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THE ENNIS CENTRE FOR PAIN MANAGEMENT

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This is an example of an assessment of a patient, involved in a rear end collision. This is a Section 24 Assessment under the S.A.B.S.

CONSULTATION REPORT UNDER SECTION 24 OF THE S.A.B.S.

Patient:	**Ms. XXXXX**
Date of Birth:	**Date**
Date of Report:	**Date**
Date of Loss:	**Date**
Insurance Provider:	**Insurance Company**
Claim No.:	**Claim No.**
Evaluator:	**Dr. J.H. Ennis, Psychiatrist**

QUALIFICATIONS:

I am a duly qualified medical practitioner licensed to practice by the College of Physicians and Surgeons of Ontario. I obtained my MSW degree at the University of Toronto in 1982, and my MD degree at McMaster University in 1988. Following my residency in psychiatry, I participated in an additional three years of supervised training in the treatment of patients with chronic non-cancer pain. I am a Consultant in Psychiatry and certified as a Fellow of the Royal College of Physicians and Surgeons of Canada in this specialty. I was an examiner for the College of Physicians and Surgeons of Ontario. I held the position Associate Director of the Chronic Pain Management Unit at Chedoke Rehabilitation Services. I was the Director of the *HSO Pain Management Group* and the *East End Multidisciplinary Pain Management Program.* Currently, I am the director of *The Ennis Centre for Pain Management,* located in Hamilton, Ontario. I hold cross appointments in the Department of Physical Medicine and Rehabilitation, and the Department of Psychiatry and Neurobehavioural Sciences. I am a part-time clinical Assistant Professor in the Faculty of Health Sciences at McMaster University in Hamilton, Ontario, Canada. My clinical practice is devoted to the assessment and

treatment of patients with chronic non-cancer pain.

CONSENT*:*

Ms. XXXXX was seen for an evaluation of her pain, capacity to cope and psychiatric status at the request of her legal representative. The purpose of this assessment is to develop a treatment plan. If a physical examination is carried out it is carried out in the presence of my secretary, Ms. ZZZZ. The nature of the examination was explained. Ms. XXXXX understood that she could stop the examination at any point for any reason. If pain was produced by any test or other aspect of the examination it should be brought to my attention and the test would be discontinued. The patient understood that she could make such a request without jeopardizing her situation. The patient gave verbal consent/signed a release form, giving me permission to forward a copy of this consultation report to the following:

Insurance Company
Primary Care Physician
Legal representation

SOURCE OF DATA:

Reports:

- Plain Film X-ray of the Cervical and Lumbar Spines dated
- Report by L. XXXXX (psychologist) dated
- Independent Functional Abilities Evaluation completed by J. XXXXX (OT) and M. XXXXX dated
- Executive Summary from the Hamilton Hospitals Assessment Centre completed by J. XXXXX (OT)
- Report by E. XXXXXn (orthopaedic surgeon)
- Report by S. XXXXX (neurologist) dated
- Assessment from Ontario Hospital Alliance of Assessment Providers completed by L. XXXXX (psychologist) dated
- Vocational Evaluation Report by J. XXXXX (OT) dated
- Independent Functional Capacity Evaluation Report completed by J. XXXXX (OT) dated
- MRI of the Lumbar Spine dated

Clinical Assessment:

Patient:	**Ms. XXXXX**
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A clinical assessment was conducted on date.

SECTION I

The information contained within this section derives solely from the subjective verbal history provided by the patient.

IDENTIFYING DATA:

Ms. XXXXX is a 56-year old woman. She has been divorced for three years and has two adult children and two grandchildren. The son and his daughter live with the patient and she has a granddaughter from her daughter who has lived with her for most of her life. The patient was working as a cleaner at location prior to the accident that took place on date (index MVA). Associated with the accident has been the onset of headache and axial spine pain with a reduced level of function.

HISTORY:

On the day of the accident Ms. XXXXX was driving east on location. She was moving into a curb lane just before location. As she was going through the intersection on a green light another vehicle made a left turn. The other vehicle landed up hitting her in the rear driver's side. Her car was pushed towards oncoming traffic. Her son was "screaming". She was able to stop the car prior to coming into the traffic. There was no bruising reported on her head.

The son was taken by ambulance to local hospital. Ms. XXXXX gave her report at the scene of the accident and was taken by her daughter to the hospital where it was recommended that she get checked up as well. By that point she had pain in the low back, neck and shoulders and pain in the left leg. She was given a neck brace but two days later she saw her primary care physician who told her to take it off and only use it when she absolutely had to. She was then referred to physiotherapy and massage therapy. She continues to attend both. She has had acupuncture as well. The physiotherapy has not helped. She gets limited benefit from massage therapy and acupuncture. She has also had trials of opioids and other medications but she would rather not take medications. She is quite fearful about the issue of addiction.

