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Australian and Ontarian approaches to
disability income support design and mental
illness: A comparative study

Ashley McAllister

A thesis submitted in fulfilment of the requirements for the
degree of Doctor of Philosophy

School of Public Health
The University of Sydney
2015
DECLARATION

The work presented in this thesis is, to the best of my knowledge and belief, original except as acknowledged in the text. I hereby declare that I have not submitted this material, either in full or in part, for a degree at this or any other institution.

Signature: Annette M. Callel

Date: 8/12/14
AUTHOR’S CONTRIBUTION

The work presented in this thesis was carried out by the author under the supervision of Professor Stephen Leeder and Associate Professor Maree Hackett. I conceived and designed this project under the guidance of my supervisory team. Throughout my research program, I refined the key aims and objectives as well as the methods I used in this thesis. I conducted all aspects of research for this thesis.
ABSTRACT

Mental illness is becoming the leading cause of disability in high-income countries, and the features of mental illness – early average age of onset, episodic nature and lack of diagnostic tests – pose challenges when designing eligibility criteria for disability income support programs. Yet there is limited evidence about the process of designing these programs. The aim of this thesis is to contribute knowledge on how disability income support policy is designed, especially in regard to mental illness. This thesis is a comparative case study between Australia and Ontario (Canada) applying constructivist grounded theory. 45 semi-structured interviews were conducted with five types of key informants involved in the design or assessment of disability income support – advocates, legal representatives, physicians, policy insiders and researchers. Analysis followed the steps of grounded theory including transcript coding, detailed memo-writing and diagraming.

Findings revealed that the key informants were concerned about the process of making sure only suitable people are given disability income support. This thesis contributes to the literature by developing a conceptual model to explain this process. The model involves two stages: i) establishing the gate and ii) gatekeeping, and explores the challenges associated with each stage. Findings show that most of the challenges are related to the gatekeeping stage due to the difficulty of interpreting disability income support eligibility criteria. This thesis specifically explores three of these challenges: physicians making judgements about eligibility; expecting applicants to ‘perform’; and the notion of an ‘ideal type’ of disability. There was little variation in this process between Australia and Ontario. The thesis demonstrates the need for specific focus on mental illness in this process; and provides an explanation for why the perception of ‘too many’ people on disability income support persists.

Keywords: mental illness; disability income support; grounded theory; social policy, Australia, Ontario
ETHICAL CLEARANCE
The Human Research Ethics Committee at the University of Sydney has approved all of the empirical research included in this thesis. A copy of the approval letter can be found in Appendix A.
ACKNOWLEDGEMENTS

*No man is an island...*  
(Donne 1839)

Although many moments of the PhD process were solitary, completing this journey would not have been possible without the guidance and support of so many.

First, thanks must go to my primary supervisor, Professor Stephen Leeder. It has been a privilege to learn from someone who has been so influential in academia and policy. Steve has encouraged me to pursue a topic I was passionate about, take risks with my research and always reminded me of the ‘bigger picture’. I am extremely grateful for his time and generosity throughout the entire process. Second, thanks must go to my associate supervisor, Associate Professor Maree Hackett, for her endless pragmatism. Maree has continuously encouraged me to put my ‘hat in the ring’ and reminded me that regardless of the outcome, every experience makes you a stronger and better researcher.

The Menzies Centre for Health Policy at the University of Sydney has been a very supportive environment while undertaking my PhD research. I have received particular support from Bev, Diana, Emma and Sandie throughout the entire process, especially by providing on the ground support while I completed my thesis in Sweden.

In addition to those in Sydney, I have been lucky to have spent the last year of my PhD working with the Health Policy and Equity Group at the Karolinska Institute in Stockholm, Sweden. I am grateful to Professor Bo Burström for welcoming me into this group. A special thank you to Bo and the rest of the group: Anneli, Daniel, Diana, Janna, Johanna, Kristina, Lotta, Mimi, Mona, Pelle and Sara for generously providing comments on a final draft of this thesis and overall encouragement during the final stretch. Tack så mycket!

Final completion of this thesis would not have been possible without the generous financial support of the Foreign Doctoral Research Award from The Canadian Institute for Health Research.

I am forever indebted to the key informants who participated in this research. Without their participation, there truly would be no thesis. I thank them for their generosity in time and candour.
I am also thankful for my mentors in the policy world, Elizabeth Doherty and Terry Hewak. I am grateful to Eliz for giving me my first job as an economist and teaching me that designing tax policy can be innovative and full of research opportunities. Terry has provided encouragement for almost a decade – from my days as an Ontario Ministry of Finance summer student through to my PhD.

I would also like to thank my parents, James and Cathryn McAllister, for instilling in me the importance of education, perseverance and the pursuit of social issues. Together they have taught me to be creative and pragmatic, two qualities that have been essential for completing my thesis. Both also provided endless support during my fieldwork including chauffeuring me to interviews. I am grateful to both of them for their love and support over the years. Thank you to my Australian in-laws, Greg and Kathy Moffitt, for always asking about my thesis and supporting Ben and I in our many moves to find the ‘right’ apartment.

I am also grateful for my friends – Alex, Bec, Ingrid, Laura and Jon – my Australian ‘family’ – who have provided love, support and help navigating life in Sydney. Those in Canada – Anthea, Care, Jenna, Jules, Lisa and Sarah – have supported me in more than my PhD, and I am so appreciative of their encouragement. All of them have inspired me with their own endeavours.

Last but not least, I would like to thank my husband, Ben. It is hard to summarise how grateful I am for his love, support and encouragement, not just during my PhD but in all areas. He has been my rock and biggest fan! It was a risk to both embark on our PhDs alongside each other but I cannot imagine it any other way. His discipline and enthusiasm for academia has provided a much needed benchmark for me. He has read this thesis with eagle eyes, listened, provided insight when I needed to refine my ideas, and provided chauffeur services around all the suburbs of Canberra during my Australian fieldwork. Most importantly, he has always given me perspective when I needed it. Ben has been my partner for over eight years, and every minute has been an adventure. I look forward to so many more with him over the years. I dedicate this thesis to Ben, and our latest addition, William.
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<th>Full Form</th>
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<tr>
<td>AAT</td>
<td>Administrative Appeals Tribunal</td>
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<tr>
<td>ABS</td>
<td>Australian Bureau of Statistics</td>
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<tr>
<td>AIHW</td>
<td>Australian Institute of Health and Welfare</td>
</tr>
<tr>
<td>CAMH</td>
<td>Centre for Addiction and Mental Health</td>
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<tr>
<td>CRS</td>
<td>Commonwealth Rehabilitation Services</td>
</tr>
<tr>
<td>CSR</td>
<td>Case study research</td>
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<tr>
<td>DAU</td>
<td>Disability Adjudication Unit</td>
</tr>
<tr>
<td>DEEWR</td>
<td>Department of Education, Employment and Workplace Relations (Australia)</td>
</tr>
<tr>
<td>DHS</td>
<td>Department of Human Services (Australia)</td>
</tr>
<tr>
<td>DSM-5</td>
<td>The Diagnostic and Statistical Manual of Mental Disorders, 5th edition</td>
</tr>
<tr>
<td>DSP</td>
<td>Disability Support Pension (Australia)</td>
</tr>
<tr>
<td>FaHCSIA</td>
<td>Department of Families, Housing Community Services and Indigenous Affairs (Australia)</td>
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<tr>
<td>GP</td>
<td>General practitioner</td>
</tr>
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<td>GWB</td>
<td>General welfare benefit</td>
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<tr>
<td>ICES</td>
<td>Institute for Clinical Evaluative Services</td>
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<tr>
<td>JCA</td>
<td>Job Capacity Assessor/Assessment</td>
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<tr>
<td>MAU</td>
<td>Medical Advisory Unit (Australia)</td>
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<tr>
<td>MCSS</td>
<td>Ministry of Community and Social Services (Ontario)</td>
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<tr>
<td>NSA</td>
<td>Newstart Allowance (Australia)</td>
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<td>ODSP</td>
<td>Ontario Disability Support Program</td>
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<tr>
<td>OECD</td>
<td>Organisation for Economic Co-operation and Development</td>
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<td>OHIP</td>
<td>Ontario Health Insurance Plan</td>
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<td>OW</td>
<td>Ontario Works</td>
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<tr>
<td>Abbreviation</td>
<td>Definition</td>
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<tr>
<td>RCT</td>
<td>Randomised controlled trial</td>
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<tr>
<td>UK</td>
<td>United Kingdom</td>
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<td>WHO</td>
<td>World Health Organisation</td>
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<tr>
<td><strong>Addiction</strong></td>
<td>“Addiction is a primary, chronic, neurobiological disease, with genetic, psychosocial and environmental factors…It is characterized by behaviours that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving” (Savage et al. 2003: 662).</td>
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<td><strong>Administrative Appeals Tribunal</strong></td>
<td>A tribunal that provides independent review of administrative decisions made by the Australian Government including decisions related to social security.</td>
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<td><strong>Capacity to work</strong></td>
<td>The amount that an individual is able to work in relation to their impairment. For example, in Australia, a partial capacity to work is defined as a person who is unable to work for 15 hours or more because of their impairment (Department of Human Services [DHS] 2014b).</td>
</tr>
<tr>
<td><strong>Centrelink</strong></td>
<td>An Australian Government department that delivers payments and services to those seeking income support including the Disability Support Pension (DHS 2014a).</td>
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<td><strong>Contemporary welfare reforms</strong></td>
<td>For the purpose of this thesis, these will be considered from 1991 to 2013 and include the introduction of welfare reforms based on mutual obligation and the introduction of many welfare-to-work policies, representing a structural shift from entitlement (‘passive’ welfare) to one of obligation (‘active’ welfare) in many Western countries.</td>
</tr>
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<td><strong>Depression</strong></td>
<td>Depression (unipolar) is a common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration for at least two weeks (World Health Organisation [WHO] 2014a).</td>
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Disability
For the purposes of this thesis, a disability is a reduced capacity to work as a result of impairment.

Disability Adjudication Unit
This unit reviews applicants’ medical information to determine whether the applicant meets the requirements for the Ontario Disability Support Program. The unit is comprised of health professionals ranging from physicians to physiotherapists (Ministry of Community and Social Services [MCSS] 2011a: 5).

Disability income support
The main benefit payment of last resort (meaning an individual has no other option for subsistence) provided by the government to those who are unable to work as a result of a physical, intellectual or psychiatric disability.

DSM-5
The most recent version of the Diagnostic and Statistical Manual of Mental Disorders. It is a classification and diagnostic tool created by the American Psychiatric Association and used by physicians, researchers, policy-makers, etc. It provides a common language and standard criteria for the classification of mental disorders (American Psychiatric Association 2014).

Economic model of disability
This model defines people with disabilities as workers and considers disability related to the loss of productivity. As a result, income support eligibility criteria using this model are based on a person’s inability to work (Hyland 2001: 26).

Exchange rates
All non-Australian dollar figures were converted into Australian figures. This was done by using the average rate for year ended foreign currency exchange for the Australian financial year 2013-14 as at 30 June 2011 (Australian Tax Office 2014).

‘Gate’
A point of entry to a disability income support program.

‘Gatekeeper’
A person who can grant or refuse access to disability income support.
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<th>For the purposes of this thesis, an impairment is a continuing loss of function of body or mind lasting at least one year.</th>
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<td>A disability income support tool used in Australia to assess how a person’s impairment affects their capacity to work.</td>
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<td><strong>Job Capacity Assessors</strong></td>
<td>Those responsible for determining eligibility for the Australian Disability Support Pension. Some assessors have an allied health background. However, not all assessors have qualifications relevant to assessing impairment (DSS n.d.).</td>
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<td><strong>Medical model of disability</strong></td>
<td>This model defines people with disabilities as patients and considers disabilities in relation to the individual, excluding all social and economic factors. As a result, income support eligibility criteria are based on how a person’s impairment relates to their medical diagnosis of illness (Hyland 2001: 26).</td>
</tr>
<tr>
<td><strong>Medicare</strong></td>
<td>An Australian universal health insurance scheme in which medical and hospital services are provided at little or no cost to the patient for medically necessary treatments.</td>
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<td><strong>Mental illness</strong></td>
<td>Mental illness is “… a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.” (American Psychiatric Association 2013a).</td>
</tr>
<tr>
<td><strong>Ontario Health Insurance Plan (OHIP)</strong></td>
<td>An Ontarian universal health insurance scheme in which emergency and preventative medical care are provided at no cost to the patient. It does not cover prescription drugs or dental care.</td>
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The first human rights code in Canada, enacted in 1962. The Code prohibits actions that discriminate against people based on a protected ground in a protected social area” (e.g. disability) (Ontario Human Rights Commission n.d.).

The general welfare benefit payment of last resort in Ontario. It provides temporary financial need to those who are not employed. Receipt of this payment is conditional on participation in job search activities (MCSS 2008b).

Any direct expenses that are incurred by individuals in relation to any medical costs that will not be reimbursed by the government or private health insurance (Australian Institute of Health and Welfare [AIHW] 2014b: 124).

A type of benefit that is provided only when a person has no other options for subsistence (Marttila 2012: 1).

Australia and Ontario do not have official poverty lines; therefore, the Organisation for Economic Co-operation and Development (OECD) measure (50 per cent of the current median income in each jurisdiction (OECD 2010c)) was used to estimate a poverty line for each jurisdiction reviewed. This indicates “an income level that is considered minimally sufficient to sustain a family in terms of food, housing, clothing, medical needs, and so on” (OECD 2005).

“Schizophrenia is a severe mental disorder, characterized by profound disruptions in thinking, affecting language, perception, and the sense of self. It often includes psychotic experiences, such as hearing voices or delusions” (WHO 2014c).
Social Benefits Tunbunal

An independent body that operates at arm’s length from the Ontario Ministry of Community and Social Services (MCSS). The Tribunal is less formal than a court but holds appeal hearings related to social assistance. The members are appointed by the Ontario Government and have varying educational and occupational backgrounds (e.g. business owners, physicians, teacher) (Government of Ontario 2002).

Social model of disability

This model was developed in response to the medical model of disability and suggests that systematic barriers and negative attitudes within society cause disability. As a result, a person’s impairment relates to factors such as stigma, social exclusion, etc.

Stigma

Stigma can be defined as a social response to any feature that deviates from the ‘norm’ and leads to discrediting the individual with that feature (Yang et al. 2008: 219). Stigma is often broken down into three social responses – stereotypes (e.g. beliefs), prejudice (e.g. negative attitudes) and discrimination (e.g. unfair treatment of others based on stereotypes or beliefs).
OTHER OUTCOMES FROM THIS THESIS

Reports

Media


Conference presentations


Grants and awards


CIHR Travel Award (2014). Funded by CIHR for attending the ASPHER young researchers forum at the 7th European Health Association Conference, Glasgow.

Association of Schools of Public Health in the European Region (ASPHER) Young Researchers Conference Support (2014). Funded by ASPHER for being selected to present at the Young Researchers Forum at the 7th European Health Association Conference, Glasgow.


Royston George Booker Scholarship (2013). Funded by the bequest of R.G. Booker (via the University of Sydney) for overseas fieldwork expenses.

Collaborative Research Group Fund (2012, 2013). Funded by the University of Sydney to support training and development workshops in health policy and qualitative methods.
CHAPTER I: INTRODUCTION

Welfare systems built on (medically inspired) definitions of disability will comprehend disability as stemming from individual, as opposed to social and environmental, causes.

(Albrecht et al. 2001: 418)

Despite the great attention western countries pay to the mind and human consciousness in philosophy and the arts, disturbances of mental health remain not only neglected but also deeply stigmatised across our societies.

(Horton 2007: 1)

By 2030, mental illness will be the leading cause of disability in high-income countries and the associated costs will be immense (Mathers and Loncar 2006: 442). Current estimates of the cost of mental illness are now about AUD$50 billion1 per year in Canada alone (Mental Health Commission of Canada [MHCC] 2013: 1). As recognition of and treatment of mental illnesses increase, how do policy-makers determine who can and cannot work as a result of their mental illness? How do they decide who needs publicly funded support? Clear answers to these questions are not found in the academic literature. What is apparent in the literature is that the prevalence of mental illness among disability income support recipients is rising, making this group a cause for concern.

Over the past 20 years, there has been a change in thinking about people who receive disability-related income support in many high-income countries, including Australia and Canada. The view has changed from considering people with disabilities as permanently unemployable to seeing them as potentially employable. This has resulted in growing concern about the rising number of disability income support recipients and their capacity to work. Disability income support payments are not universal, meaning they are limited to people that meet certain eligibility criteria. As with any policy that has eligibility criteria, there are boundaries drawn between who can and cannot receive government support. However, there has been little analysis about how this line is drawn, and more importantly, the impact this line has on people with certain types of disability such as mental illness.

1 Note all figures in this thesis are in Australian dollars. Canadian dollars were converted using the average exchange rate for Canada for the year ended published by the Australian Tax Office (Australian Tax Office 2014).
This thesis will address the gaps in the literature noted above to understand how policy-makers design the eligibility and assessment process for disability income support and how mental illnesses are perceived in this process. The thesis takes a unique approach by learning about this process from key informants who have been or are currently involved in disability income support design. It is also focuses solely on the design of the system rather than the individual – a new approach for the Australian or Ontarian setting.

This chapter provides the rationale behind why designing disability income support is an important area to explore, and why mental illness presents challenges to designing this program. It outlines the thesis aims and key research questions and provides a rationale for the approach used in this thesis. The chapter concludes by providing an overview of the structure of this thesis.

**Overview of disability income support**

Disability income support, as defined in this thesis, is a payment of last resort, meaning that a person has no other options for subsistence (Marttila 2012: 1). This means before a person’s disability is assessed, the applicant must meet certain financial requirements. For most programs, this means an applicant is expected to have exhausted all other sources of income. For example, applicants should be unemployed, have little to no savings and, in some programs, have no assets. This requirement distinguishes disability income support from other types of financial support available to people with disabilities (e.g. workers’ compensation or disability insurance schemes). It is also the only type of disability program that requires a person to be unemployed. Unlike other schemes, it could be assumed that most (if not all) of those who meet the financial eligibility requirements are economically marginalised. This makes disability income support an interesting program to study because not being accepted to the program could have significant economic consequences for the individual (i.e. not having an adequate income) and society (i.e. costs related to homelessness).

In addition, disability income support is more than just an income replacement benefit. Access to these benefits typically includes additional benefits, the value of which is often not quantified. Examples include subsidised pharmaceuticals, subsidised

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2 In the literature, disability income support is sometimes referred to as social assistance.
housing, discounts on essential services (e.g. electricity) and discounts on public transport.

Internationally, disability income support programs share many features such as financial and disability tests to determine eligibility. Despite these similarities, each program has its own detailed rules, differing payment rates and is influenced by contextual factors. As such, to thoroughly understand how disability income support is designed, in-depth case studies are needed. For the purposes of this thesis, two cases were selected – Australia and Ontario (see section entitled “Selection of case studies – Australia and Ontario (Canada)” for justification of selection on p. 8). Chapter II summarises disability income support programs in Australia and Ontario.

**The challenges of mental illness**

In addition to the economic burden, mental illness is an important category to study because they bring many challenges to disability income support policy design. First, many are characterised by their episodic nature. How do episodic conditions fit into a program like disability income support with its assumptions that disability is stable? This is unclear in the literature. Second, many mental illnesses lack diagnostic certainty, meaning there are few ways to objectively prove a person has a mental illness. Third, and related to the previous characteristic, many mental illnesses are invisible. Unlike physical disabilities, such as paraplegia, there is typically no visual representation that a person has a mental illness. Stigma also brings a set of challenges as there are many assumptions related to mental illness (e.g. people with mental illness are lazy or all will recover with treatment) that could influence the assessment. It is unclear in the literature how policy-makers deal with these challenges when designing disability income support. Chapter II provides more information on the characteristics of mental illness, related policy challenges and how the broad spectrum of mental illness will be addressed in this thesis.

**Research aims and questions**

The broad aim of my thesis is to contribute knowledge on how disability income support policy is designed, especially in regard to mental illness, based on data from those who designed the policies. More specifically, I aim to develop a conceptual model that explains how policy-makers draw boundaries around who is eligible for
disability income support and how mental illness is considered in this process in Australia and Ontario.

**Research questions**

a) How do policy-makers choose a definition of disability?
b) How do policy-makers apply this definition in practice?
c) How is mental illness considered in disability income support design?
d) How do answers to these questions vary between Australia and Ontario?

**Areas outside the scope of this thesis**

The topic of disability income support is wide reaching and not all aspects could be covered in this thesis. This thesis is concerned with the process of determining who is eligible for disability income support. It focuses on the design of the system and not the individual. It is recognised that the following aspects are important areas of research but outside the scope of this thesis. They include:

- supporting people with disabilities in employment;
- removing disincentives and/or creating incentives for people with disabilities to work;
- factors related to maintaining disability income support;
- inadequate rates of disability income support; and
- factors related to other disability compensation benefits (e.g. workers’ compensation, disability insurance such as the National Disability Insurance Scheme in Australia).

**Rationale of approach**

**Methodology**

This thesis uses grounded theory methodology to address the research questions. Unlike many other qualitative approaches, grounded theory uses a systematic set of procedures to develop theory about a phenomenon (Strauss and Corbin 1998: 24). It is a highly utilised qualitative methodology in health research and considered one of the most suitable qualitative methods to learn about process (Bryant and Charmaz 2007: 47; Sbaraini et al. 2011: 196). A major strength of grounded theory is that the participants provide *their* understanding and meaning about the process (Charmaz 2006: 25). This was a crucial reason for selecting grounded theory because the aim of
this thesis was to contribute knowledge about disability income support design based on the data from key informants who design the policy. Two other features of grounded theory – iteration and theoretical sampling – deemed it the most appropriate approach for completing this thesis compared to other qualitative approaches (this is further discussed on p. 7).

Grounded theory has many variations. Sbaraini, Carter et al. (2011: 2) argue that there are four main types of grounded theory: classic grounded theory (Glaser et al. 1968); basics of qualitative research (Strauss and Corbin 1998); constructivist grounded theory (Charmaz 2006); and postmodern situational analysis (Clarke 2005). In this thesis, the principles of constructivist grounded theory were applied.

Constructivist grounded theory shares many features with classic grounded theory such as being inductive, comparative, emergent and utilising an open-ended approach (Morse et al. 2008: 137). However, the key distinction is that “Constructivists view data as constructed rather than discovered, and we see our analyses as interpretive renderings not as objective reports or the only viewpoint on the topic” (Morse, Stern et al. 2008: 31). Overall, constructivist grounded theory situates the researcher and participants in their context and acknowledges that this affects the data collection and analysis (Morse, Stern et al. 2008: 141).

The process of welfare policy-making is inherently value-laden. Since the introduction of the Elizabethan Poor Laws, welfare policies and laws have been about separating the ‘deserving’ from the ‘undeserving’ (Stone 1984: 51; Lightman et al. 2009). The constructions of the ‘deserving’ and ‘undeserving’ have shifted throughout history, illustrating the subjective nature of these distinctions.

Constructivist grounded theory provides the most suitable theoretical framework to acknowledge that these notions about who is ‘deserving’ of disability income support are influenced by social constructions of disability.

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3 The ‘deserving’ and the ‘undeserving’ is a type of classification system derived in the Elizabethan Poor Laws as a way of distributing public funds. It is argued that welfare policies are still divided into these classifications (Stone 1984: 51; Chunn and Gavigan 2004: 231; Lightman et al. 2009) with general welfare benefits being for the ‘undeserving’ poor and disability income support being for the ‘deserving’ poor.

4 For example, historically people with disabilities were considered part of the ‘deserving’ category. However advances in technology and reduction in the stigma attached with having a disability (e.g. the idea that people with disabilities are not capable of working) have changed the notion that all people with disabilities should be categorised as ‘deserving.’ Another example is that prior to the 1990s, people who were unemployed due to social or economic factors (e.g. low education or low labour market potential) were considered ‘deserving.’ This perception has changed and these people have been shifted to the ‘underserving’ category.
Methods

For this thesis, a mixed-method approach was taken, drawing on grounded theory and comparative case study research (using multiple cases). Mixed-methods allow researchers to collect richer and a wider array of evidence than a single method (Yin 2014: 66). Unlike many other methodologies, grounded theory uses a prescribed set of methods that allow the researcher to be systematic in data collection and analysis (Sbaraini, Carter et al. 2011: 196). Comparative case study research was selected in addition to grounded theory because disability income support is context specific. Comparative case study research allows for in-depth analysis of phenomena (e.g. disability income support programs) in their contexts. It is a particularly useful method to “enhance our understanding of the policy-making process” (Molloy 2010: 117) and a commonly used method in public policy research. As such, specific jurisdictions and their corresponding programs needed to be selected. Australia and Ontario (Canada) were chosen because of their similarities and accessibility of data sources (further discussed in the section on Selection of case studies – Australia and Ontario (Canada) on p. 8).

Comparative case study research and grounded theory are useful methods when answering research questions of “how” and “why”. Table 1 provides an overview and comparison of these two methods.
As illustrated in Table 1, comparative case study research and grounded theory are complementary methods. They share many features but some of the limitations of case study research are countered by the strengths of grounded theory. These methods are used in tandem to understand processes. As such, they are best suited to achieve my aim of developing a conceptual model about the process of disability income support design and mental illness.

The iterative nature of grounded theory was also important for this thesis. As little is known about the disability income support design process (this is further discussed in Chapter III), the open-ended approach was imperative to ensure that the research reflected the process as expressed by the key informants, rather than being guided by hypotheses. As such, I was able to refine my research questions as the data emerged. Additionally, theoretical sampling – a major tenent of grounded theory – was important for this thesis so that conceptual categories could be refined. These features of grounded theory distinguish it from other qualitative methods (Watling and Lingard 2012: 856). This is further explored in Chapter IV – Methods, while Chapter X discusses the strengths and limitations of these methods.

<table>
<thead>
<tr>
<th>Case studies</th>
<th>Grounded theory</th>
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<tr>
<td><strong>Definition</strong></td>
<td>A case study is an empirical investigation of contemporary phenomena in their context.</td>
</tr>
<tr>
<td><strong>Key features</strong></td>
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<td></td>
<td>• constant comparison;</td>
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<td>• generates emergent concepts;</td>
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<td>• inductive – producing a theory rather than testing a theory.</td>
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<tr>
<td><strong>Strengths</strong></td>
<td>• rigorous systematic process;</td>
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<td>• attention to process, conditions, consequences and variation; and</td>
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<td></td>
<td>• generates rich data.</td>
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<td><strong>Limitations</strong></td>
<td>• limited generalisability;</td>
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<td></td>
<td>• time consuming;</td>
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<td></td>
<td>• limited to the concepts generated by the participants; and</td>
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<td></td>
<td>• multiple approaches (e.g. classical versus constructivist).</td>
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</tbody>
</table>

### Table 1 – Comparison of case studies and grounded theory

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</tr>
<tr>
<td><strong>Key features</strong></td>
<td>• examines complex conditions;</td>
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<td></td>
<td>• deals with multiple variables;</td>
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<td></td>
<td>• inductive and theory building;</td>
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<td></td>
<td>• relies on multiple sources of data; and</td>
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<tr>
<td></td>
<td>• often comparative (e.g. multiple cases).</td>
<td>• iterative – data collection and analysis occur in tandem;</td>
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<td>• analyses real-life problems; and</td>
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<td></td>
<td>• multiple cases highlight how processes alter across different contexts.</td>
<td>• rigorous systematic process;</td>
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<tr>
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<td></td>
<td>• attention to process, conditions, consequences and variation; and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• generates rich data.</td>
</tr>
<tr>
<td><strong>Limitations</strong></td>
<td>• lack of rigour – not systematic;</td>
<td></td>
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<tr>
<td></td>
<td>• susceptible to researchers’ bias;</td>
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</tr>
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<td></td>
<td>• limited generalisability; and</td>
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</tr>
<tr>
<td></td>
<td>• time consuming and quantity of data can be unmanageable.</td>
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</tr>
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</table>
Selection of case studies – Australia and Ontario (Canada)

Disability income support programs in Canada are run provincially whereas in Australia there is a national system of disability income support. As an entire thesis could be dedicated to comparing the different provincial systems in Canada, this research is limited to the province of Ontario. Ontario is Canada’s most populous province (Statistics Canada 2014b) and structurally reformed their disability income support system in the 1990s – one of the first provinces to do so during this time period. Australia and Ontario were selected as case studies primarily for logistical and pragmatic reasons. I am a former policy-maker in both places, which afforded me access to key informants and policy documents. The opportunity to live and study in both places also provided me with rich contextual knowledge. In addition, my supervisors were able to contribute their Australian contextual knowledge and resources to the study.

These countries were also selected using principles of Mill’s Most Similar Systems Design (MSSD) approach in which cases are selected because of shared similarities (Otner 2009). In this approach, cases should be similar but have a major difference. In this thesis, Australia and Ontario share many features, but policy-makers have developed different definitions of disabilities. I wanted to understand if and how this difference might affect the process of designing disability income support for people with mental illness. The following is a summary of the major similarities and differences between Australia and Ontario. It should be noted that the similarities section focuses on Australia and Canada as comparisons whereas the differences section explains why a provincial focus is necessary.

Similarities

Australia and Canada are natural choices for comparison, for a number of reasons. Both remain members of the Commonwealth and have inherited political traditions from Britain. Both have a federal system of government with provinces/states/territories. Both are geographically vast and sparsely populated with several large cities. These countries have also been previously compared in the literature (Hurley et al. 2002; Deber 2005; Moulding et al. 2009; Tempier et al. 2009).

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5 The objective of MSSD is that by studying similar systems research, we can focus on the major difference to understand why similar cases may have different outcomes (Otner 2009).
Due to these similarities, these two countries provide opportunities for comparative study with a view to transferring policy successes from one to the other. A practical example of policy transfer between these countries is Australia basing its Medicare program on Canada’s national health insurance plan (Dunlop 1983: 1140).

**Differences**

Although they are both federalist countries, Canada’s social services are decentralized, with the provinces and territories responsible for disability income support. On the other hand, the Commonwealth Government in Australia takes responsibility for social policy administered across the states and territories.

Australia and Ontario represent two different types of disability income support models. In Australia, disability income support is based on an economic model (sometimes referred to as a capacity-based model) that means that an applicant’s impairment relates to an inability to participate in paid employment. In Ontario, disability income support is based on a medical model that means that a person’s impairment relates to a medical diagnosis of illness. Chapter II provides detail of the disability income support programs in Australia and Ontario.

In addition to disability income support, people in Ontario have access to contributory benefits such as unemployment insurance and social assistance. Disability income support programs are only available to those who do not (or no longer) qualify for the contributory benefits.

**Universal health care system with caveats**

Both Australia and Ontario have universal health insurance systems but require modest out-of-pocket costs for patients. In both jurisdictions, health care is free for ‘medically necessary’ treatment by Medicare and the Ontario Health Insurance Plan (OHIP) respectively. In Australia, what is deemed ‘medically necessary’ provides less comprehensive coverage for a wider range of services than in Ontario. This means that many services are covered but require a co-payment. There is also a parallel private health care system. In Ontario, what is deemed ‘medically necessary’ provides more comprehensive coverage for a narrower range of services. This means that fewer services are covered than in Australia, but that services covered require no co-

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6 Australia does not have a contributory social insurance system. Contributory social insurance programs in Canada (e.g. the Canada Pension Plan – Disability) are outside the scope of this thesis and will not be discussed.
payment. In terms of mental health services, some services and medication in both jurisdictions require out-of-pocket costs for the patient. Table 2 provides a summary of Medicare and OHIP coverage in both jurisdictions.

Table 2 – Summary of coverage of mental health services by Medicare in Australia and OHIP in Ontario

<table>
<thead>
<tr>
<th>Service provider</th>
<th>Medicare</th>
<th>OHIP</th>
</tr>
</thead>
<tbody>
<tr>
<td>General practitioner (GP)</td>
<td>Services are free if the GP bulk bills. Otherwise, the patient will be required to pay a 15% gap or more, and seek reimbursement of the Medicare rebate.</td>
<td>All visits are covered by OHIP.</td>
</tr>
<tr>
<td>Psychiatrists</td>
<td></td>
<td></td>
</tr>
<tr>
<td>In-hospital</td>
<td>Yes – if the patient is admitted to a public hospital.</td>
<td>Yes – in all cases.</td>
</tr>
<tr>
<td>Out-of-hospital</td>
<td>Partially covered by Medicare. However, a select few may bulk bill to low-income or ageing patients.</td>
<td>Most psychiatry services are covered.</td>
</tr>
</tbody>
</table>

In Australia, many psychiatrists are in private practice and do not bulk bill (e.g. no cost to the patient), meaning that patients are charged a fee but may get a rebate or some coverage from Medicare. In Ontario, psychologists are not usually covered by OHIP, so require out-of-pocket costs (unless covered by employers’ insurance). In both places, prescription coverage also requires out-of-pocket costs. However, these costs are significantly reduced for recipients of disability income support. Lack of coverage for many mental health services make these jurisdictions interesting to study as the consequences of not receiving the medical benefits associated with disability income support have significant implications for people with mental illness being able to afford care.

Structure of thesis

This chapter has set the scene for why it is important to study disability income support design and mental illness. It has also provided an overview of the main aims, 

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7 Better Access is an initiative by the Australian Government to increase access to mental health practitioners through Medicare. The program provides Medicare rebates for up to ten individual and ten group allied mental health services per year (Department of Health and Ageing [DoHA] 2012: 1).

8 Bulk billing is a discounted payment option under the Australian Medicare system that allows a health service provider to directly collect any government rebates available for the service provided. Bulk billing means there are no out-of-pocket costs to the patient. However it does mean that physicians are not fully reimbursed for the cost of the service (DHS 2014c).
research questions and approach to this thesis including justification of the selection of Australia and Ontario.

Chapter II provides background information on mental illness and disability income support in Australia and Ontario. It has been divided into two parts. The first part provides an overview of mental illness including a definition, burden of disease and the challenges of mental illness. The second section provides a working definition of impairment and disability and a brief overview of the Australian Disability Support Pension and Ontario Disability Support Program.

Chapter III consists of a systematic literature review of the existing evidence on disability income support design and mental illness in Australia and Ontario. The review demonstrates a significant gap in the existing literature on disability income support design and mental illness in Australia and Ontario.

Chapter IV provides a detailed account of the research design. It outlines the methods used, the steps of data collection and a description of data analysis. Specifically, it outlines the steps of grounded theory and case study research and details how the 45 key informants were selected for participation in this thesis.

The following five chapters explore the five conceptual categories that emerged during analysis:

Chapter V explores the concept of the ‘gate’, a metaphor used by the key informants to describe the entry to disability income support (i.e. the definition of disability). The gate is made up of many components and adjusting these components can affect the size of the gate (e.g. how many people can enter disability income support). The chapter describes these components and the factors that influence how they are chosen. Discontent with the growing number of recipients for disability income support programs is also discussed.

Chapter VI explores the concept of ‘gatekeepers’ – those who decide who is suitable for disability income support and who is not. The chapter outlines the different types of gatekeepers and the obstacles to effective gatekeeping. Formal and informal tools to help gatekeepers overcome these obstacles are also discussed.

Chapter VII is about physicians making judgements about disability income support eligibility despite not having the authority to grant disability income support
payments. The chapter explores how physicians make these judgements and what influences their decisions. Strategies used by policy insiders and applicants to manage physicians making judgements are also discussed.

Chapter VIII is about expecting disability income support applicants, especially those with invisible illness, to ‘perform’ their illness. ‘Performing’ is about how an applicant chooses to display his or her symptoms to the gatekeeper. The chapter explores the types of performances – exaggerating symptoms and downplaying symptoms – and reasons why an applicant might choose one type of performance over another. Key informants perceived that applicants are more likely to exaggerate than downplay symptoms, and the consequences of this type of performance are discussed.

Chapter IX introduces the concept of an ‘ideal type’ of disability. An ‘ideal type’ of disability has features that enable gatekeepers to identify an applicant as suitable for disability income support. In contrast, disabilities that do not have these features are labelled ‘imperfect’ disabilities. Features of both are detailed in this chapter. This chapter also illustrates that most mental illnesses are perceived as imperfect disabilities.

Chapter X summarises and discusses the main results and provides a conceptual model for understanding the process of disability income support design. It summarises the reflections from comparing the systems in Australia and Ontario and discusses the strengths and limitations of the study.

Chapter XI summarises the contribution of this study and provides implications for policy, practice and future research.

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9 An invisible illness is an illness which is defined by its symptoms with no objective tests to provide a definitive diagnosis. The diagnosis and degree of impairment associated with many mental illnesses are largely reliant on an individual’s description of their symptoms.
CHAPTER II: BACKGROUND

This chapter aims to provide background information on disability income support and mental illness. This chapter is divided into two parts. Part I addresses mental illness and Part II addresses disability income support programs in Australia and Ontario. Part II includes a discussion on the contestation of defining impairment and disability.

Part I: Mental illness

Overview of mental illness

Defining mental illness is a challenge. Definitions vary and usually encompass a wide array of illnesses leaving definitions broad and murky. However for the purposes of this thesis, mental illness is defined as “… a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.” (American Psychiatric Association 2013a).

Burden of mental illness

The burden of disease is an estimate of years of healthy life lost due to mortality and morbidity (Murray et al. 2012). Prince et al. (2007: 859) estimate that 14 per cent of the global burden of disease can be attributed to mental illness, most notably, addiction, depression and psychoses. It is estimated that by 2030, mental illness will be the leading cause of disability in high-income countries (Mathers and Loncar 2006: 442). Historically, mental illness was not a global health priority but the increasing burden of disease has changed this (Whiteford et al. 2013: 1575). Unlike cancer and cardiovascular disease, mental illness is typically non-fatal (Mathers et al. 1999; Prince et al. 2007) and the average age of onset of many mental illnesses is in childhood or adolescence (Baron and Salzer 2002: 594; Health Canada 2002; McGorry et al. 2007: S5). As such, people with mental illness could experience disability throughout their entire working life (Begg et al. 2008: 38; Gibb et al. 2010: 126).
Mental illness in Australia

One in five Australians experience mental illness in any year with the most common mental illnesses being addiction, anxiety and depression (AIHW 2014a: 15). The Australian Institute of Health and Welfare (AIHW) estimated that the burden of disease related to mental illness was 13.3 per cent of the total burden of disease in Australia in 1996\(^{10}\) (Mathers et al. 1999: 88). Prevalence of mental illness decreases with age. Of those with a mental illness in Australia, the highest prevalence was reported for those aged 16 to 24 (26.4%) and 25 to 34 (24.8%) (Slade et al. 2009: xii).

Mental illness in Ontario

One in five Canadians experience mental illness in any year (Smetanin et al. 2011). As previously mentioned in Chapter I, the Mental Health Commission of Canada estimates that the current cost of mental illness in Canada are approximately AUD$50 billion per year (MHCC 2013: 1). Researchers from the Institute for Clinical Evaluative Sciences (ICES) estimate that the burden of mental illness in Ontario is more than “1.5 times that of all cancers and more than seven times that of all infectious diseases” (Ratnasingham et al. 2012: 2).

Mental illness and its challenges

As noted in Chapter I, mental illness brings certain challenges to designing disability income support. The following is a summary of these challenges:

Episodic nature

Many mental illnesses are episodic conditions, meaning that it is difficult to predict if a person will have one episode or many episodes of a mental illness throughout their lifetime (Kirkby and Keon 2006: 174; SANE Australia 2014: 3). For instance, the person may only experience one schizophrenic episode in their lifetime while another could have multiple episodes and suffer from constant psychosis, creating a much higher level of impairment and disability.

