Social Security Tribunal of Canada | Tribunal de la sécurité sociale du Canada

Citation: *K. S. v. Minister of Employment and Social Development,* 2016 SSTADIS 215

Tribunal File Number: AD-15-267

BETWEEN:

K. S.

Appellant

and

Minister of Employment and Social Development

Respondent

SOCIAL SECURITY TRIBUNAL DECISION
Appeal Division

DECISION BY: Neil Nawaz

DATE OF DECISION: June 17, 2016

Canada

REASONS AND DECISION

DECISION

[1] The appeal is allowed.

INTRODUCTION

[2] This is an appeal of the decision of the General Division (GD) of the Social Security Tribunal issued on February 18, 2015, which dismissed the Appellant's application for a disability pension on the basis that the Appellant did not prove that his disability was severe, for the purposes of the *Canada Pension Plan* (CPP), by his minimum qualifying period (MQP) of December 31, 2010. Leave to appeal was granted on July 10, 2015, on the grounds that the GD may have erred in rendering its decision.

OVERVIEW

[3] The Appellant submitted an application for CPP disability benefits in November 2010. He indicated that he was a high school graduate and had spent much of his adult life working as a carpenter in the construction industry. In 1999, he suffered multiple fractures after falling from a ladder in a workplace accident. He recovered but was left with chronic pain, leading him to take on lighter work. In November 2008, he was involved in a motor vehicle accident, and has not worked since.

[4] The Appellant was 43 years old at the time of his MQP. In the questionnaire accompanying his CPP application, the Appellant claimed numerous functional limitations, including an inability to sit, stand or walk for extended periods. Lifting and carrying caused him neck pain and tension, and he had lost much of his flexibility. He suffered from headaches and reported difficulties with his memory and powers of concentration. He had been seen and treated by numerous specialists, but there had been no appreciable improvement in his pain or functionality.

[5] At the hearing before the GD in February 2015, the Appellant testified that pain governs his daily life. He is noise and light sensitive and sleeps poorly. He received vocational counselling for a year. He took antidepressants but found they did little to improve his mood. He had received pain management counselling and epidural injections to little effect.

[6] In its decision dated February 18, 2015, the GD found that the Appellant's disability fell short of the requisite severity threshold, in part because he did not mitigate his mental health condition and related chronic pain by following recommended treatment.

[7] On or about May 12, 2015, the Appellant filed an Application for Leave to Appeal with the Appeal Division (AD) of the Social Security Tribunal alleging numerous errors on the part of the GD. On July 10, 2015, the AD granted leave on the grounds that the GD may have:

(a) Made an erroneous finding of fact that "most doctors" who evaluated the Appellant suggested that he consult with a psychologist and take antidepressant and antianxiety medications;

(b) Made an erroneous finding of fact that the Appellant refused treatment when in fact he took counselling whenever this form of therapy was available;

(c) Erred in law and fact by obliging the Appellant to mitigate his impairments even though there were extenuating circumstances that that may have explained his failure to receive treatment, including the fact he was unaware of specific medical recommendations.

[8] On April 7, 2016, the AD decided to proceed on the basis of the documentary record for the following reasons:

(a) The complexity of the issues under appeal;

(b) The fact that the Appellant or other parties were represented;

(c) The requirements under the *Social Security Tribunal Regulations* to proceed as informally and quickly as circumstances, fairness and natural justice permit.

[9] The Appellant's submissions were set out in his Application for Leave to Appeal and Notice of Appeal of May 12, 2015. Further submissions were made on August 23, 2015. The Respondent's submissions were filed with the AD on August 24, 2015.

THE LAW

[10] According to subsection 58(1) of the *Department of Employment and Social Development Act* (DESDA) the only grounds of appeal are that:

(a) The GD failed to observe a principle of natural justice or otherwise acted beyond or refused to exercise its jurisdiction;

(b) The GD erred in law in making its decision, whether or not the error appears on the face of the record; or

(c) The GD based its decision on an erroneous finding of fact that it made in a perverse or capricious manner or without regard for the material before it.

