

**HELPING A CLIENT'S VOICE BE HEARD:  
ADVOCATES AND THE ODSP APPEALS PROCESS**

HELPING A CLIENT'S VOICE BE HEARD:  
ADVOCATES AND THE ODSP APPEALS PROCESS

By

PETER WESLEY OLIVER HOUGHTON

Bachelor of Social Work

Registered Social Worker

A Thesis

Submitted to the School of Graduate Studies

In Partial Fulfillment of the Requirements

For the Degree

Master of Social Work

McMaster University

© Copyright by Peter Wesley Oliver Houghton, August 2005

MASTER OF SOCIAL WORK  
(2005)

McMaster University  
Hamilton, Ontario

TITLE: Helping A Client's Voice Heard: Advocates And The ODSP  
Appeals Process

AUTHOR: Peter Wesley Oliver Houghton, B.S.W., R.S.W. (King's University  
College at The University of Western Ontario)

SUPERVISOR: James J. Rice

NUMBER OF PAGES: v, 79

## Abstract

This study seeks to understand how a client's voice is transmitted through an advocate who is representing them in front of a Social Benefits Tribunal (SBT). Three clients and three advocates were separately interviewed in a southwestern Ontario city for an average of fifty minutes. While not specifically trained to work in an adversarial system, the literature reflects that social workers can be well suited to work in settings such as the SBT. This study reports that clients felt that their advocate accurately represented their voice within the hearings and that their voice was stronger than it would have been without the advocate. The participants also shared that there are many ways the SBT, ODSP frontline staff and administrative procedures both hear and silence their voice. This study suggests that the application process for ODSP should be made more simplified and user friendly. It concludes that the weighting of the client application forms and treatment of medical evidence should be clarified. While advocates typically perform their jobs with a high level of excellence, it is felt there is some room to enhance accountability and the client's knowledge of complaint procedures. Advocates should continue to do what they do well; recognizing the injustices clients experience, and working to correct them. They also should seek multi-disciplinary cooperation to target the rules and regulations that they find unjust. Further research should continue to highlight the injustices of the ODSP system and seek to better understand how intersecting oppressions influence the client's voice. Finally, advocates have harnessed the power of the SBT to achieve a small level of justice for their clients and should continue to use these techniques as a "manageable and effective technique in the practice of social work" (Kutchens et al, 1987, 132).

### **Acknowledgements**

I would first like to thank all of the people I interviewed in preparation for this thesis. Without your stories, experiences and expertise, this thesis would never have been written. I felt that every person I talked to had a unique, valuable and very personal story to share. I am very glad that you choose entrust your narrative with me. I hope that I have treated your contributions with the dignity and respect that they deserve and that they might be used to better ODSP.

I would like to thank Janet, who without complaint helped with the proofreading. Without you, I probably would still be sitting in front of my computer figuring things out. I would also like to thank my supervisor Dr. James Rice, whose ability to crystallize complex problems, in understandable ways, was helpful in helping me understand what exactly it is I wanted to write. My second reader Dr. L. William Lee was also quite helpful in his written feedback to me in adding the final finishing touches. I would like to thank my family back home, who was able to understand that if they did not hear from me for over a month, it was not personal; I was immersed in my work. I also owe a debt of gratitude to the people upstairs who made sure I was both well fed and made sure I had some human contact during the week. I am also thankful for the patience of my many friends who never complained when I was unavailable to talk or do things. I also would like to thank the many people who have influenced my path over the last 10 years. I was not always destined to be a social worker, nor was I the most enlightened person when it came to issues of disabilities. Finally, a special thanks goes out to Mary, who shared with me the secret of what every first draft should be: fully biodegradable, have special fertilizing capabilities and a pungent odour. I saved a special copy of the first draft for you.

## **Table of Contents**

<b>Section I</b>	
Introduction	1
Process of Advocating in the ODSP System	2
<b>Section II – Reasoning and Methodology of the Research</b>	
Rationale	7
Epistemology & Methodology	9
Methods	13
Limitations	15
<b>Section II – Findings Related to Advocates</b>	
Success of Advocates	18
Empowerment	19
Client Loyalty	28
Negative Experiences of Client's with Advocates	29
The Effects of Stress	31
Advocates, Client's and Frontline ODSP Staff	34
<b>Section III – Findings Related to The Social Benefits Tribunal (SBT)</b>	
Pre-hearing Experiences	40
The Hearing	41
Members of the SBT	44
<b>Section IV – Administration</b>	
Application Barriers	53
Treatment of Medical Evidence	56
Scheduling of Hearings	60
<b>Section V - Recommendations / Conclusions</b>	
Applications and the Disability Adjudication Unit	62
Social Benefits Tribunal	65
Local ODSP Offices	67
Advocates	69
Advocates and other systems	70
Further Research Opportunities	72
Conclusion	73
References	74

**Section I - Introduction**

Government support to the unemployed has been eroding since the 1970s (McBride, 1999). This erosion accelerated in Ontario during the mid-1990s, with welfare reforms and a twenty percent cut in benefits by the progressive conservative government. Many of the reforms occurred in parallel at both the Ontario Disability Support Program (ODSP) and the new Ontario Works (OW) program (Chouinard & Cooks, 2005). These reforms resulted in more restrictive intake regulations and increased surveillance of program users (Herd, 2005). These reforms were enforced through increased localization and increased reliance on the municipality (Herd, 2002). For people with disabilities, this meant that it was much harder to receive ODSP benefits, and they would then have to rely on the OW program to meet their income needs. On OW, persons with disabilities who have been once denied ODSP are required to participate in workfare initiatives. For many people with disabilities, their impairments make it difficult to comply with the workfare expectations.

Alongside the reforms, an erosion of the client's voice also occurred. Funding to human rights commissions and similar governmental bodies were reduced, making it more difficult for citizens with disabilities (among others) to access these forums to voice their concerns (Chouinard, 2001). Today, many citizens are denied access to the ODSP, not because they do not meet the criteria for benefits, but because they are unable to navigate the complex rules and regulations (Fraser et al, 2003). In response, some of the people who qualify for ODSP benefits, but have been denied access because of their

inability to prove their case, have been assisted by social work advocates who work on their behalf. Despite the many “horror stories” circulating about ODSP application and appeals processes (Chouinard, 2005), the advocates are frequently able to use the adversarial system of the Social Benefits Tribunal (SBT) to successfully secure benefits for their clients.

A lack of a “decent home, satisfactory income, good health... and freedom from discrimination and abuse” creates a situation where persons with disabilities “are unlikely to view or be viewed as an asset to their neighbourhoods” Bates (2004, p. 2005). By securing their clients benefits, advocates are able to assist citizens to participate more fully within their communities and in society. Many advocates hope that this will help empower their clients and strengthen their voices. While it seems that the success of gaining clients access to benefits can empower them, it has also been suggested that the relationship between advocates and their clients can also strengthen a client’s voice. This research effort hopes to discover if and how the actual process of advocating within the ODSP appeals processes can strengthen a client’s voice.

### **Process of Advocating in the ODSP System**

Before an in-depth discussion of how advocacy processes within ODSP can affect clients’ voice, it is important to first understand what exactly appealing ODSP decisions entails. This section will briefly outline the role of an advocate and the how they interact with their client within the ODSP system. For a deeper, more technical description of the application and appeal mechanisms within the ODSP system, please see Fraser, Wilkey



and Frenschokowki's report "Denial by Design... The Ontario Disability Support Program" (2003).

Advocates are highly involved in a client's case once it is brought to them. They are often not part of the clients initial application to ODSP, but instead get involved in the case at a point when a client is experiencing resistance, has been denied funding or had that funding taken away. When a client first sees an advocate, the advocate will get basic information about the case, as well as make copies of any documentation the client has brought with them outlining their situation. Based upon this information, the advocate asks increasingly specific questions about the case, to determine what steps should occur next. If the case is a denial in response to an application, the advocate will request a copy of the client's file, to determine what information ODSP has, and find out why the Disability Adjudication Unit (DAU) decided to deny benefits. Upon receiving this information, the advocate will contact medical professionals with whom the client is active, to request further information that would either support or dispute the DAU's rationale. If the client is not already involved with specialists, the advocate will ensure that the client is referred to a medical specialist to get detailed medical information. The next most common type of case usually involves clients who have been assessed an overpayment. This occurs when the government believes that they paid the client more benefits than they were entitled to. Finally, in some cases, the client was denied some form of benefit such as a dietary allowance or funds for medical devices or aids. As the advocate receives updated information that can be used to refute the decisions, the

advocate will submit the information in the hopes of having the case overturned before the hearing. After receiving the initial letter of rejection or assessment of an overpayment, an internal review must be submitted within 10 days of receipt of the decision. At this stage, new information will often not be considered unless it indicates that a clear mistake was made. Often, the internal review is returned upholding the decision (Fraser et al, 2003) at which point the client then has 30 days to file an appeal to the Social Benefits Tribunal (SBT). A hearing will be scheduled, which typically is 6 months to a year away. During time before the SBT, the client and advocate will work together, to submit new medical documentation in cases of denial. In cases of overpayment or requests for supplementary benefits, documentation relevant to proving these cases will be submitted. If no prior resolution is made, the advocate will attend the Social Benefits Tribunal (SBT) with their client, which is presided by a single member of the SBT. The “member of the SBT” is often referred to as a “hearing officer” colloquially by both the advocates and clients interviewed. Therefore, the two terms will be used interchangeably throughout the body of this thesis. Also present at the hearing are any witnesses and often a government lawyer from the DAU to argue against the client’s claim. Upon completion of the hearing, the client does not immediately know the decision, but finds out the decision within six weeks. If the decision is unfavourable, there is the option to request reconsideration on technical grounds. The advocates interviewed for this study do not intervene beyond the SBT, and would either recommend

the client start the process again by reapplying or procure legal representation for the reconsideration stage.

The work that advocates do is important, as it relieves social and material pressures caused by blocked attempts to secure food, shelter and income. The work of an advocate is fully compatible with a social worker's ethical obligation of seeking social justice within the context of their client's environment, in which they seek to "eliminate or reduce social problems such as poverty [and] unequal access to opportunity" (Lee, C., 1998 in Kielica, 2001, p 387; Lens, 2000, 2004; OCSWSSW, 2001). While this type of case advocacy does not usually cause the type of structural changes required to create a fair and just society, it does rectify an immediate and important need of the clients they serve. (Lee, B, 2001). Advocacy by social workers has been a valued aspect of the profession since the profession's beginning (Sousin, 1983). So highly valued is the role of an advocate within social work, some attempts to define advocacy seek to create a broad definition that tries to encompass any role a social worker could take. Rather than try to justify all social work roles as having an element of inherent advocacy, Sosin & Caulum (1983) suggest a more prudent definition, which looks at the acts rather than roles that a social worker performs and subsequently define advocacy as:

An attempt, having a greater than zero probability of success, by an individual or group to influence another individual or group to make a decision that would not have been made otherwise and that concerns the welfare or interest of a third party who is in a less powerful status than the decision maker (p. 12).

Operating within this definition, in order to advocate, there must be a minimum of three people or groups involved. In the context of advocacy in the ODSP system, the force attempting to make an influence would be the advocate, the client would be a person of less powerful status and finally the decision making representative would be from ODSP. If the process leads to a SBT, the decision-making power then shifts to a member of the SBT away from ODSP.

The SBT itself is an adversarial process. Kutchens & Kutchens (1987) report that while the adversarial process is the traditional domain of the legal profession, social workers can learn the adversarial skill sets of persuasion and procedures; therefore, social workers can be quite successful in administrative hearings such as the SBT. Ashford (1987) also suggested that social workers have unique skills that can be valuable in an adversarial role, as social workers have been trained with the expertise of interviewing and accessing environmental and community resources of clients. In addition, with a social worker's understanding of a multi systems perspective, appreciation for human suffering can act as an asset in advocating for clients within these complex systems. In negotiations leading up to the SBT, the social worker's skills in picking up nuances in conversational communication, or even the use of silence, can be helpful negotiation tools in gaining success for the client (Lens, 2004).

