistakable impression left by the evidence as a whole is that all positions are treated as equally safety sensitive. The Employer does not seek, and apparently will not consider, any information from the employee's family physician or other health care professional who may have been involved in the employee's care before requiring the IME. No assessment is made regarding the risk(s) associated with allowing the employee to remain in the workplace.

Ms. Meidl's evidence was that she "goes straight to an IME" when she becomes aware of an employee with a suspected substance use disorder. If the employee is covered by the benefit plan, this involves engaging GWL for the assessment. IHA itself arranges the IME for part-time employees (and, in the case of Ms. C, arranged the IME directly in order to expedite the process). In those instances, Ms. Meidl does not tell employees they have a choice regarding who will carry out the assessment, and simply tells them "how I'm selecting [the specialist]". She usually makes the referral to whoever will be available first.

The Employer's practice regarding the appointment of addictions specialists finds some support in the Draft Report prepared by Dr. Els. In response to a question regarding disclosed or suspected "substance dependency" (i.e., towards the severe end of the spectrum) and how quickly an employee should be assessed, he wrote:

> The presence of a substance use disorder (or the reasonable suspicion of such) may be associated with the foreseeable ongoing consumption of impairing substances, which may in turn foreseeably impact on occupational capacity and risk. The ongoing consumption of impairing substances (whether recreational use, or use in the context of the diagnosis of substance use disorder) is incompatible with working in a safety-sensitive position. *Hence, the recommendation is for a swift referral for an assessment at the earliest possible opportunity, along with an assessment of any other pressing clinical matters* (e.g. potential for risk of harm to self or others, as well as risk of intoxication or withdrawal) (p. 12 of 54; italics added)

Nonetheless, Dr. Els proceeded to include the following qualifications in his Draft Report:

> In order to remedy the potential for ongoing occupational or other risk, removal from the workplace and completion of an assessment is considered a priority. When a substance use disorder is suspected, an individual should be relieved of safety-sensitive duties, pending assurance of the resolution of the associated and putative risk. *If a delay is inevitable, where appropriate, the individual may be accommodated in a non-safety-sensitive position*, or may be placed on medical leave pending the determination of risk and the resolution thereof. (p. 13 of 54; italics added)

There is no evidence to establish that the Employer considers the individual circumstances of employees before removing them from the workplace and requiring an IME (in fact, the opposite appears to be the standard practice). This omission is of particular concern in the case of employees who may voluntarily disclose past dependency problems where there might not have been any issue in the workplace for a significant period of time. In those circumstances, there may be existing health care providers who can readily supply reliable information about the employee's condition. In fact, the Guidelines direct that written authority should be requested to contact an addictions specialist who has diagnosed an employee but there is no evidence of this step being taken. Such individuals are treated exactly the same as an employee who may have been involved in a serious workplace incident due to present impairment. This lends support to Dr. Livingston's opinion that the Policy promotes structural stigma because it applies to individuals with substance use disorders as a homogeneous group and does not consider the individual degree of risk in the workplace.

There is another significant area where the Policy does not allow for individualized assessment, and that concerns the IME itself. This shortcoming applies to both the IMEs arranged by the Employer and those arranged through GWL. In neither case does the Employer ensure that the specialist receives basic information such as the employee's job description, a list of tasks associated with the position or other similar

documentation. Dr. Els identified the various characteristics of an IME in his Draft Report, and stated:

> iii. It includes a review of background information / clinical and other records / documentation, typically prior to the actual day of the IME. It further includes obtaining a current history taken through interview, a physical examination (in some situations), obtaining collateral information; requesting further testing (under certain circumstances), and compiling of an opinion report, which includes responses to specific questions posed to the evaluating physician. (p. 14 of 54)

Dr. Els elaborated on these requirements in his testimony. He stated a "critical piece" of an IME is "informed, written consent" by the person being assessed. He stressed the importance of receiving "background information" from the referring party, including how the issue developed and the nature of the individual's job. He later spoke to the importance of taking into account "all relevant records … from any source" as the failure to consider all sources may lead to an erroneous opinion. He similarly agreed in cross-examination with the statement that "[c]ollateral information is an essential component of a comprehensive disability evaluation" (see the "AAPL Practice Guideline for the Forensic Evaluation of Psychiatric Disability" in *The Journal of the American Academy of Psychiatry and the Law*, Volume 36, November 4, 2008 Supplement at p. S13). This includes requesting collateral information where it has not been provided. Dr. Els explained further that such information includes the clinical records of an employee's GP, and stated he speaks with the GP as part of his practice when assessing someone.

The IMEs described by the Union's three lay witnesses all fall short of the standards recommended by Dr. Els, and all were considerably shorter in duration than the estimate of the required time to perform a proper assessment. Recall as well the largely uncontradicted evidence of Ms. A that Dr. Yang did not perform several of the "Components of the Assessment" identified in the letter informing her of the appointment, and that none of her health care providers were contacted in preparation of the resulting report. Ms. Meidl's evidence was that it is not her practice to ask about limitations and restrictions in her referral letters for employees suspected of having a

substance use disorder, even though she is aware of the Employer's duty to accommodate.

These omissions are not without import. A large part of the Employer's case is that it simply follows the advice of the addictions specialist in terms of the conditions imposed on employees when they return to the workplace. However, the lack of information provided to the specialist in the first instance means that any risks may not be meaningfully assessed.

Finally, it may well be appropriate to remove employees from the workplace pending an IME in the vast majority of cases given the safety sensitive nature of health care. But before taking this step, the Employer has not shown it would be an undue hardship to consider each employee's individual circumstances. That is what the law requires.

B. Employee Disclosure Obligations

The Union maintains that employees with "substance use disorders or perceived substance use disorders" are required to disclose their diagnosis to their frontline managers. Further, employees with "past substance use disorders" are required to disclose their past medical history even if there is no requirement for accommodation or impact in the workplace.

As clarified already, the terms of the Policy are not as encompassing as the Union asserts. They more narrowly mandate disclosure in the case of "current alcohol or drug *dependency* problems" and "past alcohol or drug *dependency* problems" (as further defined). Leaving aside that distinction for the moment, the Union submits further that the disclosure requirements involve three adverse impacts:

(a) First, the forced disclosure of an employee's substance use disorder or perceived substance use disorder and treatment information is itself an adverse impact. Diagnosis and treatment

information are recognized to be particularly sensitive medical information: *West Coast Energy Inc. and CEP, Locals 449, 862, 686-B, Re*, [2004] B.C.C.A.A.A. No. 341, 2004 CarswellNat 7565 (WL Can) (Hall) at para. 50. Much of the biographical information disclosed in the IME report is similarly sensitive, potentially including such details as childhood trauma and intimate partner violence. In itself, the disclosure of highly sensitive medical information is an adverse impact: *Davis v. Revera Long Term Care Inc. (c.o.b. Sandringham Care Centre)*, 2015 BCHRT 148, at paras 292, 299, 330.

It has been stated that "good faith requests for medical information made sensitively and addressed to the employer's duty to inquire in the circumstances are not discriminatory" (*Petrar v. Thompson Rivers University,* 2014 BCHRT 193, at para 109). However, the duty to inquire only arises where an employer has reason to believe an employee's medical condition may be adversely impacting his or her ability to work: *Gardiner v. Ministry of Attorney General*, 2003 BCHRT 41, at para 164. The Policy compels and authorizes disclosure in the absence of anything that would give rise to the duty to inquire.

(b) Second, such disclosure exposes employees who have or are perceived to have substance use disorders to others' prejudiced views and behaviour. As noted by Dr. Livingston, individuals with substance use disorders are highly stigmatized. Substance use disorder-related stigma manifests throughout society, consciously and unconsciously. The broader the disclosure within the workplace, the more likely such stigma will negatively affect employees with substance use disorders or perceived substance use disorders.

(c) Third, and as further noted by Dr. Livingston at p. 5 of his Expert Report, disclosure negatively impacts the ability of individuals who have or believe they may have substance use disorders to seek treatment. Fear of stigma causes individuals to be less likely to disclose their concerns. The less they can rely on such information remaining confidential, the less likely they will be to disclose and seek treatment. By compelling and authorizing broad disclosure, IHA deters the very treatment-seeking behaviour it purports to promote. (Closing Argument, at para. 452)

The Union maintains the disclosure requirements are discriminatory and cannot be justified as a *bona fide* occupational requirement.

I will address below the related question of whether employees should be required to disclose current problems to their manager/supervisor or, alternatively, to Disability Management. In terms of whether there should be any obligation to disclose, the Union asserts the evidence does not establish the mere existence of a "current" substance use disorder presents such a significant safety risk that employees can be compelled to disclose their medical conditions in the absence of any impact on the workplace. More particularly, it says the evidence does not show a risk that individuals with mild or moderate substance use disorder pose a risk of working impaired, and argues disclosure is not reasonably necessary to promote workplace safety.

The Employer answers these arguments in large measure by noting (as clarified already) that the Policy is limited to the disclosure of alcohol or drug "dependency". The Guidelines similarly speak to "substance dependency". The Policy defines "Substance Dependence" to mean:

> A primary, progressive, chronic and often fatal disease characterized by compulsive, obsessive use of drugs or alcohol or both. Dependency is characterized by a preoccupation with the drugs or alcohol, loss of control, increased tolerance, harmful consequences in one or more major life areas, denial and relapse. (p. 1)

Therefore, under the Policy, employees in safety sensitive positions must only disclose their alcohol or drug disorders when the disease has progressed to the stage where there is a loss of control and the potential for harmful consequences.

The evidence at arbitration establishes that "substance dependency" under DSM-IV (the standard reference when the Policy was developed) is now classified as a "severe" substance use disorder under the current DSM-5. Thus, and contrary to the Union's submissions, the Policy does not require the disclosure of mild or moderate disorders. (Nor, for that matter, does the Policy require the disclosure of recreational use although employees are expected to arrive at work fit for duty.) The evidence establishes further that there is an elevated risk of individuals with severe substance use disorders

attending the workplace while impaired. This risk is consistent with the reason for the current disclosure requirement found in the Policy:

> … Current alcohol or drug dependency problems must be disclosed to the employee's supervisor and/or manager in order that managerial and supervisory employees are able to ensure that the safety aspects of Interior Health's operations are addressed. … (p. 4)

Finally, in relation to current disclosure, any doubt on this aspect of the Policy was removed by the recent decision in *Stewart v. Elk Valley Coal Corp*., 2017 SCC 30 ("*Elk Valley*"). The policy there required disclosure of dependence or addiction issues before any drug-related incident. A human rights tribunal had found an employee had been terminated for failing to comply with the policy; therefore, there was no *prima facie* discrimination. This conclusion was upheld by the majority of the Court as reasonable. The minority held that substituting a lesser penalty than termination for breach of the policy "… would compromise the employer's valid objective to prevent employees from using drugs in a way that could give rise to serious harm in its safety sensitive workplace" (para. 55).

