APPEAL

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 12 June 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 his ability to perform daily living activities (DLA) either continuously or periodically for extended periods; and,

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

The ministry determined 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

PART E – Summary of Facts

With the consent of parties, this hearing was conducted in writing pursuant to 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 10 December 2013. The appellant chose not to complete a Self Report. The Application contained:
   - A Physician Report (PR) dated 19 December 2013, completed by a general practitioner/hospitalist (GP) who had seen the appellant multiple times on hospital rounds during his hospital stay, caring for him since 04 November 2013.
   - An Assessor Report (AR) dated 19 December 2013, completed by a nurse practitioner (NP) who had met the appellant once; she worked in the patient assessment and transition to home unit of the same hospital.
   - A letter from a hospital social worker dated 02 December 2013.

2. The appellant's Request for Reconsideration, dated 09 June 2014, with no reasons given.

Physician Report

In the PR, the GP diagnoses the appellant's impairment as hepatitis C, onset 2009. The GP confirms that the appellant's impairment will likely continue for two years or more, commenting that a transplant will take approximately one year for the body to rehabilitate before he will then start hepatitis C treatment, which will last for approximately 2 years.

Under health history, the GP notes muscle wasting, fatigue and memory loss explaining that total bilirubin levels can cause itchiness, fatigue, and encephalopathy (change in level of consciousness). The appellant has had to go to multiple doctor appointments while waiting for a liver transplant – (recently approved, 16 December 2013). Once transplanted, he will have to take anti-rejection drugs for life, with potential side effects: tired, off balance, not coherent. Chronic hyponatremia (low sodium) symptoms can include but are not limited to nausea, vomiting, fatigue, weakness. Abdomen CT scan (20 October 2013) showed scarring of the liver (cirrhosis), liver nodules, and large spleen, distended gallbladder with related stones.

Under additional comments, the GP writes that the appellant was admitted to the hospital on 28 October 2013 for a three month history of feeling weak/unwell. During the admission, he has been treated for low sodium (hyponatremia). His INR value has been high. The INR value indicates the body's ability to clot blood and if the value is high there is a greater risk for bleeding.

The GP noted that the appellant's height and weight are relevant: 5' 11" and 85 kg.

The GP indicated that the appellant had not been prescribed any medication and/or treatments that interfere with his ability to perform DLA.. She also reports that the appellant does not require any prostheses or aids for his impairment.

As to functional skills, the GP reports that the appellant can walk 4+ blocks unaided, climb 5+ steps, lift 15 to 35 lbs. and has no limitation as to remaining seated. The GP reports that the appellant has no difficulties with communication.

The GP reports that the appellant has significant deficits with cognitive and emotional function in the areas of memory and attention or sustained concentration, commenting that the appellant scored 26/30 on an MMSE test on 19 December 2013. [Panel note: MMSE = mini-mental state examination. A score of 26 - 30 is considered normal in the general population.] He did have decreased level of consciousness when initially admitted to hospital (delirium).

Regarding the ability to perform DLA, the GP reports that the appellant's impairment does not restrict his ability to perform DLA. The GP indicates that the appellant is not restricted in all areas: personal self care, meal preparation, management of medications, basic housework, daily shopping, mobility inside and outside the home, use of transportation, management of finances and social functioning.

Assessor Report

In the AR, the NP reports that the appellant is currently homeless.

The NP assesses the appellant's ability to communicate as good in all areas: speaking, reading, writing, and hearing.

Regarding mobility and physical ability, the NP assesses the appellant as independent for walking indoors, walking outdoors, climbing stairs, standing and lifting. No assessment is provided for carrying and holding.

In terms of cognitive and emotional functioning, the NP assesses a moderate impact of the appellant's impairment on daily functioning in 6 areas: consciousness, emotion, attention/concentration, executive, memory and motivation. A minimal impact is assessed in the areas of bodily functions and motor activity. No impact is assessed in the following areas: impulse control, insight and judgment, language, psychotic symptoms, other neuropsychological problems, and other emotional or mental problems. The NP reports the same MMSE score (26/30) as the GP.