Management

Australia and Ontario have universal health insurance systems that provide free access to ‘medically necessary’ care. As noted in Chapter I, this is typically limited to

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\(^{10}\) The Australian Institute of Health and Welfare is currently updating the total burden of disease. At present, the 1996 estimates are the most current.
hospital care or general practitioners (GPs) visits. However according to the literature, ‘medically necessary’ care for people with a mental illness extends beyond the borders of a hospital or a GP’s surgery. Mental health professionals also include clinical psychologists, nurses, social workers, occupational therapists and counsellors. Care provided by a combination of these mental health professionals is often referred to as collaborative care, and evidence suggests that this type of care is effective in managing those with mental illness (Prince et al. 2007). However, this type of care is not always completely covered by universal health insurance in either Australia or Ontario. Funding for psychologists, social workers, occupational therapists and counsellors is patchy and often requires co-payment by the patient. There are a high proportion of people with a mental illness who are socially and economically marginalised and co-payments (no matter how small) may not be affordable. Kohn et al. (2004: 86) found a gap in treatment across all disorders, estimating that at least two-thirds of people with mental illness do not receive treatment, including those in high-income countries. In a recent article, Whiteford et al. (2014: 84) estimate that over half of Australians with mild to moderate mental illness do not access any treatment. Lack of treatment can have significant consequences. For example, Bijl et al. (2003: 130) note that longitudinal research shows that untreated mild mental illness leads to a higher risk of hospitalisation and work disability.

**Mental illness and the social determinants of health**

Another challenge related to mental illness is that “Multiple social, psychological, and biological factors determine the level of mental health of a person at any point of time” (WHO 2014b). However the prevailing approach to assessing impairment and disability for disability income support ignores any non-biological factors. It is assumed that other factors are not relevant to the person’s level of impairment. However there is extensive literature that contests this notion. For example, the life course perspective proposes that “health at adult ages is partly determined by exposure to biological and social factors at the start of life” (Mackenbach 2012: 763). It is well documented that exposure to certain risk factors (e.g. poor prenatal nutrition, inadequate nurturing, abuse) in early life increase the risks of mental illness later in life (Heim and Nemeroff 2001; Kieling et al. 2011: 1516; Walker et al. 2011). Health selection, another perspective, suggests that health problems can lead to lower socioeconomic status (Marmot and Wilkinson 2005: 81; Mackenbach 2012: 764).
Studies have shown that there is a greater distribution of people with severe and common mental disorders in lower socioeconomic groups (Fryers et al. 2003; Muntaner et al. 2004; Fryers et al. 2005). Graham (2007: 108) notes that “Chronic ill health can prevent people from entering paid work and can push those in work down the occupational hierarchy and out of the labour market”. The average early age of onset of many mental illnesses can lead to interruption of significant education periods (e.g. completing high school or starting university) (Kessler and Foster 1995: 1031; McGorry and Goldstone 2011: 95). As such, this could prevent the person from obtaining qualifications to sustain upward social mobility.

The life course perspective and health selection perspective are just two illustrations of how overall life context is integral to a person’s experience of mental illness and as such, needs to be taken into account.

**Stigma and discrimination**

Stigma related to mental illness contributes to the burden of mental illness and manifests in different ways (Weiss et al. 2006: 277). Stigma can be defined as a social response to any feature that deviates from the ‘norm’ and leads to others discrediting the individual with that feature (Yang et al. 2008: 219). Stigma is often broken down into three social responses – stereotypes (e.g. beliefs), prejudice (e.g. negative attitudes) and discrimination (e.g. unfair treatment of others based on stereotypes or beliefs). The public tends to have more negative attitudes towards people with mental illness than physical illness (Socall and Holtgraves 1992: 441; Rüsch et al. 2005: 530). Examples of negative attitudes include the belief that people with mental illness will be violent/dangerous or unpredictable (Crisp et al. 2000: 6; Angermeyer and Dietrich 2006: 170); a perception that mental illness is caused by personal weakness (Jorm et al. 2005: 766); or that the person is responsible for their illness (Corrigan et al. 2002). Attitudes and beliefs towards mental illness tend to be negative and unfounded but still pervade the general thinking (Angermeyer and Matschinger 2003a; Angermeyer and Dietrich 2006: 304). These attitudes can lead to discrimination against people with mental illness. Table 3 provides examples of beliefs and negative attitudes broken down by three types of mental illness.
Table 3 – Beliefs and negative attitudes towards addiction, depression and schizophrenia

<table>
<thead>
<tr>
<th>Beliefs</th>
<th>Addiction</th>
<th>Depression</th>
<th>Schizophrenia</th>
</tr>
</thead>
<tbody>
<tr>
<td>• addiction is a personal responsibility</td>
<td>• caused by psychosocial factors (e.g. stress)</td>
<td>• caused by biological factors</td>
<td></td>
</tr>
<tr>
<td>• the person needs to 'pull self together'</td>
<td>• treatment leads to little risk of relapse or deterioration</td>
<td>• treatment leads to little risk of relapse or deterioration</td>
<td></td>
</tr>
<tr>
<td>• addiction is a behavioural illness, not a bio-medical illness</td>
<td>• the person needs to 'just snap out of it'</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• only affects weak people</td>
<td>• only affects weak people</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• not caused by biological factors</td>
<td>• violent</td>
<td>• violent</td>
<td></td>
</tr>
<tr>
<td>• unpredictable</td>
<td>• attention seeker</td>
<td>• unpredictable</td>
<td></td>
</tr>
<tr>
<td>• lazy</td>
<td>• lazy</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The broad spectrum of mental illness

Mental illness is an umbrella term used to describe many different types of illnesses, for example addiction, depression and schizophrenia. Even within these types of mental illnesses, there are many variations (e.g. depression could mean unipolar depression or bi-polar depression). While many mental illnesses share broad characteristics such as lack of definitive diagnosis or effects of stigma, each has unique characteristics including symptoms, forms of treatment and impairments. In addition, within each type of mental illness there is a spectrum and a person can experience mild to severe impairment.

For the purposes of this thesis, three mental disorders have been selected for use when more specific analysis of policy design is needed, as they represent conditions that contribute most to the burden of disease attributable to mental illness (Prince et al. 2007: 859) and different policy challenges. These are:

- drug and alcohol addiction (hereinafter referred to as ‘addiction’);
- depression (unipolar); and
- schizophrenia.

Addiction is a disputed mental illness. Although the DSM-5 and literature emphasise the medical nature of the illness (McLellan et al. 2000), addiction is still viewed by some as a social problem, not a mental illness. This is particularly relevant for disability income support programs’ conceptualisation of disability (Brucker 2007: 7).

Addiction contributes 17.3 per cent to the total non-fatal burden of mental disorders (Whiteford et al. 2013: 1578). Depression represents a common mental disorder that has a varying spectrum and is increasing in its burden of disease. Depression
contributes 42.5 per cent to the total non-fatal burden of mental disorders (Whiteford et al. 2013: 1578). Schizophrenia represents a severe but less common mental disorder. Schizophrenia contributes 7.4 per cent to the total non-fatal burden of mental disorders (Whiteford et al. 2013: 1578). Table 4 summarises definitions, examples of symptoms and treatment for these three disorders.
### Table 4 – Definitions, symptoms and treatment for addiction, depression and schizophrenia

<table>
<thead>
<tr>
<th></th>
<th>Addiction</th>
<th>Depression</th>
<th>Schizophrenia</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition</strong></td>
<td>“Addiction is a primary, chronic, neurobiological disease, with genetic, psychosocial and environmental factors…It is characterized by behaviours that include one or more of the following: impaired control over drug use, compulsive use, continued use despite harm, and craving” xxii.</td>
<td>“Depression is a common mental disorder that presents with depressed mood, loss of interest or pleasure, feelings of guilt or low self-worth, disturbed sleep or appetite, low energy, and poor concentration” for at least two weeks xxii.</td>
<td>“Schizophrenia is a severe mental disorder, characterized by profound disruptions in thinking, affecting language, perception, and the sense of self. It often includes psychotic experiences, such as hearing voices or delusions” xxiii.</td>
</tr>
<tr>
<td><strong>Examples of symptoms</strong></td>
<td>• loss of control of amount or frequency of use; • inordinate amount of time spent on acquiring substance; • lack of coordination; • impaired judgement; • memory problems or trouble thinking clearly; or • coma xxiv.</td>
<td>• sad, despairing mood that is present most of the time for at least two weeks; • loss of interest in work, hobbies or people; • withdrawal from family and friends; • weight loss; • fatigue; or • suicidal ideation xxv.</td>
<td>• delusions; • hallucinations; • disorganised speech; or • catatonic behaviour xxvi.</td>
</tr>
<tr>
<td><strong>Treatment</strong></td>
<td>• individual or group therapy xxvii xxviii • medications xxx xxxi.</td>
<td>• most effective treatment is a combination of drugs and psychotherapy xxvii xxxiii.</td>
<td>• family therapy and community-based interventions are effective for integration of people with schizophrenia within the community xxxv xxxv. • anti-psychotic medications (Hamann et al. 2003) xxvii xxvii xxviii xxxix.</td>
</tr>
</tbody>
</table>
Part II: Disability income support

This section of the chapter will introduce concepts related to disability income support – impairment and disability. It will also provide an overview of the specific disability income support programs in Australia and Ontario.

Defining impairment and disability

Before providing detail on disability income support in Australia and Ontario, it is important to clarify the concepts of impairment and disability. These concepts are the cornerstone of the programs and the major area of examination for this thesis. This section aims to provide clarity and provide a working definition of these two concepts. Table 5 provides examples of definitions of disability and impairment to illustrate how the definitions can differ.
### Table 5 – Definitions of impairment and disability

<table>
<thead>
<tr>
<th>Source</th>
<th>Impairment</th>
<th>Disability</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CLINICAL DEFINITIONS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>The World Health Organisation – International Classification of Impairments, Disabilities, and Handicaps</td>
<td>“Any loss or abnormality of psychological, physiological, or anatomical structure or function” (x).</td>
<td>“Any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range considered normal for a human being” (x).</td>
</tr>
<tr>
<td>International Classification of Functioning, Disability and Health</td>
<td>“Problems in body function or structure such as a significant deviation or loss” (x).</td>
<td>The experience of dysfunction “at one or more of these same levels: impairments, activity limitations and participation restrictions” (x).</td>
</tr>
<tr>
<td><strong>ADMINISTRATIVE DEFINITIONS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Disability Support Pension (Australia)</td>
<td>A loss of functional capacity affecting a person’s ability to work that results from the person’s condition (x).</td>
<td>Not being able to work more than 15 hours per week in the next two years as a result of a severe (at least 20 points in the Impairment Tables (x)) impairment (x).</td>
</tr>
<tr>
<td>Ontario Disability Support Program (Ontario)</td>
<td>A substantial restriction in the person’s ability to:</td>
<td>“The direct and cumulative effect of the impairment on the person’s ability to attend to his or her personal care, function in the community and function in a workplace, results in a substantial restriction in one or more of these activities of daily living” for at least one year (x).</td>
</tr>
<tr>
<td>• work;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• take care of him or herself; or</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• take part in community life (x).</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>OTHER DEFINITIONS</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Centre for Disability Studies – University of Leeds</td>
<td>An injury, illness or congenital condition that causes or is likely to cause a loss or difference of physiological or psychological function (x).</td>
<td>The loss or limitation of opportunities to take part in society on an equal level with others due to social and environmental barriers (x).</td>
</tr>
</tbody>
</table>

The above definitions are all primarily premised on the concept that an impairment is a loss related to the body or mind that affects a person’s ability to function, while a disability restricts a person’s ability to perform activities (i.e. work or self-care) related to the impairment. Despite the similarities in the definitions, there are also differences. For example, only the definition of disability from the University of Leeds suggests that disability is related to the person’s environment rather than the individual themselves. Another difference is that the administrative definitions specify how an impairment should affect a person’s ability to function (e.g. work), suggesting that the meaning of disability is contingent on the purpose for which the definition was created (Altman 2001: 5). Since the purpose of disability income support is to provide income when an individual cannot attain a sustainable income

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\(x\) The Impairment Tables is a legislative instrument used to assess impairment for Disability Support Pension eligibility in Australia. There are 15 tables, each relating to a certain bodily function (e.g. mental health function, visual function) (DSS 2012).
from employment due to a disability, the following definitions of impairment and disability will be used:

- impairment – a continuing loss of function of body or mind lasting at least one year; and
- disability – reduced capacity to work as a result of impairment.

The Australian Disability Support Pension

In Australia, providing disability income support is the responsibility of the Commonwealth Government. The Disability Support Pension (hereeto referred to as DSP) is a means-tested program available to all Australian citizens or residents who meet certain financial and medical eligibility requirements. The main purpose of the program is to provide financial support to those that are unable to work as a result of their disability. Recipients of DSP also receive many other non-quantifiable benefits such as subsidised prescription medications, discounts on utilities and housing subsidies. See Appendix B for a summary of the history of disability income support in Australia.

DSP eligibility requirements

According to the Australian Department of Human Services (DHS) (2014b), to meet the DSP eligibility requirements a person must:

- be permanently blind; or
- have a physical, intellectual or psychiatric impairment assessed at 20 points or more under the Impairment Tables; and
- have an inability to work or be retrained for work, for 15 hours or more per week for the next two years because of an impairment.

If at least 20 points are not allocated under a single impairment table, an applicant must have also actively participated in a Program of Support. See Appendix C for the two Impairment Tables related to mental illness (Impairment Table 5 and Impairment Table 6). In Australia, the definition of disability is primarily based on an economic model of disability. This means that the definition is based on a person’s impairment as it relates to an inability to participate in paid employment. Sometimes

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12 A Program of Support is a program of vocational, rehabilitation or employment activities that are suited towards a person’s degree of impairment.
this model is also referred to as a capacity-focused model since it focuses on a person’s capacity to work.

DSP assessment process

Job Capacity Assessments (JCAs) are used to determine medical eligibility for DSP. To assess eligibility, Job Capacity Assessors – typically allied health professionals\(^\text{13}\) – require medical evidence provided by physicians to support an application. These assessments are completed face-to-face and focus on identifying any barriers to work as a result of impairment. See Appendix D for a flow chart of the eligibility and assessment process for the DSP.

Characteristics of DSP recipients

There were more than 821,738 DSP recipients as at June 2013 (or 3.5 of the total Australian population) (Department of Social Services [DSS] 2013: 6; Australian Bureau of Statistics [ABS] 2014). The three major categories among DSP recipients are mental illnesses (31.2 per cent), musculoskeletal conditions (26.1 per cent) and intellectual disabilities (12.4 per cent). The proportion of recipients with mental illness has been rising over the past 15 years (DSS 2013: 6).

The overall grant rate – the proportion of applicants that are granted assistance – for DSP has fallen to 43.3 per cent in 2012-13 from 64.5 per cent in 2008-09 (DSS 2013: 6). The primary reason for rejection of assistance was on medical grounds (78.4 per cent) because a person’s condition was not fully diagnosed, treated and stabilised. This accounted for 38.4 per cent of rejections. The second most common reason for rejection of DSP was not having more than 20 impairment points, which accounted for 35.3 per cent of rejections (DSS 2013: 7).

The Ontario Disability Support Program

In Canada, providing disability income support is the responsibility of the provinces. Ontario is home to more than one third of Canada’s population (Statistics Canada 2014b) and was among the first of the provinces to structurally change its welfare support system in the 1990s. The Ontario Disability Support Program (hereo referred to as ODSP) is a means-tested program available to all Ontario residents who meet certain financial and medical eligibility requirements. The main purpose of ODSP is

\(^{13}\) Allied health professionals include all types of health care professionals that are not physicians, nurses or dentists. Examples include dieticians, physiotherapists, psychologists and speech pathologists.
to provide financial support to people with disabilities who are unable to support themselves financially (e.g. rent, food). Recipients of ODSP also receive many other non-quantifiable benefits such as subsidised prescription medications, discounts on utilities and housing subsidies. See Appendix E for a summary of the history of disability income support in Ontario.

**ODSP eligibility requirements**

According to the Ontario Ministry of Community and Social Services (MCSS) (2014a), to be eligible for the ODSP, an applicant must have a substantial mental or physical impairment that:

- is continuous or recurrent, and
- is expected to last for a year or more.

The physical or mental impairment must directly result in a substantial restriction to the person’s ability to: work; take care of him or herself or take part in community life. In Ontario, the definition of disability is primarily based on a medical model of disability. This means that the definition is based on a person’s impairment as it relates to a medical diagnosis.

**ODSP assessment process**

Each applicant must complete the Disability Determination Package that includes obtaining medical evidence from a physician. The Disability Adjudication Unit (DAU) – typically comprised of allied health professionals – reviews all ODSP applicants and the process is entirely paper-based. See Appendix F for a flow chart of the eligibility and assessment process for the ODSP.

**Characteristics of ODSP recipients**

As of June 2014, there were 444,688 ODSP beneficiaries (or 3.5 per cent of the total Ontarian population) (MCSS 2014b; Statistics Canada 2014b). In 2011, mental illness comprised 56 per cent of ODSP cases, however the definition of mental illness includes psychoses (21 per cent), neuroses (17 per cent) and developmental delay (18 per cent) (MCSS 2011b: 10). This definition of mental illness is much broader than the definition used to calculate Australian DSP statistics on recipients with mental illness.
In 2010, 89 per cent of appeals at the Social Benefits Tribunal (SBT)\textsuperscript{14} were related to people being denied ODSP benefits (Social Benefits Tribunal 2011: 3) Most of the appeals contested rejections of assistance based on the claimant being deemed “not disabled” (Social Benefits Tribunal 2011: 5) and more than half were overturned by the SBT (Social Benefits Tribunal 2011: 8).

\textsuperscript{14}See p. xviii for explanation of the Social Benefits Tribunal.
CHAPTER III: SYSTEMATIC LITERATURE REVIEW

Sickness and disability policy should be a key economic policy concern in all OECD countries, but tends to receive less attention than it deserves.

(OECD 2007: 3)

Chapter I illustrated why disability income support and mental illness together comprise an important social policy issue. Chapter II considered: i) disability and mental illness and ii) the development of contemporary disability income support in Australia and Ontario. However, it still remains unclear how these two areas converge. For example, how do policy-makers deal with the challenges of mental illness when creating definitions of disability? What approaches (if any) do policy-makers use when considering how people with mental illness should be assessed for disability income support?

This systematic literature review aims to address this gap by determining what type of evidence is available on this topic. Specifically, the main objective of this review is to examine the literature systematically to answer:

How have Australian and Ontarian policy-makers considered mental illness when designing contemporary (since 1991) disability income support programs?

In particular, this review addresses the following sub-questions:

- How do mental illnesses come to be considered eligible disabilities?;
- What tools are used to assess eligibility?; and
- What challenges exist in this process and what approaches are used to address these challenges?

The review is concerned only with literature about how those with existing mental illness obtain disability income support. It does not consider the effect that being a recipient of disability income support has on a person’s mental health.

In addition to articles about mental illness in general, documents concerned with one or more of these types of mental illness were reviewed.

Justification for limiting the review to articles from Australia and Ontario was provided in Chapter I: Introduction (p. 8).
Method

The review broadly followed the Cochrane Review approach (Higgins and Green 2011). The *Cochrane Handbook for Systematic Reviews of Interventions* “provides guidance to authors for the preparation” (Higgins and Green 2011) of their reviews. See Appendix J for a flow chart of the steps taken to identify the documents included in this review.

Criteria for selection

*Types of articles*

The review concentrated on relevant literature on mental illness and disability income support in Australia and Ontario (the case studies). Literature included relevant academic articles and ‘grey’ literature (e.g. legislation, policy documents, reports etc.) in Australia and Ontario. Only the most current version of a report was included. Opinion-based documents were excluded (Bambra et al. 2005: 10). Literature that mentioned mental illness but did not provide separate findings in relation to mental illness is listed in an additional table.

*Setting of articles*

Australia and Ontario were chosen to represent two different types of models of disability income support – an economic model and a medical model respectively (as explained in Chapter II). They also have foundational similarities as discussed in Chapter I: Introduction.

*Types of mental illness addressed*

As noted earlier, for the purposes of this thesis, mental illness is defined as “… a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning. Mental disorders are usually associated with significant distress or disability in social, occupational, or other important activities.” (American Psychiatric Association 2013a). Studies were limited to those concerning mental illness and not mental health. In recognition of the broad spectrum of mental illness, three mental illnesses were selected to represent different policy challenges:
addiction – a disputed mental illness;
unipolar depression – a common mental illness; and
schizophrenia – a low incidence but high impairment mental illness.

Studies specifically focusing on addiction, unipolar depression and schizophrenia as defined by the DSM-5 were included. Intellectual disabilities and dementia were excluded.

**Types of government support**

The types of benefits included in this review were limited to the DSP in Australia and the ODSP in Ontario. All other types of benefits (e.g. workers’ compensation benefits or employment benefits due to disability) were excluded. As disability income support is a payment of last resort (meaning no other source of income is available) for people unable to work, the review is limited to individuals of working age (16 – 65)\(^\text{15}\).

This review was limited to literature published between January 1, 1991 to December 31, 2012. The time-base for the review was the 22 years since the Australian DSP was introduced. The ODSP was not introduced until 1997 in Ontario.

**Types of interventions/policies**

To be included in this review, the research had to address specific challenges experienced by those with a mental illness obtaining disability income support. In addition, documents concerning the challenges faced by policy-makers when designing disability income support for people with mental illness were included.

Studies on the following were excluded:

- employment barriers for people with a mental illness;
- disability income support without a specific reference to mental illness; and
- attaching people with a mental illness to the labour force.

**Types of outcome measures**

To be included in this review, the article had to address a primary outcome. Primary outcomes included recommendations for, or critiques of designing disability income

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\(^{15}\) 65 years of age is when Australians and Canadians are eligible to receive pensions related to old age as at 30 June 2013.
support for people with mental illness (e.g. defining disability, assessing disability, eligibility criteria, exclusion or inclusion of certain mental illnesses).

**Search methods for identification of articles:**

The following electronic databases were searched:

- Embase;
- Informit;
- Medline via Ovid;
- ProQuest Health and Medical;
- PsychINFO;
- Scopus; and
- Web of Knowledge.

See Appendix G for an example of search strategy and key words used.

See Appendix H for a summary of articles identified by database.

‘Grey’ literature is defined as any literature not produced by commercial publishers (Hopewell et al. 2007: 2) such as conference proceedings, government documents, working papers, etc. It was identified through website searches, key informant interviews and direct contact with relevant policy-makers in Australia and Ontario. See Appendix I for a list of websites searched.

Other resources searched included:

- bibliographies of included publications;
- Trove via National Library of Australia (Australian theses);
- Library and Archives Canada (Canadian theses);
- journals related to the field such as the Australian Social Policy Journal, the Canadian Review of Social Policy and Disability Studies Quarterly; and
- conference proceedings for the Australian Social Policy Conference.

**Data collection and analysis**

Articles were reviewed by title and abstract against inclusion and exclusion criteria. The full-length article was retrieved for all articles considered relevant. Two
reviewers\textsuperscript{16} independently reviewed and selected the articles for inclusion from the culled citation list. Disagreements were resolved through discussion and the primary reviewer confirmed the final list. This increased the inter-coder reliability (Cho 2008). The primary reviewer solely completed the ‘grey’ literature search. See Appendix J for a flow chart of document identification.

\textit{Data extraction}

Both reviewers completed initial data extraction and entered the data from the databases independently using a specially created template. Again, any discrepancies were solved through discussion. The primary reviewer entered all data related to ‘grey’ literature and entered the data from the templates into a summary table. Data extracted included:

- the article: author, year and type of publication;
- Australia or Ontario;
- aim and focus of the article;
- methods used (if applicable);
- key points; and
- strengths and limitations.

No specific quality appraisal tool was used as “methods for critically appraising qualitative research is still under development” (Petticrew and Roberts 2008: 150). However a quality appraisal instrument developed by Gallacher et al. (2013) was used as a guide when determining the strengths and limitations of each article. See Appendix K for the list of questions developed by Gallacher et al. (2013).

\textbf{Results}

Nineteen documents met all of the inclusion criteria and reported at least one outcome of interest.

\textbf{Type of articles}

Five articles were peer-reviewed articles (Carney 1991; Mendelson 2004; Brucker 2009; Hales-Ricalis 2010; Madden et al. 2011). Fourteen documents were classified

\textsuperscript{16} The two reviewers included myself (primary reviewer) and Ms. Anna Fraser (secondary reviewer). Ms. Fraser is an honours student in the Political Economy Department at the University of Sydney and provided assistance with cross checking the initially identified documents. As primary reviewer, I completed the search for all articles, made all final decisions regarding inclusion and completed final data extraction of the included articles.
as ‘grey’ literature. These documents were further categorised into four types of ‘grey’ literature – government reports, legal research and reports, stakeholder reports and other reports. Table 6 – Table 10 summarise the 19 reviewed documents, grouped under the type of document. Results were presented in these groupings to identify the key sources of information on disability income support design.

**Setting of articles**

Most articles (11) had an Australian focus but one article was a comparison study that included Australia and Canada (Brucker 2009). However, this article focused on national disability support (e.g. Canada not Ontario). Eight articles had an Ontario focus.

**Types of mental illness addressed**

Many articles referenced mental illness but only the articles included (see Table 6 – Table 10) discussed specific issues related to mental illness and disability income support. Most articles (12) did not delineate between different types of mental illness. Four focused specifically on addiction (Brucker 2009; Chu 2009; Copes and Bisgould 2010; Hales-Ricalis 2010), three on depression (Glozier 2008; Social Security Reporter 2010; Social Security Reporter 2011) and none on schizophrenia.

**Types of benefits**

All articles focused on either the Australian Disability Support Pension or the Ontario Disability Support Program.

**Types of data collection**

Methods were outlined in four documents. Only one (Brucker 2009) detailed the data collection and analysis used. Some of the other documents referred to the type of data used to support arguments (e.g. case law, policy documents, etc.). Case law was a commonly cited data source (Carney 1991; Income Security Advocacy Centre 2003; Mayson et al. 2006; Chu 2009; Copes and Bisgould 2010; Hales-Ricalis 2010; Patton et al. 2010). Case law can be defined as legal rulings that set a precedent for future decisions\(^\text{17}\).

\(^{17}\) The Tranchemontagne case is an example of Ontarian case law. See footnote on p. 48 for explanation of this case.
Review of the tables for the assessment of work-related impairment for Disability Support Pension (Department of Families Housing Community Services and Indigenous Affairs [FaHCSIA] 2011) was the only document that included policy-makers in data collection. However Madden et al. (2011: 10) received comments on their article from the former Department of Families, Housing, Community Services and Indigenous Affairs (FaHCSIA) and the Department of Education, Employment and Workplace Relations (DEEWR) – two departments responsible for the DSP at the time.
<table>
<thead>
<tr>
<th>Article</th>
<th>Aim &amp; focus illness</th>
<th>Methods</th>
<th>Key points</th>
<th>Strengths</th>
<th>Limitations</th>
<th>Related publication</th>
</tr>
</thead>
</table>
| Brucker (2009)          | **Aim:** To demonstrate that target populations of public policies are based on social constructions.  
**Focus:** Addiction                                    | • Qualitative comparative analysis (10 countries) – how national disability systems address issues of addiction.  
• Data – mix of documents (policies, reports, articles and public informational materials) and key informant interviews to triangulate the results of the document analysis. | • US was the only country to exclude those with a primary condition of addiction from disability benefits.  
• Basing policies on social constructions led to persons with disabilities being identified as dependents and people with addictions classified as deviants.  
• Australia and Canada *“have defined disability to include substance use disorders…”* (p. 421). | **Strengths**  
• Critical engagement with disability income support policy design and addiction.  
• Clearly defined section on methods.  
**Limitations**  
• Limited to national disability schemes. No mention of Ontario excluding addiction from eligibility for ODSP.  
• Unclear if only English language documents included. | **Brucker (2007)** |
| Carney (1991)           | **Aim:** To explore if the 1990 Australian social security reforms prove repressive of rights to income security, or social control of the disabled.  
**Focus:** General mental illness                                      | • Not specified.  
• Draws on secondary data including academic literature, case law and policy documents to support arguments. | • Government took a reactive approach to designing the “intake gate” – initial point of application – by narrowing eligibility criteria to control numbers instead of ‘activating’ people.  
• Criticises the Impairment Tables for:  
  - an inability to include social background;  
  - weakness in assessing fluctuating conditions (e.g. mental illness); and  
  - being developed for another purpose. | **Strengths**  
• Unique approach – emphasises role of DSP administrators.  
• Detailed analysis of the operational challenges of DSP.  
**Limitations**  
• Limited analysis of mental illness.  
• Methods not described. | **Brucker (2007)** |
| Hales-Ricalis (2010)    | **Aim:** To demonstrate the ODSP addiction exclusion provision contributes significantly to the social stigma of people with addiction.  
**Focus:** Addiction                                                   | • Not specified.  
• Draws on “excerpts from the Respondent’s (Ontario Government) defence and the Social Benefit Tribunal’s decision” (p. 1). | • Legislation creates a distinction between what is and is not an acceptable disability – exclusion of addiction implies that it is not a legitimate disability.  
• Eligibility criterion is based on how disabilities were created and whether or not the cause of disability is socially acceptable. | **Strengths**  
• Primary focus is ODSP policy design and addiction.  
• Demonstrates using legislation as a tool for social inclusivity.  
**Limitations**  
• Methods not described. | **Brucker (2007)** |

**Abbreviations:** DSP – Disability Support Pension; ODSP – Ontario Disability Support Program.
| Madden et al. (2011) | Aim: To discuss eligibility and assessment for two major disability-related national programs in Australia including the DSP. | • Not specified.  
• Draws on secondary data to support arguments.  
• Received comments on paper from two departments responsible for these programs.  
• Criticises the use of the term impairment in the Impairment Tables for:  
  - combining aspects of diagnosis and functioning – confusing the term;  
  - focusing too much on medical diagnosis; and  
  - lacking recognition of impairment from mental illness is multi-faceted.  
• Lack of evidence to support a direct relationship between the presence of psychiatric disorder and employment status or work performance making judgements about future work capacity difficult.  
• Decisions about eligibility seem to rely on judgement and unclear if the Impairment Tables are evidence-based. | Strengths  
• Specific section on mental health and disability.  
• Involved government departments in writing process.  
Limitations  
• Methods not described. |
| Mendelson (2004) | Aim: To explore the different rating scales available to assess psychiatric impairment in Australia. | • Not specified.  
• Reviewed 20 statutory schemes that assess psychiatric impairment (e.g. the rating scale used and corresponding legislation) including the Impairment Tables part of The Social Security Act, 1991.  
• Impairment Table to assess psychiatric impairment not based on empirical studies. Designed to assess functioning, not rate impairment.  
• Rating scales (e.g. the Impairment Tables) designed for alternative purposes can lead to external factors influencing the outcome of the rating. | Strengths  
• Emphasis on the assessment of psychiatric impairment not disabilities in general.  
• Highlights the difficulty in assessing psychiatric impairment.  
• Written for clinical audience.  
Limitations  
• Limited section on DSP.  
• Methods not described.  
• Does not delineate between different types of psychiatric impairment. |

**Abbreviations:** DSP – Disability Support Pension.
### Table 7 – Disability income support design: A summary of government reports

<table>
<thead>
<tr>
<th>Article</th>
<th>Aim &amp; focus</th>
<th>Methods</th>
<th>Key points</th>
<th>Strengths and limitations</th>
</tr>
</thead>
</table>
| FaHCSIA (2011)   | **Aim:** To describe the process of reviewing the Impairment Tables including outcomes and recommendations. | Stakeholder consultations  
Sample size: 28 stakeholders participated by sending comments and submissions. | Stakeholder consultations  
Issues with mental health table:  
- Needs a more dimensional approach;  
- Expand the range of acceptable evidence;  
- Focusing on medical diagnosis and treatment is limiting; and  
- Biased in favour towards psychotic disorders.  
Issues with addiction table:  
- Focus is on usage and pattern of addiction not its effects.  
**Workshops with Job Capacity Assessors**  
Sample size: 13 assessors and managers from Centrelink and CRS Australia. | **Strengths**  
- Representation of mental health experts on Advisory Committee.  
- Involvement of assessors and stakeholders.  
- Recognises broad spectrum of mental illness.  
**Limitations**  
- Small sample sizes.  
- Scope of review does not allow for alternative methods of assessment to be considered.  
- Participant selection process unclear.  
- Analysis not clearly explained. |
|                  | **Focus:** General mental illness | **Usability testing of the draft Impairment Tables**  
Sample size: 215 DSP assessments.  
Analysis: Reliability and validity testing. | **Strengths**  
- Representation of mental health experts on Advisory Committee.  
- Involvement of assessors and stakeholders.  
- Recognises broad spectrum of mental illness.  
**Limitations**  
- Small sample sizes.  
- Scope of review does not allow for alternative methods of assessment to be considered.  
- Participant selection process unclear.  
- Analysis not clearly explained. |

**Lattimore (2007)**  
Australia  
*Note: Only Chapter 8 met inclusion criteria.*  

| Aim: To understand why there has been an increase in unemployment among Australian men. | Not clearly defined.  
- Draws on literature to support arguments. | Inclusion errors are more likely when assessing disabilities that lack diagnostic certainty and are close to the threshold of eligibility for the DSP (e.g. mental illness).  
- Doctors may err on the side of a patient in cases of uncertainty.  
- System incentives (e.g. higher payment/fewer obligations) encourage people to overstate their impairment to qualify.  
- Inclusion errors by the physician are more likely a result of non-clinical factors than issues of fraud. | **Strengths**  
- Recognises the difficulty in defining disability.  
- Identifies specific challenges associated with defining and assessing disability for people with mental illness.  
**Limitations**  
- Lack of evidence to substantiate claims.  
- Limited analysis on mental illness and disability income support (e.g. only Chapter 8). |

**Abbreviations:** CRS – Commonwealth Rehabilitation Services; DSP – Disability Support Pension.
### Table 8 – Disability income support design: A summary of legal research and reports

<table>
<thead>
<tr>
<th>Article</th>
<th>Aim &amp; focus</th>
<th>Methods</th>
<th>Key points</th>
<th>Strengths</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chu (2009)</td>
<td>Aim: To summarise the Ontario Superior Court of Justice decision to uphold the Social Benefits Tribunal’s decision that the ODSP addiction exclusion provision is discriminatory. Focus: Addiction</td>
<td>N/A. Summary of court decision.</td>
<td>• Government’s arguments used to support exclusion including: - all people with addiction are capable of working; and - lower rate of OW assists in recovery by limiting the amount available to the recipient to spend on their addiction. • Respondents’ arguments used to support the appeal to the addiction exclusion including: - some people with addiction will never recover or be employable; and - recovery more likely when people have higher incomes on ODSP than OW.</td>
<td>Strengths: Provides insight into rationale for implementing the ODSP addiction exclusion provision. Limitations: Lack of critical analysis of case results.</td>
<td></td>
</tr>
<tr>
<td>Copes and Bisgould (2010)</td>
<td>Aim: To summarise the arguments used by the Respondents for Court of Appeal for Ontario case – Director, Ontario Disability Support Program versus Robert Tranchemontagne and Norman Werbeski. Focus: Addiction</td>
<td>N/A. Summary of arguments.</td>
<td>• The interpretation of the definition of disability contravenes ODSP legislation. • No rationale for why the ODSP addiction exclusion was initially created. • Exclusion is based on assumptions about people with addiction.</td>
<td>Strengths: Highlights discrepancy between the written definition and interpretation of definition of disability. Limitations: Arguments largely supported by case law and expert opinions not empirical evidence.</td>
<td></td>
</tr>
<tr>
<td>Patton et al. (2010)</td>
<td>Aim: To develop a principle-based evaluation tool – a “Rights-outcome lens” – to assess eligibility criteria (e.g. ODSP). Note: A “Rights-outcome lens” evaluation tool is premised on the fact that people with disabilities are rights holders. Focus: General mental illness</td>
<td>Data collection included a review of academic and ‘grey’ literature; focus groups and key informant interviews. Two step analysis – 1) outline the “Rights-outcome lens”; 2) evaluate the tool against ODSP.</td>
<td>• The legal definition of disability in ODSP legislation is inclusive but application of the definition in practice is stricter. • Mental illness is poorly framed and understood in policy materials leading to difficulty in understanding how it fits within the eligibility criteria. • Administrative process discourages application and appeals and leads to inappropriate denials. • Courts have acknowledged the social role in disability, but the administrative application remains medicalised.</td>
<td>Strengths: Develops a tool to help assessors apply eligibility criteria for government programs that promotes consistency and is evidence-based. Strong focus on ODSP. Limitations: No clear definition of “Rights-outcome lens”. Participant selection process unclear. Limited analysis of mental illness.</td>
<td></td>
</tr>
</tbody>
</table>

**Abbreviations:** AAT – Administrative Appeals Tribunal; ODSP – Ontario Disability Support Program; OW – Ontario Works.
<table>
<thead>
<tr>
<th>Social Security Reporter (2010)</th>
<th>Australia</th>
<th><strong>Aim:</strong> To summarise the case Roberts and Secretary of FaHCSIA – ATT case.</th>
<th><strong>Focus:</strong> Depression</th>
<th>N/A. Summary of court decision.</th>
<th>• Treating doctor’s evidence deemed insufficient, confirmation from mental health specialist was required to prove applicant’s depression satisfied the eligibility requirements.</th>
<th></th>
</tr>
</thead>
</table>
|                               |           |                                 |                      |                               | **Strengths**  
|                               |           |                                 |                      |                               | • Demonstrates preference for medical evidence provided by specialists for mental illnesses.  
|                               |           |                                 |                      |                               | **Limitations**  
|                               |           |                                 |                      |                               | • No rationale as to why a specialist report is needed for mental illness and not physical illness.  
|                               |           |                                 |                      |                               | • Evidence provided is subjective (e.g. opinion of physician).  |
| Social Security Reporter (2011) | Australia | **To summarise the case Erb and Secretary of FaHCSIA – an ATT case** | **Focus:** Depression | N/A. Summary of court decision. | • ATT agreed depression did not meet the eligibility criterion of a condition being fully treated and stabilised.  
• Overturned decision based on applicant’s physical illness meeting the eligibility criteria. |  |
|                               |           |                                 |                      |                               | **Strengths**  
|                               |           |                                 |                      |                               | • Demonstrates challenges related to proving depression is fully diagnosed and stabilised.  
|                               |           |                                 |                      |                               | **Limitations**  
|                               |           |                                 |                      |                               | • Evidence provided is subjective (e.g. opinion of physician).  |

**Abbreviations:** AAT – Administrative Appeals Tribunal; FaHCSIA – Australian Department of Families, Housing, Community Services and Indigenous Affairs; ODSP – Ontario Disability Support Program; OW – Ontario Works.
### Table 9 – Disability income support design: A summary of other reports

<table>
<thead>
<tr>
<th>Article</th>
<th>Aim &amp; focus</th>
<th>Methods</th>
<th>Key points</th>
<th>Strengths</th>
<th>Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cowling (2005)</td>
<td><strong>Aim:</strong> To explore whether the Australian Welfare-to-Work reforms will deliver improved employment outcomes for people with mental illness or exacerbate their vulnerability.</td>
<td>• Not specified.</td>
<td>• Eligibility outcomes will depend more on the “type of assessor” than on a “consistent assessment process” based on empirical research (p. 6).</td>
<td>• Highlights the role of assessors in outcomes – differs from OECD that focuses more on definition of disability than assessors of disability.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Focus:</strong> General mental illness</td>
<td>• Draws on academic and ‘grey’ literature to support arguments.</td>
<td></td>
<td></td>
<td>• Focus is on employment outcomes.</td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Only Section 3 of the report met the inclusion criteria.</td>
<td></td>
<td></td>
<td></td>
<td>• Methods not described.</td>
</tr>
<tr>
<td>OECD (2012)</td>
<td><strong>Aim:</strong> To identify and narrow the knowledge gaps by reviewing evidence on the main challenges and barriers to integrating people with mental illness in employment.</td>
<td>• Not clearly defined.</td>
<td>• Suggests that disability income support programs were designed for people with physical illness and this has made it easier for people with mental illness to get onto the program (p. 35).</td>
<td>• Recommends emphasis on mental illness in disability income support design.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Focus:</strong> General mental illness</td>
<td>• Comparative analysis of disability income support policies.</td>
<td>• Nature of mental illness not well addressed in disability income support;</td>
<td>• Acknowledges lack of data.</td>
<td></td>
</tr>
<tr>
<td></td>
<td><strong>Note:</strong> Only Chapter 4 of the report met the inclusion criteria.</td>
<td>• Statistics presented from OECD questionnaire on mental health.</td>
<td>• Majority of people with moderate or severe mental illness do not receive a disability income support benefit.</td>
<td>• Mostly focuses on employment for people with mental illness.</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Lack of data on this topic.</td>
<td>• Limited to national disability schemes. No mention of ODSP.</td>
<td></td>
</tr>
</tbody>
</table>

**Abbreviations:** ODSP – Ontario Disability Support Program; OECD – Organisation for Economic Co-operation and Development.

