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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 April 15, 2015 which held that the appellant did not meet 3 of the 5 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 a medical practitioner confirmed that the appellant has an impairment that is likely to continue for at least 2 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 those restrictions, in the opinion of a prescribed professional, the appellant requires help, as it is defined in the legislation, 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

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PART E – Summary of Facts

Evidence before the ministry at reconsideration

- A PWD application comprised of the appellant's Self-report (SR) dated July 29, 2013, a Physician Report (PR) dated August 23, 2013 completed by the appellant's general practitioner (GP) of one year, and an Assessor Report (AR) dated July 21, 2013 completed by the appellant's social worker (SW #1) of one year.
- February 15, 2013 3-page report respecting a cervical spine and brain MRI.
- June 13, 2013 consult letter from a sleep medicine neurologist.
- June 26, 2013 consult letter from a neurologist.
- March 16, 2015 2-page letter from a nurse practitioner (NP) who had been working with the appellant since January 2015 and reviewed medical records dating back to 2008 (also signed by a physician who works with the NP).
- March 24, 2015 4-page handwritten submission from the appellant plus an additional page of handwritten notes ("reconsideration submission").

Based on the difference in handwriting, it appears that the appellant has added her own hand-written comments on a number of the above documents including the PR and the neurologist's consult letter.

Additional information submitted on appeal and admissibility

- 7 page handwritten submission from the appellant ("appeal submission").
- Diagnostic imaging report for a December 18, 2014 CT head scan.
- April 24, 2015 letter from a second social worker (SW #2).
- April 22, 2015 letter from the NP, also signed by a physician.

Section 22(4) of the *Employment and Assistance Act (EAA)* limits the evidence that a panel may admit. Only information and records before the minister at the time of reconsideration and oral and written testimony in support of the information available at reconsideration may be admitted for consideration by the panel. In concert, section 24 of the *EAA* establishes the panel's decision-making authority, limiting the panel to determining whether the ministry's reconsideration decision is reasonably supported by the evidence or a reasonable application of the applicable legislation and confirming or rescinding the reconsideration decision, accordingly. Consequently, the panel is without the authority to make a new decision of its own or assume the role of a first-time decision maker by basing its decision on evidence that was not in support of the evidence at reconsideration.

The ministry's written submission on appeal did not raise an objection to the admissibility of the additional information. The information in the appellant's appeal submission either reiterates or corroborates her previous testimony. The CT scan confirms previous diagnostic results. The April 22, 2015 letter from the NP and the letter from SW #2 substantiate information provided by the appellant and the NP at reconsideration. Accordingly, the panel admitted the additional information pursuant to section 22(4) of the EAA as being in support of the information at reconsideration. The panel notes that the appellant's appeal submission also included argument which is reflected in the summary of the appellant's position in Part F of the panel decision.

Summary of relevant evidence

Diagnoses

A medical practitioner, the GP who completed the PR, specifies the diagnoses related to the appellant's impairment as follows: depression, fibromyalgia 1996, degenerative disc disease of the cervical spine, and anxiety disorders. The GP notes that the appellant claims she suffers from multiple sclerosis (MS) and fibromyalgia (FM) and that recent consultations with 2 neurologists in 2013 did not find any signs of MS or fibromyalgia. At reconsideration, the NP and co-signing physician introduced a diagnosis of COPD.

Physical Impairment

In the PR, the GP provides the following information:

- Main problem is chronic pain originating from neck and muscles "with no specific diagnostic reason for the amount of pain she claims she is suffering from."
- Anxiety and depressed mood is a contributive factor to her pain.
- The appellant can climb 2 to 5 steps unaided, lift 5 to 15 lbs, and remain seated for 1 to 2 hours; the distance she can walk unaided is unknown.
- Based on his clinical findings, he does not see the appellant as a "disabled" person.

