APPEAL #

PART C – Decision under Appeal

The decision under appeal is the Ministry of Social Development and Social Innovation (the ministry) reconsideration decision dated March 18, 2015 which found that the appellant did not meet three of the five statutory requirements of Section 2 of the *Employment and Assistance for Persons with Disabilities Act* for designation as a person with disabilities (PWD). The ministry found that the appellant met the age requirement and that her impairment is likely to continue for at least two years. However, the ministry was not satisfied that the evidence establishes that:

- the appellant has a severe physical or mental impairment;
- the appellant's daily living activities (DLA) are, in the opinion of a prescribed professional, directly and significantly restricted either continuously or periodically for extended periods; and,
- as a result of these restrictions, the appellant requires the significant help or supervision of another person, the use of an assistive device, or the services of an assistance animal to perform DLA.

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

APPEAL #

PART E – Summary of Facts

The evidence before the ministry at the time of the reconsideration decision included the Person With Disabilities (PWD) Application comprised of the applicant information dated October 3, 2014, a physician report (PR) and an assessor report (AR), both of which are dated October 3, 2014 and completed by a general practitioner who had met with the appellant once for the purposes of completing the reports. Asked to describe the approaches and information sources used to complete the form, the general practitioner indicated an office interview with the appellant and no other sources.

The evidence also included the following documents:

1) Fax dated December 30, 2014 from the ministry to the general practitioner requesting copies of medical consults confirming the appellant's diagnoses and outlining any relevant information in relation to such diagnoses. The general practitioner's handwritten response is: "no consult available;" and,
2) The appellant's Request for Reconsideration dated February 18, 2015.

Diagnoses

In the PR, the appellant was diagnosed by the general practitioner with ADHD [attention deficit hyperactivity disorder] since childhood, Borderline Personality Disorder, depression, and anxiety with onsets in 2012, and migraines since the appellant was a teenager. In the AR, when asked to describe the impairments that impact the appellant's ability to manage daily living activities, the general practitioner wrote "chronic weakness and fatigue, anxiety, depression, poor concentration and poor memory, poor sleep, poor appetite, poor motivation, migraines incapacitating, confusion, disorientation."

Physical Impairment

In the PR and AR, the general practitioner reported that:

- Regarding "health history", the appellant has "chronic weakness and fatigue all the time- moderate to severe; migraines some of the time- severe."
- The appellant does not require an aid for her impairment.
- For functional skills, the appellant can walk 4 or more blocks unaided, she can climb 5 or more steps, it is unknown how much she can lift and she can remain seated less than 1 hour.
- The appellant is independent in all areas of mobility and physical ability, specifically walking indoors and outdoors, climbing stairs, lifting and carrying and holding, and takes significantly longer than typical with each activity. The general practitioner wrote "weakness and fatigue- 2 to 3 times as long."
- In the section of the AR relating to assistance provided through the use of assistive devices, the general practitioner did not identify any of the listed items.

Mental Impairment

In the PR and AR, the general practitioner reported :

- In terms of health history, the appellant has "depression all the time- moderate to severe; anxiety some of the time- moderate to severe; poor concentration; poor memory; agitation and restless; confusion and disorientation; poor appetite; poor sleep; poor motivation."
- The appellant has cognitive difficulties with communication, described as: "poor concentration; confusion and disorientation." The appellant has a good ability to communicate in speaking and hearing and poor reading and writing due to "poor education."

- The appellant has significant deficits in her cognitive and emotional functioning in the areas of consciousness, executive, memory, emotional disturbance, motivation, impulse control, motor activity, and attention or sustained concentration and, under comments, the general practitioner wrote: “from depression, anxiety, ADHD.”
- For the section of the AR assessing impacts to cognitive and emotional functioning for an applicant with an identified mental impairment or brain injury, the general practitioner indicated major impacts in the areas of bodily functions, consciousness, emotion, attention/concentration, executive, memory, motivation, and motor activity. There are no impacts reported for the remaining six listed areas of functioning. The general practitioner wrote: “depression, anxiety, ADHD and personality disorder have major impact on functioning as listed above.’”
- The appellant is independent in 2 aspects of social functioning, specifically making appropriate social decisions and interacting appropriately with others. She requires periodic support/supervision with dealing appropriately with unexpected demands, described as “very poor skills in these areas.” The appellant requires continuous support/supervision with developing and maintaining relationships and securing assistance from others. The explanation by the general practitioner is “very poor skills in these areas.”
- The appellant has very disrupted functioning in both her immediate and extended social networks. No further comment is added to this section by the general practitioner.
- Asked to describe the support/supervision required which would help maintain the appellant in the community, the general practitioner wrote: “requires (illegible)/support in most areas of social functioning as listed above some to all the time.”