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Current Symptoms:

Ms. XXXXX reported that she has a constant headache across the forehead. The headaches are not associated with a scatoma. They are always present. She has pain across the neck and interscapular pain as well with a tightness across the shoulders. She describes “shooting pain into the head and eyes”. Her eyes feel like “empty sockets”. She endorses nausea and episodic vomiting. She endorses photophobia.

The patient reports having low back pain with pain radiating down the left leg. Bowel and bladder function are intact.

Level of Function:

Prior to the Ms. XXXXX reported working full time as a cleaner at location. It was a heavy job. She socialized regularly, did her own gardening and took care of her home and cooked for the family.

Now, she does a little bit of cooking. She does a bit of housework. She is no longer able to cope with work demands. She feels upset because the house does not look the way she would like it to and she feels her life has stopped since the accident.

The patient will try and go for a walk on a daily basis but social activity has greatly reduced. She has become irritable with family members and that is not typical for her.

PAST MEDICAL HISTORY:

Ms. XXXXX has a history of hiatus hernia that she now states is more symptomatic over the past month. She has a pre-accident history of irritable bowel syndrome.

PRE-ACCIDENT PSYCHIATRIC HISTORY:

The patient has been involved in driving rehabilitation and has found it very helpful.

MEDICATIONS:

Replacement Estrogen

Cloversyl for hypertension

Tylenol 3 two times per week

Tylenol 1 about two times per week

She has no formal allergies and does not smoke. She does not abuse substances.

FAMILY MEDICAL AND PSYCHIATRIC HISTORY:

The family history is positive for diabetes mellitus and cardiovascular disease and social anxiety.

PERSONAL HISTORY:

Ms. XXXXX was born in location. She is the eldest of a sibline of seven. She reported being sexually molested by five different family members but she never talked about it because she knew she would be blamed. Her mother abused alcohol. She described her father as a calm man. From her point of view she helped to raise all the children since she was about seven years of age. Even after she was married she would still come home and babysit the children. Her family was evicted from house to house because the mother would drink away the rent money. There were also days when there was not enough food. However she does not endorse flashbacks or nightmares related to her developmental years. She stated that she was involved in sexual abuse counselling for many years and stopped about a year and a half ago.

The husband left Ms. XXXXX after they were married for over 30 years. Money was involved in the issues and he blamed her for making him poor. The patient has investigated this more and has discovered that in fact it was he who had done this. He has remarried and they have no contact with each other.

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MENTAL STATUS EXAMINATION:

Ms. XXXXX presented as a moderately well groomed woman who did not demonstrate pain behaviours. Her mood is chronically down but she tries not to let other people see that. She has gained 20 pounds since the accident and she is now going to a clinic for weight loss. Sleep has been chronically problematic with middle insomnia. She enjoys family and friends and her children. She has sufficient energy but she is unable to do things. Concentration is poor. Her self image is poor. She does not have suicidal ideation or intent.

She gets very anxious when she thinks about her future. She believes that her life is in the hands of the insurance company and they can do anything they want. She recognizes that she is almost 57 and has a very limited education and it is unlikely that she can ever be retrained to do something else.

Ms. XXXXX does not endorse having nightmares related to the accident. She is able to drive through the area where the accident occurred without any anxiety. Her thought for and content were normal and there was no evidence of perceptual disturbance. Cognitive examination was grossly normal.

BRIEF PHYSICAL EXAMINATION:

A brief physical examination was conducted. The patient had functional range of motion of the neck although she reported pain at end range of motion in all planes. The same was true of the lumbar spine. She had 12 out of 18 tender points but she also reported pain with less than feather light touch. This is a non-organic finding.

