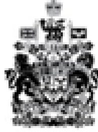

Citation: *KP v Minister of Employment and Social Development*, 2022 SST 1426

Social Security Tribunal of Canada
Appeal Division

Decision

Appellant:	K. P.
Representative:	E. M.
Respondent:	Minister of Employment and Social Development
Representative:	Rebekah Ferriss

Decision under appeal:	General Division decision dated March 14, 2022 (GP-20-2074)

Tribunal member:	Kate Sellar
Type of hearing:	Teleconference
Hearing date:	September 20, 2022
Hearing participants:	Appellant Appellant's representative Respondent's representative
Decision date:	December 20, 2022
File number:	AD-22-366

Decision

[1] I'm allowing the appeal. The General Division made errors. I'll give the decision that the General Division should have given: the Claimant is entitled to a disability pension.

Overview

[2] K. P. (Claimant) worked as a welder. He injured his back at work in October 2010. He worked again briefly in November 2010. He hasn't worked since. Doctors have provided different diagnoses at different times for the Claimant, including adjustment disorder with depressed mood, anxiety disorder, cannabis use disorder, post-traumatic stress disorder symptoms (PTSD), and attention deficit hyperactivity disorder (ADHD).

[3] The Claimant applied for a disability pension in May 2020. The Minister of Employment and Social Development (Minister) refused his application initially and on reconsideration. The Claimant appealed to this Tribunal.

[4] The General Division dismissed the Claimant's appeal. The Claimant had to show that his disability was severe and prolonged within the meaning of the *Canada Pension Plan* (CPP) on or before December 31, 2011. The General Division dismissed the appeal based on the evidence about the Claimant's treatment efforts.

[5] I must decide whether the General Division made an error under the De*partment of Employment and Social Development Act* (the Act).

[6] The General Division made an error of law and error of fact about the Claimant's treatment. I'll give the decision that the General Division should have given: the Claimant is entitled to a disability pension.

Issues

[7] The issues in this appeal are:

a) Did the General Division make an error of law or of fact about the Claimant's treatment?

b) Did the General Division make an error of fact by ignoring medical evidence that the Claimant provided from several of his doctors?

c) Did the General Division make an error of fact by ignoring medical evidence about the medications the Claimant was taking?

Analysis

[8] In this decision, I'll describe the approach the Appeal Division takes when reviewing General Division decisions. Then I'll explain how I've decided that the General Division made an error of law and an error of fact about the Claimant's treatment. Then I'll give the decision that the General Division should have given.

Reviewing General Division decisions

[9] The Appeal Division does not give the Claimant or the Minister a chance to re-argue their case again from the beginning. Instead, the Appeal Division reviews the General Division's decision to decide whether it contains errors.

[10] That review is based on the wording of the Act, which sets out the "grounds of appeal." A claimant has a ground of appeal where the General Division makes an important error of fact either by ignoring or misunderstanding the evidence (such that the finding isn't supported by the evidence).[1]

[11] The General Division is assumed to have considered all the evidence, even if the General Division does not discuss all of that evidence in its decision. However, an

[1] For more about errors of fact, see *Walls v Canada (Attorney General)*, 2022 FCA 47.

appellant can overcome that assumption if the evidence was important enough that the General Division should have discussed it.[2]

Errors about the Claimant's treatment

– What the law says about treatment

[12] A claimant's treatment efforts are relevant to deciding whether a disability is severe in two ways. Treatment is important because the General Division needs to consider:

- whether the Claimant made efforts to manage his medical conditions[3]
- whether the Claimant refused treatment (if he did, then the General Division needs to consider whether refusing treatment was reasonable, and whether the treatment would have had an impact on his disability status)[4]

[13] In *Sharma*, the Federal Court of Appeal appears to agree with the way the Appeal Division referred to requirement for treatment as requiring Claimants to make **reasonable efforts** to follow medical advice or to provide a **reasonable explanation** why the claimant did not do so.