STANDARD OF REVIEW

[11] Until recently, it was accepted that appeals to the AD were governed by the standards of review set out by the Supreme Court of Canada in *Dunsmuir v. New Brunswick*[1]. In matters involving alleged errors of law or failure to observe principles of natural justice, the applicable standard was held to be correctness, reflecting a lower threshold of deference deemed to be owed to an administrative tribunal often analogized with a trial court. In matters where erroneous findings of fact were alleged, the standard was held to be reasonableness, reflecting a reluctance to interfere with findings of the body tasked with hearing factual evidence.

[12] The Federal Court of Appeal decision, *Canada (MCI) v. Huruglica*[2], has rejected this approach, holding that administrative tribunals should not use standards of review that were designed to be applied by appellate courts. Instead, administrative tribunals must look first to their home statutes for guidance in determining their role.

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[1] *Dunsmuir v. New Brunswick,* [2008] SCR 190, 2008 SCC 9

[2] *Canada (Minister of Citizenship and Immigration) v. Huruglica,* 2016 FCA 93

ISSUES

[13] The issues before me are as follows:

(a) What standard of review, if any, applies when reviewing decisions of the GD?

(b) Did the GD make an erroneous finding of fact that “most doctors” who evaluated the Appellant suggested that he consult with a psychologist and take antidepressant and antianxiety medications?

(c) Did the GD make an erroneous finding of fact that the Appellant refused recommended mental health treatments?

(d) Did the GD err in law and fact by failing to consider factors that explained the Appellant’s failure to receive recommended mental health treatments?

SUBMISSIONS

(a) What is the appropriate standard of review?

[14] Both the Appellant’s and Respondent’s submissions on this issue were made prior to *Huruglica*, which was released on March 29, 2016.

[15] The Appellant endorsed the approach set out in *Dunsmuir,* asking that reasonableness be adopted as the standard of review on questions of fact, mixed law and fact and questions of law related to the tribunal’s own statute. A range of acceptable outcomes were possible, defensible on the facts and the law.

[16] The Respondent’s submissions discussed in comprehensive detail the standards of review and their applicability to this appeal, concluding that a standard correctness was to be applied to errors of law, and reasonableness was to be applied to errors of fact and mixed fact and law.

(b) Did GD Err In Finding “Most Doctors” Recommended Counselling and Medication?

[17] The Appellant submits that the GD erred in finding that “most doctors” recommended counselling, when only two health care providers (one of whom was not a doctor) suggested

consultations with a psychologist and trials of antidepressant and antianxiety medications. Dr. Capstick and Dr. Ogbinosa merely suggested treatments; they did not indicate that the Appellant "should" undergo psychological counselling or "would/could" benefit from it. It was unreasonable for the GD to characterize the comments from these two doctors as recommendations when they were only suggestions. The only clear recommendation was made by Mary Kemp, physiotherapist. She wrote to Dr. Ogbinosa prior to December 2010 and "recommended" psychological assessment. Ms. Kemp is not a medical doctor and mental health issues are not within her area of expertise.

[18] The Respondent submits that the GD conducted a thorough review of the medical, documentary and oral evidence before it. There was no erroneous finding of fact. Its decision reviewed and summarized the medical evidence of six doctors and a physiotherapist in paragraphs 10 through 19. In this summary, the GD noted that four of the seven healthcare professionals involved in treating the Appellant between 2008 and 2010 found that underlying anxiety and depression were a playing a role in the symptoms experienced by the Appellant. Furthermore, the GD Member noted that, according to Dr. Capstick, the Appellant's symptoms in 2009-10 were not related to the symptoms of his injuries he sustained in his motor vehicle accident. Three of the doctors and the physiotherapist recommend the use of antidepressants and anxiety medications, as well as a mental health referral for counselling and assessment of the Appellant's anxiety disorder. The majority of the health care professionals recommended some form of treatment for the Appellant's issues with anxiety and depression.

(c) Did the GD err in finding the Appellant refused treatment?

[19] The Appellant submits that the GD erred in finding that he refused treatment when in fact he accepted therapy whenever it was available. It is clear that Dr. Capstick and Dr. Javidan left it up to Dr. Ogbinosa to consider their suggestions, but the family physician indicated in his November 5, 2010 report that the only further consultations or medical investigations planned (GD1-47) were a pain clinic and botox injections. It is unreasonable to fault the Appellant because his family physician did not refer him to a psychologist. It is patently unreasonable to fault the Appellant for being unaware of suggestions and recommendations that were made to his doctor or his lawyer, particularly as there is no evidence he was aware of them. At the

hearing, the GD did not ask the Appellant whether he knew about the suggestions contained in these reports.