In the present proceeding, the Policy requires disclosure of current dependency problems but does not incorporate sanctions where employees fail to comply. Subject to what will be said regarding the appropriate recipient of disclosure, I find the requirement is not inherently discriminatory. Whether the requirement is discriminatory in practice (e.g., because an employee's disability was a factor in any failure to disclose) must be assessed on a case-by-case basis.

This leaves for consideration the "past" dependency disclosure requirement. The Union seeks to distinguish and discredit *Vancouver Shipyards Co. -and- United Assn. of Journeymen and Apprentices of the Plumbing and Pipefitting Industry, Local 170* (2006), 156 LAC (4th) 229 (Hope), which relied on *Entrop v. Imperial Oil Ltd*. (2000), 2 CCEL (3d) 19 (Ont. C.A.), to uphold the mandatory disclosure of past dependency problems

involving alcohol or drugs within the past six years. The grievance was dismissed for these reasons:

> In an age when drug and alcohol addiction is routinely seen as a disability that requires accommodation by employers, the balancing of interests implicit in the approach dictated in the legislation and the relevant Court and arbitral decisions requires that disclosure be limited to the level necessary to permit the Employer to respond objectively. It is implicit that an employee who has a current drug or alcohol problem must disclose that fact and thus permit managerial and supervisory employees to be informed to ensure that the safety aspects of an employer's operation are addressed. By contrast, disclosure of past problems that are acknowledged to have been in remission for up to six years favour a restriction on the level of reporting. In particular, the interests of the Employer would be preserved if disclosure is made to a designated medical authority so that the implications of the past problem and the possibility of a relapse can be assessed and accommodated. (para. 23)

The Union submits as well that the standard in *Entrop* is unnecessarily onerous, and maintains it has tendered evidence in this proceeding to show the standard is inappropriate.

I agree with the Employer that the Union has not, in fact, adduced sufficient evidence to counter the existing case law on the question of past disclosure. This is essentially a medical question. It was not addressed by Dr. Sutherland who stated in direct examination that she does not have expertise in occupational health, and acknowledged in cross-examination that she is "not really familiar with work issues". Dr. MacDonald's testimony dealt with "odds ratios" from a literature review perspective. His report was not directed to whether disclosure is required by employees working in safety sensitive positions.

I note the most recent version of the Canadian Human Rights Commission's Policy on Alcohol and Drug Testing provided in argument (Revised October 2009), continues to cite *Entrop* for the following guideline:

> Employers can require employees who work in safety-sensitive positions to disclose current use of alcohol and drugs, as well as a history of alcohol or drug abuse within the last five or six years for *alcohol dependency*, and six years for *drug dependency*, the point where the risk of relapse is "no greater than the risk a member of the general population will suffer a substance abuse problem." (p. 8; italics added)

In short, the record before me is not sufficient to depart from the existing case law which permits an employer to require disclosure of past dependency issues during the previous six years based on the increased risk of relapse.

C. <u>Obtaining Medical Information</u>

Protection from infringement of physical integrity of the person is well recognized in the common law, and has been applied routinely in the arbitral case law. Employees have a strong right to privacy with respect to their bodily integrity and any medical treatment. As stated in the now dated language of *R. v. Dyment*, [1988] 2 SCR 417, "… the use of a person's body without his consent to obtain information about him, invading an area of personal privacy essential to the maintenance of his human dignity" (quoted at para. 50 of *Irving*).

Arbitrator Lanyon has written extensively on the subject of employer access to employee medical information. While discussing application of the "least intrusive" means concept in *Rio Tinto Alcan and Unifor, Local 2301*, [2016] BCCAAA No. 44, he remarked:

> The application of these principles may vary depending upon the specific stage of a medical inquiry. For example, with respect to the intermittent absences of employees due to their temporary sickness or illness, these are often accompanied by a family doctor's prescription pad note, stating the employee is ill and will return to work in a few days. This usually suffices for short term illnesses. However, it is well established that when an employee seeks to be accommodated, or there is a need to determine whether an employee is fit to return to work, an employer is entitled to greater access to that employee's medical information. This may include not only information about the history of that employee's illness or

> injury, but also involve an independent medical examination by a specialist.
>
> However, even with respect to this increased sphere of entitlement to medical information and examinations, there are still restrictions. An employer is entitled only to the specific information that it requires to make any of its medical determinations: *Accenture Business Services for Utilities v. Canadian Office and Professional Employees' Union, Local 378* [2008] B.C.C.A.A.A No. 115 (QL).
>
> * * *
>
> Employers and trade unions can, and do of course, negotiate health and welfare plans that may determine the eligibility requirements to benefits, including the requirement of medical evidence. These plans are of significant benefit to employees, however, they cannot compel the disclosure of medical information in the absence of an employee's consent. An employee who decides not to consent may suffer the consequences of refusing to provide the medical information required to establish their entitlement to those benefits. This is a choice they make. Further, they may not be permitted to return to work or be accommodated until they provide the required medical evidence. Each collective agreement needs to be examined in order to ascertain the rights and obligations that would flow from such a refusal to consent to a disclosure of medical information.
> (paras. 51-52 and 54)

In an earlier award, *Telus Communications Co. and TWU* (2010), 192 LAC (4th) 240, Arbitrator Lanyon dealt with a policy grievance concerning an employer’s ability to obtain medical information. One of the questions was whether the employer was required to turn first to an employee’s own physician when additional medical information was required, or to take other steps before requiring an IME by a doctor of its own choice. He responded:

> In short, the answers are yes. This selection process is consistent with the principle of applying the least intrusive measure. Thus, the Employer is required to go back to the employee's own physician first for additional information. If a specialist is required because the family doctor does not have the necessary expertise then the employee should be given the option of attending a specialist of their own choice.
>
> It is after these particular options have been exhausted that the need for an IME arises (as opposed to the employees own specialist who may not have proved conclusive). First, such an Independent Medical

> Examination should be conducted by a physician that is agreeable to both parties. It is only after this route has been attempted, or where an employee refuses to attend an IME, that the employer should have the right to demand an IME of its choice. (I do not intend these examples to be exhaustive.) (paras. 115-116)

I acknowledge these answers were provided in relation to the extent of medical information required for purposes of STD benefit coverage, and the case did not involve the duty to accommodate or a concern over substance use affecting the workplace. However, arbitrators have routinely adopted the "least intrusive" means approach to any request by an employer for employee medical information.

The Union proceeds to argue that requiring an employee to attend an IME with a specialist selected by the Employer can only be justified as a measure of last resort. It submits the escalation must be justified by a legitimate reason, and the obligation is on the Employer to establish both the necessity of the information and the further escalation of the means to obtain the information.

I find the Union's ensuing characterization of the evidence at arbitration regarding the referral of employees for an IME is accurate:

> Evidence elicited at the hearing of this matter, especially the evidence of Ms. Meidl, clearly indicates that the Employer, in interpreting the Policy: a) makes no assessment of whether or not an IME is reasonably necessary in the circumstances; b) makes no inquiry to obtain a medical certificate or information from the employee's own physician; c) makes no effort to permit an employee to select their own addictions specialist; and d) makes no effort to find a mutually agreeable addictions specialist. Ms. Meidl was clear, however, that where other disabilities were in issue, the Employer does seek information from employees' personal physicians; if that information is unclear, she seeks clarification from that physician; and the only circumstance in which Disability Management would seek an IME for health issues other than substance use disorder were at the behest of the employee's physician seeking an expedited referral through Great West Life. Further, Ms. Meidl did not provide a single instance, even when pressed, where she thought Disability Management would seek an IME without an employee's physician being involved. (Closing Argument, at para. 439)

I find as well that the Employer does not tell employees with suspected substance use disorders that they have a choice as to which specialist carries out the IME.

The Employer responds in part by submitting the Union's arguments fail to differentiate between the Policy and the associated practices of IHA, as distinct from the practices of Great West Life. The latter assumes responsibility for permanent employees with benefits who may have a substance use disorder, which are most of the employees who become subject to the Policy. The Employer submits it has "no say" over how GWL undertakes the assessment, treatment or monitoring of persons with substance use disorders. Nonetheless, the Employer maintains its practice is consistent with that of GWL both in terms of arranging an IME with an addictions specialist and the ensuing steps.

The Employer submits I do not have jurisdiction to address any allegations concerning the practices of GWL, citing *HEABC and HEU* (2009), 99 CLAS 146 (Burke). Without deciding the point, I note there is authority which holds an employer cannot use that company as a shield to effectively contract out of the proper administration of its collective agreement: see *Canada Post Corp. -and- CUPW,* [2016] CLAD No. 247 (Gordon), at para. 33. Regardless, I do not accept that the practices of GWL necessarily justify the Employer's practices under the Policy. The Union's possible inability to challenge GWL because the insurer is not a party to the Collective Agreement cannot be taken as an acceptance of the latter's practices. Nor is the Union is precluded from challenging actions taken by the Employer before one of its members "enters" the GWL process, or from asserting there are steps the Employer should take while its members are being assessed under that process. Finally, and obviously, the Union is not precluded from raising issues over how its members are treated by the Employer once they "exit" the GWL process and return to the workplace.

A more specific answer to how the "least intrusive" means of obtaining medical information should apply in the present circumstances turns to a large degree on another

issue raised by the grievance: whether the Employer should seek information from an employee's physician or whether arranging an assessment by an addictions specialist is more appropriate. That issue will accordingly be addressed next.

D. The Appropriate Source of Medical Information

As part of its position that the Employer must follow the "least intrusive" means of obtaining medical information, the Union submits the Employer should turn first to an employee's own physician. It submits the Employer cannot compel employees to attend an IME with an IHA-selected physician as a first course of action, without reasonable grounds to suggest they cannot obtain sufficient information from the employee's personal physician. Moreover, the Union says the practice of automatic referral to an IHA-selected specialist ignores: the possibility of the family physician referring the employee for an assessment; the selection of an independent specialist by the employee; or, the selection of a mutually agreeable specialist by the Union and the Employer should that be justified.

The evidence of the experts differs as to whether family physicians have sufficient training to deal with addictions, as well as whether they should carry out an assessment because of a potential conflict (referred to as the "dual agency" concern). As a starting point, I turn to the Draft Report of Dr. Els, where one finds the following (bold in original, italics added):

> **a. What professional qualifications are appropriate to diagnose a substance dependency and to determine treatment needs?**
> The clinical diagnosis of addiction requires a comprehensive biological, psychological, social and spiritual assessment by a trained and certified professional. *The qualifications of a Family Physician, Social Worker, Psychiatrist, or Psychologist would typically be reasonable to suggest sufficient training and experience to diagnose a substance use disorder, and to determine treatment needs and conduct basic treatment planning. Additional specialized training is available to qualify as an addiction specialist.* The requirements for a forensic (including in the context of fitness to work, disability, and other civil forensic applications) evaluation are outlined below.