– General Division's decision about the Claimant's treatment

[14] The General Division found that the Claimant did not follow medical advice. The General Division described what the law says about treatment as follows:

> To receive a disability pension, an appellant must follow medical advice. If an appellant doesn't follow medical advice, then he must have a reasonable explanation for not doing so. I must also

[2] See the Federal Court of Appeal's reasons in *Simpson v Canada (Attorney General)*, 2012 FCA 82 and the Federal Court's reasons in *Lee Villeneuve v Canada (Attorney General)*, 2013 FC 498.
[3] The Federal Court of Appeal explained this in a case called *Sharma v Canada (Attorney General)*, 2018 FCA 48.
[4] The Federal Court of Appeal explained this in a case called *Lalonde v Canada (Minister of Human Resources Development)*, 2002 FCA 211.

> consider what effect, if any, the medical advice might have had on his disability.[5]

[15] The General Division stated that the Claimant tried a rehabilitation program through workers compensation (the program) and the treatment team discharged him from the program because of poor effort and participation.[6] The General Division decided that if the Claimant had more actively participated in the program, he may have had some benefit for his back pain.[7] The Claimant "didn't follow medical advice that might have affected his disability. This means that his disability wasn't severe."[8]

– Error of law about the Claimant's treatment

[16] The General Division made an error of law about the Claimant's treatment. It seems to me that the General Division decided that being discharged from the program under the Claimant's circumstances amounts to **refusing** treatment. However, there is no supporting analysis for the finding that attending a program and then being discharged from it is captured by the legal tests for taking reasonable steps to manage medical conditions or refusing treatment unreasonably. Skipping over a part of the legal test means the decision maker is no longer applying the test.[9]

[17] The Minister argues that the General Division made no legal error, and that since the Claimant was discharged from the program for poor performance and effort, he breached both the duty to take steps to manage his conditions and to follow medical advice.[10]

[18] I agree with the Minister that there are two separate legal questions here about treatment.

[19] I describe the questions as follows:

---

[5] See paragraph 35 in the General Division's decision.
[6] See paragraph 37 in the General Division's decision.
[7] See paragraph 37 in the General Division's decision.
[8] See paragraph 44 in the General Division's decision.
[9] See *Teal Cedar Products Ltd. V British Columbia*, 2017 SCC 32.
[10] See AD4-10.

- First, what does the Claimant’s participation, effort, and then discharge from the program tell us about whether he took steps to manage his medical conditions?

- Second, given all of the available evidence, did the Claimant’s failure to complete the program due to discharge amount to an unreasonable refusal of treatment that would have impacted his disability status?

[20] Refusing treatment is not necessarily the same thing as performing poorly in a particular treatment program such that a treatment team discharges a claimant at a particular time. On its face, medical staff discharging a claimant from a program suggests that the treatment team is refusing the claimant a particular treatment, rather than the patient is refusing treatment. It is important to note as well that the Claimant continued treatment efforts outside of the program, and was later re-admitted to the program.

[21] First, the General Division did not really analyze first whether the Claimant participated enough in the program that he met the basic requirement to lessen the impact of his disability or manage his medical conditions. The General Division does not need to question the medical information in the discharge report of course, but it does need to decide whether failing the standard as set by that particular 8-week program also means that he has failed to take reasonable steps to mitigate the medical condition.

[22] Second, the General Division did not really answer the question of whether the Claimant’s participation and performance in the program (that led to discharge) was significant enough to amount to a **refusal** of treatment. The General Division seems to have moved on to consider whether the refusal was reasonable without first deciding whether the circumstances surrounding the discharge from the program actually amounted to a refusal.

[23] As a result, I cannot tell whether the General Division applied the legal framework for considering the Claimant’s treatment. There must be a finding that the

Claimant refused recommended treatment before there can be a decision about whether that refusal was reasonable or what affect the treatment may have had on the disability. That part of the reasons is insufficient because there is no finding about what constitutes refusal in this unique context of the program the Claimant attended. As a result, it appears that the General Division did not follow all the parts of the required legal analysis about treatment.

[24] If I am wrong about that, and the General Division did not make an error of law in its analysis of the Claimant's treatment, the General Division still made an error of fact about the Claimant's treatment.

– Error of fact about the Claimant's treatment

[25] The General Division ignored some important evidence about whether the Claimant's "refusal" was reasonable. Some of the evidence about the Claimant's limitations, his prognosis, and the change in his diagnoses were important to consider before deciding whether the Claimant's "refusal" was reasonable. In this case, the General Division needed to consider more than just what the Claimant said about the program at the hearing when deciding whether he unreasonably refused treatment.