Daily Living Activities (DLA)

In the PR and AR, the general practitioner indicated that:

- Regarding health history, the appellant “requires help with food prep and cooking- most of the time; with laundry and housework all the time; with shopping some of the time; with budgeting all the time;”
- The appellant has not been prescribed any medications and/or treatments that interfere with her ability to perform DLA.
- The appellant is independently able to perform every task of several listed DLA, namely: personal care (dressing, grooming, bathing, toileting, feeding self, and transfers in/out of bed and on/off chair), medications (filling/refilling prescriptions, taking as directed, safe handling and storage) and transportation (getting in and out of a vehicle, using public transit, and using transit schedules and arranging transportation). All tasks of personal care take significantly longer than typical, with a note: “at times does not do item at all” and using public transit also takes longer due to “poor motivation, anxiety, fatigue and weakness.”
- The appellant is independently able to perform most tasks of some of the DLA, specifically: shopping (going to and from stores, reading prices and labels, paying for purchases and carrying purchases home), while going to and from stores she takes longer due to “poor motivation” and carrying purchases home takes longer due to “weakness and fatigue.” The appellant requires periodic assistance with making appropriate choices, which also takes significantly longer than typical, due to “poor judgment; impulsive.”
- The appellant requires continuous assistance with the DLA basic housekeeping, described as “weakness, fatigue, poor motivation.”
- Additional comments are that the appellant “needs help all the time with housekeeping and some of the time with shopping.”

- Most tasks of finances are performed independently (banking and paying rent and bills), while the appellant requires continuous assistance with budgeting as she "does not know how to budget."
- The appellant requires continuous assistance with most tasks of the DLA meals, specifically meal planning, food preparation and cooking, while she is independent with safe storage of food. The general practitioner wrote "poor motivation, weakness, fatigue, poor concentration."
- Additional comments are that the appellant "needs help most of the time with meals and all the time with budget."

Need for Help

In the AR, the general practitioner reported that the help required for DLA is provided by no one specifically, and wrote that the appellant "needs help most of the time with food prep and cooking, all the time with laundry and housework, some of the time with shopping, all the time with budget, some to all the time with social functioning." In the section of the AR relating to assistance provided through the use of assistive devices, the general practitioner did not identify any of the listed items as being applicable.

Additional Information

In her Notice of Appeal dated April 9, 2015, the appellant expressed her disagreement with the ministry's reconsideration decision and wrote that she is appealing because her PWD meets all the criteria in law.

At the hearing, the appellant provided a letter dated April 22, 2015 from a psychiatrist to another doctor who the appellant identified as her current family doctor. The psychiatrist provided an initial outpatient psychiatric consultation which included the following information regarding the appellant's medical condition:

- The appellant filled out a preliminary questionnaire which assesses many syndromes in psychiatry and the psychiatrist interviewed her.
- The appellant stated that she is "not herself" and the last year has been very hard, with lots of stress related to people dying. When she is active and social, she feels well. She avoids relationships and her primary feeling is apathy. She has no interest, motivation or ability to enjoy herself.
- Her PHQ-9 depression rating score is 18 and that is considered moderately severe. Her symptoms of depression seem to be worsening as time goes by.
- The appellant did take medication, which she does not know the name of, which was helpful. She is not interested in medication and the psychiatrist thinks that it is probably not necessary.
- The appellant mentioned her stressors as a lack of money, lack of motivation and feeling lost.
- Regarding medical history and substance abuse history, the appellant has been gaining weight slowly, which has never happened before, and she feels she is addicted to sugar.
- With respect to family history, there is a history of migraine and substance abuse in both of her parents.
- Regarding mental status, the psychiatrist wrote that the appellant came across as alert, cooperative and open. Her affect was sad and she was appropriately tearful discussing her situation. Her manner was suspicious and that lessened, to an extent, through the

interview.

