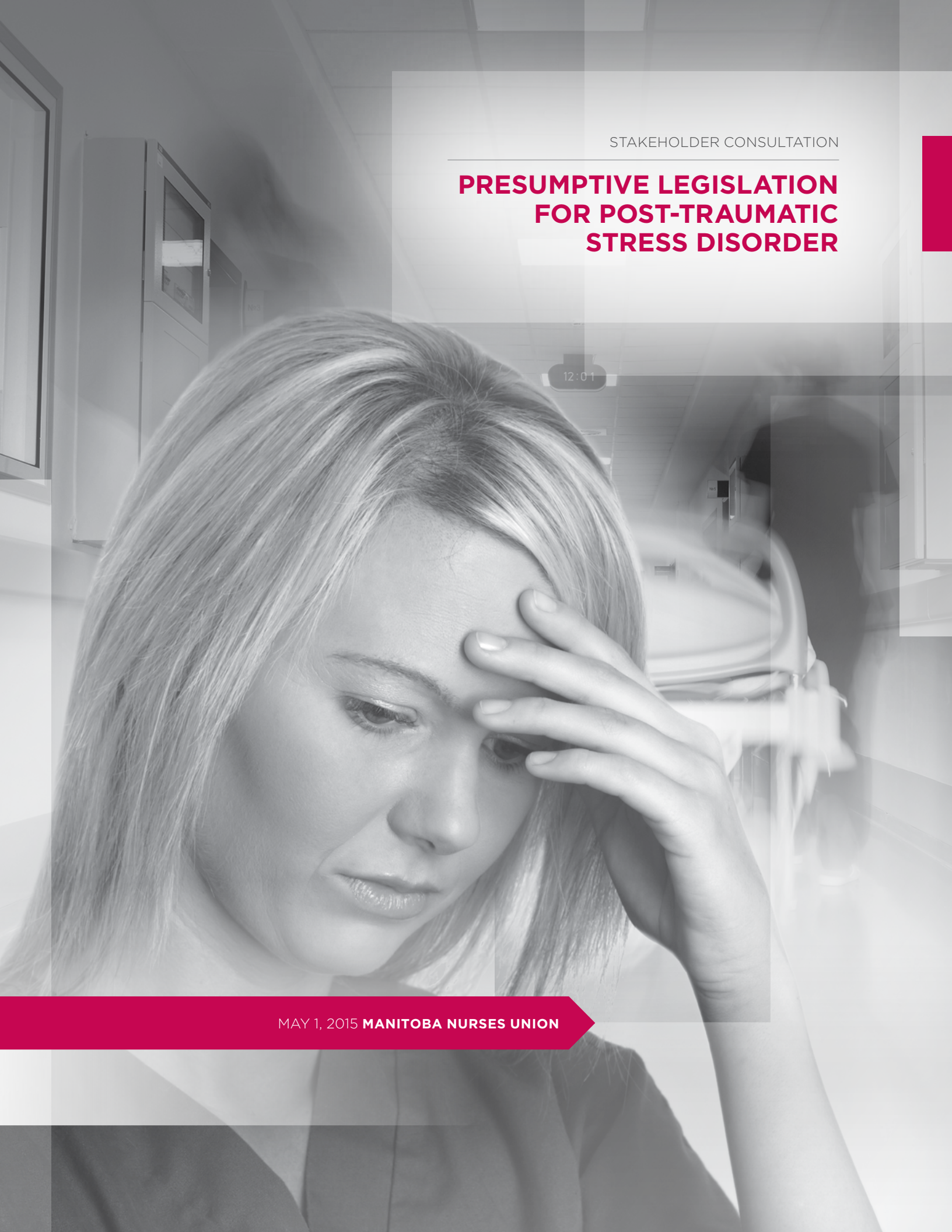

STAKEHOLDER CONSULTATION

PRESUMPTIVE LEGISLATION FOR POST-TRAUMATIC STRESS DISORDER

MAY 1, 2015 **MANITOBA NURSES UNION**

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Trauma doesn't end when the shift does.