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![Table 9](image-url)
### Table 10 – Disability income support design: A summary of stakeholder reports

<table>
<thead>
<tr>
<th>Article</th>
<th>Aim &amp; focus</th>
<th>Methods</th>
<th>Key points</th>
<th>Strengths and limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Canadian Mental Health Association – Ontario and Schizophrenia Society of Ontario (2011) Ontario</td>
<td><strong>Aim:</strong> To provide a response to the Ontario Social Assistance Review and highlight issues with the most relevance to persons with mental illness in relation to social assistance. <strong>Focus:</strong> General mental illness</td>
<td>Not specified. Text includes quotes from survey but details not provided.</td>
<td>• Heterogeneity of mental illness makes it unique in social assistance design. • Workfare approach could exacerbate a person’s mental illness. • Lack of mental illness treatment services availability in Ontario makes treatment as a condition of benefit receipt dangerous. • Current ODSP definition of disability is more inclusive of mental illness because it incorporates a social definition of disability.</td>
<td><strong>Strengths</strong> • Stresses the heterogeneity of mental illness. <strong>Limitations</strong> • Limited focus on disability income support. • Methods not defined.</td>
</tr>
<tr>
<td>Glozier (2008) Australia</td>
<td><strong>Aim:</strong> To provide background information to physicians on depression and work-related disability and outline the complex relationship between the two. <strong>Focus:</strong> Depression</td>
<td>Not specified.</td>
<td>• Degree of impairment cannot be determined using a checklist or algorithm because the number of symptoms does not necessarily correlate with the degree of impairment (p. 4). • Studies show that conditions such as depression are often under-reported and receive other official labels for their work-related disability.</td>
<td><strong>Strengths</strong> • Focus on assessing disability and depression. • Focus on a single mental illness (e.g. depression). • Supporting evidence cited. • Provides specific examples of how symptoms of depression can affect capacity to work. <strong>Limitations</strong> • Aim not clearly stated – had to be inferred. • Methods not defined.</td>
</tr>
<tr>
<td>Income Security Advocacy Centre (2003) Ontario</td>
<td><strong>Aim:</strong> To summarise the challenging aspects of the ODSP application and adjudication process and make recommendations for change. <strong>Focus:</strong> General mental illness</td>
<td>Not specified.</td>
<td>• Lack of clarity on forms, particularly in relation to mental illness, and perceived inadequate reimbursement levels for physicians, affects the quality of evidence GPs provide. • Evidence from GPs regularly ignored, over-ruled by or cherry-picked by the DAU.</td>
<td><strong>Strengths</strong> • Report only focuses on issues of policy design. • Provides detailed description of assessment process. <strong>Limitations</strong> • Methods not defined. • Limited focus on mental illness.</td>
</tr>
</tbody>
</table>

**Abbreviations:** DAU – Disability Adjudication Unit; GPs – General practitioners; ODSP – Ontario Disability Support Program.

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18 ‘Workfare’ means receiving income support benefits are conditional on recipients participating in compulsory work activities (e.g. work search activities or performing labour and/or services) (Torjman 1996: 1).
| **Mayson et al. (2006) Ontario** | **Aim:** To examine factors contributing to the significant failure rate of initial ODSP applications compared to the correspondingly large number of successful appeals to the SBT.  
**Focus:** General mental illness | **Strengths**  
- Entire report concentrates on the ODSP application process and assessment.  
- Highlights mismatch between denial of initial applications and success of appeals – key policy design issue.  
**Limitations**  
- Limited focus on mental illness.  
- Limited reference list.  
- Some statistics not cited or references not provided.  
- Methods not defined. |  
| **ODSP Action Coalition (2003) Ontario** | **Aim:** To summarise the results from “Access to ODSP” Forums held throughout Ontario in 2002.  
**Focus:** General mental illness | **Strengths**  
- Includes primary data.  
- Centres on ODSP application and assessment.  
**Limitations**  
- Participant selection process and forum sample size not specified.  
- Limited focus on mental illness. |

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**Abbreviations:** GPs – General practitioners; ODSP – Ontario Disability Support Program; SBT – Social Benefits Tribunal.
Peer-reviewed research

Five articles were categorised as peer-reviewed research (Carney 1991; Mendelson 2004; Brucker 2009; Hales-Ricalis 2010; Madden et al. 2011). Two articles were about inclusion of addiction as an eligible condition in disability income support programs (Brucker 2009; Hales-Ricalis 2010). Both of these authors argued that disability income support eligibility criteria are based on social constructions of what is socially acceptable as a disability rather than being evidence-based, using addiction as an example. Hales-Ricalis (2010: 3) extends the argument suggesting circularity – eligibility criteria are based on what is socially acceptable, but legislation can dictate what is socially acceptable. These articles illustrate the precarious relationship between addiction and disability income support design.

The other three articles critiqued the Australian Impairment Tables (Carney 1991; Mendelson 2004; Madden et al. 2011). None of the articles supported the Impairment Tables as a ‘good’ tool for assessing eligibility, especially mental illness. The authors raised the following concerns:

- the Impairment Tables were designed to assess functioning, not to rate impairment (Carney 1991: 233; Mendelson 2004; Madden et al. 2011) and not to be used as ‘sudden death’ criteria (Carney 1991: 232; Madden et al. 2011: 9);
- doubt that the Impairment Tables are evidence-based (Carney 1991; Mendelson 2004; Madden et al. 2011: 9);
- there is too much focus on medical diagnosis and a lack of recognition that impairment from mental illness is multi-faceted (e.g. social determinants of health) (Carney 1991: 233; Madden, Glozier et al. 2011: 5);
- there is not enough consideration of the episodic nature of mental illness or the difficulty of predicting work impairment in the assessment process (Carney 1991: 233; Madden et al. 2011: 9); and
- eligibility decisions are judgements and influenced by external factors (Mendelson 2004: 473; Madden et al. 2011: 9).

Carney (1991: 234) critiqued the Australian DSP definition of disability but emphasised that outcomes are more related to the assessors’ skills and workload than the definition itself.
Overall, the five articles demonstrate the many challenges mental illness presents when designing disability income support. These challenges could indicate that mental illnesses were not considered in the disability income support design process.

**Government reports**

Two Australian documents were categorised as government reports as they were written for government departmental purposes (Lattimore 2007; FaHCSIA 2011). Both noted concerns with the assessment process. Neither article was primarily about mental illness but both noted the challenges associated with mental illness being invisible, particularly in providing medical evidence to prove eligibility. However it was unclear whether these challenges helped or hindered people with mental illness in obtaining the Disability Support Pension. The *Review of the tables for the assessment of work-related impairment for Disability Support Pension: Advisory committee final report* suggested the newly developed Impairment Tables might disadvantage people with mental illness applying for DSP (FaHCSIA 2011: iv, 30), whereas the *Men at Work* report suggested the contrary (Lattimore 2007: 169 - 72).

**Legal research and reports**

Five documents were categorised as legal research and reports (Chu 2009; Copes and Bisgould 2010; Patton et al. 2010; Social Security Reporter 2010; Social Security Reporter 2011). A report was categorised as legal if its primary purpose was to describe a legal matter. Four articles were about the appeals of applicants initially rejected – two related to the ODSP addiction exclusion provision (Chu 2009; Copes and Bisgould 2010) and two centred on depression not meeting the eligibility requirements of the Australian DSP (Social Security Reporter 2010; Social Security Reporter 2011). The fifth article was about developing a better tool to assess eligibility criteria (Patton et al. 2010).

Two articles identified a discrepancy between the written definition of disability and the application of the definition, arguing that in practice, a more stringent definition is applied (Copes and Bisgould 2010; Patton et al. 2010).

Chu (2009: 39) and Copes and Bisgould (2010: 1) argued the ODSP addiction exclusion is based on assumptions about people with addiction (e.g. that they are lazy or not wanting to recover) rather than evidence.
Both Social Security Reporter articles imply that proving eligibility is clearer for a physical illness than mental illness (Social Security Reporter 2010; Social Security Reporter 2011). For example, GP evidence related to the appellant’s mental illness was rejected but the GP evidence related to the appellant’s physical illness was accepted.

**Other reports**

Two reports (Cowling 2005; OECD 2012) were classified as other reports because they were not stakeholder related or legal, and therefore did not clearly fit into the other categories. Both reports were written by independent research organisations – the Centre of Full Employment and Equity and the Organisation for Economic Co-operation and Development (OECD) – however were not peer-reviewed so were classified as reports rather than peer-reviewed research. Both reports were primarily about employment outcomes for people with mental illness but had sections on disability income support. Unlike other documents, the OECD report specifically discussed the lack of available data on this topic (OECD 2012: 12, 210). The authors also lauded the Australian DSP assessment process for incorporating the fluctuating nature of mental illness (OECD 2012: 156). However similar to Carney (1991: 243), Cowling (2005: 6) argued the outcome of assessments are reliant on the assessors, not definition or tools used.

**Stakeholder reports**

Five documents were categorised as stakeholder reports (Income Security Advocacy Centre 2003; ODSP Action Coalition 2003; Mayson et al. 2006; Glozier 2008; Canadian Mental Health Association - Ontario and Schizophrenia Society of Ontario 2011) and all except one (Glozier 2008) were from Ontario stakeholders. For the purposes of this review, a stakeholder report is written by a group that has an interest in disability income support outside of government.

Many similarities were noted across the Ontario stakeholder reports. First, all highlighted access to physicians, especially mental health specialists, as a problem. A lack of available mental health services in Ontario makes it difficult for applicants with mental illness to provide adequate medical evidence to support their applications. Disability income support application forms not adequately addressing the nature of mental illness were another concern. Mayson et al. (2006: 9) used the Activity Daily
Living Index (see Appendix L for an excerpt) as an example of a form that “does not ask appropriate questions…particularly those related to mental illness”. In terms of assessment, the authors noted that evidence from GPs is sometimes discounted and purported that assessors apply a stricter definition of disability than the legal definition (Income Security Advocacy Centre 2003: 19; ODSP Action Coalition 2003: 9).

Overall the stakeholder reports highlighted three unique features of mental illness that create challenges in disability income support policy design including:

- the broad spectrum of mental illness (Canadian Mental Health Association – Ontario and Schizophrenia Society of Ontario 2011: 3);
- the lack of relationship between number of symptoms and degree of impairment make assessing work capacity difficult (Glozier 2008: 2); and

Despite the variation in the type of documents, the following key themes emerged during synthesis of the documents:

- assessment for impairment is too medicalised and needs to include social factors;
- disability income support policy is not evidence-based;
- there is a discrepancy between the written definition of disability and the interpretation; and
- there are problems with physicians completing forms for applicants with mental illness.

**Excluded articles**

The main reason articles were excluded was due to a focus on employment outcomes (Purnima and Ochocka 2004; Bambra, Whitehead et al. 2005; Waghorn et al. 2005; Bill et al. 2006; Shankar 2009; Gewurtz 2011; Shankar et al. 2011) or issues of homelessness (Morrell-Bellai et al. 2000; Bessant 2004; Forchuk et al. 2006; Noel et al. 2006; Forchuk et al. 2007; Meehan et al. 2007; Piat et al. 2009; Lee et al. 2010). I have listed a selection of excluded articles in Appendix M. These articles were listed
in a separate table because either they met all of the inclusion criteria except for the outcome criteria or they met most of the criteria and emerged in more than one search result (e.g. bibliography, database search, key informants or website search) and were therefore perceived as important to review. The main reasons for exclusion of the selected articles included:

- not meeting outcome criteria (all the articles in Appendix M);
- lacking critical engagement about disability income support design (i.e. too descriptive) (Wilton 2004; Bill, Cowling et al. 2006; Forchuk et al. 2007; Gewurtz 2011);
- lacking critical engagement about mental illness (i.e. mentioned but did not discuss) (Carney 2003; Carney 2006; Lightman et al. 2009);
- focusing on employment outcomes (Purnima and Ochocka 2004; Shankar 2009);
- focusing on prevalence of disability income support recipients with mental illness (Butterworth 2003; Butterworth et al. 2004; Butterworth et al. 2006; Butterworth et al. 2011b); or
- focusing on people with mental illness on other types of income support (e.g. general welfare benefits (Berger 2001).

The OECD has published many reports on the issues of work-related disability, mental illness and employment, including three major reviews on working-age disability and mental health across different countries – Transforming disability into ability (OECD 2003); Sickness, disability and work (OECD 2007; OECD 2010a; OECD 2010b); and Mental health and work (OECD 2012). These reports were identified many times throughout the literature search. However only the Mental health and work (OECD 2012) report met all of the inclusion criteria.

**Discussion**

The aim of this review was to systematically evaluate peer-reviewed and ‘grey’ literature to determine if and how mental illness was considered in disability income support policy design in Australia and Ontario since 1991. As previously mentioned in the methods section, the review broadly followed the Cochrane Review approach (Higgins and Green 2011). Methods were described and recorded to allow for replication. However this can be challenging and not always possible with ‘grey’
literature since many were found through website searches and through interviews with key informants, both of which may not be replicable (Chapter IV provides more information on key informants).

The results revealed few peer-reviewed articles and even fewer solely focusing on disability income support and mental illness. Findings also revealed that ‘grey’ literature is a key source of information. Most articles pertained to the Australian disability income support system, not the Ontarian system. Many challenges related to disability income support design and mental illness, particularly in the assessment process, were described. There was no discussion regarding how these challenges would be addressed. It would appear that the design of the system in Australia and Ontario could disadvantage people with a mental illness.

**Is disability income support based on evidence?**

Findings suggest that disability income support design (e.g. definition of disability and assessment of disability) is not based on evidence. First, this review found limited evidence available in the Australian and Ontarian settings, most of which was not empirical evidence. Second, articles were difficult to locate. Most documents were found through alternative search methods (e.g. the ‘grey’ literature search, key informants, etc.), not through databases. Third, some of the authors included in this review argued that evidence is not being used to make disability income support design decisions. For example, it was suggested that the ODSP addiction exclusion provision is premised on the assumptions that people with addiction are lazy, want hand-outs and have no desire to recover (Copes and Bisgould 2010: 1). As previously mentioned in Chapter II in the section on stigma (pp. 16 – 17), these assumptions are negative and unfounded in the literature. This is just one example of how basing policy on negative beliefs or attitudes rather than evidence can lead to discrimination and can lead to people with mental illness not being eligible for disability income support.

This finding generates more questions than answers. First, are policy-makers choosing not to use evidence in their decision-making? Or are they unable to locate the evidence? Second, do you need evidence to create policy? In medicine, it would be frowned upon to make changes in practice without evidence. In fact, a key aim of systematic reviews is to generate evidence for this purpose. For example, a systematic
review of randomised-controlled trials (RCT) for a new breast cancer treatment would most likely be conducted before any changes to standard breast cancer treatment were made. However it is unclear if evidence is needed in policy-making. For example, a key aim of the *Review of the tables for the assessment of work-related impairment for Disability Support Pension* (FaHCSIA 2011: 1) was to update the Impairment Tables to reflect current medical and rehabilitation practice. However in the final version of the Impairment Tables there is only one table related to mental illness (Impairment Table 5) and one related to addiction (Impairment Table 6) (see Appendix C for excerpts from these tables). However if the updated Impairment Tables were based on evidence from the literature, it could be assumed that there should be more than these two tables to reflect the broad spectrum of mental illness (as illustrated in Table 4 – Definitions, symptoms and treatment for addiction, depression and schizophrenia on p. 19). In fact, a criticism of these new tables was that they were more suited to assessing psychotic illnesses and may not adequately address illnesses like anxiety or depression (FaHCSIA 2011: 39). I argue that the limited number of impairment tables related to mental illness suggests the broad spectrum of mental illness was not considered. This argument could be applied to the overall findings of the review. Despite looking for specific information on addiction, depression and schizophrenia, most articles were about mental illness in general. In fact, no articles addressed schizophrenia and the few articles that did address addiction and depression were not based on data.

However there is an assumption behind the claim that policy-makers are not using evidence – evidence only equals peer-reviewed research. In medicine, evidence usually refers to well-designed, systematic and rigorous peer-reviewed research (Evidence-Based Medicine Working Group 1992). In contrast, evidence for policy-making has been defined as “any information that helps to turn a department’s strategic priorities and other objectives into something concrete, manageable and achievable” (Shaxson 2005: 103). The latter definition does not have stipulations on the quality of the research, but rather focuses on its usefulness to achieve policy goals and could include “opinions, judgements and analyses, as well as ‘hard facts’” (Shaxson 2005: 105). This supports Shaxson’s (2005: 102) argument that policies are shaped by their political and social landscapes so researchers should consider these contexts if the aim is to generate policy-relevant evidence. As Levitt (2003: 29) notes,
policy needs to reflect “what society wants, needs and will consent to.” Therefore, unlike peer-reviewed research, evidence for policy-making should at least consider public opinion. As such, “Evidence is necessary, but not a sufficient, condition for any decision-making process” Shaxson (2005: 102). As such, if researchers want their studies to influence policy, their studies need to consider context and policy goals, rather than expecting policy-makers to find all existing research relevant.

**Key sources of evidence**

*‘Grey’ literature*

Findings also revealed that ‘grey’ literature is an important resource for this topic, especially legal and stakeholder reports, making up more than half of the total documents included. One explanation is that evidence in the social sciences may not be indexed in electronic databases (Petticrew and Roberts 2008: 80). Greenhalgh and Peacock (2005: 1065) found that systematic review search protocols related to policy-making failed to identify important evidence if they did not extend beyond database searching. A key strength of this review is that it did not solely rely on electronic databases to identify relevant articles. Most of the articles included in this review (including some peer-reviewed articles) were found through the ‘grey’ literature search, not databases. Evidence is growing that ‘grey’ literature is a necessary component to systematic reviews, particularly in the social sciences (McAuley et al. 2000: 1230; Hopewell et al. 2007: 6). However inclusion of ‘grey’ literature is not without its challenges. For example, it is more time consuming to locate in a systematic way and it is difficult to assess the quality of the documents.

*Legal documents*

The importance of legal documents was an unexpected result. Case law and references to legislation were used to substantiate arguments even in documents not categorised as legal documents (Carney 1991; Income Security Advocacy Centre 2003; Mayson et al. 2006). Furthermore, results show that case law plays an important role in disability income support design as decisions can set a precedent, changing the intention or interpretation of the policy. The most notable example is the *Tranchemontagne case* that resulted in the ODSP addiction exclusion being

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19 In the *Tranchemontagne case*, the appellants were rejected from the ODSP because addictions were not an eligible condition. However, the case went through many levels of the appeal process and ultimately a decision
overturned. This case was featured in many of the reviewed documents (Income Security Advocacy Centre 2003; ODSP Action Coalition 2003; Mayson et al. 2006; Chu 2009; Copes and Bisgould 2010; Hales-Ricalis 2010). Some authors appeared to use the outcome of appeals as a way to measure success of the ODSP adjudication process (Income Security Advocacy Centre 2003; Mayson et al. 2006). For example, courts overturning many of the rejections made by the Disability Adjudication Unit (DAU) signal a problem with the assessment process. One explanation for the difference between the DAU and courts could be explained by the courts incorporating a social element in their interpretation compared to the medical interpretation by the DAU (Patton et al. 2010: 46). The background of the assessors also differ, with many in the DAU having a medical or allied health background, whereas the Social Benefit Tribunal members have backgrounds ranging from teachers to business owners, and courts are overseen by those with legal backgrounds. The legal system appears to not only influence policy but also monitor it. However limitations of case law should also be acknowledged. For example, judicial decision-makers can only base decisions on facts presented in court and therefore decisions may not be based on the available peer-reviewed research.

**Lack of recognition of the broad spectrum of mental illness**

Three mental illnesses were chosen in recognition of the broad spectrum of mental illness. However most of the articles referred to mental illness in general rather than any specific types of mental illness. These articles neglected to recognise the unique characteristics attributed to each type of mental illness as illustrated in Chapter II in Table 4 (p. 19). In addition, it was noted in Chapter II (p. 13) that schizophrenia greatly contributes to the burden of mental illness, yet not one article focused on this illness. One explanation could be that schizophrenia is defined as a severe condition, leading to the perception that people with this illness are suitable for disability income support. On the other hand, addiction and depression may be perceived as less severe and therefore there is more of a focus on these illnesses in relation to their suitability for disability income support. This issue is further discussed on p. 131 and p. 148.

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20 See p. xvi for explanation of the Disability Adjudication Unit.
21 See p. xix for explanation of the Social Benefits Tribunal.
Other limitations

Overall, results demonstrate that the relationship between disability income support design and mental illness is neglected in the literature, despite calls for greater attention towards mental illness in policy design, especially disability income support (WHO 2001: xviii; Goldman et al. 2008; Butterworth et al. 2011b: 60). However it is acknowledged that some documents may not have been found. In addition, literature outside the Australian and Ontarian setting was not in the scope of this review. As such, it is possible that there is literature from other settings about disability income support design and mental illness.

Overall, the lack of description of methods in many studies makes it difficult to determine from the available evidence what is anecdotal or empirical data. Detailed study designs could correct this issue, providing more substantial evidence to support claims. Forchuk and Roberts (1993: 49-54) developed guidelines to appraise qualitative research, however these guidelines could also be used as a checklist for qualitative researchers or report writers to ensure that their studies include essential elements (e.g. details about study design). Many issues raised were related to the assessment process but only the authors of the Review of the tables for the assessment of work-related impairment for Disability Support Pension (FaHCSIA 2011) spoke to the assessors themselves. While stakeholder reports are invaluable in identifying challenges and barriers experienced by those the policy was designed to capture, policy-makers are a key resource for assessing how these challenges could be addressed. Future research should consider using key informant interviews to learn more about disability income support policy design from those who create it.

Similarities and differences between Australia and Ontario

The issues related to mental illness and disability income support were similar across the Australian and Ontarian research (as illustrated by the key themes on p. 44). Both jurisdictions seem to struggle with the unique features of mental illness in their approaches to disability income support design, however documents from both settings provided little in the way of solutions.

Quantity of documents was a key difference, as most articles included in the review were Australian. One explanation could be that Australia is a country whereas Ontario is a province. As such, there may be more interest in researching a larger system. An
alternative explanation is that the Australian disability income support system has
gone through more reforms than the Ontarian system. The dates of most of the
Australian documents coincide with key reform dates. For example, the introduction
of the 1991 Disability Support Pension in 1991 (Carney 1991), the 2005–06 Welfare-
to-Work reforms (Cowling 2005; Lattimore 2007) and the more recent 2011 reforms
where the Impairment Tables were overhauled (FaHCSIA 2011; Madden et al. 2011).
As such, I argue that proposed reforms generate analysis. In contrast, the ODSP in
Ontario has not reformed since it was introduced in 1997. However the dates of two
of the stakeholder articles (Income Security Advocacy Centre 2003; ODSP Action
Coalition 2003) coincide with the 2003 Ontario provincial election where a new
government was formed. I argue that these documents were created to push ODSP
reform onto the political agenda.

What’s new?

The search was replicated in August 2014 to find articles published since the initial
review date (December 2012). Embase and Informit were searched as the most
relevant results in the initial search were retrieved from these databases. No new
articles meeting the review criteria were found. Most were excluded because they
focused on employment for people with mental illness on disability income support,
进一步支持了在该主题区域进行研究的这一关键领域。一件额外的
‘灰色’ 文献通过网站搜索和参与者推荐发现。表11总结了该文献。
### Table 11 – Summary of additional literature

<table>
<thead>
<tr>
<th>Article</th>
<th>Aim &amp; focus</th>
<th>Methods</th>
<th>Key points</th>
<th>Strengths and Limitations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Commission of Canada (2013) Ontario</td>
<td><strong>Aim:</strong> Identify current and new practices that could improve employment outcomes or sustainable income for people with serious mental illness. <strong>Focus:</strong> General mental illness</td>
<td>Data collection included: ● Literature review of disability support policies across Canada and abroad; ● Semi-structured interviews with key informants in Canada and abroad; ● OECD consultation; and ● workplace know-how questionnaire. ● Analysis of data not specified.</td>
<td>● DIS programs not designed for mental illness. ● DIS policies need better recognition of the intermittent nature of mental illness. ● Canadian programs should shift from a medical model to economic model (e.g. recommends Australian DSP as an exemplar). ● Most literature found was ‘grey’ and found online.</td>
<td>● Primary focus on mental illness. ● Literature review includes ‘grey’ literature. ● Primary aim about employment outcomes not system design. ● No specific focus on Ontario.</td>
</tr>
</tbody>
</table>

**Abbreviations:** DIS – Disability income support; DSP – Disability Support Pension; OECD – Organisation for Economic Co-operation and Development.

Most of the outcomes of this report support the outcomes of the other included articles. However this report again highlights the importance of ‘grey’ literature when researching policies.

**Implications**

**Policy**

This review demonstrated that there is a lack of local research available to policymakers in Australia and Ontario about disability income support and mental illness. While I do not argue that mental illnesses are more important than other types of illnesses, findings from this review show that mental illnesses bring unique challenges to the policy design process and need special consideration. If policymakers consider these challenges in future reforms, it could reduce the disadvantage experienced by those with mental illness who are applying for disability income support.

**Practice**

The limited available evidence suggests that current tools used to assess disability income support eligibility leave room for assessors’ judgement that could be putting people with mental illness at a disadvantage. As such, development of better tools for disability income support assessors are needed to reduce these disadvantages. It could be useful to collaborate with the legal community when developing such tools. Collaboration could ensure more consistency and a truer interpretation of the written legislation when applied in the assessment process. This could address the problem of
discrepancy between the written definition and the application of that definition in practice.

Research

While there is limited research available on this topic, the evidence available has been of inadequate design. All resources, including ‘grey’ literature, should better delineate the methods used including:

- type of data collected and rationale of approach;
- description of participants (if applicable);
- description of analysis (e.g. how results were determined); and
- acknowledgement of the strengths and limitations of study.

Inclusion of these factors would strengthen any results found and make it easier to distinguish whether results are based on anecdotes or data.

It would also be beneficial for similar systematic reviews to be conducted in other jurisdictions. Results from these studies could elucidate whether lack of data on this topic is a context specific or an international problem. Researchers should also disseminate results in more digestible formats for policy-makers (e.g. presentations, briefing notes, etc.).

Conclusion

Despite limited literature on this topic, the evidence available demonstrates a need for further research. Results suggest that mental illness is included in the definitions of disability in Australia and Ontario (with the exception of addiction in Ontario prior to the Tranchemontagne decision) but is not well understood or defined in the assessment process. As a result, the questions outlined in the introduction of this review still remain largely unanswered. The review confirmed that mental illness presents many challenges when designing disability income support (e.g. episodic nature, impact of non-medical factors, etc.). However, the choices made about the definition of disability (e.g. why some illnesses are included while others such as addiction are not) and the ways of addressing the challenges associated with assessing the eligibility of people with mental illness for disability income support still remain unclear.
In the remaining chapters of this thesis, I aim to address some of the gaps identified in this review by:

- learning about the disability income support design process from key informant interviews (see Chapter IV – Methods); and
- adding to the limited evidence-base on how disability income support policy-makers deal with the challenges of mental illness in the eligibility and assessment process (see Chapters V – IX).
CHAPTER IV: METHODS

*Grounded theory serves as a way to learn about the worlds we study and a method for developing theories to understand them.*

(Charmaz 2006: 10)

Chapter III demonstrated a gap in research into the design of disability income support and mental illness. This chapter explains how grounded theory was applied to two case studies—Australia and Ontario—to answer the research questions stated in Chapter I and begins to address the gaps noted in the Chapter III. To reiterate, grounded theory is systematic, with a series of guided steps (Charmaz 2006: 3) (see the Chapter I on pp. 4 – 7 for the rationale for using these methods). Comparative case study research shares many features with grounded theory. For example, both are iterative, grounded in the data and can be used to generate inductive theories about a process (Eisenhardt 1989; Bryant and Charmaz 2007). The following chapter explains how these research methods were used in this thesis.

**Data collection**

Two types of data were collected: data extracted from interview transcripts, and data from other documents (see below for further detail). Collecting two types of data allowed for triangulation that helped reduce potential bias and increased the accuracy of results (Krefting 1991: 217; Shenton 2004; Gewurtz 2011: 83). The intention was that documents could be used to corroborate what key informants said, or key informants could elaborate on the content of the policy documents.

**Interviews**

Semi-structured, in-depth interviews were the main source of data collected. Interviews allowed examination of the research questions with those who have relevant experiences (Charmaz 2006: 25). In this thesis, “relevant experience” was defined as people who had been, or were currently involved in the disability income support policy or practice in Australia or Ontario since 1991. The main purpose was to “explore one person’s knowledge, views, understandings, interpretations, experiences, perceptions and interactions” (Carter and Mooney-Somers 2011: 1)

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22For the purposes of this thesis, the use of the term case studies does not refer to medical research data but Australia or Ontario—the selected cases for this thesis. For more information on case study research in social sciences see Eisenhardt (1989) and Yin (2014).
associated with designing disability income support. Table 12 (p. 57) provides for further information on types of key informants. Further details about the interviews are discussed later in the procedure section and in Table 13 (p. 61). Appendix N and Appendix O provide examples of the interview guides.

*Key informant quotations*

It should be noted that judicious use of ellipsis (…) was used to remove repetitive text, stuttering and ums and ahs, etc. but never to change the meaning of a quote. To delineate between key informants in Australia and Ontario, (A) will denote an Australian key informant and (O) will denote an Ontarian key informant. Reference to emphasis in key information quotations (e.g. *(emphasis)*) denotes that the key informant placed an emphasis on that word.

*Documents*

Official policy documents, legislation, Hansard transcripts and other reports or documents recommended by the key informants were also reviewed (see Appendix B and Appendix E for examples of documents). Documents were used as ancillary data to complement and triangulate data from interviews. They also provided another way of identifying key informants and ‘triggering’ key informants’ memories when they were asked to recall details.

*Sampling strategy and recruitment*

*Purposive expert sampling*

Purposive expert sampling “generates a sample that is suited to the research questions and specific needs of the study” (Marttila 2012: 29). This method is best suited to research topics where there are a limited number of people with the appropriate knowledge or expertise in the area. The aim of this research was to understand how disability income support was designed in Australia and Ontario and how mental illnesses are considered. The selection criteria for key informants in the study were people who had been or were currently involved in the design of disability income support in Australia or Ontario since 1991 (see Table 12 on the next page for criteria). As such, the key informants were purposefully selected and are not considered to be representative of the general population.
Table 12 – Explanation of categories of the key informants

<table>
<thead>
<tr>
<th>Category</th>
<th>Description &amp; contribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Advocate</td>
<td>A person who liaises between those on whose behalf they advocate (i.e. welfare recipients) and the government responsible for the policy. e.g. policy analyst at a peak body or member of a peak body organisation.</td>
</tr>
<tr>
<td></td>
<td><strong>Contribution:</strong> To be a voice for the recipient, inform/educate the recipient about government policies, provide policy advice to the government and identify areas for improvement (i.e. consult with the community or provide ‘grey’ literature to help inform policy decisions).</td>
</tr>
<tr>
<td></td>
<td>Note: Key informants in other categories may also identify as an advocate but it is not their primary function.</td>
</tr>
<tr>
<td>Legal representative</td>
<td>A person within the legal system who provides legal support and/or representation for DIS applicants or DIS recipients regarding issues such as rejections or other types of appeals. e.g. community legal worker, lawyer or member of a legal aid team.</td>
</tr>
<tr>
<td></td>
<td><strong>Contribution:</strong> To provide legal protection to those applying and receiving DIS outside of the policy atmosphere. Key informants in this category can also identify policy design issues.</td>
</tr>
<tr>
<td>Physician</td>
<td>A clinician with experience working with people with mental illness who are receiving or would benefit from receiving DIS. e.g. addiction specialists, GPs or psychiatrists.</td>
</tr>
<tr>
<td></td>
<td><strong>Contribution:</strong> To provide evidence and testimony to the DIS adjudicators.</td>
</tr>
<tr>
<td>Policy insider</td>
<td>A person who is directly involved in the policy-making process – it is part of their job description. e.g. advisor to the minister, deputy minister/secretary, former minister or policy analyst.</td>
</tr>
<tr>
<td></td>
<td><strong>Contribution:</strong> To design and implement the DIS system.</td>
</tr>
<tr>
<td></td>
<td>Note: A person in this category could be a public servant, a politician or an advisor to a politician. This category is deliberately broad as key informants may be easily identifiable to readers.</td>
</tr>
<tr>
<td>Researcher</td>
<td>A person who studies the DIS system or its recipients. e.g. an academic or research assistant.</td>
</tr>
<tr>
<td></td>
<td><strong>Contribution:</strong> To provide peer-reviewed evidence and ‘grey’ literature – to help inform policy decisions.</td>
</tr>
</tbody>
</table>

**Abbreviations:** DIS – disability income support.

As there was no comprehensive list of those involved in the design of disability income support, snowball sampling was used (Tansey 2007: 770; Noy 2008: 331). Snowball sampling works by identifying one or two initial key informants who meet the selection criteria and relying on them for referral to other key informants who meet the criteria (Miles and Huberman 1994: 28). This sampling technique was particularly useful in this study, as public servants are not typically acknowledged for
their involvement in policy design. Therefore I relied on initial key informant networks and specialised knowledge to generate my sample.

One criticism of snowballing sampling is that the sample may be limited in size to those in the initial key informant’s network (Heckathorn 2002: 13; Penrod et al. 2003: 102; Magnani et al. 2005: 69). To counteract this, several ‘chains’ with multiple initial key informants were started in Australia and Ontario to reduce bias and increase accuracy of the data (Penrod et al. 2003: 102). I recorded details about each key informant and who had referred me to them in a table to be able to track each chain. I received more than one referral to many of the key informants, even those started in different ‘chains’. Chapter X provides further discussion on the limitations of this sampling procedure.

Initial key informants were identified through Senate Estimate Committee Hearings (Australian Government 2013), government organisational charts, government submissions, literature and informal discussions. Subsequent key informants were identified through snowball sampling (as described above). Snowball sampling was also used to find relevant policy documents. Key informants would suggest or provide access to key policy documents. These documents in turn led to suggestions for other key informants.

Key informants were initially limited to policy-makers who had worked inside the disability income support policy areas (e.g. directors or government policy analysts, directors) – henceforth referred to as policy insiders. However, the first few key informants spoke about the role advocates, legal representatives and physicians play in disability income support policy development and practice so the criteria for key informants was broadened to include these groups.

**Theoretical Sampling**

Theoretical sampling involves selecting key informants (or documents) to elucidate information that will further explain conceptual categories rather than to produce findings that are representative (Bryant and Charmaz 2007: 7; Birks and Mills 2010: 11). It is a strategy used to fill in any gaps identified in the analysis. As such, key informants towards the end of data collection were chosen to help elaborate and refine major categories (Charmaz 2006: 12).
**Procedure**

Forty-five key informants were interviewed. The characteristics of the key informants are shown in Appendix P. I conducted all of the interviews. Each interview lasted between 25 and 120 minutes. The time varied depending on the availability of the key informant and the depth of what they wanted to say. Interviews took place at a location convenient to the key informants. This was typically their office or at a local café or in three instances their homes. No one was renumerated for his or her participation, however if we met at a café, I offered to pay for a hot beverage.

Many interviews were conducted in ‘sets’ – a set was comprised of eight to 12 interviews with different key informants over a short period (one to four weeks) – to allow for analysis between sets. Data were collected over a period of 18 months – March 2012 to September 2013.

Participation in the study was voluntary and the key informants were presented with a participation information statement and a consent form at the beginning of each interview (see Appendix Q and Appendix R for a copy of these forms). The key informants, especially the policy insiders, consented subject to not being identified in any publications or results. Most interviews were conducted one-to-one except for two where two participants were present in each at the request of the key informants. Interviews were conducted face-to-face and via Skype. Four interviews were not recorded – two at the request of the key informants and two due to digital recorder malfunctions. In these instances, handwritten notes were taken, then sent to the key informant so they could add anything they felt was missing. Most recordings were outsourced for transcription. This allowed initial analysis to be conducted and subsequent interview guides to be updated accordingly. I checked all transcripts against the recordings for accuracy. Two key informants participated in a follow-up interview to elucidate and clarify on their initial interview. It was also an opportunity to elucidate on categories that needed further development.

Each interview began by asking the key informants to discuss their role and experience with disability income support. I then probed, asking about more specific topics such as defining disability, interpreting the definition of disability and mental illness. The interview guide contained a few guiding questions but was left open to allow the key informants to guide the process. The initial interview guide contained
very broad questions; however the guide was refined after each set of interviews, allowing the subsequent interviews to elucidate on topics that needed further probing. This is consistent with grounded theory (Charmaz 2006; Glaser and Strauss 2009; Charmaz and Belgrave 2012). Appendix N and Appendix O provide examples of the initial interview guide and an updated one to show how the questions evolved throughout the process.

For the most part, the key informants, especially the policy insiders, needed very little prompting to discuss the topic of disability income support. The physicians needed more prompting as some did not perceive themselves to have a role in policy (despite making contributions that have arguably changed disability income support policy). However when the discussion was re-framed around their experience with their patients who needed disability income support as opposed to their role in policy, little prompting was needed.

Data analysis

This section is divided into two parts. First, I explain the key steps of grounded theory, drawing on Sbaraini et al.’s (2011: 3) “Fundamental components of a grounded theory study”. For the purposes of this thesis, I have added two phases – pre-interview preparation and informal discussions. Second, I explain how the steps were applied using grounded theory. Many of these steps were repeated throughout the entire research process (Glaser and Strauss 1967: 43). Unlike grounded theory, comparative case study research does not have a specified set of a steps for analysis (Yin 2014: 133). As such, the following section will be limited to describing how the principles of grounded theory were applied during analysis. Table 13 on the following page outlines the steps of grounded theory used in this thesis.
### Table 13 – Grounded theory process and application

<table>
<thead>
<tr>
<th>Process</th>
<th>Application</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Memo writing</strong></td>
<td>Memos are “informal analytic notes” (Charmaz 2006: 72) used to capture ideas and analysis as the research progresses. Memo-writing is one of the most important parts of grounded theory (Morse et al. 2008: 12).</td>
</tr>
<tr>
<td><strong>Constant comparison</strong></td>
<td>Constant comparison occurs in all stages – within an individual’s transcript and across transcripts – and is an integral part of grounded theory. A key aim of grounded theory is to be able to note the variations and see how and why people may explain the same process differently (Charmaz 2006; Bryant and Charmaz 2007: 6).</td>
</tr>
<tr>
<td><strong>INTERVIEWS</strong></td>
<td></td>
</tr>
<tr>
<td>Informal discussions</td>
<td>Informal discussions are not typically part of the grounded theory process, however they are integral to analysis and can help to articulate initial ideas to others.</td>
</tr>
<tr>
<td>Pre-interview preparation</td>
<td>The interview guide should reflect the key informant’s specialised knowledge and also be informed by previous interviews.</td>
</tr>
<tr>
<td>Post-interview reflections</td>
<td>Field memos are used for immediate reflexivity on the interview. This could include reflections about anything ‘new’, emerging codes or notes to improve data collection process.</td>
</tr>
<tr>
<td><strong>CODING</strong></td>
<td></td>
</tr>
<tr>
<td>Line-by-line coding</td>
<td>Constructivist grounded theory uses two types of coding – line-by-line and focused. “Codes are short analytic and active” (Bryant and Charmaz 2007: 6) and are used to describe what is happening in the data.</td>
</tr>
<tr>
<td>Focused coding</td>
<td>Focused coding is used to identify the codes generated from line-by-line coding that seemed frequent and/or significant either to the key informant or the researcher.</td>
</tr>
<tr>
<td><strong>CONCEPTUAL DEVELOPMENT</strong></td>
<td></td>
</tr>
<tr>
<td>Diagramming (or mapping)</td>
<td>Diagramming is used to see how focused codes are connected. Diagrams or maps can take any shape. Diagrams can also help identify which areas do not ‘fit’ and where more clarity is needed. This information can inform future interviews.</td>
</tr>
<tr>
<td>Theoretical saturation</td>
<td>“Categories are ‘saturated’ when gathering fresh data no longer sparks new theoretical insights, nor reveals new properties of these core theoretical categories” (Charmaz 2006: 113). It is the point when data collection ceases.</td>
</tr>
<tr>
<td>Generate a theory</td>
<td>The aim of grounded theory is to produce a theory at the end of analysis that explains the process being studied (Strauss and Corbin 1998: 24). Connections between conceptual categories are made and these links are the basis for generating a theory about the process. A theory should be relevant to the process studied, explain any problems and variations in the process and be modifiable if new data was collected.</td>
</tr>
</tbody>
</table>

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23 It should be noted that grounded theory uses codes not themes. Braun and Clarke (2006) define thematic analysis as “a method for identifying, analysing and reporting patterns (themes) within data”, but also situate it in relation to other qualitative methods such as grounded theory. Some of the differences they note are: while grounded theorists also seek out patterns, the aim is to generate a theory grounded in the data whereas thematic analysis is not meant to generate a theory; thematic analysis is also not situated within any particular theoretical framework as opposed to grounded theory (Braun and Clarke 2006).
Memos

No memos were deleted – each one was kept as a record of my thoughts and analytic journey. To help with this, electronic memos were dated, labelled (e.g. date and title) and saved as a PDF. To increase reflexivity\(^{24}\), a separate notebook was kept to document my analysis through memos and diagramming that could be taken along during fieldwork. Memos varied in length with some being a few lines – a ‘thought bubble’ – to a more sophisticated lengthy description of an emerging conceptual category.