[20] The Respondent submits that the GD was reasonable in arriving at the conclusion that the Appellant failed to mitigate his illness. The GD noted that the physiotherapist, Ms. Kemp, approached the Appellant about seeking help from a psychologist and in response he said that he preferred to attend a pain clinic. In testimony, the Appellant noted that he would rather attend a 12-step program than take any more antidepressants. He also testified that the only reason he did not want to try new antidepressants, as suggested by his doctor, was because the last ones did not work. Furthermore, the GD noted that the Appellant was diagnosed with bipolar disorder in 1996, a diagnosis he did not agree with, but he did not seek a second opinion regarding this diagnosis, nor did he seek treatment or follow up on other mental health issues.

(d) Did the GD err in ignoring extenuating circumstances that accounted for the Appellant's failure to receive treatment?

[21] In his submissions, the Appellant suggests that the GD erred in law and fact by not taking into account circumstances that excused the Appellant's failure to receive mental health treatment recommended by his physicians. In making this argument, the Appellant cited *MHRSD v A.B.R.*,[3] a decision of the now-defunct Pension Appeals Board, for the principle that a claimant cannot be faulted for treatment omissions if there are valid reasons for them.

[22] The Appellant offered several reasons why he did not take additional psychotropic medications or seek psychological counselling, among them:

- He was not aware of some of these recommendations as he relied on his family doctor to make write prescriptions and make referrals;
- Psychological counselling was only available at a significant distance from his home and was not covered by the Medical Services Plan of British Columbia;
- He had tried antidepressants previously but found that they did not work.

[3] *Minister of Human Resources and Skills Development and A.B. R.* (P.A.B. CP 26100 April 2009)

[23] In its submissions, the Respondent did not specifically address the Appellant's allegation that that the GD gave insufficient consideration to the reasons for which he might not have received psychological treatment. It did, however, emphasize evidence that the Appellant preferred to attend a pain clinic and 12-step program rather than follow recommendations to see a psychologist and take more antidepressants.

ANALYSIS

(a) Standard of Review

[24] Although *Huruglica* deals with a decision that emanated from the Immigration and Refugee Board, it has implications for other administrative tribunals. In this case, the Federal Court of Appeal held that it was inappropriate to import the principles of judicial review, as set out in *Dunsmuir*, to administrative forums, as the latter may reflect legislative priorities other than the constitutional imperative of preserving the rule of law. "One should not simply assume that what was deemed to be the best policy for appellate courts also applies to specific administrative appeal bodies."

[25] This premise leads the Court to a determination of the appropriate test that flows entirely from an administrative tribunal's governing statute:

> … the determination of the role of a specialized administrative appeal body is purely and essentially a question of statutory interpretation, because the legislator can design any type of multilevel administrative framework to fit any particular context. An exercise of statutory interpretation requires an analysis of the words of the IRPA [*Immigration and Refugee Protection Act*] and its object… The textual, contextual and purposive approach mandated by modern statutory interpretation principles provides us with all the necessary tools to determine the legislative intent in respect of the relevant provisions of the IRPA and the role of the RAD [Refugee Appeal Division].

[26] The implication here is that the standards of reasonableness or correctness will not apply unless those words or their variants are specifically contained in the founding legislation. Applying this approach to the DESDA, one notes that paragraphs 58(1)(a) and (b) do not qualify errors of law or breaches of natural justice, suggesting the AD should afford no deference to the GD's interpretations.

[27] The word "unreasonable" is nowhere to be found in paragraph 58(1)(c), which deals with erroneous findings of fact. Instead, the test contains the qualifiers "perverse or capricious"

or “without regard for the material before it.” As suggested by *Huruglica*, those words must be given their own interpretation, but the language suggests that the AD should intervene when the GD bases its decision on an error that is clearly egregious or at odds with the record.

