PART C – Decision under Appeal

The decision under appeal is the reconsideration decision of the Ministry of Social Development and Social Innovation (the ministry) dated 08 January 2014 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 her ability to perform daily living activities (DLA) either continuously or periodically for extended periods; and,

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

The ministry determined 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

The ministry did not appear at the hearing. After confirming that the ministry was notified of the hearing, the hearing proceeded in accordance with section 86(b) of the Employment and Assistance Regulation.

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

1. The appellant's PWD Designation Application dated 20 August 2013. The Application contained:
   - A Physician Report (PR) dated 17 August 2013, completed by the appellant's general practitioner (GP) who has known the appellant for 4 years and has seen her 2-10 times in the past year.
   - An Assessor Report (AR) of the same date, completed by the appellant's GP.

2. The appellant's Request for Reconsideration, dated 20 December 2013, to which was attached:
   - A Self-Assessment (SA) form completed by the appellant, to which the appellant's psychiatrist has indicated, with his signature dated 17 December 2013, that the assessment is an accurate assessment of his patient's overall condition and her current circumstances, noting that he "can only comment on mental and emotional impairments, though."
   - A Self Report (SR) prepared by the appellant.
   - A Psychiatric Consult Report prepared by the appellant's psychiatrist dated 28 August 2013.
   - A written submission prepared by the appellant's advocate.

In the PR, the GP diagnoses the appellant's impairments as:

- severe post traumatic stress disorder
- severe endogenous depression
- bronchial environmental spasm
- arthritis hands & feet
- brain injury – assault 1996
- thoracic scoliosis.

The panel will first summarize the evidence from the PR and AR relating to the appellant's impairments as it relates to the PWD criteria at issue.

Severity/health history

The GP writes: "Coughs with any contact with cigarette smoke, suffers with severe depression and background of PTSD combined with brain injury from assault has added up to confusion, brain fog and concentration and mood problems. Her arthritis hands – feet cause problems walking outside."

The GP indicates that the appellant has not been prescribed any medication and/or treatments that interfere with her ability to perform DLA. He reports that she does not require any prostheses or aids for her impairment.

Physical impairment

PR:
The GP reports that the appellant can walk 1 to 2 blocks unaided, climb 2 to 5 steps, lift 5 to 15 lbs. and remain seated for 1 to 2 hours. He reports no difficulties with communication.

AR:
Regarding mobility and physical ability, the GP assesses the appellant independent for walking indoors and requiring periodic assistance from another person for walking outdoors, climbing stairs, standing, lifting, and carrying and holding, commenting "back pain" for the functions where periodic assistance is required.

Mental impairment

PR:
The GP reports that the appellant has no difficulties with communications.

The GP reports that the appellant has significant deficits with cognitive and emotional function in the following areas: executive, memory, emotional disturbance, motivation, and attention or sustained concentration.

AR:
The GP assesses the appellant's communications abilities as satisfactory for speaking, reading, writing, and hearing.

With respect to restrictions to cognitive and emotional functioning, the GP assesses a major impact for emotion (inappropriate anxiety, depression), and moderate impacts in the areas of bodily functions (sleep disturbance), consciousness, impulse control, insight and judgment, attention/concentration, executive, memory, and motivation. No impacts are reported for motor activity, language, psychotic symptoms, other neuropsychological problems, or other emotional or mental problems.

Ability to perform DLA

PR:
The GP assesses the appellant's ability to perform DLA as restricted on a continuous basis for meal preparation, basic housework, daily shopping, mobility inside the home, mobility outside the home, management of finances, and social functioning. The GP reports that the appellant is not restricted in the areas of personal self care, management of medications, and use of transportation.

With respect to social functioning, the GP comments: "isolated and energy loss, suspicious of contact."

The GP comments regarding the degree of restrictions: "severe."

AR:
The GP provides the following assessments:

- Personal care – independent in all aspects, takes significantly longer than typical for transfers in/out of bed and on/off of chair.
- Basic housekeeping – continuous assistance from another person or unable and takes

significantly longer than typical for laundry and basic housekeeping.