## **Section II – Reasoning and Methodology of the Research**

### **Rationale**

This study is primarily concerned with the client's voice, and how it is heard or not heard within the ODSP system. There are many different definitions and understandings of voice, a literal definition in which a person has voice if they can use their vocal cords, a second in which a person has the ability to express themselves and finally a metaphorical understanding which represents both freedom and power in contemporary society (Reinharz, 1994). It is this later understanding which this research most closely emulates. Therefore in the context of this study, a client has voice when their message is received by the person they are communicating to in which the receiver carefully considers what has been said and incorporates it into their response. The focus of the research is to understand how the advocate can act as a conduit of the client's voice at a SBT and the events leading up to it. This research also hopes to fill a gap in social work literature. Lee (2001), in his research of advocacy, found that it is underrepresented in recent social work literature. It is interesting that voice, which is often discussed in the context of empowering a client, does not seem to be frequently connected within the literature. Of the over 1600 journal articles with the keyword empowerment in the social work and social sciences abstracts available in the McMaster university library, only 10 contain the word voice; many of which are referring to a collective rather than individual voice. This is surprising, given the individual emphasis of both empowerment and client voice in current social work education. Empowerment is about increasing the power of

those who have less power. Social workers and other advocates involved in income security case advocacy do not directly give power to their clients, but rather can act as an aid (Chappell, 2001; Colby & Dziegielewski, 2001). Facilitating access to resources (Dubois & Miley, 1996) is one among many ways this power transfer can be encouraged. In the cases where an advocate is working on behalf of an individual, empowerment can also occur through the transmission of information, so that the client is better equipped to advocate for themselves in the future (Lee, 2001). Part of the frustration reported by people who are on social assistance is that they often feel that their concerns are not taken seriously, that they are not heard. In this author's previous experience as an income security advocate in a student placement, many clients would often bring letters they had written to social assistance expressing their frustrations. The response they received often comprised of a form letter or one that did not acknowledge their feelings or experiences. Clients expressed the hope that by having an advocate, the workers at social assistance could *finally* understand where they were coming from. While the primary goal of clients was the receipt of funds or benefits they were entitled to, at some level they also hoped that their experience could also be understood by those administering these resources. Other clients had become cynical; expressing that not only was social assistance unable to hear them, but that the government was intentional in an effort to silence them. By asking how voice is affected by the advocacy process, it is hoped that a better understanding of how empowerment and advocacy interact with each other will be gained. While seeking to highlight the themes of empowerment through voice and the

advocate, this research also seeks to complement previous research that seeks to expose the inadequacies of the current ODSP system.

### **Epistemology & Methodology**

This research is situated within a body of literature that outlines the need to increase voice of the client while researching issues of disability. Documenting and researching the experiences of people with disabilities, in an effort to decrease society's oppression of people who are disabled, is not new or novel (Barnes, 2003; Artman & Hall, 1854). Similar to the ongoing development of critical social science and feminist research methods that highlight the importance of themes such as: the 'influence of the researcher', the 'importance of contextual individual experience', using 'gender as a basis of meaningful analysis', and the 'transformation of knowledge' (Neuman, L., 1997; Neysmith, 1995); the body of anti-oppressive knowledge around the research methods of disability issues is also developing. Barnes (1996), in particular, highlights that in research of disability issues, there is no such things as an independent researcher free of external considerations. Emancipatory disability research has built upon these foundations to encourage research that seeks to identify tools in which to allow for the empowerment of people with disabilities rather than to seek knowledge which could oppress them (Barnes, 2003). This approach to research tends to emphasise a social model of disability, in which a person's environment dictates whether or not an impairment is a disability. In other words, a disability is only a disability because we have constructed it as such. Andrews (2005) discusses the popularity of the social model

of disability, which like the medical model, tends to assume “sameness” in how people experience disability. Andrews’ experience and this researcher agree that while the social model of disability is an important frame in which to understand how a label of disability impacts a client, environmental understandings (Goodley, 2001) and medical model frames, also affect the lives of the participants and are thus relevant in interpreting the data. An understanding of the medical model is especially important in deconstructing the actions of the Disability Adjudication Unit (DAU), which seems to work primarily from this framework.

Theories and models of disability tend to dichotomize issues such as “health and illness, disability and ‘normality’, impairment and empowerment” in such a way that the space between the two labels are not fully explored (Corker, 1999, p 633). In the impairment and empowerment dichotomy, there are many literature references to the inadequacies of impairment-focused solutions to issues of disability. At the other end of the spectrum, there is literature that highlights the benefits of full empowerment through self-advocacy groups. The advocate participants in this study seem to occupy this space between the impairment and empowerment dichotomy. In their endeavours to assist clients find the tools and pathways to empowerment; they must do so through an impairment-focused system. If full empowerment is to be achieved through removing the label of “disability”, and allow people with significant impairments on ODSP to lead fully empowered lives, ODSP in its very nature is counter to this goal through it’s emphasis of labelling people as “disabled”. Consequently, much of the time of the



advocate within the ODSP system is spent in seeking the label of disabled for the client so that the client can receive financial income. While the increased financial resources can be seen as one step towards greater empowerment, the label of “disability” can also be used to disempower a client. This process is often intuitively counter to social work in that the focus is on what a client cannot do rather than the strengths of the client. Therefore, much of the work of the advocate exists in this tension between seeking empowerment for the client, while seeking to emphasize impairments of a client. In the process, a holistic view of the client is often not presented to ODSP. This is not a criticism of the advocate, but rather the system in which they must operate. However, it is clearly evident that advocates must be careful in the way in which they act on their clients behalf so as to minimize the disempowering aspects of the process while seeking to maximize opportunities in which client’s can empower themselves. While the term “disability” has been used to label and oppress people historically, the reporting of this research uses the term disability in a way to describe how a person’s environment “takes no account of people who have... impairments and thus excludes [that person] from mainstream social activities” (UPIAS, 1976 quoted in Goodley, 2001, p. 208 and Oliver, 1990, p. 11)

A final concern is the format and reporting style of this research. “The university system, implicitly if not explicitly, compels academics and researchers to write primarily for other academics and researchers rather than for the general public” (Barnes, 1996, p. 107). In this context, I am an academic person preparing a thesis for evaluation by

experienced academics to which I must achieve certain standards in order to receive a passing grade. While I recognize that the requirements of a thesis by nature are at odds at making the results universally accessible, I hope to create a document that is easy to understand, but not at the cost of making complex issues more simple than they are (Shakespeare, 1996, p. 117-8). While it is easy to criticize academia, it should also be recognized that the university environment also provides access to resources and information this author would not have access to otherwise. This is in addition to the safeguards it provides to the public through its regulations and ethics board (Bury, 1996). While it would have been ideal to include client ownership over all processes of this research from design, collection and ownership of the results (Beresford & Evans, 1999), this was not possible given the time and resources allotted to this research. The stories of the people interviewed have been layered throughout the presentation of this paper in the hopes that the individual stories can help show the impacts of current social policy implementation through ODSP (Lens, Vicki & Gibelman, 2000).

It is my hope to make these results available to interested individuals and organizations via the World Wide Web in a way that is comprehensive and understandable in addition to other avenues I may choose to pursue. This work is not an isolated effort on this author's part to understand and be involved in the efforts to eliminate the oppression people with disabilities experience. It is through previous experience as an income security advocate at a student placement, and employment as a respite care relief worker in a setting with children and young adults with disabilities, that

this author has become familiar of the need to fight against the parts of society which facilitate a very real oppression against people labelled as disabled. Barnes (1996) reminds the reader that “there is no independent haven or middle ground when researching oppression: academics and researchers can only be with the oppressors or with the oppressed” (p. 110; Freire, 1970). It is this author’s hope, that as a person without any significant impairments to prevent full participation in society, to be an ally against the oppression of people with impairments labelled as “disabilities.” This paper is one, amongst a continuum of efforts, to achieve this collective goal.

### **Methods**

This research has been approved by the McMaster University Research Ethics Board (MREB). In order to ensure confidentiality, identifying information has been removed or altered from the data collected. The participant’s direct quotes are referred to in either a generic “advocate” or “client” voice depending on their role within the system. By not using a pseudonym for each individual participant, their confidentiality is further increased. Three advocates and three clients from a city in southwestern Ontario were recruited to participate in the study. All of the advocates were recruited by word of mouth. An invitation to participate in the study was placed on an electronic mailing list seeking both clients and advocates for participation. This facilitated the forwarding of the invitation to individuals, organizations and other electronic mailing lists within the income security advocacy community. Two advocates approached the researcher while two others were approached by the researcher via electronic means after being given

indication that they might be interested. Of the four advocates who showed interest, only three were interviewed. Two of the advocates interviewed were what Tesolowski et al (1983) would classify as 'professional advocate'. Professional advocates are social workers who are dedicated to advocating for their client's rights as their primary task. The "professional advocates" interviewed received their funding from a non-profit third party source and saw their clients without a fee. Not only did these advocates assist clients with issues surrounding ODSP, they also assisted clients with other government organizations such as Ontario Works. The third social worker was a 'practitioner advocate', a social worker who uses their skills of advocacy in their practice to protect their client's rights, but also fulfills other roles in the interaction with their clients. This particular social worker worked within a community organization that worked clients with various psychiatric illnesses. During the course of her work, she would encounter clients who received ODSP benefits, some of whom were having difficulty with ODSP and requested assistance with their difficulties.

Three advocates (not all who participated in the study) offered to assist in recruiting clients. Two of the advocate contacts offered to have their agency send an invitation to their clients. In one case, this was done through a short paragraph in their organizational newsletter and another used the distribution of posters. These mailings and posters resulted in the recruitment of two client volunteers. In both cases, the individuals contacted the researcher directly. A third advocate offered to directly pass along copies of the poster to clients whom he saw during the course of his work. Due to

confidentiality concerns, it was mutually agreed not to pursue this avenue. The final client participant was recruited through an ad placed in a local advertisement flyer which was delivered to all addresses in the city. Two of the clients' advocates were social workers, while the third was a lawyer who worked in an advocacy oriented, free of charge legal clinic.

Interviews took place in locations convenient for the participants. Two interviews with advocate participants took place in their offices and the third interview took place in the advocate's home. Two of the interviews with the client participants occurred in a local library meeting room. After twice attempting an in-person interview, both cancelled due to medical emergencies, the third interview occurred via the use of the telephone. Before the formal portion of the interview commenced, the clients were reminded of the voluntary nature of the study, and were informed of the risks and benefits of participation as well as the scope of confidentiality. In cases where the participant received an honorarium, it was given after the client gave their informed consent but before the question and answer portion of the interview commenced. This gave the client the flexibility to withdraw from the interview at anytime without feeling coerced to complete the interview in fear that they may not receive the honorarium. The exception to this was the telephone interview, in which the participant had read an electronic version of the consent form and was reminded of the contents via the phone. The signing of the form and receipt of the honorarium occurred later in person. The interviews lasted between 40 and 65 minutes with an average interview time of approximately 50 minutes.

The interviews were semi-structured, using an interview guide. Recognizing that any research is an intrusion on another person's life, in which there is not equal reciprocity (Kayser-Jones & Koenig, 1994), the questions were designed to minimize the burden of being too time consuming, and questions of a personal nature were asked only to the extent and depth required. All of the questions on the interview guide were asked, however the participants were asked follow-up questions based upon their responses and were given opportunities to discuss topics that were not covered by the interview guide, but which they felt were important to the focus of the study. All of the participants indicated they wished to receive a copy of the results upon completion of the research. To facilitate this request, they will receive a copy of the final thesis in addition to a cover letter highlighting key findings.

### **Limitations**

Overall, the research effort met its goals. Due to the academic intent of this paper, the research did not go beyond an exploratory effort. Given the exploratory nature of the research and resources available, the goal was not to be comprehensive but to rather highlight findings and themes for further exploration. It was felt a minimum of six participants (three advocates and three clients) were needed to identify many of the major themes. Because of the limited sample size and limited geographic region of the participants, it should not be assumed that the results can be generalized to a larger population. Strauss and Corbin (1998) recommend that 12 – 26 people should be interviewed in order to capture all of the possible theme categories. Given that two

distinct populations (advocates and clients) were contacted, future research may wish to double this number to be able identify all of the relevant themes themes.

Where possible, research of disability issues should try to acknowledge intersecting oppressions, such as gender issues, sexuality and ethnicity (Dowse, 2001). Given the limited sample size and homogeneity of the sample (all female, of which only one person was of an identifiable race which was not Caucasian), no meaningful analysis of these dimensions was made. Gender in particular is an important dimension to study in regards to social assistance, as next to people with disabilities, lone mother families are the next group most reliant on assistance (Dooley, 2000). Excellent research exists on the gendered axis of income assistance or disability, which should be referred to for further information (Mosher et al (2004); Keeler, 2002; Little, M. H. & Morrison, 1999;).