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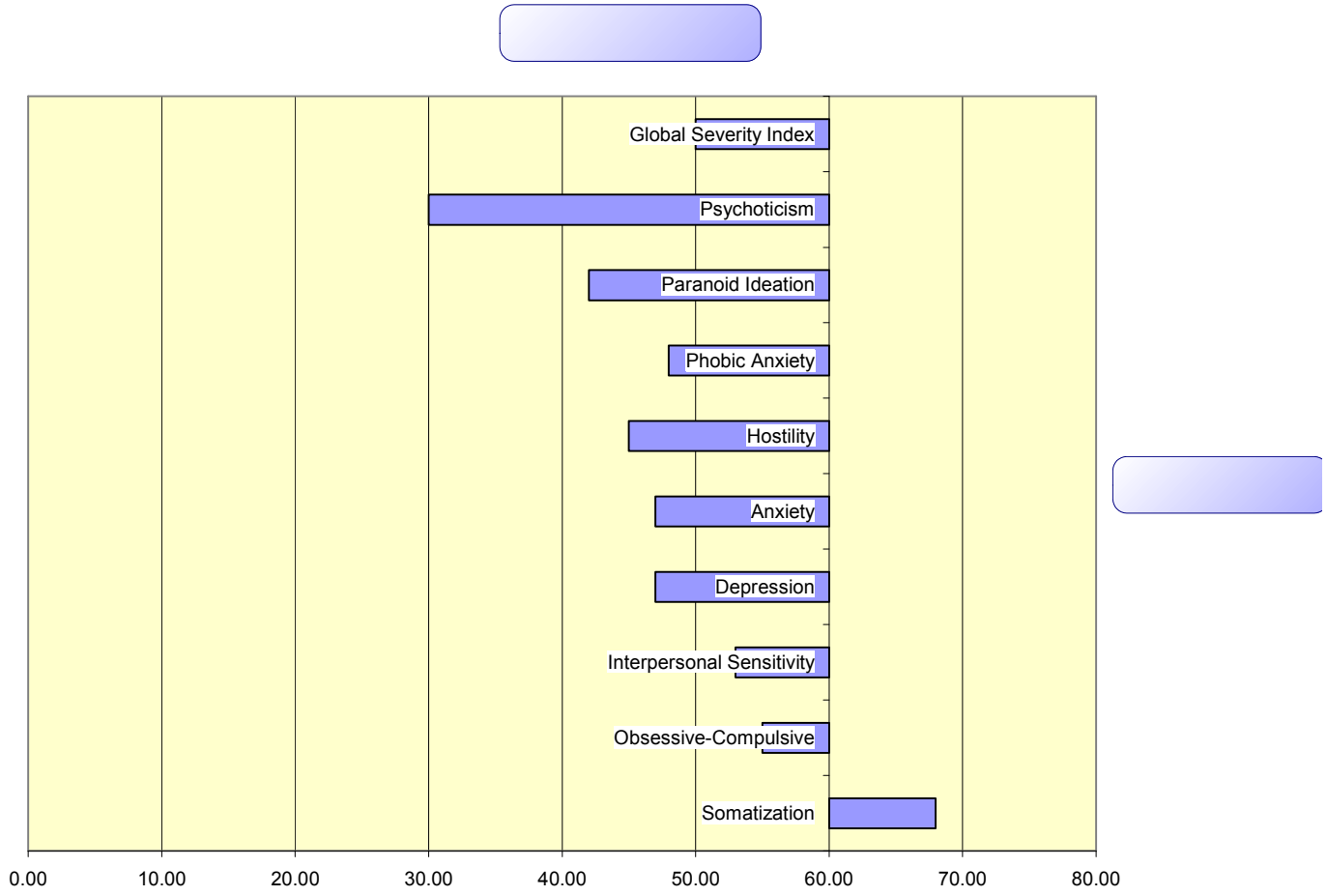
SECTION II

The information in this section derives solely from objective psychometric testing.

Psychopathology:

On the **SCL90-R**



Scores above 60 are considered to be clinically significant. The subscale for somatization is clinically elevated.

The patient did not complete the PTSD Checklist.

On the **AUDIT** Ms. XXXXX scored 1 indicating no issues related to alcohol use.

On the **DRUG USE QUESTIONNAIRE** Ms. XXXXX scored 0 indicating no issues related to substance use.

On the **SOAPP,** scores above 7 indicate issues related to addiction when treatment with opioids is initiated. Ms. XXXXX scored 8. However, she does not have interest in using opioids. She has been treated with them in the past and prefers not to use them.

On the **PAIN CATASTROPHIZING SCALE** scores above the 75th percentile are considered to be clinically significant. Ms. XXXXX's total score was in the 88th percentile. On the rumination subscale she scored in the 86th percentile. On the Magnification subscale she scored in the 86th percentile and on the helplessness subscale she scored in the 83rd percentile.

Pain and Disability:

The patient's **PAIN RATING** is as follows: pain right now is 9 out of 10, at its worst is 9 out of 10, at its least at 5 out of 10 and the pain that she can tolerate is 5 out of 10 where ten is the worst pain ever experienced.

The patient did not complete the **PAIN DISABILITY INDEX**.

Ms. XXXXX's **KARNOFSKY score** is 70 indicating that she can care for herself but is unable to perform normal activity or do active work.

The patient did not complete the **OSWESTRY BACK PAIN AND DISABILITY QUESTIONNAIRE**.

On the **OSWESTRY NECK DISABILITY QUESTIONNAIRE** the patient scored 54 indicating that she perceives herself as severely impaired as a result of back pain.

On the **OREBRO MUSCULOSKELETAL PAIN QUESTIONNAIRE,** scores above 109 indicate risk of disability and inability to work. Scores above 130 indicate a very high likelihood of chronic disability and a low likelihood of return to work. Ms. XXXXX scored 136.

On the **TAMPA SCALE OF KINESIOPHOBIA** Ms. XXXXX scored 41 which is in keeping with typical median scores seen in patients with chronic pain.

