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PART C – Decision under Appeal

The decision under appeal is the reconsideration decision of the Ministry of Social Development (the ministry) dated 03 Aug 2012 denying the appellant designation as a person with disabilities (PWD). The ministry determined that the appellant did not meet all of the required criteria for PWD designation set out in the Employment and Assistance for Persons with Disabilities Act, section 2. Specifically the ministry determined that the information provided did not establish that the appellant has a severe mental or physical impairment that in the opinion of a prescribed professional

(i) directly and significantly restricts the person's ability to perform daily living activities (DLA) either continuously or periodically for extended periods; and,

(ii) as a result of those restrictions, the person requires help to perform those activities.

The ministry did determine that the appellant satisfied the other 2 criteria: he has reached 18 years of age; and his impairment in the opinion of a medical practitioner is likely to continue for at least 2 years.

PART D – Relevant Legislation

Employment and Assistance for Persons with Disabilities Act (EAPWDA) – section 2
Employment and Assistance for Persons with Disabilities Regulation (EAPWDR) – section 2

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PART E – Summary of Facts

The evidence before the ministry at reconsideration consisted of the following:

1. The appellant's Application for PWD Designation signed 23 February 2012. The application included a Self Report (SR), a Physician Report (PR) dated 05 December 2012 and an Assessor Report (AR) of the same date, both prepared by the appellant's general practitioner (GP), who has treated the appellant since March of 2011 and seen him 2 – 10 times over that period.
2. Numerous medical reports – see below.
3. The appellant's Request for Reconsideration, dated 01 July 2012.

In the SR, the appellant writes that he suffers from mental illness every day. He is scared to leave the house. He states that he is antisocial due to his depression and anxiety, suffering from a personality disorder – he is bipolar and feels like he doesn't belong anywhere. He has panic attacks, about six per day. He had a very bad back injury and if he were to have surgery it would put him in a wheelchair for the rest of his life. It takes him 1 ½ hours just to get dressed. His youngest daughter comes over and prepares their meals. He can't sit for more than 5 minutes and can only stand for approximately 10 minutes.
He states that he can't really take care of himself due to his disabilities. His doctor has said he can walk four blocks but he is wrong - he can only walk 1/2 a block. He has a new doctor that doesn't have all his records yet. He cannot climb 5+ stairs – if he did he would not be able to walk for weeks due to his back. He can only lift under 5 lbs. otherwise he gets severe pain in his back. He says that he has to take cabs wherever he goes because he cannot afford the bus pass. He only takes cabs to the doctor.

The appeal record also contains the appellant's "Disability Self Report" work-sheet and pain chart to be used by his GP in completing the PR. This worksheet set out entries consistent with his SR.

In the PR, the GP diagnoses the appellant with generalized anxiety disorder; panic attacks (onset ++ years) and low back pain; sciatica (onset c. 2001). Under health history, the GP writes:

> "The patient experiences daily anxiety manifest in fear of going out in public where he might get a panic attack, fear of having EMR personnel or bystander perform CPR on him. He gets a "full-blown" panic attack about once a month and feeling of disaster – non-specified -most days. These symptoms are very difficult for him. He has been on long-term [anti-anxiety medication] for this - he doesn't feel it has helped much. He has chronic daily pain in the lower back - radiated down the right leg - no numbness or weakness - worse since 2008 - unable to access the shelves below countertop."

In answer to the question whether the appellant has been prescribed any medication and/or treatment that interferes with his ability to perform daily living activities (DLA), the GP answers "No." In answer to whether the appellant requires any prostheses or aids for his impairment, the GP answers "No." The GP indicates that the appellant's impairment is likely to continue for two years or more commenting, that both his diagnoses are likely to be lifelong.

With respect to functional skills, the GP reports that the appellant can walk 4+ blocks unaided on a flat surface, climb 5+ steps, lift 5 to 15 lbs., has no limitation with respect to remaining seated and has no difficulties with communication. With respect to whether there are any significant deficits with cognitive and emotional function, the GP answers "Yes," noting emotional disturbance (anxiety) with

a comment that generalized anxiety limits his ability to interact socially in general public settings.