> **b. Is there a difference between family physician qualifications and other qualifications in this respect?**
> *Yes, and the qualifications to diagnose a substance use disorder are distinct from the requirements to conduct an independent psychiatric and addictions assessment.*
>
> *Family physicians (and other professionals) are reasonably qualified to clinically manage, i.e. diagnose and treat substance-related disorders.* An additional degree of specialization for dealing with substance use issues is available by certification (by examination) with any one or more of the following: Canadian Society of Addiction Medicine, International Society of Addiction Medicine, or American Board of Addiction Medicine. Primary care physicians and specialists are potentially eligible to work towards this certification as an addiction specialist.
>
> *For civil forensic assessments (including fitness-to-work and disability determinations) an additional degree of experience or credentialing may be required. These assessments are not clinical assessments, and the "knowledge, skill, experience, training, or education" for forensic assessments are* not *the equivalent of that required for clinical assessments. The skill set required to perform a high-quality IME requires specific training that is not provided in the standard medical curriculum.* It is recommended that the evaluator has qualifications in the following two areas: (1) Medical knowledge and/or training in the specific area or areas pertinent to the subject case; and (2) Experience, training, and preferably additional credentials in the area of Independent Medical Examination per se.
>
> Standards within the profession suggest that prior to accepting any case, and assuming there exists no conflict or interest (e.g. dual agency bias), the forensic evaluator should determine whether he or she has the proper [sic] required for the particular forensic-legal question under consideration. … (pp. 10-11 of 54)

Consistent with the Draft Report, Dr. Els testified that the highest standard in addiction diagnosis and treatment is provided by a physician certified as an addictions specialist. Dr. Sutherland testified that family physicians in British Columbia do not receive much addictions training in medical school, and it has been "challenging" to incorporate the subject in curriculums across the country. She nonetheless disagreed with the opinion of Dr. Els that ABAM Certification is required to diagnose and treat

addiction. She stated family physicians are able to address substance use disorders, and spoke to the relationship of trust between patients and their own physicians.

This leads to the question of dual agency bias, where Dr. Els opined in part:

> **DUAL-AGENCY CONCERNS**
> One of the major concerns about the ethics of evaluating patients is the dilemma of so-called *dual agency*, that is, the tension between the treating physician's obligation of beneficence toward patients and the conflicting obligations to the requesting party, e.g. the employer requesting a fitness-to-work (or other) determination. This role conflict in civil forensic (i.e. fitness-to-work, disability, and disability-related evaluations, etc.) occur when a treating health professional assumes the role of both treatment provider and independent evaluator. The incompatibility of these roles has been extensively documented and summarized in a landmark text: "Occupying these dual roles inevitably affects evaluator's perceptions of the dynamics of the relationship between the patient/evaluee's psychological issues and external work-related circumstances. The processes associated with a treatment role and evaluation role typically create irreconcilable conflicts due to differences in methodology, ethics, alliances, and goals". (pp. 15-16 of 54; footnotes omitted)

The Employer submits the arbitral case law recognizes that "… an employer's duty to inquire *requires* that an employer obtain an assessment from an addictions specialist when it has reasonable grounds to believe an employee has an substance use disorder" (Outline of Argument, at para. 300; italics in original). It cites *Saskatchewan Gaming Corp. and PSAC* (B.(A)), [2015] SLAA No. 27 (Comrie), as an example, and argues:

> At the hearing [in *Saskatchewan Gaming Corp.*], an addictions specialist, who testified for the union, gave evidence that "the typical family doctor receives little or no training in addiction medicine, with the result that only specialists in the area are capable of meaningful input" ([*Saskatchewan*], at para. 111).
>
> The addictions specialist also testified to the following (at para. 112):

> [O]nce the addiction sets in, and the craving combines with the guilt felt around the ongoing addiction, then the addiction starts to tell you what to do and you will lie and manipulate to any extent necessary to satisfy the habit. This is particularly relevant in the workplace context where the addict typically lies to his or her employer about the very existence of their addiction or the existence of a relapse. Denial, a major element of the disease, is used by the addict to prevent a perceived threatened loss of income which is necessary to support the ongoing habit.

> Arbitrator Comrie explained that, as a result, if an employee is suffering from an untreated addiction (or relapse), the employee cannot be expected to cooperate with the employer in identifying the need for an accommodation (at paras. 115-117). Consequently, when an employer has a reasonable basis to believe that an employee suffers from a substance use disorder, it has a duty to request all the information necessary from the right people to make a proper assessment, which will often include consultation with an addictions specialist (para. 125).

> Arbitrator Comrie held that in *Saskatchewan Gaming Corp*., *supra*, the employer had reasonable grounds to question the status of the grievor's addiction, and as a result, it should have obtained a professional assessment of the grievor (paras. 129-130). (Outline of Argument, at paras. 302-305)

The award in *Saskatchewan Gaming Corp*. was very much driven by the personal circumstances of the grievor and her medical condition. The arbitrator found she had a diminished duty to cooperate in the identification of her disability (para. 17). He later concluded the employer had reasonable grounds to question her addiction, and should have called for a professional assessment by someone skilled in such services (para. 130). However, this conclusion was preceded by the following analysis:

> If the employer is alert to the fact it is dealing with an addicted employee and aware of a need to investigate the potential need for an accommodation, what are its responsibilities and what degree of investigation is necessary to exhaust the duty to accommodate?

> For example, should the manager responsible for the addicted employee be advised by human resources of the employee's addiction, and at least have enough training that he or she knows when to call for help? Will it be satisfactory for an employer to rely on the opinion of a family doctor who has no training in addiction medicine and has never been

> involved in the treatment of an employee's addiction? *Should the employer call for an assessment of the employee by a qualified professional once the issue of a possible disability arises?* At the very least, where an employee is a known addict and issues have been raised about the possible need for an accommodation, such as treatment for relapse, the employer should seek the input of its own employee assistance plan professionals to assess the situation. *These are all general principles that need to be canvassed in the circumstances of each particular case*. (paras. 128-129; italics added)

The Employer also relies on the following remarks in *Elk Valley Coal Corp. -and- International Union of Operating Engineers, Local 115 (Lindley Grievance)*, [2004] BCCAAA No. 249 (Sanderson):

> In my view, the employer's decision to propose the grievor undergo an assessment by a medical specialist in addiction medicine was appropriate and reasonable. The information the employer had received regarding the grievor's drug usage could be better interpreted and explored with the grievor by a medical person experienced in addiction research who could then provide his views and recommendation to the employer, the union and the grievor. (para. 71)

This paragraph must be read in light of the facts. The grievor had been involved in a workplace accident which he had failed to disclose; he initially refused to provide a urine sample pursuant to the employer's policy; when he later submitted to a drug test, all three samples tested positive, and the third sample was higher than any the expert witness had found in more than 20 years of studies; and, the grievor had been evasive and uncooperative throughout. The arbitrator found the grievor's condition was "a reasonable line of inquiry" in the circumstances and that his condition became increasingly more relevant as the investigation continued (para. 61). Following the paragraph quoted above, the arbitrator remarked that "[t]he urgent need for such [a medical] assessment was apparent from what had been learned during the lengthy investigation triggered by the accident" (para. 78). Thus, the award does not support the appropriateness of an IME in all circumstances. Rather, it reinforces the general arbitral approach that the particular facts must be examined to determine "next steps".

The Employer relies as well on *Canadian National Railway Co. -and- National Automobile, Aerospace, Transportation and General Workers Union of Canada (CAW-Canada), Local 100*, [2013] CLAD No. 249 (M.G. Picher), and says the arbitrator in that case held "it was reasonable for the employer to require that employees attend a medical evaluation by an addictions specialist when there was a possibility that they had a substance use disorder" given the safety sensitive nature of the workplace (Outline of Argument, at para. 299). That was an eventual step in the process, but it is important to recognize what preceded referral to an addiction medicine physician (or AMP) certified by the Canadian Society of Addiction Medicine. As described in the award:

> The Company's representative stresses that the process triggered by the loss of an employee's driving privileges for an alcohol related offence is both focused and balanced. The first step is what the Company characterizes as a confidential preliminary assessment. A Company nurse conducts an interview of the employee, frequently by telephone, which involves a series of questions relating to drug and alcohol use. The first of the tests is described as the AUDIT Test (Alcohol Use Disorders Identification Test) developed by the World Health Organization, while the second questionnaire was fashioned by the Company's Medical Department to identify the possibility of drug use disorders. At the confidential interview stage there is no physical medical examination nor is there any taking of samples such as breath, hair or urine.
>
> The result of the initial assessment is then communicated by the O.H.S. nurse to a Company consulting occupational health physician. It is at that stage that a determination is made as to the existence of a possible underlying substance use disorder. In the Company's parlance that phrase refers to either substance dependence or substance abuse, disorders which it notes are defined within the medical standards of the DSM-IV.
>
> All of the process above described is, the Company stresses, conducted entirely in confidence within the Company's Occupational Health Services, and without any disclosure whatsoever to an employee's managers or supervisors. When the three to five day period for the preliminary assessment is concluded, should the occupational health physician form the opinion that an individual's medical history and information does not indicate the likelihood of a substance abuse disorder, the matter goes no further. Conversely, should the occupational health physician form the opinion that the information provided suggests that the employee may have a substance use disorder, a further referral is then made to a physician specialized in the identification and treatment of

> substance use disorders. Such specialists are now designated as Addiction Medicine Physicians and are certified by the Canadian Society of Addiction Medicine.
>
> Upon completion of the AMP's assessment, the specialist will inform the Company's Occupational Health Services of his or her conclusion as to whether the employee does suffer from a substance use disorder and whether the individual's condition is stable. The information so provided remains confidential within the Company's Occupational Health Services. The only fact which may ultimately be disclosed to line management is whether the AMP assessment has resulted in a determination that the employee is fit to work, unfit or fit to work only with certain restrictions. In the Company's submission the process so envisioned will generally be completed within six weeks of the Company learning of the individual's loss of driver's privileges. During that period the Company undertakes to provide alternative duties to the employee, as available, or failing the availability of appropriate work, to arrange for the payment of disability benefits based on an assessment of the employee's individual circumstances. (paras. 23-26)

There are obviously several features of the process described in this *CNR* award which stand in contrast to practices under the Policy, including the various confidentiality measures and the provision of alternative duties pending assessment. The fundamental point for purposes of the immediate analysis is that the process did not immediately and automatically default to a company-selected specialist.

