

**Automobile Injury Appeal Commission
Province of Saskatchewan**

Citation: *F.N. v. Saskatchewan Government
Insurance, 2007 SKAIA 004*
Date: 20070108
File: 033 of 2005

BETWEEN

F.N., Applicant

and

Saskatchewan Government Insurance, Respondent

Appearances:
F.N., Applicant
Dale Brown, for the Respondent

Before: **Joy Dobko, Chair**
Stephanie Pfefferle, Commission Member
Darleen Topp, Commission Member

**THIS DECISION HAS BEEN EDITED TO PROTECT THE PERSONAL AND HEALTH
INFORMATION OF INDIVIDUALS BY REMOVING PERSONAL IDENTIFIERS AND
OTHER IDENTIFYING INFORMATION**

Heard at **Saskatoon**, Saskatchewan
November 22, 2005

DECISION

[1] This is an appeal by the Appellant, F.N., of a decision made by Saskatchewan Government Insurance (“SGI”) dated December 9, 2004 which was sent to the Appellant to advise her that her funding for psychological counselling would end on December 31, 2004.

FACTS:

[2] The Appellant was involved in a motor vehicle accident on September 4, 2000 (the “accident”) near Calgary, Alberta. The Appellant was the backseat passenger of a motor vehicle which was T-boned at highway speeds. The Appellant was [age] at the time of the accident. She suffered very significant physical and psychological/emotional injuries as a result of the accident.

[3] The Appellant was transported by air ambulance and admitted to the Foothills Hospital on September 4, 2000, where she was diagnosed as having suffered an open fracture of her left distal tibia and fibula, a transverse fracture of her midshaft left humerus and multiple facial fractures. Facial fractures included the anterior and posterolateral wall of the left maxillary sinus; fracture of the left zygomatic arch; fracture of the left infraorbital; non-displaced fracture of the left lateral orbital wall; small displaced fracture of the nasal septum and small transverse fracture of the anterior wall of the right maxillary sinus. She was hospitalized in intensive care for 7 days. While in intensive care, she underwent repair of her tibia, fibula and humerus on September 5, 2000 and repair to her facial fractures on September 9, 2000. On September 11, 2000 she was transferred to the trauma unit at Foothills Hospital.

[4] The Appellant’s surgery on her left leg on September 5, 2000, consisted of irrigation and debridement of the open tibial fracture; an intramuscular nail in the left tibia and closed reduction and sugar-tong casting of the mid shaft fracture of the left humerus.

[5] On September 9, 2000, the Appellant underwent an eight hour surgery to repair her facial fractures. The Appellant underwent the following procedures to repair her facial fractures: open reduction and internal fixation of the maxilla; open reduction and internal fixation of the left zygoma; open reduction and internal fixation of the nose and open reduction and internal fixation

of the orbital floor with a bone graft. The Appellant, in her testimony at the appeal, stated that the left side of her face was “smashed”.

[6] She was discharged from the Foothills Hospital on September 16, 2000.

[7] The Appellant clearly suffered a number of serious and traumatic injuries in her accident. We have not attempted to outline her entire course of treatment for all of her injuries. This is not to minimize any of her injuries or any of the treatment that she has undergone. We have focused upon the treatment, assessment and medical opinions with respect to her psychological condition so far as it relates to her accident injuries as this is the central issue in this appeal.

[8] The Appellant completed her Application for Benefits on September 18, 2000. The Appellant reported extensive trauma injuries to her left side of her face, left arm and left leg. She also reported headaches, a sore neck and sore back. At the time of the accident, the Appellant was working approximately 20-30 hours per week at the [bank] as a customer service representative.

[9] On October 11, 2000, the Appellant attended upon Dr. Ernst. Dr. Ernst placed her in a humeral splint brace and instructed her to begin ambulation with a cane for her left tibia/fibular fracture. He also referred her to Dr. Blushke for follow-up on her facial surgeries. X-rays taken of the left shoulder and humerus on November 6, 2000 showed that although new bone was seen, the fracture lines were still clearly visible. The Appellant saw Dr. Ernst in follow up of her left humerus fracture on November 22, 2000. At that time, x-rays taken of the humerus showed that it was consolidating. He referred the Appellant for physiotherapy for her elbow, shoulder and leg.

[10] On November 9, 2000, Dr. Blushke met with the Appellant regarding her facial scarring. He reported:

Client was quite emotional in the office and fully expected that she could have some revisional surgery immediately and she wanted a complete guarantee that her appearance would be returned to what she felt was normal. I had a detailed discussion with her regarding the healing phase of these facial fractures and that she may have a chance to have some revisional surgery, but I think that she will be left with some residual defects on the left side of her face. She was clearly upset by my opinion regarding this.

[11] The Appellant attended Smithwick's Physiotherapy on 21 occasions from November 24, 2000 to January 18, 2001.

[12] On January 30 and 31, 2001, the Appellant underwent a tertiary assessment at FIT for Active Living ("FIT"). The Summary of Assessment Findings were:

Physically, [the Appellant] presented with an altered facial appearance including surgical scars to the left side of her face. There was altered posture. There was scarring over the left leg. [The Appellant] walks with an abnormal gait and was unable to stand on the left leg for extended periods of time. She was not able to use her left arm. No examination could be completed to the left arm due to a recent fracture. Some decrease was noted in the range of motion in the neck area, mid and lower back. There was weakness of the left upper extremity. Altered sensation was reported on the left side of the face. There was joint stiffness and irritability in the neck, upper and mid back predominantly on the left, as well as the lower back. Weakness was found around the hips. There were some altered mechanics in the left foot and ankle.

Medically, [the Appellant] was in good health prior to her motor vehicle accident. In the motor vehicle accident she sustained a fracture of the lower half of the left tibia which is healing well. This fracture was repaired with external fixators. She went through protracted surgical procedures, and periodically she has transient loss of voice. She had a fracture of the left orbit and currently has double vision on looking left. There is scarring over the left leg. [The Appellant] takes Tylenol 3 for pain and experiences constipation. On January 23, 2001, she re-fractured her left arm. Examination was limited due to left arm fracture. [The Appellant] reported problems with sleeping due to pain.

Functionally, [the Appellant] reported difficulties with two-handed activities such as dressing, made worse by recent fracture. She described difficulty with walking, climbing stairs, and prolonged standing. Her boyfriend was reported to do the majority of household tasks. Ms Kuffner had not returned to work since her motor vehicle accident. She perceived herself to be below the sedentary level, which is consistent with her presentation.

Psychosocially, [the Appellant] is currently experiencing significant symptoms of posttraumatic stress, and depression as a result of the motor vehicle accident itself, and her resulting facial injuries. The latter is currently a significant barrier to resuming functional activities outside of the home, including returning to work and socializing in public. [The Appellant's] emotional and physical difficulties due to the motor vehicle accident have likely been exacerbated by the recent physical assault she suffered.

[13] The Diagnoses were:

1. Multiple bilateral facial fractures (left orbit) with surgical repair and residual facial asymmetry.
2. PTSD
3. Left tibia-fibula fracture with operative repair
4. Left humerus fracture (re-fracture January 23, 2001)
5. Abnormal gait

6. Depression
7. Biomechanical dysfunction of lower back
8. Lower extremity weakness
9. Whiplash associated disorder II
10. Mild TMJ dysfunction

[14] The FIT team recommended secondary treatment as soon as the Appellant was medically cleared and also individual psychosocial counselling. They also recommended that the Appellant be re-assessed in five to six months. The assessment team noted that there appeared to be a “recession of the left eye socket, scars under both eyes and a protruding piece of bone on the lateral side of the left cheekbone”. The team stated that the Appellant was very concerned about the appearance of her face and that it was very important to her. The team also reported that the Appellant presented with somewhat flat affect and limited eye contact and seemed self-conscious about the appearance of the left side of her face. The Psychosocial Report, completed by psychologist, Dr. Stacy Thomas, described the Appellant’s general emotional well being as follows:

[The Appellant] presented as pleasant, cooperative, and forthcoming about her difficulties. She was tearful for a good part of the interview, particularly while recounting the recent physical assault she experienced, and her concerns about her facial appearance.

[The Appellant’s] self-report suggests she is currently experiencing significant symptoms of post-traumatic stress in response to the accident. These symptoms include: spontaneous flashbacks and intrusive memories of the event accompanied by distress, increased irritability, nightmares about the accident and about upcoming surgery, sleep disturbance due to rumination/worry, feelings of detachment/numbing in relationships, inability to recall aspects of the trauma, and greater vigilance for news of accidents. [The Appellant] also noted that her experience of intrusive thoughts, worry and “flashbacks” interfere with her ability to concentrate. Her report of perceiving her experience during the accident and, at times, in the present as “surreal”, suggests that she might also dissociate when overwhelmed. In addition, [the Appellant] reported problems with anxiety as a passenger when traveling on the highway, or when in a car making a left turn on city streets. She reported that she often imagines being hit by other cars when in such situations.

Although anxious while traveling in a car, her passenger anxiety is not severe enough to limit her ability to engage in activities away from home. Rather than passenger anxiety, [the Appellant’s] distress about her facial appearance is a current barrier to her participation in activities in public. [The Appellant] currently believes that she looks like “someone with Down’s Syndrome”. She reported that she rarely does things in public because of her self-consciousness about her appearance. She stated that she has always prided herself in her appearance, but did not realize how important her looks were to her self-esteem until they were “taken away”. [The Appellant’s] report suggests that she has experienced the injuries to her face and resulting reconstructive surgery as traumatic events. In addition to avoiding activities in public, [the Appellant] reported that she avoids looking at herself in the mirror, and when in public, will try to hide as much as

possible by covering the left side of her face with her hair and sitting in the corner of the room. She also reported significant anxiety, which interferes with her ability to sleep and concentrate, about her upcoming facial surgery in early February 2001. She reported specific fears about the pain, the inability to communicate during the initial recovery phase and the surgery failing to restore her facial appearance. [The Appellant] reported that she goes to bed at 11 p.m. but will lie awake, worrying for 3-4 hours. She then wakes at 7 a.m., and then goes back to bed and sleeps from 8 am-12pm.