- Shopping – independent for reading prices and labels; continuous assistance from another person or unable and takes significantly longer than typical for going to and from stores and carrying purchases home; periodic assistance from another person required for making appropriate choices and paying for purchases. The GP comments: "confusion, pain joints, back."
- Meals – independent for meal planning; periodic assistance from another person and takes significantly longer than typical for food preparation, cooking and safe storage of food.
- Pay rent and bills – periodic assistance from another person and takes significantly longer than typical for banking, budgeting and paying rent and bills.
- Medications – independent and takes significantly longer than typical for filling/refilling prescriptions; independent for taking as directed and safe handling and storage.
- Transportation – periodic assistance from another person and takes significantly longer than typical for getting in and out of vehicle; continuous assistance from another person or unable and takes significantly longer than typical for using public transit and using transit schedules and arranging transportation.

Regarding social functioning, the GP reports that the appellant requires periodic support/supervision for all listed areas: making appropriate social decisions, developing and maintaining relationships, interacting appropriately with others, dealing appropriately with unexpected demands and securing assistance from others.

The GP describes how the appellant's mental impairment impacts her relationships with her immediate and extended social networks as marginal functioning.

Help provided/required

PR:
The GP comments that the appellant needs "counseling help with [illegible]"

AR:
Regarding social functioning, the GP comments: "isolated and needs continuing counseling and help to motivate."

The GP notes that assistance is provided by family and by one health authority counsellor. He comments that the appellant needs "more social support, $."

The GP indicates that the appellant does not routinely use any assistive device and that she does not have an assistance animal.

Documents submitted at reconsideration

Self report

In her self report, the appellant writes that when the physician was filling in his portion of the PWD application she found it hard to explain the severity of her body's physical decline and the cognitive and mental impairments to him when he asked questions. She would lose track of her thoughts, her

memory recall didn't seem to exist, she forgot information she had written down to bring to him, and she would get emotionally triggered and frustrated trying to cope with the inability to express herself. She is exhausted. She goes on to write:

> "I could not even do the self report when I sent to the PWD application in at the end of August 2013. This report [including the SA] has taken me two weeks to complete. [I] had to fill in the checklist four times, due to written mistakes and misunderstanding information required on the document. This document [the SR] was typed by someone else. The community support workers and clinical counsellor guided me through the paperwork daily or when I got emotionally triggered by what I need to express on paper. The psychiatrist explains the head injury to me in the office."

Describing her disabilities, the appellant writes she has severe PTSD. She has been exposed to a minimum of thirty disasters, traumas or hostilities since she was young. She feels on edge all the time, stays at home more and more, has severe memory loss and forgetfulness and cannot concentrate on one thing for more than 30 seconds. She has severe depression and doesn't know a time when she was not depressed. She has a severe reaction to cigarette smoke and finds very few places to go in the environment where this is not present. Her osteoarthritis has caused joint deterioration and inflammation, limited range of motion and flexibility and she cannot lift heavy objects anymore. She has functional impairment in her left foot as her left big toe does not move anymore. Her thoracic scoliosis causes instability; she tires easily and movement in between her shoulder blades and arms is restricted. She has extended times when she feels uncomfortable – 3 out of 4 weeks. The medications she takes for mental illness cause her to be unsteady on her feet and have ringing in her ears; they also cause nausea, loss of appetite and unusual tiredness.

The balance of the SR addresses how her disability affects her ability to take care of herself. This is also addressed in her Self-Assessment, as summarized below.

Self-Assessment

The appellant's SA is a 6 page advocate-prepared questionnaire in which the appellant checks boxes against aspects of DLA in which she is restricted and with which she requires assistance, providing hand-written detailed comments. The panel has summarized the salient points as follows:

- Meal preparation – chops food for 2-3 minutes and then rests/resumes task/prep time 30-40 minutes; standing at sink or stove, rests one foot on stool for stability; understanding recipes and labels, reads through 2x/maybe understands/goes back again because does not recall information; remembering having food on the stove or in the oven, uses timer.
- Managing money and paying bills – remembering to pay bills and budgeting, needs to keep track in a book and write everything down; therapist gives her strategies for impulse control and reasoning skills.
- Eating – being motivated to eat, disinterested; chewing and swallowing, 3-4 minutes extra; therapist gives her tips to motivate her to eat.
- Shopping – stops and sits every 5 minutes for 5 to 10 minutes; understanding labels and prices, needs to read a couple of times; moving groceries from shelves to cart, can only lift 1-2 lbs at the time; being able to be in a crowded store without feeling anxious or scared, very rare, uses self talk or doesn't go; therapy is the tool she uses for these issues of anxiety and fear.
- Using transportation – doesn't take the bus due to hypersensitivity to cigarette smoke; riding in

a car, front seat only, stops every 20-30 minutes to stretch, uses support cushion; getting in/out of vehicles, periodic support if stiff or inflamed, someone helps; takes elevators instead of stairs when available; therapy is needed because transportation is a huge trigger for her psychologically.