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Summary of Findings:

Unfortunately, a number of important scales were not completed. What can be said is that there is evidence of somatization. The patient perceives herself as severely impaired. She has catastrophic thinking. The score on the Orebro is above 130 indicating high risk of chronic disablement. However, Ms. XXXXX is motivated to try and increase her function in order to return to her pre-accident activities. This should be capitalized upon with appropriate treatment.

SECTION III

The information in this section derives solely from the available medical-legal brief.

REVIEW OF AVAILABLE DOCUMENTATION:

Notes that are handwritten and photocopied will be commented on if they are completely legible only. Documents will be commented on only if they are complete and are not missing any pages.

Plain Film X-ray of the Cervical and Lumbar Spines dated:

No acute abnormalities identified.

Report by L. XXXXX (psychologist) dated:

It was the opinion of Dr. XXXXX the patient was presenting with a somatoform pain disorder associated with psychological factors. He states that the patient's perception of pain and anxiety are contributing to her inability to return to work and her previous activities of daily living. Again he states that she is not substantially disabled from housekeeping maintenance and returning to work. However psychological symptoms are an impediment to activation. He states the patient is not substantially unable to complete the essential duties of her job from a psychological view point.

The primary diagnostics is based on three tests. The Clinical Assessment of Depression, the Personality Assessment Inventory and the Pain Symptom Rating Inventory.

This patient has done the PAI multiple times. On the Clinical Assessment for Depression there was an atypical response on one of the validity scales. Therefore there was a question of reliability. The overall score was considered to be in a clinical risk range.

On the Personality Assessment Inventory there were marked elevations. This consists of an individual reporting significant distress and significant concerns about physical function with evidence of depression. There was evidence of maladaptive behaviour in

order to control anxiety. There is a negative self evaluation.

On the Pain Symptom Rating Inventory the results were in a questionable valid range compared to normal pain patients. This suggests that there should be some caution taking the patient's pain and perceived pain. The GAF is rated at 65.

Independent Functional Abilities Evaluation completed by J. XXXXX (OT) and M. XXXXX dated:

On the Oswestry Low Back Disability Questionnaire she scored 62% suggesting she perceives herself as crippled. She did demonstrate pain behaviours during the assessment as well as other somatic concerns. The patient shows evidence of capacity to manage light range physical activity. She also underestimates her capacity and perceives herself as significantly disabled. She is also deconditioned. She does not have good pain management strategies.

Executive Summary from the Hamilton Hospitals Assessment Centre completed by J. XXXXX (OT) dated:

Orthopedic evaluation determined that injuries caused by the motor vehicle accident were soft tissue affecting the cervical and lumbar spine and the patient had some pre-existing episodic back pain related to work. Neurology identified soft tissue strain. Twenty-seven years ago the patient sustained a presumed fracture at C5 and had pre-existing degenerative changes in the cervical spine a condition that could prolong recovery. Psychology diagnosed the patient with somatoform disorder.

The orthopedic surgeon identified the patient as not having any significant clinical impairment. The same was true in regards to neurology. From a psychological point of view it is stated the patient's pain perception and anxiety are contributing to her inability to return to work. It is stated that the patient is not considered substantially disabled from completing her activities of housekeeping and home maintenance but "psychometric test results indicate that her psychological symptoms are currently an impediment to her re-activation and will need to be addressed"
.
It is stated that from an orthopedic perspective the accident did not make a material contribution to the patient's current symptoms. The neurologist stated it was minimally contributory and the psychologist states that "problems with pain, perception and mood/anxiety control related to the accident, while not disabling on their own continue to contribute to her difficulty returning to her work and daily activities".

Recommendations are made for 12 sessions of physiotherapy.

Report by E. XXXXX (orthopaedic surgeon):

On physical examination the primary finding was that light touch was reported as decreased in terms of perception on the entire left arm circumferentially from shoulder to finger tip with negative Tinel's sign without any wasting and neurologic examination of the upper extremity was normal. Range of motion of the neck was reduced in all planes with wide spread reports of pain on palpation. Motor function was graded as five. Straight leg raise on the right side seated was 70 degrees with pain in the neck and low back.

Report by S. XXXXX (neurologist) dated:

The patient is diagnosed with atypical posttraumatic headaches with a prognosis that is considered fair. She has recurrent vestibulopathy from inner ear abnormalities but there are also features of non-organic pain focused behaviours. There is a history of hypertension that predates the accident.

The accident is described. The patient was driving a 1993 Ford Taurus. The accident took place at location. The patient was going into a curb lane to get into a Pizza place. She was going through the intersection on a green light but a vehicle T-boned her on the rear driver's side. Air bags did not deploy. The patient did not know she hit her head and she was concerned about her son because he was "screaming". The son was taken to the hospital and she went to see him there and she went on to develop back pain with swelling of the left leg and was assessed at that time. She had CT scan of the neck and was given a neck brace and diagnosed with whiplash.
The patient is independent in self care but her capacity to take care of the home is reduced and she is not working.