[The Appellant] also appears to be suffering from moderate symptoms of depression, including severe fatigue and lack of energy, loss of interest in and pleasure from previously enjoyed activities, feelings of being punished and increased tearfulness, sadness, guilt and pessimism. These symptoms are likely due to the impact of the accident on her self-esteem, relationship with her partner, and future plans. They might also be related to the recent assault she suffered just prior to the assessment. This assault left [the Appellant] with a broken left arm and she believes it further compromised her emotional difficulties. She reported that the night she was assaulted was the first time in months that she had gone out socially with friends. In addition to increasing her weariness of socializing in public, [the Appellant] reported feelings of shame as a result of this physical assault, as she believes others will assume that this event is a reflection of her lifestyle.

[The Appellant] reported experiencing a great deal of anger towards her boyfriend, who was driving at the time of the accident. [The Appellant's] reported relationship difficulties prior to the accident, which appear to have been exacerbated by this event. In addition to anger, she reported feeling emotional distant from her partner; she attributed her decreased libido to the increased emotional distance and anger she currently feels toward him. The accident has also interfered with her future plans, most notably a trip to Thailand.

[15] On February 9, 2001, the Appellant underwent a second eight hour facial surgery. During this surgery, a coronal incision was made through the hair and scalp, which was elevated to expose the orbital rims, and in particular, the zygomatic arch on the left side. The infraorbital rim was exposed through the old scar on the left lower eyelid, and an incision was again made in the upper bulcal sulcus to expose the maxilla. The old plates were removed and the bone was osteotomized or cut, through the lateral orbital rim, the lateral orbital wall and floor, and the lateral buttress of the zygoma-maxilla, while the arch itself was cut in three places to correct the projection of the zygomatic arch. The Appellant remained in hospital for four days for pain control and until she could mobilize with relative comfort. The Appellant, in testimony, described this as an ear to ear surgery to reposition her cheekbone and to work on the orbit of her left eye.

[16] In March 2001, the Appellant met with psychologist Dr. Shepel, for counselling. She later advised SGI that she did not feel a good rapport with Dr. Shepel and asked if she could see an alternate psychologist. Dr. Kostyniuk referred the Appellant to Dr. Lana Shimp. Sometime in or around March 2001, the Appellant became pregnant. Her expected due date was November 12, 2001. She was very ill with morning sickness and as a result was not medically cleared to

start the physiotherapy component of her secondary treatment until May 14, 2001. She commenced primary physiotherapy treatment on May 28, 2001. Her secondary treatment program commenced on June 4, 2001 at Saskatoon Musculoskeletal Rehabilitation Center.

[17] On July 5, 2001, the Appellant was reviewed by Dr. Ernst with respect to her left ankle and left humerus injuries. His examination revealed normal alignment to both lower extremities. It was his opinion that her ongoing problems with her left ankle were soft tissue related and he recommended aggressive calf strengthening.

[18] In August 2001, Dr. Kostyniuk opined that he did not believe that the Appellant had recovered sufficiently from her injuries to participate in a gradual return to work following her discharge from the secondary program on August 28, 2001.

[19] Upon referral from Dr. Kostyniuk, Dr. Lana Shimp, psychologist, met with the Appellant on August 20, 2001. Dr. Shimp reported to SGI that the Appellant continued to report symptoms of depression and trauma but had agreed to individual counselling sessions to work initially on issues related to changes in her facial appearance.

[20] The Appellant was discharged from secondary treatment on August 28, 2001. It was noted that she had not reached maximum medical improvement. The team opined that physically, the Appellant was functioning in the light physical demand level and was ready for a graduated return to work. However, Dr. Shimp expressed concern about the Appellant's psychological readiness to return to work given the psychological issues identified by the FIT team and the lack of psychological services that had been received as of August 2001. Dr. Kostyniuk was also of the opinion that the Appellant was not able to return to work due to depression and post-traumatic stress symptoms. The Appellant had one psychological appointment with Dr. Shepel during her secondary treatment.

[21] On September 27 and October 1, 2001, Dr. Shimp performed a psychological assessment on the Appellant to clarify diagnosis; to facilitate the development of treatment plans; to determine the psychological readiness of the Appellant's to return to work; and to determine the relationship of psychological issues to the motor vehicle accident. Dr. Shimp's summary and recommendations were:

1) Psychological/Diagnostic Issues

- [The Appellant] has post-traumatic stress disorder (PTSD). Her PTSD symptoms are of high severity and are causing significant impairment in social and occupational functioning.
- She also has associated symptoms of depression, which is of moderate to high severity. There is suicidal ideation present, although no intent or plan.
- The client has significant social anxiety, which is making it difficult for her to leave her home. This is related to self-consciousness about the changes in her facial appearance and also represents avoidance behavior that is symptomatic of PTSD.
- [The Appellant] is having difficulties coping with pain. This issue is not significant now that she completed her secondary treatment and is less active, although it is expected to become more problematic when activity level increases and there are attempts at return to function.

2) Comments on Etiology

[The Appellant's] PTSD is directly related to the trauma of her MVA and associated changes in her facial appearance. The abuse by her previous boyfriend over 4 years ago may have created a vulnerability to having difficulties coping with the trauma of the MVA, although the differences in the nature of the trauma and her good social and occupation functioning prior to the MVA does not suggest any direct link between this abuse and the current trauma symptoms. The assault at the bar, which occurred after the MVA, likely interfered with coping at the time, although does not appear to be an ongoing issue.

Difficulties with depression are secondary to the PTSD, changes in appearance, associate disruption in lifestyle, and ongoing difficulties with pain. Strain in her relationship with her partner, due in part to anger at him for the MVA, is also likely playing a role in maintaining her depression. There is a history of depression and alcohol over-use, suggesting there are likely some pre-existing personal vulnerabilities to difficulties coping when faced with a stressor.

3) Return to Work Issues

The client is *not psychologically capable* of returning to her pre-injury work at this time given her PTSD and depression, which has been largely untreated to date. No vocational plan has been established. Her social avoidance, discomfort with being around others, and lack of self-confidence are the biggest barriers to return to pre-injury work at present. She does not think that she is physically capable of returning to work as a waitress and is uncertain about whether she wants to return to work at the bank. It is *more likely than not* that she will be able to work at the bank and as a waitress, from a psychological perspective, after she receives additional therapy and addresses her fears related to being around the public. At this point, the client is planning to take a year off work to care for her new baby. If she was not taking a maternity leave, she would likely be psychologically able to begin a graduated return to work to her pre-injury positions in 4-6 months. Return to work to a different position, that involves minimal stress and little social interaction, could begin sooner if this was available (i.e., within 2-4 months). These time frames would need to be adjusted according to her response to future reconstructive surgery, as there may be further psychological setbacks depending on outcome.

4) Recommendations

- a) [The Appellant] will require regular, intensive psychological services to address her PTSD, depression, and social withdrawal. Therapy should initially focus on helping her

come to terms with the changes in her physical appearance and gradually help her become more socially active while learning ways to cope with the associated anxiety. [The Appellant] has been hoping that further surgery will restore her facial appearance and has been struggling with proceeding with her life as she awaits further surgery. Exposure work with regards to processing the MVA also needs to occur after she has been taught concrete coping strategies to manage the anxiety and re-experiencing symptoms. Increasing activities and cognitive restructuring techniques will likely be helpful in treating the depression. The relationship issues that are due to anger with her boyfriend for the accident, indicate that some couples work may also be needed. It is anticipated that *at least* 6 months of weekly therapy sessions will be required, although a more specific time frame can be established after her initial response to therapy is assessed (i.e., after approximately 2 months of therapy).

- b) Assistance with pain management will be needed if she returns for additional rehab and/or if there are increased difficulties coping with pain when she becomes more active following the birth of her child.
- c) A vocational plan needs to be developed after the client has made some gains in therapy. Her vocational worker needs to be aware of the client's psychological status and recommendations. The vocational worker should consult with the psychologist, with regards to the nature and timing of appropriate employment. It would be anticipated that return to work issues could be explored after 3-4 months of therapy, although it is recognized that [the Appellant] does not plan to return to work for a year after her baby is born. Psychological services will need to be provided to help [the Appellant] through the return to work process, particularly if she goes by to work in a position where she is heavily involved with the public.

[22] In November 2001, SGI wrote to Dr. Shimp and addressed a concern over the Appellant's lack of counselling since the accident despite the recommendations of the FIT team of the necessity for counselling. SGI was interested in suggestions on how to ensure regular counselling sessions would occur. Dr. Shimp responded advising that she had not been aware of the lack of counselling but that the development of a therapeutic contract to address attendance issues would be presented to the Appellant. The Appellant resumed counselling on December 5, 2001 and was scheduled to meet weekly with Dr. Shimp commencing on January 2, 2002.¹

[23] In February 2002, Dr. Shimp reported that the Appellant was responding positively to therapy. Dr. Shimp also recommended that the Appellant be as involved as possible in the upcoming FIT Assessment scheduled for February 12 and 13, 2002.

[24] A reassessment took place at FIT on February 26 and 27, 2002. The Summary of Assessment Findings with respect to the Appellant's psychological well being was:

...

¹ The correspondence states that weekly sessions will begin January 2, 2001. This was obviously a typing error and it was intended to read January 2, 2002.

Psychologically, [the Appellant] continued to present with significant emotional distress in response to the impact of the accident on her lifestyle, and appearance. Consistent with the findings from the initial FIT assessment, and the more recent psychological assessment by Dr. Lana Shimp, psychologist, [the Appellant] currently appears to be experiencing symptoms consistent with diagnoses of Post-Traumatic Stress Disorder (PTSD), which includes symptoms of passenger anxiety and moderate symptoms of depression. Although her report suggests that she continued to meet the criteria for PTSD, the intensity of some of her symptoms, has changed since the initial FIT assessment. As in the Initial FIT Assessment, the accident and her resulting emotional difficulties have caused difficulties in her marriage. Her emotional difficulties, particularly her distress regarding her appearance, continue to be a significant barrier to resuming work and other activities of daily living.

[25] The FIT team recommended primary physical therapy for six weeks for the left shoulder, ankle and spine as well as a home program. FIT also recommended a three month gym pass and weekly psychological counselling with Dr. Shimp for six months to be extended at the direction of Dr. Shimp. It was recommended the Appellant receive a referral to a neuro-ophthalmologist regarding her TMJ dysfunction. Further, she was to obtain a referral for x-rays of the left leg and referral for an orthotic for her left ankle injury. It was also recommended that a Stand Alone FCE be completed in one year.

[26] On May 2, 2002, Dr. Shimp provided a progress review in which she reported that the Appellant was responding well to the therapy and that weekly sessions would continue.