POST-TRAUMATIC STRESS DISORDER

PTSD

Introduction

The nursing profession can be gratifying, challenging and rewarding. However, it also exposes nurses to an inordinate amount of trauma, pain, suffering and death. Post-traumatic stress disorder (PTSD) remains prevalent in the nursing profession but is often underreported and under recognized, which causes PTSD in nurses to be masked behind misdiagnoses of other illnesses such as critical incident stress or occupational burnout. Because PTSD is an individual's unique processing to a traumatic event, it is important to recognize that reactions to trauma vary among individuals. Reactions to traumatic events are subjective, so many nurses do not recognize what their PTSD triggers are or at times even recognize their own PTSD symptoms. Furthermore, common elements within the nursing profession such as critical incident stress, emotional labour and occupational burnout are important to recognize as key influential factors that have been identified to increase nurses' susceptibility and exposure to PTSD development.

As PTSD remains a reality for nurses, more attention is required in order to recognize how occupational factors within the nursing profession influence PTSD development. As such, the Manitoba Nurses Union (MNU) is advocating on behalf of its members for the implementation of stronger supports to address the stigma of mental health in the workplace. This has been apparent in the MNU's efforts to implement a robust communication strategy to increase awareness of PTSD in the nursing profession. The MNU has also developed a comprehensive research report, Post-Traumatic Stress Disorder (PTSD) in the Nursing Profession: Helping Manitoba's Wounded Healers, which examines unique factors within the nursing profession that influence PTSD development. This report also offers recommendations for necessary workplace supports that are intended to alleviate the effects of PTSD and other mental illnesses for nurses.

As the Workers Compensation Board (WCB) of Manitoba examines opportunities to strengthen its legislation for PTSD, stakeholder input from the perspectives of both employees and employers is integral to ensuring legislation is inclusive, especially for occupations that have a higher risk of PTSD. This Consultation Response of the MNU offers a rationale for why presumptive legislation will be a valuable resource for the nursing profession. On behalf of its members, the MNU will further demonstrate the nature of the nursing occupation and provide evidence that PTSD is an occupational illness due to the fact that nurses experience increased exposure to trauma, critical incidents and triggering events within their daily work environment. The MNU will also demonstrate how the enactment of presumption legislation would alleviate many barriers that nurses currently face in accessing PTSD supports efficiently and effectively.

Background – The Prevalence of PTSD in the Nursing Profession

This section presents the MNU's responses to the consultation questions that the WCB of Manitoba proposed to its stakeholders (Appendix A).

1. History of Workers Compensation Board Claims for PTSD

In the past five years[1], a total of 74 psychological claims were submitted by registered nurses and licensed practical nurses to the WCB of Manitoba. Of these claims, five were for PTSD and 69 were for claims coded as anxiety, stress or neurotic disorders as per the WCB's coding manual. It is important to note that despite the separate WCB coding, "anxiety," "stress" and "neurotic disorders" represent core symptomology of PTSD as per The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5)[2]. Of the claims that were submitted, 47% (35) were accepted, while 53% (39) were denied. Of the denied claims, 46% (18) went forward to the Appeals Commission but only seven of those claims (38.7%) were accepted.

As per the MNU's records of Appeal Commission claims, a total of 41 PTSD claims were submitted from January 1, 1999, to March 6, 2015[3]. Of these claims, 37% (15) were accepted, while 63% (26) were denied. It is important to note that the majority of the accepted appeal claims fell outside the criteria outlined in the WCB's Adjudication of Psychological Injuries Policy (Policy 44.05.30). The MNU has found that claims denied at the adjudication level are typically rejected because it is extremely challenging for the claimant to locate one acute event that is believed to be the cause of their PTSD. As per WCB Policy, the ability to locate a single, acute event as the cause of PTSD is a key factor in approving claims[4].

2. Consistency and Efficiency of PTSD Claim Adjudication

Based on its members' history with PTSD claims and results from its PTSD focus group interviews, the MNU supports the notion that an amendment to Manitoba's existing Workers Compensation Act is required in order to improve the timeliness and consistency of adjudication for PTSD claims, specifically those of nurses.

During the MNU's PTSD focus group interviews, two key issues were identified by nurses in reference to the process administered for PTSD claims at the WCB. The first issue refers to the increasing onus placed on claimants to provide evidence of their PTSD. This includes in-depth medical support that extends beyond a PTSD diagnosis and identifying one event as the source of their PTSD. In general, nurses

believe these requirements act as barriers to accessing WCB supports because they do not recognize the cumulative nature of PTSD and fail to recognize how exposure to trauma is so prevalent in the nursing profession that it takes time for nurses to even acknowledge they have PTSD symptoms.