As to assistance required in performing DLA, the NP assesses the appellant as independent in all aspects of personal care, basic housekeeping, paying rent and bills, medications and transportation. The NP assesses the appellant requiring periodic assistance from another person for all aspects of shopping: going to and from stores, reading prices and labels, making appropriate choices, paying for purchases, and carrying purchases home. Regarding meals, the NP assesses the appellant requiring periodic assistance from another person for safe storage of food and independent in all other aspects: meal planning, food preparation and cooking.

With respect to social functioning, the NP assesses the appellant as independent for making appropriate social decisions, ability to develop and maintain relationships, interacting appropriately with others, and ability to secure assistance from others. The NP assesses him as requiring periodic support/supervision for ability to deal appropriately with unexpected demands.

The NP describes the appellant's relationship with both his immediate and extended social networks as marginal functioning.

Apart from the reference to the MMSE score, the NP provides no other commentary regarding the

above assessments.

Social worker's letter

The SW's letter predates the PWD designation application. The SW notes that the appellant's file is open with the ministry but he has been denied PWD designation. However, she believes he would qualify now as his health status is quite precarious and this can be verified by his physicians. He has been hospitalized since 28 October 2013 and cannot go back to his former living arrangements due to his former residence being incompatible with his current health status. Therefore he is currently homeless and looking for suitable accommodation. She seeks advice from her ministry contact as to how to proceed with PWD designation.

Information submitted after reconsideration.

The appellant submitted his Notice of Appeal on 23 June 2014, stating: "Please see psychiatrist's letter." Attached to the Notice of Appeal was a letter/consultation report from a health authority hospital psychiatrist dated 23 June 2014. This letter had the following attachments:

- A mental health unit referral screening by the hospital intake and cognitive therapist dated 11 June 2014.
- A letter from a specialist in internal medicine dated 27 May 2014.
- 3 reports of visits to the hospital emergency room by the appellant.

In her letter, the psychiatrist writes:

> "I will address this letter primarily to the Appeals Tribunal as the patient has recently been denied PWD and as I review the material, I can see readily that the person who filled out the application was not aware of the necessary essential components on an application form that will be considered successful."

Later, the psychiatrist goes on to write:

> "This patient who has a life threatening illness is in most dire need of increased financial aids and some of the benefits the PWD status can provide him. Withholding this will likely cost this man his life. The most valuable thing I can do for this man's mental state is to have this appeal support letter sent immediately. I would also request that it be considered an emergency appeal as time is of the essence and I would hope that in future when people are turned down for PWD due to inadequate information, it might be sent back to the referring agency with clarification about paucity of information causing a negative decision."

In a late submission dated 28 July 2014 to the written hearing, accepted by the panel chair, the ministry wrote:

> "At the time of the reconsideration decision was made the attached information was not provided. The Minister made the decision based on the evidence at the time. The Minister acknowledges the submission of the supplemental information as it was intended for the reconsideration decision and does not object to the supplemental information. If this information had been submitted at the time of the reconsideration decision, it may have resulted in an approval."

The panel will summarize the relevant information from this "supplemental information."

Psychiatrist's letter

The psychiatrist writes:

> "Please be advised that this man suffers with a myriad of diagnoses. His multiple diagnoses include cirrhosis of liver advanced, hepatitis C, chronic organic brain syndrome secondary to hepatotoxicity, alcohol addiction/remote, substance abuse and addiction/remote, type II diabetes, cholelithiasis and gastroesophageal reflux disease. This list of diagnoses is not complete but it highlights the best of my understanding of this diagnoses at this date."

And:

> "This patient also upon today's assessment would clearly have adjustment disorder with depressed and anxious mood secondary to his multiple medical diagnoses. He would also fulfill criterion for dysthymic disorder and likely generalized anxiety disorder.

The psychiatrist writes that the appellant is currently being assessed for a liver transplant and it is obvious from the consultation reports that he will not have long to live if he is not successful in procuring a transplant. Critical to that is his need to be in a safe and supportive environment for his post-op recovery. The appellant and his father have attempted to find him a home where an RN presides. His extreme financial distress is certainly a huge hindrance and if not rectified very quickly, may prematurely end his life.