[26] The General Division acknowledged that before the Claimant started, the Claimant's treatment team thought that he would be a good fit for the program. But the General Division ignored other evidence arising before, during, and after the program that suggested that the program may not be successful for the Claimant due to the very nature of his disability-related functional limitations.

[27] For example, before he started the program, the Claimant's Global Assessment of Functioning (GAF) was 60-65. An orthopaedic surgeon stressed the role that anxiety was playing in the Claimant's physical symptoms.[11]

[28] During the program, there was evidence about the Claimant's prognosis (which was only guarded), the fact that he filed for bankruptcy during the program, and

[11] See GD2-207.

that his GAF was 60. He was taking Percocet and lorazepam. He had limited insight into his condition.[12]

[29] By week four of the program, the reports stated that he had a poor prognosis for return to work and that he wasn't making sufficient progress.[13] He was missing time at the program to attend the hospital emergency room for pain. The medical team decided that his efforts were poor and the Claimant argued that his efforts were high. The treatment team discharged the Claimant from the program.[14]

[30] After the program, the Claimant saw the same psychiatrist linked to the program. That psychiatrist changed his medications, updated his diagnosis to include ADHD, and began treating that ADHD for the first time.[15]

[31] After staff discharged him from the program, the Claimant also attended cognitive behavioural therapy with the same psychologist he saw during the program. The psychologist stated that the Claimant had clinically significant barriers to return to work.[16] The documents reference the Claimant's symptoms like impulsivity, irritability, impatience and impulsiveness improving with new medication.

[32] In my view, all of this evidence about the Claimant's treatment was important enough to discuss before deciding that the Claimant had unreasonably refused treatment.

[33] The Minister argues that the General Division did not make an error of fact because its findings about the Claimant's insufficient participation in the program were supported by the evidence. The General Division considered the evidence in the discharge report and the details it provided about the Claimant's lack of effort and participation as the reason he did not continue in the rehabilitation program.[17]

---

[12] See GD2-213.
[13] See GD2-268.
[14] See GD2-289.
[15] See GD2-289, which describes the follow up report at GD2-304.
[16] See GD2-285 and 315.
[17] See paragraphs 41 and 42 in the General Division decision, for example,

[34] The Minister argues that the General Division did not make any error when it decided that the Claimant unreasonably refused treatment. The Minister argues that claimants have a duty to take steps to manage the severity of their conditions and a personal responsibility to cooperate in their healthcare.[18]

[35] However, while that discharge report states that there was no medical reason why the Claimant could not progress in the rehabilitation program, there was other evidence that contradicted that finding that the General Division should have discussed and weighed. If the General Division preferred the evidence from the discharge report to the evidence after discharge that identified clear psychological barriers to returning to work, the General Division would need to provide reasons to explain that decision.

[36] The General Division needed to resolve whether the Claimant's lack of participation in the program was unreasonable or not. The evidence I've discussed before, during and after the program was relevant and the General Division should have discussed it. There were signs before the program about the challenges the Claimant might face during the program, there was evidence about what the medical team considered poor effort and participation (like missing time in the program because of hospital visits for pain) that the General Division needed to consider.

[37] The evidence after discharge was also so important because the Claimant received more treatment, including from some of the same professionals who treated him while he was in the program. They identified psychological barriers to return to work. The psychiatrist refined his diagnoses and changed his medications. The General Division didn't grapple with all of the relevant evidence about the Claimant's participation in the program. Evidence of psychological limitations can be quite relevant to making decisions about treatment efforts.[19]

---

[18] The Minister relies on the decision in *Brown v Canada (Attorney General)*, 2022 FCA 104.
[19] See for example *Minister of Employment and Social Development v JR*, 2019 SST 584.

Fixing the errors

[38] Once I find that the General Division made an error, I can decide how to remedy (fix) the error.

[39] I can give the decision that the General Division should have given, or I can return the matter to the General Division for reconsideration.[20] I can decide any question of law necessary for dealing with an appeal.[21]

[40] The Claimant and the Minister both agreed that if I were to find an error, I should give the decision that the General Division should have given.