The second issue refers to inconsistencies observed during the adjudication process. The WCB Policy and Information Manual is intended to explain the process for which psychological injuries will be adjudicated and to provide rationale for why some types of psychological injuries will not result in compensable claims. It is noted, however, that the current adjudication policy for psychological claims contains a wide scope of subjectivity that rests on interpretation and is not conducive to the medical symptomology of PTSD. As per WCB Policy 44.05.30, the WCB must determine whether the event that caused PTSD arose out of and in the course of employment, whether the worker has suffered a psychological injury (symptoms of PTSD), and if there is a causal connection between the injury and the specified event. Furthermore, the incident believed to have caused PTSD must be either a chance event (i.e., car accident), a wilful and intentional act (i.e., physical abuse or violent acts), or an acute reaction to a traumatic event (occupational disease).

The subjectivity of the policy lies within the definition of an acute reaction to a traumatic event, which would determine if a psychological injury, such as PTSD, were an occupational illness. A claim may be considered as an occupational disease when a worker experiences a psychological injury after the last of many traumatic events that occurred over a long period of time. In that type of claim, the WCB may be satisfied if one or more of the events caused the psychological injury. However, the claim may not be approved if the WCB cannot determine that a specific event or series of events caused the PTSD. Furthermore, the WCB does not require the event to be "serious" from an impartial observer perspective, but the policy states that if the WCB does not find the event to be overtly serious, the adjudicator may find it more difficult to learn how the incident caused the PTSD and the claim may be subject to denial. This places more onus on the individual to not only identify the event but also provide a strong rationale for why they feel that a particular event caused their PTSD.

The parameters outlined in WCB Policy may be articulated in a general context as an attempt to be inclusive of the various experiences individuals may encounter. While this suggests that the WCB may accept and compensate for claims related to psychiatric and psychological disability on a broad basis, in practice, policy directives appear to limit compensation to claims that result from physical or emotional reactions to workplace trauma. This exposes claims to various

[1] These numbers were produced by the Workers Compensation Board of Manitoba for the period of 2009-2014.Data for the report was extracted from WCB of Manitoba's database on March 11, 2015. Claims are counted based on year that the WCB was notified of the injury/illness. Claims were extracted using a combination of occupation and nature of injury codes.

[2] American Psychiatric Association. Diagnostic and statistical manual of mental disorders 5th ed. (2013).

[3] Despite the noted time period, the first PTSD case to be forwarded to the Appeals Commission did not appear until 2001.

[4] Adjudication of Psychological Injuries Policy, Workers Compensation Board of Manitoba. Section 40, Policy 44.05.30. 2012.

interpretations and inconsistencies, since adjudicators and appeal panel members may have differing interpretations about whether the incident meets the criteria outlined in the policy and whether they believe the incident caused the claimant's PTSD.

Key examples of adjudication inconsistencies have appeared throughout many Appeal Commission decisions, most notably in the Manitoba Appeal Commission Public Decision No.86/2008[5] in which a worker suffered PTSD after experiencing ten years of harassment at work. In 2004, the WCB denied the claim on the basis that the event did not meet the requirements of a psychological claim, given that the information the worker provided did not clearly indicate that a traumatic event occurred. When the case went forward to the Review Office, the denial was upheld for a different reason, when it was deemed there was insufficient evidence to confirm the event caused PTSD, and PTSD was the reason for the claimant's time loss at work. It was further identified that the WCB could not confirm whether the worker suffered serious psychological harm as a result of an acute reaction (as defined by the WCB) from a traumatic event. When the case appeared before the Appeal Commission in 2008, the panel approved the claim, and it was noted that the panel did not base their decision on the section (c) of the WCB policy that was used as a rationale for the denial of the claim. Rather, the panel confirmed they based their decision on their belief that the worker's harassment, though not specifically listed, was of a similar nature and seriousness to the non-exclusive list of incidents that may give rise to psychological conditions identified in WCB Policy.