Constant comparison

Overall this project is a comparison between Australia and Ontario, so I used this process at each analytic stage (e.g. initial data, between codes, between concepts and between categories) (Glaser and Strauss 1967; Charmaz 2006: 54). Constant comparison forced me as a researcher to look for patterns and question why certain participants described similar phenomenon differently. Eisenhardt (1989: 541) notes that looking for differences between similar cases can lead to a “more sophisticated understanding” by breaking out of a “simplistic frame”.

Any variations that emerged were crosschecked in subsequent interviews across different types of key informants and between Australian and Ontarian key informants. This process was particularly important to identify how designing disability income support varied between Australia and Ontario. It is also a key aim of comparative case study research. As such, similarities and differences were summarised in each of the results chapters.

Informal discussions

Prior to beginning data collection, I had informal discussions with people familiar with the disability income support systems in Australia and Ontario to gain background knowledge and suggestions for potential key informants. Some of these people became key informants.

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\(^{24}\) According to Charmaz (2006: 188-89) reflexivity is “the researcher’s scrutiny of his or her research experience, decisions and interpretations...” and acknowledges the role of the researcher in the analytic process. The purpose is to increase the trustworthiness of qualitative research by making the researcher’s bias transparent to the reader (Lincoln et al. 2011).
Pre-interview

As key informants were purposefully selected because of their specific experience in disability income support design or practice, it was important that I drew on their specialised knowledge. I researched each informant so I could respectfully interview them, indicating I had taken time to learn about their career. This also assisted with the flow of conversation and demonstrated a genuine interest and knowledge of the field, thus increasing credibility of the researcher.

Post-interview

As previously mentioned in the procedure section, due to financial and logistical reasons, some interviews were conducted in ‘sets’ (about eight to 12 interviews per set) over shorter periods (one to four weeks). Field notes – written descriptions immediately after the interview – were extremely important to the process, especially when transcribing between interviews was not possible. Field notes and memos informed subsequent interviews.

Once an interview was transcribed, I would listen to it while reading the transcript. This combination provided me with the tone and expressions used in the interview (e.g. when the key informant put emphasis on words or laughed) and added “richness to the analysis” (Morse et al. 2008: 54). It also jogged my memory regarding specific sections of the interview. I wrote another memo after listening to each interview.

Coding

Line-by-line coding

The first six transcripts were coded line-by-line before writing a memo. In these memos, I noted what was going on, what changed, what stayed the same, what seemed important to each informant and what seemed significant (Charmaz 2006: 51). After each new ‘set’ of interviews, two transcripts were also coded line-by-line. This helped identify any new codes that may not have emerged during the initial interviews.

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25 Interviews done in ‘sets’ were outsourced for transcription. Outsourcing these interviews provided an opportunity to get the transcript and begin analysis when there was little time between interviews. I transcribed the interviews that were conducted outside of these ‘sets’.
Focused coding began after the initial six interviews were coded line-by-line. Focused codes included topics repeated by the informants and topics that seemed significant. As such, a topic only mentioned once could be considered a focused code to be explored in subsequence interviews. Focused codes were eventually used to generate the results chapters.

Conceptual development

Diagramming

I used various types of diagrams and flow charts to see how the focused codes were connected. For example, the concept of a ‘gate’ – an entry to disability income support – appeared in most of my diagrams even early in the interview process. However the concept of ‘gatekeepers’ – those who operate the gate – evolved as my analysis progressed. I used this process throughout all of the grounded theory steps. The visual representation of the codes helped me to articulate my thoughts and plan the results chapters. It also helped identify which areas still did not ‘fit’ and where more clarity was needed. I used this information to inform subsequent interviews.

Theoretical saturation

Theoretical saturation occurs when no new properties of the theoretical category emerge (Charmaz and Henwood 2010: 243). The above steps were repeated several times (not always in this order) until theoretical saturation occurred. Theoretical saturation can be difficult to identify. For this thesis, theoretical saturation occurred after 42 interviews were completed. However, I completed an additional three interviews to confirm that conceptual categories were sufficiently developed.

Generating a theory

To reiterate, the purpose of grounded theory is to generate a substantive theory about a process. A substantive theory is context specific and can be used to develop a formal theory when applied in other settings (Silverman 2013: 438). As noted in Table 13, the key properties of a grounded theory are: conceptual categories must be connected, it must explain any problems or variations in the process and be modifiable if new data was collected. While I created a conceptual model (see Figure 1 – Process of making sure the suitable people get onto the program: A conceptual
model on p. 67) and not a theory, I argue that the model generated holds the key properties of a grounded theory. Five conceptual categories emerged during analysis:

- The gate;
- Gatekeeping;
- Expecting applicants to ‘perform’ their illness;
- Physicians making judgements about eligibility; and
- Creating an ‘ideal type’ of disability.

These categories are further explored in Chapters V – IX, while Chapter X provides more details about the model generated, including an explanation of variations in the process. I developed a conceptual model rather than a substantive theory because the findings of this thesis fall “somewhere between grand theories and empirical findings” in attempting “to understand and explain a limited area of social [and political] life” (Bryman 2012: 22). In other words, the specificity of the topic area and setting allow for abstraction but limit the generalisability of claims – a key distinction between a model and theory. A conceptual model provides an explanation of the process in the specific setting while still being applicable to other contexts. As such, the findings from this thesis lend itself to a model.
INTRODUCTION TO RESULTS CHAPTERS

*If you are designing a program which is specifically for people with disabilities…the biggest question that has to be answered is what’s the, what’s the right gateway to the program? Who qualifies from a disability perspective? ... how do you capture the people that you intend?*

**Policy insider 5 (O)**

To the key informants, designing disability income support was primarily about the process of making sure the suitable people get onto the program. As discussed in Chapter II, suitable people for disability income support in Australia and Ontario are people with disabilities whose impairments reduce their capacity to work. Overall, the results show that many people with mental illness are not perceived as suitable people for the program despite comprising a large portion of recipients in Australia and Ontario.

During analysis, five main conceptual categories emerged to explain this process and provide an explanation for why some people with mental illness may not be considered suitable for disability income support. In the following section, I will explain how the five conceptual categories connect to understand the process of making sure the suitable people get onto the program. Findings revealed that there are two main stages in the process of finding the suitable person: i) establishing the gate and ii) gatekeeping. This process was the same in Australia and Ontario. I have set out this process in Figure 1 below.
Making sure suitable people get onto the program: A conceptual model

Figure 1 - Process of making sure the suitable people get onto the program: A conceptual model

- Stage I: Gates
  - Choose the components of the gate
  - Factors influencing choices about the gate

- Stage II: Gatekeeping
  - Different types of gatekeepers
  - Obstacles to effective gatekeeping
  - Tools to help gatekeepers

- Decisions about eligibility
  - Affects
    - Can lead to suitable people
    - Can lead to unsuitable people

Chapter V
Chapter VI
Chapter VII
Chapter VIII
Chapter IX
The following provides an explanation of each component of Figure 1:

**Stage one: Establishing the gate**

The gate is the point of entry to a disability income support program. This stage involves deciding eligibility criteria for the program (e.g. the definition of disability). Choices are influenced by many factors but most relate to political objectives and appeasing the perceived opinion of the taxpayer (see Chapter V).

**Stage two: Gatekeeping**

It is the responsibility of the gatekeeper to operate the gate. The gatekeeper interprets the eligibility criteria that were established in stage one (e.g. assessment of disability). Ultimately, it is the gatekeeper who decides who is let in and who is kept out. There are different types of gatekeepers – official, judicial and physician – involved in making the decision however, *only* the official gatekeeper actually operates the gate (see Chapter VI).

**Tools to help gatekeepers**

Creating eligibility criteria is less challenging than interpreting it. How can you be sure a person can only work 15 hours? Or is severely and not moderately impaired? Gatekeepers need tools to help interpret the criteria. Examples include:

- **Forms** – Forms are documents that need to be completed by an applicant or physician. Forms can provide the gatekeeper with all the necessary information about the applicant.
- **Guidelines** – Guidelines (typically internal documents) are documents that detail the rules of disability income support policy and/or provide information to gatekeepers on how to interpret the information that is provided on a form.
- **Heuristic devices** – Heuristic devices or mental shortcuts are informal tools that gatekeepers can use to help identify suitable people for disability income support (see Chapter IX).

**Obstacles to effective gatekeeping**

Gatekeepers also have to deal with challenges when determining an applicant’s eligibility for disability income support. These challenges can be internal (e.g. trouble understanding the written definition of disability) or external (e.g. physicians making decisions about eligibility). External challenges can often be a result of interference...
with a tool used to interpret the eligibility criteria. For example, a physician not providing ‘objective’ evidence on the form can interfere with the gatekeeper making decisions about who is suitable. Another example of an obstacle is an applicant ‘performing’ their illness. Interference with the operation of the gate is a key reason for gatekeepers believing that unsuitable people are getting onto the program (see Chapter VII and Chapter VIII).

**Decisions about eligibility**

Ultimately, the purpose of the two stages is to identify suitable people to receive disability income support. However, the different elements related to gatekeeping can affect these decisions, leading to the perception that suitable and unsuitable people are getting through the disability income support gate.

**Summary**

The conceptual categories are presented across five separate results chapters:

- Chapter V: The gate
- Chapter VI: Gatekeeping
- Chapter VII: Physicians making judgements about applicants’ eligibility
- Chapter VIII: Expecting applicants to ‘perform’ their illness; and
- Chapter IX: Creating an ‘ideal type’ of disability.

In each chapter, I will explain the conceptual category and explore the main concepts associated with the category. The concepts or codes explored in these sections were selected because they best explain the conceptual categories. Therefore not all concepts or codes are presented in these sections. The evidence used in the following chapters are key informant quotations and policy documents.
CHAPTER V: THE GATE

I think the objective is to fairly let in those that you think should be receiving the payment and exclude those who you don’t think should be doing it. I think that’s the challenge. It’s not a totally shut gate but it’s also not a totally open gate for anyone.

Policy insider 20 (A)

Disability income support is not a universal public program; parameters are needed to determine who should receive the benefit. Many key informants described the process of designing disability income support by using the metaphor of a gate (some key informants used the term gateway; however, gate will be used here unless in a direct quote). To the key informants, the gate represented an entry to disability income support and all applicants must enter through the gate to obtain support. My analysis explores the metaphor of the gate to explain how policy-makers ensure that suitable people enter the program. For the gate to open, an applicant must meet criteria that comprise the definition of disability. Gatekeepers are important in this process, which is further considered, in the next chapter. This chapter explores the concept of the gate and seeks to interpret the widely held view that more people than are strictly suitable are passing through the gate. The chapter concludes with a brief summary of the similarities and differences between Australia and Ontario as well as the key informants, in regard to the gate.

Designing the right gate

The key informants spoke about choosing different components that comprise a definition of disability that would make up the gate. A model of disability sets the framework for the definition of disability and the gate. Examples of models of disability include:

1. Economic model – a person’s impairment relates to an inability to participate in work;
2. Medical model – a person’s impairment relates to medical diagnosis of illness; or
3. Social model – a person’s impairment relates to the environment around them (e.g. factors such as stigma or social exclusion).
Australia’s definition is based on the first model and Ontario’s definition is based on the second model. However, some Australian key informants emphasised the importance of having a medical diagnosis to qualify for Australia’s Disability Support Pension (DSP). For example, Policy insider 20 (A) said:

_‘I suppose my sense is that we’ve got a hybrid arrangement. We haven’t got a medical model or a labour market model or a functional model. We’ve got something that’s a real hybrid.’_

On the other hand, Ontarian key informants stressed the importance of capacity to work, rather than having a medical-based definition. This suggests that while definitions of disability may be premised on a model of disability, when it comes to applying the definition in reality, there may be little distinction.

The key informants said a gate could be wide or narrow and the size of the gate relates to the different components of the definition of disability. A definition with few components or low thresholds would be a wide gate and thus easier to enter. A definition with many components or high thresholds would be a narrow gate and thus harder to enter. Table 14 summarises the components of the definition of disability discussed by the key informants.
The key informants also described factors that influenced the choices made about the components. Table 15 (on the following page) summarises these factors.
<table>
<thead>
<tr>
<th>Factor</th>
<th>Description and supporting quotes</th>
<th>Supporting quote</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elected government</td>
<td>As disability income support programs are government-provided, the political leaders of the day approve the final policy and therefore influence the definition. I’m a bureaucrat, that’s all I am; I’m just a lowly bureaucrat. I mean I have to follow their – each government you have to follow their agenda, their platform.</td>
<td>Policy insider 9 (O)</td>
</tr>
<tr>
<td>Finances</td>
<td>The definition of disability affects the size of the program; therefore cost is a significant consideration when choosing the components of the definition (e.g. to reduce costs, components can be tightened to a more narrow definition). It’s not just about an academic exercise…[the] Government only has so much money, it can’t afford to pay everyone.</td>
<td>Policy insider 19 (A)</td>
</tr>
<tr>
<td>Ideology</td>
<td>Ideology is a set of ideals or a belief system. Dominant ideologies such as neo-liberalism or ideologies about work can influence choices made about the definition of disability. I think in their [ODSP] documents, there’s a stated intent of…promoting independence, of self-sufficiency, so there is a real neo-liberal goal…we want to promote independence – financial independence and self-sufficiency.</td>
<td>Researcher 3 (O)</td>
</tr>
<tr>
<td>Legal framework</td>
<td>Definitions of disability are found in legislation. As such, the definition needs to be compatible with the legal context it is situated (e.g. does not infringe on other pieces of law). Our political culture and our legal situation makes it much more difficult to implement that [Impairment Tables] and…</td>
<td>Policy insider 11 (O)</td>
</tr>
<tr>
<td>Stakeholders</td>
<td>Stakeholders can put pressure on the government to alter the definition of disability. Governments may make certain decisions to appease stakeholders. Through a lot of lobbying and consultation and presentations to the legislature, the Government backed down on the use of severe [in the definition] and put in the word substantial impairment.</td>
<td>Legal representative 2 (O)</td>
</tr>
<tr>
<td>Taxpayers/public</td>
<td>The public are voters and their perception of who is suitable for disability income support influences the definition of disability. I think the political beast does look towards the public often for the direction they’re going to go in.</td>
<td>Policy insider 9 (O)</td>
</tr>
<tr>
<td>What other jurisdictions have done</td>
<td>Governments rarely want to ‘reinvent the wheel’. Governments may be more likely to pursue a definition that has been proven successful elsewhere than create a new one. We were certainly looking at a range of arrangements in other countries and not just for what was good, but also looking at some of the difficulties that other countries had got into...</td>
<td>Policy insider 20 (A)</td>
</tr>
</tbody>
</table>
Table 15 illustrates that choices about the components are influenced by many factors, however ultimately it is a political decision. As Policy insider 17 (A) notes:

…you’ve got to let politicians make these value judgments. You [bureaucrats] shouldn’t do that; you might have those views but it’s the politicians that have to work out the economic versus the equity-type arguments.

Policy insider 17 (A)

Table 15 also illustrates the point made by Policy insider 17 (A), since many factors are related to the political party in power (e.g. ideology, politics, public perception and stakeholders), suggesting that factors that help achieve political objectives of the government (e.g. re-election) may have the greatest influence on the final definition of disability. Policy insider 17 (A)’s quote also notes that decisions about disability are not objective, but are sometimes based on the subjective views of the government.

Table 16 (on the following page) compares the definition of disabilities and the different components in Australia and Ontario (as at July 2013).
Table 16 – Comparing the definitions of disability in Australia and Ontario

<table>
<thead>
<tr>
<th>Model of disability</th>
<th>Australia</th>
<th>Ontario</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Economic-based</td>
<td>Medical-based</td>
</tr>
</tbody>
</table>

**Excerpts from the legal definition**

**Australia**

Section 94 – Qualification for disability support pension

(1) A person is qualified for disability support pension if:

(a) the person has a physical, intellectual or psychiatric impairment; and

(b) the person’s impairment is of 20 points or more under the Impairment Tables; and

(c) one of the following applies:

(i) the person has a continuing inability to work;

(ii) the Health Secretary has informed the Secretary that the person is participating in the supported wage system administered by the Health Department, stating the period for which the person is to participate in the system;

III.

**Ontario**

Section 4 – Person with a disability

4. (1) A person is a person with a disability for the purposes of this Part if,

(a) the person has a substantial physical or mental impairment that is continuous or recurrent and expected to last one year or more;

(b) the person has a physical, intellectual or psychiatric impairment; and

(c) one of the following applies:

(i) the person has a continuing inability to work;

(ii) the person is participating in the supported wage system administered by the Health Department, stating the period for which the person is to participate in the system.

**Thresholds**

**Australia**

Impairment – Severe; interpreted as 20 points under the Impairment Tables.

*Note: A medical condition cannot receive any points under the Impairment Tables unless it has been fully diagnosed, treated and stabilised.*

Work capacity – unable to work more than 15 hours per week.

*Note: Different threshold (unable to work for 8 hours per week) for those aged 35 years and under.*

Duration – two years.

**Ontario**

Impairment – Substantial.

Work capacity – N/A

Duration – one year.

**Type of disabilities**

**Australia**

Includes a physical, intellectual or psychiatric impairment.

Eligible conditions are listed in the Impairment Tables.

*Note: Relevant tables included Table 5 – Mental Health Function and Table 6 – Drug and Alcohol.*

The Impairment Tables specify instructions for episodic and fluctuating conditions.

**Ontario**

No specific list but includes mental or physical impairments.

Legislation reads that drug and alcohol addiction are ineligible but case law struck this and these conditions are now eligible.

Specifies that an impairment can be recurrent to include episodic conditions.

**Non-medical factors**

**Australia**

Excluded.

**Ontario**

Case law requires that certain factors are included (e.g. age, education and work history) but only after a medical impairment has been established.

*Note: Socio-economic factors (e.g. the unemployment rate) are excluded.*

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26 The ruling in the case ODSP (Director) v. Gallier [2000] OJ#4541 (QL)(Div CT) requires the Disability Adjudication Unit to take certain non-medical factors into consideration (Ontario (Director of Disability Support Program) v. Gallier 2000).
Table 16 illustrates the differences between the definitions of disability in Australia and Ontario. As already noted in Chapter II, their disability income support programs are based on a different model of disability. However this table shows the differences between the components of the definitions. For example, Australia and Ontario have different thresholds for impairment and duration. Australia explicitly lists eligible conditions in the Impairment Tables, but Ontario does not. Both definitions exclude social factors.

**Believing ‘too many’ people are getting through the gate**

Many key informants held a belief that ‘too many’ people are receiving disability income support. Policy insider 5 (O) explained:

*I would say though...have we captured the right sort of people? I am not sure that we have...I think that there...are more people on the program than one would ideally want ...who could and should be participating in employment activities; who are not required to because they are on ODSP*.

Some key informants distanced themselves personally from these perceptions but most key informants noted that they had come into contact with these views. Advocate 2 (A) also explained:

*... when they [policy insiders] talk about clients and when they make policy that there’s a whole lot of rorting going on.*

In their view, the idea of people ‘rorting’ the system has led to the perception within the Australian government that there are ‘too many’ people on DSP. Physician 7 (A) agreed ‘too many’ people are on the DSP and said:

*Yeah...I know a considerable number of people who are on the DSP, who could definitely work part-time. I know a number who could work full-time. Equally, I know a number of people who aren’t on it who possibly [laughs] should be on it.*

Physician 7 (A)’s last comment implies that suitable people are *not* getting through the gate. Legal representative 5 (A) made a similar statement, noting that adjudicators are looking for any reasons to reject claimants.

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27 It should be noted the ODSP Act, 1997 stipulates that the effect of the impairment must have an effect on at least one of the following: personal care, function in the community or function in a workplace. As such, a person could have a capacity to work and still be eligible for ODSP if their impairment affects their personal care or function in the community.
In Ontario, some key informants said that the fact many ODSP rejections had been overturned at the judicial level illustrated that suitable people were not getting through the gate. For example, Physician 4 (O) said:

And if that doctor, even if they do decide to fill out the forms, that doctor doesn’t really understand how the form’s adjudicated, that’s where they run into trouble. That’s why 60 per cent of Legal Aid clinic work ends up being on ODSP appeals because someone else, who does understand the process, has to work back through the application, figure out where things went wrong and how things could’ve been represented in a different way and then re-submit it. But that’s a huge waste of time, number one. Number two is there are many people who never bother appealing, so they try, they get rejected, they move on, which I think is tragic, given that they could almost double their income by getting on ODSP.

Physician 4 (O)

Physician 4 (O) notes that the problem lies with physicians not providing the adequate information for the adjudication process. The comment also highlights that applicants initially deemed unsuitable may never appeal despite actually being suitable for the program.

So what is the ‘right’ number of people to have on disability income support? No key informant said what the ideal number of people on the program would be. When asked directly what the right number might be, Researcher 4 (O) said it was impossible to give a number but suggested there are ‘too many’ people on disability income support:

So there’s probably a lot of people who don’t have to be on [ODSP], if there were other kinds of opportunities made available to them, through accommodation of other kinds of support. But there probably are too many.

Researcher 4 (O)’s quote highlights the perception that there are ‘too many’ people receiving disability income support. Policy insider 1 (A) agreed that there is a perception that there are ‘too many’ people on the program but provided an alternative solution to the problem:

I think that focusing on trying to have fewer people entering the disability income support pool on the grounds that there are too many there is not the
right way to go. I mean, to me the major concern is are there jobs available? Are there employers employing people with disability? Are jobs themselves being changed?...Are the jobs that they [people with disabilities] are able to get...[able] to accommodate their needs? That is, I believe, where the emphasis should be, not on making income support eligibility tougher.

To this key informant, rising numbers of people on disability income support reflects structural problems rather than people ‘rorting’ the system. Policy insider 21 (A) said rising numbers should indicate that further investigation is needed.

A tension emerged – why does the perception of ‘too many’ people on disability income support persist, if choices are deliberately made about limiting who gets through the gate? I explored this concept in latter interviews, including asking how this problem should be addressed. Some key informants, such as Policy insider 5 (O) suggested tweaking certain components of the definition:

And we set a moderate severity level with...probably a relatively short duration period. In my view, that’s probably...the reason why the case loads have grown significantly year over year as they have in a lot of other Canadian jurisdictions.

Policy insider 11 (O) said the duration of disability in the ODSP definition should be increased.

And probably the most important part of the definition, in my opinion, is that it’s the duration is only one year which is quite unusual and I think internationally, most jurisdictions have something about a prolonged [disability] or permanent [duration] in their definition.

On the other hand, some key informants said the components were too strict.

The legislation is written in such a way that you need to be supremely disabled in order to gain the Disability Support Pension. And it’s unfair legislation at the moment.

Legal representative 5 (A)

Other key informants thought that it was the model of disability that needed altering. For example, some Ontarian key informants suggested moving towards an economic-based model, such as the Australian model.
So the shift that we are hoping for which is why we started looking to the OECD and Australia, is one that focuses on capacity.

Researcher 1 (O)

Ok so we have a fairly traditional although liberal definition…and everybody, you know all the reasons the OECD, and Australia and UK have all been recommending and moving to capacity assessments. We’ve been very interested in [that] because that [sic] [our] definition doesn’t really help you determine very well people who have capacity for work and who do not...

Policy insider 11 (O)

In their view, this model better detects those that are suitable for ODSP. As noted in Chapter III, the OECD has lauded the Australian DSP economic model for its assessment of capacity to work. As a result of this endorsement, Australia’s system has been of interest to Ontario disability income support policy insiders. The key informants made reference to the OECD endorsement and the Australian system was used as an example in the Ontario Social Assistance Review (Lankin and Sheikh 2012: 50).

Some key informants thought the problem was with interpretation of the definition of disability rather than the definition itself. Legal representative 2 (O) said:

Yes, it’s [the ODSP definition of disability] complicated, but I guess any definition would be when you’re determining whether you’re going to give income support to someone based on disability...there are certainly things I would change in the procedure and how it’s interpreted, but I don’t think there is that much wrong with the basic definition.

The problems with interpretation of the definition of disability are further explored in Chapter VI.

Lacking evidence to support the perception

Most key informants were not aware of any proof to support claims that there are ‘too many’ people on disability income support. Policy insider 5 (O) contradicted his initial statement that there “are more people on the program [Ontario Disability Support Program] then one would ideally want…”, stating:
I think that people would like to believe that lots and lots and lots of people with disabilities who typically qualify for income support programs can work and...I don’t think that...there is not an awful lot of evidence to support that.

Policy insider 5 (O) was not the only key informant to speak about the lack of evidence to support the claim of ‘too many’ people or unsuitable people on the program. Advocate 2 (A) and Advocate 3 (A) said when independent evaluations on social security fraud have been conducted in Australia, results show less than one per cent are fraudulent cases. Policy insider 15 (A) conducted a similar evaluation and said:

There continues to be a moral panic about increasing numbers and the Government puts it down to people being work shy or being malingerers. Although there is no evidence to support this.

In this evaluation, the rise in DSP recipients could be explained as such:

40 per cent accounted for demographic characteristics...only 1 per cent of growth was due to increase in DSP recipients and the other increases were due to changes from other policies. Spike in certain age groups were a results [sic] of changes to other programs [e.g. wife pension].

Policy insider 15 (A)

In other words, the opinion of these key informants refuted the argument that rising numbers of disability income support recipients was due to people ‘rorting’ the system. Policy insider 14 (A) agreed with the points made by Policy insider 15 (A) and said:

Some in the community have the idea that too many of those on DSP are malingerers with bad backs who are ‘gaming’ the system but there is actually little evidence to support these views.

This quote is a good illustration of the influence that negative beliefs rather than actual evidence about people on disability income support can have. In later interviews, I explored whether benchmarks are used to indicate when ‘too many’ people are on the program.

And the public statements that were being made by the Minister were that too many people were on ODSP...And what this was based on is like, what the
optimal number is? Or what’s too many? Or how many people should be working?

Legal representative 1 (O)

When asked if they were provided an optimal number of recipients by MCSS, Legal representative 1 (O) said as far as they are aware, there are not any. No key informant could provide any information about benchmarks used. One explanation could be that there is little data on this group of people, as Policy insider 13 (O) said:

Well there’s no data. Well we don’t really know who’s on, we don’t know much about them.

These quotes further support that no evidence is available to substantiate claims that there are ‘too many’ people on the program. However two questions remain: i) what is the ‘correct’ number of recipients? and ii) if there is no evidence that programs are being accessed by unsuitable people, why does this perception persist?

Similarities and differences between Australia and Ontario

Despite making similar choices about the same types of components, Australia has a much narrower definition of disability than Ontario. Some Ontarian policy insiders perceived Australia’s narrower definition to be more desirable. However two Ontarian key informants said Ontario could not adopt Australia’s system because of:

- Cost – implementing a work capacity assessment like Australia’s would require face-to-face interviews with applicants resulting in significant administrative costs as face-to-face interviews are not currently part of the process in Ontario (Policy insider 11 (O)); and
- The legal framework – Ontario was described as a litigious environment (Policy insider 9 (O), Policy insider 11 (O)). This made aspects of Australia’s definition unfeasible (e.g. Impairment Tables that list disabilities infringe on the Ontario Human Rights Code (OHRC) (Policy insider 11 (O)).

The perception that there are ‘too many’ of people on the program was spoken about in both jurisdictions, despite having different definitions of disability based on different models of disability. However no key informants provided evidence of ‘too many’; provided a ‘correct’ number of people who should be receiving disability income support; or provided evidence to the contrary.
**Similarities and differences between the key informants**

Opinions about inclusion of non-medical factors in definitions of disability differed among the key informants. Most of the policy insiders said that non-medical factors are irrelevant. For example, Policy insider 17 (A) said:

*So for social factors, we’ve always tried to exclude social factors [from DSP assessment] ...the view’s always kind of been social factors should be able to be addressed. So it shouldn’t be a disadvantage, we should be able to do something about social factors.*

In this policy insider’s view, social factors are obstacles that can be overcome and therefore are not relevant to the eligibility process. On the other hand, the advocates, legal representatives and some physicians disagreed, saying these factors were relevant.

*Well, I think in general, we need to take those [social factors] into account because otherwise you may end up with a disparity, again, which is what social assistance is meant to eliminate or reduce. I think ignoring the social context of the person coming in would be ludicrous because the opportunities available to that person to warrant function and to get better is a lot less than somebody who might come from means.*

**Physician 3 (O)**

Physician 3 (O) then gave an example to illustrate his point:

*If I had a movie star with a very significant addiction, they may be disabled but they have so many means around them that if I can help them channel them they may not need to get assistance from the state to manage those things. Whereas somebody else, who has lost everything, doesn’t have anything, will need the state’s assistance to make sure there’s a roof over their head.*

Most of the policy insiders argued that an applicant should meet the requirement of impairment irrespective of non-medical factors. The other types of key informants – advocates, legal representatives, some of the physicians and a couple of the policy insiders – argued that these factors could contribute to impairment, especially in relation to mental illness. To them, excluding these factors demonstrates a lack of understanding about the reality of people with mental illness.
Summary

In summary, this chapter has explored the concept of the gate as described by the key informants. It has demonstrated that Australia and Ontario have different definitions of disability. It also examined the perception that there are ‘too many’ people on disability income support in Australia and Ontario but that there is no evidence to support this perception. A debate about the relevance of including social factors as eligibility criterion was also introduced. As the gate cannot open on its own, the following chapter will explore the concept of the gatekeeper and how the definition of disability is interpreted in Australia and Ontario.
CHAPTER VI: GATEKEEPING

While we have legislative criteria for how a person with disabilities is defined for purposes of eligibility, it’s not a hard gate. It’s open to interpretation.

Policy insider 5 (O)

Creating a definition of disability is the first stage in the process of finding suitable disability income support recipients. The next stage is what the key informants referred to as ‘gatekeeping,’ or knowing when to open the gate. Overall, gatekeeping is about interpreting the definition of disability. It is about being able to identify those people who meet the criteria that were established in the definition. For example, being able to identify when a person has a severe impairment rather than a mild impairment. Gatekeepers are the people responsible for this task. Gatekeepers make the decision about who is suitable and who is not, and are the only ones that can let people through the gate. It emerged during analysis that there is more than one type of disability income support gatekeeper making decisions about who is in and who is out and the challenges this creates. This chapter explores the key informants’ perceptions of the different types of gatekeepers; obstacles to effective gatekeeping; and the tools gatekeepers use to overcome these obstacles. The chapter ends with a brief comparison between Australia and Ontario as well as the key informants.

Types of gatekeepers

You’re in or you’re out. You either have this condition or you don’t [laughs].

And it’s either, we’ll put you over here, or you’re in or you’re not in on the basis of our criteria.

Researcher 4 (O)

Gatekeepers are tasked with making the binary decision described above. The key informants spoke about three types of gatekeepers:

The official gatekeeper

Official gatekeepers are those that make the final decision of who is considered eligible for disability income support. In Australia, they are called Job Capacity
Assessors\textsuperscript{28} (JCA) and in Ontario they are called the Disability Adjudication Unit\textsuperscript{29} (DAU).

**The judicial gatekeeper**

These gatekeepers are typically found in the judicial system and are the only other type of gatekeeper (besides the official gatekeeper) who can make decisions about who is suitable. While they do not make day-to-day decisions about who gets onto the program, they do have the power to overrule any initial decisions when appeals to initial decisions are made. Typically, these gatekeepers are at arm’s length from government and have their own set of guidelines and interpretations of the definition of disability. In Australia, these include the Social Security Appeals Tribunal (SSAT) and Administrative Appeals Tribunal (AAT). In Ontario, these include the Social Benefits Tribunal (SBT), the Court of Appeal for Ontario and in some cases, can go as high as the Supreme Court of Canada.

*I mean they’re not shaping policy or the law, well they are kind of shaping policy cause they’re sending a message to us that they don’t agree with something but they’re putting people on the program for various reasons that we may or may not agree with.*

**Policy insider 9 (O)**

This quote illustrates that judicial gatekeepers have the power to grant disability income support regardless of what the official gatekeepers think. Courts cannot only overturn decisions, but can also alter the definition of disability and the way the official gatekeepers must interpret the definition. Ontarian key informants provided many examples of this, the most notable being the case of Tranchemontagne.

*You know the Human Rights Commission makes [a] ruling that…people with those disabilities [addiction] should be eligible for the program, for a benefit and there’s nothing the Ministry can do about that, I mean, they can sort of go to court about it but it’s the courts that decide.*

**Policy insider 10 (O)**

\textsuperscript{28} See p. xvii for explanation of the Job Capacity Assessors.  
\textsuperscript{29} See p. xvi for explanation of the Disability Adjudication Unit.
On the other hand, the Australian key informants did not discuss changes to the interpretation of the definition of disability. Policy insider 17 (A) provided one explanation, noting that decisions do become case law but if the outcome of the decision is unfavourable for the Government, they can change the law to overcome the case law decision. Policy insider 9 (O) said this was not possible in Ontario as it would “open a can of worms”, meaning once the legislation is ‘opened’, all elements of the definition (not just the issue related to the case law decision) is subject to debate. This was the rationale provided by Ontarian policy insiders when asked why the ODSP addiction exclusion provision still exists in the written definition of disability but is no longer enacted.

The physician gatekeeper

These gatekeepers are typically physicians (but can also include allied health professionals and sometimes social workers) who provide evidence to help the first two types of gatekeepers make their decision. Physicians do not make any final decisions but their evidence plays an important role in the final decision.

*The doctor doesn’t decide whether the applicant is disabled or not. The doctor gives their opinion around the person’s medical conditions and impacts of those conditions. We have a unit that looks at all of those all the information and says you meet the criteria of eligibility...you don’t meet the criteria.*

Policy insider 5 (O)

However if we return to the definition of a gatekeeper – a person who decides who is let through the gate – then a physician is not formally a gatekeeper. That said, this does not prevent physicians from perceiving themselves as gatekeepers or acting like gatekeepers. Physicians making judgements about eligibility is further explored in Chapter XII.

Other gatekeepers

Legal representative 5 (A) spoke about the form that applicants must complete to obtain disability income support as being another type of gatekeeper. While a disability income support application form cannot decide who gains access to the program, the key informant argued that the design of the form could deny people access to the program. Legislative representative 5 (A) said the form in Australia only
has room for two conditions (see Appendix S). This could prevent physicians from listing additional conditions relevant to the application. It should be noted that the form does not specify that only two conditions can be listed but only provides space for two and notes physicians can add to these if necessary. The application form design was also brought up by Physician 6 (O) who perceived the Ontarian ODSP form as geared more towards getting information about physical disabilities than mental disabilities.

You sort of think rather than you having to fill in a form that seems to be geared towards physical problems, that you would have a form that’s geared towards mental health problems because that’s where most of the money’s going to go. But it doesn’t, instead we’re doing it sort of back to front in my mind.

Physician 6 (O)

Physician 6 (O) perceived that forms are organised based on functional needs. This is supported in the Activity Daily Living Index (see Appendix L for an excerpt) where most of the first page pertains to questions about physical rather than mental abilities.

Obstacles to effective gatekeeping

The key informants spoke about obstacles that arise when gatekeeping. For example, physicians making judgements about eligibility when this is not their role was a key concern. This obstacle is further explored in Chapter XII. Expecting applicants to ‘perform’ their illness was another key concern. This centres on gatekeepers not trusting an applicant (especially those with invisible illnesses) to accurately describe their symptoms. It is an obstacle because the gatekeeper needs to distinguish between a performance and legitimate impairment.

...we don’t ever actually know what’s going on inside someone else’s [an applicant’s] head; we know what they tell us, and we know what we can see.

Policy insider 18 (A)

This obstacle is further explored in Chapter XIII. Table 17 provides a summary of other obstacles mentioned by the key informants.
<table>
<thead>
<tr>
<th>Obstacle</th>
<th>Description and supporting quotes</th>
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<tbody>
<tr>
<td>Being able to interpret the components of the definition of disability</td>
<td>Gatekeepers need to understand what is meant by each of the components of the definition to be able to identify those that meet the criteria. <em>I think showing you have a substantial physical or mental impairment is reasonable. The problem is, what does that mean by – substantial is perhaps purposely vague a little bit.</em> Legal representative 2 (O)</td>
</tr>
<tr>
<td>Courts changing the interpretation of definition</td>
<td>Case law decisions can change the original intention of the definition and decisions create precedent for how future decisions must be made. <em>The population of people that the…government thought would get on with a definition that they put in the [ODSP] Act has probably somewhat expanded based on the case law…It’s [the definition] sort [of] expanded from the perspective that we are now including people that we probably didn’t expect to include with our definition.</em> Policy insider 6 (O)</td>
</tr>
<tr>
<td>Ensuring consistency across decisions</td>
<td>Gatekeepers will have different interpretations of the definition and this can lead to variations among decisions. <em>I suppose it’s just a reality that if you have 40 people looking at a particular set of guidelines, you might have 40 different interpretations.</em> Policy insider 20 (A)</td>
</tr>
<tr>
<td>Having too many types of gatekeepers</td>
<td>Each type of gatekeeper operates in different ways and sees the applicant in a different setting. These differences lead to variation in decisions. This obstacle differs from the previous one because it is about variation between the different types, rather between different individuals. <em>As well as the fact that you don’t necessarily, in the same way as I think you view the different interpretations amongst the service delivery staff, you would also have the same perspective around the treating professionals [doctors], that they would have different interpretations of the one form.</em> Policy insider 20 (A)</td>
</tr>
<tr>
<td>Making judgements based on beliefs or values</td>
<td>Some key informants noted that while gatekeepers aim to make informed decisions, in the end they are judgements. These judgements are not immune from the gatekeepers’ beliefs or values. <em>Because I don’t believe anyone operates without it, even if it’s unconscious values.</em> Policy insider 16 (A)</td>
</tr>
<tr>
<td>Not having enough information</td>
<td>Gatekeepers can only make decisions on the information that they are provided. Lack of information can make it very difficult to make an informed decision. <em>Again, they [Disability Adjudication Unit] want all the information they can do and sometimes when you get a crappy filled form, that’s all they’re going to work with and unfortunately it isn’t until the appeal process that when a legal clinic gets involved or an advocate gets involved then finally they get the information…</em> Policy insider 9 (O)</td>
</tr>
</tbody>
</table>
Tools to help gatekeepers

...when I am reviewing their [adjudicators'] files and I see a really questionable decision, I'll go up to them [the Medical Advisory Unit30] and say I think the adjudicator [has] made a problem here. What tools do you think we need to help them? Because I am seeing these repeated things.