## **Section II - Findings Related to Advocates**

When asked about the role of the advocate, clients and advocates described several themes. Overall, they found that the process of advocating was very successful. Client's reported that their most recent advocate was able to help them successfully navigate the appeals process of ODSP. The second theme was that advocates do seem to create spaces for assisting client empowerment while advocating on their behalf through two specific approaches. It was reported that clients were quite loyal to their advocates despite, as the final theme explores, some clients had had previous experiences with advocates that were negative.

### **Success of Advocates**

Advocates reported a high range of success in their work. One of the "professional advocate" stated her success rate was over 90 percent<sup>1</sup>, while the "practitioner advocate" found that all of her clients who had initially applied under her guidance were accepted on the first try. These appraisals are significantly better than the 65 percent SBT success rate with representatives (SBT, 2005) or the approximately 50 percent of application denial rate by the DAU (Fraser, 2003). The reasons for the high reports were unclear, although the advocates hinted that their knowledge of a client's environment was typically better than that of the average representative. Additionally, it was unclear if the advocate's selection process would bias the rates of success or not.

---

<sup>1</sup> Based upon statistics sent to the advocate's funder. "Success" is defined when client receives money from ODSP or the case is resolved to the client's satisfaction.



Advocates also reported many personal success stories. In one case, the advocate was able to recognize an intellectual disability in a client who had no documentation indicating that this was the case. Up until this point, the client was misdiagnosed many different times for differing psychiatric diseases, such as schizophrenia and a personality disorder. After making the appropriate referrals and getting the proper diagnosis, the advocate was asked by the hearing officer why the client, who had attended two previous hearings, once on her own and once with a legal representative, had never noticed the disability before. This highlights the ability of the advocate to gage what the client reports in the context of their environment. The advocate also understood the medical model well enough to recognize that what was being said by the client and reported on paper did not match. While social workers are not trained to make medical diagnosis, the advocate was able to refer the client to the appropriate specialist. Clients reported that one of the biggest assets was that their advocate was able to connect them to the proper medical professionals. Often times, clients would not be involved with specialists because nobody until that point had suggested it. Not only were the specialists helpful in getting the documentation to win the case, but in many instances the specialists were able to help the clients better manage their conditions.

### **Empowerment**

While advocates were very successful in winning their cases, they also reported that clients experienced empowerment throughout this process. The advocates identified two different approaches that they used to facilitate empowerment and strengthen voice

for their clients. While there were differences in these approaches, they both had some commonalities. The advocates believed that many clients were empowered by having access to information. Tesolowski et al (1983) discusses how properly implemented, advocacy is a “tool for demystifying the legal aura that surrounds” the rights of people with disabilities (p. 35). All of the clients reported that they would not have been successful at their hearing without their advocate. The advocates also felt it was important that clients always knew what was going on with their cases. Many of the advocates would routinely phone their clients as new information became available.

Clients also found it easy to consult with their advocate via the telephone or appointments about letters they received from ODSP. This was essential because denial and other letters in response to ODSP applications were either hard to understand, or were useless to both advocates and clients due to the lack of information. The letters would not state the specific reason for the denials, nor were they helpful in determining what would have been required to meet the standard of having a “substantial impairment” to receive benefits. Additionally, the letters were not designed for easy comprehension by people with reading difficulties or developmental disabilities. Thus, part of the advocate’s information sharing role was to explain the letters.

The advocates also indicated it was important for clients to know what to expect and to be fully aware of the process. The advocates also tried to give realistic probabilities of the outcome of their case. Sometimes this meant the advocate would

communicate that there was not a high chance of success, but felt strong about the merits of the case.

While all the advocates felt it was important for an advocate to facilitate the empowerment of their clients through access to information, the advocates had two distinct approaches in how the client would gain much of the information. This appeared to be partly influenced by the nature of the professional relationship between the advocate and the client. In one of the cases, the advocate acted in that capacity as part of her larger role as a long-term support worker in a mental health setting. Thus, part of her goal with some clients was to teach long term life and communication skills and would not do things for the client she knew the client could do on their own. The advocate reported that she would “limit the information to the client that they can get on their own” so that the client could use their own skill sets in obtaining the information they required. The advocate did this in the hopes that the client could increase their confidence in information seeking. This often involved directing the client to a website, if they had internet access, or helping to script a phone inquiry to the ODSP office. In this way, the advocate was imparting tools onto the client that they could use to find information in the future in the hopes that the client would feel empowered to self-advocate. If the client was unable to access the information on their own, or was blocked during the process; the advocate would step in and acquire the information to share with the client. The advocate would also set dates in her calendar to indicate when the material requested by ODSP was due. For ODSP applications, she would often set the date five days before it was

actually due. This way there would be 5 days “grace” for the client and advocate to work together on the material to ensure that it was submitted on time, containing all the necessary information. The advocate indicated she had much success in this method, and to date none of the initial ODSP applications she assisted clients with had been denied. She felt the strengths of her method were that clients did much of their work themselves, and would give more in-depth assistance when required. Thus, the client was able to take much of the credit for their successful application, and learned skills that they could use in future situations to advocate on their own behalf. This method facilitated the clients’ voices to be heard, and more frequently heard directly through their own voice. While there is a risk that this technique could be used to make the client do research that is unrealistic, done properly, in a client-focused manner, clients are able to take much of the credit in their own successes.

The other approach used by advocates involved reducing the burden of navigating the ODSP system. In the agencies that used this approach, the sole purpose of the worker was to help clients with a single issue and to advocate on their behalf until resolved. In this approach, the advocate makes most inquiries on the client’s behalf. This would often include contacting ODSP, medical professionals and anybody who had information relevant to the case. The advocate would also make submissions of evidence on the client’s behalf. In this approach, the advocate only has the client do things that the advocate cannot do herself, such as asking a doctor for a referral for an X-ray. In this way, clients feel that they are able to contribute to their own cases in concrete ways. This

also ensures the client is fully informed of the process, as the advocate will phone the client as new information comes available, or when the case progresses. The client's expertise in their own illness is heavily relied upon, as the advocate prepares submissions to the SBT and the approach to the case. By reducing the workload on the client, the advocate is able to reduce the stress on the client, and reduce some of the anxiety caused by waiting for the hearing to occur. Much of this approach relies on recognizing that the client comes to the office in crisis, and by taking on the burden of the paperwork and preparation, the client is able to better deal with other areas of their life. The advocates that reported using this approach found that most of their clients were in crisis in many areas of their lives, including housing. Experiencing multiple crises can create a paralysis that makes it difficult for the client to respond effectively to situations. Therefore, the advocates using this approach see it as a way to enable their clients to take a pause from the crisis caused by having their ODSP monies at risk, and can focus on other important issues. This approach of taking on a significant amount of the client's load seems to reflect the redefinition social workers experience between themselves and their clients when fully immersed in representing clients in an adversarial system (Kutchens, H. & Kutchins, 1987). Rather than seeking therapeutic goals in the relationship, the social worker seeks to obtain the resources the client needs. In the process, the social worker often does use therapeutic techniques to assist the client in stabilizing their crisis, but the primary goal is not this stabilization, but increased resources for use by the client.

The clients interviewed were all recipients of the “burden” reducing method that advocates used in their cases. This approach does open the possibility that the advocate may do too much work on the client’s behalf. In such a scenario, the client’s empowerment would decrease, as the client is less self-reliant and more reliant on the advocate. The clients interviewed did not seem to indicate this was the case with their advocates. When the clients were asked how involved they were with their cases, they indicated that they felt there was a good balance of expectations. One client explained that “I get overwhelmed quite easily, I think I would have been overwhelmed with more” while at the same time there was enough work to feel involved in the process. Clients provided basic information such as the name of their doctors and would also be involved in approaching their doctors to see if they would be willing to provide additional information, or be willing to support their ODSP application. One of the clients was actively involved in her case even though she knew it was not expected of her. This particular client drew on her expertise with her previous education in assisting her advocate in gathering documentation. She would write summaries of some of the data they had gathered, and found that what she wrote was greatly appreciated by the advocate. She felt her contributions were valuable, as the advocate would integrate her work into the body of the submissions sent to the SBT. Clients felt very informed during the process leading up to a hearing, and some clients shared stories about how the advocate would contact them about new developments, before the client themselves

received the information from ODSP later that day. Clients found that this ongoing communication between the client and the advocate was essential in building trust.

Most of the advocates using either method were unable to articulate ways in which they found clients were more or less empowered through the client's direct participation in the process. One advocate however, suggested that there are many factors that influence how active a client is in their case. It was felt that the more active a client was in their case, the more accurately their voice would be heard. It was suggested that clients who had previous successes through self-advocating or being involved in other cases were more likely to be active in the process. This increased involvement often occurred through being more proactive in gathering information, writing letters to include in submissions to ODSP or doing their own independent research on the issue to share with the advocate. The reverse was also true. Clients who felt they had been "blocked at every turn" or found that systems would not respond well in their self-advocacy efforts were less likely to be active in the process. The advocate felt this partly had to do with the fact they had been failed by systems before, and had no reason to believe the advocate would be more effective than any of the other systems that had failed them previously. These clients would tend not to go beyond what was expected of them, because repeated failures caused them to feel that this would be wasted energy. The advocate also suggested that some clients had a "fighting spirit" that would cause them to be more involved in cases. In these cases, since the client had been failed so many times, they would lose trust in any professional they worked with, thus one way of

keeping tabs on the advocate would be to become as active in the process in possible. In this way, the increased activity would result in increased contact with the advocate and the client would be better able to gauge if whether or not they could trust the advocate.

The importance of opportunities for empowerment through transactions with an advocate is stressed by one client who explained her feelings of the system: “it cannot be stressed enough, the inequality and ineffectuality that most people in my situation feel, and further, that people like me are very rare in terms of being able to fight back.” The client based these comments on her experiences of interacting with many other people in her own situation. She also stressed that much of the abuse she felt she experienced through ODSP was systemic in nature, and that before she met her advocate, she did not have anybody to help her rectify the wrongs she experienced. When she started to work with her advocate however, she began to experience some hope. One advocate pointed out the importance of being personable. She felt that because many clients had the experience of not being treated as a person, but rather as someone who was considered suspect by ODSP, the importance of respectful and ongoing communication with clients was essential. Clients who shared examples of negative interactions with advocates found that this communication did not happen, and that the contributions they would try to make to the case, whether written or through sharing something orally with the advocate, was not acknowledged nor integrated into the body of the advocate’s work for them. Thus the attitude in which she treated her clients had an impact that was essential, to overcome some of the dehumanizing experiences clients had experienced in other



systems. Both clients and advocates shared examples of the importance being “personable”. One client shared several examples of when either she or the advocate would use humour to lessen the tension when going over cases. Another client shared that her advocate, “Was for the people, and did not discriminate” and felt that despite her disability, her case was taken very seriously by the advocate. Generally, clients who had experiences of attending hearings without advocates shared they felt less heard without an advocate. Primarily, this was because they did not know how to answer many of the questions asked. Some of the clients had “mock hearings”, which they found to be quite helpful in preparing for the actual hearing, and reducing the actual stress of worrying about what they would say. Advocates felt that some clients were more vocal during the hearings than they would have been otherwise due to the preparation pre-hearing. They also found this preparation was helpful in teaching clients the types of information the hearing officer was looking for, and what types of things to emphasize. One example is that often the representative of the DAU asks if the client’s condition has gotten worse recently. Since most clients’ conditions are degenerative in nature, the answer is usually yes. In these cases, the argument is made that the client should receive benefits, but through a new application, and that at the time the original application was made, the decision was correct, as the client’s condition had not yet degenerated. Thus the advocate is able to coach the client to answer truthfully, that yes it has gotten worse, but that it always has been severe enough as to not be able to work gainfully.

Clients generally reported that they got along well with their advocate. Given the long duration of some clients' work with their advocate, disagreements will sometimes occur. One client indicated that while she respected her advocate, she did report that on occasion she did butt heads with him. Often this was the result of wanting to rush the process along faster than what was possible. She said that her advocate was very good at explaining why rushing things would not work, and gently asked to let things happen in their own time.

Overall, clients felt that their contributions were quite valued by their advocates, and felt that the door was open to contribute as much as they wanted. Clients also valued how the advocates were able to recognize and acknowledge their fears and worries about the case, and how it affected their lives.