In the AR, the social worker writes that due to fatigue and vertigo-like (balance) symptoms commonly associated with FM, the appellant:

- Is unable to stand (balance and fatigue).
- Uses an assistive device for walking indoors and outdoors (does not walk any distance due to balance issues).
- Needs to use handrail to climb stairs.
- Is limited to lifting/carrying/holding 15-20 lbs maximum all of which take significantly longer than typical.

In the SR, the appellant writes that:

- She cannot sit, stand, or walk for any length of time.
- Her FM and spinal degeneration have worsened to the point that she cannot function without aid on a daily basis.
- She has continual dizziness (vertigo), numbness of hands and feet with painful spasms, is exhausted all the time, has poor sleep, and constant back and muscle pain, especially in her neck and mid-back.
- She has 80% loss of hearing in her right ear and IBS.

The 2013 MRI results note:

- White matter changes in the brain in keeping with small vessel ischemic disease with no convincing evidence of inflammatory demyelination.
- Multi-level degenerative change along the cervical spine with mild to moderate spinal stenosis

at C5-6 and C6-7 with some effacement of the cervical cord. Advanced left foraminal narrowing at C3-4 and C6-7 and advanced right foraminal narrowing at C4-5.

The sleep medicine neurologist notes the MRI of the cervical spine reveals degenerative changes at the level of mostly C5, 6 and 7 resulting in mild to moderate narrowing of the spinal canal; however, the spinal cord is not significantly impinged. He also notes the following findings upon examination: good language, 5/5 motor strength, normal finger to nose coordination, no evidence of gait disturbance. He concurs with the findings of the brain MRI - small vessel ischemia – especially knowing the appellant's 40 pack (sic) a day smoking history. A 10 year history of smoking marijuana is also noted. Smoking cessation is recommended to reduce the risk of recurrent small vessel ischemia and to prevent worsening of cervical spine degeneration. He also notes degenerative changes on the cervical spine "that maybe causing some pain" and recommends increasing pain medication dose and seeing a neurosurgeon about possible surgical intervention.

The neurologist consultation letter indicates that:

- Upon examination, the appellant did not appear to be in any discomfort during the "long period of time" during which she provided her history clearly, concisely with no referral to notes.
- The appellant's neurological exam is normal and he cannot make a firm diagnosis of MS, noting that it's possible her visual alteration was due to that, and she has a lot of pain which is unrelated to the nervous system, with the appellant referring to arthritic changes in her neck.

The 2014 CT scan results confirms the white matter ischemic changes "but given the patient's age, demyelinating process is also in the differential." The panel notes that the appellant appears to haves underlined "demyelinating" on this document and added "M.S. or inflammation of brain { spinal cord"

In her reconsideration submission, the appellant reports:

- Flare-ups of FM and back pain render her unable to leave home due to physical pain and reduced cognitive functioning.
- A lifting limit of 5-10 lbs and that her overall physical condition has declined at an accelerated rate, partially due to lack of funds.
- COPD renders her winded after walking one block.
- She bumps into things when walking indoors and has many bruises and a few falls. She does not go out often.
- Her ailments are greatly exacerbated by the cold.
- She is often exhausted and requires 9-11 hours of sleep, which is not often restorative.

In her appeal submission, the appellant adds that;

- Her chronic pain has caused depression which usually results in loss of income which causes anxiety.
- Her constant back pain is 5-9 on a scale where 10 is the highest.

Information from the NP (at reconsideration and on appeal) is that:

- The appellant has severe cervical neck pain secondary to osteoarthritis, with radiculopathy to the left hand and, on her worst days, is unable to use her left hand secondary to numbness, weakness and spasms.

- The appellant also has COPD with chronic bronchitis and can only walk 1-2 blocks and climb up 5 stairs before requiring rest due to shortness of breath, and can remain seated for half an hour at a time.
- The appellant has yet-to-be diagnosed symptoms including daily nausea, swelling to the extremities with numbness and weakness, slurred speech, constipation, and difficulty maintaining a healthy weight.