Physical examination did not reveal any abnormalities on physical exam.

Neurologic examination did fail to reveal any objective findings but there was pain focused behaviours and non-organicity on the exam. Nerve conduction studies were recommended.

Assessment from Ontario Hospital Alliance of Assessment Providers completed by L. XXXXX (psychologist) dated:

A series of questions are answered. Dr. XXXXX responds to the question of diagnosis. It was his opinion the patient met criteria for a somatoform disorder specifically a pain disorder associated with general medical condition and with psychological factors

It was his opinion the patient had a complete inability to engage in employment for which she is reasonably suited by education, training or experience.

In terms of personal history the patient was born in location and is the eldest of a sibline of seven. Her parents were drinkers. Her mother was absent frequently from the home because of drinking. The family was poor because of alcohol use and often household bills were not paid. They were often evicted. Her father was a truck driver and died 23 years ago from bowel cancer and the mother is still living. The patient becomes pregnant at the age of 17 and she left school, married her husband and has two children. She has been separated from her husband after 33 years of marriage. He left because he felt that she had ruined him financially. There are multiple ongoing financial issues. The patient's son and eleven year old granddaughter live with her as well as her older granddaughter the eldest child of her daughter. This grandchild has lived with her since childhood. She suffers from severe social anxiety and has been unable to attend regular school. The patient has less than grade 10 education. She went to college later in life to study business but dropped out due to her daughter becoming ill. The patient worked as a cleaner for three years for a company that had a contract with location. Her former position no longer exists.

The typical psychometric testing is utilized in this report. Specifically the Personality Assessment Inventory. Scores are valid. There are elevations on the somatic complaint subscale. Health concerns was elevated. There were also elevation on depression subscales. The Pain Catastrophizing Scale was in the 75th percentile indicating significant level of catastrophizing.

Based almost entirely on the testing the patient was diagnosed as described above.

In regards to treatment recommendations are made for a "course of cognitive behavioural treatment". He recommends a multidisciplinary pain program. He also makes recommendation in regards to medications. (This is outside of his area of expertise.)

Vocational Evaluation Report by J. XXXXX (OT) dated:

The patient was given a general vocational aptitudes test. gain jobs such as cashier, sales clerk, door attendant and postal clerk are offered as options. Multiple assistive devices are also recommended.

Independent Functional Capacity Evaluation Report completed by J. XXXXX (OT) dated:

Based on the assessment the patient demonstrated physical ability to complete work at the light level but did not demonstrate the ability to sustain work for eight hours a day. Recommendations are made for a graduated return to work. It is stated that "three of the endurance tasks were self limited". (The use of the word self-limited has a negative connotation.)

Suggestions are made of types of employment such as cashier, door attendant, postal clerk, food service counter attendant and food prepare and it is again repeated the patient did not demonstrate the ability to manage eight hours per day.

In terms of treatment to date the patient has been treated by her primary care physician with physiotherapy and passive treatments. She does massage therapy with manual traction. She now has a membership at a fitness centre with a personal trainer. Apparently her car broke down and therefore she was unable to attend fitness on a regular basis.

MRI of the Lumbar Spine dated 29/10/11:

There is mild multi level degenerative disc and facet joint changes in the lower lumbar spine with the worst being at L5 S1 and there is mild bilateral neural foraminal stenosis without significant spinal canal stenosis.

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SECTION IV

This section is Dr. Ennis' formulation of the data contained in Section I, II, and III.

DIAGNOSIS:

Axis I Pain Disorder Associated with both Psychological Factors and a General Medical Condition.

Dysthymia

Axis II Deferred

Axis III ? Fibromyalgia.

Axis IV Ms. XXXXX reports stress related to her inability to work. This has caused significant financial stress for her. By way of example she cannot afford to buy any medications if prescribed.

Axis V Current GAF 50-55/100.

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Global Assessment of Functioning (GAF) Scale (DSM - IV Axis V)

Note: The complete GAF scale on page 32 of the DSM - IV and should be consulted for clinical use.

