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Beyond the Label: Rethinking Workplace Substance Use Policies

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BEYOND THE LABEL: RETHINKING WORKPLACE SUBSTANCE USE POLICIES

I. Introduction

> Alcoholism drives the alcoholic to consume alcohol, and any measure of consumption would be an abuse. It is an evil addiction which would thereby have the alcoholic injure himself, those who love him, or anyone else who comes close. However, it is a disability which the alcoholic can overcome. Recognizing the destructiveness of this disability, he can lock it away inside himself. Recognizing its seductiveness, he can make firm his resolve to never let it escape. He will need help, but this is what he can do. Therefore, alcoholism itself is not a cause for discrimination.[1]

1 *Interfor v. USWA, Local 1-3567*, [2005] B.C.C.A.A.A. No. 184 (QL) at para. 42 ["*Interfor*"]. The title of this paper, *Beyond the Label*, is a reference to a 2005 publication of the same name, produced by the Centre for Addiction and Mental Health, to promote awareness and understanding of the impact of stigma on people living with mental health and substance use problems (Centre for Addiction and Mental Health, "Beyond the Label" (2005), online: <www.camh.ca> [CAMH]). *Stigma* has been described as a socially constructed attribute, or mark, which is deeply discrediting. It both leads to and results from prejudicial attitudes, manifesting in bias, distrust, fear, and stereotyping. The comments from the decision in *Interfor*, reproduced above, reflect the pervasive stigmatization of people with substance use problems in our arbitral and human rights jurisprudence.

Workplace substance use policies and practices typically impose various requirements and restrictions on employees with addictions.[2] For example, the following rules (or variations thereof) are commonly found in these types of policies and practices, and are usually enforced automatically, without consideration of an employee's particular circumstances, including the specific nature of her substance use problem:

(1) An employee who is impaired at work is removed from the workplace. If the employee's position is "safety-sensitive," she may be forced to submit to drug/alcohol testing prior to removal. If a substance use problem is suspected or disclosed, the employee will be compelled to submit to an "independent medical examination" ("IME"). The employee will be referred to a physician selected by the employer, or the employee will "choose" a physician, but this "choice" will be restricted by, and subject to the approval of, the employer.

(2) An employee with an addiction, with no history of workplace impairment, but who occupies a so-called safety-sensitive position, and who self-discloses her disability to the employer, will be removed from the workplace and may be required to submit to an IME.

(3) An employee with an addiction, who has been removed from the workplace, and who occupies a safety-sensitive position, will not be permitted to return to work unless and until she has satisfied various requirements and "agreed" to several conditions. Before she is permitted to return, the employee will be obligated to complete a treatment plan that has been approved by the employer (and which has been recommended by a physician selected or approved by the employer). The treatment plan will invariably involve prolonged, specialist treatment (typically in a residential setting) and participation in 12-step programming.

(4) Just prior to the employee's return to work, she will be required to sign a return-to-work "agreement." This agreement will typically mandate, among other things, complete abstinence, ongoing participation in 12-step programming, adherence to a prolonged monitored relapse prevention program, or "medical monitoring," and compliance with random biological testing. An employee who previously occupied a safety-sensitive position may not be permitted to return to that position.

(5) If, during the multi-year term of her return-to-work agreement, the employee is not abstinent at any time (at work or off-duty), or if she "relapses" (at work or off-duty) during the term of the agreement, or if she otherwise violates her return-to-work agreement, she will be removed from the workplace. At this point, the employee may be disciplined or terminated. Alternatively, she may be permitted to return, subject to the various requirements and conditions outlined above.[3]

The requirements and restrictions that I have outlined here (the "Requirements and Restrictions") are usually imposed under threat of discipline, up to and including termination. Employers assert that the purpose of these types of absolute rules is workplace safety, the implicit assumption being that any employee with a substance use disorder poses a unique and unacceptable safety risk.

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2 *Substance use* is a broad term, "describing the wide range of use of alcohol and other drugs, from moderate use to problem use." *Addiction* is "a state of dependence on a drug, in which the person continues substance use despite significant substance-related problems that may include harm to physical and/or mental health, social well-being and/or economic functioning" (CAMH at 61-62).

3 Workplace substance use policies also commonly include rules around drug/alcohol testing and searches of employee possessions.

Not surprisingly, there is no shortage of Canadian case law related to workplace substance use policies. Over the last two decades in particular, decision-makers have been asked to resolve many disputes involving employer-imposed policies in relation to substance use, addiction treatment and workplace safety. In many of these cases, factual assumptions and findings have been based on "expert evidence," commonly in the form of reports or testimony from physicians who have been certified by the American Board of Addiction Medicine ("ABAM").[4] These facts and assumptions have, in turn, deeply influenced legal analysis and outcomes in this area.

The assumptions and analysis typically articulated in the case law reflect what has been described as the "traditional view" of substance use and addiction treatment, and related workplace policies (*Vancouver v. CUPE, Local 1004*, [2011] B.C.C.A.A.A. No. 149 (QL) at para. 66 ["*Vancouver*"]). This approach is characterized by various standard concepts and notions, including the following:

(1) Sustained abstinence is the fundamental premise upon which all treatment plans must be based (see *Vancouver* at para. 66).

(2) People with addictions and substance use problems must be held responsible for their voluntary behaviours and the choices that they make (see *Vancouver* at para. 66; see also *Rio Tinto v. CAW-Canada, Local 2301* (2011), 204 L.A.C. (4th) 265 at para. 20 ["*Rio Tinto*"]).

(3) Addiction, though treatable, is an incurable, chronic disease, which is progressive if left untreated (see *Rio Tinto* at para. 20; *Interfor* at para. 39).

(4) People with addictions must hit "rock bottom" before they have a chance to recover (see *Vancouver* at para. 66; *Rio Tinto* at para. 20).

(5) People with addictions are deceitful, dishonest and untrustworthy (see *Shaw Cablesystems v. T.W.U.*, [2014] C.L.A.D. No. 79 (QL) at paras. 168-72, 290 ["*Shaw*"]).

(6) An employee's substance use problem, in itself, represents a risk to workplace safety (see *Rio Tinto* at para. 37; see also *Seaspan ULC v. I.L.W.U., (Local 400*), [2014] B.C.C.A.A.A. No. 108 (QL) ["*Seaspan*"]).

(7) Both from a therapeutic perspective, and from the perspective of ensuring workplace safety, the most effective and appropriate treatment regime for an employee with an addiction must generally include: early intensive treatment (typically in a residential setting); mandatory participation in Alcoholics Anonymous (AA)/Narcotics Anonymous (NA) or another 12-step, mutual support group program; a requirement of complete abstinence; and adherence to a medical monitoring program for an extended period of time (i.e., at least two years), involving random drug and/or alcohol testing, with disciplinary consequences for non-adherence (see *Interfor* at para. 44; see also *Seaspan*).

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4 The ABAM certifies physicians across a range of medical specialties and fields, including family medicine, paediatrics and osteopathic medicine. To receive ABAM certification, a candidate must successfully complete a five-hour computer-based examination. To qualify for this examination, the candidate must be a medical school graduate, possess a valid medical license, and have completed an accredited residency program. During the five-year period preceding the examination, the candidate must have accumulated 1,920 hours of experience (i.e. research, administration, clinical care, etc.) in relation to one or more substance use disorders (e.g. addiction to alcohol, tobacco, etc.), usually including 400 hours of direct clinical care. Candidates must also have completed 50 continuing medical education credits related to addiction or substance use disorders during the two-year period prior to examination. See American Board of Addiction Medicine, online: <www.abam.net>.

The Requirements and Restrictions outlined above, which are common components of workplace substance use policies and practices, are more or less consistent with this traditional view of substance use and addiction treatment. Yet some of the standard concepts and notions listed here, which characterize the traditional view, are generalizations. Some are simply not true. Some perpetuate harmful misconceptions and negative stereotypes. And none are well-supported by controlled, scientific research. Somehow, however, taken together, these concepts and notions now form the foundation upon which most substance use policies and many addiction-related legal decisions have been constructed.

It is, therefore, time to fundamentally rethink and rebuild this area of law and workplace policy. In this paper I attempt to lay out a blueprint for this rebuilding project, as it relates to unionized workplaces.

The paper proceeds in four parts. First, I touch briefly on the issue of stigmatizing views among treatment professionals. Then, I highlight aspects of the research literature related to substance use and addiction treatment, and the implications of this evidence. Next, I turn to the relevant legal analysis, focusing on first principles. I begin by laying out the arbitral approach for assessing unilaterally-imposed policies related to safety concerns in unionized workplaces. I then discuss the discrimination analysis under the *Human Rights Code*, R.S.B.C. 1996, c. 210 ["Code"]. I conclude by asserting that conventional wisdom and standard practice around substance use policies must be challenged.

II. Stigmatizing Views Among Professionals

> The fact that an individual is a doctor of medicine does not shelter him from prejudices.[5]

The general population "often stigmatizes people with mental health and substance use problems" (CAMH at 73, citing E.B. Ritson, "Alcohol, drugs and stigma" (1999) 53(7) Int'l J. Clin. Pract. 549-51 ["Ritson"]).[6] But prejudice is not limited to members of the public.

Academic research has shown that professionals working in the mental health and substance use field share many of the same attitudes and beliefs as the rest of society, and some hold stigmatizing views of their clients (CAMH at 73, citing Ritson; see also Fulton). Some of these views may be based on misperceptions (e.g., viewing people with addictions as dangerous and/or blameworthy), while "others may result from feelings of inadequacy, frustration and disappointment that arise when professionals are working with clients with complex needs" (*ibid.*).

Discussions of physician biases are not limited to the academic literature. Legal experts and decision-makers have also addressed this sensitive issue. For example, in *Robinson*, a case involving an employee with epilepsy, the Canadian Human Rights Tribunal offered the following observations (at 18):

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5 *Robinson v. Canada*, [1991] C.H.R.D. No. 9 at 8 (QL) ["*Robinson*"].

6 See also Rebecca Fulton, "The Stigma of Substance Use and Attitudes of Professionals: A Review of the Literature" (2001) [submitted to The Committee on Stigma and Addictions, Centre for Mental Health and Addictions], online: <www.camh.ca> ["Fulton"]. For more on the stigma of substance use and its impacts (e.g., marginalization, systemic disadvantage), see Centre for Mental Health and Addictions, "The Stigma of Substance Use: A Review of the Literature" (1999), online: <www.camh.ca>.

> It should also be pointed out that unwarranted generalizations on the physical fitness and capabilities of persons handicapped by certain disabilities are not made only by neophytes. Some physicians can give in to this temptation … Thus, when a physician, especially if he has a close working relationship with an employer, gives the opinion that an applicant presents a risk for work safety because he is an epileptic, this is not necessarily an adequate individual assessment of the real capabilities and risk the particular applicant might present in the job he is seeking. His assessment might be based on pure, groundless generalization or on outdated medical studies. As Professor William Black has pointed out, it might also be coloured by his bias in favour of his client, who is the employer:
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> > Often medical examinations of job applicants are done by a doctor who has an ongoing relationship with an employer … Even though the doctor may try to be objective, I think it is unavoidable that the interests of the firm will be preferred to those of the applicant in close cases. Usually, an unsuccessful applicant will simply disappear, whereas a doctor is likely to be criticized if he or she approves an applicant who subsequently proves unable to perform the work … I believe that doctors conducting medical examinations usually view their job as one of determining who are the least risky applicants rather than determining whether a person can perform the required duties.

III. Research on Substance Use and Addiction Treatment

> The treatment and research communities appear to continue operating on different wavelengths and with different philosophical agendas, probably to the detriment of persons with alcohol-related problems.[7]

There is currently a troubling disconnect between the "traditional view" of substance use and addiction treatment described above, and the academic research in this area. In this section of the paper, following a brief discussion of the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders* ("DSM-5"),[8] I review a number of key points from the literature.

A. DSM-5

DSM-5 is the most recent edition of a publication that is widely used in the US and Canada to diagnose and classify mental disorders, including substance use disorders.[9] The definitions and criteria in DSM-5 are commonly referenced in workplace substance use policies.

DSM-5 describes a "substance use disorder" as a problematic pattern of substance use leading to clinically significant impairment or distress, as manifested by at least two of the following symptoms, occurring within a 12-month period:

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7 Frederick Rotgers, Book Review of *Handbook of Alcohol Treatment Approaches: Effective Alternatives* (2nd ed.) by Reid K. Hester & William R. Miller, eds. (January 1996) J. Stud. Alcohol 101.

8 American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 5th ed. (Washington: APA, 2013).

9 There are alternatives to DSM-5 (see, e.g., World Health Organization, *International Classification of Diseases*, 10th ed.), and the manual is not immune from criticism (see, e.g., Allen J. Frances & Thomas Widiger, "Psychiatric Diagnosis: Lessons from the DSM-IV Past and Cautions for the DSM-5 Future" (2012) 8 Annu. Rev. Clin. Psychol. 109-30).

(1) The substance is often taken in larger amounts or over a longer period than was intended.

(2) There is a persistent desire or unsuccessful efforts to cut down or control the substance use.

(3) A great deal of time is spent in activities necessary to obtain the substance, use the substance, or recover from its effects.

(4) Craving, or a strong desire or urge to use the substance.

(5) Recurrent substance use resulting in a failure to fulfill major role obligations at work, school or home.

(6) Continued substance use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the substance.

(7) Important social, occupational, or recreational activities are given up or reduced because of substance use.

(8) Recurrent substance use in situations in which it is physically hazardous.

(9) Substance use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance.

(10) Tolerance, as defined by either of the following:

  (a) A need for markedly increased amounts of substance to achieve intoxication or desired effect.

  (b) A markedly diminished effect with continued use of the same amount of the substance.

(11) Withdrawal, as manifested by either of the following:

  (a) The characteristic withdrawal syndrome for the substance.