In his April 24, 2015 letter, SW #2 notes that the appellant consistently presents with a mild tremor in her hands, appears fatigued with a greyish pallor to her skin tone and appears quite thin/gaunt.

Mental Impairment

In the PR, the GP reports:

- No difficulties with communication.
- Significant deficits with cognitive and emotional functioning in 2 of 12 listed areas – emotional disturbance and motivation with additional narrative "no significant deficits: she in on chronic meds for her mood and anxiety."
- No restriction with social functioning.

In the AR, the social worker:

- Reports good communication abilities via speaking and writing, satisfactory reading ability (concentration affected by cognitive deficits consistent with FM) and poor hearing due to build-up in ears;
- Did not complete the sections of the AR addressing cognitive and emotional functioning or social functioning for those with an identified mental impairment or brain injury.

In the SR, the appellant reports having panic attacks and short-term memory impairment, confusion and trouble concentrating.

In her reconsideration submission, the appellant reports:

- She has an inordinate amount of confusion, and the taking of copious notes, but still manages to forget and miss appointments.
- Often being at a loss for words with slurred speech sometimes, isolating herself as a result.
- She has brain fog due to sleep problems.
- She has been diagnosed with B.P.D. [borderline personality disorder] and is attending D.B.T. classes.

In her appeal submission, the appellant provides reasons for the delay with her PWD application including marital breakup, moving and travelling for 2 months to a foreign country to receive proper medical care.

The sleep medicine neurologist's findings on examination include: alert, oriented times three, related history in good detail.

The neurologist notes the appellant's ability to provide a long and detailed history concisely with no referral to notes.

At reconsideration, the NP reports that the appellant:

- Has had severe and persistent depression since 2013, with suicidality and dysregulation, making concentration extremely difficult and causing poor memory and follow through with executive function, speculating that this may explain the appellant's delay in submitting her PWD application.
- Maintains all health appointments and seeks care responsibly.
- Has borderline personality as a problem in addition to depressive disorder.
- Has difficulty expressing herself concisely, requiring frequent health care visits with her primary health care team.

On appeal, the NP notes:

- A severe impact on: concentration and memory – uses extensive notes which she then cannot track; executive – has no planning ability and quite literally "stuck"; sleep - unable to fall asleep, excessive sleepiness, fatigue; and, severe emotional dysregulation with a severe impact with family and intimate relationships.
- A moderate to severe impact is noted for consciousness (confusion), insight and judgement and motor activity (no future planning/goal setting).
- Moderate, minimal or no impact is noted for other aspects of cognitive and emotional functioning.

In his letter, social worker #2 writes that:

- He has worked with the appellant since her arrival at a transition house intended to provide space for people to develop a plan to move forward ie. seek market rent but that at this pointin time the appellant lacks the funds to secure market rent.
- The appellant appeared "somewhat dysregulated" for approximately 6 weeks following her arrival at the house, noting that the appellant needed redirection back to relevant topics with great frequency and had difficulty word-finding and sometimes stumbled over her speech.
- He currently observes a lack of insight and judgment and executive planning/goal setting abilities which are major impediments to her thriving in society and notes that the appellant "has consistently argued her diagnoses and routinely asks for second or third opinions without any sense of being satiated."

DLA

In the PR, the GP reports:

- It is unknown if impairment restricts the ability to perform basic housework, daily shopping, and mobility inside the home.
- No restriction in the ability to perform personal self-care, meal preparation, management of medications, mobility outside the home, use of transportation, management of finances, and social functioning, adding that "From her visits in my office I never got the impression that this patient 'claimed disability' affects her "ADL."'

