

Discourses of Concealment and Resistance:
A Critical/Feminist Disability Analysis

of

BC's Disability Designation Review

by

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ABSTRACT

In 2002, British Columbia's (BC) Liberal Government introduced new social assistance legislation which radically changed the philosophy and access to social assistance for poor people with and without disabilities throughout the province. This thesis is an analysis of one aspect of this policy shift, the Ministry of Human Resources' Disability Designation Review, a massive review of almost 19,000 people who had been receiving Disability Benefits 2 under the previous legislation. Using the tools of feminist and post-structural discourse analysis and a critical/feminist disability lens, I challenge the apparent objectivity and neutrality of the Reassessment Form and the Ministry's rationale for the review by unpacking the discursive strategies the Ministry used to legitimize the review as a fair, impartial, objective, and neutral information gathering exercise to ensure services were going to those "most in need."

I argue that rather than a neutral, objective, and harmless information gathering exercise, the review was yet another attack against poor people in the welfare wars fuelled by the neoliberal ideology and governing practices common to many western liberal democracies. In addition to deconstructing the discourses used to justify, promote and rationalize the review, I explore the resistance to the review by analyzing the discourses disability advocates and their supporters used to challenge and disrupt the government's agenda. I conclude that the review is an example of disabling social policy which forced people with disabilities to position themselves as unable and incapable as possible in order to claim their right to income and support.

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CHAPTER ONE: INTRODUCTION

In Canada, as in other western liberal democracies, neoliberal ideologies and governing practices of privatization, deregulation, and downloading have resulted in what researchers have referred to as a “hollowing out” of the welfare state (Brodie, 1996). Social assistance programs have come under particular attack as provincial governments have responded by tightening eligibility and thus access, while simultaneously developing strategies that move people off welfare and into jobs as quickly as possible. Feminist political philosopher Nancy Fraser (1989) coined the phrase “welfare wars” which accurately captures the attacks on poor people on welfare evident in British Columbia’s (BC’s) new social assistance legislation - Bill 26, *Employment and Assistance* and Bill 27, *Employment and Assistance for People with Disabilities*, which took effect September 30, 2002.

With Bill 27 the Ministry of Human Resources (MHR) tightened eligibility to its new Persons with Disabilities (PWD) category by introducing a more restrictive definition of disability. This meant that many people receiving benefits could expect to lose them under the new criteria. Once the legislation took effect, the MHR launched a massive review of almost 19,000 people’s disability designation to determine their continued eligibility for the new PWD category. Therefore, while the review was a provincial policy process, it is situated within this broader context of neoliberalism and welfare restructuring.

Purpose of the Study

Policy processes such as the Disability Designation Review (DDR) are political - although their political nature is often hidden by their objective and neutral language. In this study I approach the review process as a terrain of political struggle in which discourse is a key strategy used by both government and disability activists. Using the tools of feminist and post-structural discourse analysis and a critical/feminist disability lens I situate the review within its larger context, deconstruct the discourses the state used to justify, rationalize, and legitimize the review, and analyze the discourses disability activists and their supporters used to resist. The struggle for adequate income, disability supports and recognition is an ongoing one which requires continual contact with state agencies and ministries. The purpose of this research project is to produce an analysis of this particular encounter between people with disabilities and the state that can inform future resistance.

Motivation/Location

My decision to focus on the DDR review is both personally and politically motivated. One of the ways I have located myself within the research process has been by exploring my interest and motivation for this research project.

I first got involved in the disability movement through my work with the Women's Research Centre (WRC). The WRC was a community-based feminist group in Vancouver, BC which developed research methods to facilitate action on women's issues. As I worked with the Vela Housing Society, the BC Family Support Institute, and the BC Association of Community Living (BCACL), I got to know and work with many women and men with disabilities and their non-disabled allies. Through this work I began

