APPEAL #

PART C – Decision under Appeal

The decision under appeal is the reconsideration decision of the Ministry of Social Development (the ministry) dated 10 July 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: she has reached 18 years of age; and her 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

PART E – Summary of Facts

With the consent of the parties the appeal hearing was conducted as a written hearing in accordance with section 22(3)(b) of the Employment and Assistance Act.

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

1. The appellant's PWD Designation Application dated 02 May 2012. The Application contained:
   - The appellant's Self Report (SR)
   - A Physician Report (PR) dated 20 April 2012 completed by the appellant's general practitioner (GP) who has known the appellant for 8 months and seen her 2-10 times over that period.
   - An Assessor Report (AR) dated 10 March 2012 completed by a registered nurse (RN) in private practice who had met the appellant once.
2. Also attached to the application were:
   - Numerous psychiatric progress notes detailing meetings (and missed appointments) between a Health Authority psychiatrist and the appellant from August 2011 to February 2012.
   - A list from a pharmacy of prescription drug expenses from October 2011 to May 2012.
3. The appellant's Request for Reconsideration dated 09 July 2012, to which was attached prescription receipts from the above pharmacy and a list of prescriptions from another pharmacy for the period November 2010 to February 2012.

In the SR, the appellant writes that she has great anxiety going through this process. Physically she has had many injuries since she was 21, including whiplash, broken feet, back injuries and a broken left arm. She mentions that she is left-handed. She was diagnosed bipolar in 2004. She is very impulsive in her decision-making, not thinking of the consequences. She is also very anxious and can't sleep. She has racing thoughts and finds it difficult to keep appointments. She is often confused and overwhelmed. She has continuous shoulder, hip, back and joint pain, but feels that she is disbelieved and her medical records overlooked. She wakes up in excruciating pain. She has hearing loss and poor concentration. She has difficulty walking at times. She is unable to maintain daily functions unless it is on her schedule. She gets very stressed out and isolates and has eating disorders. She has had many abusive relationships, verbal emotional and physical. She self medicates. She has had four marriages... she just leaves. She has abandonment issues.

In the PR, the GP diagnoses the appellant with bipolar disorder (manic), cluster B personality traits - impulsive behavior, histrionic and borderline traits - and polysubstance abuse (alcohol, cocaine). Under health history, the GP writes:

> "Severe refractory impairment of daily functioning due to bipolar disorder & polysubstance abuse. No physical disability detected on objective exam & x-rays etc. -- despite numerous somatic complaints (for secondary gain?). Unresponsive to Rx due to lack of compliance & relapsing substance abuse (mainly alcoholism)."

The GP indicates that the appellant has not been prescribed any medication and/or treatments that interfere with her ability to perform DLA. He indicates that she will need permanent prescriptions for mood stabilizers. The GP indicates that the appellant requires no prosthesis or aids. The GP reports that the appellant's impairment is likely to continue for two years or more commenting: "indefinite

disability- due to poor compliance with Rx."

With respect to functional skills, the GP reports no limitations with physical function: she can walk 4+ blocks unaided, climb 5+ stairs, with no limitations to lifting or remaining seated and with no difficulties with communication. As to significant deficits with cognitive and emotional function, the GP reports deficits in the following areas: executive (judgment), memory, psychotic symptoms, emotional disturbance, motivation (loss of initiative or interest), and impulse control. The GP comments: "frequent impairment by substance abuse."

In terms of DLA, in answer to the question as to whether the appellant's impairment directly restricts the appellant's ability to perform DLA, the GP answers "No." However in the table below this question/answer, the GP indicates that the appellant is actively restricted in the management of medications on a periodic basis, in the management of finances on a continuous basis and in social functioning (noting decision making). The GP reports that the appellant is not restricted in the areas of personal self care, daily shopping, mobility inside and outside the home and the use of transportation. Restrictions in the areas of meal preparation and basic housework are unknown. The GP explains that the periodic restrictions to the management of medications with the comment: "Impaired by substance abuse, poor judgment from lack of control of bipolar disease." The GP makes a further comment: "chronic refractory lack of control of mental illness due to poor compliance with treatment & substance abuse." Regarding assistance required for DLA, the GP states: "minimal if any assistance with ADL. Primarily needs supervision to comply with treatment. No objective signs of physical disability despite somatic complaints."

Under additional comments, the GP states:

- -- Numerous histrionic somatic complaints related to old healed injuries and stable benign degenerative disease of neck and low back with no functional disability. No objective signs of significant pulmonary disease despite subjective complaints.
- -- Inability to maintain sobriety more than a few weeks at a time. Frequent[ly] presents impaired.
- -- Noncompliance with recommended treatment.
- -- Impulsivity, poor judgment puts patient at risk of harm. Unmotivated to remain sober or compliant.
- -- No objective signs to correlate with subjective physical symptoms.