In the AR, the social worker reports:

- That the FM appears to have progressed in recent months and combined with spinal degeneration, significantly impair activities of daily living to the extent that the appellant is unable to manage work responsibilities at this time.
- *Personal care* – grooming, toileting, feeding self, and regulating diet are managed independently with no noted restriction. The appellant needs to be seated for dressing, must hold onto a rail for bathing, and must use supports for balance stability when transfers in/out of bed and on/off chair, which take her significantly longer than typical.
- *Basic housekeeping* – takes significantly longer as she can only complete 10-15 minutes of light housework before needing a break for a similar length of time.
- *Shopping* - reading prices and labels, making appropriate choices, paying for purchases are managed independently with no noted restrictions. Must drive or be driven to go to and from stores (could not manage on foot) and requires shopping trolley and vehicle for carrying purchases home.
- *Meals* – meal planning and safe storage of food are managed independently while family members are relied on for continuous assistance with food preparation and cooking as the appellant is limited to 10-15 minutes of activity before requiring rest.
- *Paying rent and bills* and *medications* – all aspects are managed independently.
- *Transportation* – the appellant takes longer to get into a vehicle due to stability. Public transportation tasks are N/A (not applicable).

In her reconsideration submission, the appellant writes that:

- She has to pace herself with housework and personal care and needs breaks often, depending on the task.
- She cannot do many things, especially if they require good balance and lifting over 5-10 lbs.
- She has forgotten and missed appointments and many times forgot to take medication.

The NP reports that due to cervical neck pain and COPD, the appellant takes 2-3 times longer than a healthy person to cook, clean, shop and perform self-care.

Need for Help

In the PR, the GP describes the assistance required from another person, equipment and assistance animals as “none.”

In the AR, the social worker notes that:

- The appellant is very reliant on the physical/practical support of her mother (with whom the appellant lives) and family at this time.
- A handrail in the shower is required
- An assistance animal is not used.

In her reconsideration submission, the appellant writes that she would use an assistive device, although none is identified by the appellant, but cannot afford one.

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PART F – Reasons for Panel Decision

Issue on Appeal

The issue on appeal is whether the ministry's decision to deny the appellant designation as a PWD was reasonably supported by the evidence or was a reasonable application of the applicable enactment in the circumstances of the appellant. In particular, was the ministry reasonable in determining that:

- a severe physical or mental impairment was not established;
- the appellant's daily living activities (DLA) are not, in the opinion of a prescribed professional, directly and significantly restricted either continuously or periodically for extended periods; and
- as a result of those restrictions, in the opinion of a prescribed professional, the appellant does not requires help, as it is defined in the legislation, to perform DLA?

Relevant Legislation

EAPWDA

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).

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EAPWDR

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.

(2) For the purposes of the Act, **"prescribed professional"** means a person who is authorized under an enactment to practice the profession of

(a) medical practitioner,

(b) registered psychologist,

(c) registered nurse or registered psychiatric nurse,

(d) occupational therapist,

(e) physical therapist,

(f) social worker,

(g) chiropractor, or

(h) nurse practitioner.

Severe Physical Impairment

The appellant argues that her physical disabilities have deteriorated since the initial application and that the GP who completed the PR saw her on occasions when she was in less pain and able to make her appointments. She argues that the information from the NP, whom the appellant has seen 10 times in 5 months for half an hour at a time, clearly demonstrates her physical problems. Further, her condition is worsened by the inability to afford necessary medications, treatments, and a sufficient diet. She also argues that she has all the symptoms for MS which is difficult to diagnose, can be active or in remission, and has not been excluded as a possible diagnosis and that she is being denied disability due to her inability to afford the expertise needed for a definitive diagnosis. With

respect to her spinal degeneration, the appellant argues that the ministry ignored the 2013 MRI findings of advanced narrowing.

In response to the ministry argument that the NP had only known the appellant for 2 months at the time of her first letter and uncertainty about the role of the co-signing physician, the NP indicates that at the time of her first letter, she had reviewed the appellant's medical files and that the co-signing physician is part of a team of health care professionals providing care for the appellant, who no longer sees the GP who completed the PR.