[41] Giving the decision that the General Division should have given is an efficient way to move forward in many cases.[22]

[42] I adopt the reasons of the General Division in most of the key findings and summaries, namely:

- The Claimant's functional limitations do affect his ability to work. By January 2011 he had an L4-5 disc bulge, and he was diagnosed with adjustment disorder, anxiety disorder, cannabis use disorder, and ADHD (attention deficit hyperactivity disorder) by December 31, 2011.[23]

- The medical evidence supports that the Claimant had functional limitations with bending, back pain, and anxiety that prevented him from doing his usual job as a welder by December 31, 2011.[24]

---

[20] See section 59 of the Act.
[21] See section 64 of the Act.
[22] See section 2 of the *Social Security Tribunal Regulations* about the need to proceed in a way that is fast, fair, and just.
[23] See paragraphs 22, 26 and 28 in the General Division decision.
[24] See paragraph 33 in the General Division decision.

[43] I will complete the analysis by:

- Considering the Claimant's personal circumstances, since he did have functional limitations that affected his ability to work.[25] The Claimant's background (including age, level of education, language abilities, and past work and life experience)[26] are a component of the test to determine whether his disability is severe.

- Considering the steps the Claimant has taken to manage the medical conditions and whether he has unreasonably refused any treatment, with reference to parts of the record I found were missing from the General Division's analysis.[27]

The Claimant's background

[44] When deciding whether the Claimant has functional limitations that affect his ability to work, I need to consider how employable the Claimant is in the real world, given his:

- age
- level of education
- ability to speak, read, and write in English
- past work and life experience[28]

---

[25] The Claimant needs medical evidence to show that he had a serious medical condition at the time of the MQP, see *Dean v Canada (Attorney General)*, 2020 FC 206. However, the medical evidence does not to "support" every functional limitation in order for me to accept it.
[26] These factors I need to consider come from a case called *Villani v Canada (Attorney General)*, 2001 FCA 248.
[27] See *Klabouch v Canada (Social Development)*, 2008 FCA 33; and *Sharma v Canada (Attorney General)*, 2018 FCA 48. In those cases, the Federal Court of Appeal explained that claimants need to make reasonable efforts to manage medical conditions. There is no reference to exhausting all treatment options. The requirement set out in *Lalonde v Canada (Minister of Human Resources Development)*, 2002 FCA 211, is that claimants are cannot unreasonably refuse treatment, which is different from exhausting all treatment options
[28] See *Villani v Canada (Attorney General)*, 2001 FCA 248.

[45] In December 2011 (at the end of his MQP), the Claimant was only 35 years old. He had 15 years to go before even an early retirement under the CPP. Age is not a barrier to his participation in the workforce.

[46] The Claimant completed grade 9, and then attended a vocational school.[29] He completed a welding program and received a certificate. As the years went by, he kept up with the safety certifications required to work in welding.

[47] The Claimant can speak, read, and write in English. At the hearing, he explained how uncomfortable he finds it is to read doctors reports and the legal documents for his appeal, particularly aloud as he feels he can only do that to a grade 9 level.

[48] The Claimant's past work and life experience is especially relevant here. Once he had his certificate, he transitioned from his job in fast food to welding at the age of 17. The Claimant worked exclusively as a welder. The job was physically demanding in terms of hauling equipment, walking on uneven terrain, welding with precision (he was a pressure welder), and requiring focus.

[49] He never did any other work of any kind once he started welding. The Claimant testified that there is no sedentary or modified work for welders. As welders on teams get older, they don't carry as much equipment.

[50] At the hearing, the Claimant was so shocked by the idea of an alternate job to welding; it seems to me that he didn't fully understand the question. The Claimant's education in anything other than welding ends at grade 9. He has done no other type of work since he was a teenager. In my view, the Claimant has excellent experience in one specialized area that he is no longer capable of physically or psychologically. I find that the Claimant's narrow work experience is a barrier to returning to work in the sense that he will likely need to retrain if he were to access work within his physical restrictions. Realistically, he might need to upgrade his education first to complete a high school equivalency, and then retrain.

---

[29] The Claimant's testimony about his personal circumstances is in the Recording of the General Division hearing mostly from about 30:00 to about 42:00.