Policy insider 9 (O)

As Table 17 illustrated, there are many obstacles to effective gatekeeping. The key informants, mostly the policy insiders, spoke about developing tools to overcome these obstacles. In this section, four of these tools are explored. The first three are formal tools – guidelines, impairment tables and access to experts and the fourth is an informal tool – heuristic devices.

Providing guidelines

The adjudicators [official gatekeepers] have received more information, more guidelines, more updates, more training but this [Disability Adjudication Manual] is one of the documents that helps guide their process in thinking of whether or not it rises to the level of substantial for restrictions and impairments.

Policy insider 9 (O)

Guidelines (typically internal documents) can provide examples and explanations of how to interpret the definition of disability. In this instance, these guidelines are specifically related to assisting the official gatekeepers in making their decisions. The policy insiders spoke about the challenges involved in interpreting the definition and the fact that their departments created materials to make it less challenging for the official gatekeepers. While some guidelines were already publicly available, such as the Guidelines to the Impairment Tables (DSS 2011c), others were not and some policy insiders provided copies such as the Disability Adjudication Manual. Many key informants also explained that these documents are works-in-progress, constantly being updated as program changes and new challenges emerge. As such, it was

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30 See p. 92 for an explanation of the Medical Advisory Unit.
preferred that these guidelines were not referred to as ‘gold standards,’ but rather resources that were made available to gatekeepers\(^{31}\).

In Australia, many of the guidelines that were provided to me or spoken about related to the Impairment Tables or Job Capacity Assessment. In Ontario, they were more related to case law, providing gatekeepers with the latest court or tribunal decisions that may change the way the definition of disability is interpreted. Examples of these guidelines are the *Ontario Disability Adjudication Framework* (MCSS 2011a). The Clinic Resource Office (part of Ontario Legal Aid) also provides papers and reference guides on case law decisions. However these documents are meant as resources to policy-makers and legal clinics and are not made publicly available. The Ontarian key informants noted summaries of case law as a key resource for interpreting the definition of disability.

The purpose (regardless of the format) of guidelines is to overcome some of the obstacles listed in Table 17, particularly: being able to interpret the components of the definition of disability; ensuring consistency across decisions; and making judgements based on beliefs or values.

**Creating Impairment Tables**

*It’s [Impairment tables] a tool for gateway into a payment.*

_Policy insider 19 (A)_

For the Australian key informants, the Impairment Tables are a key tool used to interpret the definition of disability. Unlike guidelines, the Impairment Tables have created a points system and those with enough points (more than 20) are considered suitable for DSP.

_So there was a fair bit of inequity in the system. So the Impairment Tables have made a really quite astounding difference to the outcomes in terms of the grant rates._

_Policy insider 14 (A)_

...the Impairment Tables help quite a lot, because they describe in detail what you’re looking for, what kind of functional impairment.

\(^{31}\)The policy insiders provided me with policy documents including guidelines but requested that they not be shared or used in publications.
Both policy insiders spoke favourably about the Impairment Tables. However not all of the key informants thought the Impairment Tables created equity within the system and many were critical of this tool. For example, two key informants said:

_The new Impairment Tables are much worse, which means that persons, who were already on DSP, if they are tested against the new Tables, will have their DSP cancelled._

Legal representative 5 (A)

_They [the Impairment Tables] seem to contradict the capacity assessment concept…_

Policy insider 11 (O)

A key purpose of the Impairment Tables is to create clarity when interpreting the definition of disability. However Advocate 2 (A) noted,

_They [consumers and carers] weren’t sure how they [the new Impairment Tables] were going to be implemented which was always the big concern._

The above quote implies that the Impairment Tables contribute to uncertainty rather than eliminate it.

**Providing access to experts**

Policy insider 19 (A) and Policy insider 9 (O) spoke about providing access to experts for gatekeepers. In Australia, these experts are located in the Health Professional Advisory Unit (HPAU).

_We have a Health Professional’s Advisory Unit that actually works to advise doctors and help, so they can ring for advice if they’re not sure._

Policy insider 19 (A)
According to the Guide to Social Security Law, the HPAU is a team of health professionals who:

...can provide advice, interpretation and clarification to job capacity assessors and other Centrelink staff on a person’s medical condition(s) and its impact on their work capacity.

(DSS 2014a)

In Ontario, these experts are located in the Medical Advisory Unit. As Policy insider 9 (O) explained:

The Medical Advisory Unit, they provide a lot updated information on conditions and things like that and we do ask the question in the province of Ontario, how many people have suffered from addiction. And is our a [sic] case load, is it skewed, is it representative, we do look at numbers like that to understand and the social economic demographics as a whole; we do consider looking at those.

According to the departmental description online, the Medical Advisory Unit:

...provides and facilitates medical advisory services and educational stewardship of the Ministry’s disability determination adjudicators. The unit plays a key role in the maintenance of program integrity by supporting accountability measures, providing quality assurance measures and medical advice related to health benefits associated with ODSP and litigation related to its area of responsibility.

(Service Ontario 2012)

It should be noted that these units also provide education and training. However many of the physicians who also fill out disability income support forms noted that they have very little understanding of the definition of disability or had received very little information about the program (further discussed in Chapter VII). There seems to be a disconnect between making information available and physicians receiving or using the information.
Heuristic devices

But people with genuine disabilities, the public will play with, what is a disability? ...And so there’ll be certain categories that will be more deserving than others in the public’s eye.

Policy insider 16 (A)

Heuristic devices or mental shortcuts (Tversky and Kahneman 1974: 1124) are informal tools that gatekeepers use to help identify suitable people. This was a tool that emerged during analysis but was not explicitly spoken about by the key informants. For example, the gatekeeper might rely on an ‘ideal type’ of disability, attributing certain characteristics to this type. These characteristics could be based on evidence but also morals, stereotypes or other non-evidence based factors. The ‘ideal type’ is used as a benchmark when making judgements about eligibility. For example, those that are closest to the ‘ideal type’ would be identified as suitable, and those less like the ‘ideal type’ would be identified as not suitable. Creating an ‘ideal type’ of disability is an example of a heuristic device that was described by the key informants and is further explored in Chapter IX.

Similarities and differences between Australia and Ontario

Key informants in both Australia and Ontario spoke about there being different types of gatekeepers. However the Australian key informants spoke mostly about official gatekeepers and physician gatekeepers whereas Ontarian key informants also spoke about judicial gatekeepers. The obstacles to effective gatekeeping did not differ between Australia and Ontario.

Not surprisingly, the tools the key informants discussed were different, as Ontario does not have Impairment Tables. However during the interviews some of the Ontarian key informants were reviewing the Australian disability income support system and gave opinions about the Impairment Tables. Gatekeepers in both settings rely on informal tools such as heuristic devices.

Similarities and differences between the key informants

One difference between the key informants was the perception about physicians as gatekeepers. The policy insiders did not view the physicians as gatekeepers but rather
as interfering with the gatekeeping process. However, many of the other types of key informants perceived physicians as gatekeepers.

Another difference was how the Impairment Tables were viewed as tools. The Australian policy insiders mostly spoke positively about the Impairment Tables as a tool for gatekeeping whereas the advocates and legal representatives mostly spoke negatively about the Impairment Tables.

**Summary**

In summary, this chapter has introduced three types of disability income support gatekeepers – two that can make decisions about eligibility (the official and judicial gatekeeper) and one that cannot (the physician gatekeeper). It also briefly examined the obstacles experienced by these gatekeepers and the tools used to overcome these obstacles. While the obstacles experienced by the gatekeepers were similar across settings, the types of gatekeepers and the tools used varied. The following chapters will elucidate on the obstacles and tools introduced in this chapter.
CHAPTER VII: PHYSICIANS MAKING JUDGEMENTS ABOUT ELIGIBILITY

...part of what I think physicians face and [are] dealing with these programs, they start to see themselves as the gatekeepers for these programs... I mean we’re not the gatekeepers. We’re not trained to be gatekeepers. Again, we don’t even know what the definitions are of disability that we’re gatekeeping for, right?

Physician 4 (O)

Physicians play an integral role in the disability income support assessment process. As discussed in Chapter VI, they provide medical evidence used by the official gatekeepers to make decisions about an applicant’s eligibility for disability income support. However during analysis, it emerged that physicians make judgements about an applicant’s eligibility – deciding who is suitable and who is not for disability income support – despite it not being their role in this process. This chapter explores the key informants’ perceptions of the following:

- how a physician makes these judgements;
- factors that influence these judgements; and
- managing physicians making these judgements.

The chapter finishes with a brief comparison between Australia and Ontario as well as the key informants.

Physicians choosing how they want to fill out the form

Several of the physicians said they make judgements when filling out disability income support forms. Physician 7 (A) said:

As a clinician...my role can be – and in fact – and you can write these things however you want to...if I think that actually this isn’t a good thing for my patient, I can undermine the level of disability that I write in that. Conversely, I know that it’s very – well it is not uncommon for people to overdo the level of disability if they think that someone should be on the DSP. So you do have an influence on what – on the – on what the assessment might be.

Physician 7 (A)
According to the key informants, physicians are more likely to make judgements about an applicant’s eligibility for illnesses that lack diagnostic certainty (e.g. many mental illnesses) than illnesses that have diagnostic certainty (e.g. many physical illnesses). One reason they cite is that evidence for these types of conditions relies on the applicant describing their symptoms (or ‘performing’ their illness – see Chapter VIII) and the physician choosing to accept or reject that performance. In the absence of diagnostic tests, the physician’s testimony is paramount.

The key informants spoke about physicians either being lenient or strict in filling out disability income support forms. In this context, lenient means getting more applicants through the gate than are perhaps suitable.

*I think some doctors give – are too soft and...some doctors are very keen to oblige with what the patient wants, and it is hard to say no.*

**Physician 10 (A)**

*So, I mean, that’s all that I do [describe their symptoms] and I can’t go following them around to ascertain [that they are no longer using drugs or alcohol] them, which is the next logical step, which is ridiculous of course.*

**Physician 2 (O)**

Both of the above quotes relate to a physician being lenient, but the first is about acquiescing to their patient, even if the physician disagrees, whereas the second quote is about trusting how their patient describes their symptoms. No key informant explicitly discussed how a physician could be lenient; however, descriptions similar to those above imply that one way could be by accepting their patient’s ‘performance’.

On the other hand, being strict means limiting who is considered suitable. The key informants spoke about two ways a physician could be strict – by rejecting the applicant’s performance when completing the form or refusing to fill out the forms (an exception to this is when an applicant can shop around for a less strict physician, which is discussed later in this chapter).

*People for instance – some physicians for instance – will refuse to fill out these forms.*

**Physician 4 (O)**
Not providing medical evidence – a requirement to support a disability income support application in Australia and Ontario – is one way to prevent a person from obtaining disability income support. Legal representative 2 (O) provided another way that a GP\textsuperscript{32} could refuse to fill out forms. She said that GPs sometimes only focus on a patient’s physical impairments and refuse to fill out the form in relation to mental illness.

**Non-clinical factors influencing judgements**

The key informants perceived that physicians were deciding how to fill out forms based partially on non-clinical factors. This section explores two of these non-clinical factors – first, physicians relying on their attitudes and beliefs; and second, lacking time to fill out forms.

**Physicians relying on their attitudes and beliefs**

Many key informants spoke about physicians relying on their attitudes and beliefs about disability income support when filling out disability income support applications for patients. For example, Physician 2 (O) had knowledge of doctors telling patients:

*You should be working. Why should I be filling out these forms? I don’t believe in this [disability income support] anyway.*

Policy insider 9 (O) said that physicians have the same biases as the broader public.

*...they [physicians] also have to put aside their biases ‘cause I think they’re sometimes looking at the public bias that they shouldn’t be on social systems, what do they need? Well you [physicians] obviously don’t know what the benefits are in social assistance, maybe for this person who may clearly have a disability that is affecting them greatly.*

*Interviewer: So doctors are having those biases as well?*

*Yes. I firmly believe so ‘cause I have seen evidence of doctors saying, “I don’t believe they should be receiving social assistance”*.  

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\textsuperscript{32} Some key informants used the term general practitioner (GP), while others used family physician/doctor. Ontarian key informants more commonly used family doctor.
The above quote suggests that physicians are not immune to their own biases. However, a physician acting on these attitudes or beliefs can have significant consequences for the applicant (i.e. not getting the evidence needed to support a disability income support application).

Other key informants said physicians’ negative attitudes or beliefs about mental illness can result in the physician being strict. For example, Advocate 3 (A) said that some physicians might attribute responsibility for the mental illness to the applicant.

There’s still quite a long way to go in terms of not viewing it [mental illness] as a fault of the person, or as something that people don’t really have a good understanding of. And also even within the mental health profession we have consumers and carers say that there’s a high level of stigma and discrimination that they feel by people who are supposed to be paid to support them.

Advocate 3 (A)

Advocate 2 (A) said some physicians assume all people with mental illness should respond in a similar way to their illness.

It [is] kind of assumed that they [people with mental illness] will be affected in the same way that all those people that they [doctors] were seeing in acute unit were...Because the doctors meet so many people that are in that acute place of un-wellness, or that chronic un-wellness that they just assume everyone is like that.

Advocate 2 (A)

This assumption demonstrates a lack of understanding about the continuum of mental illness and how the degree of impairment is related to the individual. Physician 7 (A) provided another example, describing two theoretical patients:
Person 1:

...I think often the disconnect between the symptoms of depression and being depressed, and the functioning, actually to a large extent reflect your personal mores, your culture, your background and your – they do reflect things that aren’t the illness. And so you see these people who you think actually have really quite a severe illness and they’ll say things to you like I’ve got to go to work, I’ve got three kids, I just have to do this…I’m miserable and I’m anxious every second of the day, but if I’m not there they starve.

Person 2:

And there are other people who are, well, take the much more– much more entitled view or they come from a background where – actually I don’t know anybody who works, this is what you do, you get to a certain level and you get some symptoms and you go on the DSP.

Physician 7 (A)

In these examples, the assumption is that these two theoretical patients have exactly the same disorder (depression), the same severity and ‘choose’ how they react to it. However individuals have different thresholds and respond differently to illnesses. As such, the legitimacy of a person’s impairment should not be related to that person meeting a physician’s expectation of how they should respond to their illness.

Not all key informants believed that physicians were antagonistic towards welfare programs. For example, Policy insider 18 (A) said:

No, they [physicians] seem quite cooperative. Look, most doctors want the best outcome for their patients.

Lacking time

The key informants also perceived physicians’ lack of time as another non-clinical factor that influenced how physicians fill out disability income support applications.

Lacking time to fill out forms

The key informants’ view was that physicians did not want to spend their time filling out disability income support forms. Interestingly, none of the physicians noted a personal lack of time as a factor in being able to complete this paperwork.
Doctors hate paperwork and filling out forms, and just sometimes there’s boxes where they can do check-marks, and that’s not so bad...but usually additional details are needed, they should be writing in more, and they just don’t take the time to do that.

Legal representative 2 (O)

This example infers that physicians do not want to and will not spend time on disability income support forms.

Lacking time to deal with mental health problems

Some key informants spoke about time in relation to dealing with mental health problems. To them, physicians may be less willing to spend time on mental health problems than physical health problems.

...and then the other thing is, doctors are so busy. Even if patients try to talk to them [about their mental health problems], some doctors will say, well, one thing at a time. You came to me about your knee pain and I’m sending you to a specialist for that, but that’s it. I don’t want to talk to you about anything else.

Legal representative 2 (O)

The key informants spoke about this particular problem in relation to GPs (further discussed in the next section). Additionally, not all key informants agreed time was an issue. In contrast, Policy insider 18 (A) said:

Some reports are really thorough, and doctors obviously taken quite a lot of time to document what’s going on with the person.

While most key informants spoke about a lack of time leading to physicians being strict in their approach to disability income support applications, it could also lead to being lenient. If the physician does not have enough time (whether this lack of time is real or perceived), this could lead to a physician accepting a patient’s ‘performance’. Presumably, checking a patient’s ‘performance’ could be equally (or more) as time consuming as eliciting their true state of health.

Specialists being less influenced by non-clinical factors

Overall, the key informants spoke about how mental health specialists (e.g. psychiatrists or psychologists) are perceived as better suited to completing disability
income support forms than GPs. These perceptions were related to whether or not a certain type of physician is more likely to be affected by negative attitudes and beliefs or time pressures.

Advocate 3 (A) thought GPs were more likely to be affected by societal stigma than mental health specialists:

*But I mean there’s a general – and it depends how specialised the profession is I guess. But with the more generalist mental health practitioners, they’ll be very much affected by that sort of societal stigma.*

**Advocate 3 (A)**

In contrast, Physician 1 (A) thought specialists were more likely to be antagonistic towards welfare than GPs.

*Now within medicine, there are doctors who really are antagonistic to welfare support probably not as much now as then and I think (long pause)…I think the ways specialist[s] view this role of certifying disabilities and impairment is at quite a different level than a general practitioner would.*

Physician 1 (A) then said specialists had a reputation to uphold, whereas a GP is more likely to understand the environment and context of a person. In terms of time, the key informants perceived GPs as less suitable for filling out disability income support forms than mental health specialists.

*…well if I was talking about GPs, I don’t know that they would feel as though they have the time to tackle that [mental health issues]. You’re trying to process people in five to 10 minutes; the worst thing is when they tell you, I feel depressed or something or other.*

**Physician 9 (A)**

To Physician 9 (A), a specialist has more time to fill out the application, probably because mental health specialists allocate more time to see patients and deal with mental health problems. In Australia, a full psychiatric assessment takes a minimum of 45 minutes. Physician 4 (O) said having time is essential to adequately address a person’s mental health:

*One is that it [assessing a person’s mental health] takes time and physicians hate spending time on things, especially busy family physicians, especially when*
you need to take 30 or 45 minutes to really have a conversation to figure out what’s going on with your patient. You kind of get the sense that something’s wrong and something’s happening, but to really pinpoint down what is going on can take a lot of time to get a full sense – I mean, ODSP asks for a sense of someone’s ability to function in a wide range of areas, so to get a sense of that, you’ve really got to sit down and hear what someone’s story is and ask fairly specific questions around people’s functioning and their social realm, their work realm, their personal care realm, all these sort of things, and again, [a GP] may either not know how to ask those questions or not really want to take the time or be used to taking the time or have the skills to sort through that.

Physician 4 (O)

In the absence of diagnostic tests, physicians need to elicit a patient’s symptoms. The above quote provides an understanding of how this takes time. Physician 4 (O) suggests while time is one factor, GPs may not have the knowledge to adequately assess mental health issues.

While there was a debate about what type of physician was most suitable to complete disability income support forms for people with mental illness, the policy insiders definitely preferred specialists to GPs. To them, there was a concern that the patient-physician relationship would impact on the evidence provided by GPs.

So there was a strong sense of this is not an objective assessment that – you shouldn’t expect the treating doctor who may well have family and other relationship linkages with the person to provide you with a totally objective perspective.

Policy insider 20 (A)

While the perception among the policy insiders was that a GP was more likely to be affected by the patient-physician relationship, there is no indication why specialists would be any less affected by the patient-physician relationship.

Managing physicians making judgements

The key informants spoke about strategies that policy insiders and applicants use to manage the fact that physicians often make judgements about eligibility. This section
explores three of these strategies – not accepting evidence, not educating physicians about the program and shopping around for the right gatekeeper.

**Not accepting evidence**

The most discussed strategy was official gatekeepers ignoring physician’s evidence in their decision about an applicant’s eligibility. Table 18 summarises the key reasons provided by the key informants for employing this strategy.
<table>
<thead>
<tr>
<th>Reason</th>
<th>Description and supporting quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians being too lenient</td>
<td>Some key informants spoke about the perception among policy insiders that some physicians (especially GPs) may over-exaggerate their patient’s symptoms to get them onto disability income support.</td>
</tr>
<tr>
<td></td>
<td><em>There was a concern that they [physicians] were probably being overly generous [in the way they filled out DSP forms] ...[saying] this person should be on the pension ‘cause they can’t work ever again, thanks a lot, no.</em></td>
</tr>
<tr>
<td></td>
<td><strong>Policy insider 17 (A)</strong></td>
</tr>
<tr>
<td></td>
<td>An exception to this was when Physician 7 (A) said:</td>
</tr>
<tr>
<td></td>
<td><em>So we have a little bit of that, but we [physicians] don’t make the final decisions, and again I’ve seen things come back, and I’ve written some reports ‘cause I think it’s – I really don’t want this person on the DSP ‘cause I think it’s going to disable them and make things difficult, and they come back three weeks later and they’re on it.</em></td>
</tr>
<tr>
<td>Not accepting GPs’ evidence for conditions that lack diagnostic certainty</td>
<td>Some key informants spoke about the perception that GPs do not have the expertise to provide medical evidence for conditions like mental illness. GPs providing evidence for conditions with objective tests appeared more acceptable. Physician 4 (O) spoke a lot about how he thinks mental illness is perceived differently to physical illness.</td>
</tr>
<tr>
<td></td>
<td><em>I have easily enough experience and expertise on this to be able to represent their situation, as I would if they had cancer or some other condition, which the DAU [Disability Adjudication Unit] would probably accept from me. But they have their own biases around this [mental illness], and I’m not entirely sure why.</em></td>
</tr>
<tr>
<td></td>
<td><strong>Physician 4 (O)</strong></td>
</tr>
<tr>
<td>Wanting specialists to verify mental illness</td>
<td>The key informants spoke about the perception that evidence from specialists is more reliable for disability income support applications, especially for applicants with mental illness.</td>
</tr>
<tr>
<td></td>
<td><em>So they were good at diagnosing conditions and telling about the prognosis but really, particularly GPs, if you’re in a practice and you’re just doing your day-to-day work, there was a view that they weren’t the people that was best — would have the best knowledge about whether or not people with disability could work.</em></td>
</tr>
<tr>
<td></td>
<td><strong>Policy insider 17 (A)</strong></td>
</tr>
<tr>
<td></td>
<td><em>The thing is that we [psychiatrists] have a much higher success rate...I don’t think I have ever been declined when I write a letter and I know that a lot of time my patients have been declined before when their family doctor wrote the letter...completed the form. Now maybe it is that they don’t know how to do the form, I shouldn’t necessarily jump to the conclusion that they prefer psychiatrists but this is what I’m understanding from my family physician colleagues, that they have several of their referrals turned down or returned for more documentation.</em></td>
</tr>
<tr>
<td></td>
<td><strong>Physician 5 (O)</strong></td>
</tr>
</tbody>
</table>
Some of the policy insiders spoke about the circumstances when they would (and do) accept evidence from physicians other than specialists, especially in the case of mental illness.

*Well, GPs can be [the appropriate person to provide evidence] if they’re the only medical professional around. So you might have situations in remote [access], where there is no visiting specialist, and someone’s been assessed by a specialist three years beforehand, their treatment is managed by, sometimes a community nurse, sometimes by a GP.*

**Policy insider 18 (A)**

In this example, evidence from a GP or nurse is acceptable but only because the diagnosis was made by a specialist and because specialists are not around. Policy insider 18 (A) also said if a GP had specific mental health training then their evidence would be acceptable. Policy insider 18 (A) provided one rationale as to why specialists are preferred:

*And there’s really good policy reasons for that [wanting a clinical psychologist to diagnose over a GP], and in fact during the development of the Impairment Tables, it’s not the only area in which you need a specialist. It’s one of those things where you would assume that someone who is so severely impaired that they cannot work, would get some kind of specialist support, and or specialist diagnosis, or specialist treatment, so that they had the greatest chance of living at their capacity.*

**Policy insider 18 (A)**

To many of the key informants, especially the physicians, the policy insiders not accepting evidence from GPs in regard to mental illness was problematic due to the lack of access to mental health specialists.

*So the fact that you have to get a doctor’s certificate, and most of the people who try to get ODSP...for their mental health problems are not being seen by a psychiatrist is something that can be problematic.*

**Physician 6 (O)**
It is very hard to get mental health services, particularly access to a psychiatrist, unless you are acutely suicidal or acutely psychotic or unless you have money.

Physician 10 (A)

So while Policy insider 18 (A) viewed not seeing a specialist as a sign of a milder disability, many of the physicians viewed it as an issue of accessibility.

Not educating physicians about the program

[Physicians] Probably [know] some of the basics [about the program]...but you don’t necessarily want to have a program that is so well known that they know what responses are really important. I mean, to some extent you’re wanting to get objective information, so part of the challenge is actually getting that from them. No more, no less.

Policy insider 20 (A)

In this quote, Policy insider 20 (A) implies that not educating physicians about the program could prevent physicians from manipulating the forms to achieve a certain outcome. While no other key informants spoke explicitly about this strategy, many of the physicians noted a lack of understanding of the program.

I have never seen any materials [from Centrelink] like that [when there are changes to the Disability Support Pension]; all I have ever seen is the form.

Physician 10 (A)

Physician 6 (O) said he was not sure physicians had a good understanding of the program because no one was talking about it in their professional circle.

In contrast to Policy insider 20 (A), Policy insider 9 (O) said that a lot of information has been provided to physicians about how to fill the forms:

So the Ministry [of Community and Social Services] is aware of the difficulties that health care professionals [have], but mostly doctors, have an understanding [of] what ODSP is, how to complete the forms, like I don’t know how much messaging you can do to state “fill it out fulsome, give information, attach those reports, give us that information to help make an informed decision and help your client too”.

Policy insider 9 (O)
To this policy insider, physicians’ lack of understanding is about not using the information that government departments provide.

**Shopping around for the right gatekeeper**

Physician 7 (A) spoke about one way applicants can manage a strict physician under the Australian system – by shopping around for a less strict physician.

*Here, of course, you can go and see a GP, and if you don’t like what that GP does, you can literally walk down the road immediately to go and see somebody else, and sit in their waiting room. And because of these large medical centres, which don’t have a practice list, as long as you’re prepared to wait you’ll see a GP.*

However this is less of an option in Ontario, where patients are tied to a general practice.

**Similarities and differences between Australia and Ontario**

Most of the Australian and Ontarian key informants spoke about making judgements about their patients in a similar way. However in Australia, applicants are able to shop around until they find a lenient physician. Another key difference was that Policy insider 20 (A) said *not* educating physicians was a strategy in Australia, whereas Policy insider 9 (O) said educating physicians was a strategy in Ontario.

**Similarities and differences between the key informants**

Most key informants perceived that physicians’ judgements about their patients’ eligibility for disability income support are partially based on non-clinical factors, specifically relying on negative attitudes and beliefs about disability income support and mental illness.

Perceptions about GPs differed among the key informants. Many of the policy insiders considered GPs to be too lenient. In the policy insiders’ opinion, the patient-physician relationship is more likely to interfere with them providing objective evidence. On the other hand, many physicians considered GPs as being too strict because of a lack of time to deal with mental health issues and in some instances, a lack of understanding.
Perceptions of the leniency or strictness of physicians differed. To many policy insiders, a strict physician was perceived positively because those physicians were preventing people gaining access to disability income support, whereas a lenient physician was perceived negatively as they were trying to get people onto the program. However, other key informants’ perceptions were the inverse of the policy insiders. To these key informants, gaining access to disability income support was perceived positively and therefore so were physicians who tried to get their patients onto disability income support.

**Summary**

In summary, this chapter explored how physicians perceived themselves as gatekeepers, despite not having authority to grant disability income support payments. The lack of objective tests available for conditions such as mental illness provides physicians with significant leeway in how they complete disability income support forms. In addition, a physician’s negative attitudes and beliefs as well as a perceived lack of time partially contributes to how a physician chooses to complete these forms. Policy insiders have responded to physicians making judgements about eligibility by sometimes rejecting evidence or not educating physicians about disability income support programs. In Australia, patients have responded by shopping around for physicians that are more lenient. The patient’s ‘performance’ in this process was briefly introduced in this chapter. The following chapter expands on the key informants’ perception of this concept.
CHAPTER VIII: EXPECTING APPLICANTS TO ‘PERFORM’ THEIR ILLNESS

What the assessment processes are usually like across the board is: prove to me why I should give you money and...you have to basically create the case for yourself that you, you are unable to work now and probably won’t be able to work.

Researcher 1 (O)

Expecting applicants to ‘perform’ is another concept that emerged during analysis. It is about the gatekeepers not trusting an applicant to present their symptoms in a truthful manner. In this instance, ‘performing’ is how an applicant chooses to display their illness to the gatekeepers. The concept of ‘performing’ has been chosen because there is a perception among many of the key informants that people with certain types of disabilities (e.g. those that do not fit the ‘ideal type’ – see Chapter IX for more) can exercise control over how they present their symptoms and associated impairment. This chapter explores the key informants’ perceptions of the following:

- how an applicant could ‘perform’ their illness – focusing on exaggerating symptoms or down-playing symptoms;
- reasons why an applicant would ‘perform’ their illness; and
- consequences of ‘performing’.

The chapter concludes with a brief summary of the similarities and differences between Australia and Ontario as well as the key informants.

‘Performing’ an illness is most relevant for illnesses that are invisible and lack diagnostic certainty such as many mental illnesses. ‘Performing’ is one way an applicant could influence gatekeepers accurately identifying who is suitable for the program.

Exaggerating symptoms

Many key informants were concerned that a person with mild symptoms of a mental illness may “exaggerate” symptoms to appear more disabled than they actually are (Policy insider 12 (A)). When the key informants spoke about exaggerating symptoms they referred to applicants with mental illness but also those with chronic pain or musculoskeletal conditions. The unifying features of these illnesses are invisibility,
being episodic in nature, and very few have diagnostics tests available to objectively confirm their illness. In other words, these illnesses have the features of an imperfect disability (Chapter IX provides further explanation of an imperfect disability). The key informants gave different reasons for why an applicant might choose to exaggerate their symptoms, which are explained below.

**Wanting a higher payment**

Policy insider 20 (A) called the disability income support the “gold card” of income support payments. Disability income support often includes better health benefits and requires fewer, or in Ontario no, work obligations than a general welfare benefit. In addition, the recipient receives more money than a general welfare benefit. Many key informants spoke of suspicion among some of the policy insiders and physicians that a person could ‘overdo’ the degree of their disability as a way to gain access to this “gold card” payment. Table 19 provides a comparison of disability income support benefits, general welfare benefits and the poverty line in Australia and Ontario.

A poverty line can be defined as “an income level that is considered minimally sufficient to sustain a family in terms of food, housing, clothing, medical needs, and so on” (OECD 2005).

**Table 19 – Comparison of disability income support and general welfare benefit payments in Australia and Ontario**

<table>
<thead>
<tr>
<th></th>
<th>Australia</th>
<th>Ontario</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Poverty line</strong></td>
<td>$37,500</td>
<td>$36,600</td>
</tr>
<tr>
<td><strong>Disability income support benefit</strong></td>
<td>$20,200</td>
<td>$12,800</td>
</tr>
<tr>
<td><strong>General welfare benefit</strong></td>
<td>$13,400</td>
<td>$7,400</td>
</tr>
</tbody>
</table>

Note: Amounts are annual and in Australian dollars. Benefit rates as at 15 October 2014.

33 A general welfare benefit is a main benefit payment of last resort provided by the government for those that are unemployed. In Australia and Ontario, this payment is meant to be temporary until the recipient finds employment. In Australia, the payment is called Newstart Allowance and in Ontario, the payment is called Ontario Works.

34 Australia and Ontario do not have official poverty lines, therefore the Organisation for Economic Co-operation and Development (OECD) measure (50 per cent of the current median income) was used to estimate a poverty line (OECD 2010c). It should be noted that the OECD measure is considered a conservative measurement of the poverty line.

35 Welfare benefits are complicated and rates and additional benefits often vary (e.g. based on number of children, age, etc.). As such, the example of an adult single person was used. This composite was used as most disability-related welfare recipients are single (MCSS 2011b: 11; DSS 2013: 14). This allows assessment of each jurisdiction’s main income support benefit rather than additional benefits that may be provided due to age or number of children. All benefit rates were current as of 15 October 2014.
Table 19 demonstrates that both types of payments in Australia and Ontario are well below the poverty line, meaning that recipients of these payments may not be able to afford basic needs such as food and shelter.

According to many of the policy insiders, the difference between these payments was the primary perceived incentive leading an applicant to exaggerate their degree of disability or impairment. Policy insider 11 (O) provides an explanation:

...it’s depressing to be unemployed and bummed about experiencing that degree of poverty...and then they have an opportunity, if you will, to become even more disabled and apply to ODSP where they can literally double their income support...because our ODSP program is literally double...now and that is a pretty powerful motivator for someone who is poor and struggling with employment and may have...mental illness.

This quote suggests that the applicant is applying for disability income support not because their mental illness impairs function, but because the applicant is “bummed” about their situation and is seeking more money. Policy insider 11 (O), noting that the applicant has an opportunity to become ‘more’ disabled, implies the applicant has agency over their disability. Overall, the lack of diagnostic ‘objectivity’ related to illnesses like depression seems to create suspicion that a person applying with a mental illness is not applying for reasons of genuine disability (lack of ‘objective’ evidence is further explored in Chapter IX). The key informants discussed this more in relation to depression and anxiety than schizophrenia. An exception to this view, was noted by Physician 6 (O), who said in his experience it is easier for ODSP adjudicators to understand the symptoms related to depression in relation to being unable to work than psychosis.

**Wanting validation that their illness is legitimate**

The key informants spoke about how being deemed eligible for disability income support is one way of validating that a person has a legitimate disability (Policy insider 4 (A)) and exaggerating symptoms is one way to get this validation. Policy insider 4 (A) said the DSP in Australia was one of the few ways to get a:

...formal acknowledgement that you have a capital D for disability.
Policy insider 19 (A) also perceived that disability income support could be one way a person could gain recognition for their impairment. Policy insider 19 (A) also said an applicant may feel the program has invalidated their disability if their application is rejected. To them, the challenge was to validate a person’s ability, not their disability.

Physician 9 (A) spoke about the physician’s role in validating a person’s disability. The key informant gave an example when their diagnosis conflicted with another physician’s diagnosis. Physician 9 (A) said that their patient said:

“... you don’t know how bad I feel or I can’t do that [work], I’m sick, don’t you understand, the other doctor said I was depressed or I had a mental illness, you’re invalidating [my illness]” – well they don’t use that word [invalidating] but they feel I’m invalidating them.

This quote implies that applicants may ‘perform’ for all types of gatekeepers, in order to receive validation for their disability.

**Getting out of the paid work role**

Some of the key informants said that exaggerating symptoms was about avoiding having to work, especially for applicants who may not be in satisfying jobs or are unemployable.\(^{36}\) Physician 6 (O) explained the importance of the work role:

>You have all of these different roles...So what’s happened over time is we’ve shrunk those roles and we’ve said the most important role that you have is the work role, and the problem with that is that then people get caught with their biggest role being something that isn’t necessarily the most satisfying thing in their life ’cause everybody isn’t going to be the boss and some people are going to be doing jobs that they don’t particularly like...

Physician 9 (A) made a similar point by discussing Parsons’ notion of the sick role,\(^{37}\) noting that the person in the sick role is exempt from his or her normal roles including working.

>Whereas we have this sort of sick role that exempts people from everything.

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\(^{36}\) In this instance, a person may be considered unemployable if they lack the skills or experience to obtain work.

\(^{37}\) The sick role is a concept developed by medical sociologist, Talcott Parsons. Parsons purported that those who are ill enter into a position of “sanctioned deviance” and with this role comes certain rights and obligations including: the person is not responsible for assuming this role; the person is exempt from normal social duties (e.g. work, family); the person must try to get well and the person must seek medical care (Parsons 1951).
To them, this looked like another incentive for an applicant to overdo their symptoms to get onto disability income support. Policy insider 19 (A) spoke about this in a different way. To them, it was not about getting out of the work role but about maintaining a person’s work identity.

...they [men who were labourers] saw themselves as their family’s main support, so they needed to get a [disability support] pension, because that’s the only way they could stay as the breadwinner.

Policy insider 19 (A)

In other words, being on disability income support is seen by some as a legitimate way to maintain a family’s income.

Overall the key informants did not deny that a person may have a mental illness, but rather inferred that many mental illnesses were mild, could be overcome and should not impair capacity to work sufficiently to meet the definition of disability used for disability income support.

**Downplaying symptoms**

Not all of the key informants spoke about applicants “overdoing” their disability. A few of the key informants spoke about how a person could downplay their symptoms. Policy insider 9 (O) said:

...the flip side of it, sometimes applicants don’t want all the information especially around mental health issues, sometimes they don’t want things put on their forms...[and]...it’s only so much as an applicant wants to present or have presented...

Policy insider 18 (A) provided an example of how a person could downplay their symptoms:

So – you see it sometimes with people with [an] intellectual disability. They desperately want to please the interviewer, and so – or acquired brain injury is the other one. Desperately want to please the interviewer. [Assessor asks] “Do you have any problems with this?” [Applicant replies] “No”. [Assessor asks] “Do you have any problems with that?” [Applicant replies] “No. No, I drive my car”. [Assessor asks] “Do you have a license?” [Applicant replies] “Ah, not so much. Don’t tell my doctor I drive my car”.
Table 20 provides reasons the key informants gave to explain why a person might conceal their disability:

### Table 20 – Reasons for why an applicant may conceal their disability as described by the key informants

<table>
<thead>
<tr>
<th>Reasons</th>
<th>Supporting quotes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not wanting to bring shame upon their family or community</td>
<td>There’s lots of shame about disability in many cultures, so often, there’s under-reporting in disability in some cultures, because of the shame and that’s European cultures as well…. And that’s what – they often want to conform to meet what the government wants too, and not bring shame on their community…And indigenous people often feel they don’t want to bring shame on their culture or their community, and there’s a whole lot of issues. So, yeah, people often have a perspective that some cultures are out to gain the most, when in fact, the opposite sometimes happens.</td>
</tr>
<tr>
<td></td>
<td>Policy insider 19 (A)</td>
</tr>
<tr>
<td>Not challenging authorities</td>
<td>So – and particularly refugees, they’ve come from pretty different cultures, you’re meant to do the right thing with the authorities and not challenge them.</td>
</tr>
<tr>
<td></td>
<td>Policy insider 19 (A)</td>
</tr>
<tr>
<td>Concealing mental illness (especially in rural areas)</td>
<td>You’re visible. You go to a – well, if there is a service in town, everyone knows who is going in and out, absolutely.</td>
</tr>
<tr>
<td></td>
<td>Policy insider 19 (A)</td>
</tr>
<tr>
<td>Not wanting government help</td>
<td>In some cases they’re like, “I don’t want any help from the government. I don’t want any medication. I don’t want any counselling support. I don’t really want to do anything”.</td>
</tr>
<tr>
<td></td>
<td>Policy insider 18 (A)</td>
</tr>
<tr>
<td>Lacking awareness about their illness</td>
<td>I’ve seen cases where applicants have written saying their health care professional is a liar, that they don’t have these conditions and whatever and it just shows they have – obviously they’re having more issues or in denial or whatever.</td>
</tr>
<tr>
<td></td>
<td>Policy insider 9 (O)</td>
</tr>
</tbody>
</table>

As Table 20 illustrates, only a few key informants discussed downplaying symptoms. However the table demonstrates that there are many reasons why a person may not disclose their illness. Many of the reasons were either culturally related (e.g. not wanting to bring shame onto their community or challenging authorities) or about applicants not having awareness about their condition. Regardless of whether an applicant exaggerates or downplays their mental illness, there seems to be an implication that they have control over how they present their symptoms.

The key informants noted several consequences of a person ‘performing’ a disability. Consequences related to exaggerating their symptoms included: being condemned to a lifetime on the disability income support payment; and applicants redefining
themselves as severely disabled. The consequences related to downplaying their symptoms included not getting access to income support. As the latter consequence is self-explanatory, the next section explores the perceived consequences of an applicant exaggerating symptoms.

