Report on a Stakeholder Conversation

About principles and criteria to guide the development of regulations for the Post Traumatic Stress Disorder Presumption for Frontline or Emergency Response Workers

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The Workers' Compensation Board wishes to the thank all of the people and organizations that contributed their time and effort to help organize and to participate in these conversations.

EXECUTIVE SUMMARY

Introduction

Nova Scotia's Department of Labour and Advanced Education asked WCB Nova Scotia to conduct a stakeholder consultation process to identify principles and criteria that could be applied by decision-makers to develop regulations that will ensure:

- The occupations listed under frontline or emergency response workers are well defined;
- Other occupations that reflect equivalent levels of risk and exposure can be added;
- Those given the authority to diagnose have the ability and expertise needed; and
- The timelines for eligibility are clear.

The WCB engaged an independent consulting firm, Landry & Associates to facilitate the consultation process. The process engaged about 120 people (representing their personal views and/or the views of over 60 organizations), in group conversations and individual interviews over a one month period from May 22 to June 19, 2018.[1]

Key Themes

Six key themes emerged from the conversations. These emerged as recurring topics or ideas reflecting shared perceptions, that transcended stakeholder/representational lines repeatedly across all and within all the sessions:

1. *"The real issue" is* that -

   It is not possible to "protect" Frontline and Emergency Response Workers from *frequent and persistent exposure* and therefore that workers, employers and the WCB have a *shared duty* to:

   - Prepare and support these workers to build and maintain the resilience required to sustain a state of mental wellness and well-being;
   - Acknowledge that PTSD is one of a spectrum of stress responses and conditions through which a worker passes before their condition escalates to PTSD; and
   - Ensure these workers receive treatment and support as early as possible and *before* their conditions escalate to become PTSD.

[1] A list of participating organizations is attached as Appendix A

2. While most jobs fall somewhere along a spectrum of risk of exposure, what distinguishes Frontline or Emergency Response Workers is the certainty, that their voluntary and/or paid employment will involve *frequent and persistent,* direct and/or indirect exposure to violent and traumatic situations (as defined in the DSM-5);

3. Authorized diagnosticians need to be accessible to workers and qualified to make an objective, accurate and thorough diagnosis.

4. The vast majority of participants, regardless of whose view they were representing, have greatest confidence in, and therefore would prefer, diagnoses and treatment plans that are provided by psychiatrists and psychologists assuming the WCB can arrange this within 30 days.

5. PTSD can and does inhibit a worker's capacity to take the steps that a "reasonable" person would take to seek help or a diagnosis, and/or to ensure that their affairs are in order; and therefore, that regulators should err on the side of flexibility when determining timeframes for eligibility for the presumption; and

6. There are a wide range of views with respect to the principles that people feel should be applied to select the effective date for the presumption, and by extension, to what the effective date for the presumption should be.

This Document

This document provides an overview of the consultation process and the key points from the conversations through which these themes emerged.

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INTRODUCTION

In summer 2017, the Department of Labour and Advanced Education (LAE) conducted a process to inform and consult with stakeholders about proposed amendments to the *Workers' Compensation Act* to provide the benefit of presumption for Post-Traumatic Stress Disorder (PTSD) to emergency response workers.

Following the consultation, in October 2017, Government passed amendments to the *Act* that:

- Provided the benefit of presumption for PTSD to Frontline or Emergency Response Workers;
- Established a list of workers who may have access to the presumption:
  - police, firefighters, paramedics, nurses, continuing care assistants, correctional officers, and emergency dispatchers;
- Clarified that a PTSD diagnosis from an authorized diagnostician is a prerequisite to the presumption;
- Established timelines for eligibility; and
- Created authority for regulations.

The amendments take effect in October 2018, one year after they received Royal Assent. Government is using that year to focus on regulatory development, working with the Workers' Compensation Board (WCB) and stakeholders to inform the process.