### **Client Loyalty**

In addition to feeling empowered, clients were intensely loyal to their advocates who had performed their duties well. One client stated:

“it would be a shame not to see them around... it is important work that they do, you know, to represent the people who don't have the funds, you know, sometimes they don't do it on their own, they have a true disability, emotional problems and physical problems. They're there for you.”

It was reported that advocates tended to be very respectful of their clients, and would quickly return their calls and proactively contact their clients when a new issue would arise. Another client stated “she don't discriminate, if you're retarded [sic] or whatever, so you know, if you need it, she'd do it.” This loyalty sprouts from a couple of factors.

The most important is that clients heavily rely on their advocates to secure the financial resources they require through successful appeals to the SBT. It makes sense that there would be a lot of loyalty towards someone who is able to secure income, or assist in reversing large overpayment assessments. Clients described their advocates as compassionate, caring, upbeat, supportive and reassuring. They explained that many of these traits were difficult to find in other people within the ODSP system. Clients found that their advocates were sympathetic to their emotional pain, depression and other types of ailments that other people within the ODSP system were not as sympathetic to. In particular, advocates seemed empathetic to the fact that clients will miss appointments on occasion as their impairments sometimes make it onerous to leave the house. The attention to the cases, and to the needs of the clients, also seemed paramount in gaining a client's trust. Clients indicated that advocates were involved in many other areas of their lives, including housing and in one case childcare. Overall, clients could not imagine their lives without their advocates. As one client stated, "Nobody should apply for disability, without my advocate. I don't care who they are. [My advocate] is the best thing going."

### **Negative Experiences of Client's Working with Advocates**

Not all of the clients interviewed had positive experiences with all of the advocates they worked with. The framework in which the people advocate for clients creates a power imbalance in which the advocate has greater control over how the case is dealt with (Azzopardi, 2000). Therefore, particular attention should be paid to reports in

which clients feel failed by their advocates as there is a real risk for a loss of voice, and consequently power (Booth & Ainscow, 1998). While all the clients indicated they were happy with their most recent advocate, two had prior negative experiences. In one case, the advocate took on the case but never followed through. After a month, the client contacted the advocate, who indicated that she did not have the time to follow the case through and referred the client to another agency. The client was quite frustrated that the advocate was unable to take the time to inform her of the change, and instead waited for over a month with no work done.

The second negative experience occurred when an advocate did not prepare adequately for the hearing. The advocate told the client that it was not required for her to be there for the hearing. Upon reading on the internet that she could lose by default by not attending the hearing, she decided to go. When the client arrived at the hearing, the advocate did not immediately recognize her, and told the client an adjournment would be requested, as the client had brought some materials she thought would be helpful to her case but had not pre-submitted. The advocate did not have a thorough version of the client's history, or medical condition. The advocate was "scolded" by the tribunal representative, and was granted an adjournment on the basis there was unsubmitted medical evidence, and that the advocate was ill prepared. The client stated that:

I was disappointed, I wanted to get this dealt with and not have to go through this again. And, I was worried [the advocate] was going to blame it on me and make it look like it was my fault, just worried about how bad it would look, whether the next time would be any better, because I knew the advocate hadn't done any work.

The adjournment also created the stress of waiting, as the next hearing was not for quite time. The next hearing was delayed twice, once by the SBT for an administrative reason and then for a medical emergency related to the impairment.

The client indicated she knew that the advocate did not understand either her story or the details of her condition before going to the hearing. The types of questions she was asked were very general, and the advocate did not seem interested in learning the specific details. She also indicated that she was fearful to say anything to the tribunal representative, because of the intimidation perceived by his position of power and because he was angry that his time was being wasted by an unprepared case. The client also did not feel that there was anything she could do about her situation to ensure the advocate would be prepared. It was not until her case was taken up by a different advocate, who earned her trust, that she was able to have her views of the previous advocate heard at a level where it could be looked into.

### **The Effects of Stress**

In both of the negative advocate experience cases, it appears that the advocates partially failed in their duties, caused by the overload or stress of their positions. In the first case, the advocate stated she had no time to continue with the case, and in the other case, this was indicated through the advocate not having performed adequate research. All of the clients were acutely aware that their most recent advocates, who they felt represented themselves well, did work hard and were busy people. One client stated that while she had “nothing but the highest respect for them [advocates],” workplace stress

and overload of advocates was a concern. She felt “it’s only natural that there are details that will be missed” when overworked, and felt there was a potential for this to have a negative effect on the client. A client also reported she had observed an advocate get agitated when questioned by another client, because the overworked advocate misinterpreted the questioning as a judgement. All indicated that they wish there were more people like their advocate to do the work and alleviate the stress load.

Advocates were not the only group of people for whom increased stress had an impact on the clients. All of the participants in the study reported they had observed signs or indications that reflected a possible stressful work environment for frontline ODSP workers. Clients felt that overworked frontline ODSP workers had a direct negative impact on themselves (the client). All of the advocates and two of the clients indicated that documentation they had submitted to ODSP would get lost. If the mistake of sending in an original document had occurred, the onus would then be on the client to replace it. In cases where the client was required to get a new copy of the document, they often would not have access to the funds to pay for the expense of receiving a new one. The loss of documentation occurred frequently enough that one advocate felt that the issue must be systemic in nature. One advocate reported that one set of papers were lost even though the copies were submitted independently by both the client and the local MPP. On the reverse end, one advocate found that occasionally she received copies of files of client’s that were not her own. These omissions were taken very seriously when

discovered by ODSP, but at the same time raise concerns about the workload stress that causes such errors in addition to the method of document storage and retrieval processes.

The participants seemed most aware of the stress through their telephone conversations with ODSP staff. The clients reported that their interactions with ODSP staff members ranged from rushed to rude. One client reported that some of the staff would “treat you disrespectfully... [and] completely unconcerned about your personal travails... who insist upon an attitude of gratitude, and if they don’t get it, your going to be punished.” One of the advocates shared that it was common that many ODSP workers would omit the “courteousness and politeness that goes with a telephone conversation.” She felt that this was so unusual that she hypothesized that the workers were “so used to talking down to the clients” that they were unable to stop doing so when talking to other professionals. Another advocate observed that many of the workers had an “edge” in the conversation, but noticed that as a newer team format (which was intended to reduce workload through the sharing files) was instituted in the ODSP office, the “edge” occurred less often.

One client who had her annual review around the time of the interview shared her frustrations at the pacing of the appointment. She felt bombarded by papers, and was asked to sign forms she felt she did not have the time to read fully. Only upon being asked did the ODSP worker offer to photocopy the forms for the client to take home with her to read later. When she challenged the worker about why the appointment was rushed and copies of the forms were not automatically given to clients, the client was told

it was because the workers had appointments scheduled tightly together. The worker shared that currently the “annual” reviews were only taking place every three years, and that they were trying to catch up as best they could. The worker also indicated that the office did not have the resources (time and paper) to provide copies of forms to every client who came into the office. Thus to save on resources, copies of the signed forms were only provided upon request. The worker gave the client her manager’s contact information and suggested the client could inquire about the ODSP policy around time scheduling for annual reviews and recommend more time allotted. This vignette also serves as a reminder that not all income assistance workers agree with all of the policy implementations, and in combination with high caseloads and paperwork demands, this can act as a significant source of stress (Gorlick, C., & Brethour, G. 2000).

### **Advocates, Client’s and Frontline ODSP Staff**

While clients did find many front-line ODSP staff abrupt or rude, the clients found that their interactions with local staff ODSP were “less abusive” when they had an advocate. One client shared that she found ODSP staff would take a closer look at her file or “dig into” the issues more seriously. At the same time however, the client found that the staff resented her. She found that she would have to “jump through more hoops” to access special benefits such as funds for a medical device. She suggested that the ODSP staff were doing this intentionally as she had to wait for what were, in her experience, unusually long periods of time, and found that she had to ask her advocate to contact ODSP to give them a nudge before her request would be processed.



When asked about areas in which clients had difficulty being heard, both an advocate and a client indicated that the area of dietary supplements needed more attention. It was the experience of both that, on occasion, the dietary supplement would be removed without explanation. In one case, the client had not been made aware that it had been over a year since the supplement was issued, and that ODSP required an updated form. When she phoned ODSP, she was told a letter had been sent to tell her that the supplement would be removed if she did not submit a new form. The client stated that she had not received such a letter, and said that her history indicated that she always replied to any letter sent to her by ODSP. What frustrated the client the most was that her supplement was for diabetes, a condition for which she was told she would need to monitor with diet for the rest of her life. It did not make sense to her why she would have to continually reprove her case. In another case, although the dietary needs amount was being received by the client; for an unknown reason, it was not received one month but perplexingly, was received the month thereafter. When ODSP was contacted, the advocate was told they did not know why the amount was not placed on the cheque, but if the client wanted to be retroactively paid for that one month, they would have to file an appeal and potentially take it to the SBT. In a third case, the client reported she had been requesting the dietary supplement for her medical condition for five years, and she was continuously told she already had it. After doing some research on the internet for a different issue, the client discovered that she had not been receiving the supplement because the numbers on her cheque and the internet did not match. When she phoned

ODSP a final time, she finally convinced the worker she was not receiving the supplement. The client was confident the reason this error occurred was because of the patronizing attitudes she perceived from the staff, indicating it was assumed she did not understand what she was asking for. Clearly, no person had double-checked the file to ensure the supplement was being received. Despite the fact the client had paper documentation indicating her request for the supplement for the past five years, ODSP refused to consider a retroactive pay from the time of her first request, stating that a request of that time length was “impossible and unheard of” and then instructed her that she could appeal the decision if she liked.

The clients found that navigating the observed negative attitude of many of the ODSP workers was difficult, and made finding out information difficult. In this way, many of the clients’ questions and concerns were not addressed by the ODSP, which, in effect, diminished their voice. One advocate indicated it was obvious that clients were being “stoneblocked along the way,” as evidenced by the number of clients who came to her office for routine information she felt should be available through the ODSP office. Another advocate found that many of her clients would “respond” to the attitude they received from workers. The advocate felt this was likely because clients do worry their primary source of income relies on being able to successfully comply with all the rules and regulations, and when the clients encountered resistance on the phone, they would naturally become apprehensive. One advocate observed that clients with increased communication skills tended to fair better in their telephone conversations with ODSP.

Similarly, another advocate has found some success assisting some clients to increase their communication skills through scripting information requests in such a way the client can avoid “feeding” the attitude. Most scripts focused on being pleasant during the phone call and asking for the information, while trying to be as personable as possible. All of the advocates have reported success in their efforts to be personable on the phone lines themselves, and have found over time they are able to recognize and make connections with individual workers.

The advocates have found that, the more of a relationship they can build with the ODSP workers, the easier it is to get information and have cases dealt with in a timely manner. However, two of the advocates did report that to achieve this cooperation, they had to make phone calls to supervisors, and explain that they are workers like them trying to help their clients as best they can. The advocates, by not viewing those they are working against “as an unfair, unfeeling bureaucrat” but rather, as someone with whom they have a shared goal (serving the client), are better able to build connections with ODSP staff (Lens, 2004, 508). An informal agreement seems to exist between these advocates and ODSP workers to co-operate with each other as much as possible, especially in cases that can be solved administratively before escalating (or continuing to escalate) the case. One advocate noted that workers in the past have been told to cooperate with her offices’ requests for information by higher levels of management, so that ODSP can avoid the added expense of taking cases to tribunals that could have simply been resolved by taking a closer look at the circumstances. This saves on time

and resources, and serves to achieve the client's goals sooner. The advocates would likely agree with Lens (2004) that the purpose of this cooperative is not to avoid conflict, but to achieve the goals of the client. In cases that cannot be resolved by this type of negotiation, advocates will take the case to the hearing level.

One of the advocates suggested, however, that communication skills alone would not solve some of the difficulties with client / worker interactions, as she felt there were systemic issues that exist from the "top down". In one instance, the advocate placed a complaint regarding one interaction she had, and followed the issue up with the governmental ministry. She said she got a letter from the director indicating an investigation would occur into the incident, yet after four months has not been updated on the status of any investigative efforts. The advocate shared her frustrations in perusing such situations:

They don't owe us [advocates] an explanation, they don't owe the client any explanation... It just reinforces to me what their views already were. They don't feel accountable to anybody.