  (b) Substance (or closely related substance, such as benzodiazepine with alcohol) is taken to relieve or avoid withdrawal symptoms.[10]

Under DSM-5, the presence of two to three of these symptoms indicates a "mild" substance use disorder; the presence of four to five symptoms indicates a "moderate" disorder; and the presence of six or more symptoms indicates a "severe" disorder.[11]

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10 In this paper, I use the terms *substance use disorder* and *addiction* interchangeably.

11 The terminology and diagnostic thresholds and criteria in relation to substance use disorders in DSM-5 are somewhat different from those in DSM-4 (American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (Washington: APA, 1994)). DSM-4 described two distinct substance use disorders: *substance abuse* and *substance dependence*. Under DSM-4, *substance dependence* was described as a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by at least three of seven symptoms, occurring within a 12-month period. The seven symptoms were: tolerance (see DSM-5, criterion 10); withdrawal (see DSM-5, criterion 6); usage in larger amounts or over longer periods (see DSM-5, criterion 1); efforts to control use (see DSM-5, criterion 2); excessive time spent obtaining, using, or recovering (see DSM-5, criterion 3); foregoing other activities (see DSM-5, criterion 7); continuing to use despite problems (see DSM-5, criterion 9).

Thus, within the population of people with substance use disorders, there is considerable variety in experiences and harms. In fact, there are over 2,000 possible combinations of the diagnostic criteria for substance use disorder, including over 1,000 possible combinations of the criteria for severe substance use disorder, some with no overlap in symptoms. Moreover, studies show that "symptoms are not equivalent in terms of severity, suggesting that there is actually a continuum of severity *within* the disorder," meaning that there is "a broad spectrum of substance-related harms in the general population" (Karen Urbanoski, *Workplace Policies for Employee Substance Misuse* (2014) [prepared for the Hospital Employees' Union] at 9-10 [Urbanoski (2014)]; see also Thomas C. Harford et al., "The Dimensionality of DSM-IV Alcohol Use Disorders Among Adolescent and Adult Drinkers and Symptom Patterns by Age, Gender, and Race/Ethnicity" (2009) 33:5 Alcohol Clin. Exp. Res. 868-78).

Perhaps not surprising given the broad spectrum of the disorder, evidence supports a variety of addiction treatment options and therapeutic approaches; however, little is actually known about what option or approach may work best for any given person (Urbanoski (2014) at 8).

B. Highlights from the Literature

Earlier this year, the Hospital Employees' Union ("HEU") engaged an expert at the Centre for Addiction and Mental Health ("CAMH") in a project involving a review of academic and scientific work pertaining to substance use and addiction treatment. The expert, Dr. Karen Urbanoski, produced a written report, which included references to relevant studies and additional reading.[12]

Drawing on this report, the following is an outline of several key aspects of the research literature, and the implications of this evidence.

1. Heterogeneity in Experiences, Harms and Recovery

As I noted above, there is considerable heterogeneity in experiences and harms among people with substance use problems—even within the subset of people with severe disorders.[13] However, this "population perspective" on substance use "is not always fully appreciated in policy and clinical settings" (Urbanoski (2014) at 10).

a. Recovery Without Treatment and Non-Abstinent Recovery

There has long been a disconnect between the view, in clinical circles, of alcohol dependence as a chronic relapsing disorder, versus the perspective, held by addictions researchers taking a population health approach, of a more heterogeneous picture observed in epidemiological studies (John A. Cunningham & Jim McCambridge, "Is Alcohol Dependence Best Viewed as a Chronic Relapsing Disorder?" (2011) 107 Addiction 6 at 6-8 [Cunningham & McCambridge]).

Research shows that most people who experience problems related to their substance use, including a sizable proportion of those who meet the criteria for substance dependence under

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12 HEU asked Dr. Urbanoski for assistance in evaluating workplace substance use policies recently introduced by major employers in BC's health care sector. Dr. Urbanoski is a Scientist in the Social and Epidemiological Research Department at CAMH. She is also an Assistant Professor at the Dalla Lana School of Public Health at the University of Toronto. The views expressed in her report are her own and do not necessarily represent those of CAMH or the University of Toronto.

13 Urbanoski (2014) makes the same point in relation to "substance dependence," as defined under DSM-4.

DSM-4, recover without treatment (Urbanoski (2014) at 10; see also Linda C. Sobell, John A. Cunningham & Mark B. Sobell, "Recovery from Alcohol Problems with and without Treatment: Prevalence in Two Population Surveys" (1996) 86:7 Am. J. Pub. Health 966-72; Deborah A. Dawson et al., "Recovery from DSM-IV Alcohol Dependence: United States, 2001-2002" (2005) 100 Addiction 281-92 [Dawson]).

According to Cunningham & McCambridge at 7:

> The majority of people who meet criteria for alcohol dependence at some point in their life: (i) do not seek treatment…(ii) resolve their alcohol dependence without any formal treatment or similar help … and (iii) do not relapse repeatedly to alcohol dependence.

Cunningham & McCambridge stress that "this is not to say that some people with alcohol dependence do not relapse repeatedly and that a chronic care model of treatment would be ill-advised for this subpopulation—just that most people who experience alcohol dependence do not relapse again and again" (Cunningham & McCambridge at 7). The "key message" here, then, is that "not everyone who experiences substance-related problems requires prolonged, specialist treatment" (Urbanoski (2014) at 10).

Similarly, despite conventional wisdom, not everyone who experiences substance dependence must achieve complete abstinence in order to recover. In fact, studies "have demonstrated substantial levels of recovery from alcohol dependence, often without benefit of formal or self-help (e.g., 12-Step) treatment and culminating frequently in asymptomatic drinking … rather than abstinence" (Dawson at 282). Research shows that alcohol dependence (as defined under DSM-4) does not necessarily preclude a return to low-risk drinking for some individuals (*ibid.* at 290). Thus, claims that all substance-related problems are chronic, progressive, and can only be resolved through intensive and prolonged treatment and monitoring are inaccurate (Urbanoski (2014) at 11).[14]

It is also worth noting that the abstinence orientation of mandated (e.g., employer-imposed) addiction treatment regimes "is arguably not reflective of a chronic illness model of addiction, which calls for recognition of the role of relapse and the potential for multiple treatment episodes over the course of recovery" (Karen A. Urbanoski, "Coerced Addiction Treatment: Client Perspectives and the Implications of their Neglect" (2010) 7:13 Harm Reduction Journal at 7 [Urbanoski (2010)]). Moreover, according to Urbanoski (2010) at 7:

> Abstinence-based programs with punitive sanctions may not be suitable for all individuals with substance use problems. Those with severe and entrenched disorders may be at a higher risk of failing, thereby incurring additional punishment rather than treatment.

b. Additional Variability

Even among people with chronic addictions, there may be a high degree of heterogeneity, in terms of pattern of onset, course, intensity, functional severity (e.g., impact on work), and outcome, thereby necessitating a "high level of individualized assessment and treatment—both across clients and at different points of time in the life of the same client" (William L. White, Michael Boyle & David Loveland, "Alcoholism/Addiction as a Chronic Disease: From Rhetoric to Clinical Reality"

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14 CAMH emphasizes that the notion that people with concurrent mental health and substance use problems cannot be helped until they are abstinent is false: "Although total abstinence is recommended for many people with concurrent mental health and substance use problems, *harm reduction* strategies—which allow for reduced use—is a more realistic goal for some."

(2003) 3:4 Alcoholism Review Quarterly 107-130 [White, Boyle & Loveland]. Additionally, methods of recovery "and viable support structures vary by developmental age, gender, ethnicity, social class, and profession," as well as "by one's 'recovery capital' (the intrapersonal, interpersonal and community resources that can be brought to bear on the initiation and maintenance of recovery)" (White, Boyle & Loveland).

Ultimately, treatment should be matched to client needs. For example, there is "emerging consensus on the need to take into account cultural and past experiences, including trauma, in providing addiction services and supports" (Urbanoski (2014) at 8; see also V.B. Brown, M. Harris & R. Fallot, "Moving Toward Trauma-Informed Practice in Addiction Treatment: A Collaborative Model of Agency Assessment" (2013) 45:4 J. Psychoactive Drugs 386-93 [Brown, Harris & Fallot]; Jean Tweed Centre, "Trauma Matters: Guidelines for Trauma-Informed Practices in Women's Substance Use Services" (2013), online: <www.jeantweed.com>). In particular, among subpopulations such as First Nations/Aboriginal groups, where discrimination is highly prevalent, culturally-appropriate care may be especially warranted (Urbanoski (2014) at 9; see also M. Brady, "Culture in Treatment, Culture as Treatment. A Critical Appraisal of Developments in Addictions Programs for Indigenous North Americans and Australians" (1995) 41:11 Soc. Sci. Med. 1487-98).

With respect to trauma, Brown, Harris & Fallot (at 386) stress the importance of "a system of care that takes into account the impact of trauma and violence" in the lives of many people with addictions, and emphasize that services "need to be delivered in a way that avoids triggering trauma memories or causing unintentional re-traumatization." Notably, principles and core elements of "trauma-informed care" include client empowerment, collaboration between provider and client, client control and choice, and establishing trust in therapeutic relationships (*ibid.* at 387-88).

c. Variety of Treatment Approaches

As I noted above, the research literature supports a variety of addiction treatment options and therapeutic approaches, including motivational interviewing, brief interventions, and 12-step facilitation (Urbanoski (2014) at 8). There is "no single superior approach to treatment for all individuals." Rather, "there is an encouraging array of promising alternative approaches," and different types of individuals may respond differently to different treatment approaches (Reid K. Hester & William R. Miller, *Handbook of Alcoholism Treatment Approaches: Effective Alternatives*, 3rd ed. (Boston: Allyn & Bacon, 2002) at 6; see also E.F. Kaner et al., "Effectiveness of Brief Alcohol Interventions in Primary Care Populations" (2007) 2:CD004148 Cochrane Database of Systematic Review [Kaner et al.]; Anne Moyer et al., "Brief Interventions for Alcohol Problems: A Meta-Analytic Review of Controlled Investigations in Treatment-Seeking and Non-Treatment-Seeking Populations" (2002) 97 Addiction 279-92).

Taking "a *scientific perspective*," then, "there are a variety of treatment approaches with demonstrated effectiveness for helping to resolve substance-related problems," and there is "little reason to restrict … options to one particular form of intervention on the basis of the research conducted to date" (Urbanoski (2014) at 11).

2. Most Alcohol-Related Harm is Not Caused by People With Severe Disorders

Excessive drinking "contributes significantly to social problems, physical and psychological illness, injury and death" (Kaner et al. at 2). However, most alcohol-related harm is not caused by drinkers with severe alcohol dependency problems, but rather by excessive drinkers whose consumption exceeds recommended drinking (*ibid*.).

Substance-related harms "are widely distributed throughout the population, rather than being limited to those with dependence or what is commonly thought of as 'addiction'" (Urbanoski (2014) at 9). Substance-related *problems*, not *dependence*, actually "account for most of the harm and costs to society" (Urbanoski (2014) at 9; see also Kari Poikolainen, Tapio Paljarvi & Pia Makela, "Alcohol and the Preventive Paradox: Serious Harms and Drinking Patterns" (2007) 102 Addiction 571-78); O.J. Skog, "Alcohol and the So-Called Prevention Paradox: How Does it Look Today?" (2006) 101 Addiction 155-58). These harms and costs include those "stemming from impaired driving, intentional and unintentional injuries, and myriad health and social consequences of acute intoxication and heavy use" (Urbanoski (2014) at 9).

3. No Compelling Evidence Base Regarding Utility of Coercive Treatment

Social pressures occur frequently in addiction treatment around the world (T. Cameron Wild, "Social Control and Coercion in Addiction Treatment: Towards Evidence-Based Policy and Practice" (2006) 101 Addiction 40-49 at 40 [Wild]). Wild describes the term "social pressure" as referring to the following three types of social control strategies that are used to facilitate treatment:

(1) *Legal* social controls include court-ordered treatment programs, either as adjuncts or alternatives to criminal sanctions for substance-misusing offenders.

(2) *Formal* social controls include mandatory treatment referrals by employers.

(3) *Informal* social controls refer to "persuasive interpersonal tactics (e.g., threats, ultimatums) initiated by friends and family members to convince substance misusers to enter treatment."

Formal social controls are standard features of workplace substance use policies in unionized workplaces, and are discussed below.

a. Formal Controls: Employer Mandates, PHPs, and Medical Monitoring

Studies that have evaluated employer-mandated treatment suggest that "workplace or employer mandates are generally effective at getting people to *enter* and *attend* addiction treatment" (Urbanoski (2014) at 4; (emphasis added)).[15] Urbanoski (2014) summarizes this body of literature and related research as follows:

> Specifically, those who are pressured or mandated to enter treatment through their workplace tend to stay in treatment at least as long as, if not longer, than others in treatment (i.e., those without a workplace mandate) … In addition, studies have shown that those who are mandated have similar outcomes to those without a

15 It should be noted that entry into, and attendance at, treatment do not necessarily equate to treatment engagement and effectiveness, particularly in the context of social controls. According to Wild at 44, "while the broader literature on addiction treatment questions the construct validity of treatment engagement using behavioural measures such as attendance (Gainey et al. 1995), attendance is the most commonly used outcome variable in studies of coerced treatment." Urbanoski (2010) at 5 notes that "retention figures heavily into evaluations of treatment under social controls and coercion," yet the "meaning of retention in mandated and coerced treatment may be particularly limited." Although "physical presence in treatment may form part of client engagement, it does not guarantee meaningful participation." Moreover, insofar as session attendance is already compulsory, "retention-based measures may be particularly poor proxies for the internalization of treatment content and behaviour change" (Urbanoski (2010) at 5-6; see also T. Cameron Wild, John A. Cunningham & Richard M. Ryan, "Social Pressure, Coercion, and Client Engagement at Treatment Entry: A Self-Determination Theory Perspective" (2006) 31 Addictive Behaviors 1858-72 [Wild, Cunningham & Ryan]).