to see how unaware I had been of the many barriers they continually faced and the segregation that still exists between many people with disabilities and non-disabled people. I began to see the landscape of my non-disabled privilege. My involvement in the BC Self-Advocacy Foundation's (BCSAF) oral history project, which documented the journey from institutionalization to community living of 28 people with developmental disabilities in BC, was particularly powerful. This project resulted in the multi-media art exhibit "From the Inside/Out!" at Vancouver's Roundhouse Community Centre in the fall of 1998. Since then, elements of the show have been remounted in a few other communities in which the narrators/artists lived. I valued the opportunity to be a part of this collaborative project dedicated to making this hidden aspect of BC social history visible. In addition to learning about the history of institutionalization and the community living movements,¹ struggle to shut down the large institutions, I also learned about the strength and resilience of the self-advocates² who participated as narrators and artists in this project. During this process I began to define myself as an ally to people in the various disability movements.³

Just before I started the Masters Program in the Department of Educational Studies (EDST) at the University of British Columbia in September 2001, I worked part-time at the BC Coalition of People with Disabilities (BCCPD) a provincial, cross-disability advocacy organization, as their Health Literacy Coordinator. As I met with various disability groups to build a Health Literacy Network, I broadened my understanding of the advocacy agendas of people living with various disabilities. Many

¹ The community living movement advocates for and supports people with developmental disabilities to live in the community and to participate in various aspects of community life.

² A term used by people with developmental disabilities who speak out and advocate for their rights.

³ An individual who works to end a form of oppression which gives one privilege.

of the people who met with the BCCPD's Advocacy Team needed help with an application or appeal to what was then called the Disability Benefits Program - social assistance for people with disabilities.⁴ Working at the Coalition gave me insight into the effects of government cutbacks to needed services and supports such as home care, along with the realities facing people with disabilities who receive social assistance. As I entered graduate school in the new Feminist Approaches to Social Justice in Education specialization in EDST, I decided to continue my work on disability through my research.

In January 2002, BC's Liberal government announced their program of cutbacks and radical restructuring. Like so many other people, I was both outraged and overwhelmed by the depth and breadth of cuts to welfare, legal aid, health, education, disability programs, women's programs and more. The loss, not only of programs, but of almost every avenue of advocacy to protect people's rights and well-being was shocking. I saw the destruction of community infrastructure in the name of a deficit reduction crisis generated by the Liberal government's own tax cuts as a devastating attack on the poorest and most marginalized people in the province. I wanted my research to address some aspect of what was happening. While I struggled with the dilemmas of my position as a non-disabled woman doing research on disability within my new location in the University, I began to think about how my research could integrate my commitment to disability issues with BC's rapidly changing political context.

In November of 2002 I was invited to collaborate with two other feminist researchers, Dr. Allison Tom and Linde Zingaro, to write a "Report Card" on the effects of the Liberal government cuts to women and children with disabilities for the UBC

⁴ Bill 27- *Employment and Assistance for Persons with Disabilities* repealed the Disability Benefits Program Act.

Centre for Research in Women's Studies and Gender Relations website. After we met with Margaret Birrell, the Executive Director of the BCCPD to get more information about the review process, we decided to organize a meeting to inform and recruit people at UBC as volunteers to help people fill out the DDR Re-assessment Form. Given the cuts to funding and staff, many community groups and agencies across the province could not cope with the numbers of people needing help to complete the Forms by the original January 15th deadline. I attended a meeting where a BCCPD advocate guided us through the 23 page Re-assessment Form, providing the information and advice that people needed to complete it. Sitting there, I could feel the anxiety, distress, anger, and confusion this process had created. As I read through the Form I was stunned by its definitions and assumptions about disability and the lengthy assessment required by health professionals. I also attended a large public meeting organized by the Vancouver Status of Women and the Anti Poverty Coalition that included a panel discussion and strategizing session. My participation in these events focused my research interest on the review process.