- Housework – washing counters, cleaning bathrooms, washing dishes, vacuuming etc., restricted continuously because of depression and arthritis stiffness and inflammation; manages one task a day, works for 5-10 minutes/rests/resumes task/resumes task/rest again to complete; washing walls and windows, doesn't do it; therapy and a day planner are the tools she uses if she can.
- Mobility inside the home – getting in/out of bed, restricted periodically 2-3x/week, depends on flexibility; walking from room to room, continuous restrictions, depends on inflammation in feet; sitting in chairs, only 20-30 minutes, uses a support cushion; climbing and descending stairs, slowly and deliberately 1-2 steps up and 3-4 steps down then rest, 5-10 minutes extra to get anywhere; uses hot packs and cold packs daily.
- Mobility outside the home – climbing and descending stairs or ramps, same as inside the home; walking more than 1-2 blocks needs to rest; going out without being anxious, daily, severe, 1-2 hours extra to get out the door; needs therapy for anxiety and fear.
- Personal hygiene and self care – remembering or having energy/motivation to bathe every day and to brush teeth and hair everyday, continuous daily restrictions, 20 minutes to think about it and prepare and focus to get these done; therapy needed for motivation.
- Managing personal medication – taking the right amount of medication, compliance and motivation are issues; coping with side effects of medication, with difficulty; psychiatric support is needed.
- Mental and emotional skills – coping with anxiety and agitation, self talk daily 5-6x for 5-10 minutes; coping with depression, stays in bed or isolates but mostly pushes herself; coping with stress, stays in bed, watches DVDs, checks in with therapist; planning ahead, doesn't do it; attending to the most important things first, does one task a day if she can manage it; never-ending always coping and struggling daily; completing tasks, takes 2 hours to motivate herself to complete 1 task/day; never-ending, always coping and struggling daily; therapy and medication are the tools she uses.
- Social skills – socializing without being anxious or scared, never; no interaction with friends and family, strangers; developing and maintaining relationships, doesn't do it; takes her days to ask for help; dealing with unexpected situations, anxiety goes through the roof and takes her 3x longer to process the information and 2x longer to do something about the situation; therapy is the tool she uses.
- Communication – making herself understood, gives several explanations and needs to search for the right words, gives up then gets mad; understanding others, has to ask people to talk slower; speaking or listening to people without becoming anxious and scared, never; medications and therapy are the tools she uses to help her.
- Assistance/supervision required – 17.5 to 20 hours per week.
- Assistance received – from a counsellor, psychiatrist, community support workers and a charitable organization.

Psychiatric Consult Report

The psychiatrist summarizes the appellant's personal (including an assault with being knocked out, and the death of her son) and employment (community service executive and health care) history.

He then reviews the presenting complaints, which include: being very socially isolated; low mood at times, very angry and irritable at other times; feels like her "mind is not working properly;" diminished concentration and drive and poor short term memory; feels like she cannot express herself properly and mixes up her words; so lethargic often in the mornings that it takes her 2 hours to get out of bed and get dressed; has nightmares which are often very distressing and she also has "flashbacks" relating to her son's fatal accident; currently sleeps less than before but at times goes through periods where she sleeps up to 18 hours a day; feels like her mood is fluctuating and has been for a long time; admits to elevated mood at times, when she becomes very irritable and verbally aggressive, periods when she describes as being "angry;" has had long-standing thoughts of suicide, often coming into her mind passively; did slash her wrists, once when she was 14 but has not done anything to herself since then; describes herself as feeling "empty inside" and then goes on to say "I do not know what happiness is."

The psychiatrist also provides the following Mental State Examination:

> "[The appellant] presents as very neat and well-kempt. She is cooperative, well spoken, and friendly. She seems to be a good historian, in general. Her mood, she reports is a little edgy, "worried about the outcome of this consultation." Affect is normal. [The appellant] admits to occasional vague experiences of hearing voices but she describes this as being internal and she sees this as her "spiritual guide." She says the voices always give her guidance and she experiences them as "soft and gentle." This does not seem to amount to true hallucinations, however. There is no formal thought disorder, nor are there any delusions. As mentioned, she has not recently experienced any significant suicidal thoughts. Her sleep has been variable but her appetite, generally, is stable."