- A borderline screening questionnaire was completed as another psychiatrist had wondered about this diagnosis. Her score is 6/10 and there is ambivalence about the abandonment question.
- She certainly has the symptom of feeling like she has no idea who she is or that she has no identity. That often can lend itself to difficulty answering questions about herself. Her sensorium was intact and intellect was at least average. Thought processes were coherent, with no signs of psychosis. Her insight and judgment were preserved.
- She does not engage in self-harm and has never tried to take her life.
- The diagnostic impression is that the appellant "has borderline personality disorder and that is affecting both her view of herself and how she responds to other people. Chronic persistent depression is also a symptom she has had for some time. Her depressive symptoms are significant enough to say that she has major depression now."
- The management/suggestions are for the appellant to read self-help books, consult various websites, listen to a radio program, attend group support meetings, and see another psychiatrist for a second opinion.
- Medication is not necessary at this time and the appellant can always come back to a group medical visit to discuss that if she feels the need. The primary treatment that is necessary is psychotherapy.

At the hearing, the appellant's advocate stated:

- The essential issue is that the evidence provided by the appellant in the PWD application was deemed inadequate by the ministry because the physician did not have a history of contact with the appellant.
- The central issue is the length of time that the appellant has known the medical practitioner. However, by the very nature of a mental health condition, the medical practitioner must rely on the patient's self-report of symptoms.
- The ministry was unreasonable to draw a negative inference because the appellant had met with the medical practitioner only once.
- In the reconsideration decision, the ministry wrote that the information provided by the medical practitioner is based on the appellant's self-report as he had "little opportunity for (sic) to develop an opinion based on a history of contact, experience, observations and knowledge of [the appellant]."
- The medical practitioner has identified diagnoses and the ministry is not in a position to challenge these, in the absence of evidence that contradicts or calls these diagnoses into question, and must accept it as absolutely factual. The medical practitioner is a licensed professional and the ministry is not qualified to make determinations about diagnoses. The letter from the psychiatrist confirms the diagnoses of borderline personality disorder and major depression.
- Both the assessment by the medical practitioner and by the psychiatrist are based on the appellant's self-report because there is no other diagnostic tool available. There is no blood test or X-Ray to determine a mental health diagnosis. It is patently unreasonable for the ministry to not accept the reports because they are based on the appellant's self-report and refuse to give them full weight because a mental health diagnosis is fundamentally based on a self-report.
- The medical practitioner identified significant deficits in the appellant's cognitive and emotional

functioning and assessed major impacts in several areas. The ministry's form instructs that comments are to be provided in addition to the checklist "if impact is episodic or impact varies over time" and additional narrative is not otherwise required.

- The psychiatrist's letter does not speak to the appellant's limitations with DLA because it is part of her treatment plan and not a PWD application.
- In the reconsideration decision, the ministry refers to having contacted the medical practitioner on or about December 30, 2014 to request supporting medical documentation to confirm the diagnoses and the medical practitioner responded that he did not have any supporting documentation. However, it is the role of the physician to assess the situation, based on the appellant's self-report as well as her facial cues and body language, to determine if there is malingering. If grounds for corroboration were indicated, that would have been highlighted by the medical practitioner.
- In the reconsideration decision, the ministry wrote that the ministry makes the decision based on the physical, mental and daily living assessments provided by a prescribed professional "with a history of contact and recent experience with the applicant, and the information is to be based on knowledge of the applicant, observations, clinical data and experience." However, there is nothing in policy, regulation or legislation to permit the ministry to set its criteria thus. This type of bar is an almost impossible one to meet when the appellant's tendency to isolate socially has been identified. Without support/supervision, the appellant is precluded from developing an ongoing history with medical professionals.
- The original decision summary includes a reference to the diagnoses by the medical practitioner being problematic since there was no indication that the medical practitioner reviewed any medical consultations to corroborate his diagnoses.
- The only reason that the ministry denied the application is that the ministry does not trust the medical practitioner's opinion and, as members of the laity, the ministry is not in a position to refuse to give deference to the medical practitioner's expertise.