As part of that work, the WCB was asked to consult with stakeholders to identify principles and criteria that could be applied by decision-makers to develop regulations that will ensure:

- The occupations listed under frontline or emergency response workers are well defined;
- Other occupations that reflect equivalent levels of risk and exposure can be added;
- Those given the authority to diagnose have the ability and expertise needed;

and

- The timelines for eligibility are clear.

The WCB engaged an independent consulting firm, Landry & Associates, to facilitate the consultation process. The process engaged about 120 people (representing their personal views and/or the views of over 60 organizations), in group conversations and individual interviews over a one month period from May 22 to June 19, 2018.

This document provides an overview of the process and a summary of the results of those conversations - what we believe we heard.

2 CONSULTATION PROCESS

The consultation process was designed to provide interested and affected Nova Scotians with multiple opportunities to share their views about the principles and criteria they feel should be applied to the PTSD regulations.

To that end, ten facilitated conversations were hosted in three locations across the province. The sessions were scheduled to occur on eight days, some in the morning, afternoon and evening; and over the course of four weeks to ensure participants would be able to pick the time and/or the place that worked best from their perspective.

Participants were extended an invitation a month in advance so they would have time to join the discussion in person or by conference call.[2] For those who were interested but unable to attend any of the sessions, we conducted one-on-one interviews and accepted written submissions.

Ultimately, about 120 people shared their views and/or the views of the over 60 organizations they represented including workers, injured workers, employers, clinicians, industry associations and advocacy groups. The vast majority of these participated in person in one of the facilitated conversations.

Each session was roughly three hours long and conducted in five parts including:

1. Welcome, Introductions, and Context
2. Definition & Designation of Occupations
3. Authorizing Diagnosticians
4. Time Frames
5. Next steps.

Participants were invited to share their views freely and with the understanding that we were looking for the fullness of their input rather than any level of agreement or consensus.

We were gratified by the energy and perspective they brought to the conversation and hope we have done justice in this summary of our understanding of what they shared.

[2] The consultation schedule is attached as Appendix B

3 SUMMARY OF RESULTS

3.1 TOPIC 1 - DEFINITION & DESIGNATION OF OCCUPATIONS

The purpose of this conversation was to develop principles, criteria, and indicators that could be used to inform decisions about the next level of definitions; and to guide future decisions about the designation of other occupations.

3.1.1 Principles:

Participants generally felt the definition and designation of occupations should reflect:

- **Fairness** - That workers facing *equivalent levels* of risk and exposure *should be treated the same way*; and
- **Consistency/Equity** - That the application of criteria to assess eligibility should be applied to categories of workers whose work duties and environments are *relatively homogeneous;* and
- **Responsibility** - The scope of the presumption should not exceed the scope of employers' responsibility under the terms of the workers' compensation "historic compromise".

3.1.2 Criteria:

Participants consistently acknowledged that while most jobs fall somewhere along a spectrum of risk of exposure, what distinguishes Frontline or Emergency Response Workers is the certainty, that their voluntary and/or paid employment will involve *frequent and persistent,* direct and/or indirect exposure to violent and traumatic situations (as defined in the DSM-5):

- **Certainty** - "…this is what they signed up for…";
- **Frequency** - "… spend every day at the worst moments in other people's lives";
- **Persistence** - "… they have to deal with or be prepared to deal with this every day, and sometimes, multiple times a day."

3.1.3 Indicators

Participants were equally consistent about which indicators they would consider to determine if it made sense to presume that a worker's employment would involve certain, frequent and persistent exposure:

- The Worker's **Duty:**
  - Direct Exposure: In the service of the public - to respond first, to run toward the trauma; to control, protect, save, or support people "on the worse days of their lives"; and to not fight back.
  - Indirect Exposure: To take the call, clean up the scene, transcribe the notes, watch the videos, or assist with the health care.

- Their **Workplace:**
  - Direct Exposure: "Wherever the trauma is". For example at accident sites; at crime scenes; in lockdown facilities; on phone lines; and in institutionalized care facilities;
  - Indirect Exposure: Wherever trauma is relived . For example in counsellors' offices and court rooms.