These examples demonstrate that even though specific criteria are outlined in WCB Policy, those criteria are open to wide interpretation at different levels of the decision process. To rectify adjudication inconsistencies for PTSD claims, the Act should be amended to ensure that the criteria adjudicators use to assess claims are conducive to the nature of PTSD and closely reflect the extensive criteria used to medically diagnose PTSD.

3. Legislative Presumption

Based on research and feedback from its members, the MNU believes that presumption for PTSD coverage would improve the timeliness and consistency of adjudication for PTSD claims because claimants would no longer be responsible for proving the causal connection between an event and PTSD. Depending how the presumption was structured, the adjudication process would be more efficient, since claimants would only have to validate their diagnosis of PTSD, and confirm that the event(s) took place during their employment.

Specifically in Alberta, presumptive legislation for PTSD has led to a simplified adjudication process for PTSD claims, where claimants are only required to provide a formal diagnosis from a psychiatrist or psychologist and highlight the cause of PTSD as either an event or

series of events that occurred at their workplace. If coverage were denied, the onus would be on the WCB to prove the worker developed PTSD in some other way that is external to their work environment.

If similar presumptive legislation were enforced in Manitoba, nurses would no longer have to go to great lengths to provide evidence of their PTSD and rationalize how a single event caused their condition. Rather, nurses' PTSD claims would be assessed consistently, as there would no longer be a need to rely on an adjudicator's interpretation or determination whether an incident caused PTSD. Depending on how the presumption is structured, nurses would only be responsible for providing proof of their PTSD diagnosis, and possibly confirming that their PTSD resulted from events that occurred at work. Enacting legislative presumption for nurses would be advantageous for the profession because the legislation would formally recognize PTSD as an occupational illness and therefore increase access to supports.

4. Presumption Based on Occupations

The advantage of a presumption based on specific occupations is that it recognizes the increased susceptibility and exposure that many occupations have to PTSD. This is especially critical for the nursing profession, as recent research is

[5] Manitoba Appeal Commission Public Decision No.86/2008 http://appeal.mb.ca/default.aspx

starting to show that nurses may be more prone to PTSD than war veterans, due to their increased exposure to trauma[6]. Furthermore, a recent member survey conducted by the MNU found that one in four nurses is consistently experiencing PTSD symptoms as a result of their work.

Another advantage of the presumptive model is that it would decrease the administrative burden on both the claimant and the adjudicator because there would no longer be a need to identify the causal connection between the event and diagnosis of PTSD. Specifically for nurses, presumptive legislation would acknowledge the ongoing nature of critical incident stress, secondary traumatic stress, occupational burnout and workplace violence as key occupational factors that contribute to PTSD development.

Criticisms of Alberta's presumptive legislation are structured around the belief that the legislation has a narrow focus as it applies to specific occupations that face a higher risk of PTSD while excluding workers in general. This criticism is based on the fact that triggering events can occur in any workplace. It is important to note however, that if a presumption were not made specific to occupations with a greater risk of PTSD, employees would be at a disadvantage because claims would be assessed against generic criteria and would rely on variations of interpretation. As a result, the adjudication process would be prolonged for employees in professions with greater exposure to PTSD. This would also prolong access to supports for professions who may rely heavily on such supports. It is important to develop the presumption in a way that acknowledges specific occupations in which PTSD is prevalent and where employees face a greater risk of developing PTSD. Occupations outside the presumption would still have coverage, since PTSD is already a compensable condition for the WCB of Manitoba. The presumption would simply make the adjudication process more accessible for occupations who face the greatest exposure to PTSD.

5. The Need for a Legislative Presumption in the Nursing Profession

If a presumption is made for occupations, it is recommended that the nursing profession be included on the basis that validated research has demonstrated how this profession faces an increased exposure to trauma and PTSD. Unlike other first responders, nurses interact with individuals once they have been removed from a crisis situation and accompany patients on their journey to recovery or end of life. Understanding PTSD from a nursing perspective makes it easier to recognize key components of the nursing profession that influence nurses' exposure to trauma and critical incident stress.