While the advocates found their social worker credentials were an asset in accessing information, advocates who used the title of "advocate" found that sometimes it could create a barrier. One advocate shared that "the title advocate, with the majority of places I work with, I find I don't get a very warm reception. People assume you're a warmonger. So I tend not to use that title if I'm asking for something." Thus in many situations, the advocate would identify themselves through their professional title of social worker, rather than their organizational title of advocate to maximize the benefit of

their requests for their clients. This reflects Kiselica et al's (2001) observation that many advocates are unjustly labelled as troublemakers. This can place stress on the advocate as the potential for backlash increases. One client reported this was also true whenever she attempted to self-advocate. She reported that "anyone who doesn't immediately come down, yes sir, no sir, three bags full sir. Anyone who has questions and anyone who presents a challenge, anyone who wants questions answered, that is someone who is immediately suspect, who needs to be controlled is someone who needs to be put in their place."

Overall, when an advocate was effective, the clients found their advocate extremely effective. The reverse was also true, when an advocate failed to fulfill their obligations; there was profound disappointment and betrayal of trust. In the end, all of the clients interviewed received their benefits and felt that ODSP had come to an understanding of their case. While clients found that front-line ODSP workers were slightly more courteous once they were aware the client had an advocate, clients also felt that the occasional "slip-ups" occurred more frequently with their file resulting in further intervention by their advocates.

**SECTION III – Findings Related to the Social Benefits Tribunal**

This section splits the client's experiences of the SBT into three sections. The first section will explore the events leading up to just prior the SBT. The actual experience of the SBT will then be investigated and finally how the style of the member of the SBT or hearing officer influenced the client's perception of voice will be outlined.

**Pre-Hearing Experiences**

Two of the clients expressed feelings of nervousness and apprehension during the days just prior to the hearing. Extreme apprehension was also reported in the minutes leading up to the hearing. In one case, this was amplified by the nature of the client's medical condition. Clients appreciate the comments made to them by their advocates just prior to entering the room where the SBT was to be held. In some cases, the advocate would reassure the client that they (the advocate) would do most of the talking and to just follow their lead. This helped to reassure the client that they would not be going in alone, but instead would be well supported. Clients reported that their advocates would often reassure them of the merits of the case, or ask the client if there was anything particularly salient they wanted shared during the hearing. This also helped to reinforce the supportive role of the advocate, and sent the message "we're in this together" mentality which clients seemed to appreciate. One client indicated that she was quite calm before the hearing because she had been attending hearings for several years, but just as importantly realized that she herself and her advocate had all of their "ducks in a row." She determined that "there was nothing to fear but fear itself" and because of her

perceived preparation, felt quite ready for the hearing, so that her case could be sorted out. All of the clients also indicated that they noticed the nervousness of their advocates before the hearing. This nervousness did not detract from the client's general positive regard for their advocates. The nervousness seemed to validate the client's own anxiety and gave permission to be apprehensive. Some advocates verified that they were often nervous before a hearing; usually out of fear of failing the client. Much of the nervousness seems to be attached to the apparent unpredictability of the hearing itself. One advocate shared that she can tell how well a hearing will go when she finds out who the hearing officer is just before entering the room.

### **The Hearing**

One client compared the hearing to the biblical David and Goliath scenario, where David slays Goliath the giant using a slingshot. In many ways, the advocate acted as the slingshot in which the client felt they had a chance to succeed in their appeal to the SBT. Clients often found that the burden of proof was on them, even when they felt it was ODSP making the requests. In one instance, a client was accused of not paying back part of an overpayment, which she had paid, and ended up having to take the issue to a SBT. The client felt that the burden was on her to prove her innocence, and was fortunately able to prove her case by providing a photocopied cheque from 10 years ago. While the client was victorious in her case, she was quite infuriated that, if she had not found that document, she would have been required to pay a large sum of money to ODSP. Because of her previous experience and training, and her interactions with other clients of ODSP,

she strongly felt that many clients she had interacted with would have been required to pay back the money a second time, as they would not have either the skills or access to the documentation required to prove their case.

The advocates reported many ways in which they felt their clients felt they were heard during the SBT. In hearings that the advocates attended, they found that space was created to ask their clients questions, to provide answers for issues that they felt were relevant. Clients were also usually given an opportunity to make a statement or comment on anything that was raised during the hearing that they had not been fully explained. One advocate estimated that in her range of experience of all the SBTs she had attended, the number of hearings in which she felt the clients were heard was around 90%. She felt that the remaining 10% “were absolutely brutal” and felt that they were the source of the horror stories circulating about SBT experiences. Advocates were able to share many examples of when they felt the hearing officer took particular care or attention in hearing the client’s story. In one case, the hearing officer was willing to let a client remove their prosthesis to look at the nature of the deformity of the limb. The client nodded in agreement when SBT member commented that it looked quite painful due to the rawness of the client’s skin. The advocate reported that the client appreciated that the hearing officer was not repulsed by the limb but was instead “truly interested in his case.”

While some clients felt that they were heard because they won the case, they also indicated that it was quite possible to be heard without winning their case. One advocate in particular emphasized the distinction between a client winning a case versus being



heard. She commented that many clients do win their cases, but not because the SBT was able to hear the clients day to day experience. Success was often found through the quantifying the portrayal of the clients' experience, rather than having that experience directly shared. For example, the emphasis of the clients experience was often not about how the client felt about the fact he could not get out of bed in the morning, but instead was more interested in the number of hours the client spent in bed. With this understanding, the advocate felt that while most of the cases with advocates were successful, she felt that only in about 50% of clients with advocates were truly heard by the hearing officer in terms of their ability to truly understand how the client's disability influenced their day-to-day life. It was this ability of advocates to transfer the qualitative experiences of their clients into more concrete and quantitative understandings that seemed to be an important factor in the advocates' successes. In effect, the client's voice seemed to be distilled by the advocate to communicate what the hearing officer needed to hear the most to make a determination in the client's favour.

A negative hearing experience is not solely predicated on the actions of the hearing officer. Advocates shared that hearings do have an aura of unpredictability. One advocate shared a case where the hearing officer was very understanding and sympathetic to the client, but for an unknown reason, the client's responses to the questions were quite different from what the client had told the advocate. Another advocate illustrated the unpredictability in a case in which the client had a strong grasp of the English language but when it came to some medical terms, it was hard for the client to understand.

Therefore, the advocate requested a translator be present at the hearing. At the hearing, it was stated that procedures required that if a translator was to be used, the client would be required to go through the translator throughout the entire hearing, not just portions of the hearing where the terminology became too complex. The hearing did not go well, with the client's story communicated very differently than it had in the advocate's office. As well, it was clear that the translator was not translating verbatim as usually expected of translators, and was reprimanded by the presiding SBT member when it appeared the translator was attempting to have a discussion with the client. The advocate could not offer an explanation as to why the client's story changed between the time she prepped the client and the actual hearing. In retrospect, the advocate shared she would have had the client and herself meet the translator ahead of time so that everybody would know what to expect. That way, if the advocate noticed inconsistencies, troubleshooting could occur before the high stakes of the SBT. While there were many factors that influence a hearing, the most important player in setting the tone of the hearing are the hearing officers themselves.

### **Members of the SBT**

The 'member of the SBT' or 'hearing officer' seemed to dictate the tone of the hearings. Advocates and clients noticed early during the hearing cues that the hearing officer gave that assisted them in differentiating whether or not the hearing was going to be positive or negative. Given the stress and high stakes of the SBTs, anything a hearing officer can do to reduce or relieve the stress level of the client while remaining neutral

greatly assists the client in their ability to focus on proving their case. It also aids in creating the perception of the client that she or he was actually heard during the process, regardless of whether or not the decision was favourable to the client. Hearing officers that leaned forward, nodded their head as if they were listening, and took notes seemed to be looked upon more favourably by the clients and advocates. Officers categorized as positive also tended not to interrupt clients while talking, and would not assume guilt in their line of questions if there was an inconsistency in the client's testimony. One client appreciated how the hearing officer in her SBT asked intelligent questions about her case, showing that she understood the file, and got straight to the issue of the actual denial. Another indicated that her hearing officer apologized for making the client go through the process upon seeing the evidence, demanding to know why it had not be settled earlier by the DAU.

The opposite was generally true of hearing officers who were perceived as negative examples. Clients and advocates reported that hearing officers with their arms folded, a frown on their face, continually looked at the ceiling, did not take notes and interrupted the client while talking did not seem to "hear" what they were saying.

The hearing officers at the SBT hearing have a great amount of influence on the tone and experience of the actual tribunal. Both advocates and clients expressed that the hearing officers actions either caused them to become tense or more relaxed while at the hearing. Descriptions of hearing officers ranged between understanding, neutral, adversarial and demeaning. Advocates shared that they could tell what kind of hearing

they were going to have soon after entering into the room. Two advocates shared stories where a well-intentioned client told the hearing officer that they could call them by their first name. The hearing officer admonished the client, informing them that it was a formal proceeding and therefore could only address the client by their surname. It was felt by the advocate that a “bit of God playing” was occurring, as it was her experience that this was not true, and many hearing officers did respect such requests. In this situation, and many others, the tone of voice the hearing officer greatly influenced how the message was interpreted by the client. During a hearing without an advocate, one client felt that the hearing officer felt he was “better” than the client, as indicated by the disgust she sensed in his voice. She felt that the hearing officer thought he had better things to do with his time, and that she was wasting his time. In another situation, an advocate reported that a hearing officer had made a decision about the hearing before it started. When the advocate attempted to point out why under the legislation she felt a mistake had been made, the hearing officer “slammed his hand on the table and raised his voice” refusing to hear what she had to say. In addition to this type of behaviour, the types of questions asked by the hearing officer also led clients and advocates to believe some of the hearing officers had a fundamental disrespect of the client. An example of a disrespectful question included:

we all get depressed sometimes, so what makes yours worse than the others?’ when this [client] had attempted suicide on many occasions and had been on many anti-depressant medications for several years.

Advocates found that many hearing officers would directly challenge the client's experience in a way that caused the client to feel that they were seen as lying. One client reported that "from start to finish, you were guilty until you proved yourself innocent." In cases in which the DAU representative attended the hearing, this would result in two people at the hearing aggressively questioning the client." Clients that had previous experiences with no advocate present reported that when directly challenged in this manner, they would not know how to respond. Although clients found that the hearing officer would try and "dish it out" during hearings in which advocates were present, the clients felt that the advocate was able to stand firm and answer the questions. One client shared a story in which the SBT member was going to dismiss the cornerstone medical evidence of the case, citing that there was no indication of that impairment in her initial application. However, the advocate reportedly was ready for the question and was able to direct the SBT member to the single line in the application in which the doctor made mention of it, thus allowing all of the evidence to be admissible. Regardless of the evidence presented in these situations, one advocate felt that both the hearing officer and the DAU representative would simply "regurgitate what was written for denial" without incorporating the new data.

It was observed by clients that sometimes the tone of the hearing would sometimes change throughout. A client who initially found the hearing officer to be condescending noticed that as the SBT progressed, the hearing officer changed his attitude. The client noticed that the hearing officer would look her in the eye, and no

longer referred to her as “she” but rather used her name or directly talked to her. She “suddenly became a person who [was] in the room.” The client felt this reflected the hearing officer’s change in attitude towards whether or not the officer thought she was telling the truth. While the client was glad her advocate was able to assist in proving to the hearing officer her innocence, she found it disconcerting that it was assumed she was guilty when she walked into the room. It should be noted that while most notions of the presumption of innocence are found in criminal courts of law, quasi-judicial courts such as the SBT are not legally obligated to presume the innocence of client. Instead, it is often assumed that ODSP or the DAU made the correct decision and the onus is on the client to prove their case.

While clients and advocates all shared what they felt were negative experiences with hearing officers, some shared experiences of a more neutral nature. One advocate described the hearing officer of her case as “stone-faced” while a client characterized her more neutral hearing officer as stern. The characterizations appear to arise out of experiences with hearing officers that are difficult to read; their body language neither warm and approachable, nor rude and closed but more matter of fact and straight to the point. Both the client and advocate described this type of hearing officer as being professional, and while they would have preferred the warm and accepting type of hearing officer, they recognized that the hearing officer did need to maintain a level of professionalism and neutrality. One advocate shared that sometimes hearing officers will express that the reason that they are asking challenging questions, especially when the

DAU representative did not attend the hearing, is to ensure that the government does not appeal their decision to a higher level. Interestingly, the client who found her hearing officer stern and somewhat intimidating for that reason, also reported that he also showed compassion when she began to get upset, because the topic of discussion had entered into a realm of significant historical trauma, he directed most of his attention to the advocate allowing her space and time to recompose herself. She also found that the hearing officer did listen attentively when she explained her types of physical pain and how it affected her day-to-day life. It was clear to both the client and advocate that this type of hearing officer was absorbing much of the detail of the case through their note taking and recording. They felt that the fact they each succeeded at their respective hearings affirmed that this type of hearing officer indeed was able to hear the message being sent, although the client did comment she felt she would have been listened to even if she had lost the case.