In the AR, the RN indicates that the appellant's mental or physical impairments that impact her ability to manage DLA are: bilateral carpal tunnel syndrome (CTS), # left knee (fall 2011), # back, respiratory issues (emphysema?, chronic bronchitis), PTSD, bipolar, cluster B personality traits, anxiety, anorexia, depression (insomnia, OCD, substance abuse - currently abstaining). As to ability to communicate, the RN reports that the appellant has a good level of ability for speaking and writing and a poor level for writing (comment: aching left hand, arm and shoulder) and hearing (comment: hearing loss from mumps as a child? right ear.)

With respect to mobility and physical ability, the RN assesses the appellant independent for walking indoors, independent for walking outdoors but taking significantly longer than typical (comment: winded when walking: aching body and hips daily) and independent for standing. Periodic assistance from another person is required for lifting and carrying and holding (comment: left arm/hand issues problematic; walks, carries a few items to sustain for a few days or gets help - calls a cab/ride from

friend). The RN comments: "Client is unable to crouch or kneel due to knee issues. Client experiences persistent breathlessness or being winded when performing mildly physical activities. She has issues with both hands and her back which impacts her ability to lift and carry or hold."

In terms of cognitive and emotional functioning the RN assesses major impacts in the following areas: (comments are in parenthesis) bodily functions (eating problems, sleep disturbance), emotion (anxiety and depression -- with too many people, she feels overwhelmed and claustrophobic), impulse control, insight and judgment, motivation (fluctuations are prolonged), and motor activity (agitation, ritualistic or repetitive actions). The RN assesses a moderate impact for attention/concentration (easily distractible), executive (over-does everything – racing – overwhelmed), memory (poor), language (comprehension problems -- in large groups problematic), and other emotional or mental problems (substance abuse -- currently abstaining, and anger outbursts). The RN assesses a minimal impact for consciousness, psychotic symptoms and other neuropsychological problems. The RN comments:

- -- Bodily functions: anorexia -- long-standing issues, eats once a day -- has to be cued to eat. Weight currently 110 pounds, thin. Sleeps poorly every night: wakeful, fitful sleeps, mind racing.
- -- Consciousness: occasional drowsiness; refill meds?
- -- Anxiety/depression: long-standing issues. Poor ability to function socially.
- -- Impulse: checking doors locked and keys repeatedly -- brushing teeth15x – 40x per day; excessive gum recession and red/inflamed; shaving legs daily; excessive focus on appearance and cleanliness; excessive hairbrushing, straightening picture, labels etc. -- Daily and ongoing.
- --Motivation: profound variations from high to low - fluctuates with moods.

With respect to DLA, the RN assesses the appellant independent in all aspects of personal care, taking significantly longer than typical for dressing (zippers/buttons - grasping and pulling takes 2x longer), regulate diet (history of anorexia - current distortion with relationship?) And transfers in/out of bed (periodic back pain issues problematic). The RN assesses the appellant independent in all aspects of basic housekeeping and shopping, except that periodic assistance is required for carrying purchases home (experiences back and knee pain, etc. 2x longer and paces activities.) For meals the appellant is assessed as taking significantly longer than typical for meal planning (poor appetite, anorexia behavior challenges her), food preparation (cutting/using knives/tools – aching and pain: grasping & using mixer -- unable), and cooking (occasionally drops items -- hand weakness). Independent for safe storage of food. For paying rent and bills, the RN assesses the appellant requiring continuous supervision for banking, budgeting and paying rent and bills (extremely impulsive). The RN assesses the appellant requiring periodic supervision from another person under all aspects of medications - filling and refilling prescriptions, taking as directed and safe handling and storage (doesn't fill prescriptions timely, runs out, went 1/12 without, forgets to take occasionally or takes more often). For transportation the appellant is assessed as taking significantly longer than typical for getting in and out of vehicle (harder to get out than in: easier in a higher car than a lower vehicle: 2 - 3x longer due to physical issues).

The RN comments that many of the appellant's personal care activities are independent but also seemed to be objects of her obsession or her repetitive tasks that she focuses on. While she is independent with providing these, she is spending excessive amounts of time with these tasks: brushing teeth, washing hair, shaving legs.