The Union concedes that a true IME may be appropriate in some instances. Its primary complaint in this area -- a valid concern supported by the case law -- is the universality of assessments by an Employer-selected specialist without any exploration of less intrusive means.

On the evidence before me, I accept the Employer’s position that referral to a certified addictions specialist is the desirable standard where there is cause/reasonable grounds to suspect a substance dependency problem. Those professionals are better suited to the role than family physicians because of their additional expertise and the conflict concerns identified by Dr. Els. However, the need for an IME must be properly

established, and resort to a unilaterally selected medical professional is the most intrusive option.

The intervening steps should include obtaining information from the family physician and/or other health professional(s) who may have been involved in the employee's care and, should that be insufficient, considering a mutually acceptable specialist. One seemingly desirable option would be for the Employer and the Union to jointly establish a roster of addictions specialists. Among other attributes, this would avoid delays associated with selecting specialists on an *ad hoc* basis.

Moving to a related subject, the apparently automatic requirement of a second IME before an employee is allowed to return to the workplace is problematic. It is a requirement under the Guidelines and does not appear to be based on the recommendations of the specialist who carried out the initial IME. For instance, after diagnosing Ms. C, Dr. Baker wrote that "re-evaluation prior to return to a Safety Sensitive/Critical position *may* be indicated" (italics added). Yet the Employer held her out of service pending a second IME based solely on the Policy.

I recognize the Employer's right and obligation to ensure its employees are fit to return to work and carry out their duties in a safe manner. But once again, the second IME is not the least intrusive means of achieving this objective -- particularly, if an employee is already in compliance with a monitoring agreement and random tests have been negative. The consistent requirement of a second IME may do little more than delay an employee's return to work and is a renewed intrusion on privacy rights.

E. Dissemination of Medical Information

Another well-accepted principle in the arbitral case law is that private and sensitive medical information should not be disseminated beyond what is reasonably necessary in the circumstances. This applies in particular to any diagnosis and treatment program being undertaken by an employee. See *Rio Tinto Alcan* at para. 49, together

with the authorities cited therein. The principle has application here in terms of the monitoring and reporting mechanisms established by the Policy, especially those which apply once an employee with a diagnosed substance use disorder returns to the workplace. Among other disclosures, the Policy:

(a) permits the disclosure of an actual or suspected substance use disorder to managers, Human Resources and Disability Management on a supposedly "need-to-know" basis, where the basis for disclosure may simply be the financial impact on the manager's departmental budget;

(b) compels employees to reveal their full treatment plan to several layers of staff, including their line manager, Human Resources and Disability Management;

(c) compels employees to disclose minute details of day-to-day compliance to both their manager and Disability Management, such as attendance at 12-step or similar programs, dates on which they have been subject to random biological testing and their results, whether they have met with their monitor and whether they have attended counseling; and;

(d) allows the disclosure of extensive medical and deeply personal biographical information to Disability Management by way of the IME report.

I find the Employer has not shown why it is reasonably necessary for employees with current alcohol or drug dependency problems to make disclosure to their supervisor and/or manager, while those with past dependency problems must make disclosure directly to Disability Management (which allows for greater confidentiality). The resulting process is the same in either situation; namely, the employee is removed immediately from the workplace and sent for an IME. Assuming the purpose of disclosure to the supervisor and/or manager is workplace safety as suggested in the Policy, the objective can be accomplished by restricting disclosure to Disability Management. I agree with the Union's submission that Disability Management is likely

better equipped to gather and assess medical information, and to then make determinations regarding an employee's ability to work safely.

Moreover, the Policy treats employees who disclose substance use issues differently than those who have other medical problems. As set out in the Guidelines, managers or their designates are directed to do the following where an employee is suspected of being impaired or unfit for work:

> - Ask the employee if there may be a medical problem.
> - *If employee acknowledges, there is, or may be, a medical problem but it is not related to substance use, refer employee to Disability Management Specialist (DMS) for assistance with that medical problem, after completing this meeting.*
> - Enquire of the employee if he/she has a substance use problem.
> - *if the employee acknowledges there is a problem related to substance use, determine if it has been diagnosed as substance dependency by a medical addictions specialist*. If yes, request written authority from the employee for the DMS to contact the addictions specialist. If no, then follow the course of action below. (p. 5; italics added)

The Employer has similarly not shown why it is reasonably necessary for employees to disclose their full treatment plan (as detailed in the Return to Work and Last Chance Agreements) to all of their manager/supervisor, Human Resources and Disability Management. While supervisors and managers admittedly require a certain degree of information when an employee with a previously diagnosed substance use disorder returns to the workplace, the Policy allows disclosure of the treatment plan and, additionally, the Return to Work Agreement contemplates regular meetings between the manager/supervisor and the employee to ensure "compliance" with its terms. This overlaps in large measure with the function of the monitor, as well as the practices of Disability Management.

Dr. Els was emphatic in his testimony regarding the importance of maintaining a "fire wall" between an employer's nursing (or similar) staff and "the actual employer" to respect confidentiality. This accords with the current view of Canadian arbitrators. Supervisors and managers should only receive information necessary to ensure the safe completion of duties, and this generally excludes the medical treatment plan. The fact that a manger's department may have paid for an IME (as in Ms. C's circumstances) cannot be regarded as a "need to know" basis sufficient to justify disclosure.

I acknowledge that aspects of the Employer's current practices may seem to align with what was written by Arbitrator Hope in the *Vancouver Shipyards* award (i.e., that managerial and supervisor personnel should be informed of an employee's current drug or alcohol problem). However, the dispute there did not concern the broader disclosure concerns raised by the Union's grievance. The law is additionally evolving and, in my view, the safeguards described in Arbitrator Picher's more recent *CNR* award reflect a more refined approach to the appropriate scope of medical information to be conveyed to line management.

Finally, the IME report itself contains highly sensitive personal information. While some of the information may go beyond what is absolutely necessary in the circumstances, I find the Employer is not precluded from receiving the full IME report provided stringent steps are in place to ensure details are appropriately confined to the Disability Management "silo" within IHA. Further, the professionals tasked with carrying out an assessment should be requested at the outset to omit from their resulting report any sensitive information that is not relevant to the medical condition being investigated.

F. <u>Duplication of Reporting/Monitoring Requirements</u>

The extensive overlap between the role of the monitor and meetings with Disability Management, as well as meetings with a manager/supervisor, has been alluded to already. As stated in the Return to Work and Last Chance Agreements, the purpose of

the meeting with Disability Management is to "discuss adherence to the treatment plan and other related matters"; similarly, the meetings with a department manager are to "review attendance and compliance with this agreement". The latter necessarily entails disclosure of sensitive information regarding treatment and details of the employee's personal life.

In addition to the duplication caused by having managers ensure compliance with Return to Work and Last Chance Agreements, the subject matter of the regular meetings with Disability Management overlaps extensively with the role of the monitor. I accept the testimony of two lay witnesses called by the Union regarding the highly similar nature of the matters discussed. Ms. A and Ms. C both testified about the marked similarity between "check-ins" with the monitors and meetings with Disability Management Advisors. The questions asked in both sessions include whether they have been abstinent, compliance with AA/NA requirements and attendance at counseling. Disability Management also asks about recent testing and the results -- something which the monitor will know already. Ms. Meidl acknowledged a similar duplication when taken through IHA's Disability Management template used for Ms. C in light of what the external monitors are expected to address.

It is important to recall that these additional "check-in" and monitoring obligations do not result from the recommendations of the addictions specialist who may have directed a period of monitoring; nor are the terms found in the resulting agreements between the employee and the monitoring agency. Rather, the meetings with managers/supervisors and Disability Management are imposed by the Employer through the Return to Work and Last Chance Agreements. Ms. Janes agreed that it is the Employer which insists on meetings between an employee and his or her manager/supervisor at prescribed intervals, as well as the meetings between the employee and his or her Disability Management Advisor at prescribed intervals. In addition to going beyond the monitoring arrangements recommended by the addictions specialist, the reporting requirements in the Agreements are plainly a "one size fits all" formula in terms of their frequency and content (see *Holtz* at para. 47). Moreover, they appear to deviate

from the direction in AU0200 for a collaborative development of those Agreements "[b]ased on recommendations from [the] medical expert" (p. 6).

Ms. Meidl testified that the check-ins with Disability Management serve a different purpose than the services provided by a monitoring agency. In particular, the latter is not responsible for the employee's return to work or accommodation. As the Employer argues:

> The Disability Management Advisor's role in the organization includes receiving and working with employee medical information, and facilitating accommodation and return to work arrangements. This includes checking in with employees being accommodated and/or in return to work plans. The Disability Management Advisor's role with respect to an RTWA/LCA is to follow up with employees on the terms of their RTWA/LCA to ensure that their return to work is proceeding well. This includes addressing any barriers that the employee may identify in the course of check-ins. (Outline of Argument, at para. 68)

Ms. Meidl testified further that she follows a template, but her sessions with employees are not "scripted in stone" and are intended to be "supportive". However, she acknowledged a large degree of duplication when taken through IHA's monitoring template (used for Ms. C) in light of what monitors are expected to address.

I accept that there is a role for Disability Management separate and apart from the monitoring agency, and most of the purposes articulated by Ms. Meidl are valid. The problem is that the check-ins with Disability Management go beyond what is reasonably necessary to achieve those purposes and, in practice, are largely repetitive of the subjects canvassed by the monitor. The evidence of both Ms. A and Ms. C confirms that these check-ins with Disability Management may be an impediment; are additional demands on their personal time; and, may cause undue stress. Additionally, the overlap likely serves to undermine the laudable objective of Disability Management in supporting employees on their return to the workplace and removing any barriers they may encounter.

In short, the Employer has not demonstrated that removing duplicative (if not triplicative) reporting requirements imposed on employees through the Return to Work and Last Chance Agreements would cause undue hardship or are reasonably necessary to ensure workplace safety. To be clear, there are valid roles for both front line management and Disability Management in addition to the monitoring agency; however, the scope of their involvement must be modified.

G. Last Chance Agreements

One of the negative consequences which the Union submits the Policy imposes on employees with substance use disorders is last chance agreements.

Paragraph 3.4 of AU0200 provides that a violation of the Policy and its related Guidelines "may result in disciplinary action up to and including termination of employment". Employees who self-disclose must sign a Return to Work Agreement before returning to the workplace. The template in those circumstances provides at paragraph 20 that a breach "will result in disciplinary action up to and including termination of employment". However, all other employees must sign the Return to Work Agreement/Last Chance Agreement. The applicable template provides that any breach "shall result in the employee's termination of employment", although the right to grieve is not precluded.