[51] I also find that the Claimant's disability-related behaviours documented in his medial file over the year, including irritability and impulsivity may negatively affect his ability to retrain. I accept the evidence as outlined by the General Division about the Claimant's emotional outbursts. He doesn't work well with people (before and after his MQP). Despite treatment, he is easily frustrated and he gets into arguments in public.[30] In my view, these kinds of functional limitations in terms of the Claimant's mood could complicate retraining efforts. Even the Claimant relationship to the medical treatment team in the programs demonstrates the challenges he faces in dealing with other people in professional settings.

[52] Further, the Claimant had physical limitations in the months leading up to the end of the MQP. He could sit for 25 minutes, stand for 20 minutes, and walk for 5 minutes. By December 31, 2011, he could walk for 30 minutes. Efforts at retraining may require the need for the Claimant to alternate between standing and sitting, which isn't necessarily an insurmountable barrier. However, it is another challenge to the retraining process.[31]

Steps to manage medical conditions

[53] The Claimant has taken reasonable steps to manage his conditions, and he has not refused any treatment unreasonably.

– **The Claimant's treatment efforts**

[54] Claimants have an obligation to show efforts to manage their medical conditions.[32]

[55] The Claimant has taken many steps to manage his medical conditions. He participated in tests to diagnose the cause of his back pain, and consulted with more than one surgeon. He had a CT scan of the lumbar spine.[33] He took medication

[30] See paragraph 40 in the General Division decision.
[31] See GD2-263 to 267, GD2-196, and GD2-310 to 313.
[32] The Federal Court of Appeal explained this requirement in *Inclima v Canada (Attorney General)*, 2003 FCA 117.
[33] See GD2-275.

prescribed to him for his pain. He attended physiotherapy regularly. He had a psychiatric assessment in March 2011.

[56] Remember that before he started the program, the Claimant's GAF was 60-65.[34] I take official notice of the fact that GAF of 51-60 is moderate symptoms or moderate difficulty in social occupational, or social functioning (for example, few friends, conflicts with co-workers.) The GAF in the Claimant's case is consistent with observations in the testimony about his trouble interacting with people in public and in a work setting. An orthopaedic surgeon stressed the role that anxiety was playing in the Claimant's symptoms.[35]

[57] In late 2011, he was accepted into an 8-week program staff by a doctor, physiotherapist and a clinical psychologist. The program has specific goals for patients to meet by the end of the program. The focus is on managing rather than eliminating symptoms and increasing functioning in order to return to work.[36]

[58] The team closely tracked the Claimant's participation in the program and discharged the Claimant before the end of the 8 weeks.

[59] During the program, there was evidence about the Claimant's prognosis (guarded), the fact that he filed for bankruptcy during the program, and that his GAF was 60. He was taking Percocet and lorazepam. He had limited insight into his condition.[37] By week four of the program, the reports stated that he had a poor prognosis for return to work and that he wasn't making sufficient progress.[38] He was missing time at the program to attend the hospital emergency room for pain. The treatment team discharged the Claimant from the program.[39]

[60] More specifically, the doctor's report stated that the Claimant was pain-focused, angry, suspicious, uncommitted to return-to-work, and convinced that he has a disabling

---

[34] Global Assessment of Functioning (or GAF).
[35] See GD2-207.
[36] See GD2-287.
[37] See GD2-271.
[38] See GD2-268.
[39] See GD2-277.

back condition. The occupational discharge that that his performance in strength and functional training circuits fell well below training goals.[40]

[61] The psychosocial discharge notes are somewhat less clear.[41] They conclude that there are no psychological barriers precluding the Claimant from returning to his job. However, at the same time, the notes state that when staff warned the Claimant about his behavior in the program, he asked for an appointment with the psychologist. He agreed to a referral to a psychiatrist because he was feeling irritable and stressed. He agreed to weekly psychological sessions to assist him with pain management.