The psychiatrist diagnoses the appellant with Post Traumatic Stress Disorder, on history, Mood Disorder, not otherwise specified, and a previously diagnosed Major Depressive Disorder. The current concern is around mood instability – would like to rule out Bipolar Disorder Type II and Borderline Personality Disorder traits.

The psychiatrist reports that he discussed various medication options with the appellant and she agreed to go on a trial of a certain medication. He suggests that the appellant continue with her current therapy process and that a referral to a health authority skills group be considered in the future.

Advocate's written submission

The submission reviewed the evidence set out in the PR and AR and the documents submitted at reconsideration; the balance of the submission went to argument.

Documents submitted on appeal

In her Notice of Appeal dated 20 January 2014, the appellant gave as reasons for appeal: "The ministry has erred in interpretation of the facts & the law."

The appellant's advocate provided a written submission dated 24 January 2014. The submission went to argument (see Part F, Reasons for Panel Decision, below).

The appellant also provided copies of her Self Report and Self-Assessment, as summarized above, endorsed by the appellant's GP with his signature and office stamp on the 2 documents, and dated 24 January 2014.

On 04 February 2014 the appellant submitted a "To whom it may concern" note from the appellant's GP dated 01 February 2014. The note reads as follows:

> [The appellant] is totally disabled with severe depression and PTSD and anxiety all requiring the help of psychiatrist [name]. She is on strong antidepressant and mood stabilizer meds. This is chronic and prevents functioning in society and in public at this time. This is continuous and is not improving and needs weekly counseling and psychiatrist – 1/mo for 2 years."

At the hearing, the appellant's advocate presented argument based on the written submission provided before the hearing.

In her remarks and in answer to questions, the appellant provided the following testimony:

- She described how, with a mental illness, while a person may look normal, it is important to appreciate that anything the person says or does takes a great deal of effort. For her, this is especially the case given the sheer volume of mental and physical issues she faces.
- She explained that the estimate of 17.5 – 20 hours/week in assistance she requires was developed with the help of her counsellor. This amount of time includes the time of her counsellor (a Registered Clinical Counsellor), one or sometimes two visits with her psychiatrist per month, the help of community support workers (who assist her with paperwork that she otherwise could not manage), calls from her pharmacist to remind her about prescription refills, and the occasional help of a friend in her apartment who will drive her to the store or pick up some food for her. She also stated that her sister will visit her once or perhaps twice a month to drive her to her appointments with her GP in another city. The sister will also take that opportunity to bring her some frozen prepared meals and do some housework for her, such as vacuuming.
- The appellant explained that during her visits to him, her psychiatrist reviews her medications and provides psychiatric therapy for her PTSD. He also provides guidance to the counsellor on how she can best help the appellant. The psychiatrist will also take phone calls from the appellant when she feels it necessary to call him.
- She explained that the GP's assessments in the AR that a DLA task (e.g. going to and from stores) showing both "continuous assistance from another person or unable" and "takes significantly longer than typical" reflect how she requires daily help from her counsellor to be motivated to do the task as well as how slowly she is able to complete the task because of her mental and physical issues. As an example, she stated that if she was in the middle of doing something outside the home and became confused or was confronted with a disturbing situation she would text her counsellor for support and advice. She noted that the need for this kind of therapeutic assistance was mentioned for 10 of the 13 areas covered in her Self-Assessment.

The panel finds that the new information provided by the appellant before the hearing and at the hearing is in support of the information before the ministry at the time of the reconsideration. The appellant's SR and SA were before the ministry at reconsideration; the submission supports the information contained therein by carrying the GP's signed endorsement. The letter from the GP

supports and clarifies his earlier assessments in the PR and AR. The testimony of the appellant clarifies the nature of the help provided her in managing her DLA. The panel therefore admits the appellant's testimony pursuant to Section 22(4)(b) of the *Employment and Assistance Act*.

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 determined 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 (1) In this section:

"assistive device" means a device designed to enable a person to perform a daily living activity that, because of a severe mental or physical impairment, the person is unable to perform;

"daily living activity" has the prescribed meaning;

"prescribed professional" has the prescribed meaning.