Regarding DLA, the GP reports that the appellant is not restricted with respect to any of the following: personal self care, meal preparation, management of medications, basic housework, daily shopping, mobility inside the home, mobility outside the home, transportation, or management of finances. The GP assesses social functioning as being restricted commenting that this is due to constant low-level anxiety and occasional panic attacks - strong tendency to avoid public spaces and going out - he prefers to stay at home in familiar environment. For assistance needed for DLA, the GP has noted "not applicable."

In the AR, the GP states that the appellant's impairments that impact his ability to manage DLA are constant moderate anxiety and occasional panic attacks. The GP assesses the appellant's ability to communicate as good in all areas. The GP assesses the appellant independent in all areas of mobility and physical ability. In terms of cognitive and emotional function the GP assesses a major impact under emotion (e.g. excessive or inappropriate anxiety, depression, etc.) and no impact in other areas (bodily functions, consciousness, impulse control, etc.) Under comments, the GP refers to earlier statements.

With respect to DLA, the GP assesses the appellant independent in all aspects of personal care, basic housekeeping, shopping (with a note relating to going to and from stores – "stays in and avoids social situations"), meals, paying rent and bills, medications, and transportation. As to social functioning, the GP assesses the appellant independent with regard to appropriate social decisions, able to develop and maintain relationships, and able to secure assistance from others. Regarding the ability to interact appropriately with others, and able to deal appropriately with unexpected demands, the GP assesses continuous support/supervision required, with comments: "moderate continuous generalized anxiety - strong avoidance traits" and "stressful stimuli may trigger full-blown panic attacks." The GP indicates the impact of the appellant's mental impairment on his relationship with his immediate social network as marginal functioning, for his extended social networks as very disrupted functioning. The GP notes that if the appellant requires help in social functioning he has good social supports – spouse.

Regarding assistance provided for the appellant, the GP indicates that the help required is provided by his family. No help is provided through the use of assistive devices or assistance animals.

The medical reports are summarized below:

- A letter dated 27 November 1996 from a specialist in physical and rehabilitation medicine. The appellant presents with a history of acute back injury in a work related accident in September 1995. A CT scan in July 1996 has confirmed an L5-S1 disk herniation. His presentation then is one more of mechanical back pain, either bony or discogenic, with no evidence of frank nerve involvement and no signs to indicate he is a surgical candidate. He would benefit by a more aggressive program of rehabilitation, starting with physiotherapy.
- A letter dated 03 September 1998 from a neurosurgeon. He gives as his opinion that the appellant has chronic low back pain and some right sciatica without roots syndrome due to a central L5-S1 disk protrusion taking to his injury in September 1995. There was consideration of an L5-S1 discectomy. He estimates that the chances of a good result are fair, probably in the order of 50%. He hesitates to recommend the surgery under the present circumstances.