> workplace mandate, in terms of substance use, psychiatric problem severity, and employment problems up to 5 years after treatment … Similar findings are reported for treatment that is mandated by legal authorities.[16]

Urbanoski (2014) is careful to note, however, that, within this body of literature, "there are differences across studies in the definitions, terms and conditions of mandates, including the treatment options that are provided and whether post-treatment random drug testing is in place" (*ibid.*).

In contrast to this heterogeneous mix of approaches to mandating treatment is the specific plan of treatment and monitoring typically used by physician health programs, or PHPs. PHPs utilize an approach that is similar to that which is outlined in the workplace substance use policies of several employers in BC's health care sector. Urbanoski (2014) describes PHPs as follows at 4:

> PHPs are characterized by referral to an approved treatment facility, followed by an intensive and prolonged monitoring period of typically 5 years. Participants sign contracts outlining the monitoring conditions, which include random drug and alcohol testing and, in some cases, also regular attendance at peer-support or mutual-help groups (AA/NA). Complete abstinence is required from all substances, and provisions are made for how to handle breaches of the agreement, including reports to the provincial or state physician licensing body.

Urbanoski (2014) reports that evaluations of PHPs in Canada and the US "have suggested that these programs are successful, with completion and abstinence rates that are much higher than is typically seen in addiction treatment" (Urbanoski (2014) at 4).

However, reliance on the body of research supporting employer-mandated treatment, generally, and PHPs, specifically, is problematic. As Urbanoski (2014) explains at 4:

> The problem in drawing conclusions from these lines of research is that the methodological quality of available studies is generally poor … An analysis of potential biases and their likely impacts on findings suggests that the evidence base is not compelling (see also Urbanoski (2010) at 5; T. Cameron Wild, Amanda B. Roberts & Erin L. Cooper, "Compulsory Substance Abuse Treatment: An Overview of Recent Findings and Issues" (2002) 8 Eur. Addict. Res. 84-93 [Wild, Roberts & Cooper]; Gloria Webb *et al.*, "A Systematic Review of Work-place Interventions for Alcohol-related Problems" (2009) 104 Addiction 365-77).

More specifically, for example, Urbanoski (2014) explains (at 6) that the "evaluations of PHPs are uncontrolled, descriptive studies of program participants," which "are among the weakest research designs" (see also Gordon H. Guyatt et al., "GRADE: What is 'Quality of Evidence' and Why is it Important for Clinicians" (2008) 336 B.M.J. 995-98).

Thus, claims of the unique effectiveness of approaches involving prolonged medical monitoring are not supported by persuasive evidence. According to Urbanoski (2014) at 7:

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16 The evidence around formal and legal social controls is not unequivocal. Pressures and mandates from employers have met "mixed" research results, "including longer retention and a greater likelihood of program completion, as well as a lack of differences in retention or substance-related outcomes relative to others in treatment." Similarly, although studies have largely found that "legal pressures promote longer retention … and that clients … show comparable or better short-term treatment responses," on the other hand, "conflicting and negative findings are [also] reported with respect to the effectiveness of treatment under legal pressures or mandates" (Urbanoski (2010) at 4; see also Ronald E. Claus & Lisa R. Kindleberger, "Engaging Substance Abusers After Centralized Assessment: Predictors of Treatment Entry and Dropout" (2002) 34:1 J. Psychoactive Drugs 25-31).

> … descriptive findings based on clinical experience and case series are prone to many biases that may potentially explain why the [physician health] programs appear to be relatively more effective than other forms of treatment. This is why these sources are seen as generating weaker evidence than research studies … It is premature for a policy that involves medical monitoring to claim that it is evidence-based.

Wild has similarly observed (at 41) that the "extent to which empirical research informs decision-making about adopting coercive addiction treatment policies and programmes is questionable" (see also Wild, Roberts & Cooper; Wild, Cunningham & Ryan). With respect to *legal* social control tactics (e.g., court-ordered treatment), Wild notes (at 41) that while US reviews have concluded that coercion "works," non-US reviews "have pointed to inconclusive findings and methodological problems that support a more cautious and critical stance" (see also Alex Stevens et al., "Quasi-Compulsory Treatment of Drug Dependent Offenders: an International Literature Review" (2005) 40 Substance Use & Misuse 269-83). Ultimately, Wild concludes (at 46) that the proliferation of social control tactics to facilitate addiction treatment "is a world-wide social experiment being implemented without compelling evidence base on its utility."

b. Social Control vs. Coercion

A key criticism of the body of literature supporting coerced addiction treatment is that most of the studies have defined coercion in terms of referral source, "neglecting the implications for client motivation, interest, or intent in pursuing treatment" (Urbanoski (2010) at 2; see also Wild). In other words, for example, court-ordered rehabilitation has been equated with coerced treatment, regardless of whether clients actually perceived any coercion. This is problematic because there is actually "ample empirical evidence supporting the lack of a direct, or one-to-one, correspondence between objective pressure strategies and perceptions of coercion" (Urbanoski (2010) at 3).[17] And just as "there is no isomorphism between referral source and client perceptions of coercion," there is similarly "no one-to-one correspondence between referral source and client motivations for treatment or behaviour change" (Wild at 44). In sum, then, "there is little evidence that referral source is a sufficiently robust explanatory variable to handle the preferential research question in this area; namely, whether or not coerced addiction treatment 'works'" (Wild at 43).

c. Potential Consequences of Coerced Treatment

Up to now I have discussed the suspect evidentiary basis for using coercion in addiction treatment. But what about evidence of harms associated with this approach?

Although there is an overall dearth of research around the potential negative consequences of policy approaches that involve compulsory treatment and medical monitoring, there is some evidence that, on average, legal mandates "undermine the client's confidence in treatment, treatment commitment and counselling rapport" (Urbanoski (2014) at 7; see also Urbanoski (2010) at 6; George W. Joe,

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17 To avoid conflating objective social pressure with coercion, Wild suggests (at 44) using the term *coerced treatment* only with reference to situations where clients perceive a lack of control over the decision to enter treatment. In other words, *coerced treatment* "refers to that which is perceived as an imposition and an infringement on autonomy, regardless of the agent or source" (Urbanoski (2010) at 2). On the other hand, Wild recommends using terms such as *social pressures* and *social controls* to refer to "the wide range of mandates and pressures that are objectively applied to ensure or encourage treatment entry, but do not explicitly account for client perceptions or assigned meanings" (Urbanoski (2010) at 2; see Wild at 44). These objective pressures include court-ordered treatment and mandatory treatment referrals by employers.

D. Dwayne Simpson & Kirk M. Broome, "Retention and Patient Engagement Models for Different Treatment Modalities in DATOS" (1999) 57 Drug & Alcohol Dependence 113-25). Additionally, "influential theories of human motivation and behaviour change support the proposition that perceived coercion is counterproductive" (Wild at 46). As Wild explains at 46:

> Social contexts that support … elements of self-determination promote interested engagement in activities and personal growth. Conversely, when social contexts promote perceptions of being controlled or coerced, intrinsic motivation (i.e. interest and engagement in activities) is undermined. These general predictions have been supported by an expansive empirical literature, and across a variety of health behaviours that are often accompanied by social pressure (see also Karen A. Urbanoski & T. Cameron Wild, "Assessing Self-Determined Motivation for Addiction Treatment: Validity of the Treatment Entry Questionnaire" (2012) 43 J. Substance Use Treatment 70-79).

Urbanoski (2010) has similarly observed (at 5) that there is "growing consensus of the importance, separate from the application of any social controls or pressures, of fostering and supporting autonomous motivation for achieving positive [treatment] outcomes—a concept that is antithetical to coercion in treatment." And Urbanoski (2014) notes (at 7) that "the assumption that all of those who are initially unwilling to enter treatment will eventually internalize the need for treatment and behaviour change remains untested."

Urbanoski (2010) sums up the evidence related to the potential long-term impacts of coerced treatment as follows at 6:

> Overall, the long-term impacts of treatment under social controls and coercion are largely unknown. There is evidence that initially beneficial outcomes of legally mandated treatment do not persist after the threat of sanctions is lifted … However, outcomes related to quality of life and economic, relational, and psychological well-being in the longer-term have yet to be evaluated. If the targeted outcomes of coerced treatment involve stable recovery from addiction and the alleviation of burden to public health and safety, rather than social control or punishment, then effectiveness has arguably not been adequately demonstrated to date.

Coerced addiction treatment, therefore, poses a complex ethical dilemma from a public health perspective. As Urbanoski (2010) explains at 7:

> Ethical frameworks for the justification of public health intervention cite factors such as effectiveness and necessity of the measure in promoting and/or protecting the health of the public, and safe-guarding a balance between positive and negative effects of the intervention, as relevant concerns in the debate over whether to infringe upon individual autonomy and liberty … Applied to the case of coerced addiction treatment, evidence would have to be brought to bear on whether the proposed course of treatment is likely to be successful in alleviating current harm and preventing future harm to the public that stems from the individual's use of substances and whether it is a necessary means to achieve these ends. Once demonstrated, it also needs to be considered whether the benefits outweigh any negative consequences resulting from the infringement of the individual's right to make their own decisions relating to treatment. It is not at all clear that past research has satisfied these conditions …
>
> It remains to be demonstrated whether the exposure to treatment among coerced clients is ultimately beneficial or harmful in the long-run for the individual and for the public.

4. Choice in Treatment is Related to Improved Outcomes

So far I have discussed three key aspects of the academic and scientific work pertaining to substance use and addiction treatment: heterogeneity in experiences; distribution of substance-related harm; and the lack of a compelling evidence base for coercive treatment approaches. In my discussion, I have touched briefly on the literature around choice and self-determination. I will now describe this research in a bit more detail.

Social-psychological theory and substantial research findings suggest that "better outcomes may occur when individuals are able to choose their own treatment" (Hilary F. Byrnes, Brenda A. Miller & Nicole Laborde, "A Comparison of Maternal Outcomes from an Alcohol , Tobacco, and Other Drug Prevention Program for Mothers Choosing an Intervention versus Being Randomized" (2013) 40:2 Health Educ. Behav. 206-215 at 206). Having a choice "is considered to lead to increased motivation and better outcomes, as intrinsic motivation is based on needs for autonomy, competence, and relatedness, which the ability to choose could provide" (*ibid*.). The notion that individuals "who are given a choice of their own treatment or intervention may experience greater levels of autonomy, personal control, and self-efficacy, and therefore better outcomes," has been supported "across a variety of contexts, such as health, education and work environments" (*ibid*. at 207).

Consistent with this theory and research, there is currently "an increased focus on the importance of patients' participation in treatment choices and involvement in changing health behaviours" (*ibid*.). Various studies, "across a variety of health behaviours, such as substance use and smoking cessation, demonstrate that patients' choosing their intervention for health outcomes is strongly related to improved outcomes" (*ibid*.).

For example, research has shown that "client engagement [at treatment entry] is predicted by client perceptions that they sought help because they identified with the goals of treatment and made a personal choice to attend" (Wild, Cunningham & Ryan at 1870). In contrast, "social pressure variables per se (referral source, social network influences to quit and/or enter treatment) are unrelated to client engagement" at treatment entry (*ibid*.).

5. No Conclusive Evidence Showing that AA Helps More than other Interventions

It is conventionally assumed that 12-step programs, like AA, are generally more effective than other interventions. However, the research does not support this assumption.

Although "12-step and AA programmes for alcohol problems are promoted worldwide," on the whole, "experimental studies have...failed to demonstrate their effectiveness in reducing alcohol dependence or drinking problems when compared to other interventions" (Marica M.F. Ferri, Laura Amato & Marina Davoli, "Alcoholics Anonymous and other 12-step Programmes for Alcohol Dependence" (2006) 3:CD005032 Cochrane Database of Systematic Reviews at 11 [Ferri, Amato & Davoli]). More specifically, for instance:

(1) There is no conclusive evidence "to show that AA helps patients to accept therapy and keep patients in therapy any more or less than other interventions" (*ibid*.).

(2) Research shows that 12-step programs help to reduce alcohol consumption similarly to other comparison interventions (*ibid*.).

(3) There is "no conclusive evidence to show that AA can help patients to achieve abstinence, nor is there any conclusive evidence to show that it cannot" (*ibid*.).[18]

Ferri, Amato & Davoli explain the practical implications of the research around 12-step and AA programs as follows at 11:

> People considering attending AA or TSF [Twelve Step Facilitation] programmes should be made aware that there is a lack of experimental evidence on the effectiveness of such programmes. It should also be underlined that in the available studies all the interventions appeared to improve at least some of the outcomes considered. Policy makers and health care professionals need to consider the options they provide and the advice they give in this regard. The active collaboration of patients or clients should perhaps be sought to identify the best intervention for that specific person.

6. Stigma Prevents Employees with Addictions from Seeking Help

In the workplace context, "fear of stigma may lead employees to choose not to disclose a mental disorder," such as a substance use disorder (Kate E. Toth & Carolyn S. Dewa, "Employee Decision-Making About Disclosure of a Mental Disorder at Work" (2014) 24:4 J. Occup Rehabil. 732-46 at 732 [Toth & Dewa]). Research shows that "peer and organizational stigma can affect decisions to disclose and seek help for mental health problems" (Urbanoski (2014) at 3; see also S. Clement et al., "What is the Impact of Mental Health-Related Stigma on Help-Seeking? A Systematic Review of Quantitative and Qualitative Studies" (2014) 26 Psychol. Med. 1-17; Toth & Dewa). Evidence clearly links "the fear of stigma to nondisclosure of concealable stigmatizing attributes" (Toth & Dewa at 733). This interplay between stigma and disclosure may impact both the employee and the employer negatively:

> Individuals who possess a stigmatizing attribute that is concealable often live in constant fear of being discovered, and significant stress results from seeking to keep the attribute hidden and making decisions about disclosure … If employees are expending considerable mental energy in identity management and seeking to conceal a mental health issue, less mental energy is available for work-related tasks (*ibid.*).