At the hearing, the appellant stated:

- The appellant has been searching for a family doctor for many years and has been unable to find one. Her previous family doctor, from when she was a teenager, retired. She saw the medical practitioner once at a medical clinic for the purposes of completing the application.
- She found a family doctor "about a year ago" to whom the psychiatrist provided the consult. Her family doctor has prescribed depression medications.
- To complete the application, she met with the medical practitioner for 30 minutes up to an hour and he asked her questions and she answered.
- She has had ADHD since she was a kid and a history of migraines.
- She has also had depression for a while and took pills about 6 years ago that had been prescribed by a doctor then. She stopped taking the medication because she "did not want to deal with it."
- Asked about the date of onset of 2012 for the diagnoses of borderline personality disorder, depression and anxiety, the appellant stated that she is not sure which doctor provided the diagnoses because she has gone to so many walk-in clinics over the years that she could not remember which ones she had gone to and had not obtained any consult reports from them.
- She remembers the condition got "more severe" at that time and her behavior began to change. It has been so long now that she "has gotten used to it" and she is not the person she used to be.

The ministry relied on its reconsideration decision as summarized at the hearing and clarified at the hearing that:

- The diagnoses by the medical practitioner are not in question, rather the deficiency in the information was the lack of explanation for how the diagnoses impact the appellant's DLA and the lack of a description regarding assistance that is required.
- There is a lack of detail provided to show what it is about the appellant's medical conditions that makes mobility and physical ability an issue, for example.
- There is no explanation or description by the medical practitioner for the major impacts indicated for the appellant's cognitive and emotional functioning.

Admissibility of Additional Information

The ministry objected to admitting the additional letter on the basis that the ministry contacted the general practitioner who completed the PWD application to ask that he provide any supporting consults and this report from a psychiatrist was not made available to the ministry at reconsideration. The advocate argued that the information in the letter does not contradict or minimize the information provided by the original physician who stated the same diagnoses and the same type and style of impacts. The ministry did not raise an objection to the oral testimony on behalf of the appellant. The panel reviewed the letter and also considered the testimony, which contained corroborating information about the appellant's diagnoses of ADHD, borderline personality disorder, depression and anxiety, and migraines, as set out in the PR and which was available at reconsideration. The panel admits the letter and the testimony as information that is in support of the information and records that were before the ministry at the time of reconsideration, in accordance with Section 22(4)(b) of the *Employment and Assistance Act.*

APPEAL #

PART F – Reasons for Panel Decision

The issue on the appeal is whether the ministry's reconsideration decision, which found that the appellant is not eligible for designation as a person with disabilities (PWD), was reasonably supported by the evidence or was a reasonable application of the applicable enactment in the circumstances of the appellant. The ministry found that the information provided does not confirm that the appellant has a severe mental or physical impairment and that her daily living activities (DLA) are, in the opinion of a prescribed professional, directly and significantly restricted either continuously or periodically for extended periods and that, as a result of those restrictions, the appellant requires the significant help or supervision of another person, the use of an assistive device, or the services of an assistance animal to perform DLA.

The criteria for being designated as a PWD are set out in Section 2 of the EAPWDA as follows:

Persons with disabilities

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.

(4) The minister may rescind a designation under subsection (2).

Section 2(1) of the EAPWDR defines DLA for a person who has a severe physical or mental impairment as follows:

Definitions for Act

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.

Section 2(2) of the EAPWDR defines prescribed profession as follows:

(2) For the purposes of the Act, "**prescribed professional**" means a person who is

(a) authorized under an enactment to practise the profession of

(i) medical practitioner,

(ii) registered psychologist,

(iii) registered nurse or registered psychiatric nurse,

(iv) occupational therapist,

(v) physical therapist,

(vi) social worker,

(vii) chiropractor, or

(viii) nurse practitioner, or

(b) acting in the course of the person's employment as a school psychologist by

(i) an authority, as that term is defined in section 1 (1) of the Independent School Act, or

(ii) a board or a francophone education authority, as those terms are defined in section 1 (1) of the School Act,

if qualifications in psychology are a condition of such employment.

Severe Physical Impairment

The appellant did not directly advance a position that she has a severe physical impairment, although she stated at the hearing that she has a history of migraines.

The ministry's position is that there is not sufficient information from the general practitioner to confirm that the appellant has a severe physical impairment. The ministry argued that the general practitioner met with the appellant only once so the information regarding the impacts from her medical conditions is considered to be based on the appellant's self-report. The general practitioner reported that the appellant is able to walk 4 or more blocks, climb 5 or more stairs; it is unknown how much she can lift and she can remain seated up to 1 hour. The ministry argued that the general practitioner also indicated that the appellant is independent in all aspects of mobility and physical abilities while taking 3 times longer with these activities and this does not indicate a severe restriction.