In terms of mental status, the psychiatrist writes that examination reveals a large man who moves slowly and appears fatigued. He is oriented. He is cooperative and coherent. At times in the interview, his lids seemed heavy and he does seem fatigued but he does stay on topic and is loose throughout. Mood is assessed to be anxious and depressed, not acutely suicidal, not psychotic, and cognitively intact. Intelligence is assessed to be average with wide fluctuations. Insight is assessed to be fair to good. Judgment is assessed to be fair.

Mental health unit referral screening

- Presenting problems – anxiety, medical/physical concerns, mood alteration and recovery from substance misuse.
- History of mental illness – "History of depression and anxiety in the context of substance misuse and life circumstances. Client reports he currently experiences lots of anxiety including automatic thoughts and negative appraisal, particularly at night that prevent him from sleeping well. He does report panic attacks but was not able to be specific regarding frequency and duration other than to say he has been having them for years. When he becomes very anxious he reports overeating to compensate. Client states depression symptoms are secondary to anxiety but does experience depressive symptoms especially regarding his current financial and living circumstances and complications with his health and finances from IA due to hospitalization. Client states he has difficulty falling asleep due to an internal voice that won't stop when he is trying to sleep. Client states this is the automatic thoughts, not a psychotic type voice. Client states his appetite is normal and weight is stable, as is his energy level most days. He reports some problems with short-term memory and concentration along with anhedonia. He is physically active, but does have some problems around ADLs."

- Social history – "…Client appears to have maintained a minimal standard of life since [the early 1980's], although he reports being sober from alcohol for 25 years. Client reports being clean from cocaine for 8 - 10 months."
- Clinical impressions – adjustment disorder and anxiety disorder.
- Current CGI [clinical global impression] – "moderately ill."
- Recommendations – referral to a rapid access clinic.

Subsequently, on 12 June 2014 the appellant was referred to the rapid access clinic by his family physician, who wrote under presenting issues: "Depression and anxiety. Frequent admission to hospital because of his cirrhosis of liver and financial difficulty."

Letter from a specialist in internal medicine

The specialist writes:

> [The appellant] is struggling with his cirrhosis, end-stage liver disease, and encephalopathy. He is now living alone temporarily in a hotel, and caring for himself although he has a community pharmacy delivering his medications daily. He has returned to [name of hospital] repeatedly, primarily with symptoms of encephalopathy, and improves somewhat and is discharged. He does have periods of some confusion. Chronic fatigue…"

The specialist lists the appellant's medications, then goes on to write:

> "This man clearly requires a liver transplantation. He is really just barely managing now, and clearly he requires more community support. He returns to [the hospital] fairly frequently which is appropriate here. He doesn't really have any other better options. I suspect that he might ultimately simply be admitted to [the hospital] at an alternative level of care while awaiting transplantation but hopefully he can continue to function on an outpatient basis…"
>
> "P.S. I have now received [doctor's name] note stating that they cannot consider him for liver transplantation as he has essentially no social supports in the community..."

Reports of visits to the hospital emergency room (ER reports)

- Date: 25/26 May 2014. Treatment/course in hospital: "The patient was brought to hospital to Emerge on May 25, 2014 as his father told the ER physician that he was confused about his medications. The patient had some heartburn overnight for which he was given [medication]. Upon me seeing him today, he is not confused all. His ammonia is 20. He is wanting to go home. I see no reason to keep him here. He is medically stable."

- Date: 04/05 May 2014. History of presenting complaint: "[The appellant] arrived in the emergency department confused yesterday, on May 4, 2014. The triage nurse simply states 'looks well; he is confused.' Clear that became worse. It is unclear how he arrived at the emergency department. He has previously attended the emergency room confused after exacerbations of hepatic encephalopathy relating to noncompliance with medications. I see that there were 2 admissions in March relating to this and 1 in April 2014…" Assessment and plan: "Confused – likely secondary to hepatic encephalopathy secondary to possibly not taking [medication]. We will provide [medication] for him and follow his ammonia..."

- Date: 15/18 April 2012. History of presenting illness: "This is a [late 50's] male, coming with

increasing weakness. Denied chest pain. No fever. No abdominal pain. No diarrhea. He is not really taking his [medication] properly, and this is his third admission in the past few months. He is very confused, and he is also drowsy." Assessment: "We will admit him. We will start the [medication] again. I will speak with [name of physician] to find out the plan from him tomorrow and if he is still on the transplantation list..."