Accordingly, submits the Union, the Return to Work/Last Chance Agreement is often both a first and a last chance agreement, with mandatory termination resulting from a breach. Ms. Janes testified that termination "will occur" should an employee breach any term of a Last Chance Agreement; the right to grieve is not precluded and an employee might be given an additional chance. She also stated IHA recognizes relapse is part of the illness but added "we don't want to enable [employees]". The Union submits this approach cannot be justified, and imposes a far higher standard on employees with substance use disorders than on any other group.

The Employer argues last chance agreements are not inherently discriminatory, and maintains the threat of discharge is reasonably necessary to create a deterrent and put an individual on clear notice of the consequences. It says further that such agreements are a *bona fide* part of a recovery program for employees who have engaged in misconduct due to a substance use disorder and work in safety sensitive positions. The thorough review of the case law found at paragraphs 148-202 of *Fanshawe College of Applied Arts & Technology and OPSEU, Local 110* (2017), 131 CLAS 1 (MacDowell), is cited in support of these submissions. The same award refers to the following excerpt from *Seaspan ULC and ILWU Canada, Local 400* (H.(G.)), [2014] BCCAAA No. 108 (Larson):

> Moreover, it should be stated that agreements such as Last Chance Agreements should not be viewed as presumptively discriminatory; for example, see *Syndicat des employes de l'Hopital general de Montreal c. Sexton*, [2007] 1 S.C.R. 161 (S.C.C.), in respect to an automatic termination provision regarding non-culpable absenteeism. Further, Settlement/Last Chance Agreements, and Return to Work Agreements, are a combination of behavioural, and therapeutic as well as legal consequences. I conclude, therefore, that they can be an important part of the accommodation process itself.

The Employer relies additionally on the recent judgment in *Elk Valley* which was canvassed briefly above. The Supreme Court upheld the dismissal of an employee for failing to disclose his drug addiction prior to an accident. He subsequently tested positive for drugs. The employer terminated him pursuant to a policy which provided that employees who failed to disclose any dependence or addiction issues before any drug-related incident occurred and a consequential positive test would be terminated. Employees who disclosed dependence or addiction issues before an incident would be offered treatment. The majority upheld a tribunal ruling affirming the dismissal based on a finding that the employee was not terminated for addiction but for breach of the policy. The tribunal had found a lesser penalty than dismissal would have significantly lessened the deterrent effect of the policy and constituted an undue hardship to the company. The Employer cites on *Elk Valley* for the proposition that, if a “no chance” rule is not discriminatory, then a “last chance” agreement can be relied on to justify termination.

I accept the Employer's submissions -- but only to a certain point. There is ample authority for the proposition that last chance agreements are not inherently discriminatory and, moreover, may play an invaluable role in the return to work process for an employee who has suffered from drug or alcohol problems. One statement regarding the utility of last change agreements is found in *Toronto District School Board and CUPE* (1999), 79 LAC (4th) 365 (Knopf):

> Last chance agreements are commonly used in sophisticated employment settings to bring home to an alcoholic the serious consequences of continued addiction and at the same time allow the employee to obtain appropriate treatment. The intention is to preserve or reclaim a failing employer/employee relationship. One of the reasons these agreements can be effective is that experience has taught us that an alcoholic often will not seek or benefit from treatment until s/he has "hit bottom" by losing his/her job. But that situation can put them in a crisis where there are often difficulties obtaining the resources necessary for successful treatment. A last chance agreement is a much more humane and progressive opportunity that allows the alcoholic to clearly foresee the consequences of continued consumption without having to face the difficulties that come with the loss of employment benefits. That is also why a last chance agreement has been seen as a form of accommodations by arbitrators. … (quoted at para. 155 of *Fanshawe College*)

The *Toronto District School Board* award was cited with approval by Arbitrator Swan in the *Kingston General Hospital* case discussed below. I note as well what was written by Arbitrator Blasina in *International Forest Products Ltd. (Hammond Cedar Division) and United Steelworkers of America Local 1-3567*, [2005] BCCAAA No. 184, ("*Hammond Cedar*"):

> A "last chance agreement" is one where the employer, union, and employee agree that a further infraction will result in the discharge of the employee. Sometimes these agreements contain wording which would preclude the employee from grieving. These agreements are usually arrived at in settlement of a preceding discharge or a contemplated discharge. A "last chance agreement" cannot block an ensuing arbitration because the grievor always has the right to challenge the propriety of the discharge. *Also, the arbitrariness of a "last chance agreement" makes less*

> *sense in non-disciplinary situations where the duty to accommodate principles would have precedence*. (para. 55; italics added)

At the same time, it is important to recall two features of last chance agreements as the concept is typically understood in the arbitral case law. First, and as just explained, they are almost invariably negotiated in circumstances where the employee had demonstrated serious workplace problems and, most frequently, had been dismissed by the employer. That is, by their very characterization, such agreements are intended to afford the employee one "last chance" to restore a relationship that would otherwise be severed.

Second, and in turn, this leads to the deference which arbitrators afford last chance agreements should they be asked to set aside a subsequent dismissal pursuant to their terms. These concepts are captured in the following passage from *Re Camco Inc. and U.S.W.A., Loc. 3129* (2000), 91 LAC (4th) 346 (Bendel), quoted at paragraph 528 of the Union's Closing Argument:

> The general arbitral approach to such agreements, often referred to as "last chance" agreements is to require strong and compelling reasons in order to vary the result which flows from a breach of the agreement. The reason behind such an approach is quite evident. If the arbitrator used his power to mitigate the penalty flowing from the breach of the agreement without regard to the terms of the agreement, *the likely long-term effect would be that such agreements would not be used to settle disciplinary disputes*. Employers would simply refuse to give employees a "last chance" if, at the end of the day, the agreement had little or no effect in the arbitrator's deliberations when considering whether to mitigate a penalty. It is obvious that it is desirable to encourage parties to enter settlement agreements such as the one in question. *The employee receives another chance to retain his job and the parties know what standard of conduct is required in the future*. The expense of the arbitration proceedings may be avoided.
>
> Accordingly, it takes compelling reasons to mitigate a penalty in the face of a "last chance" agreement.
>
> With respect, I agree with the observations of arbitrators Munroe and Rayner in the passage just cited. There is a further factor, however, that reinforces these observations in my view. *The acceptance by the union and the grievor in last chance agreements that any further breach will*

> *lead to discharge is the quid pro quo for the reinstatement in employment*. Where the employer, relying on the agreement, has reinstated the grievor in employment, it should only be in exceptional circumstances, it seems to me, that an arbitrator decides to substitute some penalty other than the agreed one if the grievor later violates the agreement. The union and the grievor, having obtained the benefit for which they contracted, are on very shaky ground when they try to extricate themselves from the promise they made. However one characterizes the last chance agreement, the employer's reliance on it deserves to be respected. (cited in *Parmalat Dairy and Bakery Inc. and Retail Wholesale Canada, Div. of C.A.W., Loc. 462* (2002), 108 L.A.C. (4th) 438 (Bendel), pp. 446-47; italics added)

In each of the awards put forward by the Employer, the last chance agreement was entered into by the parties to resolve a serious workplace issue where the employee would otherwise have been disciplined, if not discharged. For example, in *Kingston General Hospital and ONA* (2010), 195 LAC (4th) 57 (Swan), the last chance agreement had been entered into as a result of disciplinary proceedings related to attempted theft of narcotics from the workplace. In the rather renowned *Castlegar and District Hospital* proceeding, BCLRB No. B484/2000, a nurse who suffered from chronic addiction had been suspended and then terminated, and was reinstated by the arbitrator under extensive conditions which included a last chance agreement. By way of contrast, in *Hamilton Street Railway and ATU, Local 127* (2002), 114 LAC (4th) 82 (Rayner), discussed at paragraph 32 of *Holtz*, the arbitrator did not uphold the discharge of a bus driver for refusing to sign a last chance agreement which required mandatory drug testing as there was no evidence to suggest drug use or impairment during working hours.

A further hallmark of true last chance agreements is implicit in the discussion to this stage; namely, they are the product of tripartite discussions and a *bona fide* consensus of what is required in the particular circumstances: see *Kimberley-Clark Forest Products Inc. and Paper, Allied Industrial, Chemical and Energy Workers International Union, Local 7-0665* (2003), 115 LAC (4th) 344 (Levinson), where the arbitrator wrote: "The LCA is a tripartite reinstatement agreement accommodating the grievor who would otherwise have been terminated … for violating the 'Intoxicants in the Workplace' Policy, which provides a specific penalty of discharge" (para. 25). Reference was made in the same paragraph to the "negotiated requirement" that the grievor abstain from the

use of non-prescribed drugs for 36 months. The arbitrator noted further that "the parties" had comprehensively addressed the grievor's potential use of marijuana away from the workplace.

Even in respect of a return to work agreement which is not intended as a formal "last chance" agreement, Dr. Els opined:

> The relapse prevention and return-to-work agreement *should reflect a collaborative effort* involving the patient, the patient representative (e.g. collective bargaining unit representative/advocate) the independent assessor, the employer (or representative, e.g. Occupation Nurse). (Draft Report at page 41 of 54; italics added)

Dr. Els testified that return to work agreements are "typically" formulated with input from the worker and the stakeholders, and emphasized their "individualized" nature. He additionally stated it is "important to have some degree of flexibility because things happen in people's lives", adding "flexibility must be built in" to the return to work conditions. I am unable to find these practices reflected in either of the Agreements prepared by the Employer.

If any further authority is needed on this point, I return to the Supreme Court's judgment in *Irving*. The focus there was unquestionably unilaterally implemented random drug testing in the workplace. Nonetheless, in the course of its analysis, the majority of the Court endorsed *Imperial Oil Ltd. and CEP, Local 900* (2016), 157 LAC (4th) 225 (M.G. Picher), as the "blueprint" for dealing with safety sensitive workplaces (referred to as "dangerous workplaces"), and quoted this statement:

> Drug and alcohol testing is a legitimate part of continuing contracts of employment for individuals found to have a problem of alcohol or drug use. … *In a unionized workplace the Union must be involved in the agreement which establishes the terms of a recovering employee's ongoing employment, including random, unannounced testing*. … (*Irving* at para. 32; italics added)

The Employer's Policy, by its terms and in practice, does not follow these fundamental tenets. The template for the Return to Work Agreement/Last Chance Agreement is imposed in all circumstances except self-disclosure. This potentially includes situations where there has been no impact in the workplace and/or the employee was not facing disciplinary sanctions. An actual illustration can be seen with what happened to Ms. A. When her LTD claim ended, she could not return to work unless she signed the Last Chance Agreement. The blanket application of the template where an employee has not self-disclosed additionally means there is no examination of the employee's individual circumstances.