Panel Decision

The general practitioner diagnosed the appellant with migraines since the appellant was a teenager, and commented that the appellant has "migraines some of the time- severe." At the hearing, both the appellant and her advocate emphasized the impacts to the appellant from a mental impairment rather than a physical impairment and, although the general practitioner referred to the migraines as

"incapacitating," there was no further information provided regarding the frequency of the migraines. In the PR, the general practitioner reported that the appellant does not require an aid for her impairment and, in the AR, none of the assistive devices are identified as applicable to the appellant. For functional skills, the general practitioner indicated that the appellant can walk 4 or more blocks unaided, she can climb 5 or more steps, it is unknown how much she can lift and she can remain seated for less than 1 hour. Although the general practitioner reported that the appellant is independent in all areas of mobility and physical ability, specifically walking indoors and outdoors, climbing stairs, lifting and carrying and holding, he indicated that she takes significantly longer than typical with each activity, described as "weakness and fatigue- 2 to 3 times as long." The panel finds that the ministry reasonably determined that, when considered with the appellant's functional abilities and independent functional skills, taking 2 to 3 times longer does not establish a significant restriction.

Given the appellant's independent physical functioning and the lack of detail regarding the impacts from the migraines she experiences some of the time, the panel finds that the ministry reasonably determined that there is not sufficient evidence to establish that the appellant has a severe physical impairment under Section 2(2) of the EAPWDA.

Severe Mental Impairment

The appellant's position is that a severe mental impairment is established by the evidence of the impacts from ADHD since childhood plus Borderline Personality Disorder, depression, and anxiety which all had onsets in 2012. The advocate argued, on behalf of the appellant, that the medical practitioner has provided diagnoses and the ministry is not in a position to challenge these, in the absence of evidence that contradicts or calls these diagnoses into question, and must accept them as absolutely factual. The advocate argued that the letter from the psychiatrist confirms the diagnoses of borderline personality disorder and major depression. The advocate argued that it is patently unreasonable for the ministry to not accept the reports of the medical practitioner on the basis of the appellant having one appointment with him because they are based on the appellant's self-report and a mental health diagnosis is fundamentally based on a patient's self-report.

The advocate argued further that it is the role of the physician to assess the situation, based on the appellant's self-report as well as her facial cues and body language, to determine if there is malingering and, if grounds for corroboration were indicated, that would have been highlighted by the medical practitioner. The advocate argued that the medical practitioner identified significant deficits in the appellant's cognitive and emotional functioning and assessed major impacts in several areas. The advocate pointed out that the ministry's form instructs the medical practitioner to provide comments in addition to the checklist "if impact is episodic or impact varies over time" and additional narrative is not otherwise required. The advocate argued that the medical practitioner identified impacts to several areas of the appellant's social functioning and her need for either periodic or continuous support/supervision as required for PWD designation under the EAPWDA.

The ministry's position is that there is insufficient evidence to establish that the appellant has a severe mental impairment. The ministry stated at the hearing that the diagnoses by the general practitioner are not in question; rather, the deficiency in the information lies in the lack of explanation for how the diagnoses impact the appellant's DLA and a lack of description of the assistance that is required. The ministry acknowledged that the general practitioner indicated significant deficits to the appellant's cognitive and emotional functioning with several major impacts, and difficulties with communication, but argued that lesser weight is assigned to the information provided by the general

practitioner in these areas since it is based on the appellant's self-report and he had little opportunity to develop an opinion based on a history of contact, experience, observations, and knowledge of the appellant.

Panel Decision
A diagnosis of a serious medical condition does not in itself determine PWD eligibility or establish a "severe" impairment. An "impairment" is a medical condition that results in restrictions to a person's ability to function independently or effectively.

To assess the severity of an impairment, the ministry must consider both the nature of the impairment and the extent of its impact on daily functioning as evidenced by functional skill limitations and the degree to which the ability to perform DLA is restricted. In making its determination the ministry must consider all of the relevant evidence, including that of the appellant. However, the legislation is clear that the fundamental basis for the analysis is the evidence from a prescribed professional – in this case, the appellant's general practitioner and a psychiatrist.

