CLR
A Contractors' Association – Representing Change

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Canadian Nuclear Safety Commission
P.O. Box 1046, Station B
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Submitted via email and by regular post

Re: Feedback on Draft REGDOC-2.2.4 – Fitness for Duty

On behalf of Organized Construction contractors in the province of Saskatchewan, we appreciate the opportunity to provide input on the **Draft REGDOC 2.2.4 Human Performance Management – Fitness for Duty** which was issued in November 2015. The CLR represents contractors who regularly and routinely work in the uranium mines in Northern Saskatchewan for owners such as Cameco and Areva, by providing both construction and maintenance services. Depending on the scope of this document, our contractors may be impacted directly by the decisions made by the Canadian Nuclear Safety Commission (CNSC).

The CLR's contractors are very familiar with Alcohol and Drug Policies as the CLR, in conjunction with its union partners, have established our own policy for the unionized construction industry in Saskatchewan through the CODC Construction Opportunities Development Council Inc. Our policy is available online, free of charge, at www.codc.ca/downloads. Of question and concern is how the proposed REGDOC 2.2.4 would impact our existing policy and contractors who operate within it. One of the big differences is that both the CODC and the Construction Owners Association of Alberta (COAA) have both adopted the use of oral fluid testing methodologies, in addition to or in place of urine testing. While this is not the most pressing question at the moment, it is one that will need to be addressed down the road at implementation time.

The CLR has reviewed the document and offers the following feedback to the CNSC:

In broad strokes, the document should be revisited to make it more specific and prescriptive. There are a number of sections where the CNSC appears to leave discretion to licensees rather than being more formally regulatory in nature. Some of these cases may provide confusion and

create a mosaic of differing standards and processes for addressing fitness for work when it comes to alcohol and drug testing. These include sections: 4.1.4 – definition of safety sensitive positions, 5.4 – licensees should establish a testing process (this could result in a different process for each licensee), and section 5.4.2 – accreditation of laboratories & qualified review officers for test results, to highlight a few. To assist all stakeholders (licensees, sub-contractors, third party administrators, workers, etc.), the CNSC should take a firm stance on what the regulatory framework should be. In other words, set the rules and communicate them so that everyone is working from a common regulation and standard. As an industry who supports the mining of uranium, it is easier for our stakeholders to understand and comply with one comprehensive standard for the nuclear industry versus various standards that are licensee-dependent.

Specific feedback is offered in the following table:

Section	Topic	Comments
1.2	Scope	1. How broad or narrow is the CNSC's target audience for these regulations? 2. Does it include all aspects of the nuclear power production supply chain? (mining, transportation, refining, energy production, waste disposal, etc.) 3. Does the "safety sensitive work" definition include those who would be involved in construction and maintenance of mines and power plants? 4. Leaving the definition of "safety sensitive" to various licensees could create competing standards and rules across sites.
3.8	Training & Education	The Guidance section refers to the trainer should be knowledgeable in prescription or over the counter drugs and dietary factors that would affect A&D test results. First, why would the CNSC want to put the trainer in the position to coach students how to pass or fail a drug test? Second, in order for someone to have sufficient knowledge and skills to answer those questions, they would need to be trained medical professionals. This greatly reduces the pool of candidates an employer could use to train the workforce. Third, if a student in a training session has a question about their own fitness based on their dietary or medication usage, they

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		should simply be referred back to their personal physician to answer those questions. It is not the role of the trainer to comment.
4.6.2	For-Cause Alcohol & Drug Testing	This section needs clarification. There are two types of requests for testing commonly used by employers to verify compliance to the policy. They are: Reasonable Grounds (or reasonable suspicion) and post-incident (post-accident) testing. Both of these types of tests have been supported by Canadian case law. The CNSC should be clear that it is requiring both types of tests on a mutually exclusive basis, by putting them under separate headings. Otherwise, the policy could be interpreted that they are sequential; this means that following an incident an employer would need to determine that the person was 1) a contributor to the incident AND 2) is unfit on a reasonable grounds basis.
4.6.3	Follow-up Testing	This policy dictates how and when a policy violator will be monitored (once every 3 months for a minimum of 2 years). This undermines industry best practice of having the schedule, duration and number of tests determined on a case-by-case basis by professional Substance Abuse Professionals or Substance Abuse Experts (as suggested in Section 5.5). Certain cases may require an individual to undergo 12 tests in a 12 month period over the course of 2 years. These tests are done on an unannounced and random basis. An individual may go for 2 tests in one month and then skip 2 months, etc. Having the proposed testing protocol hampers and interferes with best practice. Further, this section creates some additional moral and safety hazard for CNSC and its organizations. 1. If a worker is required to do more than 1 test every three months, then an employer requiring the test would potentially be in violation of the regulation and subject to legal challenge. 2. If a worker knows the schedule, and are tested in the first month, they would know that they have 2 months without risk of being tested again.