(b) “Most Doctors”

[28] At paragraph 31 of its decision, the GD found that “numerous doctors” suggested evaluation and treatment for the Appellant’s mental health issues, and at paragraph 33, it suggested that “most doctors” had suggested antidepressant and antianxiety medications and consultations with a psychologist for evaluation and treatment. The GD did not list which doctors it might have been referring to when it used the word “most.”

[29] A survey of the treatment providers and assessors who offered mental health recommendations yields the following list:

- A report dated April 6, 2009 by Mary Kemp, a physiotherapist and occupational therapist, addressed to Dr. Igbinosa, in which she recommended “psychological assistance with his frustrations, with his pain and his perceived level of disability.” Ms. Kemp noted that the Appellant preferred to attend a chronic pain program instead.
- A consultation report dated October 29, 2009 by Dr. J.R. Capstick, an anaesthesiologist, suggested the Appellant try a tricyclic antidepressant or a SSRI for what appeared to be a combination of anxiety and depression. Dr. Capstick also suggested a mental health referral for counseling and assessment of his anxiety disorder.
- A consultation report dated April 7, 2010 by Dr. M. Javidan, a neurologist, suggested that the Appellant take Clonazepam for anxiety. Dr. Javidan also thought the Appellant would benefit from a psychological referral.
- A consultation report dated August 19, 2010 by Dr. Alan Berkman, an anaesthesiologist, who suggested the Appellant might benefit from a mood-stabilizing drug, such as Cymbalta, although he made it clear that this was something that he would leave to the family physician.

- A medical-legal report dated June 5, 2012 prepared by Dr. Berkman recommended treatment options including cognitive behavioural therapy, ongoing medication, memory training and probably vocational training.
- In another medical-legal report, dated February 3, 2013, Dr. Berkman again recommended psychological counselling, as a means of helping the Applicant cope with his pain; there was no mention that this recommendation was intended to address his depression or anxiety.
- On February 28, 2014, Dr. Berkman noted that he had recommended that the Applicant follow up with the X Regional General Hospital's Interdisciplinary Pain Management Clinic's psychologist, but due to the Applicant's memory problems, he had missed quite a few appointments.
- In November 2014, Jen Mazur, a registered psychologist, strongly suggested that the Applicant receive a neuropsychological assessment to gain a complete picture of his strengths and deficits (p. GT10-6).

[30] First, I do not accept the Appellant's premise that there is a marked distinction between a "suggestion" and "recommendation." In medical reports, these words are frequently used interchangeably, and when a treatment provider "suggests" a particular therapy, it cannot be said that he or she is doing anything less than saying it "should" be carried out.

[31] Second, I agree with the Appellant that Mary Kemp's recommendation for psychological assistance should be discounted, as she was commenting well outside her expertise as a physical therapist. That said, contrary to the Appellant's assertion, there was more than just a single medical practitioner who suggested he would benefit from mental health treatment: Dr. Capstick, Dr. Javidan and Dr. Berkman all recommended either psychological counseling or psychotropic drug prescriptions, and Dr. Igbinosa documented a prior use of an antidepressant, Effexor, since discontinued.

[32] Treatment received after the MQP is relevant in an assessment of the severity of a claimed disability (as is treatment *not* received after the MQP) where there are indications of some disabling condition that went undiagnosed or untreated during the eligibility period. The record shows that at least four medical practitioners made recommendations with respect to the

Appellant’s mental health, whether before or after the MQP. Whether this qualifies as “numerous” is a matter of judgment, but I do not think it can be fairly characterized as an error— certainly not one “capricious or perverse” or made without regard for the record. The same can be said for the GD’s use of the word “most”—a majority of the Appellant’s doctors, and certainly a majority of those qualified to offer psychological assessments, made recommendations regarding his mental health.

(c) Refusal of Treatment

[33] Lack of treatment can be taken as evidence that a claimant’s injuries are less than severe, but it can also be seen as a failure to “mitigate” one’s impairment. Mitigation is defined as the act of reducing the severity, seriousness or painfulness of a loss. Within the CPP regime, the doctrine of mitigation imposes a positive obligation on a claimant to take active steps to regain functionality—typically by following doctors’ recommendations. Refusal to do so entitles a decision-maker to draw an inference that the claimant would have got better had he or she accepted the treatment.