The general practitioner indicated in the AR that the only approach and information source used by him was an office interview with the appellant and the panel finds that the ministry reasonably assigned lesser weight to the information regarding impacts to the appellant's cognitive, emotional and social functioning since the general practitioner had little opportunity to form an independent opinion based on a history of contact, experience, observations, and knowledge of the appellant. The general practitioner had a period of only about 30 to 60 minutes during the course of one interview to arrive at an opinion regarding the nature and degree of the appellant's mental disorders, based solely on information provided by the appellant. Although much of the information to form an opinion regarding a mental health diagnosis is based on the patient's self-report, as argued by the advocate, the information relating to the impacts from these diagnoses has been gathered in a short period of time in one meeting rather than over a period of time with a history or contact and ongoing evaluation by the medical practitioner.

There was no evidence that the general practitioner used other approaches and information, such as a home assessment, file/chart information, information from family/friends/caregivers (i.e. collateral sources), other professionals, or community services. The appellant stated at the hearing that she has attended various drop in clinics over the years, was prescribed depression medications in 2012, and that she secured a family doctor "about a year ago;" however, no historical information (including clinical notes or reports from the other physicians she saw) was made available to the general practitioner. While the general practitioner did not indicate a need for corroboration due to malingering in either the PR or the AR, as argued by the advocate, there was also little time for him to form an independent assessment of the appellant's cognitive and emotional functioning in areas such as executive (e.g. planning, organizing, sequencing, abstract thinking, problem-solving, calculations) or memory (e.g. can learn new information, names etc. and then recall that information; forgets over-learned facts), for example, and little time to verify the appellant's assessment of the degree of impact to these areas from her mental health conditions.

The general practitioner set out diagnoses for the appellant of ADHD since childhood, Personality Disorder, depression, and anxiety with onsets in 2012 and wrote in the PR that the appellant has "depression all the time- moderate to severe; anxiety some of the time- moderate to severe; poor concentration; poor memory; agitation and restless; confusion and disorientation; poor appetite; poor sleep; poor motivation." In the letter dated April 22, 2015, the psychiatrist reported that the diagnostic

impression is that the appellant "has borderline personality disorder and that is affecting both her view of herself and how she responds to other people." The psychiatrist also indicated that a borderline screening questionnaire was completed "as another psychiatrist had wondered about this diagnosis" and "her score is 6/10," which the panel notes is slightly above mid-range. The psychiatrist wrote that the appellant's depressive symptoms are "significant enough to say that she has major depression now." The psychiatrist indicated that, based on the appellant's score of 18 on a questionnaire, her depression is considered 'moderately severe.' He noted that the appellant does not engage in self-harm and has never tried to take her life and indicated that medication is not currently necessary. The recommended treatment plan is for the appellant to read self-help books, consult various websites, listen to a radio program, attend group support meetings, and to see another psychiatrist for a second opinion. As well, the psychiatrist wrote regarding the appellant's mental status that the appellant "came across as alert, cooperative and open." Her affect was "sad and she was appropriately tearful discussing her situation; her manner was suspicious and that lessened, to an extent, through the interview."

The general practitioner reported in the PR that the appellant has significant deficits in her cognitive and emotional functioning in the areas of consciousness, executive, memory, emotional disturbance, motivation, impulse control, motor activity, and attention or sustained concentration and, under comments, the general practitioner wrote: "from depression, anxiety, ADHD," which the panel notes does not reference the diagnosis of borderline personality disorder. In the AR, when setting out the level of impact to the appellant's cognitive and emotional functioning, the general practitioner indicated major impacts in all of the areas identified as having significant deficits as well as in the area of bodily functions but with the exception of impulse control for which he reported no impact. The general practitioner wrote: "depression, anxiety, ADHD and personality disorder have major impact on functioning as listed above." The panel notes that the ministry form requests further comments specifically where an impact is episodic or varies over time and does not require comments where this does not apply; however, where a significant deficit has been identified in impulse control in the PR and the impact is then assessed as nil in the AR, and where the reported impact as a result of the borderline personality disorder diagnosis is not clear, the lack of an explanation by the general practitioner results in an apparent inconsistency in the evidence.