Admissibility of the supplemental information

Since the ministry acknowledges the submission of the supplemental information as it was intended for the reconsideration decision and does not object to the supplemental information, the panel will admit this information, pursuant to section 22(4) of the *Employment and Assistance Act*, as evidence being in support of the records and information that were before the ministry at reconsideration.

The panel will consider the psychiatrist's comments concerning the consequences for the appellant of not being designated as PWD only to the extent that it is relevant to the application of the legislation (see Part F, Reasons for Panel Decision, below). The panel will give no weight to the ministry's comment that If this information had been submitted at the time of the reconsideration decision, it may have resulted in an approval, as the ministry provided no reasons for this opinion.

APPEA

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 determined 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 (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.

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 identify the impairment and confirm that impairment will continue for at least two years.

In the discussion below concerning the severity of the appellant's impairments, the panel has drawn upon the ministry's definition of "impairment" as provided in 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, 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 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.

Physical impairment

In the reconsideration decision, the ministry reviewed the evidence regarding the appellant's physical functioning (able to walk 4+ blocks unaided, etc.), noting that he is independently able to do all aspects of mobility and physical abilities. No assistive devices are routinely used to help compensate for his impairment. The position of the ministry is that the functional skill limitations are not significantly restricted and that the ministry is not satisfied that the information provided is evidence of a severe physical impairment.

The appellant's position, as argued by the hospital psychiatrist, is that the appellant suffers from a myriad of diagnoses including cirrhosis of the liver advanced, hepatitis C, chronic organic brain syndrome secondary to hepatotoxicity, type II diabetes, and cholelithiasis. He will not have long to live if he is not successful in procuring a liver transplant. The appellant, who has a life threatening illness, is in most dire need of increased financial aid and some of the benefits of PWD status. Withholding this will likely cost this man his life. In light of these considerations, it is clear that the appellant has a severe physical impairment as required for PWD designation.

Panel findings

The evidence is that in the PR, the GP diagnosed the appellant with cirrhosis of liver, with a liver transplant in prospect. The hospital psychiatrist reported other internal medicine diagnoses – hepatitis C, chronic organic brain syndrome secondary to hepatotoxicity, type II diabetes, and cholelithiasis. On the appellant's visits to the ER, the ER physician reported hepatic encephalopathy, secondary to not taking medicine. The panel will consider chronic organic brain syndrome secondary to hepatotoxicity and hepatic encephalopathy to be similar and will address these conditions under mental impairment below.

The panel notes that the diagnosis and treatment of a medical condition, even a life-threatening one, are not in themselves determinative of a severe impairment: as noted above, the severity of impairment must be assessed in terms of impact of the medical condition on daily functioning, including ability to perform DLA. The legislation is also clear that the minister must be satisfied that the person *has* [panel emphasis] a severe mental or physical impairment – the legislation speaks to the degree of impairment at the time when the decision is made, not to some time in the future. In the PR, the GP comments that after a liver transplant the appellant will have to take anti-rejection drugs for life, with possible side effects such as being tired, off balance, not coherent. The GP implies that there will also be significant side effects later with hepatitis C treatment. However, the legislation does not provide for the ministry to take into account future, possible restrictions in the appellant's ability to perform DLA: the ministry can reasonably be expected to assess only current restrictions.

In the mental health referral screening, the therapist reports that the appellant is physically active, but does have some problems around ADLs. However, no description of the nature and extent of these problems is provided.

In his letter, the specialist in internal medicine states that the appellant "is really just barely managing now. Clearly he requires more community support." The hospital psychiatrist refers to the appellant's "frequent hospital admission because of this advanced cirrhosis of the liver, and financial difficulties and difficulties obtaining the necessary supports to proceed with transplantation." She also notes that "his extreme financial distress is certainly a huge hindrance." She refers to the appellant and his father having attempted to find him a home where an RN presides. The panel notes that financial need is not a criterion for PWD designation. Help required, in the form of the significant help or supervision from another person (or the use of an assistive device or the services of an assistance animal), is a criterion for PWD designation, provided such help is necessary for the person to perform DLA which are directly and significantly restricted by a severe impairment, either continuously or periodically for extended periods. While the specialist in internal medicine and the psychiatrist both refer to the appellant's need for community support, no description is provided as to what such support entails and for what DLA this support would help the appellant perform.