- The **Populations With Whom They Work:**
  - Direct Exposure: Unpredictable, abusive, violent. For example: People who are terrified; who have mental health and/or addiction issues, including dementia; who have a history of violence; who are under extreme stress (e.g. parents whose children are being removed from their care);
  - Indirect Exposure: Traumatized, injured, maimed. For example car accident victims, burn victims, victims of significant violence.

- Whether they **are or have practiced** in the "occupation":
  - This was noted by a few people within the context of the criteria that would need to be applied if the definitions were limited to certification or licensing alone.

- **Length of service**:
  - This was noted by a few people, most of whom talked about it being an indicator of frequency and persistence;
  - On that point, a former first responder reflected that "… frequency is an issue but the first event is the hardest".

3.1.4 Other Comments & Suggestions

3.1.4.1 The Use of "Occupations" To Group Workers For Eligibility

Most participants felt the use of the list of "occupations" to designate groups of workers for eligibility is problematic.

Many felt it is too restrictive and that it makes it difficult to designate workers whose *broad occupational/ professional categories may not* reflect certain, frequent and persistent exposure, but *whose jobs would.* They cited examples such as: accident or crime scene "clean-up crew" tow truck drivers and cleaners, child protection workers, anyone who works in a lockdown facility, or any member of a crime investigation team or emergency response team.[3]

At the same time, many (and many of the same people) felt it was too expansive, and that it provides the presumption to people whose certification or profession may be designated, but whose jobs, duties, and roles do not, in their opinion, reflect the level of certainty or frequency that would lead to the presumption. They cited examples such as: Continuing Care Assistants who work in low to moderate level assisted living facilities; or certified members of any of the designated occupations/professions who had never "practiced" in the profession, working instead with a similar occupational title for a retail grocery chain.

Employers in particular were concerned about the potential expansion not just in terms of cost, but in terms of the principle of accountability.

3.1.4.2 The Use of the Presumption

A few employers and clinicians raised concerns the presumption is being extended at all. They were concerned that it creates a false distinction between the designated workers and other workers; that it may lead to over or misdiagnosis; and/or may provide a disincentive to key elements of "best practice" treatment which they advised involves maintaining a connection to work, and "facing" rather than avoiding the trauma.

3.1.4.2 Suggestions

Ways of Clarifying Eligibility:

- By designating industries and/or being specific about what industries the designated occupations are in. For example: corrections, policing, para-health.
- By specifying roles/duties, locations within those industries - for example lock down emergency response team members, or lockdown mental health and addictions facilities.
- By extending the presumption to most or to all covered workers - The few people who suggested this tended to *describe the key criteria in terms of risk rather than certainty* and felt that most, if not all workers face some degree of risk in their jobs and therefore should have the benefit of presumption. They cited examples such as: bus drivers who are at greater risk of witnessing or being involved in serious road accidents; or school teachers who are at risk of being involved in and having to respond to emergency and lock down events.

[3] Participants noted a number of jobs that they felt should be considered for designation under the presumption. The list is attached as Appendix C

3.2 TOPIC 2 - AUTHORIZING DIAGNOSTICIANS

The purpose of this conversation was to identify principles, criteria, and indicators that could be used to inform decisions about who will be authorized to diagnose PTSD for the purpose of the presumption.

3.2.1 Principles

Participants generally felt that decisions about who would be authorized to diagnose should be guided by what is in the best interest of the worker, and by the basic principle that it is *in everyone's best interest* that workers have timely access to:

- The most appropriate *and* best care regardless of what the final diagnosis turns out to be; and to
- An objective, thorough and accurate diagnosis to ensure they receive the appropriate treatment.

A second principle, which is reflective of the broader context of prevention and treatment was raised. Although that issue is out of scope for this discussion, the principle is relevant and noted here because it speaks to what most participants' identify as "the real issue", regardless of what view they are representing - That it is not possible to "protect" Frontline and Emergency Response Workers from *frequent and persistent exposure* and therefore workers, employers and the WCB have a *shared duty* to:

- Prepare and support these workers to build and maintain the resilience required to sustain a state of mental wellness and well-being;
- Acknowledge that PTSD is one of a spectrum of stress responses and conditions through which a worker passes before their condition escalates to PTSD; and
- Ensure that these workers receive treatment and support as early as possible and *before* their conditions escalate to become PTSD.