Clients were appreciative that they were able to follow the lead of their advocate during the hearing. The clients indicated that they were relieved that if a point came during the hearing where they became stuck or unsure what to say, the advocate would be there to support them. In one instance the client indicated she was glad when her advocate would give her a glance to indicate he'd be willing to answer a question on her behalf when she became frustrated with the types of questions asked, and felt she might respond in an aggressive way. Clients generally estimated that they did between 5 – 20 percent of the talking during the hearing. Advocates who were there as the primary

representative, estimated that they did 60 percent or more of the talking. Typically during the hearing, the advocate would state the case and then would ask the clients questions, to which the client would respond. Then the DAU representative would be given an opportunity to reply, and finally the hearing officer would clarify any questions they had. The same process would occur for any witnesses. The formality of the process would vary between hearing officers, some would be very formal and use a strict protocol, while some hearing officers would be more informal and structure the hearing as more dialogue than a formal proceedings. Advocates also were able to sometimes control the flow of the hearing. At one hearing, where the advocate described the hearing officer as gruff and rude, the client was having a hard time keeping up with the pace of the hearing and some of the language being used. The advocate insisted that the hearing officer organize the flow in a way more conducive to the client being active during the hearing.

When asked about what the experience would have been without an advocate, one client replied, “Well it’s very simple. If he hadn’t done so, I would not have housing and I would not have an income and that’s the beginning and the end of the whole thing.” Most had been to previous hearings without success, and all agreed that their advocate was essential in winning their case. Clients and advocates suggested that there were several benefits to having an advocate help with the process, versus going alone. Clients overall felt that they were well supported by their advocate. One client stated that “[advocate’s name] is always championing me.” Other clients also felt they were well



supported by their advocate, and relieved to have someone else do most of the explaining during the process. Another benefit advocates provided was their expertise in the systems that the clients operated. Advocates were able to go through the files sent by the adjudication unit and quickly ascertain why the denial had been issued in the first place, what information would be required to argue the case, and how to request it. Clients appreciated having a “navigator” to help them to move through the system or to simply allow the advocate to do the busy work, as in many of the cases the clients did not have the energy or the drive to do this, caused by their condition. The advocates indicated that the biggest impact they had on the cases they oversaw is that they were able to ensure they made it all the way to the SBT. This is reflected by statistics from the SBT, which indicate that seventeen percent of all cases were denied, because the client failed to show up at the hearing, whereas only three percent were denied when a representative was involved (SBT, 2005). They felt that many clients give up prematurely, because they do not have an informed understanding of their options or are exhausted by being told “no” several times, that they simply give up. One client specifically stated that she would not have made it all the way through the process without her advocate. Advocates found that part of their role was to carry their client through the difficult parts of the process or to provide hope when the client’s morale was low. One client found that her response to the many frustrations encountered resulted in anger, and found that her advocate was very effective in tempering her anger and expressing her message in a more neutral way that the SBT would be more accepting of. She feared that without her advocate, she would

likely made “impassioned speeches” with “significant negative emotion.” Despite the client’s anger, the advocate “makes his point with enough force he is paid attention to and without the drama I would have injected there.”

**Section IV – Findings Related to Administration**

There were many other ways a client's voice was impacted on their journey to the SBT. Many of these impacts were structural in nature. The rules and regulations pertaining to the application and determination of the client's ODSP benefits often resulted in the loss of voice. The treatment of medical evidence often overrode the client's reports of their case. Finally, concerns raised were raised about the scheduling of SBT. In particular, it was felt that scheduling could be more conducive in having a client's voice heard sooner. Some concerns were also raised that the rules concerning the SBT hearings were on occasion abused to try and deny a hearing altogether.

**Application Barriers**

While discussing with a client about whether or not she felt that the SBT heard her message, she made a very revealing statement: "On paper, I don't think they quite understand my situation" but felt that in person they did. After some discussion with this client, and reading the interviews with all of the participants, it became quite clear that the paper application forms were a significant impediment to the client feeling that their voice was being heard. Both clients and advocates expressed difficulties they had with the initial application forms, and were often frustrated by the responses they received after submitting them.

Two of advocates specifically mentioned that a properly filled out initial application form supported by rigorous medical documentation usually are approved when they are sent. One advocate stated that the only cases in which she acts as an

advocate at an appeal level are those cases in which she was not involved in the initial application. Another advocate discussed that there are two types of cases that represent most of her ODSP caseload, the first deals with cases in which inadequate medical information was submitted initially, and the second were cases in which the client never finished the application. In the cases in which inadequate medical information was initially submitted, advocates and clients both stated that this was a significant barrier in communicating the true nature of clients' impairments. Advocates reported that many clients experience "form anxiety," usually this occurred when clients felt they did not have a strong grasp of written English, had previous negative writing experiences through school or were applying because of intellectual disabilities. It was also felt that this anxiety was heightened by the fear that an unsuccessful application meant the client would have less money for ensuring their basic needs. Thus the fear of failing, with the negative connotations of previous schooling experiences and directions that some clients found overwhelming created feelings of self-doubt and inadequacy, which made it difficult for clients to even sit down and start the forms. One advocate shared a story about a client who was so flustered by having to fill in the forms threw the self-report into the garbage, and the only reason why the application was processed was because the doctor had sent in some forms. It was also emphasized by an advocate that while many clients have difficulty filling out the forms, they are able to clearly articulate and explain verbally their conditions. Thus, some of the work done by advocates is helping the client

translate this verbal testimony into a written format, so that the message can be heard effectively by the person adjudicating the application.

Many of the clients did not experience difficulties filling in the forms, but felt that they were inadequate in expressing how their impairments affect them in their day-to-day life. One client commented that her intersecting disabilities of depression, anxiety and pain could not be adequately expressed in the forms. She explained, “when you just see written down that someone has anxiety, you don’t think of that as a disability. There’s been an ongoing and life altering problem that I was better able to get across to [the hearing officer] through [my advocate].” The client also explained that disabilities with an emotional or psychological nature are difficult to communicate on the forms. She felt that the hearing was the only way to “show” ODSP the nature of her disability, as the “evidence was right in front of the [SBT member].” Advocates agreed that intersecting impairments were generally not well understood until the hearing, at which point they could use their social work background to explain to the SBT how the less severe conditions on paper interacted with the clients environment in combination to create a disability that impaired the clients ability to work. The advocates also found that their social work credentials were well respected within the tribunal, and hearing officers would often rely on their expertise and high involvement with client as part of their decision making process.

Advocates also found that time frames to submit the paper work created another barrier. Sometimes the deadline to submit the application would be lost by the client,

because it was not on the form itself, but stamped on an envelope when it was initially sent.

When clients attempted to fill out the parts of the forms that required them to talk about their daily activities, advocates found that clients generally reported themselves higher level of functioning than they really were. Taub, McLord & Fanflik (2004) discuss how many women with disabilities seek to downplay the extent of their impairments to avoid the stigma society seeks to place on them. One client told an advocate that “I didn’t want to look at myself as not being able to dress myself properly” because of the arthritis. In some cases where the disability progressed to a point where the client had some difficulty looking after their children, they feared that to report this on the forms would cause their children to be taken away from them by the Children’s Aid Society (CAS).

### **Treatment of Medical Evidence**

Advocates found that many of the cases in front of the SBT were caused by the inadequate medical information being presented in the initial applications. This highlighted the importance of having strong medical documentation to prove their case. Clients often depended on their family doctors and specialists to be able to provide this medical documentation to assist with the appeals. It was reported that access to these materials is often made difficult because most medical offices have a policy of charging a fee for photocopies of a report or an X-ray. One advocate stated that clients are often “shocked” by these fees, and do not have the access to funds to pay for the reports

themselves. The advocates found that these fees could often be bypassed by requesting the materials themselves in exchange for a charitable tax receipt. In more rare instances, the doctors themselves were active in the case and would attend the hearing to provide their evidence first hand.

One advocate explained that disabilities that are much easier to “see” either in person, or through a medical diagnosis tool such as an X-ray are more readily understood by the SBT. The advocate shared that clients with intellectual disabilities that affected the client’s ability to communicate and could be readily observed by the hearing officer were often easier cases to prove. Illnesses that are more difficult to diagnose, or in which the tools are limited, require more effort to prove. Advocates found cases of chronic pain, fibromyalgia, and debilitating forms of depression or social anxieties to “show” to the hearing officer despite their just as serious effects on a person’s ability to work. A client reported that she was encouraged to avoid taking a prescribed “as needed” medication unless absolutely necessary so that the symptoms of her impairment would be more pronounced for the hearing officer to “see.”

Another barrier stressed by the advocates was that given the current province wide doctor shortage, many clients do not have access to family doctors. These clients often rely on walk-in clinics for their medical care. An implication is that medical documentation is more difficult to locate, as it is in potentially in multiple files. Advocates also reported that these clients would have difficulties finding a doctor to fill in their required forms, as most walk-in clinic professionals would refuse to complete the

forms, citing their lack of knowledge of the client. Walk-in clinics often will not make referrals to specialists as a matter of policy. This confounds efforts by advocates who attempt to have the clients' medical conditions confirmed. One advocate explained that even when a client had a family doctor, the client often was not aware that a "family doctors opinions [rarely] hold any weight" at the SBT, necessitating the need for specialist involvement. The advocates found that their clients were generally quite willing to personally ask their family doctor for the referrals. However, one advocate indicated that sometimes the family doctor would be resistant the requests, particularly in regards to chronic pain or depression. The advocate expressed that she found that in cases involving mechanical back pain, doctors would often indicate that nothing could be done, but in order for to demonstrate "substantial impairment under the DAU they should have at least gone to some sort of pain management clinic." It was indicated by the advocates that formal requests to doctors using their social work credentials ensured the referral occurred when a client was initially refused.

The advocates found that many family doctors spent only a short time with their patients. Therefore, it was crucial that the communication flow occurred between the family doctor and other professionals who spent more time with the client, to ensure that the doctor had all the necessary information available in order to accurately fill out the required forms for the initial ODSP application. One advocate reported that some doctors would request that she fill out the "Activities of Daily Living Form" on their behalf, or to fill out the form and compare answers later. Prior to December 2004 (ocswssw, 2004),



social workers were not permitted to fill out those forms. The advocate indicated that allowing social workers to fill out the activities of daily living was a step forward in ensuring that the clients' reality of their conditions was fully communicated. The advocates also indicated that they felt many doctors did not have the time to fill out the forms with the client present, so the doctor would fill in the forms without being able to receive feedback from the client about their perceptions of their limitations. Another advocate reported that the credentials required to fill in the activities of daily living portion should be as broad as possible, so that the person who best knows the client is able to fill out the form.

Overall, the advocates seemed sympathetic to the workload of doctors. The contribution of information by doctors in the advocates caseloads was deeply valued, and doctors were thought to be essential allies in their efforts to access benefits on their clients' behalf. The interviews indicated that the medical profession helped as best they could, despite some of the difficulties encountered. An advocate shared that:

[It] is my experience with doctors that they're really good. And days when they're not doing well, is days when I know he's overwhelmed by his practice, just like I have overwhelming days. So over all, I have nothing but good things to say about the doctors.

Despite the doctor's and advocate's best intentions, only so much can be done prior to the application as in many cases it is not completely clear what exactly the DAU expects in applications. Through practice experience, most advocates have a reasonable idea as to what is required, but even then they are

often surprised at the inconsistencies between cases that are granted benefits and those that are not

### **Scheduling of Hearings**

There was a small amount of concern raised by two advocates in the way hearings are currently rescheduled and cancelled. The primary concern was that often the SBT would review a case a few days before a hearing and grant the case in favour of the client. This is usually received as good news and both the client and advocate are elated. The concern arises not out of the experiences of the client who has had have their case decided in their favour prematurely, but rather the concern that no new hearing was scheduled in its place. It was felt that many hearings do end up prematurely resolved and that there should be an increased effort to review cases a few months ahead of time, rather than days before the hearing. This is so that in the case of a early decision, another person could be rescheduled in that place. By having their case scheduled to an earlier date, a client's voice is heard sooner.