On the basis of a qualitative study aimed at understanding the disclosure decision-making process of employees with mental disorders, Toth & Dewa found that the "culture of the workplace is...important to the disclosure process," and that study participants "assessed these conditions as part of the decision-making process." More specifically, an employee's perceived job security is critical to the disclosure decision; study participants "talked about fear of losing their jobs when asked about the problem with disclosure at work" (*ibid.*).

On the basis of these findings, Toth & Dewa stress "that a normative stance should not be placed on disclosure." Rather, employers "should strive to create an environment in which employees feel safe to disclose should they wish to do so."

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18 Additionally, while AA may work for some people, "that does not mean that AA participation is equally effective for all groups in the population; for instance, women with anxiety disorders show lower affiliation with AA and poorer outcomes, including relapse into heavy drinking" (Urbanoski (2014) at 9; see J. Scott Tonigan et al., "12-Step Therapy and Women with and without Social Phobia: A Study of the Effectiveness of 12-Step Therapy to Facilitate Alcoholics Anonymous Engagement" (2010) 28 Alcoholism Treatment Quarterly 151-162).

7. Empathy, Employment and Hope Contribute to Recovery

Research has shown that various *common factors* contribute to change in the therapeutic process (see Michelle L. Thomas, "The Contributing Factors of Change in a Therapeutic Process" (2006) 28 Contemp. Fam. Ther. 201-10 [Thomas]; see also S.D. Miller *et al.*, *Escape from Babel: Toward a Unifying Language for Psychotherapy Practice*, (New York: Norton, 1997) [Miller et al.]; M.A. Hubble *et al.*, *The Heart and Soul of Change: What Works in Therapy*, (Washington: APA, 2001) [Hubble et al.]). For example, regardless of therapeutic methods or techniques, *relationship factors* (including behaviours such as warmth, empathy, encouragement, and acceptance) contribute significantly to change (see CAMH; see also Thomas; Hubble et al.). According to CAMH, these factors can make a difference "whether the relationship is with a therapist, probation officer, housing worker or the receptionist in a doctor's office."

Studies have also shown that *extratherapeutic factors* can contribute to recovery. These factors include client strengths and supportive elements in the client's environment, such as housing and employment (see Miller et al.; CAMH; Hubble et al.).

And finally, *hope and expectancy* can contribute to change in the therapeutic process (see Miller et al.; CAMH). This factor "refers to the client becoming hopeful and believing in the credibility of the treatment" (Thomas at 203). This hope and belief "can come from the client feeling supported and respected in the relationship with the therapist," as well as from many of the extratherapeutic factors (e.g., a home, a job) that can contribute to recovery (see CAMH).

C. Why is the Research Important?

I have dedicated a considerable amount of space in this paper to a review of academic and scientific work pertaining to substance use and addiction treatment. I have done this because, despite the importance of facts and evidence in determining legal outcomes, the research findings described above are not referenced in the arbitral and human rights cases involving workplace substance use policies.

This is highly problematic, given the nature of our adversarial systems for resolving labour relations and human rights disputes. These systems are "evidence-based, not faith or belief-based" (*Mechanical Contractor Association Sarnia v. United Association of Journeymen and Apprentices Of The Plumbing & Pipefitting Industry of the United States and Canada, Local* 663, [2013] CanLII 54951 (ONLA) at para. 127 ["*Mechanical Contractors*"]). In this context, "assumptions, unsupported presumptions, anecdotal or unparticularized evidence, and broad-based statistical inferential reasoning is typically 'not good enough' to satisfy the balance of probabilities onus of proof" (*ibid.*).

Thus, the scientific facts and empirical evidence discussed above must inform legal analysis and decision-making related to substance use and addiction treatment. I discuss the arbitral and human rights frameworks for this legal analysis and decision-making in the next two sections.

IV. Arbitral Framework

> There are many conditions that can impair a worker's concentration, coordination, reaction time, perception and judgment. By far, the commonest, and arguably most associated with accidents, is fatigue … Minor illnesses … combined with the medications used to treat their symptoms cause significant impairment of cognitive function in workers … More serious medical or psychiatric diseases … will often

> cause serious cognitive impairment and jeopardize workplace safety … Finally, alcohol and other drugs must be considered, albeit well down the list, as possible causes of workplace impairment.[19]

The primary purpose of unilaterally-imposed workplace substance use policies is typically expressed in terms of safety concerns (see, e.g., *Trimac Transportation Services v. T.C.U.* (1999), 88 L.A.C. (4th) 237 ["*Trimac*"]; *Imperial Oil v. C.E.P., Local 900* (2006), 157 L.A.C. (4th) 225 ["*Imperial Oil*"]; *Mechanical Contractors*; *Unifor, Local 707A v. Suncor Energy*, [2014] A.G.A.A. No. 6 (QL) ["*Suncor*"]). An employer may sometimes articulate secondary purposes (e.g., productivity, deterrence, environmental protection); however, substance use policies tend to be expressly driven by management perceptions of workplace safety risks.

A "substantial body of arbitral jurisprudence has developed around the unilateral exercise of management rights in a safety context, resulting in a carefully calibrated 'balancing of interests' proportionality approach" (*C.E.P., Local 30 v. Irving Pulp & Paper*, 2013 SCC 34 at para. 4 ["*Irving*"]). The following is a review of this approach.

A. The KVP Test

The scope of an employer's unilateral rule-making authority under a collective agreement is set out in *KVP Co. v. Lumber & Sawmill Workers' Union, Local 2537*, [1965] O.L.A.A. No. 2 (QL) ["*KVP*"]. Essentially, under the "*KVP* test," a rule or policy unilaterally imposed by an employer and not subsequently agreed to by the union must be consistent with the collective agreement and must be reasonable (*Irving* at para. 24; *KVP* at para. 34).[20]

The reasonableness analysis under *KVP* essentially comes down to a balancing of the employer's and the employees' competing interests (*U.B.C. Health Sciences Centre Hospital Society v. H.E.U., Local 80* (1985), 21 L.A.C. (3d) 132 at para. 11). In particular, in cases involving employee privacy interests, arbitrators will weigh various factors in assessing the reasonableness of a unilateral policy, including, for example, the following:

(1) The nature of the employer's interests.

(2) The purpose and reasonable necessity of the policy.

(3) The usefulness of the policy in achieving its purpose.

(4) Any less intrusive means available to address the employer's concerns.

(5) The policy's impact on employees.

See generally *Irving*; *Vancouver (City) v. Vancouver Firefighters' Union, Local 18*, [2010] B.C.C.A.A.A. No. 81 (QL) ["*Vancouver Firefighters*"]; *Trimac*; *Mechanical Contractors*.

The dangerousness of the workplace, while highly relevant, is not determinative of the balancing of interests proportionality analysis under *KVP* (see *Irving* at paras. 4, 31; *Mechanical Contractors* at para. 144).

Additionally, for a policy to be reasonable, it must be consistent with applicable legislative provisions (*Vancouver Firefighters* at para. 162). Thus, a workplace rule that violates the *Human*

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19 Dr. Ray Baker, "Determination of Fitness for Duty" (Paper presented to the CLE conference, *Human Rights Conference – 2010*, November 2010 at 5.1.1.

20 Unilaterally-imposed rules/policies must also satisfy a number of other requirements (see *KVP* at para. 34).

Rights Code will not meet the standard of reasonableness under *KVP*. Furthermore, where Code principles and protections are incorporated into the express terms of the collective agreement, a rule that violates the Code will not meet the *KVP* requirement of consistency with that collective agreement (see *H.E.A.B.C. v. H.S.A.* (2013), 237 L.A.C. (4th) 1 at para. 167).

1. Evidence and Onus of Proof

Under the *KVP* balancing of interests analysis, the onus is on the employer to establish the reasonableness of its policy (see *Irving* at paras. 81, 92). Where employee privacy interests are affected, the employer bears the burden of proving that its policy "is a necessary and proportionate response which is likely to meet a demonstrably legitimate need in the particular workplace [and] which intrudes on employee privacy to the least possible extent" (*Mechanical Contractors* at para. 130; see also *Trimac* at para. 43).

The evidence required to satisfy this burden will depend on the circumstances of the specific case; however, "it must in any event always include cogent direct non-anecdotal evidence" from the particular workplace (*Mechanical Contractors* at para. 127). Where the policy is driven by safety concerns, uncertain or speculative health and safety improvements will not justify a significant invasion of employee privacy (*ibid*.).

2. Risk to Safety

In the context of intrusive policies imposed for safety purposes, a key aspect of the employer's evidentiary burden under *KVP* relates to risk. Where the employer seeks to justify its policy on the basis of an alleged risk to workplace safety, and where "countervailing privacy interests are at stake, there must be a balancing of impacts, such that the degree of risk must meet a threshold sufficient to override the privacy interest" (*Trimac* at para. 67).

The onus is on the employer to provide evidence of the extent of the purported risk, and "to establish that the risk threshold necessary to validate its initiative is met" (*ibid*.; see also *Irving* at para. 31). Arbitrator Burkett elaborated on this principle in *Trimac* at para. 68, stating the following in his analysis of a random testing policy aimed at alleged safety risks associated with the "residual effects" of substance use:

> It is not sufficient to simply refer to [residual effects such as] "fatigue", "crash phase" or "excited state" without establishing, by empirical studies or otherwise, the nature, extent and duration of the impairment caused by the residual effects of drug taking, relative to the work function at issue. Without such evidence, a finding cannot be made as to the extent of the risk. Do the residual effects of drugs or alcohol constitute a similar risk to that posed by an employee who comes to work with a headache, a cold, a poor night's sleep or suffering from allergies or do these residual effects constitute a greater risk sufficient to warrant the implementation of mandatory random drug testing? On the evidence, I am simply unable to make that finding. Accordingly, without stipulating what the risk threshold is, on the evidence before me, I am unable to find that a risk threshold sufficient to allow the Company to implement mandatory random drug testing and, thereby, to override employee privacy rights, has been met.

More recently, Arbitrator Surdykowski made a similar point in *Mechanical Contractors* at para. 185, in relation to a "pre-access testing" policy:

> [Employer witness] Ray Curran asserts … that the "Effects of drug or alcohol use are known to be a cause of workplace accidents, often with catastrophic results." Is that so? Where is the evidence of this alleged truism? Further, there are

> undoubtedly numerous factors which tend to contribute to workplace health and safety issues. For purposes of this case the question is: to what degree of significance do alcohol and drug issues contribute to a health and safety problem on Suncor worksites which privacy-invasive pre-access testing is likely to significantly decrease?

B. Testing, Medical Exams, and Searches

Workplace substance use policies commonly involve rules around alcohol and drug testing, medical examinations, and searches of employee possessions. Within the general *KVP* framework outlined above, a fairly consistent arbitral jurisprudence has developed around each of these specific issues. I touch on these issues very briefly here.

1. Substance Use Testing

The arbitral approach to alcohol and drug testing was authoritatively reviewed in the recent Supreme Court of Canada decision in *Irving*. In its findings, the majority of the court summarized the jurisprudence as follows at para. 5-6:

> … arbitrators have found that when a workplace is dangerous, an employer can test an individual employee if there is reasonable cause to believe that the employee was impaired while on duty, was involved in a workplace accident or incident, or was returning to work after treatment for substance abuse. In the latter circumstance, the employee may be subject to a random drug or alcohol testing regime on terms negotiated with the union.
>
> But a unilaterally imposed policy of mandatory, random and unannounced testing for *all* employees in a dangerous workplace has been overwhelmingly rejected by arbitrators as an unjustified affront to the dignity and privacy of employees unless there is reasonable cause, such as a general problem of substance abuse in the workplace.

An employee's refusal to submit to permissible substance use testing, "like the registering of a positive test, does not necessarily justify automatic termination" (*Imperial Oil* at para. 100). Any disciplinary sanction "remains subject to the general just cause provisions of the collective agreement and is an issue to be determined on a case by case basis, having regard to all of the relevant facts" (*ibid.*; see also *Rio Tinto* at paras. 62-68).

2. Medical Examinations

As a general rule, "in the absence of an agreement or statutory authority, an employer is not entitled to require an employee to submit to an examination by a doctor of the employer's choice, or otherwise to compel the employee to disclose information about his own medical condition" (*C.A.I.M.A.W., Local 12 v. Shell Canada Products* (1990), 14 L.A.C. (4th) 75 at para. 17 ["*Shell*"]). This principle is based on common law protections "against infringement upon the physical integrity of the person" (*ibid.*), which were discussed by the Ontario Court of Appeal in *Fleming v. Reid* (1991), 4 O.R. (3d) 74 (C.A.) at 10 (cited in *St. Peters Health System v. CUPE, Local 778* (2002), 106 L.A.C. (4th) 170 at para. 27):

> The right to determine what shall, or shall not, be done with one's own body, and to be free from non-consensual medical treatment, is a right deeply rooted in our common law. This right underlies the doctrine of informed consent. With very limited exceptions, every person's body is considered inviolate, and, accordingly, every competent adult has the right to be free from unwanted medical treatment. The fact that serious risks or consequences may result from a refusal of medical treatment does not vitiate the right of medical self-determination …

Notwithstanding these general protections against compulsory medical examinations, treatment and disclosure, if an employee refuses to be examined and/or denies requests for medical disclosure, and where the employer has reasonable cause to believe that the employee is unsafe or unfit to perform her duties, the employer may prohibit the employee from working (*Shell* at para. 21). Before issuing this prohibition, however, "there are certain due process requirements that devolve upon the employer which generally require that it treat the employee fairly" (*ibid.* at para. 26). For example:

> Clearly, where an employee returns from an absence due to illness, the occasion is proper for the company to require some certification of fitness. Where the certificate is not satisfactory, the company could properly require a further certificate, or could direct its own medical examination. Such a procedure, however, must be carried out in accordance with ordinary principles of fairness. If, as in the instant case, the company is to reject the medical certificate offered by the returning employee, it must state the grounds for such objection, and must point out to the employee what it requires before it will permit his return. If the certificate in itself is not satisfactory, the employee must be advised of that, so that he may either protest the reasonableness of the company's rejection of it, or request a more ample certificate from his doctor. If a further medical opinion is required, then again the company must advise the employee of that fact (*Re U.A.W., Loc. 89 and Reflex Corp. of Canada Ltd.*, July 17, 1968 (Weatherill), cited in *Re U.A.W., Loc. 27 and Eaton Automotive Canada Ltd.* (1969), 20 L.A.C. 218 (Palmer) at p. 219).