3.2.2 Criteria & Indicators

There was unanimous agreement that authorized diagnosticians would need to be accessible to workers and qualified to make an objective, accurate and thorough diagnosis.

- **Accessible** - Should be able to see the worker within 30 days, in person, locally, and as often and for as much time as is required to make a thorough diagnosis and treatment plan:
  - **Within 30 days of request for diagnosis** - to expedite the process
  - **In Person** - to build rapport;
  - **Locally** - to accommodate the worker and the worker's condition;
  - **As often and for as as much time as is necessary** - to make a *thorough* diagnosis and establish a treatment plan.

- **Qualified -** Is objective, has specific expertise, current specialist knowledge and deep experience in mental health and (ideally) in PTSD in particular; capacity to identify and understand the implications of co-morbidity for treatment planning purposes; and an awareness and familiarity with frontline emergency response culture:
  - **Objective** - free of conflict of interest
  - **Specific Expertise** - Certified / Licensed and within scope of practice;
  - **Current Specialist Knowledge** - Training / Certification;
  - **Deep Current Experience** - Specialist focus (% of practice mental health, PTSD);
  - **Cultural Awareness** - Evidence of specific work with Frontline or Emergency Response (culture) patients.

Participants did not explicitly identify 30 days as the target, rather many indicated that their concerns about the accessibility of psychiatrists and psychologists were largely addressed when they learned the WCB has negotiated contracts with psychiatrists to provide access within 30 days.

In addition, participants, and those representing worker and mental health advocacy views in particular, noted that the timeliness for treatment purposes could/should be much faster than 30 days depending on the individual case. Others were skeptical that the 30 days target is actually being achieved.

Finally, and with respect to spending time in person, locally - participants noted the importance of establishing a rapport; and their experience that while travel is a burden in terms of convenience and cost for most people, for people suffering with PTSD who have difficulty leaving the house, it can be a debilitating burden.

3.2.4 Other Comments & Suggestions

3.2.4.1 Psychologists and Psychiatrists

The vast majority of participants, regardless of whose view they were representing expressed greatest confidence that those criteria would be best met by psychiatrists and psychologists. However, the confidence was tempered by concerns about availability given:

- The limited number of practicing private psychologists and psychiatrists in the province particularly in rural areas;
- The number of psychologists who may choose not to be on the list because of issues with the administrative burden associated with workers' compensation cases and/or because of their perception that the rates the WCB pays are too low.

Some participants suggested this could be resolved by:

- ✓ Increasing the rates the WCB is willing to pay; or
- ✓ Taking the steps necessary to allow clinicians to bill the worker for the fee differential; or
- ✓ By accepting diagnosis from (or qualifying) psychologists working in Employee Assistance Programs to which workers are already attached.

3.2.4.2 Primary Care Physicians and Other Providers

Many participants acknowledged that diagnosis using the DSM-5 is within the scope of many primary health care providers, and that there are/or may be primary care clinicians in the province who would meet all or most of the criteria[4]. In addition, and with respect to accessibility, some people felt that GPs offered a good alternative to psychiatrists and psychologists particularly in rural areas where specialists are scarce.

Others pointed out that GPs are not necessarily more accessible than psychiatrists or psychologists (many Nova Scotians do not have a GP). Still others, including many employers, pointed out that regardless of scope and accessibility, they were not confident that GPs would meet the criteria particularly those dealing with depth of experience, time, and objectivity.

Finally, some participants thought they required an official diagnosis from an authorized person to initiate the claims process and so felt very strongly that GPs and other providers should be on the list. Once they understood that claims can be initiated without a final diagnosis, and that WCB will arrange and pay for a diagnostician who would be accessible within 30 days, most indicated they would prefer the final diagnosis from a psychiatrist or psychologist.