In addressing the impact the appellant's impairment on his ability to perform DLA requiring physical effort, both the GP and the NP have reported consistent assessments, with the GP reporting that the appellant is not restricted in all DLA, and the NP assessing the appellant as independent in all aspects of all DLA requiring physical effort, with the exception of shopping, where periodic help from another person is required (though no explanation is provided) and for one aspect of meals, namely safe storage of food (again no explanation is provided). In the original reports, the GP who treated the appellant for close to two months in hospital and the NP who also saw the appellant in hospital have

consistently assessed the appellant as having no limitations to his functional skills and as being independent in all aspects of mobility and physical ability.

On the basis of the foregoing, and taking account the evidence provided, including the supplemental information, the panel finds that the ministry was reasonable in determining that a severe physical impairment had not been established.

Mental impairment.

In the reconsideration decision, the ministry notes that in the PR the GP did not confirm a mental health diagnosis and states that MMSE is 26/30 on 19 December 2013 (decreased level of consciousness when initially admitted to hospital – delirium). Two deficits to cognitive and emotional functioning are reported – in the areas of memory and attention/concentration. Communication is good with no difficulty. No restriction to social functioning is reported. The NP indicated minimal to moderate impacts on daily functioning based on MMSE. The position of the ministry is that the information and narrative are not supportive of a severe mental health condition that significantly limits the appellant's ability to function either continuously or periodically for extended periods. The ministry was therefore not satisfied that the information provided is evidence of a severe mental impairment.

The appellant's position, as put forward by the hospital psychiatrist, is that the appellant suffers from anxiety and depression, as well as adjustment disorder, dysthymic disorder and likely generalized anxiety disorder. With these diagnoses, it is clear that the appellant has a severe mental impairment

Panel findings

In the PR, the GP did not diagnose the appellant with any mental health conditions, although she did refer to a history of encephalopathy (loss of global consciousness) and identified significant deficits with cognitive and emotional function in the areas of memory and attention or sustained concentration. The NP, without reference to any mental health condition, assessed moderate impacts of a mental impairment in six areas, including consciousness, emotion, attention/concentration and memory. The NP provided no commentary, except referring to the appellant's MMSE score.

The psychologist, drawing on the mental health unit intake report, diagnoses the appellant with anxiety and depression, as well as adjustment disorder, dysthymic disorder and likely generalized anxiety disorder. However, with the exception noted below, the panel cannot find anywhere in the supplemental information any description or assessment as to how and to what extant these mental health conditions restrict the appellant's ability to perform DLA, particularly with regard to making decisions about personal activities, care or finances or relating to, communicating or interacting with others effectively. In the AR, the NP assesses the appellant as requiring periodic support/supervision for dealing appropriately with unexpected demands; he is assessed as independent in all other decision-making areas. The NP describes the appellant's relationship with his immediate and extended social networks as marginal functioning, but provides no explanation and no description of any support/supervision required which would help to maintain him in the community.

The one exception is with regard to the appellant's bouts of hepatic encephalopathy. The evidence from the ER reports suggests that this medical condition, when the appellant does not take his

medication, leads to confusion or delirium. This indicates to the panel that the appellant has some difficulty with the DLA of managing personal medication. This has led to repeated hospital visits, where the presenting situation quickly resolves with medication. No restrictions for this DLA were identified in the PR or AR, and the supplementary information contains no further information as to the appellant's ability to manage his medication, except for the general comments by the physician and the specialist internal medicine that he requires support or a supportive environment.

Given the lack of information, both in the PR and AR and in the supplemental information, regarding the impacts of the appellant's mental health conditions on daily functioning, the panel finds the ministry was reasonable in determining that a severe mental impairment had not been established.

Significant restrictions in the ability to perform DLA.

The position of the ministry is that, as the majority of his DLA are performed independently or require little help from others, the information from the prescribed professionals does not establish that impairment significantly restricts DLA either continuously or periodically for extended periods.