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		This fundamentally undermines the whole purpose of follow-up tests. This issue came up in the administration of our own Return-to-Work plans and our CODC stakeholders. The following is a quote from Paul Gardiner, Manager for Integrated Workplace Solutions who is CODC's contracted Substance Abuse Professional provider. They do our assessments and oversee the return-to-work compliance programs of our workers. *There is a clinical value and potential safety benefit to the unannounced testing period which adds accountability. Workers know that at any point during that year they might get a call to go for an unannounced test - and hopefully this adds some additional incentive to remain fit-for-duty at all times - particularly during this first year, as this is when relapse is most likely to occur.* *The other alternative is that someone knows they have five tests say, they start in January and by August they have had their fifth test. If they know they are now "done" - it removes this additional accountability for the rest of the year. So we've taken the position that it is optimal not to disclose the number of tests recommended, and instead offer that accountability which comes with the uncertainty for the entire testing period. (With our customers who manage their own follow-up testing, we make this recommendation, and it seems to be followed by most.) We'd recommend the [Designated Employer Representatives] follow with this approach and not disclose the specific number of tests recommended by the [Substance Abuse Professional].*
5.4.2	Urine Testing Protocol	What is missing and is in broad use in industries that have implemented urine-based tests is consideration for the Point-of-Collection Tests (POCT) or "quick tests", which quickly test the urine sample to see whether there is presence of the prohibited substances. The quick results are typically available within 15 minutes of collection of the urine sample. This allows for a preliminary assessment of whether or not the individual presents a safety risk to return to work following the collection while the sample is sent onwards to the laboratory for

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		confirmation analysis. POCT's have become a staple in the industry for a number of reasons: 1. Typically A&D policies contain a no-harm/no-foul clause with relation to compliance to the work rule. a. The policies typically state that a person will be held out of service pending the laboratory confirmation of compliance. b. If the worker is in compliance, they typically suffer no loss of pay because they are in compliance. This means that there is significant productivity loss and costs associated for those who are in compliance with the work rule and were compliant with taking a test. c. If the worker is non-compliant, that out-of-service period becomes a suspension or unpaid leave. 2. The practical experience is that laboratory based results can take anywhere from 1 day to 1 week on average to get results. a. Complicating factors include: courier schedules, remoteness of collection site and distance to the laboratory, weekends and statutory holidays when courier and laboratory service are unavailable; time of collection (earlier in the day vs late evening) and more. All of these factors influence how long it takes for the employer to get the final confirmation results from the Medical Review Officer. 3. Sending someone home without first verifying that they may be safe by using a POCT test has significant cost and practical implications for employers: a. Lost productivity and paying for no work while someone is waiting for test results that confirms that they are compliant. b. Lost productivity if the work has to be re-allocated amongst the team to cover the loss of a worker part-way through a work shift. c. Overtime costs involved in bringing in extra workers to cover the worker's removal from shift both on the day of the tests and the following days until their return. 4. POCT urine tests are a valid and reliable way of doing a quick screening test. They are regularly relied upon by employers