The nature of nursing is such that trauma is a consistent factor found throughout the work environment. Research has shown that nurses are susceptible to primary, secondary and vicarious trauma, all of which are based on events not typically seen as traumatic but that can be emotionally and physically tolling. Primary trauma refers to an event experienced directly, such as being physically assaulted at work. Secondary trauma refers to

instances where an individual witnesses a traumatic event. Vicarious trauma, also referred to as compassion fatigue, refers to the empathetic toll a person feels while caring for a traumatized person[7]. Trauma is so embedded in the nursing profession that a nurse can experience all three forms of trauma simultaneously on a daily basis, even more so if working in areas with high exposure to trauma such as an emergency ward or intensive care unit. As such, trauma and PTSD development become daily elements of the nursing profession that have an inevitable and adverse impact on the well-being of nurses. The length of exposure to trauma is significant, given that as exposure to suffering and trauma is prolonged, the intensity and breadth of stress increases for nurses[8]. The core trigger of PTSD is not only the experience of trauma itself, but also the threat of violence or perceived trauma, which can induce equal or higher levels of stress than experiencing an incident directly.

In addition to ongoing exposure to trauma, the following work environment factors have been found to influence nurses' susceptibility and development of PTSD: critical incident stress, occupational burnout or secondary stress syndrome (compassion fatigue), and workplace violence.

Critical Incident Stress

Critical incident stress refers to the psychological, physiological and emotional response an individual encounters after experiencing an event, despite the fact that the event may not be generally viewed as traumatic[9]. During the course of their careers, nurses may witness and experience various critical incidents that can accumulate and manifest as burnout, depression, anxiety and stress, which is directly related to the nurses' likelihood of developing PTSD. Normal recovery from critical incident stress can take weeks or months, and symptoms similar to PTSD (i.e., avoidance, intrusions) can contribute to PTSD development and its most common co-morbid disorders, which are anxiety and depression[10].

A 1996 Canadian study examined the rate of PTSD in Manitoba's nurses, specifically those employed in areas that experience high exposure to critical incidents. The study found that 42.1% of nurses had high or moderate PTSD symptoms, 32.9% of these nurses had moderate symptoms, and nearly ten percent had severe symptoms (9.2%).The study outlined the five most commonly cited triggers, which included:

1. death of a child,
2. violence or abuse from patients,
3. treating patients that resemble family or friends,
4. death or injury of a patient after undertaking extraordinary efforts to save a life, and
5. heavy patient caseloads[11].

6 Powell, P. (1996). The prevalence of post-traumatic stress disorder among registered nurses. (Master's thesis, University of Manitoba, 1996). Retrieved from the Library of The University of Manitoba.

7 Adriaenssens, J., de Gucht, V., & and Maes, S. (2012) The impact of traumatic events on emergency room nurses: Findings from a questionnaire survey. International Journal of Nursing Studies 49(11), 1411-1422.

8 Meadors, P. and Lamson, A. (2008). Compassion fatigue and secondary traumatization: Provider self care on intensive care units for children. Journal of Pediatric Health Care 22(1), 24-34.

9 Ibid, 317.

10 Rassin, M., Kanti, T., & Silner, D. (2005). Chronology of medication errors by nurses: Accumulation of stresses and PTSD symptoms. Issues in Mental Health Nursing 26(8), 873-886.

11 Powell, P. (1996)

Nurses in the study commonly reported experiencing the following PTSD symptoms, in order of significance: an inability to control images of traumatic events while engaged in other activities, recurrent dreams, sudden acting or feeling as if the event is recurring, and feeling distressed when exposed to an event resembling the initial trauma. This study also confirmed that workplace stressors such as heavy patient loads, feeling overwhelmed, fear of making errors, behaviour of medical personnel and management, and healthcare re-structuring were all found to be psychologically taxing and traumatizing and also acted as core triggers for PTSD[12].

Through the MNU's member survey, it was reported that over half (53%) of nurses have experienced critical incident stress, and it is believed that nurses will experience critical incident stress and PTSD at some point in their careers. Many nurses who participated in the PTSD focus group interviews confirmed that they faced moral distress and experienced great difficulty managing stress. They noted that they had lost the ability to respond in a "normalized" way to death and had difficulty experiencing normal emotions due to withholding their true emotions in order to cope with critical incident stress. Symptoms such as sleep disturbances, nightmares, difficulty eating and developing neurotic behaviours in both personal and professional lives were all common symptoms among focus group participants, who confirmed they exhibited these symptoms as a result of critical incident stress. Some participants stated that they would actively avoid situations that were traumatizing, while others confirmed that they dreaded going to work for fear of experiencing a traumatic incident. All of these examples provide evidence of the causal relationship between critical incident stress and PTSD development.