I find the Union has not been given an opportunity to meaningfully participate in the development of terms for any of the Last Chance Agreements canvassed at arbitration (or, for that matter, the Return to Work Agreements). There are at least three statements in AU0200 which expressly contemplate multi-party collaboration "to develop a formal Return to Work/Last Chance Agreement", and the Union is listed as one of the participants. This has not occurred in practice. Ms. Janes testified that the HRBP is responsible for "pulling all of the information together" and drafting the return to work agreements. Once the document is ready, a meeting is called and the Union and the employee involved are brought in to sign. Ms. Janes testified further that the agreement is reviewed "to ensure everybody understands the terms". The Employer does not provide any information to the Union in advance, and the Union will not have seen the monitoring agreement unless it has been received from the employee.

There was a suggestion at one stage in the Employer's case that it should not be faulted for its practices when the Union has not co-operated in the process. The criticism does not justify the prevailing approach. I accept Ms. Lemky's testimony that the agreements prepared by the Employer are not mere drafts, and find there is no opportunity for meaningful collaboration.

The automatic imposition of Last Chance Agreements except for cases of self-disclosure also provides some support for the Union's contention that the Employer's

approach to employees with substance use disorders is "disciplinary". The explanation may lie in the third "risk" factor identified in the Executive Summary (quoted above) which advocated adoption of the Policy because "terminations and other disciplinary actions due to substance misuse are more likely to be upheld". Regardless of the underlying objective, I find the Policy's use of Last Chance Agreements does not accord with prevailing arbitral standards.

H. Mandatory Treatment and Testing

The Union asserts that the Policy subjects employees with substance use disorders to mandatory treatment, and additionally directs the type and duration of the treatment provided. The various forms of treatment which are allegedly "embedded in", or required by, the Policy include: residential treatment; complete abstinence from the use of all substances; monitoring; attendance at 12-step peer support group meetings; and, random testing. The Union clarifies that its objection is not based on whether an individualized treatment plan may recommend these components, but rather that they are universally required by the Policy in all cases. It maintains the Employer will not exercise its discretion to alleviate the requirements, and points in part to the following "conditions" in the Guidelines:

> CONDITIONS OF RETURNING TO WORK FOR EMPLOYEES WITH SUBSTANCE DEPENDENCY DIAGNOSIS
>
> - The employee must follow a medical treatment plan of an Addictions Specialist which may require attendance and successful completion of residential Addiction Treatment Centre program.
> - The employee has to be medically cleared by the specialist prior to returning to work;
> - The employee should have an agreement with the medical specialist or practitioner which outlines the conditions under which the employee can return to work, medical restrictions, the arrangements that must be in place to monitor for compliance with ongoing treatment recommendations including abstinence etc. and any accommodation issues which should be taken into consideration;

- The employee agrees to and signs a Return to Work or Last Chance Agreement (the title depends on the circumstances of the case) along with their union, if applicable, which outlines the conditions under which Interior Health will allow him/her to work for Interior Health again. (p. 6)

The Guidelines likewise provide on the preceding page that managers should advise employees that "… if a diagnosis of substance dependency is made, one of the requirements prior to returning to work is proof of the successful completion of an approved or recommended treatment program" (p. 5).

In support of its allegation regarding mandatory treatment, the Union relies on Ms. Meidl's testimony in cross-examination that the persons she selects to perform IME's for the Employer almost always prescribe residential treatment; always prescribe AA/NA mutual support; usually prescribe complete abstinence; and, always require "robust biological monitoring" for at least two years. The Union notes as well paragraph 13 in the templates for the Return to Work and Last Chance Agreements which identically provide:

> 13. <Employee name> agrees to: **
>
> i.) Attend at least ___ Alcoholics Anonymous and/or Narcotic Anonymous meetings every week indefinitely including a home group.
>
> ii.) Maintain regular meaningful contact with a male/female sponsor in AA or NA including at least one hour of 1 on 1, face to face contact every week and frequent telephone contact,
>
> iii.) Complete any 12 step work recommended by the sponsor; and
>
> iv.) If available and appropriate, attend a Caduceus group meeting at least twice monthly or as frequently as recommended by the addiction monitor, whichever is greater.

The double asterix in the foregoing excerpt leads to a footnote at the end of both templates which reads: "** Employee specific".

The Union cites *Brant Community Health Care System and Ontario Nurses Association (Medical Form Grievance)*, [2008] OLAA No. 116 (Harris), for the statement that "[t]reatment modalities are a matter for the doctor and the patient" (para. 29). By mandating specific forms of treatment, it says the Policy interferes with the right of employees to consent to medical treatment and also interferes with the effectiveness of treatment.

The Employer essentially answers all of these submissions by saying the allegation that IHA mandates certain forms of treatment "is simply incorrect". For instance, and as demonstrated by the evidence, residential treatment is not always required as part of the specialist's recommendations. Residential treatment was not recommended for Ms. A and Dr. Baker did not prescribe a residential program for Ms. B in recognition of her limited financial circumstances. Further, the post-treatment conditions of return to work "are always based on the recommendations of the addictions specialist" (Employer Reply Argument, at para. 106).

I find there is considerable force to the Employer's rejoinder. As noted elsewhere, the passage from page 6 of the Guidelines relied on by the Union regarding conditions of returning to work does not apply universally to employees with a substance use disorder. Instead, it focuses more narrowly on those diagnosed with "substance dependency". I also acknowledge the Employer's statement that there is a discretion under the Policy. For instance, the segment dealing with Return to Work and Last Chance Agreements provides that "[t]he agreement *may* include but is not limited to: …" (italics added). A least some of the agreements entered into evidence also confirm that they incorporate by direct reference the recommendations contained in the report by the addictions specialist. An illustration is the Last Chance Agreement of Ms. A:

> Articles/clauses numbers A, B, C, D, E, F, G, H, I, J, K, L from February 20, 20xx report from [name omitted] - Addiction Specialist, [name omitted] - Family Physician and [name omitted] will be deemed incorporated into this agreement, with the alterations necessary to make the same applicable to the purpose of this Agreement, and to the parties here instead of the parties in that agreement. The specific work restrictions and limitations are: … (para. 6)

That said, the overall impression emerging from the evidence as a whole is that the specific forms of treatment challenged by the Union are almost invariably recommended by the specialists selected by the Employer. That conclusion is supported by the inventory of Return to Work and Last Chance Agreements compiled by Ms. Lemky and the breakdown of the various components (Exhibit 22 at Tabs 1-3). In fact, the uniformity is rather striking. Thus, while the Employer is largely correct in submitting that the treatment recommendations emanate from the addictions specialists, my concern is that the construct or parameters imposed by the Employer do not adequately allow for an individualized assessment of the Union's members. That "construct" includes the unilateral selection of the specialist in the first instance, and the Employer's failure to provide sufficient information about its employees and their duties before the assessment is undertaken, including when the assessment is made by a GWL-selected specialist.

Turning to the specific requirement of abstinence, the expectation that employees will abstain from using drugs or alcohol on their return to work has been recognized in the case law. In response to the complaint in *Kingston General Hospital* that a last chance agreement contained an absolute prohibition on substance use, Arbitrator Swan wrote at paragraphs 58-59:

> Moreover, the arbitral jurisprudence in cases where expert evidence was adduced supports the notion that the imposition of stringent conditions on abstinence is a central feature of providing the supportive conditions in which recovery might become possible, while failure to make such stringent requirements, or having made them, failure to enforce them, may be a form of "enabling" an addict to continue to use intoxicants and ultimately worsen the individual's condition; see ***Re Pacific Blue***

> *Cross and Canadian Union of Public Employees. Local 1816* (2005), 138 L.A.C (4th) 27 (McPhillips), at pages 36-37.
>
> In my view, a last chance agreement which includes an absolute prohibition on continued substance abuse is not only an appropriate, but quite probably an essential part of the accommodation of addiction which is based upon the need for rehabilitation. In some circumstances rehabilitation might not be necessary to the fulfillment of the essential duties or requirements of a particular job, but I accept that in this case it was, and that an essential pre-condition for successful rehabilitation is abstinence. Indeed, in one case relied on by the Union, an arbitrator specifically increased the stringency of the abstinence requirement when reinstating an employee who had relapsed while covered by a protocol that did not quite amount to a last chance: see *Re Castlegar & District Hospital and British Columbia Nurses' Union* (2000), 86 L.A.C. (4th) 81 (Larson), at paragraph 60.

Other awards where arbitrators have upheld abstinence provisions for employees returning to work include *Capital Health Authority and Alberta Union of Provincial Employees, Local 054* (2006), 152 LAC (4th) 81 (Jolliffe), and *Telus and Telecommunications Workers Union*, [2007] CLAD No. 289 (Beattie), where the arbitrator highlighted the "safety-sensitive work environment" (para. 228). See also *Brooks v. Martin-Brower of Canada Co*., [2008] BCHRTD No. 439, where a "comprehensive, collaborative and individualized program to monitor and support [the employee] in his rehabilitation and return him to work in a safety-sensitive position" required abstinence from alcohol (paras. 58 and 60).

More broadly, the subject of "mandatory treatment" generated perhaps the greatest divergence in the expert testimony. The subject includes not only abstinence, but also residential treatment, monitoring (with its associated random testing), and attendance at 12-step or similar peer support groups. The Employer relies on the testimony of Dr. Els and what I will characterize as the "conventional wisdom" in the arbitral case law to support all of these features for employees who work in a safety sensitive setting and have been diagnosed with a severe substance use disorder. Among other things, Dr. Els stated that outcomes under the Physician Health Program model (a coerced form of

aftercare) are "among the best available", and he characterized the program as "the gold standard".

The Union disputes this conventional approach based on the testimony of its expert witnesses. I find, however, that the evidence is not sufficient to displace the current arbitral approach to drug and alcohol policies in a safety sensitive workplace. For instance, in respect of the efficacy of mandated treatment, Dr. Urbanoski stated it will be effective for some individuals but won't be for others, and candidly allowed that "not enough [research] has been done". She later stated that 25-75% of people who meet the criteria for a substance use disorder at some point in their life don't get treatment and recover. However, "the problem" is that there is a "very limited understanding" of how to predict who can recover without treatment. Dr. Sutherland takes issue with the requirement for complete abstinence, but acknowledged in cross-examination "there are two different sets of thoughts on the same issue", and described the divide as "a generational thing". In her practice, recovery can allow for non-problematic substance use. In this regard, I prefer the opinion of Dr. Els. Continued substance use may be appropriate as part of harm reduction in a community setting; however, the accepted standard of care for someone employed in a safety sensitive position following a diagnosis of substance use dependency is abstinence.