There was another concern raised that the current rules and regulations do allow for a small window of procedural abuse in which if a decision is made that is partially in favour of the client, sometimes the SBT will refuse to hear the rest of the case. In one case where the client was hoping to receive retroactive payments, he had his benefits cancelled completely before the hearing. At the last minute, at the end of the day before the hearing, the client had his benefits

reinstated. The next day it was argued that the case would not need to be heard, as the client was reinstated, ignoring the fact the appeal had been filed prior to the loss of complete benefits, and the real issue was the retroactive payment. Since the hearing was dismissed for this reason, the client who had been waiting 18 months for the hearing felt completely silenced. The advocate was fortunately able to file for a review of the case, and have the circumstances rapidly reviewed, after which it was decided the client was entitled to the retroactive pay.

**Section V - Recommendations and Conclusions**

Based upon the data gathered, this section outlines suggestions for all of the major players and processes within the ODSP system including the application process, the DAU, the SBT and the advocates themselves. Many of the suggestions complement those of other critics in both theme and specific actions. (ISAC, 2004; Fraser et al, 2003).

**Applications and the Disability Adjudication Unit (DAU)**

After reviewing the client's and advocate's comments about the application and adjudication processes, it was quite clear that most of the concerns revolved around lack of user friendliness and clarity. It is clear that, given the time and energy clients spent filling in their self-report, the adjudication of the application package undervalue these efforts. This is particularly concerning, given that these reports can reveal relevant information to the adjudication process that may not have been included in the health status or ADL forms (Fraser et al, 2003). It should be made clear to the applicant the weighting that the self-report has in making a determination, and the DAU should strongly consider increasing that weighting, or use the self-report as a guide to information that requires clarification, and make an information request to obtain that information. The self-report should have increased clarity about what exactly adjudicators want to know from the client. Currently the form is open-ended, and leaves a lot of space for the client to write with little guidance beyond the initial instruction. Instead, the form should be broken down into smaller steps, asking specific questions

about the client's conditions, followed with an open-ended section where clients can leave additional comments.

Given the nature of many of the cases that end up before a SBT, as reported by the advocates, the adjudication process seems to have difficulty recognizing the cumulative impacts of multiple impairments on a client. Therefore, the sensitivity to the cumulative effect of many impairments should be increased in the process. This could require increased training of adjudicators of how impairments interact with each other. It could also required modifications to the ADL and health status report scoring system, to better reflect a client's lived in reality. Rather than the essay format of the current self-report, a question and answer format might be beneficial in gathering specific information from clients about their conditions, leaving a more open portion at the end where the client could include data they felt was not asked, in an effort to reduce form anxiety.

The current 90-day window for a client to receive and submit the ODSP application for benefits seems quite arbitrary. While 90 days does seem like a long time, given the current doctor shortage and long wait times to receive specialist attention, it is not always long enough to gather all of the information. Clients should therefore be allotted as much time as is required to gather the required data submit their application.

In-house staff that initially determine a client's financial eligibility for ODSP should also assist the client in determining what type of medical evidence they will have to produce in order to prove their case. Guidelines should be drafted, and given to

clients, if the worker is made aware that the client is applying for reason of impairments that are more difficult to adjudicate, such as chronic pain, fibromyalgia, social anxieties and debilitating depression, clear guidelines should be made. Additionally, it should also be made explicit if a specialist opinion is required, or if the opinion of their family doctor is adequate. Staff could also be employed to assist a client to review their application package before submission, so that any holes or gaps can be corrected before it is formally adjudicated. Adjudicators themselves should exercise greater investigative powers and when such gaps are found in a client's application, and given the client's consent, the information should be requested from the appropriate source. Upon request, the DAU should also make these requests on behalf of clients who cannot afford to obtain and send copies of this information itself. This is to ensure that a lack of finances does not deny an applicant the opportunity for a fair and complete adjudication.

Finally, letters of denial sent out by the DAU were of no use to clients and advocates in understanding the reason for the denial. The notifications were form letters, which all said exactly the same thing. Given the large number of decisions the DAU makes, it is understandable for the need to use form letters. However, such letters do leave the impression that the DAU does not care about the people whose applications they process, nor are they helpful in assisting people to understand what was perhaps lacking in their application. At a minimum, a summary of the determination should be included as enclosures with the denial letters. Since these summaries are already in the client's file, the impact on the DAU to include the letters would be small. Since the

information is vital in assisting clients understand the decision, including such information would be very beneficial. The 10 days required to request an internal review after the receipt of these letters should be extended, to allow clients to take the summary to their doctor, who could then clarify or include missing information that the DAU was seeking. By allowing more time, and allowing the submission of new medical information, cases could be resolved much more rapidly, decreasing the number of SBT.

### **Social Benefits Tribunal**

The participants in this study reported that it is possible to receive a fair tribunal hearing. At the same time, it was reported that the SBT can be an intimidating process, which leaves the client feeling that they were not heard. The stress of the hearing likely plays a role in a client's ability to communicate everything they wish to during the SBT. Therefore, the following recommendations seek to decrease the stress of attending a hearing, while increasing the ways a SBT member can show that they have heard the client's message, while ensuring that the hearing meets the standard of being impartial.

While quite rare, misconduct by a SBT member in their actions has been reported. Allegations of verbal abuse or intimidation during a hearing should be taken seriously, and the subsequent investigation into the allegations should be clear and transparent to any client or advocate that wishes to submit a complaint. The hearings themselves should be recorded, unless the client specifically requests that it is not. This affords the SBT member the protection of deflecting any false allegations of misconduct, while giving the client the security that, should anything go wrong during the hearing, there is a

mechanism for accountability beyond hearsay. The SBT should proactively gather and analyze anonymous client feedback after the hearings. The data could be used to ensure that the hearings have a level of consistency between different members. If a certain SBT member's hearings seem to be more problematic compared to the others, the SBT can then troubleshoot the reasons why this is, and make corrections internally.

In some cases, the stress of the tribunal can be avoided altogether. Medical evidence submitted to the tribunal is often reviewed just before the hearing. This will sometimes result in a decision in the client's favour without having a hearing. When possible, this review should occur well in advance, so that if the hearing is cancelled, a new one can be rescheduled in its place.

While it is important that the SBT be run in a professional manor, and that the matters before the tribunal are taken seriously, overly fancy attire and locations for the hearing do intimidate some clients, and are not necessary to fulfill the mandate of the tribunal. Allowing some informality, in an otherwise formal setting would be quite helpful in lowering the stress level of clients, so that their voice may be more effectively heard. Therefore, formal hotel meeting room settings should be avoided. The hearing itself should be structured more as a formal dialogue, rather than as a court proceeding. Some SBT members already use a less formal style in the hearings, where the stress of the hearing is acknowledged, the client may be referred to by their first name, if that is their preference, and questions are asked in a way that is not an interrogation. If there are certain lines of questioning that have the potential to be intimidating, but are required to



fulfill the legal mandate of the SBT, then the member of the SBT should make that clear prior to asking, so that the client does not feel as if they are being attacked. SBT members should be trained to ask questions in a way that shows a respectful manner, and made aware how body language affects the client's perception of whether or not they are being listened to. At SBT hearings, the burden of proof is often placed upon the client. Therefore, efforts should be made to ensure that the client is well informed of this burden prior to attending the hearing. A fund managed by either ODSP or the SBT should be created to assist clients who are not able obtain the proof required by the SBT because of financial barriers. Justice should not be denied to a client attending a hearing because of their financial difficulties. This is particularly relevant, given the understanding that people who apply to ODSP are only able to do so because they are under a certain financial threshold. In the long term, if funding access to such evidence causes a hearing to be cancelled altogether, such an approach could prove to be cost effective as well.

### **Local ODSP Offices**

During the interviews, it was quite clear that there was a desire by both clients and advocates for increased respectful communication with the local ODSP agency. It is evident that many of the workers are overworked, and that this stress does have a negative impact on the telephone and in person contacts with clients and advocates. Ensuring that an appropriate level of work is assigned to the employees would be beneficial to respectful communication. A lot of the difficulty between clients and ODSP workers arises when a client is unable to fully comply with requests from the agency.

The non-compliance normally does not arise out of a deliberate omission by the client, but rather through the information overload the client experiences during appointments. Intake interviews are quite lengthy, with a lot of information, and “annual” reviews are quite short, while presenting the client with a lot of information. It is concerning that, during some meetings, clients report that they are signing forms that they do not fully understand. Ideally, clients should be given adequate time to consider and give informed consent, even when signing the forms. At a minimum, a copy of everything signed should be given to a client automatically, so that they may refer back to it later. If it is identified that certain types of impairments seem to cause decreased compliance by clients, ODSP should identify the reasons for this, and create training modules for staff so that they can better serve their clients. Training should be strength based, and seek to minimize actions that clients find patronizing.

Clients and advocates reported concerns about paper submissions to ODSP. Often these papers contained evidence of compliance that was required to ensure a cheque would be received by the client. How paper is received and moved within the organization needs to be re-evaluated. Clients need to receive some sort of receipt for every piece of information submitted to ODSP in person, so that, should a mistake be made and the paper does not reach its destination, a client has confirmation that they fulfilled their obligation. For papers sent in the mail, some sort of immediate response should be sent to confirm the papers were received. If a client does not receive a

confirmation shortly after their submission, they would then be aware that an error occurred.

### **Advocates**

Overall, clients generally have positive comments about their advocates. Advocates should continue to do what they do well; recognizing the injustices clients experience, and working to correct them. When possible, advocates should seek to expand their efforts beyond individual cases, and work collectively to change rules and regulations they find unjust. Given the trust placed upon advocates, reports of the rare advocate who fails their obligations to their clients should be taken seriously. It should be ensured that accountability mechanisms are present in environments with advocates. Many organizations have these mechanisms in place. These organizations should continue to examine and evaluate these mechanisms, to ensure that they remain relevant and fully accessible. The most important accountability mechanism is a clear and well-defined complaint procedure, in the rare event that a client does have a problem with an advocate. Clients should be made aware of this procedure during the initial interview, at the same time the advocate and client discuss the case and what the client could expect of a advocate. A small pamphlet could be given to all clients which outlines the complaint process and whom they should contact.

The advocates interviewed reported an incredible success rate in both their efforts at the SBT and assisting clients prepare documentation for ODSP. These rates were well above those of the average representatives in general (including those that are not

considered advocates). The reasons for this are not readily apparent. The advocates did indicate that, being a free service; they would often only take on cases that they felt had merit. However, it is not clear if this would account for a small or a large percentage of the difference. Further research into how the client recruiting methods, compared to advocacy methods used, affects success rates at the SBT before any definitive answer could be put forward. The advocacy methods that the advocate used also requires further scrutiny. It is still unclear what types of techniques enhance the voice of the client the most, and what the relationship between these techniques and success is. What drives a client to be more involved in their case and in what contexts this occurs also merits investigation. Finally, it is still unclear how the client's steadfast loyalty to their advocate affects their voice and level of empowerment. It seems evident that the initial advocacy efforts that create this loyalty do empower the client. In particular, it should be explored if there is a point at which the loyalty prevents a client from reaching a higher level of empowerment, and whether an advocate can influence this.

### **Advocates and Other Systems**

Advocates should continue to seek new resources with which to expand advocacy efforts, and in particular seek innovative ways to address widespread needs in the system, facilitating the use of interdisciplinary contacts. As this paper is being written, the Ontario Coalition Against Poverty (OCAP) is strategizing how to respond to Ontario Works and ODSP's inability to meet the needs of clients who are not able to purchase enough food on their current benefits. For years, clients have been vocalizing the need

for more funds, to purchase more healthy food. Recently OCAP has enlisted the help of doctors, nurses and nutritionists to run medical clinics to access the nutritional needs of income assistance recipients. The dietary needs allowance has been under utilized, as most doctors were not aware of the allowance, and consequently never considered prescribing the dietary needs that were not being met, which allow clients to receive funds. Another innovative effort, which attempts to equalize the power imbalance between clients and ODSP, is through the creation of accompaniment teams in which volunteers act as non-advise giving witnesses to appointments.