Occupational Burnout/ Secondary Stress Syndrome (Compassion Fatigue)

Occupational burnout refers to a state of physical, emotional, or mental exhaustion combined with doubts about the competence and value of one's work. This can result from a variety of factors including unclear job expectations, lack of control over decisions that affect one's job, lack of resources to complete one's job, feelings of isolation at work and in personal life, extreme chaotic activities in the workplace and consistent work-life imbalance. Applied to the nursing profession, occupational burnout can also be recognized as compassion fatigue or secondary traumatic stress (STS)[13], which applies specifically to healthcare workers as an emotional response originating from witnessing another individual experience trauma[14]. In surveying its members, the MNU has found that 62% of nurses in Manitoba currently experience compassion fatigue and 71% have experienced burnout at some point in their career. These statistics highlight how the daily working conditions of nurses exert pressures both personally and professionally that can lead to moral distress.

In assessing the emotional costs nurses pay when providing care for patients, recent research has identified four key factors that influence STS within the nursing profession:

1. empathy as a resource for individuals who work within traumatic environments,
2. personally experienced trauma by an individual in the past,
3. unresolved trauma that is activated by reports of similar trauma with patients, and
4. trauma that involves children[15].

These factors are not only apparent in the daily responsibilities of nurses but their presence also influences behaviours that are similar to PTSD symptoms. For example, studies related to nurses and STS found the most frequent reported symptoms included irritability, avoidance behaviour, difficulty sleeping, intrusive thoughts, diminished activity level and emotional numbing[16].

Studies have shown there are complexities in ensuring nurses are diagnosed correctly with PTSD as opposed to solely being diagnosed with occupational burnout. This has led to many exhibited symptoms of PTSD being overlooked as workplace stress. Some studies have also indicated that burnout and compassion fatigue are precursors to PTSD in that nurses who experience burnout also display symptoms of PTSD. Even though the connection between occupational burnout and PTSD is not yet widely explored, it is still important to recognize the contribution occupational burnout has in the development of PTSD for the nursing profession.

[12] Powell, P. (1996)

[13] Hinderer, K. et al. (2014). Burnout, compassion fatigue, compassion satisfaction, and secondary traumatic stress in trauma nurses. Journal of Trauma Nursing 21 (4), 160-169.

[14] Beck, C. (2011) Secondary traumatic stress in nurses: A systemic review. Archives of Psychiatric Nursing, 25(1), 1-10.

[15] Ibid, 3.

[16] Dominguez-Gomez, E. and Rutledge, D. (2009). Prevalence of secondary traumatic stress among emergency nurses. Journal of Emergency Nursing 35(3), 199-204.

Workplace Violence

While nurses are expected to be calm, reassuring and nurturing, many nurses have come to expect violence and abuse as part of their jobs, including from those to whom they provide care. In earlier studies focused on Manitoba's nurses, it was found that the areas of nurses' responsibility can play a large role in the development of PTSD. Physical abuse and violence occurs predominantly in emergency departments, in-patient psychiatric units, and long-term care facilities[17]. This is especially relevant for Manitoba's nursing population. The MNU member survey reports that 37% of nurses working in psychiatric units, 31% of long-term care nurses, and 30% of ER nurses experience physical violence at least once per week. There is a high incidence of violence experienced by nurses across Manitoba: 52% of Manitoba`s nurses have been physically assaulted, 17% have dealt with an individual with a weapon, and another 76% have been verbally abused. When nurses experience violence from a patient or a patient's family, such incidents may evoke emotional responses including anger, fear of the patient, a need to debrief, discomfort in caring for the patient, suppression of unpleasant feelings, or a desire to keep the incident a secret.

Other research has shown that the perceived threat of violence is a trigger to PTSD that compares with experiencing violence directly. Frequent exposure to workplace violence, combined with a perceived threat of violence, affects nurses' emotional states by increasing levels of stress and the likelihood of exhibiting PTSD symptoms[18]. Research has found that nurses who experience assaults of any nature, while continuing to work in environments densely populated with trauma, are at risk of encountering a more severe reaction to PTSD than individuals who are permitted to recover away from high levels of activity[19]. Thus, subsequent assaults following an initial violent incident can be a further stressor for the individual, and if appropriate workplace supports are not in place, experiences may accumulate and gradually manifest as either mild or severe PTSD[20].