[34] A review of the decision, particularly the three-page section headed “Analysis,” makes it clear that the GD based much of its denial of the Appellant’s claim on what it found was the Appellant’s refusal to follow medical advice:

> [31] The Tribunal must consider whether the Appellant’s refusal to undergo treatment is unreasonable and what impact that refusal might have on the Appellant’s disability status should the refusal be considered unreasonable.
>
> [31] The Tribunal finds that it was unreasonable for the Appellant not to follow suggestions of antidepressant/antianxiety medications and consultations with a psychologist for his evaluation and treatment.
>
> [32] Had the Appellant followed recommendations for mental health treatments of: psychological referral, CBT and medication, he may have had more capacity, especially since the evaluator listed depression and anxiety as one of the barrier to employment.
>
> [33] The Tribunal finds that the Appellant is not incapable regularly of pursuing any substantially gainful occupation because he did not mitigate his treatment options with regards to his mental health condition and its relationship to his chronic pain after it had been recommended by most doctors who evaluated him.

In asserting that a CPP disability claimant is obliged to pursue all recommended treatment options, the GD correctly cited *Lalonde v. Canada,*[4] although this principle has also been set out more fully in other cases.[5] The question before me now is whether the GD was correct in finding the Appellant "refused" to follow medical advice.

[35] Although the GD found that the Appellant refused treatment, its decision did not specify where he turned down a medical recommendation. When I look for specific instances in the evidentiary record that document the Appellant's refusal to follow medical recommendations, I come away empty-handed.

[36] The GD noted that the Appellant was hospitalized with bipolar disorder in 1996, although he did not agree with the diagnosis. This by itself did not amount to a refusal to accept treatment. The GD found that in 2009 the Appellant was briefly treated with a starting dose of Effexor, which was discontinued due to lack of effectiveness, but there was no evidence that he was offered, or that he refused, alternative doses or subsequent prescriptions of antidepressant or antianxiety medications. During the hearing, the Appellant stated that he preferred to address anxiety and depression with a 12-step program, but there was nothing to suggest that in doing so he had ruled out psychological counselling.

[37] To be clear, I am not questioning the GD's authority to make an assessment of severity based on the number and type of therapies that were recommended by his treatment providers. However, I must agree with the Appellant's submissions that he had never been explicitly criticized anywhere in the medical record for disobeying medical advice. There is no indication in the evidence, oral or written, that the Appellant ever refused treatment. He testified that he had tried everything his doctors recommended. While he indicated that he thought the 12-step program and the chronic pain clinic were the best strategies for him, at no point did he refuse alternatives. The evidence indicates that the Applicant eventually took advantage of counselling when this form of therapy was made available to him.

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[4] *Lalonde v. Canada (MHRD),* 2002 FCA 211

[5] *Giannaros v. Canada (MSD),* 2005 FCA 187; *Kaminski v. Canada (Social Development)*, 2008 FCA 225 and *Warren v. Canada (A.G.),* 2008 FCA 377

[38] For these reasons, I conclude that the GD had no basis in finding that the Appellant did not follow mental health treatments recommended by his physicians.

(d) Extenuating Circumstances

[39] Although the Appellant did not refuse recommended mental health treatments, it is nonetheless also true that he did not receive them—and it was on this fact that the GD rested much of its decision. The questions that remain are: (i) whether there is anything in the law that required the GD to consider extenuating circumstances that explained or excused a failure to receive treatment; (ii) whether such circumstances existed in this case and (iii) if so, whether the GD discharged its obligation to consider those circumstances.

[40] In *Lalonde*, the case cited by the GD in support of the mitigation principle, the Federal Court of Appeal stated:

> The "real world" context also means that the Board must consider whether Ms. Lalonde's refusal to undergo physiotherapy treatment is unreasonable and what impact that refusal might have on Ms. Lalonde's disability status should the refusal be considered unreasonable.

[41] The key concept here is reasonableness. Even if it has been established that a claimant did not receive recommended treatment, the decision-maker must still conduct an inquiry into whether there was some good reason for that omission, or at the very least give fair consideration to available evidence on the matter.

[42] In the present case, the Appellant submits that the following factors accounted for his failure to receive treatment for his psychological conditions:

- The reports of Dr. Capstick, Dr. Javidan and Dr. Berkman were all addressed to his family physician, Dr. Igbinosa, and he was not aware of their treatment recommendations.
- He relied on his family physician to implement specialist recommendations, and if Dr. Igbinosa did not do so, he cannot be blamed.