With respect to the two DLA that are specific to mental impairment – make decisions about personal activities, care or finances (decision making), and relate to, communicate or interact with others effectively (social functioning), the evidence does not establish that the appellant is significantly restricted in either. Regarding the decision making DLA, the general practitioner reported in the AR that the appellant independently manages the decision-making components of the DLA management of medications (taking as directed and safe handling and storage) and the DLA transportation (using transit schedules and arranging transportation). While the appellant takes significantly longer than typical and requires periodic assistance with the decision-making component of the DLA shopping (making appropriate choices) as she has "poor judgment; impulsive," the general practitioner indicated only that she needs help "some of the time with shopping", but not how much longer it takes her or how often she requires assistance. The general practitioner reported that the appellant is independent with most of the tasks of her finances DLA (banking and paying rent and bills) and requires continuous assistance with budgeting as she "does not know how to budget," but the general practitioner does not indicate how this is related to the appellant's mental impairment or diagnoses. For the meals DLA, the appellant is independent with safe storage of food and requires continuous assistance with meal planning due to "poor motivation, weakness, fatigue, poor concentration." The general practitioner also reported in the AR that the appellant is independent with making appropriate

social decisions.

Regarding the DLA of social functioning, the general practitioner reported in the AR that the appellant requires continuous support/supervision with developing and maintaining relationships and securing assistance from others, described as "very poor skills in these areas" but is independently able to interact appropriately with others. While the general practitioner indicated that the appellant has very disrupted functioning in her immediate social networks (e.g. aggression or abuse; major withdrawn; often rejected by others) and in her extended social networks (e.g. overly disrupted behavior; major social isolation), there are no comments provided to further describe the appellant's functioning. Asked to describe the support/supervision required which would help maintain the appellant in the community, the general practitioner wrote "requires (illegible) /support in most areas of social functioning as listed above some to all of the time." The general practitioner indicated in the PR that the appellant has cognitive difficulties with communication, described as: "poor concentration; confusion and disorientation." However, in the AR he reported that the appellant has a good ability to communicate in speaking and hearing and poor reading and writing as a result of "poor education" rather than due to a mental impairment *per se*.

Given the noted unexplained inconsistencies and lack of detail in the evidence from the general practitioner and the recommendations by the psychiatrist for a conservative treatment plan and a second opinion by another psychiatrist, the panel finds that the ministry reasonably determined that a severe mental impairment was not established under Section 2(2) of the EAPWDA.

Restrictions in the ability to perform DLA

The appellant's position is that her mental impairment directly and significantly restricts her ability to perform DLA on an ongoing basis to the extent that she requires the significant assistance of another person. The advocate argued, on the appellant's behalf, that while the ministry stated that it makes the decision based on the physical, mental and daily living assessments provided by a prescribed professional "with a history of contact and recent experience with the applicant, and the information is to be based on knowledge of the applicant, observations, clinical data and experience," there is nothing in policy, regulation or legislation to permit the ministry to set its criteria thus. The advocate argued that this type of bar is an almost impossible one to meet when the appellant's tendency to isolate socially has been identified by the medical practitioner. The advocate argued that without support/supervision, the appellant is precluded from developing an ongoing history with medical professionals.

The ministry's position is that the information from the prescribed professional does not establish that the appellant's impairment significantly restricts DLA either continuously or periodically for extended periods. The ministry wrote that the majority of the listed tasks of DLA are performed independently by the appellant although some tasks take longer and, for those areas that require periodic assistance, the general practitioner has not provided sufficient information to establish that there is a significant restriction in the appellant's ability to perform these activities. The ministry wrote that PWD eligibility is based on DLA assessments provided by a prescribed professional with a history of contact and recent experience with the applicant and the information is to be based on knowledge of the applicant, observations, clinical date and experience.

Panel Decision

Section 2(2)(b) of the EAPWDA requires that the ministry be satisfied that a prescribed professional has provided an opinion that an applicant's severe impairment directly and significantly restricts her

DLA, continuously or periodically for extended periods. In this case, the general practitioner and the psychiatrist are the prescribed professionals. DLA are defined in Section 2(1) of the EAPWDR and are also listed in the PR and, with additional details, in the AR. Therefore, a prescribed professional completing these forms has the opportunity to indicate which, if any, DLA are significantly restricted by the appellant's impairments either continuously or periodically for extended periods.