Code	Description of Functioning
91 - 100	Person has **no problems** OR has superior functioning in several areas OR is admired and sought after by others due to positive qualities
81 - 90	Person has **few or no symptoms**. Good functioning in several areas. No more than "everyday" problems or concerns.
71 - 80	Person has symptoms/problems, but they are **temporary, expectable reactions to stressors**. There is no more than slight impairment in any area of psychological functioning.
61 - 70	**Mild symptoms in one area** OR difficulty in one of the following: social, occupational, or school functioning. BUT, the person is generally functioning pretty well and has some meaningful interpersonal relationships.
51 - 60	**Moderate symptoms** OR moderate difficulty in one of the following: social, occupational, or school functioning.
41 - 50	**Serious symptoms** OR serious impairment in one of the following: social, occupational, or school functioning.
31 - 40	**Some impairment in reality testing** OR impairment in speech and communication OR serious impairment in several of the following: occupational or school functioning, interpersonal relationships, judgment, thinking, or mood.
21 - 30	**Presence of hallucinations or delusions which influence behavior**
11 - 20	There is **some danger of harm to self or others**

CONCLUSION:

Ms. XXXXX is a 56-year-old woman who had a pre-accident history of irritable bowel syndrome and hiatus hernia but she was functionally active. Associated with the accident has been the onset of axial spine pain and a significantly reduced level of function.

On psychometric testing there is evidence of somatization. The patient perceives herself as severely impaired. She has catastrophic thinking. The score on the Orebro is above 130 indicating high risk of chronic disablement. However, Ms. XXXXX is motivated to try and increase her function in order to return to her pre-accident activities. This should be capitalized upon with appropriate treatment. In my opinion, her presentation does meet criteria for a *pain disorder associated with both psychological factors and a general medical condition*.

Criteria for Pain Disorder

A. Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention.

B. The pain causes clinically significant distress or impairment in social, occupational, or other important areas of functioning.

C. Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain.

D. The symptom or deficit is not intentionally produced or feigned (as in Factitious Disorder or Malingering).

E. The pain is not better accounted for by a Mood, Anxiety, or Psychotic Disorder and does not meet criteria for Dyspareunia.

Code as follows:
307.80 Pain Disorder Associated with Psychological Factors: psychological factors are judged to have the major role in the onset, severity, exacerbation, or maintenance of the pain. (If a general medial condition is present, it does not have a major role in the onset, severity, exacerbation, or maintenance of the pain.) This type of Pain Disorder is not diagnosed if criteria are also met for Somatization Disorder.

Specify if:
Acute: duration of less than 6 months
Chronic: duration of 6 months or longer

307.89 Pain Disorder Associated with Both Psychological Factors and a General Medial Condition: both psychological Factors and a general medial condition are judged to have important roles in the onset, severity exacerbation or maintenance of the pain. The associated general medical condition or anatomical site of the pain (see below) is coded on Axis III.

Specify if:
Acute: duration of less than 6 months
Chronic: duration of 6 months or longer

Note: the following is not considered to e a mental disorder and is included here to facilitate differential diagnosis.

Pain Disorder Associated with a General Medical Condition: a general medial condition has a major role in the onset, severity, exacerbation, or maintenance of the pain. (If psychological factors are present, they are not judged to have a major role in the onset, severity, exacerbation, or maintenance of the pain.) The diagnostic code for the pain is selected based on the associated general medical condition if one has been established or on the anatomical location of the pain if the underlying general medical condition is not yet clearly established - for example, low back (724.2), sciatic (724.3) pelvic (625.9), headache (784.0), facial (784.0), chest (786.5), joint (719.40), bone (733.90), abdominal (789.0), breast (611.71), renal (788.0), ear (388.70), eye (379.91), throat (784.1), tooth (525.9), and urinary (788.0).

Co-morbid with the pain disorder is evidence of *dysthymia.*

Dysthymia

A. Depressed mood for most of the day, for more days than not, as indicated either by subjective account or observation by others, for at least 2 years. **Note:** In children and adolescents, mood can be

1. irritable and duration must be at least 1 year.

B. Presence, while depressed, of two (or more) of the following:

(1) poor appetite or overeating
(2) Insomnia or Hypersomnia
(3) low energy or fatigue
(4) low self-esteem
(5) poor concentration or difficulty making decisions
(6) feelings of hopelessness

C. During the 2-year period (1 year for children or adolescents) of the disturbance, the person has never been without the symptoms in Criteria A and B for more than 2 months at a time.

D. No Major Depressive Episode has been present during the first 2 years of the disturbance (1 year for children and adolescents); i.e., the disturbance is not better accounted for by chronic Major Depressive Disorder, or Major Depressive Disorder, In Partial Remission.
Note: There may have been a previous Major Depressive Episode provided there was a full remission (no significant signs or symptoms for 2 months) before development of the Dysthymic Disorder. In addition, after the initial 2 years (1 year in children or adolescents) of Dysthymic Disorder, there may be superimposed episodes of Major Depressive Disorder, in which case both diagnoses may be given when the criteria are met for a Major Depressive Episode.

E. There has never been a Manic Episode, a Mixed Episode, or a Hypomanic Episode, and criteria have never been met for Cyclothymic Disorder.

F. The disturbance does not occur exclusively during the course of a chronic Psychotic Disorder, such as Schizophrenia or Delusional Disorder.