(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 Considerations

The appellant did not complete a Self Report to accompany her original PWD application. At reconsideration, she submitted her SR and SA (see Part E above); the latter was endorsed by her psychiatrist, not simply by signing it but adding the caveat "Can only comment on mental and emotional impairments, though." On appeal, the appellant submitted the same two documents, this time endorsed by her GP, with an accompanying letter providing his opinion on the severity of the appellant's disability. With the caveat provided by the psychiatrist and the letter provided by the GP, it is the view of the panel that both medical practitioners (who by definition are also prescribed professionals under the legislation) have turned their minds to the document(s) they endorsed and accept the appellant's comments as their own. Accordingly, the panel considers these documents to reflect their opinions on the materials contained in the documents.

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 impairment

For PWD designation, the legislation requires that a severe mental or physical impairment be established. The determination of the severity of impairment is at the discretion of the minister, taking into account all the evidence, including that of the applicant. However, the starting point must be medical evidence, with the legislation requiring that a medical practitioner (in this case, the appellant's GP) identify the impairment and confirm that impairment will continue for at least two years.

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." 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]." This definition is not set out in legislation and is not binding on the panel, but in the panel's view it appropriately describes the legislative intent. The cause is usually set out as a disease, condition, syndrome, injury or even a symptom (e.g. pain or shortness of breath). A severe impairment requires the identified cause to have a significant impact on daily functioning.

The panel also notes that the legislation requires that for PWD designation, the minister must be "satisfied" that the person has a severe mental or physical impairment. For the minister to be "satisfied" that the person's impairment is severe, the panel considers it reasonable for the ministry to expect that the information provided presents a clear and complete picture of the nature and extent of the impacts of the person's medical conditions on daily functioning.

Mental impairment

In the reconsideration decision, the ministry refers to the GP's diagnoses of severe post traumatic stress disorder and severe endogenous depression and notes the GP's report of the appellant's "confusion, brain fog, concentration and mood problems," with several deficits to cognitive and emotional functioning. The ministry notes that there are no difficulties with communications and speaking/reading/writing/hearing as satisfactory. The ministry also notes that continuous restriction to social functioning is described as "isolated and energy loss, suspicious of contact." The ministry notes that of the impacts reported on daily functioning, most are moderate with one major impact on emotion and that periodic support/supervision is required with social functioning with the comment "isolated and needs continuing counseling and help to motivate." The ministry refers to the psychiatrist's consultation report and states that it does not establish a severe mental impairment: treatment recommendations are for medication, continuation of current counseling, and the possibility of referral to a skills group as well as follow-up with the psychiatrist for review in about a month. The ministry's position is that the information as a whole is not supportive of a severe mental condition that significantly restricts the appellant's ability to function either continuously or periodically for extended periods. The ministry also refers to the documents submitted at reconsideration, indicating that they have been reviewed and considered in conjunction with that presented with the original application. The ministry took the position that the new information did not demonstrate either a severe impairment or a significant restriction in the appellant's ability to perform DLA.

The position of the appellant, as set out in her advocate's submission on appeal, is that the ministry appears to discount the opinions of the GP and the psychiatrist as to the severity of the appellant's disability. Both have provided opinions, in the application and in the psychiatric consult report, and endorsed the Self-Assessment. Taken together this information demonstrates that the appellant has a severe mental impairment that directly and significantly restricts her ability to perform DLA both continuously and periodically and that she requires help to perform activities.

Panel findings

The evidence is that the appellant's psychiatrist has diagnosed the appellant with post traumatic stress disorder, mood disorder not otherwise specified and a previously diagnosed major depressive disorder. What is at issue here is how significantly these mental health conditions directly and significantly restrict the appellant's daily functioning. To the panel, it appears that the ministry based its determination that a severe mental impairment had not been established on the check marks in the PR and AR relating to ability to communicate, cognitive and emotional deficits, the number of major and moderate impacts of these deficits on daily functioning, the periodic support/supervision required for the listed areas of social functioning, and marginal functioning assessed for relationships with immediate and extended social networks. The panel notes that there is not much further commentary provided by the GP that might support a different decision based on the original application.