Given that an employer is generally not entitled to impose medical examinations, treatment or disclosure, an employee's rejection of such impositions should not be regarded as insubordination (*Shell* at para. 31).[21]

3. Searches of Employee Possessions

It is well-established in the arbitral jurisprudence that "employers have no absolute right to search the person or the personal effects of employees" (*Algoma Steel v. U.S.W., Local 2251* (1984), 17 L.A.C. (3d) 172 at para. 12 ["*Algoma Steel*"]. Whether an employer is permitted to conduct such a search comes down to a balancing of "the legitimate business interests of the employer in … light of the alternatives available to it against the concern of employees to privacy and to be free from unreasonable search or surveillance" (*Denison Mines Limited*, January 20, 1984 (unreported), cited in *Algoma Steel* at para. 12). Thus, "the employer must establish adequate cause to justify the search, including the exhausting of available alternatives" (*Algoma Steel* at para. 12). An employer does "not acquire the right to compel employees to submit to spot searches of their personal effects by the mere act of publishing rules" (*Shell* at para. 62).

In sum, then, the arbitral principles discussed above establish clear parameters around invasive employer rules that are imposed unilaterally. Unilateral rules, including the Requirements and Restrictions commonly imposed under substance use policies, must be reasonably necessary and proportionate, and minimally intrusive; they should reflect a careful balancing of competing interests. Most important, these Requirements and Restrictions must be firmly rooted in compelling evidence justifying their imposition.

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21 For a further discussion of the general legal principles applicable in the context of employer-imposed disclosure requirements, see Jonathan Chapnick & Devyn Cousineau "Need to Know: Consent Forms and Medical Certificates in Disability Management Programs" (paper presented to the CLE conference, *Human Rights Conference – 2013*, November 2013. See also *Rio Tinto* at para. 35.

V. Human Rights Code

> It is an unfortunate truth that the history of disabled persons in Canada is largely one of exclusion and marginalization. Persons with disabilities have too often been excluded from the labour force, denied access to opportunities for social interaction and advancement, subjected to invidious stereotyping and relegated to institutions … This historical disadvantage has to a great extent been shaped and perpetuated by the notion that disability is an abnormality or flaw … One consequence of these attitudes is the persistent social and economic disadvantage faced by the disabled. Statistics indicate that persons with disabilities, in comparison to non-disabled persons, have less education, are more likely to be outside the labour force, face much higher unemployment rates, and are concentrated at the lower end of the pay scale when employed.[22]

The *KVP* reasonableness framework discussed in the section above shares much in common with the discrimination analysis under the *Human Rights Code*. Both seek to balance legitimate competing interests, through the applications of principles such as reasonable necessity, proportionality and least intrusiveness on a case-by-case basis.

The Code analysis applies to disputes involving employer-imposed policies related to substance use, addiction treatment and workplace safety, insofar as these policies impact employees with disabilities, including employees with addictions/substance use disorders.[23] Section 13 of the Code prohibits discrimination in employment on the basis of disability.

A. Definition of "Disability"

A "disability" under the Code is defined broadly to include "a physical limitation, an ailment, a social construct, a perceived limitation or a combination of all of these factors" (*Quebec (Commission des droits de la personne et des droits de la jeunesse) v. Montréal (City); Quebec (Commission des droits de la personne et des droits de la je unesse) v. Boisbriand (City)*, [2000] 1 S.C.R. 665 at para. 79 ["*Boisbriand*"]; see also *Granovsky v. Canada (Minister of Employment and Immigration)*, [2000] 1 S.C.R. 703). A disability need not give rise to any limitation or functional impairment (see *Boisbriand* at para. 41; *Morris v. B.C. Rail*, 2003 BCHRT 14 at para. 186 ["*Morris*"]), and whether an employee's condition or ailment "prevented her from working is not necessarily determinative of whether she had a disability within the meaning of the Code" (*Thompson v. Providence Health Care (c.o.b. St. Paul's Hospital*), 2003 BCHRT 58 at para. 24; see *Morris* at paras. 204-21).

Thus, the concept of disability under the Code encompasses "persons who have overcome all functional limitations and who are limited in their everyday activities only by the prejudice of stereotypes that are associated with this ground" (*Boisbriand* at para. 80; *Morris* at para. 209).[24]

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22 *Eldridge v. B.C.*, [1997] 151 D.L.R. (4th) 577 at para. 56.

23 An addiction constitutes a "disability" within the meaning of the *Code* (see *Kemess Mines v. I.U.O.E. Local 115*, 2006 BCCA 58; *H.E.A.B.C. (Kootenay Boundary Regional Hospital) v. B.C.N.U.*, 2006 BCCA 57 [*Kootenay Boundary Regional Hospital*]; *Handfield v. North Thompson School District No. 26*, [1995] B.C.C.H.R.D. No. 4 (QL)).

24 For further discussion of the meaning and scope of disability-related grounds under Canadian human rights statutes, see Catherine Sullivan & Jonathan Chapnick, "Human Rights 101: The Prohibited Grounds of Discrimination in Employment" (paper presented to the CLE conference, *Human Rights Conference – 2009*, November 2009).

The following is a review of the discrimination analysis under the Code, particularly in regards to safety concerns and fitness to work issues related to people with disabilities.

B. Two-Stage Analysis

The analysis under s. 13 of the Code proceeds in two well-known stages.

First, to establish a *prima facie* case of discrimination, an employee must show that she has (or was perceived to have) a disability, she experienced an adverse impact, and her disability was a factor in the adverse impact (*Moore v. B.C. (Education)*, 2012 SCC 61 at para. 33 ["*Moore*"]; *Kootenay Boundary Regional Hospital* at para. 38).

Second, once a *prima facie* case has been made, the burden shifts to the employer to justify its rule, standard and/or conduct (hereinafter referred to generally as "standard") as a "*bona fide* occupational requirement," or "BFOR" (Code, s. 13(4); *British Columbia (Public Service Labour Relations Commission) v. B.C.G.E.U.*, [1999] 3 S.C.R. 3 at para. 54 ["*Meiorin*"]). This means that the employer must show that it has acted in good faith, and that the standard was imposed for a rational purpose (see *Meiorin* at para. 54). The employer must also establish that the impugned standard was reasonably necessary to accomplish the intended purpose, and that the "duty to accommodate" has been discharged (*ibid*.).

The legal analysis is the same whether the employee (or union) is alleging individual or systemic discrimination (*Moore* at paras. 58-60). A policy or practice "is discriminatory whether it has an unjustifiably adverse impact on a single individual or systemically on several" (*ibid.* at para. 58). The "considerations and evidence at play in a group complaint may undoubtedly differ from those in an individual complaint," but the focus of the legal inquiry is the same (*ibid.* at para. 59).

C. Prima Facie Discrimination

In the context of an allegedly discriminatory substance use policy, the key question at the *prima facie* stage is whether elements of the policy result in a disability-related adverse impact.[25]

The findings of the BC Human Rights Tribunal (the "Tribunal") in *Gichuru v. Law Society of B.C.*, 2009 BCHRT 360 ["*Gichuru*"] demonstrate that various circumstances and impacts may support a finding of *prima facie* discrimination in cases involving concerns about safety and fitness to work of people with disabilities.[26]

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25 Put another way, borrowing language used by Justice Wilson in *Law Society of B.C. v. Andrews* (1989), 56 D.L.R. (4th) 1 to describe discrimination at para. 37: Do aspects of the policy have the effect of imposing burdens, obligations or disadvantages on employees with addictions that are not imposed upon others, or which withhold or limit access to opportunities, benefits and advantages available to others?

26 In *Gichuru*, the Tribunal held that a question posed by the Law Society to prospective articling students ("Have you ever been treated for schizophrenia, paranoia, or a mood disorder described as a major affective illness, bipolar mood disorder, or manic depressive illness?"), and the process flowing from this question, adversely affected people who answered the question affirmatively. The Tribunal found that the question itself was based on stereotypical assumptions about people with certain mental health conditions, and it triggered a more intensive and intrusive evaluation of students with those conditions.

1. Singling Out

A standard or policy that singles out a particular health condition (while disregarding others), on the assumption that the condition presents a potential risk to workplace safety or employee fitness to work (while other conditions are apparently presumed to pose no such risk), may be found to adversely impact employees with that particular health condition (see generally *Gichuru*).

2. Negative Consequences and Lack of Discretion

A standard or policy that imposes burdens or negative consequences on a person with a disability, as a result or in relation to her health condition, may be found to be *prima facie* discriminatory, particularly where those burdens or consequences are imposed automatically and without any exercise of discretion (see generally *Gichuru*).

3. Overly Intrusive

Overly intrusive inquiries into the private medical information of a person with a disability, and significant intrusions into her medical autonomy, may constitute adverse treatment related to her disability, particularly where the person with the disability is subjected to a more intensive and intrusive evaluation than others (see *Gichuru* at paras. 465, 560, 565). Bodily intrusions and compulsory surrender of bodily substances may also constitute adverse impacts.

4. Financial Costs

Where a person with a disability is required to incur additional expenses to prove her physical or mental fitness (as compared to persons without disabilities), these additional costs may constitute a disability-related adverse impact (see *Gichuru* at paras. 561-64; see also *Hussey v. B.C.*, 2003 BCHRT 76 ["*Hussey #2*"]).

5. Historical Disadvantage

Historical disadvantage and present-day stigma suffered by people with disabilities are relevant considerations for determining whether a rule or policy results in a disability-related adverse impact (see *Gichuru* at para. 469).

D. Justification Test: Rational Purpose and Good Faith

Where a *prima facie* case has been made in relation to standards under a substance use policy, the burden shifts to the employer to justify each standard as a BFOR. To do so, the employer must satisfy the three-part justification test established in *Meiorin* at para. 54, by showing that each standard was:

(1) adopted for a purpose rationally connected to workplace performance;

(2) adopted in an honest and good faith belief that it was necessary to the fulfilment of the work-related purpose; and

(3) reasonably necessary to the accomplishment of the work-related purpose.

Under the third part of this test, the employer must demonstrate that the "duty to accommodate" has been discharged (i.e., "that it is impossible to accommodate individual employees sharing characteristics of the claimant without imposing undue hardship upon the employer" (*ibid.*)). In

other words, the employer must show that it could not have done anything else reasonable or practical to avoid the adverse impact of its standard (see *Moore* at para. 49).

1. **Rational Purpose**

The first part of the *Meiorin* justification test involves identifying the general purpose of the impugned standard and determining whether it is rationally connected to the performance of the relevant job or jobs (*Meiorin* at para. 57). The initial task, therefore, "is to determine what the impugned standard is generally designed to achieve" (*ibid.*). This determination must be made on the basis of the available evidence (*Gordy v. Oak Bay Marine Management*, 2004 BCHRT 225 at paras. 104-09 ["*Gordy #2*"]; see also *B.C. (Superintendent of Motor Vehicles) v. B.C. (Council of Human Rights)* (1999), 36 C.H.R.R. D/129 (S.C.C.) at paras. 24-27 ["*Grismer*"]).

As I mentioned above, standards imposed under unilateral substance use policies tend to be aimed at addressing workplace safety concerns; the purpose is generally the safe performance of each employee's job. It is important, however, to define this purpose with slightly more precision (see *Grismer* at para. 24) (i.e., what *level* of safety is the employer seeking to achieve?). The possibilities range from "absolute safety," in which case few if any employees would be allowed to work, to a "total lack of concern for safety," in which case everyone, regardless of their fitness or ability, would be allowed to work (see *Grismer* at para. 25). Between these two extreme lies "the more moderate view that reasonable safety suffices" (*ibid.*). The question is: on the evidence, where on this spectrum does the employer set the bar?

Since no employee is perfect, and since there is a range of competence and ability among employees in almost every workplace, and because many people are employed even though their physical or mental characteristics might make them less safe than the average employee, the evidence in most cases will point to a goal of *reasonable* safety (see, generally, *Grismer* at para. 26), which includes some risk of human error (see *Gordy v. Oak Bay Marine Management*, 2000 BCHRT 16 at para. 157 ["*Gordy #1*"]). Most employers do not test prospective or current employees for all health conditions that may impair judgment, jeopardize safety or result in performance errors. Nor do most employers formally assess, on a proactive and ongoing basis, the safety and fitness to work of each employee. Thus, the evidence in most cases will not support a finding that the employer takes every possible step to eliminate all workplace risks. The evidence will usually lead to the conclusion that the employer sets its bar at the reasonably safe performance of each employee's job.

Once the purpose of the impugned standard is identified, the employer is required to demonstrate that the purpose is rationally connected to the objective requirements of the relevant job or jobs. Where the goal is reasonable workplace safety, there will usually be no question as to the existence of a rational connection (see *Meiorin* at para. 58).

It is important to note that the focus at this first part of the justification test is not on the validity of the impugned standard itself, "but rather on the validity of its more general purpose" (*Meiorin* at para. 59). Careful adherence to this distinction was emphasized by Justice McLachlin in *Meiorin* at para. 59:

> 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 … 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.