3.2.4.3 Concern About Using A List

Some participants expressed concern about the use of an Authorized List at all. In particular, they worried about potential interruptions to existing therapeutic relationships, and about the possibility that the list would be used to limit who would be able to provide treatment.

Existing Therapeutic Relationships

Some worker representatives were concerned about the potential / probability that workers would be forced to abandon pre-established relationships with qualified psychologists who are not on the list, only to have to begin again with a new clinician with whom they have no rapport. Many participants felt this requirement would re-traumatize the worker and thus be counterproductive to the purpose of the presumption.

Some participants suggested this could be resolved by building flexibility to accommodate existing clinical relationships where the clinician meets the criteria.

[4] One physician noted that in addition to herself, there were between 2-6 who specialize in mental health in Nova Scotia.

The Link to Treatment

Many participants expressed concern that the list may be used to limit access to treatment providers who are not on the list. They were worried that this would compromise workers' flexibility to access the best treatment and treatment teams to meet their individual needs. They acknowledged the best treatment may include alternative therapies and providers (for example, yoga) and suggested the WCB consider acknowledging both.

3.3 TOPIC 3 - TIMEFRAMES

This conversation was about setting timelines that create space for workers to take the necessary steps to have their claims considered for the presumption. Two timelines were discussed:

1. The timeframe within which a worker must submit a claim after becoming aware of their diagnosis;
2. The timeframe within which the worker must receive a diagnosis after their last day of work as a Frontline or Emergency Response Worker.

The purpose of the conversation was to identify what principles should be applied and what factors should be considered by regulators as they specify theses timeframes.

3.3.1 Principles & Considerations

All of the participants acknowledged that PTSD can and does inhibit a worker's capacity to take the steps that a "reasonable" person would take to seek help or a diagnosis and/or to ensure their affairs are in order. The barriers include but are not limited to:

- **General Stigma** - associated with PTSD often leads to denial and self-medication
- **Job Culture -** of Frontline Emergency Response Workers makes it even more difficult to accept a diagnosis or to ask for help:
  - ➡ We are the ones who are "supposed to be in control";
  - ➡ We are trained to be the hero … to box it up… and push through.
- **Characteristics of the Condition** -
  - ➡ Often latent until triggered - sometimes years afterward;
  - ➡ Manifests slowly and in ways it's not easy to put together or understand;
  - ➡ "… having a diagnosis doesn't mean you're functional…"
  - ➡ Characterized by:
    - ✓ Denial and self-medication;
    - ✓ Confusion - difficulty self-advocating;
    - ✓ Fear and a feeling of being intimidated / traumatized by the process of facing the diagnosis and/ or the claims process;
    - ✓ Isolating coping mechanisms - to "bunker", "shun" contact, self-medicate.

3.3.2 Other Comments and Suggestions

3.3.2.1 Diagnosis to Claim

With respect to the timeframe within which a worker must submit a claim after becoming aware of their diagnosis, most participants suggested, that in the interests of consistency and simplicity, regulators should apply the same timeframe that is applied for Occupational Disease claims in Nova Scotia - 1 year - with the flexibility of extending to 5 years as long as it does not prejudice the employer.

Most also felt though, that decision-makers should err on the side of flexibility (5 years rather than 1) regardless of what standard they chose to apply.

3.3.3.2 Last Day to Diagnosis

With respect to the timeframe within which a worker must receive a diagnosis after their last day of work as a Frontline or Emergency Response Worker, most participants expressed discomfort about suggesting specific timeframes for this at all. Instead they felt the regulations should be guided by relevant research if it is available. In the absence of research:

- And in the interest of consistency, some felt regulators should be guided by what is done in other jurisdictions that have PTSD presumptions:
  - Manitoba and Saskatchewan - 2 years -
  - Other Canadian jurisdictions are silent - no cap; or
  - With Veterans Affairs.[5] - No Cap.
- Some participants suggested a sliding scale under which the worker's coverage under the presumption would be reduced gradually (for example 10 - 20% every 2 years) after the last day of work as a frontline or emergency response worker; and
- Some, defaulted to the notion of erring on the side of flexibility. Of those:
  - Many workers and most clinicians tended to lean toward the highest of the range, most advocating that the condition is sufficiently unpredictable and individual that it is impossible to set a time limit at all.
  - Most of the remaining workers and a few employers tended toward more moderate timeframes most ranging from 10-20 years to acknowledge that it is important to set a limit to give some degree of certainty to employers and equally important to be as flexible as possible to allow for delayed onset.
  - Many employers and a few workers and clinicians suggested 5 years as way to balance flexibility with reasonableness without de-motivating the worker from pursuing the diagnosis.