[62] The psychiatrist said "in the long run, while [the Claimant's] anxiety symptoms may continue to hamper his rehabilitation efforts, the anxiety symptoms themselves should not prevent him from participation in rehabilitation efforts or returning to work."[42] I find that the psychosocial report concludes (for a reason not fully specified) that the Claimant's psychological limitations **shouldn't** result in a barrier to treatment, while simultaneously recognizing that they **were.**

[63] Ultimately, the team seemed to decide that the Claimant was self-limiting, and that while he did have anxiety, mood difficulties, and a chronic history of difficulty coping with stressors, these were not "significant" barriers to him achieving the stated goal of sustained return to work. The treatment team decided that missing a psychological treatment session because he had been in the hospital the night before and had not slept, meant that he was "not fully engaged in the program."[43]

[64] The report says, "the main barrier at present would be [the Claimant's] motivation to return to work." However, the same document says that from a psychological perspective, he was making slow progress in the program and that it appeared to be a combination of "his anxiety, understanding of his symptoms, and level of motivation

[40] See GD2-286.
[41] See GD2-286 to 289.
[42] See GD2-288.
[43] See GD2-288.

(which appeared to be reflected in his effort) which contributed to [the Claimant's] limited progress" in the program.[44]

[65] After the program, the Claimant saw a psychiatrist who changed his medications, updated his diagnosis to include ADHD, and began treating that ADHD for the first time. The Claimant attended cognitive behavioural therapy with the psychologist from the program. The psychologist stated that the Claimant had clinically significant barriers to return to work.[45] The documents reference the Claimant's symptoms like impulsivity, irritability, impatience and impulsiveness improving with new medication.

[66] The Claimant returned to the program for a second time. He was physical injured during the program and was not able to complete it.[46]

– **The Claimant made efforts to manage his medical conditions**

[67] In my view, the Claimant made reasonable efforts to manage his medical conditions. The Claimant's medical records are voluminous. They show sustained efforts to seek treatment from a variety of treatment providers. He has seen doctors and specialists for his back. He's tried many types of therapies to cope with and improve his back pain, including sustained efforts at physiotherapy. He has had psychiatric and psychological treatment. He's taken a variety of prescribed medications.

[68] He tried and staff discharged him from a rehabilitation program where his progress was slow. However, in my view, his participation in that program met the threshold requirement to make efforts to manage his medical conditions.

[69] The Claimant's failure to meet the functional targets of that program does not mean that he failed to take steps to manage his own healthcare. His output was not where it should have been. I accept the medical evidence that he was self-limiting, but I also accept that he had psychological barriers to return to work that were not resolved

---

[44] See GD2-289.
[45] See GD2-285 and 315
[46] See GD2-587 about the concussion, and GD2-434, the final report before staff discharged the Claimant from the program again. This decision followed reports of dizziness, nausea, weakness, a headache, and aggravated pain in his back. The program doctor found no objective reason for the symptoms.

when doctors discharged him from the program.[47] It seems to me that some disability-related behaviours were the source of irritation and frustration amongst the medical team in the discharge report were also the subject of ongoing treatment after discharge. The Claimant ultimately returned to the program, and only stopped when he was further injured.

[70] The Claimant has not demonstrated a lack of participation in his own health care. He has advocated for himself at various times to ensure that he had access to treatments he required. He has not met all treatment goals, but he has made efforts.

[71] The next question to consider is whether the Claimant refused any treatment.

– **The Claimant's discharge from the program is not refusing treatment**

[72] Is being discharged from a treatment program mean the same thing as refusing treatment? In this case, my answer is no.

[73] In my view, being discharged from a multidisciplinary rehabilitation program as an injured worker is not the same thing as refusing treatment. The Claimant was making progress, but the progress was slower than expected and it was clear that he would not meet the requirements of that particular 8-week program.

[74] I cannot conclude that being discharged from the program is refusing treatment. The discharge itself was not a decision made directly by the Claimant. He did not quit or refuse.

[75] The Minister argues that the Claimant's failure to complete the program is similar to the situation in a case called *Brown*.[48] In that case, the General Division decided that the claimant had failed to follow medical advice because he didn't exercise and lose weight. The claimant argued that he couldn't exercise because of his knee and back pain and likened his condition to driving a car with two flat tires.

[47] See GD2-315.
[48] See *Brown v Canada (Attorney General)*, 2022 FCA 104.

[76] The Appeal Division decided that although Brown took his pain medications as his doctors prescribed, the General Division didn't make any error by finding that the Claimant unreasonably refused treatment by failing to exercise and lose weight. The Federal Court of Appeal found that the Appeal Division's decision was reasonable.