**Being ‘condemned’ to a life on disability income support**

One concern among the key informants was that a person could be “condemning” himself or herself to a lifetime on disability income support (Policy insider 14 (A)). As Policy insider 18 (A) said:

*You don’t want to put someone in a category of impairment that doesn’t represent where they really are, because that actually gives them a much worse outcome than they would’ve otherwise had.*

In this instance, Policy insider 18 (A) was referring to putting a person who has exaggerated their symptoms in order to get onto disability income support. To her, such a person could miss out on engaging or re-engaging with the workforce.

Policy insider 4 (A) explained that one of the biggest problems with putting someone who did not require disability income support on the program is:

*...once they ‘crossed the line’ we have typically left them alone.*

As Policy insider 20 (A) noted, the typical reason for exiting the program is death or going onto the Age Pension. As such, a sense of responsibility settles on the policy insiders to make sure people legitimately need the payment, and as a result, are not unnecessarily ‘condemning’ an applicant to such a path. In this regard, there was special concern about younger applicants. For example, Policy insider 19 (A) said:

*...it is a real worry if you think that someone of 30 goes onto a DSP and could be on it for 30 years.*

There is also the possibility of ‘set and forget’ (Policy insider 21 (A)) – which means that some people go onto disability income support and are assumed to be disabled and incapable for life. Some key informants doubted the likelihood of disability income support applicants returning to the labour force after time on the payment. For example, Policy insider 17 (A) said that people on the payment for more than a couple of years are unlikely to get back into the workforce because they resign “themselves to being disabled”.

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Redefining yourself as disabled/Believing your symptoms are permanent

Some key informants were also concerned that the system is designed so that a person constantly has to prove his or her symptoms, leading the person to believe the symptoms are permanent. Researcher 2 (O) explained this problem and how it follows from the way the policy has been designed:

*But what I actually find almost more problematic about the entry is that this is where folks really start to redefine themselves as incapable, as unable to work, because they’re forced to prove it over and over and to tell so many different people how incapable that they are that they really start internalizing this idea of you know, my condition means that I cannot be employed. That I am unemployable and it really starts breaking people at a personal degree.*

Having to repeatedly ‘prove’ your disability is particularly pertinent in an environment where policy insiders want to be sure an applicant has more than a mild impairment. Again, this seems to a particular concern for people with mental illness, Researcher 3 (O) provides the following explanation:

*…ʹcause people are constantly reconciling that… almost like proving I’m... really sick…this is a legitimate illness...*

The more that a person has to prove their illness, the more it may lead to a person thinking of themselves as incapable thus becoming a permanent part of their “identity (Policy insider 18 (A)). The researchers, in particular, were concerned that people redefining themselves in this way could reduce their chance of recovery and enablement.

**Similarities and differences between Australia and Ontario**

The biggest difference between the two settings was the stage in the process at which the applicant may ‘perform’. In Australia, the applicant has the opportunity to ‘perform’ in the initial adjudication. In Ontario, this opportunity is not available because the application process is paper-based. However the Ontarian key informants spoke about an applicant ‘performing’ in relation to the appeal process (Policy insider 9 (O)). In this situation, the applicant is ‘performing’ for judicial gatekeepers.
The reasons given for why a person might choose to ‘perform’ were similar in both places and the most discussed reason in both was that the person was seeking a higher welfare payment. However there was one variation – people’s desire to have their disability validated was only discussed by Australian key informants. While it cannot be known that Ontarian applicants are not also seeking validation for their disability, the Ontarian key informants do not perceive this as a great motivator for ‘performing’ an illness.

**Similarities and differences between the key informants**

The researchers spoke differently about ‘performing’ an illness than the other key informants. To them, the process itself could be forcing a person to ‘perform’ their illness and more importantly could be making a person’s condition worse. This is a significant difference – while the other key informants spoke more about applicants ‘performing’ an illness because of certain motivators, the alternative view is that people are responding to the adjudication process.

**Summary**

In summary, ‘performing’ an illness in both settings was mostly perceived to be a case of exaggerating symptoms rather than downplaying symptoms when applying for disability income support. This is largely due to the perception among the key informants that applicants are seeking higher welfare payments. Some key informants also perceived the consequences of putting a person on disability income support if they did not require it to be quite significant. On the other hand, the consequences of not putting a person in disability income support if they did require it appeared to be less of a concern. The following chapter explores a tool that gatekeepers use to distinguish between those who do and do not require disability income support: the concept of an ‘ideal type’ of disability.
CHAPTER VIII: CREATING AN ‘IDEAL TYPE’ OF DISABILITY

But people with genuine disabilities, the public will play with, what is a disability? ... And so there’ll be certain categories that will be more deserving than others in the public’s eye.

Policy insider 16 (A)

So who is the suitable person for disability income support and how are they identified? When asked to explain who the suitable person is, Policy insider 9 (O) said:

Who is the right person? Everyone has [a] different perspective here of who is the right person... I have my beliefs, I know my colleagues, they have their beliefs too, so yeah. Taxpayers do [have their own beliefs] [laughs].

The key informants spoke about characteristics related to a person’s disability that could help identify whether the person is the suitable for the program. This concept has been labelled an ‘ideal type’ (Weber 1949) of disability and is an example of an informal tool used by gatekeepers. The key informants also spoke about characteristics that lead a gatekeeper to question the legitimacy of a person’s disability. This concept has been labelled an imperfect disability. Table 21 summarises the key characteristics of an ‘ideal type’ versus an imperfect type of disability. This chapter explores the key informants’ perceptions of the following:

- features of an ‘ideal type’ of disability;
- mental illness deviating from the ‘ideal type’ of disability; and
- alternative perspectives on the ‘ideal type’ of disability.

The chapter then briefly summarises the similarities and differences between Australia and Ontario as well as the key informants.

<table>
<thead>
<tr>
<th>‘Ideal type’</th>
<th>Imperfect</th>
</tr>
</thead>
<tbody>
<tr>
<td>Visible</td>
<td>Invisible</td>
</tr>
<tr>
<td>Clear proof</td>
<td>Questionable proof</td>
</tr>
<tr>
<td>Permanent</td>
<td>Temporary</td>
</tr>
<tr>
<td>Easily recognisable as a medical illness</td>
<td>An ill-defined medical illness</td>
</tr>
<tr>
<td>Externally caused</td>
<td>Caused by the applicant</td>
</tr>
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</table>

Table 21 – Features of an ‘ideal type’ versus imperfect disability
Features of an ‘ideal type’ of disability

Table 22 defines each of the different features of an ‘ideal type’ of disability illustrated by quotes from the key informants.

Table 22 – Features and supporting quotes of an ‘ideal type’ of disability as described by the key informants

<table>
<thead>
<tr>
<th>Features</th>
<th>Explanation and supporting quotes</th>
</tr>
</thead>
</table>
| Visible  | A visible disability typically alters the physical appearance of the person with the disability so that it is easily recognised or acknowledged by others.  
  *You know there are very-very strong views out in the public about people on welfare and people with disabilities. Unless it is a very severe disability that people can see with their own eye, I think there continue[s] to be a sense that we have got people on the programs [ODSP] who could, would, should…be working and so there is not a huge amount of public sympathy.*  
  **Policy insider 7 (O)** |
| Clear proof | Clear proof means that a person can provide diagnostic evidence (e.g. blood tests or x-rays) to prove an illness meets the threshold of impairment.  
  *Well we [psychiatrists] don’t have tests like they do in the general hospital in the same way, blood tests for many things…for schizophrenia, there’s no sort of reliable test. I suppose you have rating scales but there’s no objective gold standard like there is in many physical conditions in general medicine.*  
  **Physician 9 (A)** |
| Permanent | A permanent disability is one that is perceived to last and/or have little chance of improvement.  
  *…you know from the public’s point of view… I think their assessment was, there is something quite different between someone who has got paraplegia, quadriplegia, severe developmental delay versus someone who has drug and alcohol dependence…and with you know their view is that with treatment it can be resolved and the person can go to work…*  
  **Policy insider 7 (O)** |
| Easily recognisable as a medical illness | Having an easily recognisable medical illness is about the gatekeeper relating the disability or impairment experienced by the applicant to the medical illness instead of other factors (e.g. social, economic, personal).  
  *…I think there’s something underlying now that’s saying we don’t really believe that this [mental illness] is as clearly a biomedical illness as something else.*  
  **Physician 4 (O)** |
| Externally caused | A disability being externally caused is about the gatekeeper perceiving the applicant as not responsible for his/her disability or impairment.  
  *So, I think, you have got physical problems. Then below that you have got mental health problems and then the really poor cousin is the drug and alcohol problems, because everyone figures it is their fault, anyway.*  
  **Physician 10 (A)** |

The concept of the ‘ideal type’ of disability emerged as the key informants spoke about the features listed in Table 22. To the key informants, these features indicate whether an applicant is suitable for disability income support. When asked directly if there was an ‘ideal type’ of disability, Legal representative 1 (O) said:
Well sure ‘cause it’s a disability that’s easy to document. Clear diagnosis, clear prognosis and medical evidence, diagnostics, tests that can confirm all of that and everybody’s familiar with and recognises it. So it’s the person in the wheelchair. The person in the scooter. The person with a severe physical and obvious physical disability.

This quote summarises what the features in the table imply – that an ‘ideal type’ of disability is physical. Many of these quotes are describing the features in relation to physical illnesses. As Physician 9 (A) said:

...many people are equating mental illnesses with physical illnesses very directly.

In fact many of the quotes in the table describe how a mental illness is not an ‘ideal type’ of disability by juxtaposing the features of a mental illness against a physical illness, such as when Researcher 3 (O) said:

I think the trajectory of a mental illness, it being episodic, it being unpredictable and it being associated with a lot of stigma, makes it more complex,... Whereas somebody who...has something like paraplegia or something that’s a little more concrete, it’s a bit – someone who’s blind even, it’s a bit clearer.

This provides an example of a disability (mental illness) deviating from the ‘ideal type’ of disability (paraplegia or blindness).

**Mental illness deviating from the ‘ideal type’ of disability**

As with the above example from Researcher 3 (O), many characteristics of mental illness do not correspond with the features of an ‘ideal type’ of disability. Instead, many mental illnesses have features of what has been labelled in this thesis as an imperfect disability. A summary of these features is provided in Table 23.
Table 23 – Features and supporting quotes of an imperfect disability as described by the key informants

<table>
<thead>
<tr>
<th>Feature</th>
<th>Explanation and supporting quotes</th>
</tr>
</thead>
</table>
| Invisible        | An invisible disability does not typically alter the physical appearance of the person with the disability so it is not easily recognised or acknowledged by others.  
...there’s still much more stigma around mental illness ...than there is around physical disability there’s...the invisible disability component... |
| Questionable     | Many mental illnesses are defined by their symptoms. There are no objective tests to provide a definitive diagnosis. The diagnosis and level of impairment is largely reliant on an individual’s explanation of their symptoms and a clinician recognising signs of impairment.  
They [policy insiders] may see mental illness as a greyer area for diagnosis right. They don’t get blood test results or imaging results that prove (emphasis) that someone has a mental illness. |
| Temporary        | Many key informants spoke about different ways that a person with a mental illness is expected to overcome their disability and therefore are not perceived as having permanent disabilities.  
By getting treatment  
...it’s hard to imagine (laughs) a person with substantial neurosis or anxiety qualifying under a 10-year rule... it is a treatable condition... |
| Pulling yourself up by your bootstraps | Four key informants used this phrase. Researcher 2 (O) provides a definition:  
...pulling yourself up by your boot straps...its become this idea of something that you should (emphasis) be able to do...through hard work...through hard work you should be able to do the impossible. |
| Not easily recognised as a medical illness | Not having an easily recognisable medical illness is about the gatekeeper relating the disability or impairment experienced by the applicant to the other factors (e.g. social, economic, personal) instead of the person’s medical illness.  
So although people manifest with a disability when they claim DSP, it’s actually often not the thing, which is really important for their income support history. |
| Caused by the applicant | This centres on the perception that an applicant is responsible for his or her illness.  
The key informants spoke about this particularly in regard to addiction and mood disorders (i.e. depression and anxiety).  
Because it’s [addiction] about fault, in the public’s eyes...  
...people...who use or abuse substances aren’t taking personal responsibility, and if they only would take personal responsibility for their issues they wouldn’t be using substances and they would be working, right...from a social policy perspective, addiction isn’t a legitimate disability. |
It should be noted that the features listed in Table 2 (p. 119) and Table 3 (p. 121) are examples of attitudes and beliefs, not objective evidence about disabilities. Policy insider 20 (A) confirmed this notion when he said:

_All sorts of different conditions, different social perspectives and individuals, even though they’re [adjudicators] trained in somewhat consistent ways, they’re still going to make judgements themselves. And those judgements I think are going to be influenced by their own personal values, some of the other things that come to bear as well as looking at the guidelines._

As such, creating an ‘ideal type’ of disability is one way that adjudicators can make these judgements.

**Alternative perspectives on the ‘ideal type’ of disability**

While most features described in Table 3 (p. 119) relate to mental illness, implying that mental illness is an imperfect disability, some key informants provided an alternative perspective, arguing that mental illness can be an ‘ideal type’ of disability and physical illness can be an imperfect type of disability.

**Some mental illnesses have features of an ‘ideal type’ of disability**

Some mental illnesses, particularly those perceived as severe, meet some of the characteristics of an ‘ideal type’ of disability. For example, not all key informants, especially the physicians, agreed that all mental illnesses were invisible. Physician 2 (O) noted a person’s “pride of appearance” could be affected in extreme cases. Physician 2 (O) and Physician 9 (A) gave examples of a person with schizophrenia and a person with alcohol addiction who had stopped washing and grooming themselves. Others similarly affected may not have proper clothes to make themselves presentable\(^{38}\) for work (Physician 2 (O)). In these cases, a person would not be considered to be ‘faking’ their impairment because the decline in their appearance provides a visual sign of their illness – a characteristic of an ‘ideal type’ of disability.

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\(^{38}\) It should be noted that these visual manifestations of the mental illness were not ‘conscious performances’ – i.e. they were not perceived as ‘putting it on’ in order to gain disability income support. Rather, it was simply a result of the severity of their impairment.
Physician 2 (O) also noted that certain tests for alcohol addiction could provide clear proof.

*And then there are other things one can do for alcohol, especially; you can do certain blood tests and physical exams, which will show the effects of alcohol on people. Liver function tests, as I mentioned. Even red blood cell size and, I suppose, which I think is crazy, you could do certain psychometric tests which I think are a complete waste of money…and it’s of no benefit to the individual, it’s only done to accelerate their case through the system.*

Physician 2 (O) noted that while these tests are not necessary for diagnosis in the clinical world, in their experience they prove useful for supporting disability income support applications. Physician 8 (A) noted that:

*At the more severe end, there are disability measures that are reasonably objective and repeatable and measurable. So things like…days spent in [hospital] bed. So there are instruments available that people can use to get self-report measures out of patients that have those relatively hard measures of disability.*

These tests are one way to confirm a patient’s ‘performance’. Many of the key informants cited schizophrenia as an example of a mental illness that has features of an ‘ideal type’ of disability. However, Physician 8 (A) notes:

*Now if you look at schizophrenia, people tend to view that as a terrible negative illness and they forget that a fifth of the people have a single episode of psychosis and get better and recover and about three fifths have a more chronic relapsing illness but may do reasonably well, and that only a fifth really do very badly. So again, the fifth that do very badly tend to fill the public hospital beds and so people become sensitised to that stereotypical person with schizophrenia, when, in fact, it’s the poorest prognosis 20 per cent.*

This quote highlights that there is a continuum of mental illness and assessment of the impairment should not be based solely on the diagnosis.

**Some physical illnesses have features of an imperfect disability**

On the other hand, some of the physicians debated if clear proof (or ‘objective’ evidence) exists for any disability. Physician 3 (O) and Physician 7 (A) did not think
providing evidence for a person with mental illness was any less ‘objective’ than providing evidence for other illnesses. For example, Physician 3 (O) spoke about creating thresholds or cut-offs for illnesses like morbid obesity and diabetes, noting that thresholds for these illnesses are set by coming up with criteria agreed upon by consensus, not on some clinical “gold” standard. Physician 7 (A) supported this viewpoint saying they do not: 

...buy the objectivity, subjectivity part.

Physician 7 (A) provided an example of reading two orthopaedic surgeons’ reports conducted on the same person within the same week, one surgeon rating the patient at 0 per cent whole person impairment, the other at 19 per cent. This example demonstrates even when ‘objective’ tests like “goniometers” are available there is no consensus on degree of impairment. On the other hand, Physician 4 (O) said providing the type of evidence expected by assessors was more difficult for mental illness.

I mean, the objective evidence is someone’s story and whether or not it fits together into a coherent piece that I can fit it into a diagnosis, although diagnostic categories are not necessarily gold standards. I mean, so really what they [assessors] should be looking at is probably functional abilities more than anything. And, I guess, we [physicians] try and represent that as well, but my sense is that they [assessors] want someone to definitively say, this person has this diagnosis to this degree of severity according to this checklist, which can be very hard to do when it comes to mental health.

Physician 4 (O)

This quote is about what policy insiders perceive as objective evidence rather than the sort of evidence available for a person with a mental illness. Physician 4 (O)’s quote demonstrates that mental illness does not tick the boxes of the “checklist” wanted by policy insiders.

Regardless of the perspective, what remained unclear was if there was a hierarchy to these features or whether a certain number of features were needed before a disability was considered an ‘ideal type’. Also, not having features of an ‘ideal type’ of

39 Goniometers test the measurement of angles made by joints (e.g. knees, elbows, hips) (Norkin and White 2009: 3).
disability does not necessarily mean that an applicant does not get onto the program. Rather it could help explain why there is a perception that the program is not capturing the suitable sort of people (see Chapter X – Discussion for further explanation).

**Ignoring the social determinants of health**

Many of the reasons that a mental illness is considered an imperfect disability could be explained by the fact that the social determinants of health are often ignored in disability income support design. As discussed in Chapter V, many of the policy insiders are adamant that social factors are not relevant in determining disability income support eligibility. To them, these factors are not related to medical diagnosis and therefore should not contribute to decisions about how a disability might affect a person’s functionality. However some of the other key informants disagreed and spoke about how these factors are relevant, especially for a person with a mental illness. For example, Policy insider 19 (A) and Physician 1 (A) noted that many people with a mental illness who are also in need of disability income support may have other issues that need to be addressed before work is a possibility. For example, Policy insider 19 (A) said:

...at least if they had income support, they can maybe get housing and maybe they can get support, then maybe work 10 years down the track or five years down the track.

While Physician 1 (A) said:

...the assumption in the system is they’ll get better...which people can do...but by the time they’ve reached this end point that....we are discussing...you know it’s a fantasy to think that things are gonna change much...

To reiterate, disability income support is a payment of last resort, and these quotes further illustrate the precarious economic and social situation of many disability income support applicants. Physician 8 (A) described the domino effect that having a mental illness can have on a person:

But if you’ve got mental illness and severe substance problems you can become homeless. And once you become homeless, all the dominoes start to fall. You haven’t got a mailing address, it’s harder to get the access to information, if
you were able to work you can’t field job offers, you’re much more likely to get a physical health problem, you’re more likely to get into financial problems, you’re more likely to get into forensic justice problems because of stealing, gambling, whatever, and you’re much more likely to get into either assaulting people or being assaulted.

These key informants suggest that having a mental illness can put a person at risk of being homeless which impairs their ability to work. In the above quotes, issues related to housing were a consequence of a mental illness. This is in contrast to the perceptions noted in Chapter VIII, when some key informants perceived that people are “bummed” because of their social situation rather their social situation being a result of their depression. Physician 3 (O) comments on an another way mental illness can affect another social determinant of health – education – leading to unemployment:

So – well, you’d be disabled or you would be unemployable for different reasons. You have residual effects that you are just not employable, not because your addiction currently but because it robbed you from that ability to focus on school and finish your school. So now, you are not employable because the market doesn’t have a role for you. And that happened because when you were getting ready for that role, it got – the addiction took you on a different path. So you didn’t get that experience, you didn’t get that skill set.

In this instance, the person has a limited work capacity not directly because of their disability but because of the impairment that the disability caused when gaining the necessary skills for employment. It demonstrates the importance of considering the context of the person when assessing their impairment.

Physician 8 (A) and Physician 2 (O) provided arguments as to why a person should not be considered responsible for their mental illness.

It’s a – if you look at childhood sexual abuse or physical abuse or neglect, it’s a big long-term instant risk factor for cardiovascular death, for stroke death, for diabetes, for asthma, for mental illness.

Physician 8 (A)
...the main argument was this [addiction] is a disability, like other disabilities people have, with many reasons they’re having them and 90 per cent of women with dependency were sexually assaulted during their childhood.

Physician 2 (O)

Both physicians cite a history of abuse as a risk factor for people developing a mental illness.

Similarities and differences between Australia and Ontario

The key informants in both places described the characteristics of an ‘ideal type’ of disability in a similar way. In both cases, the ‘ideal type’ of disability differs from the actual definition of disability. However an interesting difference is that while the Australian definition has always included addiction (unlike Ontario) in practice, addiction does not meet the definition of an ‘ideal type’ of disability (in most cases). This is a good example of the gap between an ‘ideal type’ of disability and the actual definition of disability. Another gap is that both jurisdictions put provisions in the official definition of disability to include mental illness (see Table 14 – Components of the definition of disability as described by the key informants on p. 72), however the characteristics of mental illness make it an imperfect type of disability. Therefore despite the different legal definitions of disability, Australia and Ontario face the same issues around an ‘ideal type’ and imperfect type of disability.

The key informants in both places spoke about the hierarchy of disability. Physician 10 (A) explicitly said the order was physical illness, mental illness then addiction. Physician 2 (O) also said:

...addicts are classical because they’re like the bottom of the heap and mental illness is barely above that and AIDS for a while was below both of them.

Physician 2 (O)

In addition, many of the key informants referred to mental illness and addiction as separate categories. For example, Advocate 1 (O) said:

We actually do look at that [addiction and mental illness] separately here [mental health organisation]. I, in my work, I haven’t really looked at addictions, per se. The numbers, and usually when I’m providing data, I usually pull addictions out of mental health conditions, just so we can see the – I don’t
want to say the true rate of mental health conditions, but because it’s – because that divide is so fuzzy, between an addiction being part of a mental health issue, I usually pull that number out.

Advocate 1 (O)

To them, addictions are not a ‘true’ mental illness and therefore should not be included in the numbers. However findings showed there are exceptions to this hierarchy as some mental illnesses are ‘ideal’ (e.g. schizophrenia) and some physical illnesses are not ‘ideal’ (e.g. back pain).

Similarities and differences between the key informants

For the most part, there was little variation in way the key informants spoke about the characteristics of an ‘ideal type’ of disability. One exception was a group of the physicians who provided arguments as to why a mental illness is just as much an ‘ideal type’ of disability as a physical illness. While some key informants tried to describe how mental illnesses were like physical illness, some of these physicians did the contrary. To make their point, they gave examples of how a physical illness could have features of an imperfect disability. As previously mentioned, Physician 7 (A) said that despite the appearance of objectivity with tests like Goniometers, in reality they are just as unreliable as diagnostic tools for mental illness. Physician 3 (O) also argued that responsibility for one’s condition could easily be placed on individuals with physical illnesses such as diabetes.

Summary

In summary, this chapter has examined an informal tool – an ‘ideal type’ of disability – used by gatekeepers to identify those suitable for disability income support. It detailed the features of an ‘ideal type’ of disability and demonstrated that many mental illnesses are not perceived to have these features, leading to it being perceived as a less suitable condition for disability income support. A debate emerged among the key informants as to whether this was true for all types of mental illness. The chapter also explored importance of including the social determinants of health when adjudicating mental illness for disability income support.
CHAPTER X: DISCUSSION

For the past several years, government leaders have made deriding social assistance recipients a core component of their political strategy. Their ideology has driven the entire system – the rules, the attitudes and the administration. Reinforcing negative stereotypes has done serious damage to people who work and live in the system.

(Matthews 2004: 29)

The aim of this chapter is to provide a discussion of the main findings of this thesis, how they relate to the literature and to highlight my contributions to the literature. The chapter also provides a summary of my reflections on how Australia and Ontario compare when it comes to disability income support design and mental illness, as well as a discussion of the strengths and limitations of this thesis.

Main findings and contributions to the literature

The following section is a discussion of the main findings of this thesis including how the findings contribute to the literature on disability income support design and mental illness.

A conceptual model for disability income support

Gates and gatekeeping are commonly used metaphors in the medical literature (Mathers and Hodgkin 1989; Mathers and Usherwood 1992; Gérvas et al. 1994; Glasgow 1996; Halm et al. 1997; Delnoij et al. 2000; Willems 2001; Forrest 2003), and are typically used to describe physicians and their role as gatekeepers. This thesis contributes to the literature by placing these metaphors into a conceptual model to explain how disability income support gatekeepers (not just physicians) decide who should be let in and who should be kept out of disability income support programs.

Research on the definition of disability is limited and mostly descriptive in nature. For example, the definition is often explained to provide context but seldom analysed (Bill et al. 2006: 216-17; Forchuk et al. 2007: 4; Gewurtz 2011: 85-86). Findings from this thesis address this gap by deconstructing the definition into different components (or units of analysis) and detailing the key factors that influence decisions about these components.
Chapter III demonstrated that there is considerably more literature on the assessment process than definition. Findings from this thesis contribute to the literature by deconstructing the assessment process into types of gatekeepers, obstacles and tools. A key aim of deconstructing this process is to allow future researchers to concentrate on these discrete parts in detail, which could lead to finding solutions to the challenges identified in this thesis, rather than continuing to identify similar problems. The literature from Chapter III and the conceptual model (Figure 1) illustrate that the gatekeeping stage has a greater influence regarding who receives disability income support than the gate stage. The results from this thesis also provide analysis on informal tools and strategies used by policy insiders in designing policy. Since much of the literature provides descriptions of the process, informal elements are neglected as these are not explicitly described in policy documents. However findings revealed that these informal elements (e.g. an ‘ideal type’ of disability or rejecting GP’s evidence) are pivotal to this process in terms of making decisions about eligibility. These elements need to be addressed.

Although this model was generated in the Australian and Ontarian context, a key strength is that raising the model to a conceptual level makes it applicable in other settings. Most OECD countries have a disability income support program and these programs have gates and need gatekeeping. Programs would also have obstacles and need tools. However there would be variation in the different components of each stage. As such, this model provides a good framework for future comparative work on disability income support.

**Mental illness is perceived as less legitimate than physical illness for disability income support**

The definitions of disability in Australia and Ontario seem to be inclusive of mental illness (e.g. explicitly using wording like episodic illnesses to include many mental illnesses). However findings from Chapters VII – IX suggest that impairment from mental illness is perceived as a less legitimate impairment than a physical illness at the gatekeeping stage of the process. This finding addresses a gap in the literature identified in Chapter III regarding whether or not people with mental illness may be disadvantaged by the disability income support design process. The characteristics that make mental illness a unique category of illnesses to examine are the same features that are leading to these perceptions. In particular, the tension between
having a binary program like disability income support and a non-binary category of illnesses was continually highlighted. Gatekeepers want certainty that people who enter the program will remain impaired, however this certainty is not always possible with many mental illnesses due to their fluctuating nature. The invisibility of mental illness also created a significant issue. It seems that visibility provides a justification to taxpayers that their money is going towards those that need it the most. The visual representation of those with disabilities helps to delineate the ‘deserving’ from the ‘undeserving’ and provides a cultural acceptability for the program (Stone 1978: 511). Stone (1978: 511) argues that this cultural acceptability and taxpayer support are central tenets for maintaining these types of public programs. Finally, the lack of diagnostic certainty and reliance on applicants to describe their symptoms created suspicion among some of the policy insiders and the physicians. For example, Chapter VIII illustrated that there is an expectation that people with mental illness will not accurately portray their symptoms.

Addressing different types of mental illnesses

Although mental illness in general was perceived as less legitimate than physical illness, I was also interested in how different mental illnesses were perceived in the disability income support design process. As stated in Chapter II, in recognition of the broad spectrum of mental illness, three types of mental illness were selected – addiction, depression and schizophrenia. The following is a brief discussion of the findings in relation to these three illnesses.

Addiction

As mentioned in Chapter II, addiction has a precarious relationship with disability income support. For example, only in the last five years have people been able to apply for ODSP solely in relation to impairment from their addiction. Many Ontarian key informants spoke about this issue and the perception that addiction was initially excluded based on prejudice and not evidence. This is congruent with the literature described in Chapter III about addiction being excluded from disability income support based on assumptions (Copes and Bisgould 2010; Hales-Ricalis 2010). I found that the key informants tended to perceive that people with addiction are not suitable for the program because they have many features of an imperfect disability, including the perception that the illness is temporary, not easily recognised as a
medical illness and caused by the applicant. Addictions possessing these features seem to outweigh the points made by some of the physicians that addictions actually do have characteristics of an ‘ideal type’ of disability (e.g. they can be visible and diagnostic tests are available). This could mean that certain features of an ‘ideal type’ of disability are more important than others. A limitation to these findings is that key informants and the literature only addressed addiction related to drug and alcohol use. Other types of addiction such as gambling were not addressed.

Depression

Depression also seemed to be a cause for concern in disability income support design. For example, it was perceived by some key informants as easily treatable and by others as something that could be overcome with enough willpower. I interpreted this to mean that some informants perceived people with depression to have a mild impairment and therefore to be unsuitable for disability income support. Similar to addiction, depression has many of the characteristics of an imperfect disability – this could be one explanation for perceiving it as unsuitable for disability income support. It should be noted that the key informants acknowledged that depression could be severe but I interpreted that most key informants thought this was the exception, not the rule.

Addiction and depression were also viewed as treatable illnesses. There seemed to be a perception among the key informants that access to treatment would reduce (or eliminate) impairment. This is consistent with Table 3 – Beliefs and negative attitudes towards addiction, depression and schizophrenia on p. 17 in Chapter II. Furthermore, there was also the perception that being on disability income support could contribute to a person’s condition deteriorating, and therefore the person was better off not receiving disability income support. The key informants’ perception of the public’s view also seemed to play an important role in viewing an applicant with addiction or depression as unsuitable for disability income support. For example, Table 22 – Features and supporting quotes of an ‘ideal type’ of disability on p. 119 and Table 23 – Features and supporting quotes of an imperfect disability on p. 121 demonstrate the key informants’ perceptions that the public does not view addiction or depression as legitimate for disability income support. Again, this could be related to Stone’s (1978: 511) concept of a disability income support program needing cultural acceptability to be sustainable.
Schizophrenia

The key informants did not express concerns related to schizophrenia in the disability income support design process. This finding is similar to Chapter III, where no articles specifically focused on schizophrenia. I interpreted that most key informants perceived people with schizophrenia to have a severe impairment which therefore made them suitable for disability income support. As explained in Chapter IX, schizophrenia is perceived to have more characteristics of an ‘ideal type’ of disability than an imperfect type of disability. Not all of the key informants agreed with this perception, especially psychiatrists. These key informants noted that while some people with schizophrenia will experience severe impairment, there are many who will not. Evidence is congruent with this point, provided people with schizophrenia adhere to treatment, otherwise the relapse rate is quite high (Robinson et al. 1999; Emsley et al. 2013).

The perception of ‘too many’ recipients despite lack of evidence

The most surprising result was the key informants’ strong perception that ‘too many’ people are receiving disability income support (especially those that are unsuitable), but that the key informants could not provide an explanation of how many is ‘too many’ or supporting evidence for these claims. Little to no research seems to exist on disability income support benchmarks in Australia and Ontario; therefore I argue perceptions of ‘too many’ remain subjective in nature. This perception plays a pivotal role in the disability income support design process. For example, the Australian Government has used claims of there being ‘too many’ disability income support recipients as justification for reforms (Costello 2005; Swan 2011; Karvelas 2014). In Ontario, growth of ODSP and Ontario Works (a general welfare benefit) was used as justification for a review of social assistance in Ontario with potential to reform the system (Wilkinson 2012). As long as this perception persists, disability income support systems will continue to be targets of reform. As such, it is important to understand why this perception persists, despite a lack of evidence. I argue findings from this thesis, particularly the concept of an ‘ideal type’ of disability provide two possible explanations – the concept is being used as a heuristic tool and the concept is being used by applicants to respond to gatekeepers’ expectations. Both explanations are further explored below.
An ‘ideal type’ of disability being used as a heuristic tool

I argue that the concept of an ‘ideal type’ of disability is being used as a way to interpret an otherwise vague definition of disability. Gatekeepers using the concept of an ‘ideal type’ of disability is an example of using representativeness heuristics, a mental shortcut that relies on comparing an object or subject to an ‘ideal type’ (Tversky and Kahneman 1974). An ‘ideal type’ of disability is an example that may be serving as benchmark for what constitutes a disability. Representativeness heuristics is well discussed in the psychiatric and psychology literature as a diagnostic tool for clinicians (Tversky and Kahneman 1974). For example, Garb (1996: 272) suggests that one way psychologists diagnose patients is by comparing patients to an ‘ideal’ patient. Saks and Kidd (1980: 127) argue that heuristics are useful when making decisions of uncertainty but caution that relying on heuristics can lead to decisions that deviate from the actual probability. Another problem that arises is that errors occur because people tend to recall dramatic cases or rely on stereotypes (Gilovich et al. 2002: 3). However there are advantages of using heuristics including allowing for timely decision-making and requiring few resources (Crumlish and Kelly 2009: 72).

As demonstrated in Chapter IX, some mental illnesses do have features of an ‘ideal type’ of disability. These mental illnesses serve as an ‘ideal type’ of mental illness and all other types of mental illness may be compared to this ‘ideal’. Mental illnesses that deviate from the ‘ideal type’ of disability may be deemed unsuitable for disability income support. An example from the literature is the updated Australian Impairment Tables. They were criticised for putting too great a focus on psychosis and not enough on other illness like depression or anxiety (FaHCSIA 2011: 30). In this instance, psychosis would be the ‘ideal type’ and all other illnesses would be compared to psychosis. In addition, the Impairment Tables only have two tables related to mental illness – Table 5 for mental health function and Table 6 for addiction – out of 15 tables (see Appendix C for excerpts). In contrast, physical illnesses have been divided into tables based on the area of the body (e.g. upper limb, lower limb, hearing, visual, etc.) (DSS 2012). However Table 4 – Definitions, symptoms and treatments for addiction, depression and schizophrenia on p. 19 in Chapter II illustrates the differences in symptoms across addiction, depression and schizophrenia. As such, it is unreasonable to expect people with different types of mental illness to present
similarly. These findings also illustrate the lack of recognition of the broad spectrum of mental illness and demonstrate a need for disability income support policy-makers to develop better assessment tools that reflect this broad spectrum. Otherwise severe mental illnesses like schizophrenia could be used as a benchmark that puts people with other types of mental illness at a disadvantage (as discussed later in this chapter). The following are two ways gatekeepers could be using an ‘ideal type’ of disability as a heuristic tool to explain the perception that there are ‘too many’ unsuitable people on disability income support:

**Using an ‘ideal type’ of disability as a proxy for a suitable person**

Finding the suitable person could be about finding those with features of an ‘ideal type’ of disability. However the ‘ideal type’ of disability does not match the written definition of disability (e.g. the definition does not require a disability to be visible). This is congruent with the results in Chapter III that revealed a discrepancy between the actual definition and its application in practice. However my findings add to the literature by providing a conceptual explanation for this discrepancy. I argue there is a gap between those with an ‘ideal type’ of disability and the actual number of recipients. This gap is made up of those with imperfect disabilities who are perceived as unsuitable for disability income support. In other words, an ‘ideal type’ of disability is being used as a proxy for a suitable person. These findings have significant consequences for people with mental illness as results revealed that many mental illnesses are perceived as imperfect disabilities and therefore could be perceived as unsuitable for the program.

**Using an ‘ideal type’ of disability to subcategorise people with disabilities**

An alternative explanation is that the concept of an ‘ideal type’ of disability is being used to subcategorise people with disabilities into ‘deserving’ and ‘more deserving’. Historically, people with disabilities have been classified as ‘deserving’ of public support (Stone 1984: 42). However in a time of permanent austerity (Pierson 2002; Giger and Nelson 2011) and increasing prevalence of disabilities, there may be a need to subcategorise. I argue that the concept of an ‘ideal type’ of disability is one way that policy-makers are making these distinctions. Unlike the previous explanation, no one in these categories is deemed unsuitable for the program, but limited fiscal resources to fund all the suitable people could be leading to a hierarchy of disabilities.
to ensure the ‘most deserving’ receive support. This explanation also highlights a key challenge for policy-makers – providing support for people while balancing expenditures. However a distinction needs to be made between not having sufficient funds to support the growing numbers of people with disability and having ‘too many’ unsuitable people on the program.

The above explanations demonstrate how gatekeepers may use the tool of the ‘ideal type’ of disability to identify either the suitable person (in the first scenario) or the ‘more deserving’ person (in the second scenario). If the concept of an ‘ideal type’ of disability is being used to identify people for disability income support, mental illness will continue to be perceived as an imperfect disability and people with mental illness applying for disability income support will continue to be at a disadvantage.

While the literature does not examine the perception that there are ‘too many’ recipients on disability income support, it does provide some explanations for why numbers are rising despite numerous changes to eligibility criteria. McVicar and Wilkins (2013: 346 - 47) found that almost 20 per cent of additional DSP recipients since 1982 could be explained by population growth and another 17 per cent from population ageing. Another explanation is that the rise in the number of recipients is due to changes to other payments (Butterworth et al. 2011a: 53; McVicar and Wilkins 2013: 353). For example, the elimination of benefits like the Widows Pension in Australia may have shifted those recipients who also have a disability onto the DSP.

‘Performing’ is a way of responding to the ‘ideal type’ of disability

Much of the literature suggests that the financial benefits of disability income support encourage malingering – feigning illness to get out of work (Berry et al. 1991: 585 - 86; Nies and Sweet 1994; Chafetz 2008: 530; Chafetz 2011: 237). However findings revealed that there is little evidence of fraud when it comes to disability income support in Australia and Ontario. A second explanation of why there maybe a perception that ‘too many’ people are on disability income support, is that ‘performing’ an illness, especially exaggerating symptoms, may be a way for applicants to respond to the ‘ideal type’ of disability. In this instance, the applicant ‘performing’ is a way to make their impairment seem more relatable to what the adjudicators perceive as legitimate. Goffman (1959: 49) argues that people respond to the expectations of those they converse with in everyday life. In this explanation, the
applicant is not the ‘wrong’ person for the program, but is trying to adjust to the adjudicators’ conceptualisation of a legitimate disability. It could also be argued that ‘performing’ may lead to a person redefining him or herself as disabled. While this is a neglected area in the literature, there is some evidence in the simulated patient literature to suggest that simulating symptoms can have negative health effects on the simulated patient including psychological effects (Woodward and Gliva-McConvey 1995: 419; McNaughton et al. 1999: 137; Bokken et al. 2004: 1091). This could suggest that applicants ‘performing’ could also lead to psychological effects. However further research on disability income support applicants and recipients is needed to substantiate these claims.

**Physicians are not gatekeepers for disability income support**

In the medical literature, physicians are often referred to as gatekeepers. GPs are gatekeepers to specialists (Mathers and Hodgkin 1989; Bushnell et al. 2005: 631; Hawkes 2014: 24) and physicians in general are often gatekeepers to special benefits including disability-related ones (Stone 1978; Claussen 1999: 231; Thorstensson et al. 2008; Markussen 2009: 3). Gatekeeping has become a key aspect of their role. However findings from this thesis contradict the literature. In terms of disability income support, physicians are not gatekeepers since is not their role to suggest whether or not their patient is eligible for the program. It is their role to provide ‘objective’ evidence about their patient’s illness and any associated impairment. One explanation for why they may still be acting as informal gatekeepers is that it could be difficult for physicians to disassociate from the role of gatekeeper. However this type of informal gatekeeping has consequences. First, there are no formal tools for physicians to use to make this decision. As a result, findings from this thesis revealed that physicians are relying on non-clinical factors, especially negative attitudes and beliefs, when choosing how to fill out their patients’ disability income support applications. While there is limited literature on physicians’ role in disability income support, there is a literature on physician attitudes towards those with mental illness. Some of the literature suggests that physicians hold similar negative attitudes as the public towards people with mental illness (Jorm et al. 1999; Thornicroft et al. 2007). However the problem does not lie in a physician having these attitudes or beliefs, but rather, when these attitudes influence their behaviour. For example, Wahl and Aroesty-Cohen (2010: 59) note that physicians’ negative attitudes towards people
with mental illness can impact on the quality of patient care. This is in line with the findings of this thesis that suggest the way a physician chooses to complete a disability income support form may be based on these negative attitudes or beliefs. These are examples of when stigma leads to discrimination.