As discussed above, the general practitioner indicated in the AR that the only approach and information source used by him was an office interview with the appellant and the panel finds that the ministry reasonably assigned less weight to the general practitioner's assessments of the resulting impacts because the assessments were not based on the prescribed professional's knowledge of the appellant, observations, clinical data and experience. While the panel acknowledges the advocate's assertion that one of the appellant's symptoms is a tendency to isolate socially which may impact her ability to consult with medical professionals, the appellant stated at the hearing that she had secured a family doctor "about a year ago" and yet no other reports regarding impacts to DLA were provided on the appeal.

The general practitioner reported in the PR that the appellant has not been prescribed medications that interfere with her DLA. The appellant is independently able to perform every task of several listed DLA, namely: personal care, medications and transportation. All tasks of personal care take significantly longer than typical, with a note: "at times does not do item at all" and using public transit also takes longer due to "poor motivation, anxiety, fatigue and weakness." The general practitioner did not indicate how much longer it takes the appellant to perform these tasks, making it difficult for the ministry to gage the degree of restriction. The appellant is independently able to perform most tasks of some of the DLA, specifically: shopping (going to and from stores, reading prices and labels, paying for purchases and carrying purchases home), while going to and from stores takes longer due to "poor motivation" and carrying purchases home takes longer due to "weakness and fatigue." The appellant requires periodic assistance with making appropriate choices, which also take significantly longer than typical, due to "poor judgment; impulsive." While the general practitioner wrote that the appellant needs help "some of the time with shopping", he has not indicated how much longer it takes the appellant for these tasks, or how often she requires periodic assistance.

The general practitioner reported that the appellant requires continuous assistance with the DLA basic housekeeping, described as "weakness, fatigue, poor motivation." Tasks of finances are performed independently (banking and paying rent and bills), while the appellant requires continuous assistance with budgeting as she "does not know how to budget," which, along with her poor ability to read and write due to "poor education," suggests a lack of knowledge rather than a lack of ability due to mental impairment. The appellant is independent with safe storage of food but requires continuous assistance with the other tasks of the DLA meals, specifically meal planning, food preparation and cooking, due to "poor motivation, weakness, fatigue, poor concentration." Additional comments by the general practitioner are that the appellant "needs help most of the time with meals and all the time with budget." The advocate acknowledged that the letter from the psychiatrist does not speak to the appellant's limitations with DLA because it is part of her treatment plan and not part of the PWD application. As discussed under the severity of mental impairment, with respect to the two DLA that are specific to mental impairment – decision making and social functioning- the available evidence does not establish that the appellant is significantly restricted.

The panel finds that the evidence demonstrates that the appellant manages most of her DLA without assistance and that the ministry reasonably determined that there is insufficient information to allow

the ministry to determine that those tasks that take longer or require periodic assistance are significantly restricted. Therefore, the panel finds that the ministry reasonably concluded that there is not enough evidence from the prescribed professionals to establish that the appellant's impairment significantly restricts her ability to manage her DLA either continuously or periodically for extended periods, thereby not satisfying the legislative criterion of Section 2(2)(b)(i) of the EAPWDA.

Help to perform DLA

The appellant's position is that she requires the significant assistance of another person to perform DLA.

The ministry's position is that because it has not been established that DLA are significantly restricted, it cannot be determined that significant help is required from other persons. The ministry argued that no assistive devices are required and the appellant does not require the services of an assistance animal.

Panel Decision

Section 2(2)(b)(ii) of the EAPWDA requires that, as a result of direct and significant restrictions in the ability to perform DLA, a person requires help to perform those activities. Help is defined in subsection (3) as the requirement for an assistive device, the significant help or supervision of another person, or the services of an assistance animal in order to perform a DLA.

In the AR, the general practitioner reported that the help required for DLA is provided by no one specifically, and wrote that the appellant "needs help most of the time with food prep and cooking, all the time with laundry and housework, some of the time with shopping, all the time with budget, some to all the time with social functioning." In the section of the AR relating to assistance provided through the use of assistive devices, the general practitioner did not identify any of the listed items as being applicable.

The panel finds that the ministry reasonably determined that as direct and significant restrictions in the appellant's ability to perform DLA have not been established, it cannot be determined that the appellant requires help to perform DLA as a result of those restrictions, as defined by Section 2(3)(b) of the EAPWDA.

Conclusion

Having reviewed and considered all of the evidence and relevant legislation, the panel finds that the ministry's reconsideration decision, which determined that the appellant was not eligible for PWD designation under Section 2 of the EAPWDA, was reasonably supported by the evidence and therefore confirms the decision.