In summary, and without reviewing all of the controversies covered in the expert testimony, I find a greater consensus on different approaches must emerge from the medical field before the arbitral case law should begin to chart a new course. The currently accepted approach may include, among other requirements, random alcohol and drug testing for a limited period of time (most commonly two years) under an employee's rehabilitation program (again, see *Irving*).

In any event, many of the differences expressed by the expert witnesses in this proceeding can be set aside because there was a general consensus underlying the formulation of any treatment plan. Namely, it should be prepared by a qualified professional who follows an evidence-based approach and gives due consideration to the

circumstances of the individual employee. This, of course, is consistent with and reinforces the prevailing view of Canadian arbitrators regarding the duty to accommodate for any disability.

The opinion of Dr. Els regarding the essential features of an IME have been canvassed already. Dr. Beckson stated that the diagnosis will guide the treatment recommendations; for example, the diagnosis of a mild substance use disorder would typically result in recommendations that do not look anything like those for a person diagnosed with a severe disorder. Dr. Livingston agreed in cross-examination that sending an employee for an individualized assessment is not stereotyping. He agreed further that it would not be stereotyping if the specialist made recommendations appropriate for the employee's return to work provided an evidence-based approach was followed. Dr. Urbanoski stated there are a variety of treatment approaches with demonstrated effectiveness for helping to resolve substance-related problems, and "no one type of intervention works for everyone". Consistent with that view, she added that there should be an individualized assessment "for people who enter the system", and treatment should be based "on what is found in that assessment". She later agreed in cross-examination that individualized assessment by an addictions specialist is appropriate.

A straight-forward illustration of why treatment plans must be individualized arises in relation to AA/NA or equivalent 12-step programs. Again, this appears to be a contested area, but I accept Dr. Urbanoski's opinion that questions of safety may arise for women and the public speaking component may be difficult for them and others. Dr. Sutherland also explained that women often dislike AA because it is very male dominated and they may get "hit on". Dr. Els described AA as an "add-on with acknowledged limitations". He makes use of the program or reasonable alternatives, but again emphasized flexibility and said he provides individuals with a "menu" of options.

I appreciate that the paragraphs in the templates for the Return to Work and Last Chance Agreements requiring attendance at AA/NA meetings are said to be "Employee

specific", coupled with the Employer's position that it is simply following the recommendations of the addictions specialist. However, all but two of the 21 documents in the inventory prepared by Ms. Lemky contain this stipulation. The degree of uniformity begs the question of whether a truly individualized assessment was carried out in the first instance. The homogeneity of the Return to Work and Last Chance Agreements is undoubtedly due as well to the fact that those documents are not true tri-partite arrangements. The flexibility contemplated by the templates has not been translated into the final agreements.

Once again, the Employer's primary response to the Union's allegation that the Policy directs mandatory forms of treatment is that return to work conditions are always based on the recommendations of an addictions specialist. It submits more fully:

- As a condition of continued employment in a safety sensitive workplace, the employer may require an employee to sign a RTWA or LCA, which may include, amongst other things, medical monitoring and random testing, *as recommended by an addictions specialist*. (Outline of Argument, at para. 264; italics added)

There is, however, one form of testing challenged under the grievance which is not based on a specialist's recommendations. Under paragraph 9(i) in both of the Return to Work and Last Chance Agreements, an employee must:

> At the Employer's request *on reasonable suspicion of a relapse*, attend for a biological assessment immediately (within 15 hours) and give consent for the testing facility to provide the results to the Employer and the monitoring physician on an immediate basis. Failure to attend will be considered and treated as a positive result. (italics added)

The definition of "Relapse" in both AU0200 and the Guidelines is identical: "The recurrence of the use of mood altering substances and/or engagement in old behaviours following a period of abstinence".

The Employer acknowledges that "the right [sic] to test on reasonable suspicion of relapse does not arise from the Policy, but from the RTWA or LCA" (Reply Argument, at para. 18). It emphasizes the word "reasonable" and says this requires IHA to consider the circumstances and exercise discretion.

I find the term "old behaviours" is excessively broad given the potential consequences for employees under the Agreements. More fundamentally, the Employer has not shown that a discretionary "right" to order tests based on suspicion of relapse is reasonably necessary beyond the biological testing conducted by a monitor, where random testing has been recommended by a specialist. In determining the need for this unilaterally imposed term, it is relevant to additionally bear in mind the provision of the Policy subjecting employees in safety sensitive positions to "reasonable cause testing and/or post incident testing for substance use …" (AU0200 at Section 3.3.4). As the Union submits, the Employer did not call evidence to establish what, if any, safety gains may be achieved by the reasonable suspicion testing, or to demonstrate undue hardship if the requirement is eliminated.

Lastly, and in relation to treatment generally, where a reasonable rehabilitation/return to work plan has been properly formulated, it is well established that the employee must comply with the terms of the agreement in accordance with the tripartite nature of the accommodation process; see *Pacific Blue Cross and CUPE, Local 1816*, [2005] BCCAAA No. 37 (McPhillips); *Kingston General Hospital*; *Irving*; *International Forest Products (Hammond Cedar Division)* especially, at para. 44; and *Taylor v. New Westminster*.

I. Lack of Notice to the Union

As the authorities canvassed above illustrate, arbitrators have routinely held that an employee's bargaining representative must be included in negotiations for a last chance agreement. In my view, and while it may not be required by the case law, the

Union should be involved as a matter of prudence from the point when an employee is removed from the workplace due to disclosed or suspected substance use problems.

The Employer does, through Disability Management, involve EDMP stewards at some stage of the process, although they may never be involved in the case of casual employees. However, the role of EDMP stewards is limited, and they do not represent the Union's members in labour relations matters at the worksite. There is no mechanism in the Policy to invoke shop stewards or other Union labour relations personnel either before or when employees are told they must attend an IME. According to Ms. Janes, the Union is not engaged unless and until there is an investigation into alleged workplace misconduct (this is consistent with the "Subsequent Meeting" section of the Guidelines), or even later when the Union is called to a meeting to sign a return to work document.

While only placed on the record for purposes of identification, I note the Roles and Responsibilities section of the equivalent Fraser Health Authority policy expressly contemplates the following participation of the bargaining agent (bold in original):

Union

- **Promote early, voluntary referrals.**
- **Work with management** to advise employees of options.
- Collaborate with Manager, DMC, HRC and employee to develop a return to work plan.
- Support and assist the employee during return to work.
- Participate in the development and delivery of staff education programs.
- Practice confidentiality.

Curiously, the "Specific Responsibilities" section of AU0200 parallels in many respects the FHA policy, but there is no equivalent segment envisaging a role for the Union.

J. Financial Consequences

The burdens and negative consequences which the Union maintains are imposed on employees with substance use disorders include "significant financial burdens". In this regard, it points to the monitoring agreements which are incorporated into the Return to Work and Last Chance Agreements. The Employer does not pay for this monitoring, which typically lasts for 24 months or longer. The cost estimates on the record range from $150 to $800 per month.

The Union notes the evidence of Ms. Meidl who testified that some employees outside of the Facilities Bargaining Association (who typically receive higher wage or salary rates) have access to other resources to cover at least some of the required monitoring period. In contrast, the testimony of the Union's members in this proceeding confirms the relative financial hardship created by the cost of monitoring, especially for part-time or casual employees. The fees represent an appreciable portion of their income and negatively impact their ability to use their earnings for other basic needs. The financial burdens are exacerbated by the Employer's position that no employees with a diagnosis of substance use disorder may return to work until they have been cleared by a second IME, meaning the employees may have no income at all for a period of several months.

The Employer argues it is not unreasonable nor a breach of the Code to require employees to bear some of the costs of their treatment, monitoring and/or drug testing. It refers to the statement by the arbitrator in *Vancouver (City) Board of Parks and Recreation and Canadian Union of Public Employees, Local 1004*, [2011] BCCAAA No. 149 (Thorne), that "I cannot find any authority in the jurisprudence for the proposition that a failure by an employer to pay for treatment results in a conclusion that it has failed to accommodate" (para. 148). The Employer notes as well that it pays 100% of the premiums for the LTD plan under Article 39.03 of the Collective Agreement, which entitles all regular employees who may have a substance use disorder to an assessment with an addictions specialist, as well as to treatment (including residual treatment)

without cost. It also pays for an addictions specialist to assess casual or probationary employees. In short, the Employer maintains its financial contributions and other support has satisfied its obligation to accommodate employees with substance use disorders.

The statement in *City of Vancouver* relied on by the Employer was proceeded by this observation from the arbitrator:

> In many of the arbitral authorities I reviewed, the applicable employers did indeed pay for treatment received by their respective grievors. I would be happier when considering whether the Employer accommodated the Grievor up to, but short of, undue hardship, if the Employer had done so in this case. … (para. 148)

Moreover, the employer in that case granted interest free loans to employees in order to assist with the cost of treatment. See also *Hammond Cedar* where the employer effectively provided interest free loans (para. 33). In *Taylor v. New Westminster (City)*, [2009] BCHRTD No. 139, the employer paid for "the majority of the treatment *and monitoring services*" which the employee received (para. 41; italics added).

What arbitrators may or may not have ordered in other cases is somewhat beside the point. So too is the Employer's contention that it does not pay for the treatment of employees with other medical conditions where negotiated benefit coverage falls short. In this regard, Ms. Janes gave the example of a diabetic who does not have all supplies and testing covered by the benefit plan and must pay "out of pocket". However, the analogy does not hold unless those employees are also being accommodated in the workplace. The ultimate question in all cases of accommodation is where to draw the line in determining what constitutes undue hardship on the part of the Employer. As emphasized near the outset of my analysis, the determination can only be made on an individualized basis.

Nonetheless, as a general observation, I do not rule out an obligation on the Employer in certain situations to shoulder some or all of the expense associated with ongoing monitoring. Relevant considerations in these circumstances are the size of the

Employer’s operation and the given financial cost: *Central Alberta Dairy Pool v. Alberta (Human Rights Commission)*, [1990] 2 SCR 489, at p. 521.

K. Employee Searches

This is a relatively minor and discrete allegation, and was advanced by the Union on the basis of written submissions alone.

The Guidelines provide on the final page for searches:

> Interior Health will inspect any part of its premises at any time when it has reasonable grounds to believe that the Substance Use Disorder Policy has been violated, and will conduct such other searches as are reasonably necessary for enforcement of the policy, including, but not limited to, *the personal effects of those employees engaged in safety-sensitive positions if there is reasonable cause to believe that they have violated this policy*. Failure or refusal to cooperate with such inspections or searches will constitute a violation of this Policy. (p. 11; italics added)

The reasonableness of a search policy, or its implementation, lies in a balancing of interests between an employee’s right to privacy and the employer’s right to manage the workplace. As stated in *Progistix-Solutions Inc. v. CEP, Local 26* (2000), 89 LAC (4th) 1 (Newman), the approach requires the employer to: establish adequate cause to justify the search, including exhausting available alternatives; take reasonable steps to inform both the employee and the union; and, conduct the search in a systematic and non-discriminatory fashion (para. 31). The more intrusive the type of search involved, the greater the right and expectation of privacy on the part of the employee.