Another concern is the finding that official gatekeepers to disability income support are more likely to reject GP evidence for being perceived as less objective than specialists. This finding is congruent with the results from Chapter III that also noted that GP evidence was being discounted. However findings from this study revealed that no type of physician (GP or specialist) was more likely to provide ‘objective’ evidence for people with mental illness. The debate does not seem to be solved in the literature either. For example, Mathers and Hodgkin (1989: 173) argue that GPs are better at detecting the well and specialists are better at detecting the unwell. However Thornicroft, et al. (2007: 118) suggest that GPs are more likely to be influenced by stigma related to mental illness than psychiatrists, meaning they would be likely to be strict gatekeepers. Finally Jorm et al. (1999: 82) found that neither GPs or psychiatrists were more likely to have negative attitudes towards people with mental illness. However more evidence is needed to determine if GPs’ evidence is less reliable than specialists for the purpose of disability income support.

Rejection of GP evidence highlights a bigger problem within the disability income support design process – the lack of coordination between social services and health. Many people with mental illness rely on GPs for treatment for their mental illness and may not see specialists. Furthermore there are accessibility issues that were highlighted by many of the physicians in Chapter VII. In Australia, there are out-of-pocket costs for many specialists, while in Ontario there is a shortage of psychiatrists (Mulvale and Bourgeault 2007), and in both settings there are accessibility issues for those in rural areas (Judd and Humphreys 2001; O'Reilly et al. 2007). Therefore requiring evidence from specialists may not be realistic for people with mental illness.

**Are policy-makers using evidence to design disability income support?**

Policy-makers’ use of evidence was not part of the initial research questions, but throughout the literature review and interviews it emerged as an important question. Findings from Chapter III and the results chapters suggest that evidence is not being used by policy-makers, at least when it comes to addressing issues related to
applicants with mental illness. For example, there is substantial evidence that addictions are a bio-medical illness (for examples see Leshner 1997; Nestler and Aghajanian 1997; Volkow and Li 2005; Baler and Volkow 2006; Vrecko 2010), yet negative assumptions about addiction being more of a behavioural illness prevailed over such evidence with the ODSP addiction exclusion provision. Another example, as discussed in the sections about social determinants of health (p. 15 and p. 125), is that impairment related to mental illness cannot be separated from the person and their context. There is substantial evidence that shows the social determinants of health contribute to developing a mental illness and the level of impairment (Folsom and Jeste 2002; Patel et al. 2007b). Despite this, disability income support in Australia and Ontario does not seem to recognise this evidence. In short, if disability income support policy-makers used evidence about the challenges of mental illness, the outcome of the policy design should be different. However, as was discussed in Chapter III, it is unclear whether evidence is not being used intentionally or because there is a lack of access to such evidence.

**Reflections on the similarities and differences between Australia and Ontario**

Findings revealed many similarities between Australia and Ontario in the process of finding suitable people for disability income support. These findings are significant because these jurisdictions have taken different policy paths and chosen to base their definition on different models of disability. The numerous similarities suggests that the conceptual model of disability income support design could be applicable to other Western settings especially New Zealand, the UK or Sweden. These are all countries that have strong welfare states but are dealing with rising numbers of disability income support recipients.

The biggest difference between Australia and Ontario was that they have different gates. Australia’s gate is economic-based and much narrower than Ontario’s medical-based gate. However findings suggest that gates may not be as important than gatekeepers when finding suitable people for disability income support. Statistics support this argument because the same proportion of people are on disability income support in Australia and Ontario – about 3.5 per cent of the total population (see p. 23 and p. 24). In theory, Ontario’s wider gate should result in a much higher proportion
of recipients. Therefore the difference between the gates may not be significant in terms of the proportion of people on the program.

The assessment process also differs in the two settings. Australia’s is face-to-face whereas Ontario’s is paper-based. This difference could explain why ‘performing’ was more of a concern among Australian key informants than Ontarian key informants. Ontario’s paper-based process does not provide the same opportunity to ‘perform’. Ontarian applicants’ ‘stage’ for ‘performance’ is more relegated to their physician’s office or appeal process upon rejection.

There was also a significant difference in regard to the role of case law. Case law proved to be an important part of the disability income support design process in Ontario. These findings are congruent with those of Chapter III. In Ontario, case law has shaped the definition of disability and its interpretation. Again, the best example is the Tranchemontagne case that reversed the ODSP addiction exclusion provision. In Australia, the key informants did not perceive case law to be as influential. This difference illustrates the importance of the legal framework in the disability income support design process. Ontario’s framework (especially the Ontario Human Rights Code) has a significant influence on what components of the definition are possible and what tools can be used in the assessment.

**Main strengths**

Many of the strengths of this thesis have been outlined in the previous section of the main findings. Overall, this thesis fills an important gap in the research on disability income support design and mental illness by building a foundation of evidence for future research.

This next section will focus on the strengths of methods used for this thesis.

**Systematic review**

To the best of my knowledge, this is the first systematic review on disability income support design and mental illness in the Australian and Ontarian setting. Systematic reviews are regarded as a strong evidence source because they reduce the level of bias found in many traditional literature reviews and are replicable (Petticrew and Roberts 2008: 9). The review contributes to the literature in three ways. First, it demonstrates that the definition of evidence in policy-making may be in contestation with the
definition of evidence in research. Second, it contributes to the literature by demonstrating that ‘grey’ literature is an important source of information on this topic and should not be ignored when reviewing the literature of available evidence, especially when studying the policy process. Third, it contributes to the literature by synthesising the relevant literature on this topic, creating a resource tool for policy-makers in Australia and Ontario. Since the methods have been detailed, it provides the framework to allow continual updates and also to apply the questions of this review in other international settings.

**Findings represent the reflections of the key informants**

Few studies on disability income support design and mental illness in Australia and Ontario have been based on interviews with policy-makers. As Chapter III noted, only one piece of ‘grey’ literature interviewed policy-makers, and data collection and data analysis were not detailed. Previous research has focused on analysing policy documents (Carney 1991; Income Security Advocacy Centre 2003; Mendelson 2004; Cowling 2005; Hales-Ricalis 2010; Madden et al. 2011) or interviewing applicants or recipients of the program (ODSP Action Coalition 2003).

Grounded theory and case study research are two methods that produce rich data about the experiences of the key informants. A major strength of these methods is that key informants were asked to explain processes in their own words. This allowed for the elucidation of topics that were unexpected in the initial research design. For example, discussion of informal tools and strategies would not have emerged if data was restricted to policy documents or interviews did not include those involved in designing disability income support. The inclusion of informal elements to the conceptual model of disability income support design is a key contribution to the literature.

**Grounded theory is systematic**

Grounded theory is a systematic set of procedures used to generate theory. The systematic nature of this method helps overcome the criticism that qualitative research lacks rigour. Each stage of the process is recorded in detail that provides an audit trail of analysis. This thesis fills a key gap identified in Chapter III about research on disability income support design and mental illness lacking adequate study designs. Data collection and analysis have been clearly detailed and strengths and limitations
of this study have been discussed. Systematic procedures and detailed recording of the methods provide transparency and increase the rigour in this thesis.

Having extensive contextual knowledge

Context is important in case study research and a key strength of this study was that I had extensive general knowledge of Australia and Ontario. Being familiar with both settings provided a distinct advantage in the interviews. For example, many key informants used local vernacular (e.g. “a Rosedale type” meaning a typically upper class person who lives in Rosedale – an upscale area in downtown Toronto, Ontario). Local knowledge allowed me to interpret these references and include them in my analysis when relevant. However a disadvantage of having such local contextual knowledge is that at times key informants did not elaborate because they assumed I already had the knowledge. This limitation was overcome by explaining to the key informants that even if I might have tacit knowledge, it was important that they provide the explanation in their own words.

Limitations

Key informants’ reflections may not represent their actions

Qualitative interviews are based on the key informants’ “perceptions/interpretations and do not necessarily reflect what is actually happening in encounters” with disability income support applicants (Åsbring and Närvänen 2003: 713). Åsbring and Närvänen (2003: 713) also note that “norms and conventions may influence interview responses” and they can create a disparity between what is said and what they think. Therefore while these interviews can give insight into the policy world, they cannot be assumed to be completely representative of what occurs in practice.

Another potential issue is that some key informants may have given responses about what they think they should say – what Glaser (1998: 8) refers to as “properline” data – rather than their actual perceptions. This seemed to be a particular issue with the key informants who were also researchers. They seemed more conscious of the research aims and their responses at times may have reflected what they perceived I wanted to hear rather than their true perception. However this was overcome by asking general questions as to not lead the key informant to give certain responses. The aim was that general questions could produce a level of rapport that could
elucidate more personal reflections of the key informant, rather than “properline” data. Finally, some key informants, especially the policy insiders, were not able to explicitly describe some of their actions for reasons of confidentiality. In addition, many policy documents that would have provided a clear rationale for disability income support policy decisions are sealed by Cabinet and therefore unavailable. Some of the information could have been requested through the Freedom of Information Acts in both jurisdictions, however key informants remarked that most information would be redacted.

**Open-approach methods are subject to key informant tangents**

A key limitation to open-approach methods such as grounded theory and case study research is that the key informants can guide the discussion in tangential directions. For example, many key informants wanted to discuss employment supports for people with disabilities rather than disability income support design. As Chapter III demonstrated, the literature focuses heavily on employment supports rather than disability income support design and further supports the argument that disability income support design is a neglected area in the literature.

**Potential sources of bias**

A key limitation of qualitative research is that samples are subject to potential bias because key informants are selected to produce rich data, not to be representative (Malterud 2001: 487). In this thesis, key informants were selected based on their experiences in disability income support policy design. Logistically, it was not possible to interview or identify all those who have participated in this process. Findings are limited to the perspectives of those who participated and may not reflect those who did not participate. Obviously, this limits the generalisability of the thesis findings. This limitation was also addressed in Chapter IV (p. 58).

**Focusing on one category of illness**

While this thesis provides a conceptual model for disability income support design in general, a primary aim was to understand how mental illness is perceived and dealt with in this process. This selection was made in order to focus on a category of illness that could create policy challenges, and not in order to overlook other types of illnesses.
I argue that mental illness needs special consideration in the disability income support design process because of its unique characteristics such as the fluctuating nature, invisibility and lack of diagnostic certainty. However it needs to be acknowledged that there are many other types of illnesses that also share these features including some physical illnesses (e.g. chronic back pain and chronic fatigue syndrome). Presumably, these illnesses could also be perceived as less legitimate for receiving disability income support and may need special consideration in the disability income support design process.
CHAPTER XI: CONCLUSION

There is a certain irony in the fact that mental illness, the type of disease we now consider the hardest to define, should have been separated conceptually and practically in welfare policy before physical illness.

(Stone 1984: 44)

There is no question but that the mentally ill in our society have suffered from historical disadvantage, have been negatively stereotyped and are generally subject to social prejudice.

(Supreme Court of Canada 1991)

This chapter provides an overview of how this thesis met the overall aim and answered the research questions identified in Chapter I. Recent Australian disability income support reforms are also briefly discussed. The chapter concludes by outlining implications for policy, practice and research.

The broad aim of this thesis was to contribute knowledge about how disability income support policy-makers draw boundaries around who is eligible for disability income support and how mental illness is considered in this process, using mixed methods of comparative case study research and grounded theory. In this thesis, I investigated how those involved in disability income support design perceive this process. I have presented new arguments about:

- the lack of evidence available on this topic (Chapter III);
- gatekeeping being more important to the process of finding suitable people for disability income support than the gate itself (Chapters V and VII);
- mental illness being perceived as less legitimate than physical illness (Chapters VIII – IX);
- physicians acting as gatekeepers, despite it not being their role (Chapter VIII); and
- why the perception of there being ‘too many’ people on disability income support may persist, despite a lack of evidence to support such claims (Chapter X).

In addition, I have also provided an overall conceptual model based on the consolidated findings of this thesis of how disability income support is designed (see
Addressing the research questions

Addressing the research questions posed in Chapter I, I found the following answers:

(a) How do policy-makers choose a definition of disability?

Policy-makers choose a definition that best suits the social and political landscape of the time in which it was developed. To this end, the public should ostensibly perceive the definition as ‘culturally acceptable’ (Stone 1978: 511). The definition should also be in line with overall political objectives of the government that introduces the definition. For instance, if an objective is to reduce expenditure, then the definition of disability should be narrow to achieve this objective. However this means that peer-reviewed evidence may not be considered (possibly actively ignored) if it does not align with the social and political landscape.

(b) How do policy-makers apply this definition in practice?

Gatekeepers are responsible for applying the definition of disability in practice. However findings revealed that there are different types of gatekeepers: the official gatekeeper, the judicial gatekeeper and the physician gatekeeper. Definitions of disability seem to be difficult to interpret as components such as severity of impairment and duration of impairment remain vague. As a result, significant variation of interpretation exists across gatekeepers. Any uncertainty in the application of the definition seems to lead to gatekeepers relying on their own attitudes and beliefs about disability income support and disabilities to make decisions.

(c) How is mental illness considered in the disability income support design process?

Many of the challenges of mental illness identified in Chapter II (pp. 14 – 18) do not seem to be well addressed in disability income support design. I will briefly describe each challenge, demonstrating how it has been overlooked.

Episodic nature

While the terminology of episodic conditions is included in the legislation of both Australian and Ontarian programs, it remains unclear how policy-makers interpret it
in practice. An episodic condition makes it difficult for gatekeepers to determine the level of duration of an impairment and therefore is a characteristic of an imperfect type of disability.

No definitive diagnosis

This challenge has not been well addressed in disability income support design. To illustrate, the lack of certainty around diagnosis of mental illness has led policymakers to distrust applicants to accurately portray their symptoms. It has also led to distrust of physicians’ evidence in some circumstances.

Management

Gatekeepers assume people with mental illness have access to medical services and treatment, especially mental health specialists. There does not seem to be much recognition by the key informants of the fragmentation and shortage of mental health services available in Australia and Ontario, or that there is a high rate of people with mental illness not accessing treatment. Preferring psychiatrists’ or psychologists’ care to other types of health care professionals also demonstrates a lack of recognition of the trend towards collaborative care for people with mental illness.

Social determinants of health

Despite substantial evidence in the literature and the results of this thesis supporting the interconnectedness of the social determinants of health and impairment related to mental illness, these factors are explicitly excluded in both definitions of disability. It was made clear that in terms of disability income support design, these factors should bear no weight when determining eligibility.

Stigma and discrimination

Most results chapters illustrated that attitudes and beliefs about disability income support and mental illness play a significant role in disability income support design. These attitudes and beliefs are being used to interpret the definition and guide disability income support design. Most examples of attitudes and beliefs towards mental illness in this thesis were negative. In addition, key informants spoke about all types of gatekeepers (including physicians) having these attitudes and beliefs.
Broad spectrum of mental illness

Mental illness seems to be treated as a unified category in disability income support design. There was very little evidence in the literature or results that demonstrated recognition of the broad spectrum of mental illness and the variation within the different types of illnesses. However when the different illnesses are recognised, a hierarchy seems to emerge with illnesses like schizophrenia at the top and depression and addiction at the bottom.

Overall, it can be concluded that mental illness is not well addressed in disability income support design. Despite the large number of disability income support recipients with mental illness in Australia and Ontario, there still seems to be a fundamental lack of understanding and acceptance of the unique features of mental illness. However it is unclear if these features are intentionally ignored or if there are inadequate resources available to deal with these challenges.

(d) How do answers to these questions vary between Australia and Ontario?

Surprisingly, there was little variation to these answers between the key informants in Australia and Ontario. Both places seemed to consider mental illness in the definition of disability but had trouble with the application of the definition in practice. The key difference is that Australia has a much more detailed definition of disability and assessment process. However this did not seem to alleviate any of the challenges or perceptions about mental illness in the assessment process. In both places, choosing a definition of disability and its application in practice is not a transparent process.

What’s new?

Recent Australian welfare reforms

Since completing data collection, the Australian Disability Support Pension has undergone reforms. The changes include:

- increasing the work requirements for DSP recipients under 35;
- reviewing the eligibility of DSP recipients under 35 (only those granted support between 2008 and 2011); and
- changing the portability arrangements for DSP recipients.
All of the above changes pertain to current DSP recipients and not the eligibility of the DSP. This distinction is important because this thesis focuses on the eligibility process. These changes are not within the scope of this thesis and therefore do not change the significance of findings.

In addition to the above changes, an interim report was released in June 2014 reviewing Australia’s welfare system. The most relevant recommendation in this report is that the eligibility criteria for the DSP should be narrowed to only “people with a permanent impairment and no capacity to work” (DSS 2014c: 6). In response to the report, the Mental Health Council of Australia (MHCA) and the National Mental Health Consumer and Carer Forum (NMHCCF) noted concern about how this would be applied in practice and what this might mean for a person with a mental illness (MHCA and NMHCCF 2014: 16). The proposed recommendations and responses to changes in DSP eligibility support the argument made in this thesis that people with mental illness are more disadvantaged by the design of disability income support than people with physical illness.

**Implications**

**For policy**

Findings from this thesis demonstrated that gatekeeping is more important in the process of granting disability income support than the gates themselves. However, disability income support reforms typically focus on changing the eligibility criteria in an attempt to control numbers. This is not limited to the Australian and Ontario setting. For example, the Swedish Government has premised many of its reforms on tightening eligibility criteria in an effort to reduce the rising number of recipients (Kananen 2012: 8-12). In 2010, the British Government announced structural reform of the welfare system, radically altering its disability income support program in an effort to control recipient numbers (Department for Work and Pensions 2010). This thesis provides empirical support that future reforms need to shift away from only changing eligibility criteria and focusing on the individual towards improving the gatekeeping process. If gatekeepers are uncertain about interpreting the eligibility criteria, then altering the criteria will have little effect.
Another implication is that disability income support policy design needs to recognise the broad spectrum of disabilities. This thesis generated data showing that disability income support policy has been more designed towards physical illnesses rather than mental illnesses. Future reforms should better address the challenges of mental illness in the definition and assessment of disability to reduce this disparity. As this thesis demonstrated, the consequences of not doing so can result in mental illness being viewed as less legitimate than physical illness.

More so, it still remains unclear what ‘too many’ people on disability income support actually means. Policy-makers need to be more explicit about program benchmarks. An increasing number of recipients does not automatically mean that there are unsuitable people on the program. One aspect of the process of disability income support design that was not sufficiently addressed was if (and how) evidence is used in the process. It still remains unclear if policy-makers are using evidence, what they define as evidence, and if they are not using evidence, whether this is intentional or if it is due to the fact that they unable to find relevant evidence.

**For practice – the gatekeepers**

Chapter III and the results chapters both revealed the discrepancy that exists between the written definition of disability and its application by the official gatekeepers in practice. The evidence generated from this thesis suggests the current tools used to assess disability income support eligibility leave too much room for an assessor’s judgement – judgement that can be influenced by negative assumptions about mental illness – and could be putting people with mental illness at a disadvantage when applying for disability income support. As such, better tools for disability income support assessors need to be developed to reduce these disadvantages.

Findings from this thesis demonstrated that people with mental illness needing disability income support are not well understood by any type of gatekeeper including physicians. Negative attitudes about mental illness seem to pervade the thinking of all types of gatekeepers. Until attitudes are addressed among all types of gatekeepers, reforms will do little to change the disadvantage that people with mental illness may be experiencing when applying for disability income support.
In particular, the practice of physicians making decisions about eligibility when it is not their job has significant implications for people with mental illness. Because they are not formal gatekeepers, there is no accountability or safeguards in place to monitor the decisions that physicians make. As such, applicants have few or no options for recourse if they feel they were treated unfairly.

**For research**

Chapter III of this thesis demonstrated that little evidence is available on disability income support design and mental illness. While this thesis contributed to building an evidence base on the topic, much more research is needed to fully understand the process and develop solutions for the issues identified. Furthermore, this thesis has demonstrated the need to converge these two areas of research. Hopefully the findings have demonstrated that disability income support is a health issue and mental illness is a social policy issue.

More specifically, the following are areas that need further exploration:

- the systematic review of the literature on disability income support design and mental illness in other contexts;
- the different components (e.g. tools, obstacles, gatekeepers) of the model presented in this thesis. The model could be applied to other case studies to see how the model varies across different contexts;
- qualitative interviews with assessors to learn about how they make their decisions and what tools would make decisions of uncertainty less difficult;
- an audit of adjudication files to see if (and how) decisions about physical illnesses differ from mental illnesses;
- developing disability income support program benchmarks based on empirical evidence. This could provide policy-makers with an evidence-based tool to monitor program numbers;
- physicians’ attitudes towards disability income support and mental illness; and
- how policy-makers use evidence in this process.

Chapter III also demonstrated the importance of ‘grey’ literature as a source of evidence on this topic. However, it was unclear in much of the ‘grey’ literature what methods were used to generate findings. Future research in this area – of all kinds – should be more explicit about their research design. Rationale for methods, data
collection and analysis should be included in all formats of evidence to ensure findings are based on data and not opinions.

This thesis was the first to interview those who design(ed) disability income support about the process and mental illness in the Australian and Ontarian setting. If solutions to the issues identified in this thesis are to be found, it is important that future research is based on the perspectives of those who are dealing with the problems. Furthermore, interviews with disability income support policy-makers help to elucidate informal elements of the process. This is not possible when relying on interviews with those outside the process, or analysis of documents. For example, focusing only on the written definitions of disability and not the assessment process presents a skewed view that mental illness has been adequately addressed. The written definition does not reveal any of the assumptions or informal strategies used in the assessment process.

**Concluding remarks**

Moving away from the data, I argue that the reform of disability income support by governments cannot simply be justified by increasing expenditure. It should not be assumed that rising numbers of recipients and associated expenditures are a result of unsuitable people making it onto disability income support. Rather structural and institutional barriers (e.g. economic conditions, stigma and the nature of the labour market) also need to be scrutinised. Shifting people with imperfect types of disabilities like those with mental illness onto less generous benefits or no benefits at all is a short-term budgetary solution to a much greater problem. It should be reiterated that disability income support is a benefit payment of last resort, meaning those rejected have few alternative sources of income. Some will end up on general welfare benefits – lower payments with work obligations – or no benefit at all. The financial burden could exacerbate their condition (e.g. out-of-pocket costs for health care) and result in a lengthy hospital stay. Lack of a stable income could also result in a person becoming homeless (Sosin and Grossman 1991: 338; Forchuk et al. 2013: 31). A study from Simon Fraser University, estimated that homelessness costs the British Columbian Government, on average, AUD$54,000 per person per year (Patterson et al. 2007: 11). These are two examples of the potential economic cost of disability income support rejection. Compared to a year of disability income support
in Australia and in Ontario (AUD$20,200 and AUD$12,800 respectively), it is clear
that the costs of rejection from disability income support can outweigh the costs of
providing disability income support benefits.

Although the findings do not show that disability income support policies in Australia
and Ontario have completely failed those with a mental illness, they do show that
people with mental illness are at a disadvantage. If the prevalence of mental illness
continues to rise, we must question future reforms that do not recalibrate disability
income support to account for mental illness and ask if it is intentional, or whether it
is more likely due to designing disability-related income support geared towards
physical disabilities.

It is clear from more recent reforms announced in Australia, that the welfare state is in
a permanent state of ‘crisis’ (Pierson 2002: 371), with the rising number of recipients
a constant concern and the sustainability of the system challenged. However we must
acknowledge that the characteristics of disability income support recipients are not the
same as they were 23 years ago under the structural reforms when the DSP and ODSP
were introduced in Australia and Ontario respectively. People with a mental illness
are no longer confined to the outskirts of society and placed in psychiatric institutions,
but rather since de-institutionalisation have become integrated into the community. As
such, it is important that future reform policies incorporate these changes so that
achieving government budgetary targets are not at the expense of providing adequate
financial support for people with a mental illness.
REFERENCES


Ontario (Director of Disability Support Program) v. Gallier (2000) 101 a.c.w.s. (3d) 642 [Ontario Divisional Court].


Patterson, M., Somers, J., McIntosh, K., Shiell, A. and Frankish, C. J. (2007) Housing and supports for adults with severe addictions and/or mental illness in BC. Burnaby, BC: Simon Fraser University.


APPENDICES

Appendix A: Ethical clearance

Re: [SA/KFG]

3 January 2012

Professor Stephen Leeder
Director, Menzies Centre for Health Policy
Victor Coppleston Building – D02
The University of Sydney
Email: stephen.leeder@sydney.edu.au

Dear Professor Leeder

I am pleased to inform you that the Human Research Ethics Committee (HREC) approved your protocol entitled “Are contemporary welfare reforms appropriate for people with mental illness?” at its meeting held on 13 December 2011.

Details of the approval are as follows:

Protocol No.: 14433
Approval Date: 13 December 2011
First Annual Report Due: 31 December 2012

Authorised Personnel: Professor Stephen Leeder
Ms Ashley McAllister
Dr Maree Hackett

Documents Approved:

<table>
<thead>
<tr>
<th>Document</th>
<th>Version Number</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Participant Information Statement</td>
<td>Version 1</td>
<td>31/10/11</td>
</tr>
<tr>
<td>Participant Consent Form</td>
<td>Version 1</td>
<td>31/10/11</td>
</tr>
<tr>
<td>Semi-Structured Interview Guide</td>
<td>n/a</td>
<td>undated</td>
</tr>
<tr>
<td>Notification to inform Potential Participant</td>
<td>n/a</td>
<td>undated</td>
</tr>
<tr>
<td>Safety Protocol signed 17/11/11 and 23/11/11</td>
<td>Version 1</td>
<td>31/10/11</td>
</tr>
</tbody>
</table>

HREC approval is valid for four (4) years from the approval date stated in this letter and is granted pending the following conditions being met:

The researchers are to be reminded to ensure any ethical or other approvals required at the different research sites/universities are obtained and copies provided to the Ethics Office.

Condition/s of Approval

- Continuing compliance with the National Statement on Ethical Conduct in Research Involving Humans.

Ethical approval was initially granted on 13 December 2011 and modifications were approved 13 March 2013.
Research Integrity
Human Research Ethics Committee

Wednesday, 13 March 2013

Prof Stephen Leeder
School of Public Health: Public Health; Sydney Medical School
Email: stephen.leeder@sydney.edu.au

Dear Stephen

Your request to modify the above project submitted on 24 February 2013 was considered by the Executive of the Human Research Ethics Committee at its meeting on 06 March 2013.

The Committee had no ethical objections to the modification/s and has approved the project to proceed.

Details of the approval are as follows:

Project No.: 2012/021
Project Title: Comparing how disability income support is designed in Australia and Ontario for people with mental illness

Approved Documents:

<table>
<thead>
<tr>
<th>Date Uploaded</th>
<th>Type</th>
<th>Document Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>19/02/2013</td>
<td>Interview Questions</td>
<td>McAllister_Interview Discussion Guide</td>
</tr>
<tr>
<td>19/02/2013</td>
<td>Participant Consent Form</td>
<td>McAllister_Participation Consent Form</td>
</tr>
<tr>
<td>19/02/2013</td>
<td>Participant Info Statement</td>
<td>McAllister_Participation Information Statement</td>
</tr>
</tbody>
</table>

Please do not hesitate to contact Research Integrity (Human Ethics) should you require further information or clarification.

Yours sincerely

[Signature]
E

Professor Glen Davis
Chair
Human Research Ethics Committee

This HREC is constituted and operates in accordance with the National Health and Medical Research Council’s (NHMRC) National Statement on Ethical Conduct in Human Research (2007), NHMRC and Universities Australia Australian Code for the Responsible Conduct of Research (2007) and the CPMP/ICH Note for Guidance on Good Clinical Practice.
## Appendix B: Brief history of disability income support in Australia

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Government</th>
<th>Key document(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1910</td>
<td>Invalid Pension introduced</td>
<td>ALP (Fisher)</td>
<td><em>Invalid and Old-Age Pensions Act, 1908</em> (^{lx})</td>
</tr>
<tr>
<td>1986</td>
<td>Social Security Review commissioned</td>
<td>ALP (Hawke)</td>
<td>Towards enabling policies: Income support for people with disabilities (^{ix})</td>
</tr>
</tbody>
</table>
| 1991 | Disability Income Support replaces the Invalid Pension:  
- new legislation introduced for the first time since 1910; and  
- introduced the Impairment Tables and inability to work 30hrs per week requirement. | ALP (Hawke) | *Social Security Act, 1991* \(^{lxi}\) (see DSP Ch.2; Part 3) |
| 2000 | McClure report released – the report was a precursor to 2006 welfare reforms. | LIB-NPA (Howard) | The McClure Report \(^{lxii}\) |
| 2006 | Welfare reforms introduced focusing on workfare, including:  
- reducing the ability to work requirement from 30hrs per week to 15hrs per week; and  
- the introduction of Work Capacity Assessments. | LIB-NPA (Howard) | Budget Speech 2005-06 \(^{lxiii}\) |
| 2011 | DSP claimants without severe impairments must demonstrate participation in a Program of Support. | ALP (Gillard) | Guide to Social Security Law\(^{lxiv}\) |
| 2012 | Impairment Tables revised “bring them into line with contemporary medical and rehabilitation practice”. \(^{lxv}\) | ALP (Gillard) | Review of the tables for the assessment of work-related impairment for Disability Support Pension: Advisory committee final report \(^{lxvi}\) |
| 1 July | Two changes:  
- certain DSP recipients under 35 with some work capacity are subject to work requirements as part of qualification of DSP; and  
- can keep DSP up to 30hrs per week. | | Disability Support Pension 2014 Budget measures factsheet \(^{lxvii}\) |

**Abbreviations:** ALP – Australian Labor Party; LIB-NPA – Liberal-National Party of Australia Coalition.
Appendix C: Excerpts from the Australian Impairment Tables

Table 5 – Mental Health Function

<table>
<thead>
<tr>
<th>Introduction to Table 5</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Table 5 is to be used where the person has a permanent condition resulting in functional impairment due to a mental health condition (including recurring episodes of mental health impairment).</td>
</tr>
<tr>
<td>• The diagnosis of the condition must be made by an appropriately qualified medical practitioner (this includes a psychiatrist) with evidence from a clinical psychologist (if the diagnosis has not been made by a psychiatrist).</td>
</tr>
<tr>
<td>• Self-report of symptoms alone is insufficient.</td>
</tr>
<tr>
<td>• There must be corroborating evidence of the person’s impairment.</td>
</tr>
<tr>
<td>• Examples of corroborating evidence for the purposes of this Table include, but are not limited to, the following:</td>
</tr>
<tr>
<td>o a report from the person’s treating doctor;</td>
</tr>
<tr>
<td>o supporting letters, reports or assessments relating to the person’s mental health or psychiatric illness;</td>
</tr>
<tr>
<td>o interviews with the person and those providing care or support to the person.</td>
</tr>
<tr>
<td>• In using Table 5 evidence from a range of sources should be considered in determining which rating applies to the person being assessed.</td>
</tr>
<tr>
<td>• The person may not have good self-awareness of their mental health impairment or may not be able to accurately describe its effects. This is to be kept in mind when discussing issues with the person and reading supporting evidence.</td>
</tr>
<tr>
<td>• The signs and symptoms of mental health impairment may vary over time. The person’s presentation on the day of the assessment should not solely be relied upon.</td>
</tr>
<tr>
<td>• For mental health conditions that are episodic or fluctuate, the rating that best reflects the person’s overall functional ability must be applied, taking into account the severity, duration and frequency of the episodes or fluctuations as appropriate.</td>
</tr>
</tbody>
</table>

41 Excerpt from Table 5 is from pp. 179 – 184.
<table>
<thead>
<tr>
<th>Points</th>
<th>Descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td><em>There is no functional impact on activities involving mental health function.</em></td>
</tr>
<tr>
<td></td>
<td>(1) The person has no difficulties with most of the following:</td>
</tr>
</tbody>
</table>
|        | (a) self care and independent living;  
Example: The person lives independently and attends to all self-care needs without support. |
|        | (b) social/recreational activities and travel;  
Example 1: The person goes out regularly to social and recreational events without support.  
Example 2: The person is able to travel to and from unfamiliar environments independently. |
|        | (c) interpersonal relationships;  
Example: The person has no difficulty forming and sustaining relationships. |
|        | (d) concentration and task completion;  
Example 1: The person has no difficulties concentrating on most tasks.  
Example 2: The person is able to complete a training or educational course or qualification in the normal timeframe. |
|        | (e) behaviour, planning and decision-making;  
Example: There is no evidence of significant difficulties in behaviour, planning or decision-making. |
|        | (f) work/training capacity.  
Example: The person is able to cope with the normal demands of a job which is consistent with their education and training. |
There is a *mild* functional impact on activities involving mental health function.

(1) The person has mild difficulties with most of the following:

(a) self care and independent living;

*Example:* The person lives independently but may sometimes neglect self-care, grooming or meals.

(b) social/recreational activities and travel;

*Example 1:* The person is not actively involved when attending social or recreational activities.

*Example 2:* The person sometimes is reluctant to travel alone to unfamiliar environments.

(c) interpersonal relationships;

*Example:* The person has interpersonal relationships that are strained with occasional tension or arguments.

(d) concentration and task completion;

*Example 1:* The person has difficulty focusing on complex tasks for more than 1 hour.

*Example 2:* The person has some difficulties completing education or training.

(e) behaviour, planning and decision-making;

*Example 1:* The person has unusual behaviours that may disturb other people or attract negative attention and may sometimes be more effusive, demanding or obsessive than is appropriate to the situation.

*Example 2:* The person has slight difficulties in planning and organising more complex activities.

(f) work/training capacity.

*Example:* The person has occasional interpersonal conflicts at work, education or training that require intervention by a supervisor, manager or teacher or changes in placement or groupings.
<table>
<thead>
<tr>
<th></th>
<th>There is a <strong>moderate</strong> functional impact on activities involving mental health function.</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1)</td>
<td>The person has moderate difficulties with most of the following:</td>
</tr>
<tr>
<td>(a)</td>
<td>self care and independent living;</td>
</tr>
<tr>
<td></td>
<td><em>Example:</em> The person needs some support (that is, an occasional visit by or assistance from</td>
</tr>
<tr>
<td></td>
<td>a family member or support worker) to live independently and maintain adequate hygiene and</td>
</tr>
<tr>
<td></td>
<td>nutrition.</td>
</tr>
<tr>
<td>(b)</td>
<td>social/recreational activities and travel;</td>
</tr>
<tr>
<td></td>
<td><em>Example 1:</em> The person goes out alone infrequently and is not actively involved in social</td>
</tr>
<tr>
<td></td>
<td>events.</td>
</tr>
<tr>
<td></td>
<td><em>Example 2:</em> The person will often refuse to travel alone to unfamiliar environments.</td>
</tr>
<tr>
<td>(c)</td>
<td>interpersonal relationships;</td>
</tr>
<tr>
<td></td>
<td><em>Example:</em> The person has difficulty making and keeping friends or sustaining relationships.</td>
</tr>
<tr>
<td>(d)</td>
<td>concentration and task completion;</td>
</tr>
<tr>
<td></td>
<td><em>Example 1:</em> The person finds it very difficult to concentrate on longer tasks for more than</td>
</tr>
<tr>
<td></td>
<td>30 minutes (such as reading a chapter from a book).</td>
</tr>
<tr>
<td></td>
<td><em>Example 2:</em> The person finds it difficult to follow complex instructions (such as from an</td>
</tr>
<tr>
<td></td>
<td>operating manual, recipe or assembly instructions).</td>
</tr>
<tr>
<td>(e)</td>
<td>behaviour, planning and decision-making;</td>
</tr>
<tr>
<td></td>
<td><em>Example 1:</em> The person has difficulty coping with situations involving stress, pressure or</td>
</tr>
<tr>
<td></td>
<td>performance demands.</td>
</tr>
<tr>
<td></td>
<td><em>Example 2:</em> The person has occasional behavioural or mood difficulties (such as temper</td>
</tr>
<tr>
<td></td>
<td>outbursts, depression, withdrawal or poor judgement).</td>
</tr>
<tr>
<td></td>
<td><em>Example 3:</em> The person’s activity levels are noticeably increased or reduced.</td>
</tr>
<tr>
<td>(f)</td>
<td>work/training capacity;</td>
</tr>
<tr>
<td></td>
<td><em>Example:</em> The person often has interpersonal conflicts at work, education or training that</td>
</tr>
<tr>
<td></td>
<td>require intervention by supervisors, managers or teachers or changes in placement or</td>
</tr>
<tr>
<td></td>
<td>groupings.</td>
</tr>
</tbody>
</table>
There is a severe functional impact on activities involving mental health function.

(1) The person has severe difficulties with most of the following:

(a) self care and independent living;

Example: The person needs regular support to live independently, that is, needs visits or assistance at least twice a week from a family member, friend, health worker or support worker.

(b) social/recreational activities and travel;

Example: The person travels alone only in familiar areas (such as the local shops or other familiar venues).

(c) interpersonal relationships;

Example 1: The person has very limited social contacts and involvement unless these are organised for the person.

Example 2: The person often has difficulty interacting with other people and may need assistance or support from a companion to engage in social interactions.

(d) concentration and task completion;

Example 1: The person has difficulty concentrating on any task or conversation for more than 10 minutes.

Example 2: The person has slowed movements or reaction time due to psychiatric illness or treatment effects.

(e) behaviour, planning and decision-making;

Example: The person’s behaviour, thoughts and conversation are significantly and frequently disturbed.

(f) work/training capacity.

Example: The person is unable to attend work, education or training on a regular basis over a lengthy period due to ongoing mental illness.
There is an **extreme** functional impact on activities involving mental health function.

(1) The person has extreme difficulties with most of the following:

(a) self care and independent living;

*Example 1:* The person needs continual support with daily activities and self care.

*Example 2:* The person is unable to live on their own and lives with family or in a supported residential facility or similar, or in a secure facility.

(b) social/recreational activities and travel;

*Example:* The person is unable to travel away from own residence without a support person.

(c) interpersonal relationships;

*Example:* The person has extreme difficulty interacting with other people and is socially isolated.

(d) concentration and task completion;

*Example 1:* The person has extreme difficulty in concentrating on any productive task for more than a few minutes.

*Example 2:* The person has extreme difficulty in completing tasks or following instructions.

(e) behaviour, planning and decision-making;

*Example 1:* The person has severely disturbed behaviour which may include self harm, suicide attempts, unprovoked aggression towards others or manic excitement.

*Example 2:* The person’s judgement, decision-making, planning and organisation functions are severely disturbed.

(f) work/training capacity.

*Example:* The person is unable to attend work, education or training sessions other than for short periods of time.
Table 6 – Functioning related to Alcohol, Drug and Other Substance Use

Introduction to Table 6

- Table 6 is to be used where the person has a permanent condition resulting in functional impairment due to excessive use of alcohol, drugs or other harmful substances (e.g. glue or petrol) or the misuse of prescription drugs.
- This Table applies to people who have current, continuing alcohol, drug or other harmful substance use disorders and those in active treatment.
- Former users with resulting long-term impairments should be assessed under the relevant Table(s).

Example: Table 7 (Brain Function) should be used where the person has permanent neurological impairment resulting from previous alcohol, drug or other harmful substance use.