- A medical imaging report dated 14 May 1998 giving the results of an MRI of the lumbar spine: L5-S1 - focal disc herniation posterior. The disc material does lie adjacent to both right and left S1 nerve roots. There is no significant change in appearance from the July 1996 CT scan.
- A letter dated 5 January 1999 from the same specialist in physical and rehabilitation medicine. The specialist states that the appellant continues to have lower back pain with occasional sciatic radiation into his right leg. He uses an analgesic to cope. On a good day he will take as little as three tablets and on a bad day up to eight. The specialist arranged for the appellant to attend a pain clinic. He thinks that this would be worthwhile pursuing but if things don't work out that it may be possible to review the surgical situation once more for failed back syndrome. A handwritten note on the letter indicates "pt declined."
- A consultation report from a hospital dated 27 June 2000. The appellant was admitted for right flank pain radiating to the groin with a presumptive diagnosis of right renal colic. The clinical summary states that the appellant has had a long history of multiple visits to Emergency for analgesics for various complaints including back pain and headaches as well as renal colic. He has had several episodes of renal colic, most recently in 1985 and 1980. Apparently eight months ago he spontaneously passed the stone. He developed right-sided CVA tenderness earlier that day, radiating down into the right lower quadrant and testicles.
- A diagnostic report dated 24 January 2002 reporting on K.U.B., with the impression that no definite renal calculi are seen.
- The medical imaging report dated 18 April 2002 regarding a scrotal ultrasound. The impression is extensive scrotal edema, particularly on the left side; normal testes.
- A medical imaging report dated 30 January 2002. The impression is distal right urethral calculus with mild obstructive features involving the right kidney.
- A clinical report dated 30 August 2004 following imaging of the lumbar spine. The assessment is minimal lower lumbar osteophytosis and minimal lumbar malalignment.
- Referral report dated 17 December 2007 from an arthritis centre. The arthritis diagnosis is osteoarthritis, polyarticular, with acuity of symptoms assessed as moderate to severe and impact on daily living assessed as moderate to severe. The report notes that at present the appellant is having severe pain of his right neck and shoulder radiating down to the right-hand. He also has a severe pain of his lumbar spine with L5-S1 disk herniation.
- An imaging report dated 8 April 2009 from a chest X-Ray. The lungs are slightly hyper inflated with also increased interstitial changes suggesting CODP.
- An imaging report dated 28 July 2009 from the abdomen ultrasound. The impression is mild hepatomegaly, with diffuse fatty infiltration of the liver.
- A hand-written, unsigned and undated "Medical Summary" of the appellant presumably prepared by the appellant's former physician who notes that he last saw the appellant on 20 December 2010. At that time, the physician noted "no acute problems." The following chronic problems are listed: 1: smoker; 2: early CODP; 3: mild-moderate hypertension; 4: tendency to renal stones; 5: cholesterol and especially triglycerides elevated; 6: panic attacks & anxiety (chronic) with some depression,also some degree of passive/aggressive personality disorder with anger outbursts, but most times passive; 7: lower lumbar DDD & OA, now chronic lower back pain and intermittent bilateral sciatica; 8: mild CODP from smoking & won't quit; 9: mildly impaired glucose homeostasis; 10: fatty liver; 11: mild GERD intermittently.

In his Request for Reconsideration, the appellant writes:

"…. I have had this doctor for five months. He cannot say I can walk four blocks, when I can hardly walk or dress myself. My daughter puts my shoes on; I have a bad injury to my back. Plus I do have mental illness (severe depression, bipolar and PTSD). Plus I have COPD, hypertension, and very bad panic attacks. I can't stand more than 5 minutes, or sit for more than 5 minutes. We moved from an apartment with stairs to the apartment with no stairs. My wife helps me as much as she can. I have sciatica in my back and spinal bifida. I have more bad days than good days, [I am] starting to see a psychiatrist. I have panic attacks every day. I do need assistance daily. My daughter helps me and my wife."

In his Notice of Appeal dated 11 August 2012 the appellant writes under Reasons:

"I disagree because the doctor I have has only known me for four months. I suffer from severe depression, back problems, anxiety problems, PTSD, panic attacks, [aggression disorder]. I can't walk very well; I can only walk for less than 5 minutes. I can't get up and down stairs. Our daughter comes over to prepare meals and get our groceries."

In a Submission received after reconsideration and before the hearing, the appellant's wife writes:

"My husband has severe depression, bipolar, herniated discs in his back. The doctor who did his package only knew him for about one month. His old doctor [no longer practices.] We have tried to get his records. He can't get out of bed sometimes. He can't even stand for more than 5 min. My daughters cook our meals. He has severe depression; he has had 2 mental breakdowns. He has said he wants to end his life. He cannot walk up stairs. He has to sit on his bum and get upstairs that way. He uses his cane, but a walker would be better for him. My daughter drives him everywhere. He was told by the specialist if he has back surgery it would paralyze him and he would never be able to work again. The surgeons name is Dr. [name]. His doctor has been waiting for all the CT scans and x-rays from the hospital. He has been on pure codeine since the accident. He hurt his back about 10 years ago. He misplaced his cane when we moved."