A search of employee personal effects is more intrusive than a search of employer property such as lockers used by employees. Thus, in *University Hospital v. London & District Service Workers’ Union, Local 220 (Privacy Grievance)* (1981), 20 LAC (2d) 294 (P.C. Picher), the board found there was adequate cause for the hospital to inspect lockers, particularly as prior measures to resolve a pilferage problem has been exhausted,

but did not condone the hospital's inspection of personal effects contained in the lockers (paras. 18 and 22).

The Union submits searches under the Policy are unreasonable in three respects:

(a) There is no provision for prior notice to either the Union or the employee;

(b) There is no requirement to consider other options and whether a search is proportionate; and

(c) The standard for searches on reasonable grounds to believe the Policy has been violated is overbroad, in that many Policy violations will not provide reasonable grounds to suspect an employee is in possession of property or substances the Employer may have a legitimate interest in discovering.

I find the first two complaints are self-evident from the plain wording of the Policy. Nor do I understand the Employer to contend otherwise.

I find as well that the Policy's search provisions are overly broad; i.e., the Union's third complaint. The Union allows that the Employer may have a legitimate interest in searching an employee's effects where there are reasonable grounds to believe the employee is engaged in the use, trafficking or theft of intoxicant substances at work. But the language in the Guidelines applies equally to any circumstance in which the Employer believes an employee has "violated this policy". One can readily envisage circumstances which technically constitute a breach of the Policy but would not reasonably justify a search of an employee's personal effects. An immediate example would be a failure to disclose past dependency issues where there has been no indication of recent substance use by the employee.

I find the broadly worded "trigger" for the search provision of the Policy cannot be sustained as drafted.

L. The Policy Allegedly Singles Out Employees with Substance Use Disorders

This was actually the first of the specific allegations advanced by the Union in closing argument. I have chosen to address it last for several reasons, including the fact that it draws on several complaints which were also raised separately (e.g., disclosure of a diagnosis to managers while other medical issues are referred to Disability Management). Those complaints, as well as the Policy as whole, have now been explored at considerable length.

The essence of the Union's complaint under this heading is that the Policy subjects employees with substance use disorders to different processes, standards and consequences than employees who are not disabled or who have a diagnosis other than substance use disorder. The Union submits this "singling out" of employees with substance use disorders is based on the stereotypical assumption that they pose an extraordinary risk to the workplace (whereas other employees do not), and argues "mental health profiling" of this nature is a form of discrimination. It relies on Dr. Livingston's testimony that the Policy exemplifies "structural stigma" and endorses a stereotype of individuals with substance use disorders as being inherently "dangerous" or "unpredictable".

As part of these submissions, the Union maintains the Employer chose to direct the Policy specifically at a protected group, rather than address drug or alcohol use in the workplace more broadly, and says this improperly shifts the focus from impairment and risk in the workplace to the diagnosis in and of itself. The Union points as well to evidence regarding a number of other potentially impairing conditions (e.g., epileptic seizures, cardiovascular disorders, diabetes and severe sleep apnea), yet the Employer has not shown it considered policies in relation to those sources of impairment; therefore, the "stereotypical and stigmatizing focus on individuals with substance use disorders could not be clearer" (Closing Argument, at para. 381).

I will begin with the Union's reliance on the lack of policies dealing with other sources of impairment. None of the authorities before me holds that an employer cannot introduce a properly formulated drug and alcohol policy unless it likewise promulgates provisions dealing with all potential forms of impairment or other types of risk in the workplace.

Therefore, the question quickly becomes whether the Policy is a legitimate response to the potential risk of impairment due to drugs or alcohol by employees who work in safety sensitive positions or whether, as the Union asserts, it improperly targets those with substance use disorders. In that regard, the title of AU0200 and that of the Guidelines both lend support to the allegation (i.e., "Substance Use Disorder"). It can be fairly observed as well that the Policy is more narrowly focused than many others which have been considered in the case law (see, by comparison, the policy appended to Arbitrator Taylor's *Weyerhaeuser* award). On the other hand, a closer examination of the Policy reveals that it has a broader purpose than merely identifying employees with substance use disorders. Further, and as explained already, several of the provisions challenged by the Union apply solely to employees with "alcohol or drug *dependency* problems" where the potential for on-the-job impairment is elevated. The relevant extracts include the Purpose which is repeated here for convenient reference:

> 1.0 PURPOSE
>
> To assist in protecting patients/residents/clients, employees, medical staff, volunteers, students and the public from the potential adverse effects of the inappropriate use of alcohol and drugs.
>
> To encourage and support employees to take steps to resolve their medical or health conditions that might put those in the workplace at risk.
>
> To enable employees with substance use disorders to get well. Interior Health will support the rehabilitation and return to work of employees and medical staff who are experiencing difficulties with substance dependence.

I additionally note the following elements of the Policy found under the heading "Substance Free Workplaces":

- All individuals who are employed by or carry out business for or on behalf of Interior Health are expected to arrive at work fit for duty and perform their assigned duties safely and responsibly without any limitations due to the inappropriate use or after-effects of use of alcohol, illegal drugs, medications or any other mood altering substances that may endanger their health and safety or that of any other person (WorkSafe BC Regulation, Part 4, 4.20(1)(2)(3)). Interior Health will facilitate the removal from the premises of any individual it reasonably suspects is impaired by alcohol, a drug or other substance. (Section 3.1.1)

- Interior Health does not tolerate the use of alcohol, illegal drugs and other non-prescription mood altering substances or the misuse of medications by any individual engaged in Interior Health business or working on Interior Health premises, and it is the responsibility of every individual to comply with this expectation. … (Section 3.1.2)

- Other than the handling of these substances as required in an individual's normal course of duties, Interior Health prohibits the possession, distribution, storage, offering or sale of illegal drugs, alcohol, prescription medications and mood altering substances by any individual engaged in Interior Health business or working on Interior Health premises. (Section 3.1.3)

- Employees who are placed on call are responsible for remaining fit for duty. When unexpected emergencies arise, employees who are not on call may be requested to perform unscheduled work for the Employer. If an employee who is not on call is unfit for work due the influence of alcohol and/or drugs it is the employee's responsibility to refuse the request and ask that the call to work be directed to another employee. The inability of an employee who is not on call to accept a work

assignment in these circumstances will not result in any disciplinary action. (Section 3.1.5)

- Contractors, volunteers, medical staff and students are expected to perform their duties in a manner consistent with the Substance Use Disorder policy. (Section 3.1.6)

Section 3.2 is headed "Employee Support and Assistance" and includes access to the Employer's EFAP Services:

> Individuals who believe they have a developing alcohol and/or drug problem are expected to assume responsibility and seek assistance from their personal physician(s) and or appropriate community resources before their job performance is affected or violations of this policy and related guidelines occur (WorkSafe BC Regulation, Part 4; 4.19(1)). Regular Interior Health employees and their immediate families may access the Employee Family Assistance Program. Employees may also seek assistance from the Workplace Health Safety and Wellness department and/or their Manager. … (Section 3.2.1; italics added)

In sum, I do not accept the Union's characterization of the Policy as being directed solely to all individuals with a substance use disorder (as distinct from those with substance dependency problems); nor does it target such disorders to the exclusion of impairment in the workplace caused by the use of drugs or alcohol. Therefore, while I have found above that elements of the Policy are not reasonably necessary, this overarching allegation does not provide a basis for declaring it to be void *ab initio*.

IX. CONCLUSION AND REMEDY

I will not repeat or attempt to summarize the various determinations made throughout this award regarding the allegations advanced under the Union's grievance.

The language of the Employer's policy AU0200 appears initially on its face to accord with current Canadian case law respecting the promulgation of drug and alcohol policies in safety sensitive industries. However, when the Policy as a whole is scrutinized more closely -- and especially as its practical application was explained and examined in general terms at arbitration -- there are a number of shortcomings. Suffice it to say that several elements of the Policy have been found to be unreasonable. As a consequence, they cannot be said to be reasonably necessary under the third step of the *Meiorin* analysis (i.e., the BFOR requirement); nor do they withstand scrutiny under the *KVP* analysis as a valid exercise of management rights.

The questions remaining at this stage concern the appropriate form(s) of arbitral relief.

The initial remedy sought by the Union is a declaration that the Policy is void *ab initio*. However, for reasons expressed in Part VIII above, the Union's primary allegation in support of this outcome has not been sustained. I find as well that the Union's remaining allegations, even when considered cumulatively, are not sufficient to void the Policy entirely. Put simply, the core of the Policy (i.e., AU0200 by itself) aligns substantially with the currently accepted arbitral approach to drug and alcohol policies governing safety sensitive sectors.

The Employer submits the grievance should be dismissed. Alternatively, if some aspect of the Policy needs to be amended, it says directions should be provided and the Employer should be required to make the necessary amendments with arbitral jurisdiction being reserved in the event of any dispute.

A somewhat similar remedy to that proposed by the Employer was granted in *Holtz* where Arbitrator Abramsky found the testing concept under review was reasonable, but the wording required amendment to indicate the individualized assessment of each employee's situation (para. 53). I have decided more extensive relief should be granted

in this proceeding due to the nature and scope of the deficiencies which have been revealed in both the wording of the Policy and its application.

The Policy as a whole obviously needs amendment on several fronts, including the directions given to managers and others under the Guidelines. Due to the scope of the required revisions, I have determined that the Employer must suspend operation of the Policy insofar as it applies to the Union and its members. My order is effective immediately, and the suspension will continue until such time as there is compliance with this award.

I am not prepared to grant the Union's request for a direction that the parties "seek to *negotiate* a replacement policy". In none of the authorities cited has a similar limitation been exercised over a management prerogative. However, the Employer must engage in good faith consultations with the Union for a period of not less than 90 days (unless all outstanding points are resolved before then). I reserve authority to extend the consultation period after hearing from the parties on the status and progress of their discussions.

More generally, I reserve jurisdiction: (i) to elaborate on any aspect of this award if that would assist the consultation phase; and, (ii) on application by either party, to determine whether the Employer has satisfied the terms of the award prior to implementation of a revised Policy (any such application will be heard on an expedited basis).

DATED and effective at Vancouver, British Columbia on November 13, 2018.

JOHN B. HALL
Arbitrator