As to social functioning, the RN assesses periodic support/supervision required for all listed aspects: appropriate social decisions (repeatedly involved with abusive men, constantly putting physical well-being in jeopardy or exploitive situations); able to develop and maintain relationships (poor or no boundaries - fractured and problematic); interact appropriately with others (cycle of abuse and alcohol has historically challenged her abilities to solve social issues); able to deal appropriately with unexpected demands (causes extreme anxiety) and able to secure assistance from others (extreme poor coping skills). The RN assesses very disruptive functioning for the appellant's relationship with her immediate and extended social networks. In terms of the help required, the RN states that mental health outreach would be beneficial more often as sobriety is maintained.

With respect to assistance provided by other people, the RN indicates that the appellant receives help from a friend, a health authority outreach worker and a relapse prevention group. Help is required for planning and prioritizing, budgeting assistance, meds administration (blister packs) and transportation.

The RN provides the following additional information, writing:

> "This client experiences a multitude of challenging diagnoses and issues. Her respiratory function is currently under investigation but the symptoms of which have been considerable for some time. Her sobriety/ETOH abuse fluctuates as the client possesses very few coping mechanisms to deal with life in general, much less the repeated trauma she has endured. Her mental health constantly challenges her and she exposes herself to inappropriate situations, often putting her at risk. She has had a number of significant fractures (spine, arms, knee) and experiences daily pain that is being somewhat managed by non-habit-forming meds. Her persistent sleeplessness, often for days, becomes a significant barrier to rest and recovery."

The psychiatric progress notes document the appellant's struggle with alcohol abuse, with periods of sobriety lasting up to a couple of months and many relapses. The period covered also includes the beginning and conclusion of a relationship, ending in an assault and the physical, emotional and financial consequences of that experience. Other issues are also addressed, including the appellant's anxiety, poor nutrition, and obsessive/compulsive behavior. Prescriptions for treating her bipolar disorder and neuropathic pain and other pain medication are discussed. On 08 December 2011 the psychiatrist, while noting that he is giving her a prescription for bipolar treatment, states that "bipolar disorder has being historically diagnosed but I strongly question the validity of this diagnosis."

In her Request for Reconsideration, the appellant writes that her GP did not have all the information. She states that she is attaching all the medications that she has been taking for over a year that have been prescribed by the GP and another physician. She states she is in need of assistance for daily living, referring the ministry to her mental health outreach worker.

In her notice of appeal dated 19 September 2012, the appellant writes:

> "With my meds I can't work or even get up and out to find a job. Without my meds I can't function in and around people. I pass out like a light switch. I have no balance. I need help not bull-shit. No wonder I drink."

The panel has received a submission dated 27 September from the appellant's advocate and signed

by the appellant. No new information is provided. The submission goes to argument (see Part F below).

In an e-mail dated 31 October 2012, the ministry stated that its submission in this appeal is the reconsideration decision.

APPEAL #

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 she 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 her ability to perform daily living activities either continuously or periodically for extended periods; and,

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

The Ministry did determine that she 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.

The panel will consider each party's position regarding the reasonableness of the Ministry's decision under the applicable PWD criteria at issue in this appeal.

Severity of mental impairment

In the reconsideration decision, the ministry noted that the GP reports six deficits to cognitive and emotional functioning, with the comment "frequent impairment by substance abuse." The ministry also noted that communication is without difficulty and that restrictions to social functioning are described as "impaired by substance abuse, poor judgment from lack of control of bipolar disease." The ministry notes that the RN reports a number of moderate and major impacts on daily functioning which she attributes to substance abuse, anorexia, poor sleep, occasional drowsiness due to drugs?, obsessive compulsive habits and profound variations in motivation. The ministry also referred to the psychiatric progress notes. They primarily speak of alcohol abuse causing impairment in daily functioning. The diagnosis of bipolar disease is questioned. Medication is prescribed, including antipsychotic, analgesic, and anti-convulsant drugs to treat bipolar disease, although compliance is an issue. The ministry concluded that considering the information in the application, along with the psychiatric consultations, the information speaks of polysubstance abuse as the main contributor to dysfunction in daily functioning and the minister is not satisfied that the information provided is evidence of a severe mental impairment.

The position of the appellant, as set out in her advocate's submission, is that the GP and RN paint a picture of a woman who struggles on a daily basis due to her impairment and who has significant difficulties performing DLA because of her impairment. Of particular concern is the conclusion of both professionals that the appellant's impairment puts her at risk of harm. The advocate notes that while the GP and RN do not have identical views on the appellant's condition, they do agree on several aspects of her impairment and its consequences. The advocate lists the following points of concern identified by both the GP and RN:

- diagnosed with bipolar disorder
- diagnosed with cluster B personality traits
- deficits with functioning involving judgment
- evident deficits due to emotional disturbance including anxiety
- evident deficits due to motivation
- experiences restrictions in her ability to manage her medications
- experiences restrictions with respect to her social functioning
- at risk of harm due to impulsivity and poor judgment.