The ministry argues that it cannot determine that the appellant has a severe physical impairment given: the significant discrepancies reported regarding the appellant's diagnosed medical conditions and impairments; the fact that the PWD application was completed August 2013 and not submitted until January 2015; the NP has only known the appellant for 2 months and it is unclear what involvement the physician who co-signed has with the appellant's medical care. Further, the ministry notes that the PR was completed after the AR, which suggest the GP may have read the AR and appears to disagree, indicating on several occasions that the appellant does not appear to be disabled.

Panel Decision

The legislation provides that the determination of severity of impairment is at the discretion of the minister, taking into account all of the evidence including that of the appellant. However, the legislation is also clear that the fundamental basis for the analysis is the evidence from a prescribed professional respecting the nature of the impairment and its impact on daily functioning. While the legislation does not define "impairment", the PR and AR define "impairment" as a "loss or abnormality of psychological, anatomical or physiological structure or functioning causing a restriction in the ability to function independently, effectively, appropriately or for a reasonable duration." While this is not a legislative definition, and is therefore not binding on the panel, in the panel's opinion, it reflects the legislative intent and provides an appropriate analytical framework for assessing the degree of impairment resulting from a medical condition.

When considering the evidence provided respecting the severity of impairment, the ministry must exercise its decision-making discretion reasonably by weighing and assessing all of the relevant evidence and cannot simply defer to the opinion of a prescribed professional as that would be an improper fettering of its decision-making authority.

In this case, as the ministry noted, the issue of severe physical impairment is complicated at the outset by a lack of clear or definitive diagnoses. While the GP lists FM as having been diagnosed in 1996, his additional narrative makes it clear that he questions the existence of FM as well as the appellant's assertions respecting MS. This is problematic given the emphasis that SW #1 places on the impact of the symptoms of FM, including fatigue and vertigo/balance, when completing the AR. The panel notes that SW #1 indicates that he completed the AR solely on the basis of office interviews with the appellant, and as noted by the ministry, did so prior to the PR having been completed by the GP. Furthermore, a number of the functional assessments in the AR, despite the information having been provided to SW #1 by the appellant, contradict the appellant's own written submissions. For example, in the AR the appellant is reported as being unable to stand which seems

at odds with the appellant's evidence that she can walk one block before becoming short of breath. While the appellant referred to flare-ups of her FM and back pain, there was no description provided by her or any of the medical professionals of the nature or extent of these flare-ups. Also, SW #1 reports the use of an unspecified assistive device for walking but the appellant reports she does not have an aid due to lack of funds.

The NP argues that it is unacceptable to deny the diagnoses of FM due to the neurologists' failure to diagnose FM as they couldn't be expected to do so given that FM is not a neurological disorder and the appellant was not referred for that disorder. However, despite her vigorous argument respecting the diagnoses of FM, the NP does not attribute any limitations to the appellant's physical functioning to fibromyalgia, instead attributing limitations to osteoarthritis and recently diagnosed COPD.

There is also evidence that some of the health care providers question whether the appellant has over-reported her physical symptoms. As the ministry notes, the appellant's self-reported diagnoses and degree of symptoms are repeatedly called into question by the GP, who wrote that he did not consider the appellant to be disabled. Further, the neurologist made a point to comment that he saw no evidence of "discomfort" during a lengthy office visit. More recently, SW #2 assesses the appellant as lacking insight and judgment and consistently arguing diagnoses and routinely asks for second and third opinions without ever being satisfied with the responses.

In the end, it is clear that the GP, SW #1, the NP, the medical imaging reports, and the neurology specialists all confirm degeneration of the cervical spine and that the appellant has been recently diagnosed with COPD, both of which impact her physical functioning.

As well, there is definitive past and current documentation of small vessel ischemia, which the neurologist infers may relate to smoking, noting that continued smoking may worsen her cervical spine degeneration.