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		across the country. The CNSC should strongly consider including urine POCT tests as a helpful tool for employers in conducting A&D tests, however, these tests should not be used to replace laboratory testing. Urine POCT should be used in conjunction with laboratory testing.
5.4.2	Laboratory Accreditation	This section contemplates accreditation of laboratories for A&D tests (SAMSHA & CSC), of which only one issues accreditation (SAMSHA) to labs and verifies their compliance. We are not aware of the CSC issuing any form of accreditation to Canadian laboratories, so established A&D policies in other industries only recognize SAMSHA laboratories. CNSC should do the same.
5.4.2	Medical Review Officers	The only recognized expert to rule on A&D test results are Medical Review Officers who are specially trained professionals who are medical doctors. They need to be able to understand not only lab concentrations, but also the medical need for treatment regimes for medical conditions if the sample is flagged for prescribed or over the counter medications. The MRO would also need to be able to dialogue with the worker's prescribing physician if necessary.
5.4.2	Oral Fluid Testing	The CNSC should consider including protocols for oral fluid testing. The benefits of oral fluid testing include: direct collection by the administrator rather than being collected behind screens; every sample is sent to the laboratory; and, there are no cheat kits available to interfere with the process. Unfortunately, there are currently no valid or reliable POCT oral fluid tests, so the CLR employers often rely upon urine POCT for rapid and reliable results.
5.4.3	Process for Positive Test results	This section should refer to a *Mandated Substance Abuse Professional (SAP)* or *Mandated Substance Abuse Expert (SAE)* rather than a referral to an EAP program. There is a distinct difference between SAP/SAE services and EAP services. While SAP/SAE services are often offered by EAP providers, they are often a separate service with different rules. SAP/SAE are specific to Alcohol & Drug abuse assessments, whereas EAP offers a broad range of counselling and support services to the

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		workers (family counselling, marital therapy, and some include financial and legal counselling services). Mandated referrals provide the Employer with participation in the process and access to information about the worker which is needed to properly manage the Return-to-Work program and on-going compliance. If the worker is simply directed to the EAP program, 1) they may never properly disclose why they are attending the meeting, 2) the sessions are private with the employer having no right or access to information or able to contribute to why the worker was sent in the first place, and 3) offers a way for a worker to comply with the wording of the regulation but not the intent.
5.5	Substance Abuse Evaluation (SAE)	This section is confusing and needs clarification: Does the CNSC state that an SAE need to be done by: 1. A doctor or nurse who is certified by an professional association –or- A doctor or nurse who has received training in substance abuse evaluation 2. A professional who is certified by a professional association –or- A Doctor or Nurse who has received training in substance abuse evaluations If the CNSC is restricting SAE's to be done by doctors and nurses, then it is missing out on many other qualified professionals (e.g. psychologists) who might be competent to do the work. Alternatively, many doctors and nurses may not be competent and qualified to conduct these assessments as they lack appropriate training. Further, the addictions field has many counsellors and experts who may not be competent in conducting an SAE as their training may be limited to some limited alternative training or credentialing and being a recovering addict themselves. The counselling field is generally unregulated, unlike professions such as social workers, psychologists, nurses, and doctors.

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Appendix D	Alcohol and Drug testing thresholds	There are a number of concerns with this section: 1. The standard 5 panel drug test includes Phencyclidine (PCP), however this is missing from the list of drugs. a. Is the removal of PCP intentional? b. Going for a non-standard test adds additional costs to employers. The CNSC would be missing out on economies of scale already in the industry. 2. The stated thresholds for hydromorphone, hydrocodone and oxycodone are 300 ng/ml versus the industry standard of 100 ng/ml. 3. The CLR has had to research methadone to verify whether it presents any safety risk for our own workers and employers. Industry experts have advised us that proper methadone treatment does not present a safety risk for workers. 4. What are the thoughts for testing for benzodiazepines? 5. Neither the CODC nor the COAA, nor to my knowledge the US Department of Transportation (DOT), have any protocols around dilution cut-offs. If a sample is dilute, the lab declares it as such and stops the testing procedure. The employer is then in the position of deciding whether to conduct another test. Can this dilute concentrations table be supported by the laboratories and the MRO's as evidencing non-compliance?

In summary, the CLR has a number of questions and concerns regarding the draft REGDOC-2.2.4. We hope that our constructive feedback will be useful for the CNSC in its continued development of its policy, procedure and regulations. The field of alcohol and drug testing is complex and ever-evolving. As stated at the beginning, the CLR appreciates the opportunity to provide our input.

Should you have any questions, please feel free to contact the writer at 306-352-7909 ext. 4.

Thank you,

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