The appellant's position is that the specialist in internal medicine has stated that the appellant can barely function on his own and the psychiatrist has indicated that he must live in a supportive environment. This evidence clearly shows that it is the opinion of these medical practitioners/prescribed professionals the appellant's physical and mental impairments directly and significantly restrict his ability to perform DLA, both now while he is awaiting a liver transplant and afterwards as he recovers and begins hepatitis C treatment.

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, a criterion which has not been established in this appeal. This DLA criterion must also be considered in terms of the preceding legislative language of section 2 of the *EAPWDA*, which provides 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 from the prescribed professional that would satisfy the minister that there are direct and significant restrictions in the ability to perform DLA, either continuously or periodically for extended periods, by presenting a clear and complete picture of the nature and extent of these restrictions.

The panel has reviewed in detail above, under severity of impairment, the evidence relating to the impacts of the appellant's physical and mental impairments as presented in the PR and AR and in the supplemental information. To summarize: the GP has assessed the appellant as independent for all DLA; the NP has assessed him independent in all DLA, with the exception of requiring periodic assistance from another person for all aspects of shopping, one aspect of meal preparation and one aspect of the social functioning DLA of making decisions about personal activities, care or finances; marginal functioning with immediate and extended social networks is also reported. The NP does not provide any commentary as to the nature or extent of help required for these reported restrictions. The GP reports the appellant having significant deficits in cognitive and emotional function in two

areas – memory and attention or sustained concentration and the NP identifies six areas of moderate impact of mental impairment on daily functioning; in each case however, no commentary is provided that would provide a clearer picture of these impacts, except notes relating to an MMSE score at the bottom of the "normal" range.

The psychiatrist has added reported diagnoses relating to the appellant's internal medicine conditions and his mental health disorders. With particular reference to the diagnosed mental health disorders, neither the psychiatrist nor the mental health referral therapist provides any information on the impact of these disorders on the appellant's ability to perform DLA and in particular regarding the DLA of making decisions about personal activities, care or finances and relating to, communicating or interacting with others effectively.

There is some inferential evidence, from the ER reports, that there is an interaction between appellant's encephalopathy and his ability to manage personal medication. However, to the extent that there is a restriction in the appellant's ability to manage this DLA, it is not directly addressed in the supplemental information, while in the PR and AR, the appellant is assessed by the GP and NP who treated him in hospital as independent for this DLA.

As a severe impairment has not been established and on the basis of careful review of all the evidence, the panel finds that the ministry was reasonable in determining that the information from the prescribed professionals does not establish that impairment significantly restricts DLA either continuously or periodically for extended periods.

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 position of the appellant is that he needs the help that would come from living in a supportive environment.

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. While the evidence is that the appellant would benefit from living in a supportive environment, 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. The panel therefore confirms the ministry's decision.

impact of mental impairment on daily functioning; in each case however, no commentary is provided that would provide a clearer picture of these impacts, except notes relating to an MMSE score at the bottom of the "normal" range.

The psychiatrist has added reported diagnoses relating to the appellant's internal medicine conditions and his mental health disorders. With particular reference to the diagnosed mental health disorders, neither the psychiatrist nor the mental health referral therapist provides any information on the impact of these disorders on the appellant's ability to perform DLA and in particular regarding the DLA of making decisions about personal activities, care or finances and relating to, communicating or interacting with others effectively.

There is some inferential evidence, from the ER reports, that there is an interaction between appellant's encephalopathy and his ability to manage personal medication. However, to the extent that there is a restriction in the appellant's ability to manage this DLA, it is not directly addressed in the supplemental information, while in the PR and AR, the appellant is assessed by the GP and NP who treated him in hospital as independent for this DLA.

As a severe impairment has not been established and on the basis of careful review of all the evidence, the panel finds that the ministry was reasonable in determining that the information from the prescribed professionals does not establish that impairment significantly restricts DLA either continuously or periodically for extended periods.

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The position of the appellant is that he needs the help that would come from living in a supportive environment.

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. While the evidence is that the appellant would benefit from living in a supportive environment, 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. The panel therefore confirms the ministry's decision.