While some of the medical information dates back to 2013, and the appellant argues that the more current information from the NP and SW #2 should be relied on given that she only saw the GP when feeling better and there has been an accelerated decline in her physical condition, the physical functional skills reported in the PR are almost identical to those now reported by the NP. Also, SW #2 provides minimal information respecting physical impairment. Additionally, the symptoms identified by the appellant in 2013 include the same symptoms reported today such as vertigo, balance, and ear problems. On the whole, the evidence is that the appellant has some limitations due to her medical conditions but despite her back pain, which she reports ranges from 5 to 9 out of 10, is still able to walk 1-2 blocks unaided, climb 5 stairs before requiring a rest due to shortness of breath, remain seated up to ½ hour, and is able, according to the appellant herself, to lift 5-10 lbs.

In view of these physical functional abilities, the panel finds that the ministry reasonably determined that a severe physical impairment was not established.

Severe Mental Impairment

The appellant argues that as a result of her pain she has depression resulting in loss of income which

causes anxiety and a lack of proper care which accelerates physical problems and as a result she is disabled.

The ministry's position is that the GP and SW #1 do not identify any impacts to cognitive and social functioning and that, although the NP indicates that there is extensive documentation demonstrating severe and persistent depression since 2013, this information has not been provided. While it appears that the appellant's condition may have progressed significantly since 2013, a detailed assessment of mental deficits and cognitive and emotional functioning is not included. Therefore, the ministry is unable to determine that the appellant currently has a severe mental impairment.

Panel Decision

The appellant has been diagnosed with depression and anxiety. At reconsideration, the NP referred to Borderline Personality in her letter and the appellant wrote that she is taking related classes; however, there was no specific information from a medical practitioner supporting a diagnosis.

In terms of the impact on functioning, the information in the PR is that the appellant has no difficulties with communication and no significant deficits with cognitive and emotional functioning as she is on chronic medication for mood and anxiety. In the AR, the appellant's ability to communicate by speaking and writing is good and satisfactory for reading (due to the impact of FM on her concentration) and while poor for hearing, this is identified as a physical impact due to build-up in her ears. SW #1 did not complete the two sections of the AR which are to be completed if an applicant has an identified mental impairment. The appellant writes that she suffers from an inordinate amount of confusion and memory problems and has brain fog due to sleep problems. However, the sleep medicine neurologist's findings on examination included that the appellant was alert and related her history in good detail and the other neurologist noted the appellant's ability to provide a long detailed history concisely without referring to notes. The NP identifies severe impacts on concentration, bodily functions (sleep), executive, emotional disturbance and memory, and moderate to severe impacts for other aspects of cognitive and emotional functioning, stating that depression has a severe, persistent and detrimental impact on her daily life. However, the NP reports that, despite forgetfulness and lack of concentration, the appellant responsibly attends her frequent (weekly) visits with her primary health care team and manages most DLA independently, taking 2-3 times longer than typical. SW #2 reported that upon arrival at the transition home the appellant appeared "somewhat dysregulated" and sometimes stumbled over her speech but that this lasted for six weeks. SW #2 also reported ongoing problems with insight, judgment, and executive planning/goal setting and estrangement from family members.

While there is evidence of an ongoing inability to accept medical diagnoses and opinions, there is little evidence of impacts on daily functioning, particularly to the DLA relating to a mental impairment – decision making and social functioning (discussed in more detail under "Restrictions in the ability to perform DLA"). While SW #2 identifies these problems as major impediments to thriving in society, failure to thrive is not tantamount to being severely impaired and furthermore, SW #2 notes that the appellant lacks the funds to move from the transition house, not that she is unable to do so due to her mental impairment.

Based on the foregoing analysis, the panel finds that although the appellant experiences problems

with cognitive and emotional functioning, the ministry has reasonably concluded that information respecting the impact these problems have on her daily functioning in terms of communication and daily living activities does not establish a severe mental impairment.