[77] The Minister argues that the Claimant's situation is like the claimant's in *Brown*. The Claimant took his medications including Percocet, but he didn't complete his a different part of his treatment, in this case, the program. So it was open to the General Division to decide that he failed to follow medical advice unreasonably. There's no error of law.

[78] I agree that *Brown* is similar to the Claimant's situation in that they were both compliant with medication. However, the question is whether the Claimant's discharge from the program is at all different from Brown's refusal to exercise in order to lose weight.

[79] The Claimant did not refuse the program. He participated in it. He didn't make the progress that the team expected and they discharged him for lack of effort and participation. However, the treatment team let him back into the program again later. It was open to the General Division to consider whether the Claimant refused treatment, but it did not explain this part of the decision sufficiently since there's no analysis as to whether there was refusal here the way that there was in *Brown*.

[80] I find that missing a psychological session after being in the hospital the night before is reasonable. I raise this because missing the psychological session seems to be the key evidence in the discharge report of non-participation. The Claimant missed the September 7, 2011 psychological session. The next day, the team meets with him to tell him that he is not making the effort necessary to succeed and that "additionally, he was not fully engaged in the program as evidenced by choosing to miss his psychological treatment session on September 7, 2011."[49]

---

[49] See GD2-289.

[81] The Claimant did not refuse treatment unreasonably. His output did not meet requirements of a very specific return to work program. The Claimant had a good reason for that. The psychological opinion provided after the end of the program identified significant psychological barriers to return to work. Staff readmitted the Claimant to the program again later. The Claimant wasn't meeting all the expectations of this particular treatment, but he wasn't refusing it.[50]

[82] But if I am wrong, and in this circumstance the discharge is the same as refusing treatment because discharge was so connected to lack of effort, then I would need to consider whether there is a reasonable explanation for the Claimant's discharge.

– **If discharge for poor effort and participation was refusing treatment, the refusal was reasonable**

[83] When I consider all of the factors that affected the Claimant's discharge from the program, I conclude that any "refusal" of treatment the discharge represents was reasonable.

[84] The staff based the Claimant's discharge on poor performance, participation and effort in the program. However, psychological barriers affected the Claimant's performance, participation and effort in the program. I'll review and consider both the written evidence and the Claimant's testimony about these factors leading to the discharge.

[85] The progress reports show that by week 5, it was clear that the Claimant would not meet the functional targets set out by the very specific program he attended. The program was multidisciplinary. Some of the conclusions about the role that the Claimant's psychological challenges played in his participation in the functional part of the treatment weren't clear, both within the discharge summary itself and in the psychological and psychiatric follow-ups after they discharged the Claimant. As I mentioned earlier, some of the language suggests that there were psychological

---

[50] See paragraphs 64 to 68 in this decision about whether the Claimant participated in his own treatment through his efforts in the program.

barriers, or that there weren't, or that they weren't significant, or that there shouldn't have been any.

[86] In my view, the fact that the psychologist worked with the Claimant again after discharge and documented significant psychological barriers to return to work is important. So is the psychiatrist's documentation after the program about the Claimant's ADHD and other diagnoses that resulted in irritability and impulsivity. The Claimant lacked insight into his condition. This post-program evidence shows that evidence from the program about the Claimant's effort must be understood in light of the Claimant's psychological barriers and functional limitations.

[87] I find that missing a psychological session after being in the hospital the night before is reasonable and is not the kind of failure to participate that should disentitle a person to a disability pension. I don't view that as refusing treatment unreasonably.

[88] The Claimant's performance did not meet the requirements of a very specific return to work program. The Claimant had a good reason for that. The psychological opinion provided after the end of the program identified significant psychological barriers to return to work. He was readmitted to the program again later. The Claimant was failing at treatment, but he wasn't refusing it.

[89] It is not a leap in logic to conclude here that the Claimant's psychological limitations got in the way of successful treatment.[51] The Minister argues that the only reason the Claimant did not progress in the rehabilitation program was his lack of motivation to return to work, but that finding is simply not supported by the Claimant's mental health records.[52]

[90] The Claimant also testified about his experience in the program. The Claimant said:

---

[51] See *Minister of Employment and Social Development v JR*, 2019 SST 584.
[52] See AD4-9 for the Minister's argument.