G. The symptoms are not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hypothyroidism).

H. The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.

Specify if:

Early Onset: if onset is before age 21 years
Late Onset: if onset is age 21 years or older

Specify (for most recent 2 years of Dysthymic Disorder):

With Atypical Features

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Treatment Recommendations:

1. Medication management can be used to manage dysthymia but it is not absolutely necessary. Ms. XXXXX would prefer not to use antidepressant medication.

2. In my opinion Ms. XXXXX is a good candidate for involvement in a multidisciplinary pain program. The purpose of the treatment is to treat her functional limitations but also to treat the dysthymia. She recognizes the goal of treatment is to increase function and not necessarily reduce pain.

3 The patient did ask me if she was a surgical candidate. I indicated to her that I do not have her EMG results. EMG results are more helpful in determining whether or not a patient could benefit from a discectomy than the MRI is. As well there is no overt evidence of spinal instability. I explained to the patient that if she wasn't a candidate for discectomy this surgery is for leg pain primarily and not for low back pain. When I said this to her she indicated that she was a little less interested in having a surgical consult. I indicated that if the EMG is positive associated with findings on MRI than it would be reasonable to refer her for a surgical consultation. This is something that has to be left in the hands of Dr. XXXXX to determine.

More details about this treatment can be found at the program's web site at http://www.enniscentre.com.

Goals Of Treatment

1. The goal of Ms. XXXXX's treatment in the multidisciplinary pain program at The Ennis Centre for Pain Management is to reduce/eliminate the impact disability has on this patient and to facilitate their integration into their family, the world around them and the labour market. The ultimate goal is to shorten the period of disability that Ms. XXXXX now faces. These goals are in keeping with section 16 and 57 of the SABS. It is important to recognize that the SABS does not tie disability to rehabilitation.

That section of the SABS that addresses rehabilitation is provided below:

Rehabilitation benefits

1. **16.** (1) Subject to section 18, rehabilitation benefits shall pay for all reasonable and necessary expenses incurred by or on behalf of the insured person in undertaking activities and measures described in subsection (3) that are reasonable and necessary for the purpose of **reducing or eliminating the effects of any disability resulting**

from the impairment or to facilitate the person's reintegration into his or her family, the rest of society and the labour market. O. Reg. 34/10, s. 16 (1).

(2) Measures to reintegrate an insured person into the labour market are considered reasonable and necessary, taking into consideration the person's personal and vocational characteristics, if they enable the person to,

(a) engage in employment or self-employment that is as similar as possible to the employment or self-employment in which he or she was engaged at the time of the accident; or

(b) **lead as normal a work life as possible**. O. Reg. 34/10, s. 16 (2).

(3) The activities and measures referred to in subsection (1) are,

(a) life skills training;

(b) family counselling;

©) social rehabilitation counselling;

(d) financial counselling;

(e) employment counselling;

(f) vocational assessments;

(g) vocational or academic training;

(h) workplace modifications and workplace devices, including communications aids, to accommodate the needs of the insured person;

(I) home modifications and home devices, including communications aids, to accommodate the needs of the insured person, or the purchase of a new home if it is more reasonable to purchase a new home to accommodate the needs of the insured person than to renovate his or her existing home;

(j) vehicle modifications to accommodate the needs of the insured person, or the purchase of a new vehicle if it is more reasonable to purchase a new vehicle to accommodate the needs of the insured person than to modify an existing vehicle;

(k) transportation for the insured person to and from counselling and training sessions, including transportation for an aide or attendant;

(l) other goods and services that the insured person requires, except,

(I) services provided by a case manager,

(ii) housekeeping and caregiver expenses, and

(iii) any goods or services for which a benefit is otherwise provided in this Regulation. O. Reg. 34/10, s. 16 (3).

(4) Despite subsection (1), the insurer is not liable to pay rehabilitation benefits,

(a) for expenses related to professional services described in any of clauses (3) (a) to (g) or (3) (l) rendered to the insured person that exceed the maximum rate or amount of expenses established under the Guidelines;

(b) for expenses incurred to renovate the insured person's home if the renovations are only for the purpose of giving the insured person access to areas of the home that are not needed for ordinary living;

©) for the purchase of a new home in excess of the value of the renovations to the insured person's existing home that would be required to accommodate the needs of the insured person;

(d) for expenses incurred to purchase or modify a vehicle to accommodate the needs of the insured person that are incurred within five years after the last expenses incurred for that purpose in respect of the same accident;

(e) for the purchase of a new vehicle in excess of the amount by which the cost of the new vehicle exceeds the trade-in value of the existing vehicle;

(f) for transportation expenses other than authorized transportation expenses.

Treatment and rehabilitation

57. (1) This section applies to an insured person if compliance with subsection (2) would not be detrimental to his or her treatment or recovery. O. Reg. 34/10, s. 57 (1).