Restrictions in the ability to perform DLA

The appellant argues that she has to pace herself with housework and personal care, requiring breaks often, depending on the task and that there are many things she cannot do – especially if they require good balance and lifting over 5-10 lbs.

The ministry's position is that the evidence from the GP that DLA are not restricted and from SW #1 that except for meals, DLA are managed independently though some take longer, establishes independence with DLA. Additionally, although the NP reports the inability to use the left hand sometimes due to numbness, the appellant is otherwise reported as taking 2-3 times longer overall to complete DLA which does not represent a *significant* restriction. The ministry also points to the lack of a current assessment of the impact of depression and mood disorder on the appellant's ability to perform DLA.

Panel Decision

The legislative requirement respecting DLA set out in section 2(2)(b) of the EAPWDA is that the minister be satisfied that as a result of a severe physical or mental impairment a person is, in the opinion of a prescribed professional, directly and significantly restricted in the ability to perform DLA either continuously or periodically for extended periods. Consequently, while other evidence may be considered for clarification or support, the ministry's determination as to whether or not it is satisfied, is dependent upon the evidence from prescribed professionals. Under this legislation, physicians, social workers and nurse practitioners are all prescribed professionals – though the legislation limits diagnoses solely to medical practitioners. DLA are defined in section 2(1) of the EAPWDR and are listed in both the PR and the AR sections of the PWD application with the opportunity for the prescribed professional to check marked boxes and provide additional narrative.

The panel finds that the ministry has reasonably viewed the information in the PR and AR as falling short of establishing significant restrictions on the ability to perform DLA as the former reports no restrictions, including narrative that the physician never got the impression that the "claimed disability" affects ADL, and the latter indicates that the appellant independently manages all DLA, except meals and bathing (uses a tub rail). That the appellant sits to dress, drives or is driven to shop, and uses a shopping cart is not demonstrative of a significant restriction. The panel notes that something to sit upon, a vehicle, a shopping cart (trolley), and stair rails are not assistive devices as defined in s. 2(1) of the EAPWDA – 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 – and that a vehicle and cart are regularly used means of shopping. The appeal submission from SW #2 provides little if any information on the appellant's ability to perform DLA, and suggests that but for lack of financial resources the appellant has sufficient functioning to move from transitional housing. Both the appellant and the NP report that DLA tasks are managed independently, though taking 2-3 times longer than typical according to the NP, and managed in intervals of 15 minutes according to the

appellant. The NP also reports that sometimes the appellant cannot use her left arm-hand – however, there is no information as to how often this occurs, for how long, or even if the appellant is left hand dominant.

Considering 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 indicate that the appellant is significantly restricted in either. With respect to decision making, SW #1 reported in the AR that the appellant is independent with the decision-making components of the DLA of personal care (regulate diet), daily shopping (make appropriate choices), meal preparation (meal planning and safe storage of food), "pay rent and bills" DLA (including budgeting), medications (taking as directed and safe handling and storage) and that use of transit schedules is not applicable. Regarding the DLA of social functioning, the appellant is assessed in the PR as not restricted. While the NP indicated on appeal that the appellant has severe emotional dysregulation with a severe impact with family and intimate relationships, there was no detail provided or a description of the necessary support/supervision.

In view of the degree of independence with which the appellant manages most aspects of DLA, which is in keeping with the current functional skills reported by the NP, the panel finds that the ministry reasonably determined that a direct and significant restriction in the opinion of a prescribed professional, either continuous or for extended periods, has not been established.

Help to perform DLA

The appellant argues that she requires an assistive device(s) which she is unable to afford.

The ministry's position is that because it has not been established that DLA are significantly restricted, it cannot be determined that help is required.

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.

As the ministry reasonably determined that direct and significant restrictions in the appellant's ability to perform DLA have not been established, the panel finds that the ministry reasonably concluded that it cannot be determined that the appellant requires help to perform DLA.

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 was reasonably supported by the evidence, and therefore confirms the decision.