6. Presumption Based on Triggering Events and Diagnosis

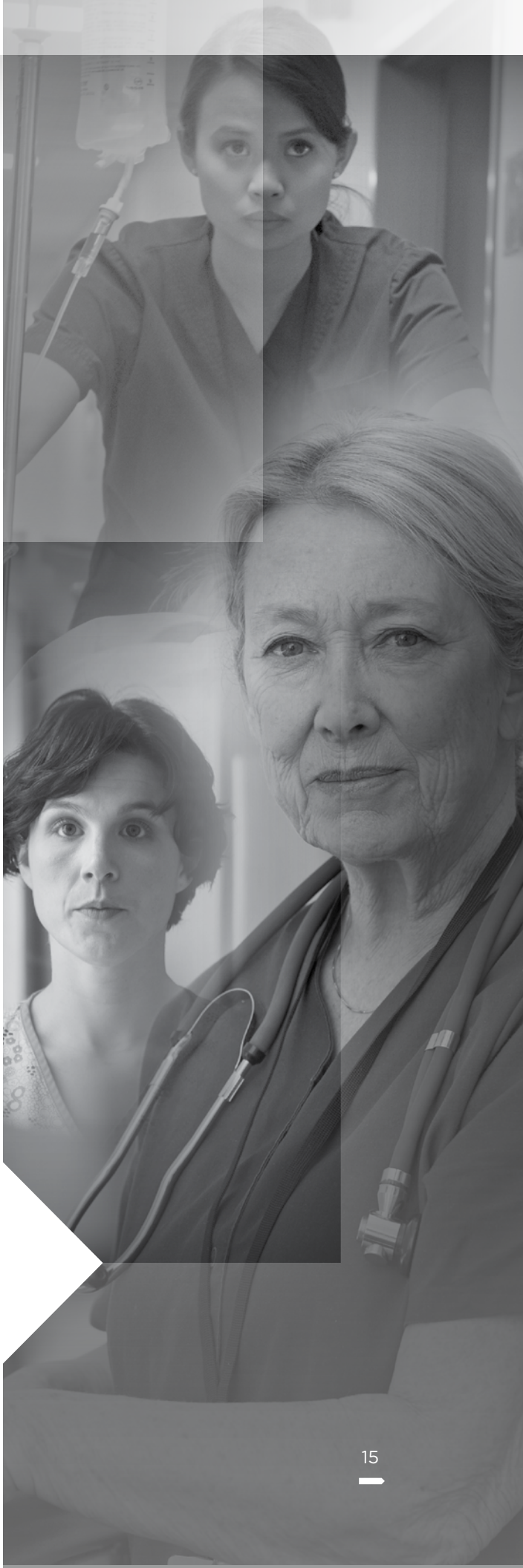
A presumption based on triggering events poses the risk that the triggers identified in the legislation will not conform with the subjective nature of PTSD. It is counterintuitive to base a presumption on triggering events because criteria in DSM-5 specifically note that "PTSD is cumulative and can stem from multiple events." Since PTSD relies highly on an individual's unique processing of an event, it is challenging to try to encapsulate all possible triggering events. Furthermore, PTSD symptoms can vary in intensity and severity over time, so various events could evoke symptoms of PTSD.

The only advantage of including triggering events in a presumption would be if they were in reference to common triggers found within occupations that have a high risk of PTSD development. For example, based on the results of the MNU's PTSD focus group interviews, nurses cited that certain triggers—patient acuity, traffic

accidents involving multiple deaths, incidents of elder and child abuse, and situations in which nurses feel they must compromise their honesty regarding recovery outcomes—contain the highest trauma and stress. However, it is important to note that not every nurse will experience PTSD as a result of these experiences, so it is recommended that the presumption encompass a diversity of experiences that may cause PTSD.

Providing a presumption based on triggering events, as opposed to occupations, may increase individuals' eligibility for the presumption but may decrease eligibility for claims in which the triggering event for PTSD does not relate to the "common events" stipulated in the scope of the legislation. In developing a presumption, it is not in the best interest of the WCB to rely solely on lay statements or only the presumption of occurrence about what caused PTSD, as this leaves the WCB open to subjectivity within their adjudication.