2. Good Faith

If the general purpose of the employer's standard is determined to be legitimate, the employer must then "take the second step of demonstrating that it adopted the particular standard with an honest and good faith belief that it was necessary to the accomplishment of its purpose, with no intention of discriminating" (*Meiorin* at para. 60). This part of the analysis "addresses the subjective element of the [justification] test," and shifts the focus "from the general purpose of the standard to the particular standard itself" (*ibid.* at paras. 60-61).

If the implementation "of the standard was not thought to be reasonably necessary or was motivated by discriminatory animus, then it cannot be a BFOR" (*ibid.* at para. 60).

E. Justification Test: Reasonable Necessity and Duty to Accommodate

The "third and final hurdle" under the *Meiorin* justification test is usually the most difficult for an employer to overcome. The employer must establish that the impugned standard is both "reasonably necessary" to accomplish its purpose, and designed inclusively to accommodate the needs and characteristics of those otherwise adversely affected (see, generally, *Meiorin* at paras. 62-68). The imposition of these dual requirements (reasonable necessity and accommodation) allows for close scrutiny and removal of systemic barriers, rather than acceptance of these barriers as natural or unchangeable. It also requires that measures be taken to provide individualized relief from disadvantageous consequences of impairments and disabilities, where it is not possible to revise the underlying exclusionary standard.

1. Institutional Change vs. Individualized Accommodation

Conceptually, it is useful to distinguish two types of accommodation as flowing from the third part of the justification test.[27] First, "institutional policy change accommodation" entails making broad-based revisions to exclusionary institutional standards where they are not reasonably necessary to accomplish a legitimate purpose (Sheppard at 552). On the other hand, individualized accommodation involves making discrete alterations and adjustments to existing standards for the benefit of a particular person or group while leaving the institutional norm, policy or practice intact.

The court in *Meiorin* stressed the importance of "rigorously assessing" exclusionary standards to expose the "complex web of seemingly neutral, systemic barriers" of which they are often a part (*Meiorin* at para. 42; see also Sheppard at 551). Otherwise, warned the Court, the law risks approving "the edifice of systemic discrimination" (*Meiorin* at para. 42). The *Meiorin* decision can therefore be understood as requiring a "comprehensive analysis of the reasonable necessity of an exclusionary practice, standard or policy" before proceeding to considerations of individualized accommodation (Sheppard at 552).

Thus, while the importance of individualized accommodation was stressed in *Meiorin* and has been repeatedly emphasized in subsequent decisions (see *McGill University Health Centre (Montreal General Hospital) v. Syndicat des employés de l'Hôpital general de Montréal,* 2007 SCC 4 at para. 22), the individual accommodation question should only be addressed "in the face of the impossibility of a more general policy change" (*ibid.*). This way, people with disabilities are not

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27 This distinction was made in Colleen Sheppard, "Of Forest Fires and Systemic Discrimination: A Review of British Columbia (Public Service Employee Relations Commission) v. B.C.G.S.E.U." (2001) 46 McGill L.J. 533 at 541-548 [Sheppard].

made more suitable for work; rather, work is made more suitable for people with disabilities (see generally Jerome E. Bickenbach, *Physical Disability and Social Policy* (Toronto: University of Toronto Press, 1993) at 149-51).

Both forms of accommodation (institutional and individualized) are capped at the point of undue hardship (see generally *Meiorin*).

2. Reasonable Necessity and Undue Hardship

The concept of "reasonable necessity" has been described as requiring that a standard not place an "undue burden" on those to whom it applies (see *Canadian Human Rights Commission v. Toronto Dominion Bank* (1998), 163 D.L.R. (4th) 193 (F.C.A.) at para. 38 ["*TD Bank*"]; see generally *Brossard (Town) v. Quebec*, [1988] 2 S.C.R. 279). This has been taken to mean that, to justify an impugned standard, an employer must show "that there is no other more reasonable, or less intrusive alternative" (*TD Bank* at para. 38). These requirements are similar to those imposed to unilateral employer policies under the *KVP* reasonableness framework.

a. Common Indicia of Unreasonableness

In its analysis under the third part of the justification test, the Supreme Court of Canada in *Grismer* described two common indicia of unreasonableness. First, the court explained that "a standard that excludes members of a particular group on impressionistic assumptions is generally suspect" (para. 31). I discuss the factual and evidentiary basis required to justify a *prima facie* discriminatory standard further below.

Second, according to the court, "evidence that a particular group is being treated more harshly than others without apparent justification may indicate that the standard applied to that group is not reasonably necessary" (*ibid*.).

This second mark of unreasonableness came up in the *Gichuru* case. In *Gichuru*, the Tribunal concluded that the Law Society generally required articling students to meet a standard of "reasonable assurance" of fitness to work, because a standard of "absolute assurance" was impossible (para. 618). However, the evidence established that the complainant (who had been treated for mental health problems) was actually being held to a higher, harsher standard—i.e., one "that was much closer to that of 'absolute' assurance than to reasonable assurance," whereby "the presence of any risk at all required conditions and management by the Law Society" (paras. 618, 637). See also *Hussey v. B.C.*, [1999] B.C.H.R.T.D. No. 63 (QL) at paras. 54-56 ["*Hussey #1*"]; *Gordy #2* at paras. 162-67.

b. Undue Hardship

Determining what constitutes undue hardship "is a question of fact and will vary with the circumstances of the case" (*Central Okanagan School District No. 23 v. Renaud*, [1992] 2 S.C.R. 970). Where safety is an issue, "both the magnitude of the risk and the identify of those who bear it are relevant considerations" (*Central Alberta Dairy Pool v. Alberta (Human Rights Commission)*, [1990] 2 S.C.R. 489 at para. 63). The *magnitude* of the risk encompasses "the likelihood that loss or injury may occur and the seriousness of the loss or injury that may result" (*Nijjar v. Canada 3000 Airlines*, [1999] C.H.R.D. No. 3 (No. TD 3/99) cited in *Shuswap Lake General Hospital v. B.C.N.U.*, [2002] B.C.C.A.A.A. No. 21 (QL) at para. 110 ["*Shuswap*"]).

In general, and particularly in a safety context, it is important to ask some key questions in assessing reasonable necessity and undue hardship, including the following:

(1) Has the employer investigated alternative approaches that do not have a discriminatory effect?

(2) If alternative rules and standards were investigated and found to be capable of fulfilling the employer's purpose, why were they not implemented?

(3) Is the standard properly designed to ensure that the desired qualification is met without placing an undue burden on those to whom the standard applies?

See *Meiorin* at para. 65.

3. Drilling Deeper Into the Reasonable Necessity and Accommodation Analysis

Most cases involving substance use policies will ultimately be decided on the basis of the analysis under the third part of the justification test. It is therefore important to drill down even deeper into this analysis.

a. Evidence, Onus, and Risk

Similar to under the *KVP* balancing of interests approach, the third part of the *Meiorin* justification test puts the onus on the employer to establish the validity of its standard or policy; anecdotal or impressionistic evidence will not suffice (see generally *Grismer*; *Shuswap*; *Gordy #2*). And under *Meiorin*, like under *KVP*, where the impugned standard is driven by safety concerns, a key aspect of the employer's evidentiary burden relates to risk. Arbitrator Gordon summarized this burden as follows in *Shuswap* at para. 114:

> In terms of the type of evidence that must be presented where a risk to safety is in issue, it is clear that impressionistic evidence will not satisfy the stringent test and will not therefore support a finding of undue hardship. Mere assertions of danger or excessive cost will not suffice. The evidence must clearly identify the risks and demonstrate why those risks cannot be reduced to an acceptable level through accommodative measures. In terms of the impossibility of reducing risks to an acceptable level, an employer must present evidence that it has considered and rejected all viable forms of accommodation.[28]

Consistent with Arbitrator Gordon's comments, the case law establishes or supports the application of the following general principles in relation to the notion of risk in cases involving safety concerns and fitness to work issues related to people with disabilities.

i. Sufficient Risk

Something more than merely a "real" or "minimal" risk must be established to justify discrimination against people with disabilities (see *Gichuru* at para. 496; see generally *Grismer*). A certain level of risk may be acceptable, depending on the circumstances (*Bendrodt v. B.C. Transit*, [1992] B.C.C.H.R.D. No. 19 at para. 139 ["*Bendrodt*"]). For example, where the evidence establishes that the purpose of the impugned standard is "reasonable safety," as opposed to

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28 Arbitrator Gordon also affirmed the principle that the onus is on the employer to show accommodation to the point of undue hardship; the employee does not bear the burden "of proving the negative" (*Interfor v. I.W.A.W.C., Local 1-3567*, [2001] B.C.C.A.A.A. No. 290 (QL) cited in *Shuswap* at para. 121).

"absolute safety," acceptance of a certain level of risk is implicit (see generally *Gichuru*; *Grismer*).[29] The question is whether there is evidence of *sufficient* risk to justify the employer's discriminatory standard (see generally *Gordy #2*).

ii. Evidence of Risk

Whether or not a particular risk is sufficient to justify the employer's standard will depend on a variety of circumstances and considerations, including the dangerous of the job, the dangerousness of the workplace, the characteristics of the specific person or group posing the risk, and the relationship between the specific risk and the safe performance of the relevant job duties (see generally *Robinson*). The "quality of the employer's evidence is therefore crucial" (*Robinson* at 18; see also *Gordy #2* at para. 148). As the Canadian Human Rights Tribunal explained in *Robinson* at 18:

> Scientific evidence, that is, "statistical and medical evidence based upon observation and research on the question [of the risk presented by certain individuals in performing a given task] … will certainly be more persuasive than the testimony of persons, albeit with great experience [in a given business]" (*Etobicoke*, *supra*, at 212). The Tribunal has had occasion several times to stress the scientific nature of the evidence concerning employment policies excluding various categories of persons with disabilities, including diabetes, asthma and epilepsy. For example, see *Rodger, supra*, in which President Lederman said the following:
>
> > … Although society cannot permit any substantial threat to public safety, it cannot condone hasty assumptions about the capabilities of the handicapped. Employers must ensure that in imposing BFORs, they are relying upon the most authoritative and up to date medical and statistical information available and adapted to the circumstances of each individual case.

The further an employer's evidence "moves from the empirical end of the spectrum towards the impressionistic end, the greater the risk that the evidence may be tainted by irrelevant factors, including prejudice and stereotypes" (*Hussey #1* at para. 47). As Chairperson Lynn Smith observed in *Cook v. Tranquille* (1983), 4 C.H.R.R. D/1510 (B.C. Bd. Inqu.) at D/1519:

> Reliance on a medical opinion may or may not provide an employer with reasonable cause, depending on all of the circumstances. The question in the end is whether assessment of an applicant was based upon his abilities as an individual rather than upon his sharing a particular characteristic with other persons where there are common preconceptions about that characteristic … such preconceptions may arise in a number of ways … and may operate on the thinking of a professional person as much as on anyone else.

On the other hand, where a scientific or medical opinion "is cogent and unchallenged, it need not be bolstered by empirical evidence where such evidence is unavailable" (*Hussey #1* at para. 48).

iii. Reducing Risk

The mere existence of a serious risk, however, does not necessarily prevent a finding of unjustifiable discrimination under the Code. Risk has a limited role under the third part of the *Meiorin* test, and

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29 The Tribunal in *Bendrodt* (at para. 139) noted that "if any risk, regardless of the magnitude, were to constitute undue hardship, then … employers whose offices were in highrise [sic] buildings would be justified in refusing to employ individuals who use wheelchairs because of the additional risk which the wheelchair users, and possibly others, would bear in the event of a fire."

is not an independent justification for discrimination (*Grismer* at para. 30). Rather, risk is *a factor* in the justification analysis (see *Gordy #2* at para. 157; see also *Grismer* at para. 30).

Even where the evidence might establish a serious or unacceptable risk to safety sufficient to justify a general workplace standard, the employer must still show that individualized assessment and/or accommodation is not possible without reaching the point undue hardship (see generally *Hussey #1*).

b. Individualized Assessment and Accommodation

In a safety context, the blanket application of a standard, with no allowance for exceptions or individual assessments, will not be justified unless there is no reasonable or practical alternative to the absolute rule (see generally *Grismer*). The standard must incorporate "every possible accommodation to the point of undue hardship" (*Grismer* at para. 32). Where a serious safety risk has been identified as the basis for the standard, it must be impossible to reduce this risk to an acceptable level through reasonable accommodation (*Shuswap* at para. 142; see generally *Grismer*).

The importance of individualized assessment and accommodation in a safety context is illustrated in *Hussey #1*. In that case, the complainant, David Hussey, was profoundly deaf, and was not permitted to apply for a Class 4 driver's licence, on the basis that people who are profoundly deaf cannot satisfy the hearing standard required to obtain the Class 4 licence.

The Tribunal in *Hussey #1* found that the respondent (the licensing authority) had met its burden of providing evidence of sufficient risk to justify the hearing standard—in general. The necessity of the standard was supported by the consensus of medical opinion. Yet the Tribunal ultimately concluded that the respondent had not established that the blanket application of the hearing standard was reasonably necessary, nor had the respondent proved that it had discharged its duty to accommodate. The Tribunal reached this conclusion because the respondent had "not established that individual assessments of [specific] applicants who do not meet the hearing standard for Class 4 licences are impractical" (para. 66). Moreover, the respondent had "not established that it could not have accommodated the complainant without undue hardship (para. 72). On the contrary, the Tribunal identified an accommodation (i.e., eligibility for a restricted or conditional licence) that would have addressed the specific adverse effect experienced by Mr. Hussey (para. 71). Thus, the respondent had not proven that there were no reasonable or practical alternatives to its absolute standard; it had not shown that it had exhausted all viable accommodative measures.

c. Reasonable Alternatives

The requirements to consider reasonable alternatives and exhaust viable accommodative measures are discussed in a number of cases involving safety concerns and fitness to work issues related to people with disabilities, and are particularly emphasized by Arbitrator Gordon in *Shuswap*.