Similarly, advocates should continue to educate medical professionals about the type of medical documentation and specialist referrals needed to prove cases of disability. The DAU seems to scrutinize cases of fibromyalgia and chronic pain syndrome and other less understood diseases, therefore the need to be to have a specialist documentation to be included is more important. Advocates should work with other professionals who fill in these forms, to encourage that they go over with the client what exactly it is they have reported to ODSP on the forms they are submitting, so that any differences between the client's and professional's understanding of the impairments is explored. Doctors should be encouraged by advocates to include copies of consultations they have made with specialists regarding their clients in the applications, rather than just mentioning them. This will help to decrease the chance that the DAU will deny benefits to clients who are missing these reports in their application, even though the doctor had noted they were available on file (Fraser et al, 2003).

Finally, many clients do not have access to doctors who can fill these forms in for them in the first place. Until a time when the doctor shortage is relieved, walk-in clinics should be encouraged to reevaluate their policies of not referring their patients to specialists, nor filling in forms. Significant consideration should especially be given to patients who use one particular clinic as their primary health provider.

### **Further Research Opportunities**

There are many future research opportunities in better understanding voice, advocacy and disability. Already mentioned has been the need to further understand how intersecting oppressions to disability affect and interact with a client's experience. Additionally, how the voice of a client is impacted by an advocate merits further investigation. While this research has identified themes and domains in which voice is influenced by an advocate, a more comprehensive investigation could yield additional themes. A comparative analysis between the experiences of those with and without advocates would be particularly useful. The importance of gender, sexual orientation, culture and their intersection with disability, and how this affects the transmission of voice through an advocate, are other dimensions that require further exploration. In efforts to study income security for people with disabilities, current research efforts should continue to seek to detect longitudinal and short-term effects of ODSP policies through time. Finally, how intersecting crises, brought on by health complications caused by some impairments and poverty, interact with the stress of applying for ODSP is another area that could yield further data.

**Conclusion**

All persons interacting within the ODSP system can be a partner in ensuring the client's voice is heard. Social workers are called to empower their clients, and ensuring their client's voice is heard and respected is a key goal in ensuring this empowerment. A compelling argument can be made to people who may view saving the taxpayers dollar as a higher priority than ensuring that a person's voice is heard. Failure to completely hear a client's voice, and properly assess a clients understanding of why they disagree with an ODSP decision, results in wasted resources in an attempt to prove or disprove their claim for ODSP benefits, or to deny an overpayment of benefits. When a client appeals the decision to deny or take back benefits, this results in the government review the decision at least four different times. The decision is initially made by the DAU in application cases, or by the local ODSP office in the case of overpayments. Then there are the subsequent internal review, pre-tribunal and SBT considerations. Advocates and other representatives, who are often recruited by clients, are another resource used. Finally, doctors and other overburdened medical professionals must deal with the information and referral requests from their patients, and advocates seeking to prove their case. Therefore, ODSP must be mindful to listen to the voices of clients to ensure that they are not needlessly denying their clients benefits or unjustly assessing them overpayments.

The current challenges within the ODSP are systemic, and while certain government policies harm some clients more than others, a radical adjustment that needs

to occur within the system, that goes beyond single case advocacy. One advocate shared that:

The system doesn't get any better. I've been at it [for over 15 years] and it's not getting better. You would think with the liberals getting in, but no... If you're not a productive member contributing [through employment], you're basically a burden, and that's the way I feel the system is set-up to feel for people.

Many voices have critiqued the ODSP system for many years, and will likely continue to do so until a more empowering system is created. Advocates and critics alike must continue to point out the injustices experienced by users of the income security net in Ontario, and develop strategies to rectify them. Kutchens et al (1987) reminds the reader that through “the thoughtful and creative use of the adversary system, advocacy can be transformed from a rallying cry to a manageable and effective technique in the practice of social work” (p. 132). Therefore, social workers seeking to correct the inequalities inherent in our current income security systems, should seek to understand and exploit these adversarial systems, such as the SBT and similar processes, to assist clients in maximizing their resources, power and voice.

## **References**

- Andrews, J. (2005). Wheeling uphill? Reflection of practical and methodological difficulties encountered in researching the experience of disabled volunteers. Disability & Society, 20 (2), 201-212.
- Artman, & Hall, L. V. (1854). Beauties and achievements of the blind. Auburn: Authors.
- Ashford, J. B., Macht, M. W. & Mylym, M. (1987). Advocacy by social workers in the public defender's office. Social Work, 32 (May / June), 199- 203.



- Azzopardi, A. (2000). A case study of a parents' self-advocacy group in Malta. The concepts of 'inclusion, exclusion and disabling barriers' are Analysed in the Relationship that Parents have with Professionals. Disability and Society, 15 (7), 1065-1072.
- Barnes, C. (1996). Disability and the myth of the independent researcher. Disability & Society, 11, (1), 107-110.
- Barnes, C. (2003). What a difference a decade makes: reflections on doing 'emancipatory' disability research. Disability & Society, 18 (1) 3-17.
- Bates, P. & Davis, F. A. (2004). Social capital, social inclusion and services for people with learning disabilities. Disability & Society, 19 (3), 195-207.
- Beresford, P. & Evas, C. (1999). Research note: research and empowerment. British Journal of Social Work, 29, 671-677.
- Booth & Ainscow, (1998) From them to us – an international study of inclusion in education. London: Routledge. In Azzopardi (2000).
- Bury, M. (1996). Disability and the myth and the independent researcher: a reply. Disability & Society, 11 (1), 111-113.
- Chappell, R. (2001) Social Welfare in Canadian Society. 2<sup>nd</sup> Ed. Scarborough: Nelson Thomson Learning.
- Chouinard, V. & Crooks, V. A. (2005). 'Because they have all the power and I have none': state restructuring of income and employment supports and disabled women's lives in Ontario, Canada. Disability & Society, 20 (1), 19-32.
- Chouinard, V. (2001). Legal peripheries: struggles over disAbled Canadians' places in law, society and space. Canadian Geographer, 45 (1), 187-192.
- Colby I. & Dziegielewski, S. (2001). Introduction to social work: the people's profession. Chicago: Lyceum.
- Corker, M. (1999). Differences, conflations and foundations: the limits to 'accurate' theoretical representation of disabled people's experience? Disability & Society, 14 (5), 627-642.

- Dubois, B. & Miley, K. K. (1996) Social work: an empowering profession. Boston: Allyn and Bacon.
- Dooley, M. D., Gascon, S., Lefebvre, P. & Merrigan, P. (2000). Lone female headship and welfare policy in Canada. The Journal of Human Resources, 35 (3), 587-602.
- Dowse, Leanne (2001). Contesting practices, challenging codes: self advocacy, disability politics and the social model. Disability & Society, 16 (1), 123-141
- Fraser, J., Wilkey, C. & Frenschkowski, J. (2003) Denial by design... the Ontario disability support program. [online] [www.incomesecurity.org](http://www.incomesecurity.org). Toronto: Income Security Advocacy Centre.
- Freire, P. (1970) Pedagogy of the Oppressed. New York: Seabury Press Inc.
- Gorlick, C., & Brethour, G. (2000). Transcripts from original focus group with program providers in the National Welfare to Work Study. Unpublished: University of Western Ontario. In Riggs (2000).
- Goodley, D. (2001). 'Learning difficulties', the social model of disability and impairment: challenging epistemologies. Disability & Society, 16 (2), 207 – 231.
- Herd, D. (2002). Rhetoric and retrenchment: common sense welfare reform in Ontario benefits, 34 (10), 2002: 105-110
- Herd, D., Mitchell, A., & Lightman, E. (2005) Rituals of degradation: administration as policy in the Ontario works programme. Social Policy & Administration, 39 (1), 65-79.
- ISAC, 2004. First steps: recommendations for social assistance reform. [online] [www.incomesecurity.org](http://www.incomesecurity.org). Toronto: Income Security Advocacy Centre.
- Kayser-Jones, J. & Koenig, B. A. (1994) "Ethical Issues". In Qualitative Methods in Aging Research, Gurbrium, J. F. & Sankar, A. (eds). Np: Sage Publications.
- Keeler, K. (2002) Resistant Voices: Structural Oppression. Hamilton: McMaster University.
- Kiselica, M. S. & Robinson, M. (2001). Bringing advocacy counselling to life: the history, issues, and human dramas of social justice work in counselling. Journal of Counselling and Development, 79 (4), 387-397.

- Kirst-Ashman K. & Hull, G. (1997). Generalist practice with organizations and communities. Chicago: Nelson-Hall. In van Wormer (2004).
- Kutchens, H. & Kuthchins, S. (1987) Advocacy and the Adversary System. Journal of Sociology and Social Welfare, 14 (3), 119 – 133.
- Lee, C. C. (1998) Professional counselling in a global context: Collaboration for international social action. In C. C. Lee & G. R. Walz (Eds.), Social action: A mandate for counsellors (pp. 3-16). Alexandria, Va: American Counselling Association. In Kiselica (2001).
- Lee, B. (2001). Case advocacy: A principles and practice guide for social workers and other community activists. Scarborough: Nu-Spin Publications.
- Lens, V. & Gibelman, M. (2000). Advocacy be not forsaken! Retrospective lessons from welfare reform. Families in Society: The Journal of Contemporary Human Services, 81 (6), 611-619.
- Lens, V. (2004) Principled negotiation: a new tool for case advocacy. Social Work, 49 (3), 506-513.
- Little, M. H. & Morrison, I. (1999) 'The pecker detectors are back': regulation of the family form in Ontario welfare policy. Journal of Canadian Studies, 24 (2), 110-136.
- Matthews, D. (2004) Report to The Honourable Sandra Pupatello, Minister of Community & Social Services: Review of Employment Assistance Programs in Ontario Works & Ontario Disability Support Program [online]  
<http://www.mcsc.gov.on.ca/NR/MCFCS/OW/Report/EmploymentAssistanceProgram.pdf>
- McBride, S. Towards permanent insecurity: The social impact of unemployment. Journal of Canadian Studies, 34 (2) 13 – 30.
- Mosher, J. et al. (2004) Walking on eggshells: Abused women's experiences of Ontario's welfare system. Available:  
[http://www.yorku.ca/yorkweb/special/Welfare\\_Report\\_walking\\_on\\_eggshells\\_final\\_report.pdf](http://www.yorku.ca/yorkweb/special/Welfare_Report_walking_on_eggshells_final_report.pdf)

- Neuman, L. (1997). The meaning of methodology in Social Research Methods: Qualitative and Quantitative Approaches, pp 60-87. Boston: Allyn & Bacon.
- Neysmith, S. M. (1995) Feminist methodologies: A consideration of principles and practice for research in gerontology. Canadian Journal on Aging 14(1):100-118.
- OCSWSSW (2004) – Ontario Disability Support Program - Regulation Amendments. [online]  
[http://www.ocswssw.org/sections/about\\_ocsw/news.asp?HeadlineId=91&NumOfHeadline=-2](http://www.ocswssw.org/sections/about_ocsw/news.asp?HeadlineId=91&NumOfHeadline=-2)
- OCSWSSW (2000) Code of Ethics and Standards Practice Handbook. Toronto: Ontario College of Social Workers and Social Service Workers.
- Oliver, M. (1990). The Politics of Disablement. Basingstoke: Macmillan. In Goodley (2001).
- Reinharz, S. (1994). Toward an ethnography of “voice” and “silence.” In E. J. Trickett, R. J. Watts, & D. Birman (Eds.), Human diversity: Perspectives on people in context (pp. 178-200). San Francisco: Jossey-Bass. In Houghton, K (2000) Responding to the Voices of the “Others”: Single Mothers and Higher Education. Pittsburgh: Duquesne University @ Shippensburg University.
- Riggs, B. (2000) Ontario Works: A Critique. Hamilton: McMaster University.
- Sosin, M. & Caulum, S. (1983) Advocacy: A conceptualization for Social Work Practice. Social Work, 28 (1), 12-17.
- SBT (2005). Private communication with the Social Benefit Tribunal.
- Shakespeare, T. (1996) Rules of engagement: doing disability research. Disability & Society, 11 (1), 115-119.
- Taub, D. E., McLorg, P. A., & Fanflik, P. L. (2004) Stigma management strategies among women with physical disabilities: contrasting approaches of downplaying or claiming a disability status. Deviant Behaviour 25, 169-190.
- Tesolowski, D. G., Rosenberg, H. & Stein, R. J. Advocacy intervention: A responsibility of human Service Professionals. Journal of Rehabilitation, 49 (3) 35 – 38.

UPIAS (1976) Fundamental Principles of Disability. London: Union of the Physically Impaired Against Segregation. In Goodley (2001).

van Wormer, L. (2004). Confronting oppression, restoring justice: From policy analysis to social action. Alexandria, Va: Council on Social Work Education.