A presumption based on diagnosis is valid and inclusive of all occupations. However, it is important to ensure that an undue burden is not placed on the claimant to provide in-depth medical evidence of their mental illness. Even though the presumption will help to challenge the social stigma associated with mental health, it is important to acknowledge the apprehension many



[17] Powell, P. (1996).

[18] International Council of Nurses (2009). Nursing Matters-Violence: A Worldwide Epidemic.
http://www.icn.ch/images/stories/documents/publications/fact_sheets/19k_FS-Violence.pdf

[19] Wykes, T. & Whittington, R. (1998). Prevalence and predictors of early traumatic stress reactions in assaulted psychiatric nurses. The Journal of Forensic Psychiatry 9(3), 643-658.

[20] Ibid, 646.

individuals face in addressing their mental illness. If a formal diagnosis becomes a requirement of the presumption, it is recommended that pathways be put in place for claimants to access psychological or psychiatric services in a timely manner in order to meet the requirement.

7. Retroactivity and Presumptive Legislation

In response to the volume of denied and in-process PTSD claims for nurses, it is recommended that Manitoba include a retroactivity clause in which a claim—that was denied prior to the presumption's coming into force date—can submit updated medical evidence for re-adjudication according to the presumption. This approach is similar to Alberta's legislation and policy, which states that any former claim providing proof of PTSD diagnosis may be re-adjudicated under the new presumption.

8. MNU's Further Recommendations

As PTSD is a mental illness that manifests over time, it is recommended that the WCB of Manitoba consider amending Section 19 (2) of Manitoba's Workers Compensation Act to extend the time limit of claim submissions from one calendar year to at least 24 months. This aligns with successes experienced from Alberta's presumptive legislation, in which Section 26 (1) of their Act permits a 24-month time limit for submitting PTSD claims. The 24-month period applies to the date of the incident that caused PTSD, or the date the worker became aware of their PTSD. The WCB of Alberta considers the date of diagnosis or treatment to be the date on which the worker became aware of the incident. Should the claim be made after the 24-month period, the WCB of Alberta has the authority to waive the limitation on a case-by-case basis[21]. It is recommended that the WCB of Manitoba take a similar approach in adjudicating claims on a case-by-case basis should they fail to meet the time limit.

In addition to the MNU's consultation responses, it is recommended that the WCB of Manitoba review and amend its existing policy and criteria for Adjudication of Psychological Injuries, specifically the section related to non-compensable psychological injuries, in which it states that, "psychological injuries that result from a burnout or daily pressures or stressor or work will not give rise to a compensable claim as the daily stressors or pressures of work do not fall within any part of the definition of 'accident'." As previously identified in this report, there is a causal connection between occupational burnout, secondary traumatic stress, and PTSD that is unique to the nursing profession. It will be important for the WCB to consider acknowledging this circumstance in order for these experiences to be validated and not overlooked during the adjudication process.

[21] Recording and Reporting Accidents Policy, Workers Compensation Board of Alberta. Policy 01-05: Part II. 2003.

Appendix A

Worker's Compensation Board of Manitoba: PTSD Stakeholder Consultation Questions

1. Have you or your organization been involved in a worker's compensation claim based on PTSD? Was the claim satisfactorily resolved, and why?
2. Is there a need to amend the Act to improve the timeliness and consistency of adjudication in respect of claims based on PTSD?
3. Is a legislative presumption an appropriate method by which to improve the timeliness and consistency of adjudication in respect of claims based on PTSD?
4. What are the advantages and disadvantages of a presumption based on particular types of occupations?
5. If the Act were amended to provide a presumption in respect of PTSD for certain occupations, what occupations should be included?
6. What are the advantages and disadvantages of a presumption based on the triggering events for, and a diagnosis of, PTSD?
7. Should a legislative presumption be made retroactive and for what period of time?
8. Do you have any other comments or suggestions on the subject of PTSD in the context of the workers compensation system in Manitoba?

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Trauma doesn’t end when the shift does.

Manitoba nurses Union

A COMMITMENT TO CARING

PRESUMPTIVE LEGISLATION FOR POST-TRAUMATIC STRESS DISORDER