[27] On June 3, 2002, Dr. Patel reported that the Appellant had complaints of diplopia on far left gaze with an associated esotropia. Dr. Patel concluded that surgery to repair the strabismus was not recommended. He further reported that she had left enophthalmos as a result of the orbital floor fracture that had caused left upper lid ptosis. He felt she could have surgery to repair the ptosis but reported that the Appellant appeared more interested in having orbital surgery to repair the 2 mm of enophthalmos.

[28] On June 11, 2002, Dr. Shimp provided the following progress review:

[The Appellant] is feeling quite discouraged after a consultation with her plastic surgeon in Calgary, who apparently does not think much more can be done in terms of the facial damage. She has resumed physical therapy again, which has also been difficult for her in terms of increased pain. Medical appointments are frequently associated with some deterioration for the client, as it requires her to discuss the MVA in more detail and deal with the reality of her injuries.

Depressive symptoms are fluctuating, but there has been a notable improvement overall. We are continuing to work on increasing self-esteem and building confidence and the client is making progress in this regard. Her eye contact is improving and she is becoming more active socially,

although this remains a source of anxiety. Relationship stressors are ongoing and are continuing to be addressed in therapy.

I will be continuing to see [the Appellant] on a weekly basis to build on pain and stress coping strategies, to address self-esteem and adjustment issues, as well as relationship problems. Further work will be needed in the future on driving anxiety. [The Appellant] continues to show good motivation and commitment to the therapy.

[29] On September 16, 2002, Dr. Shimp provided another progress review regarding the Appellant's ongoing psychological counselling:

[The Appellant] has made gains in terms of the driving anxiety. She has been able to tolerate longer road trips with manageable anxiety. Anxiety remains high, however, when driving near the scene of the accident and on the way to Calgary. The client's depression and PTSD symptoms have also been improving since therapy has been initiated, although symptoms fluctuate depending on other stressors and triggers. She is having another surgery done for facial reconstruction on November 18, 2002. The surgeon is apparently uncertain about how much gain can be achieved with further surgery. This is very anxiety provoking for [the Appellant] and raises self-esteem issues related to difficulty with coming to terms with the changes in her physical appearance. She has been gradually being more active socially, although continues to feel self-conscious and uncomfortable in social situations.

All of the sessions provided since last review have been individual sessions, as the client's partner has not been receptive to attending recently. Further couples counselling will be provided if her partner is willing to attend, as relationship issues remain problematic.

Although [the Appellant] has been making gains, she will require additional therapy to deal with the stress of the upcoming surgery, related self-esteem, adjustment, and social functioning issues, as well as continued work on the driving anxiety, PTSD, and depression. I will be continuing to see [the Appellant] on a weekly basis.

[30] The Appellant underwent a Physical Work Performance Evaluation Summary on November 12, 2002, in which it was determined that she could physically sustain medium level work for an eight hour day.

[31] A third facial operation was undertaken on November 18, 2002 when the plate at the frontozygomatic suture line on the infraorbital rim was removed and the bone graft was taken from the right iliac crest to augment the floor and the lateral wall behind the globe to attempt to improve the enophthalmos. The Appellant remained in hospital one day. Reassessment showed improvement in the orbit/eye relationship and improvement in the enophthalmos. The Appellant, in testimony, described this surgery as taking bone graft from her hip and placing it behind her sunken left eyeball.

[32] On February 11, 2003, an updated psychological report was obtained from Dr. Shimp's office. The Appellant was attending for counselling with Ms. Cherie Peterson while Dr. Shimp was away on maternity leave. Ms. Peterson noted that motivation and attendance had been good and further reported:

[The Appellant] has continued to attend counselling to deal with PTSD, depression, social anxiety, and relationship issues related to the MVA. There was some deterioration in her psychological functioning related to her recent facial reconstructive surgery, which occurred on November 18, 2002. Although the client notices some improvement in her appearance with surgery, it unfortunately heightened memories of the MVA, increased preoccupation with her appearance, and exacerbated relationship difficulties (because of increased stress and her partner's heightened sense of guilt related to being responsible for the MVA). We are continuing to address these issues in therapy and [the Appellant's] mental status is starting to stabilize as she deals with the psychological effects of her most recent surgery and the MVA.

With respect to [the Appellant's] return to work, a graduated return to work could be initiated. However, the work would need to involve minimal social contact. [The Appellant] continues to struggle from high levels of social anxiety and social avoidance due to decreased self-esteem and self-consciousness regarding her appearance. Although she continues to make efforts to become more socially active and some progress has been made in this regard, her anxiety and comfort in social situations are not yet at levels that would make work involving any significant level of social contact manageable at this time. She would not be able to manage a position where she would need to deal with the public, but could likely tolerate working with a small group of colleagues. The work would also need to be low stress. Work hours should be minimal to begin and increase in a graduated fashion, with increases in work hours occurring as the client is able to tolerate. It is recommended that [the Appellant] and myself be actively involved in working with her vocational rehabilitation worker in developing a return to work plan to increase likelihood of success and appropriate placement.

Although [the Appellant] has shown some overall improvement with therapy, she will require additional counselling to address social anxiety, and related self-esteem, adjustment, and social functioning issues. In addition, further work on PTSD, depression and relationship issues is necessary. Psychological services will also be needed to facilitate return to the workforce. The MVA has had a considerable psychological impact on [the Appellant], necessitating long-term therapy. Time frame for additional therapy depends on client progress, but it is estimated that a minimum 4-6 months will be needed.

[33] On April 30, 2003, Ms. Peterson recommended that the Appellant be accompanied on her upcoming trip to Calgary for surgery scheduled for May 28, 2003. Ms. Peterson reported that the Appellant had experienced moderate deterioration of her psychological functioning in her past trip to Calgary due to triggered memories of the accident. Also around this time, SGI was attempting to find an appropriate work placement for the Appellant. They were advised that the Appellant had been taken off the roster at the bank.

[34] A fourth facial operation took place² to correct the drooping upper eyelid. This surgery took approximately 50 minutes.

[35] On July 14, 2003, Dr. Shimp wrote to the Appellant's lawyer advising of the Appellant's psychological status and treatment. She reported:

I conducted a psychological assessment of [the Appellant] on September 27, 2001 & October 1, 2001 (see report included) and diagnosed her with severe post-traumatic stress disorder, with associated moderate to severe depression, and social anxiety and self-consciousness due to changes in her appearance resulting from the MVA. Difficulty coping with pain was also noted. She had been reassessed by Dr. Stacy Thomas in February 2002 as part of a multi-disciplinary assessment conducted through FIT for Active Living, who also diagnosed post-traumatic stress disorder, depression, and passenger anxiety. [The Appellant] has shown some overall improvement with therapy, but symptoms and functioning are highly variable. She has experienced numerous setbacks secondary to further surgeries and other life stressors, including relationship and family issues. Relationship problems, that are partly related to MVA (her partner feels guilty for causing the accident and she is more insecure due to change in appearance), contribute to problems recovering emotionally from the MVA. [The Appellant] is insightful and has become motivated and engaged in the therapeutic process and I am hopeful that she will be able to achieve further gains.

It is quite likely, however, that residual psychological difficulties related to self-esteem and trauma will remain even with further treatment given the persistence of symptoms, despite having received quite extensive psychotherapy. It is unclear if she will be capable of returning to work in a position where she needs to deal with the public because of social anxiety and insecurity related to her appearance.

In terms of history of psychological difficulties, the client reported receiving counselling at age 13 for problems related to peers, medication at age 18 for depression related to difficulty dealing with the end of an emotionally and physically abusive relationship, and heavy drinking between the ages of 18 and 19. This history suggests that she may have been vulnerable to developing difficulties with coping when faced with a stressor such as an MVA. However, the trauma of the MVA and the resulting change in her physical appearance is clearly the primary factor that has contributed to the development of her current psychological difficulties, although relationship and family issues have contributed to maintenance of difficulties.

[36] On July 22, 2003, Dr. Shimp wrote to SGI advising that the Appellant's psychological status had deteriorated following her most recent plastic surgery and requested that the work trial not commence until such time as the Appellant's mental status had stabilized again. Dr. Shimp also reported that despite extensive psychological services, the Appellant remained self-conscious and preoccupied with her appearance which was associated with social anxiety and avoidance.

² We believe this surgery occurred on May 28, 2003 however there is no documentation on the file that specifically shows the date of the procedure.

[37] In January 2004, the Appellant attended upon Dr. Mothersill, psychologist, for a Vocational and Psychological Assessment to determine the Appellant's current and future level of employability and also to identify any psychological disorders. With respect to the Appellant's psychological state, Dr. Mothersill reported:

...

Initially, her physical symptoms as well as her emotional condition prevented her from returning to her previous occupation as a bank teller. Although her physical abilities improved through the course of treatment, [the Appellant] has continued to be psychological disabled from returning to work occupations that involve a high degree of public exposure. Her PTSD and depression have been accompanied by a high degree of social avoidance and extreme fears about the acceptability of her facial appearance. Her concerns about her appearance have taken on the aspects of a Body Dysmorphic Disorder which is associated with extreme social isolation, marital difficulties, suicidal ideation, painful preoccupation with appearance, pursuit of medical treatments to rectify appearance as well as impairment in social and occupation functioning. Her appearance has been core to her sense of self and the changes due to the accident have been devastating to her confidence.

[The Appellant] continues to be psychological disabled from returning to work in any occupation. With additional treatment, she may be able to take jobs of a clerical nature that do not require social contact or dealing with the public. Although she has the intellectual capability of attending college and university programs in architectural technology, interior design, pharmacy, and drafting programs, it is highly doubtful that she will be able to sustain motivation and psychological commitment to a higher level of educational pursuits until her sense of self has been more stabilized, her psychological disorders have been successfully treated and her interpersonal difficulties have resolved. In addition, her ongoing emotional problems interfere with her ability to return to work and save money for further educational pursuits. In all likelihood, the devastating effect of this motor vehicle accident at such an important juncture in [the Appellant's] psychological, maturational and occupational development will result in her maintaining a significantly reduced level of occupational functioning and prevent her from achieving educational and occupational successes that she otherwise would have enjoyed.