The advocate submits that a fair, large and liberal construction and interpretation of the legislation would recognize the continuity of the reports of the two professionals regarding the appellant's mental health issues and her application found valid.

In the discussion below concerning the information provided regarding the severity of the appellant's impairments, the panel has drawn upon the ministry's definition of "impairment," as set out on the top of page 8 of the PR. This definition 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]." The cause is usually set out as a disease, condition, and syndrome or even by a symptom (e.g. pain). A severe impairment requires the identified cause to have a severe impact. The assessment of severity is therefore based on of the impact on daily functioning, in such

areas as functional skill limitations, cognitive and emotional deficits, restrictions on the ability to manage DLA and assistance required.

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. 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 GP has diagnosed the appellant with bipolar disorder (manic), Cluster B personality traits - impulsive behavior, histrionic and borderline traits - and polysubstance abuse (alcohol, cocaine). While the RN has listed other mental conditions, including PTSD, anxiety, OCD and anorexia, none of which have been confirmed by the GP, the panel is required by the legislation to consider only the severity of the impacts arising from the conditions identified by the GP as likely to continue for at least two years.

The panel notes that the parties present two very different interpretations of the evidence. The ministry takes the view that the information provided speaks of polysubstance abuse as the main contributor to dysfunction in daily functioning. Citing the GP's comments: "frequent impairment by substance abuse" and "impaired by substance abuse, poor judgment from lack of control of bipolar disease," the implied rationale is that, if it were not for the appellant's substance abuse, the appellant's bipolar condition and Cluster B personality traits could be effectively treated and any impacts on daily functioning from these conditions can therefore be discounted. And while no reasons are given, the panel presumes that the ministry does not consider substance abuse itself to be a severe mental impairment, as the condition is treatable and long-term sobriety can be achieved and maintained. On the other hand, the appellant's advocate focuses on the appellant's bipolar condition and Cluster B personality traits, pointing out resulting deficits due to emotional disturbance, including depression and anxiety, and motivation, with resulting restrictions in the appellant's ability to manage medications and social functioning, with the risk of harm due to her impulsivity and poor judgment. The appellant's advocate makes no direct mention of the appellant's substance abuse, setting that aside and stressing the impacts on daily functioning of her bipolar condition and Cluster B personality traits.

To the panel in weighing these two alternative interpretations, much hinges on what the GP means by using the term "refractory" ("resistant to treatment"). Under health history he writes: "severe refractory impairment of daily functioning due to bipolar disorder and polysubstance abuse." And regarding the degree of restriction to DLA he writes: "chronic refractory lack of control of mental illness due to poor compliance with treatment and substance abuse." Based on the evidence, the panel understands the GP to mean by these remarks that the appellant's bipolar condition is resistant to treatment because of her noncompliance with medication protocols arising from her substance abuse and not that the bipolar condition itself is resistant to treatment. In addition, in identifying the six cognitive and emotional deficits, the GP comments: "Frequent impairment by substance abuse," leaving the impression that these deficits are primarily attributable to the substance abuse. And given the attempts by the psychiatrist to encourage the appellant to participate in a relapse prevention group, there is no evidence that the appellant's substance abuse itself is considered clinically refractory or "untreatable." Based on the foregoing, the panel finds that the ministry's interpretation of the evidence and its position on the severity of substance abuse as a mental impairment are reasonable, and that therefore the ministry reasonably determined that a severe mental impairment had not been established.

Severity of physical impairment

In terms of physical functioning, the ministry noted that the GP reports no untoward functional skill limitations. Further, he states there is no physical disability detected on objective exam and x-rays, etc., despite numerous somatic complaints. The ministry also noted that the RN reports that the appellant is independently able to do most aspects of mobility and physical activities, with periodic help to lift/carry/hold. No assistive devices are routinely used to help compensate for impairment. As no physically inhibiting diagnosis is provided and as the GP reports no functional skill limitations, the ministry is not satisfied that the information provided is evidence of a severe physical impairment.

Although the RN lists some physical issues (carpel tunnel syndrome, knee cap and back injuries and respiratory issues, none confirmed by the GP), the panel considers the appellant's position with respect to a severe physical impairment to be that set out in her advocate's submission, where no physical issues are mentioned.

As explained above with respect to the severity of mental impairment, the panel is required by the legislation to consider only the severity of the impacts arising from the conditions diagnosed by a medical practitioner. As the GP has provided no diagnosis of any condition limiting the appellant's physical functioning, the panel finds that the ministry reasonably determined that a severe physical impairment had not been established.