The grievor in *Shuswap* was a nurse with bi-polar mood disorder, who had experienced several episodes of "mania" (a manifestation of her disorder) both at work and while off-duty. The signs and symptoms of her episodes at work included abruptness with other staff, difficulty completing work assignments, excessive charting, and excessive and sometimes inappropriate calls to physicians.

Following an episode at work in 1999, the grievor began seeing a psychiatrist and her condition improved. By early-2000 the psychiatrist concluded that the grievor was fit to return to her job. He noted, however, that her health condition was likely to cause absenteeism from work in the future. The psychiatrist confirmed that he would continue to monitor the grievor's condition and would put plans in place to help her cope with the re-occurrence of symptoms.

Subsequent to returning to her position, the grievor experienced another episode at her workplace in April 2000, and went on sick leave. In June 2000, her psychiatrist confirmed that she was fit to return to work. However, the employer refused to allow her back, without assurance that she would not relapse or that any relapse could be accurately predicted. Due to the nature of the grievor's condition, such assurance could not be provided, and so the union grieved the employer's decision not to allow the grievor to return to work.

Arbitrator Gordon allowed the grievance. On the evidence before her, she was unable to conclude that the employer had established a serious or unacceptable risk to patient safety. Or, if there was such a risk, the employer had not established that it was impossible to reduce the risk to an acceptable level through reasonable accommodative measures (para. 143). She found that in assessing whether the employer had discharged its obligation to exhaust all viable accommodation options, "all of the evidence relating to the grievor's illness and possible accommodative measures must be considered and an assessment must be made as to the viability of various relapse-reduction mechanisms and strategies" (para. 156). In this particular case, Arbitrator Gordon found that "several material facts relating to the nature of the grievor's workplace, her disability and the way it manifests itself in the workplace" had to be considered (para. 151), including the following:

(1) The nature of the workplace (a public hospital) provided "certain implicit safeguards against any risk to patient health or safety escalating to a serious or unacceptable level" (para. 152). For instance, the grievor performed her duties in a professional and team-based (as opposed to solitary) context, and could be easily observed by co-workers at the outset of each shift. She was also in ongoing contact with her professional colleagues throughout her shifts.

(2) The grievor's particular indicators of relapse had, in the past, "been readily observed by her co-workers and reported to supervisory or management staff" (para. 153).

(3) Supervisors and managers were available for reporting purposes during the grievor's shifts (para. 154).

(4) Although there was evidence that bi-polar mood disorder, in general, was characterized by a loss of insight as mania episodes evolve, there was also evidence that when her co-workers confronted the grievor with the possibility that she was unwell, the grievor accepted their observations and agreed to be replaced (para. 155).

Arbitrator Gordon also considered various other factors, including the following:

(1) The grievor and her psychiatrist had become increasingly familiar with the specific features of her disorder, and had developed "some very effective approaches to her illness in terms of treatment, monitoring and prevention of episodes of mania" (para. 157).

(2) There had been a "recent enhancement of the grievor's familial support team," such that the grievor's ability to competently and safely perform her duties could be reasonably monitored and assessed on a regular basis by her parents and husband (para. 160).

Finally, Arbitrator Gordon found that the evidence disclosed "reasonable accommodative measures that could be implemented to regularly test the grievor's competence to work as a nurse" (para. 162). For instance, "the grievor could prepare and provide [her supervisor] Ms. Thompson … with a self-monitor report, and/or the grievor could regularly report to Ms. Thompson … prior to or during her shift such that noticeable irritability could be detected and addressed" (*ibid.*).

In the end, the arbitrator (at paras. 173-74) ordered that the grievor be reinstated to active employment in her position as a nurse, on certain conditions and with various accommodative measures in place, as follows:

> In all of the circumstances of this case, I find the grievor should be returned to work as a nurse on the following conditions. The grievor must:
>
> 1. continue to regularly attend her psychiatrist and physician and immediately report indicators for relapse to them;
> 2. continue to comply with her medical caregivers' testing, monitoring, treatment and medication recommendations;
> 3. continue to regularly use her familial support team to monitor her indicators for relapse;
> 4. authorize her psychiatrist, physician, and/or husband to contact her manager if any of them identifies indicators for decompensation or has a concern about the grievor's condition;
> 5. prepare a self-report of indicators of relapse and the need to increase medication and provide a copy of it to her manager, or designate, if and when requested to do so;
> 6. meet with supervisors or other administrative personnel to monitor her condition, if and when requested to do so;
> 7. not report for work if she has a suspicion she is not well;
> 8. agree to work predictable, routine shifts, and no night shifts;
> 9. agree not to work excessive overtime;
> 10. advise her co-workers and team leader about her disorder and the indicators for relapse;
> 11. comply with any reasonable accommodative measures the grievor, her Union representative and her manager negotiate for detecting early warning signs of decompensation in the workplace.
>
> In terms of reasonable accommodative measures, the following will apply:
>
> 1. the grievor is to be scheduled for predictable, routine shifts with as few alterations as possible, and no night shifts;
> 2. the Employer is to provide the grievor's co-workers, supervisors, managers and other personnel such as the Occupational Health and Safety Officer, with an educational workshop on [bipolar mood disorder] and the detection of indicators for decompensation;
> 3. the Employer is to provide a facilitated discussion of co-worker concerns relating to the grievor's return to work;
> 4. in consultation with the grievor, her Union representative and [her psychiatrist] Dr. Gibson, the Employer is to develop a procedure for staff to utilize if they detect signs of relapse at the workplace, and bring that procedure to the attention of the grievor's co-worker's and supervisors;
> 5. the Employer is to permit the grievor to be absent from work if she identifies indicators of relapse;

6. the Employer may implement reasonable reporting mechanisms involving supervisors, other administrative personnel, or the local mental health unit to monitor the grievor's condition.[30]

d. Return to Work/Who Should Pay?

The following general factual outline from *Shuswap* is not uncommon:

(1) An employee with a disability, who works in a "safety-sensitive" job, is not permitted to work because she is unwell or is perceived to be unwell.

(2) Primarily on the basis of a perceived safety risk, the employer takes the position that the employee's return to work must be subject to certain conditions, or "accommodations" (or the employer absolutely refuses to allow the employee to return to work under any circumstances).

(3) The employee does not agree to (or cannot satisfy) the employer's conditions; however, the employer is not willing to consider any alternatives.

(4) A grievance is filed, alleging, among other things, that the employer has not considered reasonable alternatives, and has not exhausted all viable accommodative measures.

(5) The employer takes the position that there are no reasonable or practical alternatives to the return-to-work conditions that it seeks to impose; that all accommodative measures have been exhausted, short of undue hardship.

In these types of situations, determining which alternatives—if any—are "reasonable," and which accommodative measures—if any—are "viable," will depend on the particular circumstances.

i. Return to Work

In some cases, like *Shuswap*, where, for example, the employee's disability has resulted in significant absences and manic episodes at work, and where the evidence establishes an unacceptable level of risk associated with the employee's return to her position, it may well be reasonable for the employer to insist that the employee engage in an evidence-based treatment option (of the employee's choosing) to reduce the risk to an acceptable level. It might also be fair for the employer to implement minimally-invasive reporting mechanisms to monitor the employee's condition for a reasonable period of time. In these circumstances (and assuming that the parties have adhered to the principles of reasonable necessity, least intrusiveness, proportionality, informed consent, medical autonomy, etc.), the employee's conditional return to work would be properly understood as an accommodation. Without appropriate treatment and reasonable monitoring, the demonstrable and unacceptable safety risk associated with the employee's return to her job would be a barrier to her continued employment. Treatment and monitoring reduce that risk, thereby removing that barrier.

But the imposition of non-consensual treatment and mandatory medical monitoring, in circumstances where the evidence does not establish the reasonable necessity or minimal intrusiveness of these measures, is not accommodation.

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30 As I noted above, the requirement to consider reasonable alternatives and exhaust viable accommodative measures is also discussed in other cases involving safety concerns and fitness to work issues related to people with disabilities. See, e.g., *Gordy #2; Entrop v. Imperial Oil* (Interim Decision #6), June 23, 1995 (unreported).

ii. Who Should Pay?

In cases where treatment or monitoring is appropriately required—as an accommodative measure—in order to reduce the demonstrated safety risk associated with the employee's return to work and to establish her fitness to perform her job duties, who should pay for the treatment/monitoring?[31]

A somewhat analogous question—albeit in a substantially different context—arose in *Hussey #2,* which dealt with a remedial aspect of *Hussey #1* (discussed above).

Hussey

In *Hussey #1*, the Tribunal had directed the respondent "to explore the practicality of individualized assessments for deaf and hard of hearing applicants for Class 4 licences," and "to accommodate applicants where such an accommodation will not be an undue hardship." The Tribunal noted that the respondent "should seek the least restrictive solution" for each applicant (para. 87). The respondent followed these directions, and eventually offered Mr. Hussey two options for obtaining a Class 4 licence: a regular, unrestricted licence, or a licence with certain restrictions. To obtain the former, Mr. Hussey would need to meet all of the regular requirements for obtaining the Class 4 licence, plus he would be required to undergo an additional assessment conducted by an occupational therapist ("OT assessment"). Mr. Hussey would be responsible for all costs associated with the OT assessment. No additional costs were associated with the restricted licence option; however, this latter option did not meet Mr. Hussey's needs.

Mr. Hussey complained to the Tribunal, alleging that the requirement to cover the cost of the OT assessment was discriminatory, and asserting that he could not afford to pay. The respondent argued that there was no discrimination, because all applicants for Class 4 licences were required to bear the costs of establishing their fitness to drive. The respondent also argued that the cost of paying for applicants' OT assessments would constitute undue hardship.

The Tribunal decided in favour of Mr. Hussey. First, it found that Mr. Hussey had established *prima facie* discrimination, as follows:

> With respect to differential treatment, I find that the requirement that each applicant bear the cost of establishing their fitness to drive is a rule that has an adverse effect on the Complainant, because of his disability. As a result of his disability, the Complainant was required to bear a significantly greater cost in establishing his fitness to drive than were other, non-physically disabled, individuals. I find that this greater cost constitutes differential treatment for the purposes of the *Code*, and that the differential treatment arose because the Complainant has a physical disability.
>
> Further, I find that this additional cost had an adverse effect on the Complainant. Mr. Hussey testified that the additional cost presented a significant barrier to him in obtaining a class 4 licence. I also accept … that individuals with disabilities face considerable social and economic disadvantages … I find that the additional cost would add to those disadvantages (*Hussey #2* at paras. 81-82).

Second, the Tribunal found that the application of the respondent's standard (i.e., the requirement that all applicants bear all costs associated with establishing their fitness to drive) to Mr. Hussey

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31 The term "monitoring" here is not a reference to the prolonged, draconian monitoring regimes imposed by many employers through companies like Alliance Medical Monitoring. Rather, I am referring to consensual, minimally-invasive reporting mechanisms for monitoring an employee's condition over a reasonable period of time.

could not be reasonably justified. The Tribunal concluded that the respondent's evidence did not negate (or even consider) the possibility of cost-reduced alternatives to the OT assessments, nor did it establish that the cost of paying for the OT assessments would be excessive. Therefore, the respondent had not discharged its duty to accommodate Mr. Hussey to the point of undue hardship (*Hussey #2* at para. 117).

In the result, among other things, the Tribunal ordered the respondent to "cover the extra costs for those persons with hearing loss disabilities applying for class 4 drivers licences for whom the Respondent requires a specialized individual assessment" (*Hussey #2* at para. 119).[32]

Thunder Bay

In a similar vein, in *Thunder Bay Catholic District School Board v. Ontario English Catholic Teachers' Association* (2011), 209 L.A.C. (4th) 223 ["*Thunder Bay*"], Arbitrator Luborsky rejected an employer's blanket policy of refusing to consider covering or contributing to the cost of a personal bodily assistive device for an employee with a disability, in circumstances where such a device may be a reasonable accommodative option.

Thunder Bay involved a grievor with a severe hearing disability, who was incapable of performing the essential requirements of her job as a teacher without using properly functioning and maintained digital hearing aids. Her request for reimbursement for the purchase of these hearing aids was refused on the basis that the employer, as a rule, did not cover or contribute to these types of costs.

Arbitrator Luborsky found that, because of her disability, the grievor was unable to achieve a particular workplace communication standard (i.e., the ability to communicate effectively with students, parents and colleagues). Under the third part of the *Meiorin* justification test, he concluded that by "holding to a rigid policy that refuses to consider providing personal bodily assistive devices as one among all options available in the search for appropriate accommodation of a disabled employee," the employer had breached the Ontario *Human Rights Code* "in the context of the broad, purposive, flexible and liberal interpretation" of the employer's duty to accommodate (para. 109). The arbitrator found that the duty to accommodate obliged the employer "to go beyond the nature of the work and physical working environment in accommodating the disabled employee, to the consideration of [the grievor's] personal needs in fulfilling the essential requirements of her teaching duties" (para. 94).

Applying the reasoning from *Hussey #2* and *Thunder Bay* to cases involving employee substance use, then, under certain circumstances an employer may be obligated under the Code to pay for treatment/monitoring that is appropriately required as an accommodative measure. If the employee is responsible for covering all expenses associated with the treatment/monitoring, then she will be bearing a substantially greater cost in establishing her fitness to work than other employees. This may be a significant barrier to her continued employment. In these circumstances, the employer may be required to establish that cost-reduced alternatives have been exhausted, and that it could not pay for the treatment/monitoring without incurring undue hardship.

e. Liability

Liability concerns are a common corollary to employer perceptions of risk in relation to the return to work of an employee with a disability. These concerns must be closely scrutinized and assessed

32 See also *Bolster v. B.C.*, 2004 BCHRT 32.

for their validity. An employer cannot meet its burden under the *Meiorin* justification test simply by making bald references to its insurance coverage or the regulatory framework in which it operates (see *Gordy #2* at paras. 110-20).