[38] On January 23, 2004, Dr. Lindsay, plastic surgeon for the Appellant, reported that a further ptosis surgery may be conducted to readdress the position of the left upper eyelid. He further reported that the Appellant was interested in having one of the plates removed in her face to address the inner aspect of her left eye but that he did not think an operation of that magnitude would be appropriate. Dr. Lindsay further reported on the plastic surgery aspects of the Appellant's injuries as follows:

As far as the plastic surgery aspects of her injury and recovery is concerned, she suffered multiple facial fractures affecting the upper jaw, left orbit and left cheek bone particularly. She had undergone three operations under general anesthetic and one local anesthetic to address these and the complications therefrom. During that time, she has suffered from pain in the face, which may persist. The numbness in the scalp will improve, but may never go completely. The tingling in the cheek would be expected to resolve eventually. The facial scars will improve, but will forever be visible with close inspection. The position of the upper eyelid as far as its edge is related to the

pupils concerned, is asymmetrical and one further attempt to correct this will remain. The abnormal appearance as far as the medial aspects of the eyelid fissure are concerned, will not change.

[39] A Residual Capacity Evaluation was completed on February 17 and 18, 2004. The Summary of Psychosocial Status, completed by psychologist Dr. Sheckter, was:

It is clear that [the Appellant's] MVA had a substantial psychological impact and that she needs further treatment. She continues to meet diagnostic criteria for Post Traumatic Stress Disorder and Major Depressive Episode, in addition to Social Phobia, despite considerable psychotherapy and a strong desire to overcome these issues. The writer would agree with Dr. Shimp's appraisal that the predominant issue for [the Appellant] at present is her concern with her appearance. These concerns are significant enough to merit the diagnosis of BDD. Avoidance attributable to this condition and perhaps also due to PTSD, appears to have assumed a self-perpetuating quality, further exacerbating those conditions and her feelings of guilt and helplessness and her depressed mood.

[The Appellant] has expressed a strong desire to overcome her fears and resume her life, to myself and reportedly to Dr. Shimp and Dr. Thomas, and the client appears to have been provided with guidance in how to do this through her psychological therapy. However, it would appear that [the Appellant] has had some difficulty implementing the necessary exposure exercises in an effective way. It will be crucial for her to do so as soon as possible. It is commendable that [the Appellant] has overcome her initial reservations about psychotherapy and appears to have formed good rapport with Dr. Shimp. The client reported that she is very satisfied with this relationship and feels it would be helpful to continue seeing Dr. Shimp.

Cognitive behavioural therapy, including exposure with response prevention has been identified as a potentially effective treatment for BDD and it is recommended that [the Appellant] be engaged in such treatment. It is anticipated that exposure to social situations would be a component of this treatment. Since exposure is also a fundamental part of treating social phobia and PTSD, it should be possible to design exposure exercises which address all three conditions. It is imperative that [the Appellant] be actively engaged for this treatment to work and this will require a commitment on her part to follow-through on assigned exercises. It is recommended that she be coached in providing very specific and concrete goals for treatment and that adherence to those goals be a condition of continued treatment. Having [the Appellant] develop her own exposure exercises and implementation schedule may help to provide her with some sense of control over the process. A task oriented approach such as is recommended here might also help to reduce [the Appellant's] sense of being stuck, improving her sense of control.

[The Appellant] appears to have a very strong attachment to her daughter and this relationship may provide avenues for [the Appellant] to devise exposure exercises. Perhaps getting involved in toddler activities such as kinder gym where the child is the focus of attention and therefore [the Appellant] would not be as concerned about scrutiny of herself would serve as good initial activities. A graduated return to work in a position with only a few coworkers and no contact with the public at least initially, might represent another good starting point. In a work situation, social interaction are likely to be more limited in quantity and relatively more structured than in other social situations. It is anticipated that [the Appellant's] mood will improve as her avoidance is reduced and her other concerns resolve.

It is anticipated that [the Appellant's] concerns should improve with further treatment and 6 months more of weekly sessions with Dr. Shimp are recommended. It is further recommended that [the Appellant's] condition be reviewed in six months time by SGI's psychology consultant to determine: 1) the extent to which unresolved psychological distress may be MVA related vs.

premorbid; and 2) whether additional psychological treatment is warranted, and whether such treatment should be considered the responsibility of the insurer.

[40] The assessment team reported that psychosocial issues limited the Appellant's ability to return to work. The relevant portions of the report are:

6. Is there any psychiatric/psychological diagnosis, or psychosocial/behavioral issues that may be impacting on functional abilities? If yes, please explain the relation, and identify any strategies or accommodation which may minimize the impact on the functional abilities.

Yes, the client has symptoms that meet diagnostic criteria for Post Traumatic Stress Disorder, Major Depressive Disorder and Social Phobia associated with probable Body Dysmorphic Disorder. Her depressed mood appears to affect her energy level and motivation. Her post traumatic stress apparently causes avoidance of MVA reminders, in particular driving or riding in a motor vehicle. Finally, her preoccupation with her facial appearance and fear of how others might respond causes her to avoid social interaction outside of her home. These conditions, chiefly the Social Phobia, interfere with her ability to return to a workplace, particularly if there are many social interactions involved. However, she should be capable of engaging in a very gradual return to work.

It will be imperative that [the Appellant] be given time gradually to build confidence in interacting with others, and she will need assistance from her psychologist to manage her anxiety during this transition. If the return to work is arranged with sensitivity to these issues and includes a gradual increase in social interaction, it should not only be viable, but may serve a therapeutic purpose in helping to address the social anxiety and self image issues. Understandably, [the Appellant] has apparently been most successful in aspects of her rehabilitation where she was able to assert some level of control. It will therefore be important that she be involved in planning and implementing any return to work. It will also be important to have her psychologist involved in planning the return to work and assisting in anxiety management but the onus should be placed upon [the Appellant] to ensure that the agreed upon plan is followed. The client has in the past demonstrated a propensity for avoidance behavior to cope with her anxiety. While this is a common means of coping with Social Phobia, avoidance only serves to perpetuate such problems and therefore would represent a form of non-compliance.

...

10. Are there any specific activities which present a risk for deterioration of the customer's current condition? If so, please identify and advise appropriate measures to deal with such activities.

[The Appellant] requires further psychological intervention. Without such services, there is risk that her avoidance behavior will worsen. Attempting to rush her into social situations including work without a clearly delineated and consensual plan will not likely be helpful, as [the Appellant] is likely to flee any such situations before her anxiety subsides, further reinforcing her fears. Both [the Appellant] and her psychologist should be involved in developing and implementing her return to work plan to reduce this possibility.

[41] The Appellant underwent a second Physical Work Performance Evaluation Summary on March 10, 2004, in which it was determined that she could physically sustain medium level of work for an eight hour day.

[42] On April 2, 2004, Dr. Shimp provided an update on the Appellant's functioning and treatment. Dr. Shimp noted overall some improvement in the targeted areas of PTSD, depression, passenger anxiety, self-esteem, adjustment to changes in appearance and social avoidance but clearly pointed out that treatment had been inconsistent and the Appellant had difficulty maintaining her gains. Dr. Shimp further stated:

...She is quite insightful, but has difficulty translating insight into behavioral change. Response to exposure has been poor, with difficulty tolerating and working through the associated anxiety.

I encouraged [the Appellant] to consult with her physician about trying an anti-depressant (SSRI) in the hopes that this would assist with the depression and anxiety symptoms. She was uncomfortable with pursuing this option, but did try a trial of Effexor and Celexa, but discontinued because she did not feel that it was beneficial. Mood remains significantly depressed, anxiety is high, and she is still quite preoccupied with her appearance, despite having received good outcome from plastic surgery, and this seems to be taking on the quality of a Body Dysmorphic Disorder. Barriers to progress are the client's perfectionistic standards, which contribute to increased difficulty doing more recreational and social activities because she often feels like a "failure" when she encounters difficulty. She also has a tendency to believe that progress will occur with some external event (e.g., with further plastic surgery, when her legal case is settled, loses weight, is no longer receiving benefits from SGI, etc.) rather than with internal change.

I am concerned about the persistence and severity of difficulties despite having received extensive psychological intervention. At the present time, I do not see her as being capable of working (this judgment is also consistent with the opinion of Dr. Kerry Mothersill, who recently completed a psychological assessment of [the Appellant] for legal purposes), although I still think it is important to try to plan and arrange for a return to work program in a low-stress environment that has minimal social interaction. (I understand that the vocational rehabilitation consultant has had difficulty finding something suitable). The timing regarding attempt at RTW is crucial, as there is risk for further decompensation if she is too unstable, but there is also concern that without some encouragement and progress towards a return to work direction that disability will become further entrenched.

[43] In June 2004, Dr. Shimp completed some vocational interest testing on the Appellant. The Appellant's highest scores were in the artistic and investigative areas. It was also noted that the Appellant's mood had been improving and Dr. Shimp was interested in arranging some volunteer work as a precursor to return to work.

[44] In August 2004, Dr. Shimp reported to SGI that the Appellant was showing some improvement after obtaining her drivers license and increasing her exposure by running some errands on her own, albeit she still avoided places where she feared social judgment. Dr. Shimp reported that the Appellant had applied for a volunteer position as a mentor to a young girl. She further reported that the Appellant had another consultation with her plastic surgeon about removing a plate in her face and possible further surgery on her eye. Dr. Shimp specifically

noted that for the Appellant, facial preoccupation and the pursuit of surgery as a solution to her emotional problems persisted.

[45] On September 23, 2004, Dr. Pancyr, medical consultant for SGI reviewed the Appellant's medical file. His opinion was:

[The Appellant] has had difficulty availing herself of the treatment offered. She has been reluctant to take medication (i.e. aside from when she could not due to pregnancy); and she has not been compliant with recommended home assignments regarding exposure to feared and anxiety provoking situations. Consequently, her mental health status has not changed appreciably. At this point, it is unlikely further gains in her psychological functioning will be achieved with more psychotherapy. Therefore, she should be considered having reached maximum psychological improvement. Reports on file indicate she has made a reasonably good physical recovery and is not limited to return to work.

If a two year determination process is appropriate for this client, there is no psychological reason this could not be performed at this time.

The customer should receive ongoing psychotherapy by Dr. Shimp during this process as there is still some small possibility that during this process her motivation to try to return to her former level of employment might be re-ignited. Or, she might find it to her advantage to apply herself more aggressively to the exposure based treatment recommendations, and/or to consider psychotropic medications known to have some benefit for body dysmorphic disorder and similar anxiety disturbances.