At the hearing, the appellant's wife represented her husband. She read the above submission, emphasizing that the GP's assessments were "totally wrong and misinformed." Her husband cannot be of any help around the home and does not go out because of his panic attacks. As she is in receipt of disability assistance herself, their daughters do everything for them – cleaning, cooking, shopping and driving to appointments. She referred to the medical documents which she stated confirmed that, as well as the herniated disc in his back, he suffers from COPD, osteoarthritis and kidney stone problems. And as well as his anxiety and panic attacks, he is bipolar, and suffers from depression and post traumatic stress (aggression) and personality disorders. In answer to a question, she stated that the appellant was not seeing a psychiatrist on a regular basis, but had been referred to one recently. All the psychiatrist had done was prescribe some pills, to which he had a negative reaction (the details of which are not relevant to this appeal). In answer to question, she affirmed that the handwritten "Medical Summary" was prepared by his former physician, sometime in early 2011. She stated that the "Disability Self Report" had not been provided to the GP. She indicated that she was provided this form from an advocacy organization. The ministry confirmed that this was not an official ministry form.

The ministry stood by its position at reconsideration. The ministry representative noted that the

medical reports submitted were all several years old. The ministry could not rely on the handwritten "Medical Summary," as its origin had not been authenticated.

The panel finds that the new information provided in the submission by the appellant's wife and at the hearing is in support of the information and records that were before the ministry at the time of reconsideration. In particular, the reference to the appellant's use of a cane is in support of his earlier evidence concerning his difficulties walking any distance. The panel therefore admits the new information as evidence pursuant to section 22(4) of the Employment and Assistance Act.

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PART F – Reasons for Panel Decision

The issue in this appeal is whether the ministry reasonably determined that the appellant is ineligible for PWD designation because he did not meet all the requirements in section 2 of the EAPWDA. Specifically the Ministry determined that the information provided did not establish that the appellant has a severe mental or physical impairment that in the opinion of a prescribed professional

(i) directly and significantly restricts his ability to perform daily living activities either continuously or periodically for extended periods; and,

(ii) as a result of those restrictions he requires help to perform those activities.

The Ministry did determine that he met the 2 other criteria in EAPWDA section 2(2) set out below.

The following section of the EAPWDA applies to this appeal:

2 (2) The minister may designate a person who has reached 18 years of age as a person with disabilities for the purposes of this Act if the minister is satisfied that the person has a severe mental or physical impairment that

(a) in the opinion of a medical practitioner is likely to continue for at least 2 years, and

(b) in the opinion of a prescribed professional

(i) directly and significantly restricts the person's ability to perform daily living activities either

(A) continuously, or

(B) periodically for extended periods, and

(ii) as a result of those restrictions, the person requires help to perform those activities.

(3) For the purposes of subsection (2),

(a) a person who has a severe mental impairment includes a person with a mental disorder, and

(b) a person requires help in relation to a daily living activity if, in order to perform it, the person requires

(i) an assistive device,

(ii) the significant help or supervision of another person, or

(iii) the services of an assistance animal.

The following section of the EAPWDR applies to this appeal:

2 (1)For the purposes of the Act and this regulation, **"daily living activities"**,

(a) in relation to a person who has a severe physical impairment or a severe mental impairment, means the following activities:

(i) prepare own meals;

(ii) manage personal finances;

(iii) shop for personal needs;

(iv) use public or personal transportation facilities;

(v) perform housework to maintain the person's place of residence in acceptable sanitary condition;

(vi) move about indoors and outdoors;

(vii) perform personal hygiene and self care;

(viii) manage personal medication, and

(b) in relation to a person who has a severe mental impairment, includes the following activities:

(i) make decisions about personal activities, care or finances;

(ii) relate to, communicate or interact with others effectively.