- Psychological counselling was not available in his region, and BC Health Services did not cover this service. Both of these factors may have played a role in Dr. Igbinosa not referring him to psychological counselling.
- When he previously took an antidepressant, he saw no improvement and suffered side effects. Dr. Igbinosa did not see fit to prescribe alternative medications.

[43] In its decision, the GD largely ignores these considerations, addressing only the alleged side effects and lack of efficacy of the Appellant's Effexor trial. At the hearing, the GD questioned the Appellant about that trial and concluded the starting dose was inadequate to treat the Appellant's PTSD, anxiety and depression. Having reviewed the documentary evidence and listened to the relevant extracts from the hearing recording, I see no evidence that the Appellant was prescribed any other antidepressants after the unsuccessful Effexor trial, and find the GD was within its rights to infer from this that the Appellant's psychological impairment was less than severe. However, I remain unsure why Dr. Igbinosa discontinued the Effexor and why he declined to prescribe further antidepressants: Was it because he did not think they were necessary given the Appellant's condition or was it because the Appellant told him he did not want any more? The GD member did not pursue this line of questioning at the hearing, nor did she make inquiries into why the Appellant did not receive timely counselling from a psychologist, as had been recommended by specialists.

[44] If the GD chooses to make its denial contingent on a finding of insufficient psychological treatment, it must recognize the reality that most claimants depend on their family physicians to recommend treatment, as well as implement the recommendations of specialists. Claimants tend to passively accept those recommendations and do what their doctors tell them to do. There was nothing in the evidence to suggest that the Appellant resisted treatment, and if the Appellant's family physician was failing to carry out specialist recommendations or otherwise prescribe what the GD thought was appropriate treatment, it should have raised those questions at the hearing and addressed them in the decision.

[45] As noted in the Appellant's submissions, the reports of Dr. Capstick, Dr. Javidan and Dr. Berkman (as well as the letter from Mary Kemp) were all addressed or copied to Dr. Igbinosa. The GD did not ask the Appellant whether he was aware of their recommendations

that he receive psychological counselling or, if he was, whether he took any steps of his own to get it. There was evidence before the GD that psychological counselling was not readily available prior to the end of the MQP, as indicated by Dr. Capstick's October 2009 comment that a clinical psychologist was no longer associated with his clinic. In his February 2013 report, Dr. Berkman mentioned that in August of the previous year the Appellant saw a psychologist based in X, who referred him to a "recently appointed" psychologist in X, to relieve him of the need to make a longer trip. He subsequently did start seeing a psychologist (as of February 2013), which suggests that he was willing to receive treatment when it was recommended to him, but an obstacle may have been availability. It does not appear, however, that the GD canvassed this issue at the hearing and there is certainly no discussion of it in its decision.

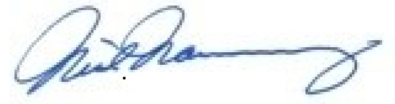
[46] All of the above persuades me that the GD did not give adequate consideration to issues of awareness and accessibility before dismissing the Appellant's claim for failure to receive treatment. This was not a case that involved a claimant flatly refusing to take recommended treatment. The evidence shows the Appellant was willing to do as his doctors advised when he became aware of it. He tried Effexor but found it ineffective. He testified that he found pain management classes helpful. Counselling was not available in any proximity to make it practicable. Once treatment options became available, he accessed them, and it should not matter whether treatment was offered after the minimum qualifying period.

[47] I find that the GD failed to consider extenuating circumstances to assess whether the Appellant's failure to receive psychological treatment was reasonable, as the existing jurisprudence suggests it must do.

CONCLUSION

[48] I would allow the appeal on two grounds: First, the GD made an error of fact without regard for the material before it in finding that the Appellant had "refused" treatment. Second, the GD made an error of mixed law and fact by failing to consider extenuating circumstances for the Appellant's failure to receive psychological treatment.

[49] Section 59 of the DESDA sets out the remedies that the AD can give on appeal. It is appropriate in this case that the matter be referred back to the GD for a *de novo* hearing before a different GD Member.



Member, Appeal Division