[46] On November 26, 2004, SGI obtained a Transferable Skills Analysis and Labour Market Survey as part of the employment determination process for the Appellant. It was determined that employment as a data entry clerk, postal clerk, telemarketer, electronics assembler and a call center operator were all suitable occupations for the Appellant given her physical abilities and psychological makeup.

[47] On December 9, 2004, SGI sent correspondence to the Appellant terminating her funding for psychological counselling after December 31, 2004. The decision letter, which is the subject of this appeal, stated:

This is with regard to funding of your psychological counselling services.

SGI agreed to fund psychological intervention during the period in which you were undergoing assessment with Kinetik and the residual capacity evaluation process. We are prepared to fund counselling on your behalf until December 31, 2004.

[48] The decision letter of SGI is somewhat confusing because the Appellant had in fact been receiving regular psychological counselling with Dr. Shimp as of August 2001. The correspondence refers to counselling through her assessment with Kinetik and the residual

capacity evaluation, however, at the time of SGI's correspondence, the Kinetik assessment was completed. The correspondence also does not refer to the opinion of Dr. Pancyr and there is very little explanation provided in the correspondence as to why SGI has terminated the Appellant's funding for psychological counselling. The Act requires SGI to provide the Appellant with written reasons for the termination of psychological counselling. We do not believe that the decision letter adequately complied with that legislative requirement even though SGI argued at the appeal that they relied upon Dr. Pancyr's opinion that further psychological counselling would not likely yield further improvement.

[49] On December 21, 2004, Dr. Shimp wrote to SGI to provide them with the Appellant's discharge summary. She reported:

I have been providing psychological services to [the Appellant] since August 20, 2001. As you aware, [the Appellant] has experienced significant psychological difficulty due to her MVA, including post-traumatic stress disorder, depression, social anxiety, driving anxiety, and body dysmorphic disorder. There has been improvement in her driving anxiety (she now has her driver's license and has been able to drive in the city and on the highway), although she is very apprehensive about an upcoming trip to Calgary (the MVA occurred on this road). She has been doing more exposure to social situations (e.g. she is now able to do some errands and grocery shopping), although remains highly anxious and avoidant in situations where she fears judgment (e.g. lounges, clothing stores, salons). She continues to be preoccupied with the changes in her facial appearance since her MVA and is still considering further surgeries. Depressive symptoms have varied in severity over the course of the treatment and at present she is currently experiencing a pervasive low mood, anhedonia, low energy, a sense of hopelessness, and feelings of guilt. There has not been any significant change in the post-traumatic stress symptoms since she was reassessed by FIT for her FCE in February 2004.

[The Appellant] remains concerned about the possibility of having had a traumatic brain injury at the time of her MVA. A review of her medical records indicates that an MRI or CAT scan of the brain was not done and there is inconsistent information regarding whether there was a period of unconsciousness. I have consulted with Dr. Terry Levitt, neuropsychologist regarding this case and he is of the opinion that if there was a brain injury (this cannot be ruled out) that it would have been mild and than any effects of the brain injury would have resolved by now. I have discussed this opinion with [the Appellant], although she continues to worry that some of the emotional difficulties she is experiencing are related to frontal lobe head injury. There does not appear to be any need for neuropsychological evaluation.

I have reviewed Dr. Pancyr's, SGI Psychological Consultant, report (September 13, 2004). He concluded that it is unlikely that further gains in psychological functioning would accompany additional psychotherapy and he recommended a two year determination process. I agree that further psychological treatment is unlikely to yield significant functional and/or symptomatic changes at this point given the response to the extensive psychotherapy that has already been provided. However, this client will likely require intermittent supportive psychotherapy to cope with her chronic MVA-related psychological conditions (the depressive symptoms particularly tend to vary in intensity and at time become very difficult for [the Appellant] to manage). I have discussed various options with [the Appellant] in terms of accessing further treatment. I would also recommend that SGI consider funding psychological services where a RTW is initiated, as

[the Appellant's] anxiety is likely to increase significantly during this time and psychological services will be needed to increase the likelihood that a RTW will be successful. [The Appellant] has went through vocational assessment and has been presented with four vocational options, although a vocational direction has not yet been established.

[50] On January 10, 2005, SGI wrote to the Appellant advising her that her determined employment was a Data Entry Clerk.

[51] Dr. Pancyr reviewed the December 21, 2004 medical report of Dr. Shimp. Dr. Pancyr's revised opinion, dated March 14, 2005, was:

I have reconsidered my previous opinion in light of this new psychological report. I would now recommend the two year determination process continue, as I had suggested previously. The only change to my opinion is that I would support her receiving brief psychological treatment to assist her return to gainful employment. I do not concur with Dr. Shimp's recommendation of intermittent psychological treatment for lingering symptoms because this did not result in any significant improvement in her condition even after many months of regular treatment. However, if the client were about to enter the workforce, I would support her receiving 20 additional sessions of psychological treatment. For example, 4-5 sessions prior to her beginning her job and 15-16 during her first few months of work would be reasonable. This intervention should be very focused of issues pertaining to her return to work only.

[52] Upon receipt of Dr. Pancyr's medical opinion, SGI wrote to the Appellant and advised that their decision to discontinue funding for ongoing psychological counselling remained unchanged but that they would consider 20 further psychological counselling sessions upon her return to work.

[53] Dr. Pancyr was asked to review the Appellant's file again by Mr. Dale Brown, legal counsel for SGI. Dr. Pancyr was asked to answer specific questions. His report dated September 19, 2005, has been reproduced in part:

Opinion:

1. When you supported 20 sessions in your March 2005 opinion, does it mean in addition to your previous decision and you think she should receive treatment "during the determination process?"

No. In my original opinion I did think she should receive psychological treatment through the determination process. But after reviewing the progress reports, and discussing her case with her treating psychologist, I did not think further psychological sessions would be of any benefit in ameliorating her lingering symptoms from the car crash. I revised my original opinion by suggesting that if the determination process had confirmed she could and should return to work, then, facing that decision and having to go to work, she might benefit from some brief, focused

treatment (i.e., 4-5 sessions before the work start date, and 15-16 after the work start date), to facilitate the return to work process.

...

4. Dr. Shimp referred to the customer attending work trials. Does she need to receive psychological treatment until these work trials occur?

No. I conclude that further treatment with Dr. Shimp, without an imminent return-to-work (RTW) date having been set, would not produce any further results. I believe Dr. Shimp agreed with that conclusion when I spoke with her. We both felt her motivation to attend and make use of psychological treatment was low. Therefore, I was, at still am, of the opinion that ongoing psychological treatment had already proven to be of limited utility. So, I revised my original opinion. My reasoning is that when faced with having to return to work imminently (i.e., within the next few weeks), she might experience an increase in symptoms that could benefit from additional psychological treatment (i.e., in the order of 20 sessions). But if the RTW date was not imminent (e.g., if she became pregnant a second time and had no plan to return to work for a year), then additional psychological treatment would not be expected to produce any further benefits than she has already achieved. So, no further psychological treatment would be deemed necessary.

...

6. Please comment on the following quote: “[The Appellant] continues to be psychologically disabled from returning to work in any occupation...it is highly doubtful that she will be able to sustain motivation and psychological commitment to a higher level of educational pursuits until her sense of self has been more stabilized, her psychological disorders have been successfully treated and her interpersonal difficulties have resolved. In addition, her ongoing emotional problems interfere with her ability to return to work and save money for further education pursuits. In all likelihood, the devastating effect of this motor vehicle accident at such an important juncture in [the Appellant’s] psychological, maturational and occupational development will result in her maintaining a significantly reduced level of occupational functioning and prevent her from achieving educational and occupational successes that she otherwise would have enjoyed.”

I disagree with this overly pessimistic prediction of this client’s future capacities. The client has overcome her driving anxiety to the point she can drive in the city and make longer trips as well (e.g., to LaRonge). She has had a child and is apparently doing well in caring for her child. This requires a high degree of skill, organization, determination, and patience. She is already “working”, albeit in the home. She is able to manage any lingering symptoms of PTSD, anxiety, or depression, sufficiently to raise her child, as far as we know. Therefore, no further psychological treatment seems necessary for her to maintain her current level of functioning. It should also be noted that she maintained this reasonably high level of functioning without the use of psychotropic medication, according to the last reports we have available.

Although she may not have had a secure vocational direction, she did have a job prior to the injury. She has been deemed physically capable of returning to that job. Psychologically, she has been deemed psychologically fit to attempt a return to work by her treating psychologist, Dr. Shimp (i.e., she spoke of work trial, but this is essentially a RTW attempt).

I believe Dr. Mothersill’s prognostication is overly pessimistic. Like many other individuals, she will need to overcome her RTW anxieties. She apparently still believes she has a brain injury, and worries about her facial disfigurement. But, she is apparently able to overcome these to the extent she is able to care for her child (e.g. shop for groceries, attend doctor appointments; go for walks; meet new people as a customer; et cetera). Dr. Mothersill’s opinion notwithstanding, she has

been deemed fit to return to work. That she might have some increased anxiety during this period is understandable, and that is why I suggested additional psychological treatment around this transition back into the work force.

She has not shown a great deal of determination or motivation for psychological treatment generally. Her psychologist issued a contract in hopes it would improve her attendance and motivation for psychological treatment. I do not believe, as Dr. Mothersill has indicated, that she requires extensive treatment to return her to her previous levels of functioning. She may always have some difficulties with a vocational direction, stabilization of “self”, and interpersonal relationships because some of these existed prior to the injury. What is reasonable to expect at this juncture, is that she commit to a return-to-work schedule, in some agreed upon capacity. If she has psychological difficulty returning to work, then more psychological treatment should be provided, once a return to work date is in place.

Extended psychological treatment to prepare her to return to work is not advised, has not shown to be effective so far, and is not likely to make any significant impact if attempted again. Brief, focused psychological treatment, in the context of a return to work schedule, may be of some benefit.