The Tribunal's analysis in *Gordy #2* provides helpful guidance for examining regulatory and insurance liability issues in a safety context. That case involved an allegation of employment discrimination against Robert Gordy, a fishing guide with bipolar affective disorder. Essentially, the employer, Oak Bay Marina, refused to allow Mr. Gordy to return to work due to safety concerns related to his disability. In attempting to make its case under the *Meiorin* justification test, the employer gave evidence regarding the regulatory framework in which it operated, as well as the comprehensive insurance coverage that it carried for its fishing guides. In its assessment of this evidence, the Tribunal commented as follows at para. 112:

> [Vice President of Operations] Mr. Prittie gave evidence that Oak Bay carries comprehensive insurance which covers the fishing guides, although liability is excluded under the policy if any activity on board is imprudent, unsafe, unduly hazardous or improper. There was no evidence that Mr. Prittie had consulted with its insurer on the issue of relying on [Mr. Gordy's treating psychiatrist] Dr. Vincent's expert medical opinion and returning Mr. Gordy to work. Further, Mr. Prittie did not provide any evidence, nor did counsel make submissions, regarding the interpretation of the policy, especially if an accident occurred as a result of a medical condition, despite medical confirmation from a specialist that the employee in question was medically fit to return to work. Nor were there any submissions concerning the interpretation of the Release [signed by customers who went out on the water with fishing guides]. Further, there was no evidence that Oak Bay ever telephoned its insurer to make inquiries about the situation. Finally, there was no evidence that [Fishing Operations Manager] Mr. Dreger turned his mind to regulatory or legal issues before refusing to return Mr. Gordy to work.

The Tribunal in *Gordy #2* went on to discuss its previous decision in *Duxbury v. Gibson's Landing Slo-Pitch League*, [1997] B.C.H.R.T.D. No. 30 (QL) ["*Duxbury*"], which involved a softball league that prohibited pregnant women from playing, for "safety reasons" and pursuant to a rule under its liability insurance against the participation of pregnant women (see *Duxbury* at para. 9).

In *Duxbury*, not only did the Tribunal find that the respondent had failed to meet "its burden to provide evidence of a sufficient risk of injury to justify the rule," but it also concluded that the terms of the respondent's insurance coverage, in and of themselves, did not constitute reasonable justification for the discriminatory exclusion of pregnant women (paras. 33-36). The Tribunal accepted that it may be advisable for a softball league to obtain liability insurance to protect against the risk of injury-related litigation. However, it could not accept that an appropriate solution to the risk of litigation was to purchase insurance that excluded certain players on the basis of a prohibited ground under the Code—unless there was no reasonable alternative. On the evidence, the Tribunal was unable to find that there was no reasonable alternative (para. 35). The Tribunal then proceeded to state the following at para. 36:

> The Respondent should be able to obtain liability insurance if it wishes to do so for *bona fide* reasons. Such coverage should include pregnant women, not exclude them as in this case. If the Respondent chooses discriminatory insurance then it or the insurance provider will need more compelling evidence than I have heard to demonstrate that such a discriminatory policy is reasonably justified.

4. Application of the Third Part of Meiorin: The Case of Gichuru

The Tribunal's analysis in *Gichuru* provides a useful and illustrative example of the application of the third part of the *Meiorin* justification test, and incorporates many of the principles discussed above.

In *Gichuru*, the Tribunal held that the following question, posed by the Law Society to prospective articling students, was *prima facie* discriminatory:

> Have you ever been treated for schizophrenia, paranoia, or a mood disorder described as a major affective illness, bipolar mood disorder, or manic depressive illness?

The Tribunal held that this question (the "Question"), and the processes that flowed from it, adversely affected people who answered in the affirmative. The Question itself was based on stereotypical assumptions about people with the listed conditions, and triggered a more intensive and intrusive evaluation of the applicant (paras. 464-65, 555). In the case of Mr. Gichuru, after having acknowledged being treated for one of the listed conditions, he was subjected to increasingly intrusive requests for medical information by the Law Society (paras. 560, 565).

The Tribunal examined the Law Society's medical fitness standard (i.e. the requirement to be medically fit to practice law competently, where medical fitness related exclusively to the conditions listed in the Question) from both a systemic and an individual discrimination perspective, and concluded—on both fronts—that it was not justified, on the basis of the reasoning below. The potential implications of applying this reasoning to the Requirements and Restrictions commonly imposed under substance use policies are, I think, clearly evident and extremely significant.

a. Development of the Standard

The Tribunal began its analysis of the reasonable necessity of the standard by scrutinizing the process by which it had been developed. Among other things, the Tribunal found the following:

(1) Although the Law Society had information relating to alternative, narrower approaches to the medical fitness issue before it, there was very little evidence that the Law Society had investigated or fully considered alternate approaches that may have had a non-discriminatory effect (e.g., asking applicants to self-identify whether they had a condition that might affect their medical fitness to practice law competently). This was contrary to the requirements that a respondent "consider the impact of its standards, and avoid choosing a standard that is broader than what is reasonably necessary to accomplish its purpose or goal" (para. 516).

(2) The Law Society had information before it that suggested there may be physical disabilities (e.g., diabetes, epilepsy) that could impact on an applicant's medical fitness. However, there was no evidence that the Law Society investigated these issues, "or conducted any investigation into any physical ailments that may have a potential effect on fitness" (para. 517).

The Tribunal commented that both the issue of whether the Question was under inclusive, and the issue of whether the Law Society was rigorous about what it was capturing in the Question, were centrally relevant to whether the standard was reasonably necessary to accomplish the Law Society's purpose of reasonably assuring competence to practice law. According to the Tribunal at para. 518:

> If there are conditions that may impact on an applicant's ability to practice law competently, which are not included in the Question and were not investigated by the Law Society, this would raise issues of whether the same question needs to be asked of the conditions that are included.

b. Content of the Standard

Next, the Tribunal examined the content of the standard, and made various findings, including the following:

(1) There was no evidence as to why the Question targeted some conditions, but not others that may have raised equal or greater concerns around fitness. The Tribunal noted that the "absence of any rationale in this regard is a significant gap in the evidence, given the onus on the Law Society to justify the Question at this stage of the analysis" (para. 520).

(2) Some of the language in the Question was broad and unscientific. For example, the Question asks about "paranoia," which "is not a psychiatric diagnosis, but rather a lay person's definition," which may include "a number of conditions, some of which may affect an individual's competence to practice law, others which likely would not" (para. 522).[33]

(3) The Question related exclusively to mental disabilities, and not physical disabilities that may have an impact on fitness to practice law. Despite the Law Society's apparent concern about ensuring high levels of both physical and mental fitness (a concern which was not reflected in the Question), the Law Society provided no evidence that the conditions listed in the Question "present a potential risk to fitness and competence that are not presented by other medical conditions, whether physical or mental" (para. 526).

(4) There was no evidence that other jurisdictions, with narrower questions, self-reporting questions, or no question at all, had experienced any problems (para. 527).

(5) While the Law Society argued that the purpose of the Question was to identify fitness risks, it was not clear that the Question was actually adequately fulfilling this purpose. The evidence indicated that the reporting rate in relation to the Question was unusually low, relative to mental illness rates for the general population, and rates for lawyers specifically (paras. 535-39).

c. Process Flowing from the Standard

In addition, the Tribunal looked at the process flowing from an affirmative answer to the Question, and found as follows:

(1) An affirmative answer to the Question resulted in the application being automatically sent for review; there was no discretion in this referral. The Tribunal concluded that the Law Society had not established, on the evidence, that a mandatory referral for review was necessary to accomplish the purpose of the Question (para. 540-42).

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33 The first two findings in relation to the content of the Question, taken together, show that a standard may be both under inclusive and over inclusive, and that both under inclusiveness and over inclusiveness undermine the argument that a standard is reasonably necessary.

(2) Once Mr. Gichuru answered affirmatively to the Question, "he was enmeshed in a process from which he could not remove himself" (para. 594) and under which he was automatically required to provide ongoing and additional medical information (see paras. 595-97). The Tribunal noted that this automatic requirement had "the effect of reducing the degree to which an independent assessment of the *need* for additional information" could be made (para. 597; emphasis added).

(3) The Law Society continued to insist on updates from Mr. Gichuru's "treating physician," despite being advised that Mr. Gichuru did not have such a physician because he was not being treated for anything (because he had been symptom free for several years). According to the Tribunal, the Law Society's continued insistence that Mr. Gichuru provide updates on his treatment or updates from his treating physician—despite having been told that Mr. Gichuru did not have a treating physician and was not being treated for any conditions—was not indicative of individualized assessment (para. 607).

(4) Mr. Gichuru's affirmative answer to the Question "was used by the Law Society to justify … an extensive investigation into Mr. Gichuru's employment history" (para. 614). The Tribunal concluded that the Law Society:

> … did not take a targeted approach to the information it was seeking, but rather a blanket approach that addressed significant periods of Mr. Gichuru's past employment. This represented a significant intrusion into Mr. Gichuru's personal life in large part because of assumptions made, or suspicions fomented, as a result of his affirmative answer to the Question.

(5) In 2003, Mr. Gichuru had been required by the Law Society to attend a medical assessment with a psychiatrist that he had no input in choosing, and he was required to pay for this assessment. The Tribunal found that this assessment option was "significantly more onerous, intrusive and invasive of Mr. Gichuru's privacy than almost any other option" (para. 616), and was not reasonably necessary:

> In the absence of any information about why this decision was made, it is impossible to find that the requirement was reasonably necessary to accomplish the Law Society's purpose of assessing whether Mr. Gichuru was fit to practice law competently. As noted by the Court in *Meiorin*, one of the factors to be assessed in determining whether the requirement was reasonably necessary is whether there is a way to carry out the function that is less discriminatory while still accomplishing the respondent's legitimate purpose … In this case, the Law Society has not established that this is so (para. 617).[34]

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34 Earlier in its decision (in its application of the test for *prima facie* discrimination), the Tribunal had found that the requirement that Mr. Gichuru pay the cost of this assessment and others "had a negative financial impact on him during a time of pre-existing financial stress" (para. 564). It had also noted that, in 2004, Mr. Gichuru had been required to attend another independent psychiatric examination, which essentially confirmed his mental fitness. Yet, following the 2004 examination, Mr. Gichuru was required, as a condition of his Call to the Bar, to undertake to obtain a treating physician and to consult with that physician. The Tribunal found this requirement to be "a significant intrusion on Mr. Gichuru's personal medical autonomy" (para. 565).

In relation to the conditions placed on Mr. Gichuru's Call to the Bar (e.g. the requirement to retain and consult with a family physician), the Tribunal found that the Law Society had overreached by intruding into Mr. Gichuru's personal health care decisions, stating the following at para. 632:

> The Law Society's concern was not to ensure that Mr. Gichuru had in place the best possible health care regime. These decisions are highly personal and individual ones. Rather, its concern was to reasonably assure itself that Mr. Gichuru would be medically fit to practice law competently. While it could be argued that ensuring all applicants have a treating family physician provides additional assurances of their continued medical fitness to practice law competently, I cannot find that these conditions were reasonably necessary to the Law Society's purpose.

Finally, the Tribunal rejected the Law Society's argument that the process flowing from an affirmative answer to the Question was accommodative. First, the Tribunal observed that Mr. Gichuru was not seeking accommodation. Rather, Mr. Gichuru's complaint to the Tribunal asserted "that the Law Society incorrectly and discriminatorily took his disability (or perceived disability) into account in the decisions it made with respect to his application" (para. 635). Second, to describe the process flowing from the Question as an accommodation was to ignore the significant power disparity between the Law Society and Mr. Gichuru (para. 636). The process flowing from the Question was, in essence, a coercive one.

In my opinion, the Requirements and Restrictions outlined in the introduction to this paper, unilaterally and universally applied, cannot withstand the type careful and thorough scrutiny and analysis described by the Tribunal in *Gichuru.*

VI. Conclusion

> The plain fact to be absorbed by any person engaged in the dangerous occupation of truck-driving is that if they believe this too high a standard to be demanded of them, there are other ways of making a living. Let those who resent control or curtailment of their drinking habits, when they might in any way effect the proper performance of their heavy responsibility, seek new fields.[35]

The legal approach to workplace issues involving employees with addictions has evolved considerably since His Worship, Magistrate J. A. Hanrahan, George Rose, Esq., and Normann Ramm, Esq. made the above-noted comments in 1951. And this area of the law must continue to evolve.

The prevailing approach to substance use and addiction treatment, described as the "traditional view" in the introduction to this paper, is widely reflected in both workplace substance use policies, and legal decisions relating to those policies. Substance use policies that incorporate elements of the traditional view are pervasive. Some, if not most, of these policies impose many, if not all, of the Requirements and Restrictions outlined above. And decision-makers have upheld these types of rules and the disciplinary consequences associated with their breach.

Yet, applying the dual-lens of the current research literature and contemporary legal principles outlined in the sections above, it is clear, at least to me, that these types of Requirements and Restrictions are grossly unlawful and blatantly discriminatory. They are not evidence-based, nor are they reasonably necessary or demonstrably effective. Rather, they are rooted in pervasive stereotypes and misconceptions about employees with addictions, and are resulting in the further

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35 *International Brotherhood of Teamsters, Chauffeurs, Warehousemen and Helpers of America, Local 880 v. Consolidated Truck Lines, Ltd.* (1951), 3 (L.A.C.) 964 at para. 32 (Hanrahan).

stigmatization of an already-marginalized population of workers. They are also extremely invasive of personal privacy and bodily integrity, and obscenely intrusive into medical autonomy and self-determination.

Accordingly, advocates, practitioners and decision-makers must make concerted efforts to re-examine and challenge conventional wisdom and standard practice around substance use policies in unionized workplaces and beyond. I hope that this paper assists in those efforts.