[5] According to their Policy Department, Veterans Affairs sets no time limits on eligibility.

3.3.3.3 Attribution

Many employers indicated that while they are supportive of the notion of flexibility they are concerned about cost, attribution and affordability:

- How the WCB would account for the impact of a workers' life experience following the last of day of work – particularly if that timeframe were set to exceed 5 years;
- How the costs of presumption claims will be allocated in general and for delayed onset claims in particular;
- What the cost implications of significant delays might mean for employers;
- Whether extended timeframes may diminish employers' capacity to "prove the contrary".

Many workers, while supportive of employers' concerns were particularly concerned that no person be denied the opportunity to be compensated for work-related PTSD because of what they felt would be an arbitrary timeline.

3.4 TOPIC 4 - EFFECTIVE DATE OF THE PRESUMPTION

The purpose of this conversation was to identify principles, to inform decisions about the effective date of the presumption - the date after which the presumption will be applied to all claims.

3.4.1 Principles

There were a wide range of views with respect to how to approach this issue. Participants tended to apply one of three different principles:

1. **False Hope** - Some participants felt making the presumption retroactive at all would be wrong. From their perspective:
    - Claims without a final decision will be adjudicated under the presumption anyway; and
    - Claims with a final decision[6], have already been reviewed at multiple levels by multiple people and have been found to be:
        - ✓ Without a diagnosis in which case they would not be eligible for the presumption anyway; and/or
        - ✓ They have been found to be non-work-related in which case "… the contrary had been shown…" and cannot be "un-shown"; and
2. **Faint Hope** / One Missed Claim is One Too Many - Participants who landed here felt that despite the fact the claim had been reviewed and found to be either without a diagnosis or non-work related there was always hope there had been a mistake.

[6] A claim for which all appeals have been exhausted.

3. **Evidence of Intent** - Most participants landed here. They felt that Government had clearly demonstrated its intent to extend the presumption when it passed the amendment in October 2017.

3.4.2 Other Comments

Some employers raised concerns about the volume of claims and associated costs of retroactivity, particularly during the Faint Hope discussion.

A few participants noted that there will also be costs associated with managing the decision if the presumption is not retroactive.

4 SUMMARY OF OVERARCHING THEMES

Six key themes emerged from the conversations. These emerged as recurring topics or ideas reflecting shared perceptions that transcended stakeholder/representational lines repeatedly across all and within all the sessions:

1. *"The real issue" is* that -

   It is not possible to "protect" Frontline and Emergency Response Workers from *frequent and persistent exposure* and therefore workers, employers and the WCB have a *shared duty* to:

   - Prepare and support these workers to build and maintain the resilience required to sustain a state of mental wellness and well-being;
   - Acknowledge that PTSD is one of a spectrum of stress responses and conditions through which a worker passes before their condition escalates to PTSD; and
   - Ensure that these workers receive treatment and support as early as possible and *before* their conditions escalate to become PTSD.

2. While most jobs fall somewhere along a spectrum of risk of exposure, what distinguishes Frontline or Emergency Response Workers is the certainty, that their voluntary and/or paid employment will involve *frequent and persistent,* direct and/or indirect exposure to violent and traumatic situations (as defined in the DSM-5);

3. Authorized diagnosticians need to be accessible to workers and qualified to make an objective, accurate and thorough diagnosis and treatment plan.

4. The vast majority of participants, regardless of whose view they were representing, have greatest confidence in diagnosis and treatment plans that are provided by psychiatrists and psychologists assuming the WCB can arrange access within 30 days.