[54] On September 23, 2005, Dr. Mothersill completed an updated Psychological Assessment with regard to the Appellant’s current psychological state and her level of employability. It was Dr. Mothersill’s opinion that with the exception of the Post Traumatic Stress Disorder, the Appellant’s overall psychological condition appeared to have become slightly worse since December 2003. Dr. Mothersill diagnosed the Appellant with major depressive disorder, chronic, moderate to severe; body dysmorphic disorder; and post traumatic stress disorder, in partial remission. Dr. Mothersill specifically reported:

In my January 2004 Psychological and Vocational Assessment, I mentioned that her presentation had taken on aspects of a Body Dysmorphic Disorder. In my opinion, I believe that [the Appellant] now meets criteria for this disorder and it is a major factor in preventing her from returning to employment. As she indicated during the course of the interview, [the Appellant] is hoping that her final surgeries will improve her facial appearance. It is anticipated that once all medical interventions have been exhausted, [the Appellant] will be able to benefit from psychological treatment that will assist her in accepting her facial condition as it is and she will no longer be waiting for significant improvements to occur. It is hoped that psychological treatment at that time will be beneficial in alleviating her Body Dysmorphic Disorder. However, in many cases, this disorder is resistant to treatment and she may be psychologically disabled for the foreseeable future.

[55] The Appellant testified at her appeal. She stated that as a result of her injuries, she has undergone six surgeries, with a total of 26 hours of surgery to her face. The Appellant reported to have had the surgeries contemplated in Dr. Lindsay’s January 2004 medical report but the date of those surgeries is not clear from the medical documentation on file. She testified that there may be two more proposed future surgeries included bringing the left eyeball forward and placing fat on her face to make it more symmetrical. She reported that the surgery to make her

face more symmetrical was scheduled for January 25, 2006. The Appellant testified that she was scheduled to undergo surgery on April 4, 2005 to remove the plates from around her eyes, nose and cheeks when she received the cancellation of her psychological counselling. We assume this surgery was completed, however, the Appellant's testimony was not clear in this regard.

[56] The Appellant admitted that she has had a lot of difficulty adjusting to the difference in her face. She stated that she needs ongoing supportive counselling to deal with issues when they become too overwhelming for her to address on her own. The Appellant says that when she does not see Dr. Shimp on a regular basis she becomes overwhelmed with her symptoms.

[57] The Appellant was tearful during parts of her testimony, particularly when talking about her guilt over why she can't accept her appearance and/or deal with her problems on her own. She reported that she never knew she was so selfish and that her appearance was so important to her. She reported that she needed to get things into perspective for the benefit of her daughter. She reported feeling very guilty for the way that she is coping and dealing with her problems. When asked about why she refused to go on medication, she reported that her symptoms were heightened during the 8-10 weeks that she tried it. She stated that the medication made her feel suicidal and like a zombie and it was a personal decision not to continue with the medication.

[58] The Appellant reported that at the time of appeal she was still seeing Dr. Shimp, although, only once or twice a month due to financial constraints. She described her appointments with Dr. Shimp as a way of getting re-centered. Dr. Shimp reminded her that her behavior is irrational and discussed with the Appellant how she can stop sabotaging herself.

[59] The Appellant reported ongoing difficulties with attending at places where she feared judgment of her facial injuries. The Appellant stated that she always placed a lot of emphasis on her surgeries and "after the surgery she is on a one month high and then she starts to pick at her face again". She stated that she continually looks at her face in the mirror. She also reported getting very upset when she saw pictures of her face from before the accident. The Appellant admitted that she knows that a time will come when she will have to accept her appearance. She believes this will happen when all the surgeries have been completed and surgical intervention is no longer an option. She hopes that the final two surgeries will be the last ones, but she

indicated that until they are completed and surgery is no longer an option, she will continue to cling to the belief that she will get better.

[60] The Appellant noted improvement in her ability to go into public since the accident. She testified that she tries to go out for dinner once a month now and that she obtained her driver's license which has helped. However, she admitted that much has stayed the same and that she too had an expectation that things would not have lasted this long.

[61] The Appellant reported that her common law relationship has ended and this has left her feeling more desperate because of her appearance. She is addressing these current difficulties with Dr. Shimp. The Appellant stated that she does not participate in her daughter's preschool activities due to avoidance issues. The Appellant reported taking a University course in which she received a very high mark but stated that she did all the work out of the text rather than attending the class. She stated that she has difficulty with doing anything outside of her home and that her daughter's father usually does all of the social activities with their daughter. The Appellant described a typical day as getting up, making breakfast, tidying the house, doing laundry, making dinner and working on the computer and treadmill. She rarely leaves her home except to get groceries and go to appointments.

[62] The Appellant reported that she was involved in a subsequent motor vehicle accident on April 8 while driving home from LaRonge. The trip to LaRonge was an exposure assignment. She reported an initial setback but stated that she is again comfortable with driving.

[63] Dr. Pancyr, psychologist, also testified at the appeal. Dr. Pancyr is a medical consultant to SGI, however, he also a clinician and provides assessments and treatment to individuals. Dr. Pancyr classified the Appellant's reaction to changes in her appearance as very severe. Dr. Pancyr does not agree with the diagnosis of Body Dysmorphic Disorder because he is not sure if the Appellant meets the diagnostic criteria for the diagnosis. Dr. Pancyr testified that the diagnostic criteria for Body Dysmorphic Disorder included: slight deformity or imagined deformity; frequent checking of deformity; and obsessive time spent on the deformity. He acknowledged that he had no knowledge of the Appellant spending hours looking in the mirror. Dr. Pancyr also acknowledged that one of the symptoms of Body Dysmorphic Disorder was to resist cognitive behavioral therapy. He further acknowledged that depression may also be a

component of Body Dysmorphic Disorder. He admitted that he was not aware of any support programs for Body Dysmorphic Disorder.

[64] Dr. Pancyr testified that psychological treatment is not like other treatment and in order for the client to be successful they must participate in the treatment and be responsible for the treatment. He questions the Appellant's participation in her treatment due to her refusal to take medication and her lack of participation in homework exercises for avoidance and exposure problems. Dr. Pancyr testified that exposure activities involved trying to engage the Appellant in her normal life. Dr. Pancyr also referred to issues of attendance and the necessity of a contract with the client as being indicative of her not participating in her treatment. He testified that she was in treatment for four years without seeing continuing benefits. As a result, Dr. Pancyr did not see a benefit to further treatment unless it was tied to going back to work or some other major hurdles for the Appellant.

[65] Dr. Pancyr was quite critical of the Appellant's refusal to use medication. He reported that all disorders could be treated with medication and that there were many alternative medications. Under cross-examination, Dr. Pancyr admitted that he was not aware that the Appellant discontinued using Effexor because of suicidal ideation. He assumed that it was for personal reasons, side effects or an opposition to ingesting chemicals into her body.

[66] Dr. Pancyr expressed concern that counselling can be used to prolong one's avoidance of dealing with issues and that the Appellant may have developed a dependency on Dr. Shimp. He describes the Appellant's attendance on Dr. Shimp as supportive therapy in that she attends when she is feeling overwhelmed. This type of counselling is just to talk about problems, there is no building of skills. It was his opinion that the Appellant was not going to achieve any further improvement unless clear goals for therapy were defined in a time limited way to deal with achieving certain goals.

[67] Dr. Pancyr could not say that the Appellant would not deteriorate without treatment but he did not necessarily expect her to deteriorate. He testified that if the Appellant experienced a flare-up directly related to the accident, then it would be appropriate to receive additional counselling services. He did admit that contemplation of further surgeries would certainly be

anxiety provoking and would warrant counselling until such time as the surgeries were completed.

[68] The Appellant also agreed that there should be timeline for counselling and that she wished to have counselling to assist her in dealing with the upcoming surgeries and the heightened anxiety that inevitably goes with them. She also believes that she will experience an increase in symptoms when she must come to terms with the fact that no further surgeries will be performed and she must accept the changes to her appearance.

LEGISLATION AND STANDARD OF REVIEW

[69] The Commission's power on appeal is provided in Subsection 193(7) of *The Automobile Accident Insurance Act*, R.S.S. 1978, c. A-35 (the "Act"). The Commission may:

- (a) set aside, confirm or vary the insurer's decision; or
- (b) make any decision that the insurer is authorized to make pursuant to Part VIII of the *Act*.

[70] Recently, the Saskatchewan Court of Appeal addressed the standard of review applicable for appeals to this Commission in *Allary v. Saskatchewan Government Insurance*, 2006 SKCA 89. Although it was not addressed in the appeal, it is necessary for us to refer to *Allary* when determining the appropriate standard of review in this case.

[71] In *Allary*, the Court of Appeal noted that more than one standard of review was indicated by the legislation. The Court of Appeal suggested that the standard of review depends upon whether SGI has discretion to grant or deny the particular benefit claimed. In *Allary*, the claimant was seeking reimbursement of payments for medical and paramedical care as provided under Subsection 163(1) of the *Act*. The Court of Appeal held that because SGI does not have discretion to decide whether to pay the claimant such benefits, the standard of review of SGI's decision is correctness, not unreasonableness. The Court of Appeal further stated that, where an

appellant disputes SGI's decision and places SGI's findings of fact in issue and there is no discretion whether to grant or deny the benefit, the standard of review is correctness.

[72] In this case, the Appellant has disputed SGI's finding of fact that further psychological counselling is of no benefit to her psychological state. In the Appellant's case, the basis upon which SGI would provide Part VIII no fault benefits to her is set out in section 110 of *The Automobile Accident Insurance Act*³ (the "Act") in force at the time of her accident on September 4, 2000. The relevant sections of the *Act* state:

110(1) In this section, "**rehabilitation**" includes any or all of the following measures, programs and treatments that the insurer considers necessary or advisable to contribute to the rehabilitation of a victim, to lessen the victim's disability caused by the accident and to facilitate the victim's recovery from the accident:

- (a) physical and acquired brain injury programs and treatment;
- (b) occupational and vocational training and programs;
- (c) alterations to a victim's residence;
- (d) modification or purchase of vehicle for a victim;
- (e) purchase of special equipment for a victim;
- (f) any additional measure, program or treatment prescribed in the regulations.

(2) Subject to the regulations, the insurer may take any measure it considers necessary or advisable to contribute to the rehabilitation of a victim, to lessen a disability resulting from bodily injury and to facilitate the victim's recovery from an accident.

[73] It is our opinion that the wording and intent of Section 110 of the *Act* provides SGI with discretion as to which "advisable" rehabilitation benefits should be provided. We are not of the opinion that SGI has the discretion to refuse a "necessary" rehabilitation benefit. If the rehabilitation benefit is "necessary", and the claimant has put SGI's findings of fact in issue, then SGI's decision must be correct having regard to all of the evidence. If there is discretion on the part of SGI as to whether to provide the benefit, and the claimant has put SGI's findings of fact in issue, then SGI's decision must be reasonable having regard to all of the evidence.