(2) An insured person who is entitled to an income replacement, non-earner or caregiver benefit **shall obtain such treatment and participate in such rehabilitation as is reasonable, available and necessary to,**

(a) permit the insured person to engage in employment or self-employment in accordance with the criteria set out in subsection (3), in the case of an insured person entitled to an income replacement benefit; or

(b) **shorten the period during which the benefit is payable**, in any other case.

Any assessment of this patient must address the issues outlined above.

Patient:	**Ms. XXXXX**
Date of Birth:	**Date**
Date of Report:	**Date**
Date of Loss:	**Date**
Insurance Provider:	**Insurance Company**
Claim No.:	**Claim No.**

About the Pain Program

A description of the program is provided below and on the program's website which is also provided below. If any assessors are involved in this process and they do not understand the purpose of the program or its structure they should call me and I will speak with them directly.

More details about this treatment can be found at the program's web site at http://www.enniscentre.com. In summary, this is a 15 week multidisciplinary pain management program. All staff is supervised by Dr. Jeff Ennis (pain specialist/psychiatrist). Dr. Ennis is present at all Wednesday sessions. The program has over 100 hours of treatment.(see below). This is a functional activation program. It has been shown in the medical literature that patients with chronic pain should be treated in functional activation programs. One to one therapy is not as effective. The program includes tai chi, aquatherapy, special activation sessions, and the Wednesday coping skills group. The staff of the program includes our office manager, psychiatrist/pain specialist, physiotherapy, occupational therapy, nursing, social work, nutritionist, aquatherapist, tai chi/martial arts instructor, and painting instructor. This patient population does not respond to conservative care which includes physiotherapy and chiropractics. The multidisciplinary program offers patients with chronic noncancer pain their last best chance of improving their level of function.

In the process of determining if the recommended treatment is reasonable and necessary I request that the reader consider the following:

1 The literature is quite specific about the management of chronic noncancer pain. Currently, the best evidence indicates that not providing this treatment to patients at high risk for developing chronic pain results in increased disability. Participation in a multidisciplinary pain management program, using cognitive behavioural methods of treatment, offers patients the best opportunity for recovery. Outcome is improved if the program has over 100 hours of treatment and if the multidisciplinary staff have additional training in the use of cognitive behavioural therapy for the treatment of chronic pain. Therefore, if one is using evidence based practice to inform treatment, the use of a multidisciplinary pain management program is central to the treatment of patients with chronic noncancer pain who demonstrate problems in functioning.

2 Individual psychotherapy is not a replacement for a multidisciplinary activation program. I am not aware of any significant evidence in the medical literature supporting the use of individual psychotherapy for the treatment of chronic noncancer pain. Such treatment is useful in the management of anxiety disorders and mood disorders.

Special circumstances do exist when individual treatment is the only option available to a patient. This might occur when a patient is unable to take time away form work to become involved in a group treatment program. Under such circumstances, treatment

should involve well-coordinated individual input between members of a multidisciplinary team, using cognitive behavioural methods of treatment. Goals should still focus on functional activation.

3 The sooner treatment is provided the better the outcome. The longer such treatment is delayed, the more likely it is that abnormal pain behaviours and cognitive distortions become well entrenched.

The Medical Legal Process

1 Patients involved in motor vehicle accidents are also involved in a complex medical legal process. There is clear evidence in the medical literature that this process has a negative impact on patient outcome. Therefore, every effort should be made to expedite treatment, using evidence based methods of practice, in order to assist in the process of case closure.

2 If it is determined that this patient requires a third party assessment to determine whether or not this treatment is considered reasonable and necessary, I am requesting that the assessor have a background in the assessment and management of patients with chronic noncancer pain. The reason for this is that the literature associated with pain management is extensive. Knowledge of this literature is necessary in order to provide an informed decision about the recommended treatment plan. Typically, residency training in general psychiatry alone does not provide expert training in the management of chronic noncancer pain.

OPINION OF THE EXAMINER:

The opinions expressed in this report are based upon the examination(s), interviews, records and/or reports described above. They are based upon the subjective complaints and history provided to the examiner, the medical records and tests provided and the physical findings. It is assumed that the material provided is correct. The author reserves the right to alter an expressed opinion, to modify, and/or amend this report should further information come to light which would warrant reconsideration of our opinion. The opinions expressed in this report have been rendered independent of the requesting party and are based upon our professional assessment. This report is not to be copied, distributed or used by other than the requesting party without the consent of the author.

Patient:	**Ms. XXXXX**
Date of Birth:	**Date**
Date of Report:	**Date**
Date of Loss:	**Date**
Insurance Provider:	**Insurance Company**
Claim No.:	**Claim No.**

J.H. Ennis, MSW MD FRCP [C]
Evaluating Psychiatrist

cc:

JHE:sac