On further examination of the reconsideration decision, however, the panel notes the following:

- The ministry refers to the psychiatric consult report and states that this did not establish a severe mental impairment. Strictly speaking, this may be the case, as the psychiatrist did not directly assess and report on the impacts of her mental health condition on her daily functioning. However, based on the appellant's history and presenting complaints and even

with the relatively positive Mental State Examination (quoted in its entirety in Part D above), the psychiatrist diagnosed the appellant with PTSD, major depressive disorder and mood disorder not otherwise specified. If he did not consider the impacts of these conditions on her daily functioning to be significant, he would not have recommended the comprehensive treatment regime he did – not only strong anti-depressant and mood stabilizer medication, but also weekly therapy.

- The ministry also notes that of the reported impacts on daily functioning, most are moderate with only one major impact – on emotion (inappropriate anxiety, depression). The panel notes that the prescribed professional providing these impact assessments is asked to do so on a relative basis – from no impact, minimal impact, moderate impact to major impact. Considering the psychiatrist's diagnoses of mood disorders, it is not surprising that the GP would give the highest relative impact rating to emotion as this is the one of overwhelming importance and the one for which treatment has been prescribed. The panel does not consider it reasonable to minimize the impacts of the 8 other areas – bodily functions, consciousness, impulse control, insight and judgment, attention/concentration, executive, memory, and motivation – just because, in relative terms, they are assessed as "moderate."

Moreover, at reconsideration the ministry had available to it the SR and SA, the latter endorsed by the psychiatrist with the caveat noted above. On review of the SA in particular, the panel notes that the ministry did not take into account many significant impacts on daily functioning resulting from her mental health conditions for which the appellant requires ongoing assistance from her therapist. Some examples: eating – she is disinterested in eating and her therapist gives her tips to motivate her; managing money and paying bills – therapist gives her strategies for impulse control; shopping – therapist gives her the tools to use for the issues of anxiety and fear while shopping; using transportation – therapy is needed because transportation is a huge trigger for her psychologically; mobility outside the home – going outside without being anxious or scared, takes 1-2 hours to get out the door, needs therapy for anxiety and fear; personal self care – bathing every day and brushing teeth and hair, needs 20 minutes to think about it and prepare to do it, needs therapy for motivation; social skills – asking for help, takes her days to ask; dealing with unexpected situations, anxiety goes through the roof; therapy is needed for these issues.

The panel notes that the SR and SA are coherent and comprehensive. This is not surprising given the executive and health care background of the appellant. The panel would estimate that a person in good mental health with her background would have been able to put together these documents independently in a couple of hours. In fact, she reports in the SR that it took her 2 weeks to complete them, and only with the assistance of her therapist and community service workers. To the panel, this speaks to the extent to which the appellant requires assistance to complete the simplest of tasks.

The panel recognizes that there are some inconsistencies between the psychiatrist's consult report as to how the appellant "presents" and some information in the SA, such as regarding her appetite vs. difficulty eating, and being "well spoken" vs. her account of difficulties expressing herself. This may be explained by the difference between how a person "presents" in a doctor's office and how she is actually able to manage her life. Also, the psychiatrist prepared his consult report after a first appointment in August 2013 and endorsed the SA 4 months later, in December 2013, when he would have had the opportunity to get to know her better. There are also some difficulties reconciling the evidence that the appellant is able to go out in public, meeting with her therapist and shopping, while the GP states that her condition "prevents functioning in society or in public at this time." It may be

that the GP was referring to employment, not a relevant consideration here, or to a more active social life but this does not negate his statement that her condition is not improving and she needs weekly counseling and continuing monitoring and therapy from the psychologist. Similarly, in the AR the GP has assessed the appellant requiring periodic, not continuous, support/supervision in the 5 areas of social functioning and has not explained the change in assessment implied in his letter submitted on appeal.

Despite these inconsistencies, the panel views the evidence as demonstrating the degree to which the appellant's mental health conditions restrict her ability to function independently and effectively, to the extent that she requires ongoing weekly, and often more frequent, support from her therapist. Although the ministry did not have the benefit at reconsideration of being advised of the GP's endorsement of the appellant's SR and SA and his letter submitted on appeal, the panel finds that, considering the evidence in its entirety, the ministry was not reasonable in determining that a severe mental impairment had not been established.

Physical impairment

The position of the ministry is that it is not satisfied that the information provided is evidence of a severe physical impairment. In reaching this determination, the ministry reviewed the GP's assessment of functional skills (able to walk 1-2 blocks, etc) and noted that while periodic help is required- to do most aspects of mobility and physical abilities, no frequency or duration is provided to determine the significance of such help from other people. These tasks take longer to perform, but no further information is provided. No assistive devices are required. While pain from arthritic joints causes problems, remedial measures such as analgesics are available to ameliorate the pain and allow for better functionality. The functional skill limitations are not significantly restricted.