5. PTSD can and does inhibit a worker's capacity to take the steps that a "reasonable" person would take to seek help or a diagnosis, and/or to ensure that their affairs are in order; and therefore, that regulators should err on the side of flexibility when determining timeframes for eligibility for the presumption; and

6. There are wide range of views with respect to the principles that people feel should be applied to select the effective date for the presumption, and by extension, with respect to what the effective date for the presumption should be.

APPENDIX A Participating Organizations

Association of Psychologists of Nova Scotia
Breton Ability Centre
Brookfield Fire and Emergency
Canadian Federation of Independent Business
Canadian Mental Health Association
Canadian Red Cross
Canadian Union of Postal Workers
Canadian Union of Public Employees (CUPE)
Cape Breton Regional Municipality
CFB Halifax Fire Department
College of Registered Nurses
Compass Rose Health and Wellness Centre
Correctional Service Canada
Cove Guest Home
Department of Health and Wellness Nova Scotia
* Doctors Nova Scotia
Elmsdale Lumber Company
Emergency Health Services
Emergency Medical Care Inc.
Employment and Social Development Canada
Fire Service Association of Nova Scotia
Fisheries Safety Association of Nova Scotia
Grand View Manor
Halifax Regional Fire & Emergency
Halifax Regional Police Association
Harbour View Haven
HomeBridge Youth Society
Individual Advocates
Individual Physicians
Individual Psychiatrists
Individual Psychologists
International Union of Operating Engineers (Local 727)
IWK Health Centre
Kentville Police Service
Life and Health Insurance Association
Mental Health Commission of Canada
Mental Health Foundation of Nova Scotia
Michelin Americas
Municipality of the County of Inverness
Northwood
Nova Institution for Women
Nova Scotia College of Social Workers
Nova Scotia Health Authority
Nova Scotia Public Service Commission
Oakwood Terrace
Office of the Employer Advisor Nova Scotia
Office of the Worker Counsellor
Pictou County Injured Workers Association
Regional Residential Services Society
Retail Council of Canada
Richmond Housing Corporation
RK MacDonald Nursing Home
Rosecrest Facilities
Saint Vincent's Nursing Home
Seaview Manor
Springhill Institution
The Meadows Home for Special Care
Tideview Terrace
Town of Antigonish
Town of Kentville
Town of Truro
Union of Canadian Correctional Officers
Union of Safety and Justice Employees
Victorian Order of Nurses Canada
Workers' Advisers Program
Yarmouth Association for Community Residential Options

* A staff representative from Doctors Nova Scotia attended the meeting as an observer; however the broader physician membership was not consulted

APPENDIX B Consultation Schedule

1	May 22	2:00 - 5:00 PM	Halifax
2	May 23	6:00 - 9:00 PM	Halifax
3	May 25	9:00 - Noon	Halifax
4	May 28	8:30 - 11:30 AM	Halifax
5	May 30	1:00 - 4:00 PM	Sydney
6	June 5	1:00 - 4:00 PM	Kentville
7	June 6	2:00 - 5:00 PM	Halifax
8	June 7	1:00 - 5:00 PM	Halifax
9	June 8	8:30 - 11:30 AM	Halifax
10	June 8	1:00 - 4:00 PM	Dartmouth (EMC Site)

APPENDIX C Participant Suggestions

This is a list of occupations suggested by participants that should be given future consideration. These occupations have not been vetted through the principles/criteria discussed through consultation.

- All people working in Corrections industries
- All people working in Policing / Peace Officers
- All people working with mental health & additions patients
- All people working in child protection
- All people working in lock down facilities includes (corrections, long term care, mental health and addictions- including federal and provincial)
- All crime, accident scene, and trauma team workers
- Search & Rescue Teams
- EMO Teams
- Crime Investigation Teams - including civilian cyber units and transcribers
- All people working in Residential Care facilities and Halfway houses
- Natural Resources Officers, Fisheries Officers
- Anyone answering 911
- Life Flight teams
- Canadian Border and Coast Guard services
- People working in the facilities under the bridges