- He didn’t complete the program because he was on medication and could not meet the functional goals set out by the program.
- The documentation on his participation in the program was one-sided. For example, the psychiatrist wasn’t trying to help him.
- The program wasn’t helping him to prepare for his old job because the physical tests were not specific to his old job requirements (like completing welding tests).

[91] If the Claimant must provide a reasonable explanation for not completing the program, I find he has provided it.

[92] Staff discharged him from the program because it was clear that he would not meet the functional goals by the 8-week mark and his effort and participation were not sufficient. I don’t have medical evidence to support the Claimant’s statement that his medications affected his physical abilities in the program, but I will not entirely discount his subjective experience of taking medication.

[93] The Claimant is correct in noting that the relationship he had with the treatment team was, in a way “one-sided.” I take the Claimant to be referring to the idea that this is an existing rehabilitation treatment program for injured workers. This is a specific program with specific time-limited goals for injured workers, and the Claimant failed to reach those goals.

[94] At least part of the reason the Claimant failed was his disability-related (psychological) limitations. The psychologist documented these limitations after discharge and before staff readmitted the Claimant to the program.

[95] The Claimant was consistent in his belief that the program wasn’t tailored to his needs for returning to work. The Minister points me to the Federal Court of Appeal’s decision in *Cvetkovski*.[53] In that case, the claimant didn’t participate in some treatments

---

[53] *Cvetkovski v Canada (Attorney General)*, 2017 FC 193.

for his mental health disabilities because he believed they wouldn’t be effective. The General Division found that this explanation was not reasonable because it wasn’t based on medical rationale, just his own belief. The General Division didn’t accept this as a reasonable explanation, and the Appeal Division didn’t give the Claimant permission to appeal. The Federal Court found the decisions of the Appeal Division and General Division to be reasonable.

[96] Here, the Claimant also provided his personal belief about what kind of treatment would have been better for him (focusing on welding specifically). If that were the only evidence about the Claimant’s experience with the program, I would agree with the Minister. Believing that there was better treatment than the program is not a reasonable reason on its own to refuse a treatment.

[97] The Claimant’s explanations point to the unique nature of the program itself, as a component of wider treatment efforts for an injured worker. Taken alone, they are not sufficient justification for failing at treatment, but taken together with the psychological information in the file, the Claimant has a reasonable explanation for his failure in the 8-week program.

The disability is severe

[98] I share the General Division’s conclusions about the Claimant’s functional limitations on or before the end of the MQP. He was not capable of his regular job at that time. When I consider his personal circumstances as well, I conclude that his narrow work experience would likely require him to upgrade his education and (or) retrain, and the Claimant’s psychological and physical limitations would be an additional barrier there.

[99] The Claimant was incapable regularly of pursuing any substantially gainful employment by the end of his MQP. His disabilities, taken together, coupled with his personal circumstances, mean that his disability was severe within the meaning of the CPP.

[100] Further, I am satisfied that his treatment efforts do not disentitle him to a disability pension.

The disability is prolonged

[101] The Claimant's disability is likely to be long continued and of indefinite duration. This means it's prolonged within the meaning of the CPP.[54]

[102] I find that the Claimant has shown he had a severe and prolonged disability by December 30, 2011. At that point, he was still showing significant pain behaviours, staff discharged him from the program, and a psychologist noted his psychological barriers in returning to work.

[103] However, a Claimant cannot be considered disabled more than 15 months before applying for the disability pension.[55] The Claimant did not apply for the disability pension until May 2020.[56] So for the purpose of the disability pension, the earliest the Claimant can be considered disabled is February 2019. Payments start four months after the onset of the disability, in June 2019.[57]

Conclusion

[104] I am allowing the appeal. The General Division made an error of law. I gave the decision that the General Division should have given: the Claimant is entitled to a disability pension under the *Canada Pension Plan*.

Kate Sellar
Member, Appeal Division

---

[54] See section 42(2)(a) of the *Canada Pension Plan*.
[55] See section 42(2)(b) of the *Canada Pension Plan*.
[56] The application that is under appeal is the one Service Canada received on May 28, 2020, see GD2-34.
[57] See section 69 of the *Canada Pension Plan*.