The position of the appellant, as set out in her advocate's submission on appeal, is that the ministry appears to discount the opinions of the GP and the psychiatrist as to the severity of the appellant's disability. Both have provided opinions in the application and in the psychiatric consult report and endorsed the Self-Assessment. These indicate that the appellant has a severe physical impairment that directly and significantly restricts her ability to perform DLA both continuously and periodically and that she requires help to perform activities.

Panel findings

The evidence is that the appellant has been diagnosed with the following physical conditions: bronchial environmental spasm, arthritis in her hands and feet and thoracic scoliosis. For the determination of a severe physical impairment, the issue is the extent to which these conditions restrict her daily functioning. As the ministry noted, the GP reports that the appellant can walk 1 to 2 blocks unaided, climb 2 to 5 steps, lift 5 to 15 lbs. and remain seated for 1 to 2 hours. In the AR the GP assesses the appellant independent for walking indoors and requiring periodic assistance from another person for walking outdoors, climbing stairs, standing, lifting, and carrying and holding, commenting "back pain" for the functions where periodic assistance is required.

As to restrictions to DLA where physical effort is required, the GP assesses the appellant as both requiring assistance from another person or unable and taking significantly longer than typical for housekeeping and laundry and for going to and from stores and carrying purchases home. At the

hearing, the appellant explained this "double assessment" as how she requires daily help from her counsellor to be motivated to do the task as well as how slowly she is able to complete the task because of her mental and physical issues.

In her SA, the appellant explains that for most cleaning tasks she is restricted continuously because of depression and arthritis stiffness and inflammation. She reports that she can manage one task a day, working for 5-10 minutes then resting. Similarly for mobility inside and outside the home she walks more than 1-2 blocks without resting, climbs stairs slowly and deliberately, resting after 1-2 steps. While the reconsideration decision did not review the material in the SA, the panel's overall impression is that while the appellant's physical conditions contribute to her restrictions in managing DLA, given her explanation of the "double assessments," she can manage most tasks requiring physical effort, albeit slowly, once she has motivated herself to do so and drawn on the support and advice of her counsellor to face the anxiety and fear that goes with the task, particularly those outside the home. On this basis, the panel therefore finds the ministry was reasonable in determining that a severe physical impairment had not been established.

Significant restrictions in the ability to perform DLA.

In the reconsideration decision, the ministry notes that a severe impairment has not been established. The ministry refers to the PR, wherein the GP reported continuous restrictions to 7 of 10 DLA and to the AR where the GP assesses continuous assistance from another person required with basic housekeeping, going to/from stores, carrying purchases home, using public transit and using transit schedules. The ministry notes, however, that the appellant in her SA reported walking independently and shopping with the use of a metal carry cart. When she reads labels a couple of times, she is able to assimilate the information. The ministry asserts that pain medication will ease her pain and allow for better functionality. The ministry states that as the appellant is sensitive to cigarette smoke, transit is limited for this reason – not that she is unable to use transit or unable to manage transit schedules. For these reasons, the need for help from another person is not considered to be continuous or periodic for extended periods.

The ministry notes that periodic help from another person is reported for several tasks but there is no information on the frequency or duration of help from another person, and her SA establishes that she is able to perform these tasks with modifications in activity (rest breaks etc.) A number of tasks take longer to perform.

The ministry further notes that periodic support/supervision is reported with all aspects of social functioning and continued counseling with the appellant's clinical counsellor is recommended.

The ministry, taking into consideration the appellant's self report and explanation of performance of DLA, and as the information from the GP does not establish a significant restriction in her ability to perform the majority of DLA, the global information including that from her prescribed professional does not establish that impairment significantly restricts DLA either continuously or periodically for extended periods.

The position of the appellant is that the GP has indicated that the appellant takes significantly longer and requires periodic or continuous assistance with meal preparation, basic housework, daily shopping, mobility inside the home, mobility outside the home, management of finances and social

functioning. The psychiatrist has reviewed and endorsed the appellant's SA of restrictions in DLA. There is sufficient evidence to establish that this criterion has been met.