- The diagnosis of this condition must be made by an appropriately qualified medical practitioner.
- Self-report of symptoms alone is insufficient.
- There must be corroborating evidence of the person’s impairment.
- Examples of corroborating evidence for the purposes of this Table include, but are not limited to, the following:
  - a report from the person’s treating doctor;
  - a report from a medical specialist (e.g. addiction medicine specialist or psychiatrist with experience in diagnosis or treatment of substance use disorders) confirming diagnosis of substance use disorder and resulting impairment of other body systems or functions;
  - results of investigations (e.g. liver function tests, alcohol and substance use assessment scales);
  - reports or other records of participation in treatment or rehabilitation programs;
  - work or training attendance records.

- The use of drugs or alcohol does not in itself constitute or necessarily indicate permanent impairment.

<table>
<thead>
<tr>
<th>Points</th>
<th>Descriptors</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>There is no functional impact from alcohol, drugs or other harmful substance use.</td>
</tr>
<tr>
<td></td>
<td>(1) The person:</td>
</tr>
<tr>
<td></td>
<td>(a) is able to reliably attend and effectively participate in work, education or training activities; and</td>
</tr>
<tr>
<td></td>
<td>(b) attends to all aspects of personal care and daily living tasks.</td>
</tr>
<tr>
<td>5</td>
<td>There is mild functional impact from alcohol, drugs or other harmful substance use.</td>
</tr>
<tr>
<td></td>
<td>(1) At least one of the following applies:</td>
</tr>
<tr>
<td></td>
<td>(a) the person engages in alcohol or illicit drug use and experiences some physical or cognitive effects that carry over into working hours (e.g. poor concentration, lethargy, irritability); or</td>
</tr>
<tr>
<td></td>
<td>(b) the person has occasional difficulties in reliably attending work, education or training sessions or appointments or completing duties or assigned tasks; or</td>
</tr>
<tr>
<td></td>
<td>(c) the person is sometimes absent from work, education or training activities due to the effects of alcohol, drugs or other harmful substance use.</td>
</tr>
</tbody>
</table>

---

42 Excerpt from Table 6 is from pp. 185 – 186.
There is **moderate** functional impact from alcohol, drugs or other harmful substance use.

(1) Most of the following apply:

(a) the person regularly uses alcohol, drugs or other harmful substances and as a result experiences difficulties performing physical or cognitive tasks;

(b) the person often has difficulty completing daily tasks and responsibilities due to the short term or long term effects of alcohol, drugs or other harmful substances;

(c) the person’s use of alcohol, drugs or other harmful substances is having a detrimental effect on family or social relationships and activities;

(d) the person has more frequent difficulties in reliably attending appointments or completing duties or assigned tasks;

(e) the person is often absent from work, education or training activities due to the effects of alcohol, drugs or other harmful substance use.

(2) This impairment rating level includes a person in receipt of treatment and in sustained remission (e.g. a person who is receiving Methadone treatment or other opiate replacement therapy) and who is able to complete most activities of daily living.

There is **severe** functional impact from alcohol, drug or other harmful substance use.

(1) Most of the following apply:

(a) the person neglects personal care, hygiene, nutrition and general health;

(b) the person spends most of the time using, procuring or recovering from the effects of, alcohol, drugs or other harmful substance use;

(c) there is medical or psychological evidence that the person has physical or cognitive impairment resulting from excessive use of alcohol, drugs or other harmful substances (e.g. diagnosed end organ damage, psychological or psychiatric assessment showing sustained and significant impairment or behavioural dysfunction linked to brain damage resulting from substance use);

(d) remission is only very brief if it occurs;

(e) the person is frequently absent from work, education or training activities due to the effects of alcohol, drugs or other harmful substance use.

There is an **extreme** functional impact from alcohol, drug or other harmful substance use.

(1) Most of the following apply:

(a) the person has a long-term, entrenched and diagnosed alcohol, drug or other harmful substance use disorder and has engaged in multiple attempts at various treatment programs without any significant periods of sustained remission or sustained improvement;

(b) the person neglects most aspects of self care, family relationships, social interaction and community involvement;

(c) there is well-documented medical evidence of significant and permanent damage to physical health (e.g. failure of the liver or other organs) or diagnosed brain injury with severely impaired cognitive function resulting from alcohol, drugs or other harmful substance use;

(d) the person is rarely able to attend work, education, or training activities due to the effects of alcohol, drugs or other harmful substance use.
Appendix D: Flow chart of DSP assessment process

DSP Claim

Meets non-medical criteria e.g. residence, age, means test

Yes

No

Medical report or other evidence

Reject

Manifest
- IQ less than 70
- Terminal condition
- Needs nursing home level care
- Permanent blind
- HIV/AIDS stage IV

Yes

No

Grant DSP

Job Capacity Assessment

20 points or more under the Impairment Tables

AND

Continuing Inability to Work

Yes

No

Grant DSP

Reject

43 Flow chart received from a key informant.
### Appendix E: Brief history of disability income support in Ontario

<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Provincial Government</th>
<th>Key document(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1943</td>
<td>The Marsh Report – ‘Blueprint’ for the modern Canadian social security system.</td>
<td>PC (Drew)</td>
<td>The Marsh Report&lt;sup&gt;lxix&lt;/sup&gt;</td>
</tr>
<tr>
<td>1990</td>
<td>Introduction of the <em>Family Benefits Act, 1990</em>, definition of disability included those who are disabled and permanently unemployable (e.g. due to lack of education or labour market availability).</td>
<td>Liberals (Peterson)</td>
<td><em>Family Benefits Act, 1990</em>&lt;sup&gt;lxx&lt;/sup&gt;</td>
</tr>
<tr>
<td>1996</td>
<td>The Canada Assistance Plan CAP expires – ban on workfare eliminated.</td>
<td>PC (Harris)</td>
<td></td>
</tr>
<tr>
<td>1997</td>
<td>Ontario Disability Support Program, a separate program for people with disabilities, replaces the <em>Family Benefit Act, 1990</em>. Eligibility no longer includes those that are permanently unemployable.</td>
<td>PC (Harris)</td>
<td><em>Ontario Disability Support Program Act, 1997</em>&lt;sup&gt;lxxi&lt;/sup&gt;</td>
</tr>
<tr>
<td>2001</td>
<td>Case law: Gallier case – ‘the person’ – ODSP adjudicators must consider the context of the person’s own circumstances.</td>
<td>PC (Harris)</td>
<td>[<em>Ontario (Director of Ontario Disability Support Program) v. Gallier</em>]&lt;sup&gt;lxxii&lt;/sup&gt;</td>
</tr>
<tr>
<td>2002</td>
<td>Case law: Gray case – broadened the interpretation of the ODSP definition of disability.</td>
<td>PC (Harris)</td>
<td><em>Gray v. Ontario (Director, Ontario Disability Support Program)</em>&lt;sup&gt;lxxiii&lt;/sup&gt;</td>
</tr>
<tr>
<td>2004</td>
<td>Review of employment assistance programs in OW &amp; ODSP.</td>
<td>Liberals (McGuinty)</td>
<td>Review of Employment Assistance Programs in Ontario Works and <em>Ontario Disability Support Program</em>&lt;sup&gt;lxxiv&lt;/sup&gt;</td>
</tr>
<tr>
<td>2008</td>
<td>Poverty Reduction Strategy launched including a commitment to reviewing social assistance.</td>
<td>Liberals (McGuinty)</td>
<td><em>Breaking the cycle: Ontario’s poverty reduction strategy</em>&lt;sup&gt;lxv&lt;/sup&gt;</td>
</tr>
<tr>
<td>2009</td>
<td>Case law: Tranchemontagne case – addictions exclusion Addictions are now considered eligible for ODSP.</td>
<td>Liberals (McGuinty)</td>
<td>Tranchemontagne v. <em>Ontario (Director, Disability Support Program)</em>&lt;sup&gt;lxvi lxxvii&lt;/sup&gt;</td>
</tr>
<tr>
<td>2012</td>
<td>Social Assistance Commission releases final report (September)</td>
<td>Liberals (McGuinty)</td>
<td>Brighter prospects: Transforming social assistance in Ontario&lt;sup&gt;lxxix&lt;/sup&gt;</td>
</tr>
</tbody>
</table>

**Abbreviations:** ODSP – Ontario Disability Support Program; OW – Ontario Works; PC – Progressive Conservative Party.
Appendix F: Flow chart of the ODSP assessment process

ODSP Claim

Meets non-medical criteria e.g. prove financial eligibility

Yes
- Manifest if:
  - receive Canada or Quebec PPD benefits
  - are 65 or older but do not qualify for OAS
  - live in certain types of institutions (e.g. mental health facility)

No
   
Reject

Aplicant completes Disability Determination Package within 90 days*

Yes
Grant ODSP

No
Disability Determination Process: DAU decides if the applicant's condition in the DDP meets the definition of disability

Yes
Grant ODSP

No
Reject

*DDP includes the Health Status Report and Activities of Daily Living Index completed by a health professional; and a self-report form completed by the applicant. Abbreviations: DAU - Disability Adjudication Unit; DDP - Disability Determination Package, OAS - Old Age Security, PPD - Pension Plan Disability

---

44 Flow chart based on information from MCSS (2008a).
Appendix G: Medline via OVID search strategy

Disability income support

1. (disability adj3 income adj1 support).tw
2. (disability adj3 support).tw
3. (invalid adj1 pension).tw
4. (disability adj3 social adj2 welfare).tw
5. (disability adj2 welfare).tw
6. (disability adj3 benefits).tw
7. (disability adj3 payments).tw
8. (Social adj1 security disability adj3 insurance).tw
9. (disability adj3 insurance).tw
10. (disability adj1 pension).tw
11. (disability adj1 public adj1 assistance).tw
12. (Ontario adj1 Disability adj1 Support adj1 Program).mp
13. (Disability adj1 Support adj1 Pension).mp
14. exp social security/
15. Public assistance/
16. 1 or 2 or 3 or 4 or 5 or 6 or 7 or 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15

Mental illness

17. exp Mental disorder/
18. (mental adj1 disorder$).tw
19. (mental$ adj1 illness$).tw
20. (mental adj1 health adj1 problems).tw
21. (psychiatric adj1 disabilit$).tw
22. (psychiatric adj1 impairment$).tw
23. (psychiatric adj1 disorder$).tw
24. 17 or 18 or 19 or 20 or 21 or 22 or 23
25. exp Depression/
26. (depress$ or dysthymi$).tw
27. ("depression" or "depressive adj1 disorder$" or "dysthymic disorder$").tw
28. 25 or 26 or 27
29. exp Schizophrenia/
30. schizophren$tw.
31. 29 or 30
32. exp Substance-Related Disorders/
33. (substance adj1 related adj1 disorder$).tw
34. (substance adj1 abus$).tw
35. (substance adj1 misus$).tw
36. (substance adj1 depende$).tw
37. (drug adj1 addict$).tw
38. (drug adj1 misu$).tw
40. (alcohol adj1 addict$).tw
41. (alcohol adj1 abus$).tw
42. (alcohol misus$).tw
43. (alcohol depend$).tw
44. 32 or 33 or 34 or 35 or 36 or 37 or 38 or 39 or 40 or 41 or 42 or 43
45. 24 or 28 or 31 or 44
46. 16 and 45
47. Ontari$.tw.
49. Canad$.tw.
50. 47 or 48 or 49
51. 46 and 50
52. Limit 51 to yr = “1991 – 2011”
Appendix H: Summary of articles identified by database

<table>
<thead>
<tr>
<th>Database</th>
<th>Date</th>
<th>Filters used</th>
<th>No. of articles</th>
</tr>
</thead>
<tbody>
<tr>
<td>Embase</td>
<td>05/03/13</td>
<td>Language: English Period: 1991 – 2011</td>
<td>974</td>
</tr>
<tr>
<td>ProQuest Health &amp; Medical</td>
<td>05/03/13</td>
<td>Language: English Period: 1991 – 2011</td>
<td>6</td>
</tr>
<tr>
<td>Scopus</td>
<td>05/03/13</td>
<td>Language: English Period: 1991 – 2011</td>
<td>4</td>
</tr>
</tbody>
</table>
Appendix I: List of websites searched for ‘grey’ literature

<table>
<thead>
<tr>
<th>Australia</th>
<th>Ontario</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>GOVERNMENT DEPARTMENTS</strong></td>
<td></td>
</tr>
<tr>
<td>• Department of Families, Housing, Community Services and Indigenous Affairs;</td>
<td>• Ontario Ministry for Community and Social Services; and</td>
</tr>
<tr>
<td>• Department of Education, Employment and Workplace Relations;</td>
<td>• Ontario Ministry of Health and Long-term Care.</td>
</tr>
<tr>
<td>• Department of Health and Ageing; and</td>
<td></td>
</tr>
<tr>
<td>• Department for Human Services.</td>
<td></td>
</tr>
<tr>
<td><strong>GOVERNMENT AGENCIES</strong></td>
<td></td>
</tr>
<tr>
<td>• Australian Institute for Health and Welfare;</td>
<td>• Ontario Ombudsman;</td>
</tr>
<tr>
<td>• Commonwealth Ombudsman;</td>
<td>• Social Assistance Review; and</td>
</tr>
<tr>
<td>• Parlinfo; and</td>
<td>• Canadian Council on Social Development.</td>
</tr>
<tr>
<td>• Australian Institute of Family Studies.</td>
<td></td>
</tr>
<tr>
<td><strong>PEAK BODIES</strong></td>
<td></td>
</tr>
<tr>
<td>• Australian Council of Social Services (ACOSS);</td>
<td>• The Canadian Mental Health Association (CMHA);</td>
</tr>
<tr>
<td>• Mental Health Council for Australia (MHCA);</td>
<td>• The Centre for Addiction and Mental Health (CAMH);</td>
</tr>
<tr>
<td>• Alcohol and other Drugs Council of Australia; and</td>
<td>• Canadian Alliance on Mental Illness and Mental Health (CAMIMH);</td>
</tr>
<tr>
<td>• National Welfare Rights Network.</td>
<td>• Ontario Disability Support Program (ODSP) Action Coalition;</td>
</tr>
<tr>
<td></td>
<td>• Income Security Advocacy Centre (ISAC); and</td>
</tr>
<tr>
<td></td>
<td>• Arch Disability Law.</td>
</tr>
</tbody>
</table>

**Brief description of search strategy:**

- Key words were typed into each website’s search engine;
- Search results (only the first 5 pages of results) were culled by opening the document/webpage and searching for the name of the program (e.g. Disability Support Pension or Ontario Disability Support Program);
- All ‘hits’ that included the name of the program and reference to mental illness were screened using titles and abstracts (or executive summaries). Duplicates or articles that were not relevant were culled; and
- All remaining articles were fully reviewed.
Appendix J: PRISMA flow diagram of the literature review process

1,214 documents identified in databases

Duplicate n = 117

1,097 documents reviewed by title and abstract

Duplicate n = 4

Excluded based on title and abstract n = 1031

116 documents reviewed by title and abstract

Excluded based on title and abstract n = 60

142 documents requiring full-text and review

123 documents excluded. Main reasons for exclusion:
- opinion piece;
- did not meet outcome criteria;
- lacked critical engagement about DIS design or mental illness;
- focused on employment outcomes;
- focused on prevalence of DIS recipients; or
- focused on other types of income support.

19 documents included

19 documents included

Peer-reviewed n = 5

Government reports n = 2

Legal reports n = 5

Other reports n = 2

Stakeholder reports n = 5
### Appendix K: Quality appraisal instrument

The following document was developed by Gallacher et al. (2013):

<table>
<thead>
<tr>
<th>Appraisal Question (apply each question to the whole study to reach an overall conclusion i.e. aims, sampling, data collection, data analysis, interpretations)</th>
</tr>
</thead>
</table>
| **Does the research, as reported, illuminate the subjective meaning, actions, and context of those being researched?**  
  i.e. is it ensured through design and analysis that emphasis is given to the interpretations of those being researched rather than the researcher’s or professional’s viewpoint? |
| **Are subjective perceptions and experiences treated as knowledge in their own right?**  
  i.e. does the study treat the data collected directly from the participants, representing their viewpoint, as the basic data for analysis? |
| **Is there evidence of the adaptation and responsiveness of the research design to the circumstances and issues of real-life social settings met during the course of the study?**  
  i.e. is the process of sampling, data collection, data analysis and interpretation iterative? Is there evidence of adaptation and redesign as the study has progressed? |
| **Does the sample produce the type of knowledge necessary to understand the structures and processes within which the individuals or situations are located?**  
  i.e. is sampling appropriate for the aims, objectives, methods and conclusions reached? |
| **Is the description provided detailed enough to allow the researcher or reader to interpret the meaning and context of what is being researched?**  
  i.e. is a rich picture produced, providing the context of an experience and the intentions and meanings that feed into it, rather than simply a set of facts? |
| **Are any different sources of knowledge about the same issue compared and contrasted and how is this done?**  
  i.e. are different methods used to answer the research question and are these examined not only for similarities but for providing different facets of the reality being investigated? |
| **Has the researcher rendered transparent the processes by which data have been collected, analyzed, and presented?**  
  i.e. is the whole process clear to the reader? |
| **Has the researcher made clear their own possible influence on the data?**  
  i.e. has the researcher stated their own background / experience and ontological / epistemological stance? |
| **Is it clear how the research moves from a description of the data, through quotation or examples, to an analysis and interpretation of the meaning and significance of it?**  
  i.e. what did the researcher do to reach their conclusions and does this make sense from the original data? |
| **Are claims being made for the generalizability of the findings to either other bodies of knowledge or to other populations or groups and if so what are these claims?**  
  i.e. is it made clear which settings the findings can be applied to and does this seem to fit? |
| **Is there any other aspect of the study that may affect the quality e.g. conflict of interest?** |
### Appendix L: Excerpt from the Ontario Activity Daily Living Index

These questions **must** be completed for all clients.

These questions seek to describe the impact of the impairment on the applicant's ability to attend to his or her personal care, function in the community and function in a workplace. It seeks to understand the restrictions in the activity specified. Please use the scaling below:

<table>
<thead>
<tr>
<th>Class 1</th>
<th>Class 2</th>
<th>Class 3</th>
<th>Class 4</th>
</tr>
</thead>
<tbody>
<tr>
<td>Within normal limits. Or Not applicable. Note: Does not prevent the performance of any activity.</td>
<td>Mild or slight limitations. Note: May result in slightly longer time requirements to complete the task or mild exacerbation of pain. Or Accommodation may be required to complete the task.</td>
<td>Medium or moderate limitations. Or Requires considerably longer time to complete the task and may on some occasions be unable to complete the task with or without accommodations and with or without moderate pain.</td>
<td>Severe or complete limitations on most occasions to completion of the task.</td>
</tr>
</tbody>
</table>

**Sample**

1. Orientation to time, person and place
2. Recognizes within normal limits common dangers in the home, workplace or community
3. Ability to comprehend, express or communicate orally
4. Use the telephone
5. Exhibits normal limits of functioning with respect to intelligence
6. Exhibits normal limits of functioning with respect to impulse control and behaviour
7. Responds within normal limits to situations requiring memory (e.g. remember where he/she lives, names of family and friends, etc.)
8. Attention span is sustainable and appropriate to task
9. Physical strength commensurate with person’s age and sex
10. Ability to participate physically in sustained activity
11. Walks three blocks or more on level ground without need to rest
12. Climbs up or down one flight of stairs (six steps)
13. Able to use means of public transport if available
14. Wash all parts of the body able to maintain personal hygiene and grooming
15. Select clothes for weather and situations
16. Bowel and bladder control
17. Can take medication(s) as directed and handlestore medication(s) safely
18. Is able to utilize commercial services (bank, hydro, phone company, etc.)
19. Financially responsible for his/her own affairs (e.g. applicant can function independently)
20. Able to feed oneself
21. Do housekeeping (cleaning, laundry, meal preparation, shopping for essentials such as groceries, clothes, etc.)
22. Able to stand
23. Able to sit for a sustained period
24. Able to transfer to and from chair, toilet, wheelchair, etc.

---

45 Ontario Activity Daily Living Index received from a key informant.
## Appendix M: Characteristics of selected excluded articles

<table>
<thead>
<tr>
<th>Article</th>
<th>Type of article</th>
<th>Disability income support</th>
<th>Mental illness</th>
<th>Location</th>
<th>Time</th>
<th>Outcome criterion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bill et al. (2001)</td>
<td>Peer-reviewed</td>
<td>✓</td>
<td>✓</td>
<td>Aus</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Butterworth (2006)</td>
<td>Peer-reviewed</td>
<td>✓</td>
<td>✓</td>
<td>Aus</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Butterworth et al. (2003)</td>
<td>Peer-reviewed</td>
<td>✓</td>
<td>✓</td>
<td>Aus</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Butterworth et al. (2011b)</td>
<td>Peer-reviewed</td>
<td>✓</td>
<td>✓</td>
<td>Aus</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Butterworth et al. (2004)</td>
<td>Peer-reviewed</td>
<td>✗</td>
<td>✓</td>
<td>Aus</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Carney (2006)</td>
<td>Book</td>
<td>✓</td>
<td>✗</td>
<td>Aus</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Forchuk et al. (2006)</td>
<td>Commentary (in journal)</td>
<td>✓</td>
<td>✓</td>
<td>Ont</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Gewurtz (2011)</td>
<td>Thesis</td>
<td>✓</td>
<td>✓</td>
<td>Ont</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Gewurtz (2012)</td>
<td>Peer-reviewed</td>
<td>✓</td>
<td>✓</td>
<td>Ont</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Lankin and Sheikh (2012)</td>
<td>‘Grey’ literature</td>
<td>✓</td>
<td>✓</td>
<td>Ont</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Lightman et al. (2011)</td>
<td>Peer-reviewed</td>
<td>✓</td>
<td>✓</td>
<td>Ont</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>OECD (2010b)</td>
<td>‘Grey’ literature</td>
<td>✓</td>
<td>✓</td>
<td>Aus</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Purnima and Ochocka (2010a)</td>
<td>Peer-reviewed</td>
<td>✓</td>
<td>✓</td>
<td>Ont</td>
<td>✓</td>
<td>✗</td>
</tr>
<tr>
<td>Wilton (2009)</td>
<td>Peer-reviewed</td>
<td>✓</td>
<td>✓</td>
<td>Ont</td>
<td>✓</td>
<td>✗</td>
</tr>
</tbody>
</table>
Appendix N: Initial interview guide

SEMI-STRUCTURED INTERVIEW GUIDE:
Are welfare reforms appropriate for people with mental illness?

As the interviews are semi-structured, the following are examples of topics and questions that may be asked however each interview will be data driven and therefore questions will vary depending on responses from the preceding interviews.

Code:

Date: Start Time:
Location: End Time:

Interviewer Name:

INTRODUCTIONS
Introductory spiel such as non-judgmental environment, confidentiality, why audiotaping is needed and how the data will be used etc. Provide a brief overview of purpose of the interview and broader project. Provide information sheet, get consent and start recording.

Sample Questions:
• What is/was your role?
• What is/was your role in your agency/organisation?
• How long have/were you been working there?

CONTEXT & POLICY EVOLUTION
• What is your recollection of the main problem that the welfare reforms were supposed to address?
• What was the main objective of the reforms?
• Could you describe the social, political and economic climate during the reforms?
• What were the main factors that were considered in the reforms?
• What specific illnesses/disabilities were you targeting in the reforms?

POLICY BREAKTHROUGH
• What were the key factor(s) in the shift of welfare policy towards mutual obligation?
• Who were some of the key players
  • How did they influence this change?
• What are some of the key factors contributing to the increase of welfare recipients at the time of the reforms?
DESIGN OF REFORMS
- What other options for reforms were considered?
  - Why were these options not chosen?
- What can you tell us about the design of the reforms and its key components?
- What agencies/departments were involved in the reforms?
- Can you explain your role in the reforms?
- What role did cross-jurisdictional analysis play in the design of the reforms?
  - Looking to see if any comparator countries are mentioned.

DECISION-MAKING OF WELFARE REFORMS
- Who were the main organisations or individuals involved in the reforms (either as advocates or opposition)?
  - How did their decisions or actions influence the design of the overall reforms?
- What were some of the main factors of agreement and disagreement on the proposed reforms?

RESULTS
- How well did the reforms meet their objectives?
- What do you think the overall impacts of the reforms have been?
- What key lessons could we draw from this experience?
  - What were the main factors that worked, and what did not work?
  - Why, and how?
- Knowing the impacts, would you have taken a different approach to the reforms?
- What are your thoughts on the current reforms?
- In your view, what is the way forward in addressing the current challenges of disability and welfare caseloads?

CONCLUSION
- Do you have any other comments that you want to make on welfare reforms?
- Is there anyone else who we should interview?
- I have no more questions. Do you have any questions for us?

BASIC DEMOGRAPHIC DATA
- Age
- Sex
- Current occupation
- Previous occupation
- Role in reforms

Thank you very much for participating in this project and spending time being interviewed today.
Appendix O: Updated interview guide

SEMI-STRUCTURED INTERVIEW GUIDE:
Comparing how disability income support is designed in Australia and Ontario for people with mental illness

INTRODUCTIONS
Introductory spiel such as non-judgmental environment, confidentiality, why audiotaping is needed and how the data will be used etc. Provide a brief overview of purpose of the interview and broader project. Provide information sheet, get consent and start recording.

Aim: Interview people involved in policy design or implementation to better understand how disability income support (DIS) has evolved over the last 20 years and what these changes may mean for a person with a mental illness and how mental illness is perceived in general when applying for DIS.

I have some questions but they are meant to be starting points, please feel free to add anything that you think is important.

OPENING QUESTIONS:

- Can you describe your work related to the ODSP/DSP income support program?
- What would you say is the overall objective of the ODSP/DSP program?
- Can you describe the gateway to get onto the ODSP/DSP program?
- Who would you consider to be the main gatekeepers to the program?
- Some policy-makers that I’ve spoken to have said we need to make sure we capture the ‘right’ sort of person on the program. Could reflect on what that might mean to have the ‘right’ sort of person to receiving ODSP/DSP might be?
  - Do you think the program currently captures the ‘right’ sort of person?
  - Can you describe a typical kind of person that would be suited to receiving a DSP payment?
- Can you tell me about any challenges that people with a mental illness might face in terms of the gateways or gatekeepers to the program?
  - Because of the nature of mental illness?
  - Because of attitudes or perceptions of mental illness?
Appendix P: Characteristics of the key informants

<table>
<thead>
<tr>
<th>Demographic</th>
<th>n = 45</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Sex</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Female</td>
<td>24</td>
<td>53%</td>
</tr>
<tr>
<td>Male</td>
<td>21</td>
<td>47%</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Under 25</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>25 - 34</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>35 - 44</td>
<td>5</td>
<td>11%</td>
</tr>
<tr>
<td>45 - 54</td>
<td>13</td>
<td>29%</td>
</tr>
<tr>
<td>55 - 64</td>
<td>13</td>
<td>29%</td>
</tr>
<tr>
<td>65+</td>
<td>5</td>
<td>11%</td>
</tr>
<tr>
<td>No answer provided</td>
<td>7</td>
<td>16%</td>
</tr>
<tr>
<td><strong>Location</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Australia</td>
<td>20</td>
<td>44%</td>
</tr>
<tr>
<td>Ontario</td>
<td>25</td>
<td>56%</td>
</tr>
<tr>
<td><strong>Primary disciplines</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Law</td>
<td>5</td>
<td>11%</td>
</tr>
<tr>
<td>Social policy</td>
<td>13</td>
<td>29%</td>
</tr>
<tr>
<td>Mental health</td>
<td>7</td>
<td>16%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>5</td>
<td>11%</td>
</tr>
<tr>
<td>Medicine</td>
<td>4</td>
<td>9%</td>
</tr>
<tr>
<td>Psychology</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Occupational therapy</td>
<td>1</td>
<td>2%</td>
</tr>
<tr>
<td>Economics</td>
<td>5</td>
<td>11%</td>
</tr>
<tr>
<td>Public policy</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td>No answer provided</td>
<td>2</td>
<td>4%</td>
</tr>
<tr>
<td><strong>Type of informant</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Advocate</td>
<td>5</td>
<td>11%</td>
</tr>
<tr>
<td>Legal representative</td>
<td>5</td>
<td>11%</td>
</tr>
<tr>
<td>Physician</td>
<td>10</td>
<td>22%</td>
</tr>
<tr>
<td>Policy insider</td>
<td>21</td>
<td>47%</td>
</tr>
<tr>
<td>Researcher</td>
<td>4</td>
<td>9%</td>
</tr>
</tbody>
</table>
Comparing how disability income support is designed in Australia and Ontario for people with mental illness

PARTICIPANT INFORMATION STATEMENT

(1) What is the study about?

You have been invited to participate in a study that seeks to understand how disability income support (DIS) policy is designed (particularly how disability is defined in DIS policy) and to identify key areas for improvements to better meet the needs of those with a mental illness. We have selected you as a potential participant because you are or have been involved in welfare reform policy or mental health policy.

Our research seeks to identify the drivers and policy barriers in designing DIS policy relevant to the local policy environment and comparing across Australia and Canada. We will conduct a policy analysis to evaluate the extent to which the design of DIS considers the unique nature of mental illnesses and identify key areas to improvement in the policy design process.

This study is important as more information is needed to better understand the historical, social, political and economic context of welfare reforms in relation to mental illness. This information will contribute to improvements to income support for people with mental illness in the future.

(2) Who is carrying out the study?

The study is being conducted by Ashley McAllister and will form the basis of her Doctor of Philosophy dissertation and papers in public health at the Menzies Centre for Health Policy within the School of Public Health and the George Institute for Global Health at the University of Sydney under the supervision of Professor Stephen Leeder, Professor of Public Health, The University of Sydney and Associate Professor Marise Hackell, Senior Research Fellow, Neurological and Mental Health Division, The George Institute for Global Health (affiliated with The University of Sydney).

(3) What does the study involve?

If you agree to participate in this study, you will be asked to take part in an interview with Ashley McAllister. This interview will take place at a location and time convenient to you. She will ask you first to sign the Participant Consent Form. The interview will be audio-taped and discussion will focus on the large scale structural welfare reforms that began in the 1990s. You will also be asked about your role as either a policy-maker or mental health expert and your opinion about what you consider to be important historical, social and economic events that helped shape these reforms. You will have the opportunity to provide additional information that you would like to include but was not covered in the interview questions. At the end of the interview, you will be asked a few questions related to basic demographics (e.g. age, gender, occupation) which will be used in categorising the interview responses.
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You may also be invited to participate in a smaller group to elaborate on themes developed in the initial set of interviews. Ms McAllister will ask you at the end of the interview whether you may be interested in participating in future interviews.

(4) How much time will the study take?
The interview will take about 60-90 minutes.

(5) Can I withdraw from the study?
Yes, if you wish, at any time. Participation in this study is entirely voluntary. You do not have to take part. If you do take part, you can withdraw at any time without having to give a reason. Only the researchers named above will be aware of your participation or non-participation.

You may stop the interview at any time if you do not wish to continue or you may elect not to answer certain questions.

(6) Will anyone else know the results?
All the information collected from you for the study will be treated confidentially, and only the researchers named above will have access to it. The study results may be presented at a conference or in a scientific publication, but individual participants will not be identifiable.

(7) Will the study benefit me?
While we intend that this research study will further increase the knowledge about the appropriateness of current welfare policies for people with mental illness, it may not be of direct benefit to you.

(8) Can I tell other people about the study?
Yes. You are free to discuss your participation in this study with anyone.

(9) What if I require further information about the study or my involvement in it?
When you have read this information, Ashley McAllister will discuss it with you further and answer any questions you may have. If you would like to know more at any stage, please feel free to contact Ashley McAllister at The Menzies Centre for Health Policy on: (02) 9114 1114.

(10) What if I have a complaint or any concerns?
Any person with concerns or complaints about the conduct of a research study can contact The Manager, Human Ethics Administration, University of Sydney on +61 2 8627 8176 (Telephone); +61 2 8627 8177 (Facsimile) or ho.humanethics@sydney.edu.au (Email).

This information sheet is for you to keep.
Appendix R: Participant consent form

PARTICIPANT CONSENT FORM

I, .................................................................[PRINT NAME], give consent to my participation in the research project:

Title:
Comparing how disability income support is designed in Australia and Ontario for people with mental illness

In giving my consent I acknowledge that:

1. The procedures required for the project and the time involved have been explained to me, and any questions I have about the project have been answered to my satisfaction.

2. I have read the Participant Information Statement and have been given the opportunity to discuss the information and my involvement in the project with the researcher(s).

3. I understand that being in this study is completely voluntary – I am not under any obligation to consent.

4. I understand that my involvement is strictly confidential. I understand that any research data gathered from the results of the study may be published however no information about me will be used in any way that is identifiable.

5. I understand that I can withdraw from the study at any time, without affecting my relationship with the researcher(s) or the University of Sydney now or in the future.

6. I understand that I can stop the interview at any time if I do not wish to continue. Should you request it, the audio recording will be erased and the information provided will not be included in the study.

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7. I consent to:

- Audio-recording  YES  NO
- Receiving Feedback  YES  NO

If you answered YES to the "Receiving Feedback" question, please provide your details i.e. mailing address, email address.

**Feedback Option**

**Address:**


**Email:**


Signature

Please PRINT name

Date

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Page 1 of 2
Appendix S: Excerpt from the DSP medical report

<table>
<thead>
<tr>
<th>Condition 2</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diagnosis</td>
</tr>
<tr>
<td>A Diagnosis</td>
</tr>
<tr>
<td>The diagnosis is:</td>
</tr>
<tr>
<td>[ ] Confirmed</td>
</tr>
<tr>
<td>[ ] Presumptive</td>
</tr>
<tr>
<td>[ ] Are further investigations/tests planned to confirm the diagnosis?</td>
</tr>
<tr>
<td>[ ] No</td>
</tr>
<tr>
<td>[ ] Yes</td>
</tr>
<tr>
<td>Date of onset (if known) / / Date of diagnosis (if confirmed) / /</td>
</tr>
</tbody>
</table>

| Clinical features |
| B History |
| Provide details including etiology, precipitating factors, underlying causes, results and dates of investigations/procedures and specialist consultations (e.g., radiology, pathology, RTTs, specialist reports). |

| C Current symptoms |
| Provide details of the current clinical features and symptoms, including frequency and severity, experienced by the patient due to this condition. Be specific in indicating the severity of the medical impairment. |

| Treatment |
| D Current treatment |
| Provide details of all current treatment for this condition (e.g., surgery, medication, counselling, physical therapy, rehabilitation). Include specific details such as dates of commencement of treatment, frequency, duration, types, etc. |

| E Past treatment |
| Provide details of all significant past treatment, duration and responses. Include specific details such as dates of commencement of treatment, frequency, duration, types, etc. |

| F Future/planned treatment |
| Provide details of any further scheduled or proposed treatment with estimates of likely dates of commencement and expected duration. |

---

46 Excerpt from Centrelink (n.d.).
<table>
<thead>
<tr>
<th>Condition 2—continued</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>G  Patient's compliance with recommended treatment</strong></td>
</tr>
<tr>
<td>Very compliant □  Usually compliant □  Rarely compliant □  Uncertain □</td>
</tr>
<tr>
<td>Detail any issues related to assessing or undertaking suitable treatment that affect the level of compliance.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Impact on ability to function</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>H  Details about how this condition currently affects the patient's ability to function</strong></td>
</tr>
<tr>
<td>Be specific and consider the effects due to the condition alone.</td>
</tr>
<tr>
<td>Consider:</td>
</tr>
<tr>
<td>• ability to sit/stand/move</td>
</tr>
<tr>
<td>• endurance</td>
</tr>
<tr>
<td>• communication</td>
</tr>
<tr>
<td>• cognitive function</td>
</tr>
<tr>
<td>• ability for self care</td>
</tr>
<tr>
<td>• need for support in activities of daily living</td>
</tr>
<tr>
<td>• need for high levels of care (e.g., nursing home level of care)</td>
</tr>
<tr>
<td>• any adverse effects of treatment.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>I  The current impact of this condition on the patient's ability to function is expected to persist for:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 3 months □  3-24 months □  More than 24 months □</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>J  Within the next 2 years the effect of this condition on the patient's ability to function is expected to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Significantly improve □  Somewhat improve □  Fluctuate □</td>
</tr>
<tr>
<td>Remains unchanged □  Deteriorate □  Uncertain □  Not applicable □</td>
</tr>
<tr>
<td>Provide details, if relevant.</td>
</tr>
</tbody>
</table>

If there are more than 2 conditions that have a significant impact on ability to function, attach a separate sheet with details.

Note: The bottom of p. 5 above notes that if a person has more than two conditions a physician must attach a separate sheet with details.
ENDNOTES – TABLES AND APPENDICES

i (Baxter and Jack 2008)
ii (Yin 2014: 237)
iii (Sbaraini et al. 2011: 196)
iv (Kristiansen and Mooney 1993)
v (Kristiansen and Mooney 1993)
vi (Crisp, Gelder et al. 2000: 5)
vii (Crisp, Gelder et al. 2000: 5)
viii (Barry et al. 2014)
ix (Angermeyer and Matschinger 2003b: 528)
xi (Angermeyer and Matschinger 2003b: 528)
xii (Walker 2008: 47)
xiii (Walker 2008: 52)
xiv (Angermeyer and Matschinger 2003b: 528)
xv (Angermeyer and Matschinger 2003b: 528)
xvi (Angermeyer and Dietrich 2006)
xvii (Angermeyer and Dietrich 2006: 170)
xviii (Walker 2008: 47)
xix (Walker 2008: 47)
x x (Angermeyer and Dietrich 2006: 170)
x xi (Angermeyer and Dietrich 2006: 170)
x x ii (Savauge et al. 2003: 662)
x x iii (WHO 2014a)
x x iv (WHO 2014c)
x x v (American Psychiatric Association 2013d)
x x vi (American Psychiatric Association 2013b)
x x vi i (American Psychiatric Association 2013c)
x x vi ii (Carroll 1996)
x x vi ii i (Petry 2000)
x x vi ii ii (Rösn er et al. 2010)
x x vi ii iii (Garbutt et al. 1999)
x x vi ii iv (Mann et al. 2004)
x x vi ii v (Pampallona et al. 2004)
x x vi ii vi (Patel et al. 2007a: 993)
x x vi ii vi i (Chilvers et al. 2006)
x x vi ii vi ii (Marshall and Lockwood 1998)
x x vi ii vi iii (Moncrieff 2003)
x x vi ii vi iv (McClure 2000)
x x vi ii vi v (Lieberman et al. 2003)
x x vi ii vi vi (WHO 1980: 27)
x x vi ii vi vi i (WHO 1980: 28)
x x vi ii vi vi ii (WHO 2002: 10)
x x vi ii vi vi iii (WHO 2002: 10)
x x vi ii vi vi iv (DSS 2012)
x x vi ii vi vi v (DSS 1991)
x x vi ii vi vi vi (MCSS 1997)
x x vi ii vi vi vi i (MCSS 1997)
x x vi ii vi vi vi ii (Northern Officer Group n.d.: 1)
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x x x x iii (MCSS 1997)
x x x x iv (MCSS 1997)
x x x x v (MCSS 1997)
x x x x vi (ABS 2013)
x x x x vi i (Statistics Canada 2014a)
x x x x vi ii (DSS 2014b)
x x x x vi iii (Income Security Advocacy Centre 2014)
x x x x vi iv (DSS 2014d)
x x x x vi v (Income Security Advocacy Centre 2014)
x x x x vi vi (Australian Government 1908)
x x x x vi vi i (Cass et al. 1988)
x x x x vi vi ii (DSS 1991)
x x x x vi vi iii (McClure 2000)
(Costello 2005)  
(DSS 2011b)  
(DSS 2011a)  
(FaHCSIA 2011)  
(DSS 2014b)  
(DSS 2012)  
(Marsh 1943)  
(MCSS 1990)  
(MCSS 1997)  
(Ontario (Director of Disability Support Program) v. Gallier 2000)  
(Gray v. Director of the Ontario Disability Support Program 2002)  
(Matthews 2004)  
(Matthews 2009)  
(Ontario Disability Support Program v. Tranchemontagne 2009)  
(Tranchemontagne v. Ontario Disability Support Program (Director) 2009)  
(Nyberg et al. 2010)  
(Lankin and Sheikh 2012)