Evidentiary issues

Based on the affirmation of the appellant's wife that his former physician prepared the handwritten "Medical Summary," the panel is prepared to give some credence to this document, despite its unauthenticated provenance. The panel notes, however, that this document simply lists a number of chronic conditions, none of which have been identified by that physician as an impairment. As to the remaining medical reports, the panel finds they have little relevance; some confirm the appellant's back condition as reported by the GP, while others deal with medical conditions (e.g. COPD, kidney problems) for which there is no evidence or argument that they relate to the impairments identified by the GP.

The panel notes that there is much evidence from the appellant about his medical conditions that is either not supported by the GP (e.g. bipolar disorder, PTSD) or that contradicts the GP's assessments (e.g. distance he can walk unaided). The reasons for this have been explained by the appellant. In this connection and with respect to the panel's findings below relating to the severity of impairments, the panel is guided by the following considerations:

- The ministry's definition of impairment consists of "cause" and "impact" components: "impairment is a loss or abnormality of psychological, anatomical or physiological structure or function [the cause] causing a restriction in the ability to function independently, effectively, appropriately or for a reasonable duration [impact]." A severe impairment requires the identified cause to have a severe impact.
- The legislation provides that the determination of the severity of impairment is at the discretion of the minister. The reasonable application of this discretion involves taking into account all the evidence, including that of the appellant. However, the starting point must be medical evidence, with the legislation requiring that a medical practitioner identify the impairment and confirm that the impairment will continue for at least two years. The identification of the impairment includes the identification of the impact on daily functioning, through assessments in such areas as functional skill limitations, cognitive and emotional deficits, restrictions on the ability to manage DLA, assistance required and treatment requirements. Therefore where the evidence of the appellant contradicts that of the medical practitioner or prescribed professional, (in this case, the GP) the panel places more weight on the latter's assessments.

Severity of mental impairment

In the reconsideration decision, the ministry reviewed the evidence relating to the appellant's mental impairment. The ministry noted that the GP has reported one deficit to cognitive and emotional functioning - emotional disturbance (anxiety) which is described as "generalized anxiety limits his ability to interact socially in general public settings." No deficit is noted in 10 of 11 other aspects. Communication is good with no difficulty. Continuous restriction to social functioning is described as "constant low-level anxiety and occasional panic attacks. Strong tendency to avoid public spaces, going out, prefers to stay at home in familiar surroundings." The ministry also noted that there are no impacts on daily cognitive and emotional functioning in 13 of 14 aspects, with one major impact on emotion. Social functioning is independent in three of five aspects, with continuous support/supervision required to interact appropriately with others (moderate continuous generalized anxiety, strong avoidance traits") and to deal appropriately with unexpected demands (stressful stimuli may trigger full-blown panic attacks). The ministry noted that the appellant has good social

supports - his spouse. He is able to relate to, communicate and interact effectively with others. Given this evidence the ministry was not satisfied that the information provided establishes a severe mental impairment.

The position of the appellant is that his generalized anxiety, bouts of severe depression, passive/aggressive personality disorder, PTSD and bipolar condition, combined with his panic attacks that make him reluctant to leave the home, are more than sufficient grounds for establishing a severe mental impairment.

As discussed above, the panel cannot consider any mental health conditions other than those identified by the GP – i.e. generalized anxiety and panic attacks. The panel notes that there is no psychiatric assessment available or any evidence that the appellant has been or is under the ongoing care of a mental health professional. Without such evidence, and given the limited cognitive and emotional deficits and impacts reported by the GP, as noted in the reconsideration decision, the panel finds that the ministry was reasonable in determining that the information provided did not establish a severe mental impairment.

Severity of physical impairment

In the reconsideration decision, the ministry noted that the GP indicates that the appellant is able to walk 4+ blocks and to climb 5+ steps unaided, to lift 5-15 lbs. with no sitting limitation. The ministry noted that the appellant is independently able to perform all aspects of mobility and physical abilities, with no assistive devices routinely used to help compensate for impairment. As the functional skill limitations are not significantly restricted, aside from lifting over 15 lbs., and as remedial measures in the form of analgesics are available to ameliorate his symptoms:, the ministry was not satisfied that the information provided is evidence of a severe physical impairment.