³ RSS 1978, c. A-35 (1995)

[74] In light of the Appellant putting SGI's findings of fact in issue, the Commission must determine firstly, whether the psychological counselling is "necessary" or "advisable" for treating the Appellant's psychological conditions arising out of her motor vehicle accident injuries. The factual issue for determination is whether or not ongoing psychological counselling is necessary to contribute to the Appellant's rehabilitation, lessen her disability or facilitate her recovery. If it is determined that the psychological counselling is "necessary" then SGI's decision to terminate funding for psychological counselling must be correct having regard to all of the evidence. If the Commission determines that the psychological counselling is only advisable, then SGI's decision need only be reasonable having regard to all of the evidence.

[75] The Commission heard *viva voce* evidence from the Appellant and Dr. Pancyr. The Commission also reviewed all of the documentary evidence on the file used by SGI in arriving at their conclusion to terminate funding for psychological counselling.

ANALYSIS

[76] Mr. Brown argued that the Appellant's ongoing treatment for psychological benefits falls within section 110 of the *Act*. He submitted that the Appellant must show a decline in her ability to function without ongoing treatment. He acknowledged that SGI and Dr. Pancyr were not aware of the upcoming and ongoing surgeries and that this was new information. Mr. Brown argued that in accordance with Dr. Pancyr's recommendations, there must be a treatment plan and a time-limited approach to treatment. Mr. Brown further submitted that some of the Appellant's counselling related to non-motor vehicle accident injuries and should therefore not be the responsibility of SGI.

[77] The Appellant testified that she requires ongoing psychological counselling to deal with symptoms when she becomes too overwhelmed to deal with them on her own. She acknowledged that there needs to be some time limitations but that she finds her surgeries very anxiety provoking and particularly requires the services of Dr. Shimp to get her through each surgery. She also disagrees with Dr. Pancyr's conclusion that she does not have Body Dysmorphic Disorder.

[78] The first issue before the Commission is to determine whether the psychological counselling which the Appellant is seeking is “necessary” or only “advisable”. There is some question over whether the Appellant suffers from Body Dysmorphic Disorder (“BDD”). We have carefully reviewed all of the medical evidence and have listened to the testimony of both the Appellant and Dr. Pancyr. We found the Appellant to be very credible. We are all in agreement that the accident has had an incredible psychological impact upon the Appellant. We also believe that she wants to get better and that she does not want to rely on psychological intervention forever.

[79] The many medical opinions on file are conclusive that the Appellant suffered from Post-Traumatic Stress Disorder (“PTSD”), Depression, Social Anxiety, driving anxiety, low self-esteem and relationship issues as a result of the facial injuries she sustained in the accident. In arriving at this conclusion we note that within five months of the accident, the FIT team diagnosed the Appellant with Post-Traumatic Stress Disorder and Depression and opined that her facial injuries were a significant barrier to her resuming functional activities outside of her home. The FIT team recommended counselling but unfortunately the Appellant did not avail herself of the counselling offered by Dr. Shepel because she did not feel a good rapport with him. As a result, the Appellant did not commence regular psychological counselling until August 2001. In September 2001, Dr. Shimp, the Appellant’s treating psychologist, made the same diagnosis as the FIT team of PTSD and Depression. She also reported that the Appellant had significant social anxiety making it difficult for her to leave her home. Dr. Shimp reported regularly to SGI with regard to the Appellant’s ongoing progress from August 2001 to December 2004 when funding for psychological counselling was terminated. Dr. Shimp reported in February 2002 that the Appellant was responding positively to counselling. The FIT team reassessed the Appellant at this time and recommended a further six months of counselling.

[80] However, despite extensive psychological intervention, many of the diagnosed psychological problems have continued for the Appellant for more than five years and were ongoing at the time of the appeal. It is our opinion that the Post-Traumatic Stress Disorder has improved somewhat but we believe that the Appellant continues to suffer from depression, social anxiety, low self-esteem and avoidance issues, all of which in our opinion are largely related to her perception of her facial appearance. SGI’s position is that further psychological counselling

will not result in any further improvement of these psychological conditions and therefore further psychological counselling is neither necessary nor advisable.

[81] With respect to the diagnosis of BDD, we found the evidence of Dr. Pancyr to be helpful in providing some insight into the diagnostic criteria necessary for a diagnosis of BDD. Dr. Pancyr identified the three diagnostic criteria for BDD to be: a slight deformity or an imagined deformity, frequent checking of the deformity and obsessive time spent dwelling on the deformity. Dr. Shimp and Dr. Mothersill are of the opinion that the Appellant meets the diagnostic criteria necessary for BDD. Dr. Sheckter reports that it is probable that the Appellant meets the diagnostic criteria for BDD. Dr. Pancyr questioned this diagnosis but admitted that he was not aware that the Appellant spent many hours looking in the mirror. It is our opinion that the opinions of Dr. Shimp, Dr. Mothersill and Dr. Sheckter should be given more weight with respect to their diagnosis of BDD because they have met with the Appellant and conducted a psychological assessment. There is no medical evidence by an examining medical practitioner that would suggest that the diagnosis of BDD was incorrect. In light of Dr. Pancyr's testimony regarding the diagnostic criteria for BDD we are satisfied that an examining and/or treating medical practitioner would be in a better position to identify the necessary criteria through their examination of the Appellant than Dr. Pancyr would be able to by doing a file review. We are not suggesting that a file review may not be appropriate in some cases, but in the circumstances of this particular case, we feel the diagnosis of BDD by the examining and treating practitioner is stronger than Dr. Pancyr's testimony that he did not believe she met the diagnostic criteria for the diagnosis of BDD. We make this finding because the Appellant testified that she told Dr. Shimp that she spends hours looking in the mirror and picking apart her face after each surgery. Therefore, we accept the diagnosis of BDD based upon the medical evidence presented to us and the testimony of the Appellant.

[82] Although we found the testimony of Dr. Pancyr to be credible we conclude that some of his conclusions should be given less weight because Dr. Pancyr did not have the benefit of meeting with the Appellant and conducting a psychological examination. While this may not be so in every case, in the circumstances of this particular case, we believe that due to the extensive nature of the Appellant's ongoing psychological problems the most reliable medical evidence are

the reports of Dr. Shimp because she has treated the Appellant for so long and has seen the fluctuation of the Appellant's psychological condition throughout that time.

[83] Dr. Pancyr reported on September 23, 2004, that the Appellant had difficulty complying with her home assignments. Aside from the initial setback in commencing counselling, we are unable to find any reference in the reports of Dr. Shimp that compliance was an ongoing problem once the Appellant had commenced regular counselling. We accept that the initial problem related to the Appellant's distrust of Dr. Shepel. Once psychological treatment commenced, Dr. Shimp reported that the Appellant continued to "show good motivation and commitment to the therapy"; that she was "insightful and has become motivated and engaged in the therapeutic process". Further, we note that in her April 2, 2004 medical report, Dr. Shimp reported that "response to exposure has been poor, with difficulty tolerating and working through the associated anxiety". Dr. Shimp did not testify at the appeal, however, we do not interpret this statement by Dr. Shimp to be a conclusion that the Appellant had not been trying to complete her exposure activities or was not participating in them. In our opinion, this statement is a reflection that the Appellant was continuing, despite all of the psychological intervention, to have extreme difficulties with social interaction. In fact, in August 2004, Dr. Shimp reported positive participation in exposure activities. There is no indication by Dr. Shimp that the Appellant has not been compliant with treatment and we find this statement made by Dr. Pancyr in his September 23, 2004 medical opinion to be unsupported by the medical reports of Dr. Shimp. In addition, Dr. Pancyr's opinion was completed immediately following Dr. Shimp's report to SGI that the Appellant has obtained her driver's license and applied as a volunteer mentor for a young girl, both of which were exposure assignments. Similarly, in December 2004, Dr. Shimp reported that the Appellant was showing improvement and participating in exposure activities although she remained highly anxious and avoidant in situations where she feared judgment. We believe that the Appellant continued to experience a great deal of anxiety associated with her exposure activities and would avoid some of them, particularly those where she feared social judgment, but we find that she was attempting to participate, however, perhaps not to the level that Dr. Pancyr would expect or require if she were his patient.

[84] Dr. Pancyr testified that the Appellant's social anxiety and avoidance tendencies could be treated through exposure exercises and that they were necessary in treating the Appellant's

psychological problems. He concluded that because she was not participating in exposure exercises, future psychological counselling would be of no benefit. He did, however, recognize the need for psychological counselling when a return to work forced her to face social interaction with her peers. Therefore, so long as she is participating in her exposure activities, we conclude that she would require supportive psychological counselling to manage the symptoms and anxiety associated with those activities, at least for some period of time.

[85] Dr. Pancyr was also very critical of the Appellant's refusal to avail herself of psychotropic medication. Dr. Shimp reported that she recommended that the Appellant speak with her physician about medication and that it was tried by the Appellant. We accept her testimony with respect to why she did not want to stay on the medication. We believe the Appellant honestly wants to get better and relied upon her treating practitioners to make recommendations for psychotropic medication. In our opinion, if the Appellant's refusal to take the medication was unfounded or not supported by her treating practitioners then we would expect to see a strong recommendation for her to try alternatives. We do not have evidence before us of an ongoing refusal to try medication that has been recommended by her physicians. In fact, a trial of medication was recommended and it was discontinued due to the Appellant's reports of suicidal ideation. We are not aware of any other physician's recommendations for psychotropic medication that have been rejected by the Appellant. We do not conclude that her refusal to avail herself of psychotropic medication should be interpreted as non-compliance.

[86] Dr. Pancyr referred, in his reports, to communications he had with Dr. Shimp which suggest that the Appellant's motivation to attend and make use of psychological treatment was low. Unfortunately, Dr. Shimp did not testify at the appeal. As stated above, we do not conclude from the reports of Dr. Shimp that the Appellant was not motivated. We have relied upon Dr. Shimp's reports rather than accepting Dr. Pancyr's interpretation of his communications with Dr. Shimp.