Whether DLA are significantly restricted

As to whether the information provided establishes that a severe impairment directly and significantly restricts DLA either continuously or periodically for extended periods, the ministry noted that a severe impairment has not been established. The ministry notes that the GP reports independent functioning in the majority of DLA and states" minimal if any assistance [is required] with ADLs, primarily need supervision to comply with treatment." The ministry again notes the GPs comment: "impaired by substance abuse, poor judgment from lack of control bipolar disease." The ministry noted that the RN reports that many activities are performed independently or require periodic help -- to carry purchases home and with medications (doesn't refill Rx in timely manner, runs out or forgets occasionally or takes more often). Continuous help is reported to pay rent/bills, with the comment "extremely impulsive," Periodic support/supervision is reported with all aspects of social functioning related to behaviors, anxiety and poor coping skills. While there is no clear explanation of the degree and duration of such supervision, the GP comments that the appellant requires minimal if any assistance with ADLs and primarily needs supervision to comply with treatment. Addiction counseling is in place. The ministry concluded that as the majority of DLA are performed independently or require little help from others, the information from the prescribed professionals does not establish that this criterion has been met.

The position of the appellant, as set out by her advocate, is that her ability to manage her DLA is significantly restricted in several areas, as identified by the RN in the AR: difficulties with judgment, including poor social judgment putting her at risk of physical harm; depression; anxiety, with unexpected demands causing extreme anxiety; motivation; needing assistance from others regarding management of medication; poor ability to function socially, with very disrupted functioning regarding immediate and extended social networks; and her mental health causing her to expose herself to

inappropriate situations putting her at risk.

The panel notes that, according to the legislation, the direct and significant restriction in the ability to perform DLA must be a result of a severe impairment, not established in this appeal. The panel will take as the starting point the evidence of the GP with respect to restrictions to DLA, drawing on the AR as appropriate. The GP reports that the appellant is actively restricted in the management of medications on a periodic basis, the management of finances on a continuous basis and with respect to social functioning particularly with respect to decision-making. All other DLA are reported as not restricted with the exception of meal preparation and basic housework, where the GP marks "unknown." For these latter two, the RN indicates taking significantly longer than typical for most aspects of meals, but noting physical issues and anorexia (neither confirmed by the GP) as the basis for this assessment; and independent for the basic housekeeping DLA. In terms of the GPs assessment regarding management of medications, restricted on a periodic basis, the GP explains "periodic" as "Impaired by substance abuse, poor judgment from lack of control of bipolar disease." The panel considers this to mean that periods of inability to manage medications correspond to periods of substance abuse and not that there is a underlying inability to manage medications arising from her mental conditions. The RN comments with respect to managing medications that the appellant "forgets to take occasionally or takes more often" and the panel finds that the evidence does not establish periodic restrictions with this DLA for extended periods of time, as required by the legislation. As to the management of finances, no description is provided as to how this restriction is manifested, and whether her "extremely impulsive" behavior as reported by the RN is specific to her substance abuse or more generalized. The GP also notes with respect to assistance needed with DLA that "minimal if any" assistance is required and that the appellant "primarily needs supervision to comply with treatment."

With respect to the additional DLA relating to a person with a mental impairment, i.e. EAPWDR section 2(1)(b)(i) make decisions about personal activities, care or finances; and 2(1)(b)(ii) relate to, communicate or interact with others effectively, the panel notes that there is no evidence that the appellant has difficulties with respect to (b)(ii). The panel notes that decision-making with respect to finances is also part of the (b)(i) DLA, and that there is other evidence to indicate that she is restricted in managing this DLA: as the RN reports and the psychiatric progress reports demonstrate, repeatedly being involved with abusive men, constantly putting physical well-being in jeopardy, and poor or no boundaries, along with poor coping skills. While there is evidence to suggest that the appellant is restricted in this DLA on a continuous basis, it is unclear to the panel as to what extent this is attributable to the appellant's substance abuse. Based on the discussion above relating to the other DLA identified as actively restricted or "unknown" by the GP, and as a severe impairment has not been established, the panel finds that the ministry reasonably determined that the information provided did not establish that this criterion had been met.

Whether help is required to perform DLA

The position of the ministry is that as it has not been established that DLA are significantly restricted, it cannot be determined that significant help is required from other persons. No assistive devices are required.

The appellant's advocate points to the appellant's need for supervision/support in the management of medications. The RN also identifies help required in other areas: planning and prioritizing, budgeting

and transportation.

The panel 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 as provided 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.