The position of the appellant is that the GP's assessments concerning his physical abilities are simply wrong and misleading. This is because the GP had only met him a couple of times when he filled out the forms and had not gotten to know him well. In fact, the appellant can only walk 1-2 blocks and that with a great deal of pain and the use of a cane. He can only climb stairs backwards on his bum, and his back pain prevents him from doing any cooking, cleaning or anything else around the home. All this points to a severe physical impairment.

The GP has diagnosed a diagnosis of low back pain and sciatica. As noted above under evidentiary issues, the panel must rely on the GP's assessments as set out in the PR. With the exception of lifting ability limited to 5-15 lbs., and the GPs comment that the appellant is "unable to access the shelves below countertop," no other physical limitations are reported. Considering the lack of such reported limitations, and without any medical evidence that supports the appellant's position, the panel finds that the ministry reasonably determined that the information provided did not establish a severe physical impairment.

Whether DLA are significantly restricted

With respect to whether in the opinion of a prescribed professional the information establishes that the impairment directly and significantly restricts DLA, either continuously or periodically for extended periods, the reconsideration decision noted that the GP reported no restriction 9 of 10 DLA.

Continuous restriction is noted with social functioning, described as "constant low-level anxiety and occasional panic attacks" i.e. ~ once a month. The reconsideration decision reviewed the same information as above under severity of mental impairment regarding social functioning being independent in 3 of 5 aspects. The ministry noted that no further information on the degree and duration of support/supervision is provided although it is recognized that the appellant has good social support from his spouse. The ministry concluded that as the majority DLA, including social functioning, are performed independently, the information from the GP does not establish that impairment significantly restricts DLA, either continuously or periodically for extended periods.

The position of the appellant is that his physical condition, due to the back pain resulting from his disc herniation, prevents him from performing DLA around the home, such as preparing meals and basic housekeeping, to the point that he and his wife, also disabled, require the daily assistance of one of his daughters for these chores. And his anxiety and panic attacks, plus his back condition, prevent him from leaving the home for shopping. All this clearly establishes that his impairments significantly restrict his DLA on a continuous basis.

The panel notes that this criterion requires the evidence to be "in the opinion of a prescribed professional." Therefore the panel must rely on the PR and AR before the ministry at reconsideration. With respect to the DLA relating to a person with a mental impairment i.e. make decisions about personal activities, care or finances; and relate to, communicate or interact with others effectively, the panel notes that there is no information that raises any questions as to his ability to make decision about his personal or family care, and with respect to the second, only that he prefers to stay at home in familiar surroundings and a mention by his former physician about some anger tendencies. In the panel's view, assessing the appellant's overall ability to function as reported in the PR and AR, it is difficult to assess the GP's opinion as confirming that these restrictions are "significant." The panel therefore finds that the ministry reasonably determined that this legislative criterion had not been met.

Whether help to perform DLA is required

In the reconsideration decision, the ministry noted that the GP has indicated that the appellant does not require any prostheses or aids and that he does not routinely use an assistive device to compensate for his impairments. As it had not been established that DLA are significantly restricted, the ministry concludes that it cannot be determined that significant help is required from other persons and that the appellant does not require the services of an assistance animal.

The position of the appellant is that he clearly needs assistance to manage his DLA: one of his daughters comes every day to help around the home or to do to the shopping. In addition he needs to use a cane for walking. These facts demonstrate that help to perform DLA is required

The panel notes that the GP makes no mention of the help provided by his daughters or the use of the cane. The panel also notes that the legislation requires that in the opinion of a prescribed professional the need for help must arise from direct and significant restrictions in the ability to perform DLA that are either continuous or periodic for extended periods. The panel finds that the ministry reasonably determined that since it has not been established that DLA are directly and significantly restricted, it cannot be determined that help is required under section 2(2)(b)(ii) of the EAPWDA.

Conclusion

Having reviewed and considered all of the evidence and the relevant legislation, the panel finds that the ministry's decision that the appellant was not eligible for PWD designation was reasonably supported by the evidence and therefore confirms the ministry's decision.