Panel findings

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, with a severe mental impairment having been established in this appeal. This DLA criterion must also be considered in terms of the framework of the legislation, which starts with the provision that the minister may designate a person as a person with disabilities "if the minister is satisfied that" the criteria are met, including this one. In exercising the discretion conferred by the legislation, it is reasonable that the minister would expect that the opinion of a prescribed professional be substantiated by information that would satisfy the minister that there are direct and significant restrictions in the ability to perform DLA, either continuously or periodically for an extended period. As discussed above under evidentiary considerations, the panel has found that the information provided in the SA and endorsed by the GP and the psychiatrist can be considered as reflecting the opinion of a prescribed professional.

As a severe mental, though not a severe physical, impairment has been established in this appeal, the panel will consider how significantly the appellant's DLA are restricted as a result of her mental health conditions.

Turning first to those DLA applicable to a person with a severe mental impairment, namely make decisions about personal activities, care or finances and relate to, communicate or interact with others effectively, as noted under severity of impairment above, the GP assessed the appellant requiring periodic support/supervision in these areas. Although the GP did not explain his change in assessment, in his letter on appeal he has given his clear and unequivocal opinion that the appellant's condition "is chronic …and is not improving and needs weekly counseling and psychiatrist – 1/mo for 2 years," thus implying that continuous support/supervision is required for these social functioning DLA. In terms of relating to others, the SA, endorsed by both the GP and the psychiatrist, makes plain that the appellant's fear, anxiety and depression significantly restricts her social life. From the summary of the SA in Part E above: *Social skills – socializing without being anxious or scared, never; no interaction with friends and family, strangers; developing and maintaining relationships, doesn't do it.* Regarding decision making, the GP assessed periodic help required in such areas as managing finances (pay rent and bills), making appropriate choices while shopping, dealing with unexpected demands and securing assistance from others. From the SA, it is clear that "periodic assistance" actually means weekly, sometimes daily, support and guidance from the appellant's counselor: *Takes her days to ask for help; dealing with unexpected situations, anxiety goes through the roof and takes her 3x longer to process the information and 2x longer to do something about the situation; therapy is the tool she uses.*

More generally, the panel considers it reasonable to read paragraphs (i) and (ii) of subsection 2(b) of the EAPWDA together:

2(2)The minister may designate a person … as a person with disabilities…if the minister is satisfied that the person has a severe mental or physical impairment that

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.

Taking this approach, the panel considers it reasonable to rely on the information of help provided as an indicator of how significantly the person's ability to perform DLA is restricted.

In the reconsideration decision, the ministry has noted those tasks for which the GP indicates continuous or periodic assistance from another person, then refers to the SA, which the ministry interprets to suggest that the appellant manages to "get by," as there is no information provided about help from another person for such DLA as housework, shopping, cooking or personal care or the use of an assistive device. The ministry uses as an example that the appellant reports in the SA that she has to read labels a couple of times, with the implied question "Doesn't everyone?" Maybe so, but this entry, along with others about reading recipes twice or using a timer on the stove, also indicates that the appellant is self-aware of how her short-term memory is deteriorating and how this affects her daily functioning. And while the ministry has given weight to this example, it has given no weight to the frequent references in the SA to the appellant's reliance on her therapist for ongoing support, tools and strategies across the whole range of DLA to get her motivated to get out of bed, take care of herself, do her housework and go out the door to do her shopping and other errands. Both the GP and the psychiatrist have stressed the need for ongoing counseling, and the therapy provided in dealing with her mental health conditions and living her life as best she is able. The panel considers this need for help, as prescribed by her physicians, as a reliable indicator of the degree to which the appellant's ability to perform DLA is continuously restricted.

For these reasons, the panel finds that the ministry was not reasonable in determining that this criterion had not been met.

Help with DLA

The ministry's position 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.

The appellant's position is that she requires ongoing help from others, particularly from her counsellor as well as from her sister and her friend.

Panel findings

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 help provided to the appellant from her sister and her friend (driving, picking up groceries, bringing food) is, in the panel's view, to meet the appellant's needs arising from her physical impairment and not so much from her severe mental impairment. For the reasons set out above regarding significant restrictions in the ability to perform DLA, the panel finds that the ministry was not reasonable in considering the 17.5 - 20 hours/week of help provided by the appellant's counselor and others as significant help or supervision provided as a result of significant restrictions in her ability to perform DLA. The panel therefore finds that the ministry unreasonably determined that this criterion had not been met.

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 not reasonably supported by the evidence. The panel therefore rescinds the ministry's decision.