[87] It is our opinion that Dr. Pancyr was at a disadvantage in this case because he has not interviewed or conducted a psychological assessment on the Appellant, unlike Dr. Shimp, Dr. Mothersill, Dr. Stacy Thomas and Dr. Sheckter. Dr. Pancyr was not aware that further surgeries were being conducted or had been undertaken and this is a definite disadvantage of only

completing a file review where all of the medical information is not on the file. In this situation, Dr. Pancyr admitted that the knowledge of further surgeries would be critical information because the ongoing surgeries relating to the Appellant's facial appearance would be very anxiety provoking for the Appellant and would necessitate the need for psychological counselling before and after each surgery. We believe that there is other information that the Appellant would share with Dr. Shimp which would not be included in the medical file which Dr. Pancyr reviewed. It is this personal interaction with the Appellant which leads us to the conclusion that Dr. Shimp's medical opinions should be given greater weight in assessing the Appellant's overall psychological condition and her ongoing need for psychological counselling.

[88] We have noted throughout the medical reports of Dr. Shimp that the Appellant would suffer setbacks when she attended for a surgery or medical appointments due to the necessity of having to recount the accident or when she was unhappy with the results of the surgery. It is these setbacks for which we believe the Appellant requires ongoing psychological counselling. Dr. Pancyr agreed that there would be certain events for which the Appellant should be provided with psychological counselling; specifically, a return to work or the contemplation of further surgeries. Similarly, we note the psychological report of Dr. Mothersill which opines that the Appellant should be provided with supportive psychological counselling when she is forced to accept her facial appearance after all medical intervention has been exhausted.

[89] Specifically we note the following setbacks during the course of the Appellant's treatment:

- a) On June 11, 2002, Dr. Shimp reported a setback after a consultation with the plastic surgeon in Calgary who advised the Appellant that not much more could be done in terms of facial damage.
- b) On September 16, 2002, Dr. Shimp reported that the Appellant would require additional therapy to deal with the stress of the upcoming surgery.
- c) There was deterioration noted by Dr. Shimp following the reconstructive surgery of November 18, 2002. The surgery was noted to heighten memories of the accident, increase the Appellant's preoccupation with her appearance and exacerbated her

relationship difficulties because of her partner's guilt related to being responsible for the accident.

- d) In May 2003 another surgery was contemplated by the Appellant and it was recommended by her care providers that she be accompanied for this surgery due to the moderate deterioration in her psychological functioning which occurred after her last surgery and trip to Calgary.
- e) In July 2003, Dr. Shimp reported that the Appellant's symptoms and functioning are highly variable and that she had experienced numerous setbacks secondary to further surgeries and life stressors. It was also requested at this time that her work trial not commence until the Appellant's psychological state had stabilized.
- f) The Appellant reported an initial setback after she was involved in another accident while traveling to LaRonge during one of her exposure assignments.

[90] In addition to the above, in determining whether ongoing psychological counselling is needed we have considered and relied upon the following:

- a) In February 2003, it was stated that long term therapy will be necessary due to the considerable psychological impact the accident has had on the Appellant.
- b) In July 2003, Dr. Shimp opined that residual psychological difficulties related to self-esteem and trauma will likely remain even with further treatment given the persistence of the Appellant's symptoms.
- c) In February 2004, Dr. Sheckter reported that the Appellant needs further treatment. Dr. Sheckter opined that the Appellant continued to suffer from PTSD, Major Depressive Episode, Social Phobia and BDD. Dr. Sheckter further recommended that the Appellant be engaged in exposure exercises to treat all diagnoses. Dr. Sheckter identified the need for counselling to manage anxiety when the Appellant is engaged in a return to work. In particular Dr. Sheckter reported "the Appellant requires further psychological intervention. Without such services, there is risk that her avoidance behavior will worsen".

- d) Dr. Shimp reported in December 2004 that the Appellant's depressive symptoms have varied in severity over the course of her treatment. Dr. Shimp reviewed the report of Dr. Pancyr and agreed that further gains with psychotherapy were unlikely, however, Dr. Shimp opined "this client will likely require intermittent supportive psychotherapy to cope with her chronic MVA-related psychological conditions (the depressive symptoms particularly tend to vary in intensity and at times become very difficult for the Appellant to manage".
- e) Dr. Mothersill reviewed the Appellant in September 2005, approximately nine months after SGI terminated the Appellant's funding for psychological counselling. Dr. Mothersill opined that the Appellant's psychological condition was worse since her previous assessment in December 2003 and that she now met the diagnostic criteria for BDD.
- f) We have considered Dr. Pancyr's report of September 19, 2005 which is largely focused on the Appellant's ability to return to work. Dr. Pancyr concluded that she is capable of managing her symptoms because she is able to raise her child and has done so without the use of psychotropic medications. He opines that no further psychological treatment is necessary to maintain her current level of function. Although this report is largely related to the Appellant's ability to work, we are unable to agree with Dr. Pancyr's conclusions surrounding the Appellant's level of function. The Appellant testified that she rarely leaves her home and that her daughter's father participates in all social activities with their daughter. In our opinion, the Appellant is managing but only so in so far as she does not have to be involved in any social situations where she fears judgment of her appearance. The ability to raise her child within the confines of her home does not suggest that the Appellant is managing her ongoing symptoms, it only means that her avoidance of social interaction is being perpetuated by the fact that she is able to remain confined to her home and to only engage in necessary activities such as grocery shopping. In our opinion, this is contradictory to Dr. Pancyr's recommendations that exposure activities are necessary to treat the Appellant's psychological problems. Dr. Pancyr also commented again on the Appellant's unwillingness to attend treatment and as

we have already pointed out, aside from the initial lapse in treatment, we find no basis for Dr. Pancyr's conclusion in that regard.

[91] Accordingly, in assessing the Appellant's need for psychological counselling it is our opinion that the need for psychological counselling is not only to yield an improvement in the Appellant's condition as stated by Dr. Pancyr but it is also important with respect to preventing a deterioration in the Appellant's psychological condition. Dr. Pancyr testified that he could not say whether or not the Appellant's psychological condition would deteriorate without treatment. Dr. Mothersill's medical report is the last medical report on the file prior to the appeal. She reported a decline in the Appellant's condition from December 2003. Dr. Mothersill diagnosed the Appellant with BDD, a diagnosis she had not previously made. Our review of the medical evidence shows that the Appellant experienced many setbacks throughout the course of her psychological treatment, especially surrounding her surgeries. We now know that since her termination of counselling benefits and at the time of the appeal, the Appellant was anticipating further surgeries. Dr. Pancyr admitted he was not aware of this and agreed that the upcoming surgeries would be very anxiety provoking and that treatment would be required. Similarly, Dr. Mothersill opined that she would require psychological treatment to assist her in accepting her facial condition once all medical interventions had been exhausted. In our opinion, the Appellant still requires ongoing psychological counselling to assist her in addressing her accident injuries. Dr. Shimp identifies that further counselling may not yield further benefits but that supportive treatment is needed to cope with the depressive symptoms when they are severe. In our opinion, psychological counselling is necessary to lessen a disability and to maintain function in the Appellant's case. The Appellant testified that she rarely leaves her home except to get groceries and to go to appointments. Without psychological intervention, the Appellant is not likely to participate in exposure activities and is able to remain secluded in her home. The medical opinions on file state that the best treatment for her psychological problems is participation in exposure activities. She requires psychological support for these types of activities, as well as for her surgeries and a return to work if one is contemplated. We are satisfied on a balance of probabilities that the Appellant has an ongoing need for psychological counselling and that is it necessary to lessen her disability and to prevent a decline in her function. However, we also

agree that the Appellant must participate in her assigned exposure activities if she wishes to gain the full benefit of her psychological counselling.

[92] It is our recommendation that once all surgeries have been completed, the Appellant undergo a psychological assessment to identify her ongoing need for counselling. Such assessment should be completed in consultation with her psychologist, Dr. Shimp. Timelines for counselling should be identified and termination of counselling benefits should also be done in consultation with Dr. Shimp and the Appellant to ensure benefits are gradually discontinued rather than terminated suddenly and without warning. All parties agreed that psychological counselling should not continue forever, however, we are satisfied that the Appellant's benefits were terminated prematurely and that SGI's decision to terminate, including their lack of reasons in the decision letter, was wrong. If we are wrong in concluding that the Appellant's psychological counselling is necessary, and it is only considered to be advisable, we would still find SGI's decision to be unreasonable for the same reasons, particularly in light of Dr. Pancyr's admission that ongoing counselling would be necessary so long as surgeries were still ongoing.

[93] Accordingly, we find that the Appellant has identified a need for ongoing psychological counselling to prevent a further deterioration in her psychological state and decline in her function. All parties agree that a timeline would be appropriate and the Appellant admitted that she does not want to undergo psychological counselling forever. For the time being, we are convinced by the medical evidence that she requires supportive counselling at least until all medical interventions have been exhausted, as well as during a return to work. We are concerned about a indefinite order for treatment and therefore we would recommend that a review of the Appellant's psychological state be completed as outlined in paragraph [93] within one year from the date of this decision if surgeries and a return to work have still not be completed by that time.

[94] Mr. Brown, on behalf of SGI, submitted that the Appellant was receiving psychological counselling for non-accident related issues and they should not be responsible for all costs of psychological treatment. We find that the Appellant was not receiving treatment for any psychological problems immediately prior to the accident and in so far as her treatment may be addressing issues not related to her accident injuries (ie. relationship issues with her common law

spouse), we rely upon Dr. Shimp to advise SGI which treatment or portion thereof is not in her opinion related to her motor vehicle accident and injuries and that the Appellant be billed personally and separately for these sessions. We are in agreement that SGI is not required to pay for psychological treatment that is not related to or connected to the Appellant's motor vehicle accident or injuries.

CONCLUSION

[95] The decision made by SGI dated December 9, 2004 which terminated funding for psychological counselling for the Appellant is set aside. Having regard to all of the evidence we find SGI's decision to be wrong. SGI is directed to reimburse the Appellant for her costs associated with psychological counselling since December 9, 2004. In our opinion, the Appellant has proven that the ongoing psychological counselling is necessary to lessen her disability and prevent a decline in her function so long as she continues to search for surgical resolution of her facial injuries and when she is faced with a return to work.

[96] As the Appellant has been successful in her appeal, she is entitled to the reasonable costs of her appeal; (including the Appeal fee) in accordance with Section 193(11) of *The Automobile Accident Insurance Act* and Section 86(4) and 96 of *The Personal Injury Benefits Regulations*

Dated at Regina, Saskatchewan, on January 8, 2007.

Joy Dobko, Chair

Stephanie Pfefferle, Commission Member

Darleen Topp, Commission Member