My interest in focusing on disability has also been informed by my commitment to a feminist anti-oppression approach to social justice work and the ongoing integration of disability issues into feminist research, theorizing, and activism. During my years of feminist community work I have seen the critical changes that feminists with disabilities working primarily through the DisAbled Women's Network (DAWN) have made in women's organizations across the country - challenging ablest attitudes and practices and the lack of accessibility to women's services, events, and information. This change is evident in the attention the changes to disability assistance and the review received from

women's centres across the province. As I reviewed the literature of the past twenty years I noted the increasing attention to disability, mostly by disabled feminists who are at the forefront of theorizing feminist disability studies. However, as many also note, disability has yet to be integrated as a category of analysis into feminist theory in a way similar to race, class, gender, and sexuality (Thomson, 1997; Samuels, 2001). One of the results of this neglect is that feminist research on social policy issues has frequently ignored the realities of women with disabilities leading to recommendations which further marginalize and oppress women with disabilities (Keith, 1992; Morris, 1993; Keith & Morris, 1995). A disability policy issue like the review typically isn't taken up by non-disabled feminist researchers on women and welfare (Fraser, 1989; Brodie, 1996; Cohen, 1997; Evans & Wekerle, 1997). One of my goals for this project has been to produce a piece of research that addresses this gap in the feminist welfare literature.

Research Questions and Methodology

My approach to the research process is rooted in my commitment to ally work, my history of community activism and community-based action research, and my new location as a university-based researcher. Michelle Fine's (1994) theorizing on feminist activist research has provided a framework that integrates the concerns and interests arising from these different locations and experiences. This framework includes an explicit discussion of one's theoretical and political stance, a critique of current social arrangements and a narrative which offers disruptive possibilities. These concerns have informed each aspect of the research process and shaped the project's research questions:

1. What are the dominant discourses used to legitimize and rationalize BC's Disability Designation Review?

2. What power relations between the state and people with disabilities were constituted by these discourses?

3. How did disability advocates and their allies disrupt and challenge the government's discourses? What did they accomplish?

Discourse

I trace the beginning of my interest in using critical discourse analysis as a tool to critique social policy to one particular evening during the early 1990s. Watching the news I was struck by how the shift to the right had made it permissible for governments and media to talk about people on welfare as lazy liars and cheats. The success of government discourses which blamed social programs for the deficit and the debt, made it increasingly difficult for oppositional voices to be heard or taken seriously. On this particular evening, as I watched then NDP MP Svend Robinson being interviewed, I was startled to see how in this new context, his social justice language sounded outdated - the discredited themes and demands of another era. Discourses of poor-bashing and deficit reduction created a climate of support for the federal government's radical policy changes to the Unemployment Insurance Program and to social assistance standards guaranteed by the Canada Assistance Plan.

I was curious about this discourse/policy relationship as I monitored the rhetoric accompanying the BC Liberal government's radical policy and program changes. I wanted my inquiry to deepen my critical understanding of what was happening to people with disabilities through the review process - what the Ministry was doing and how they were doing it. I wanted to be able to see the complexities of this policy/discourse relationship, not only to critique it, but also to think about how to effectively oppose it in

this neoliberal context. It was this interest in what oppositional strategies were possible that expanded my inquiry to include the discursive strategies used by disability advocates to challenge the government's agenda.

There is no one agreed upon definition of discourse. In this project I rely on feminist and post-structural approaches to define discourse as historically variable groups of statements which have coherence, produce meanings and have effects (Ramazanoglu, 1993; Carabine, 2001; Mills, 1997). This notion of discourse includes both language and cultural practice. As Smith (1999) argues, discourses not only produce meanings they are negotiated and used; they organize practices and social relations (p. 158).

My approach emphasizes the need for discourses to be clearly situated within their context in order to understand both their function and their effects. This context includes the different institutions and social practices in which discourse occurs along with the positions of those who speak and those the discourse addresses (Macdonnell, 1986 as cited in Mills, 1997, p.11). Like other researchers working with discourse and policy (Shore & Wright, 1997; Siedal & Vidal, 1997; Carabine, 2001) I am interested in their material and regulatory effects.

Discourses create subject positions for people as burdens, threats, productive citizens, and so on. While people are subjected by discourse, feminists working with discourse theory have also emphasized the possibilities of negotiating, interacting with and challenging structures of discourse (Mills, 1997; Smith, 1990). As St. Pierre (2000) notes, although we cannot escape power relations we can resist the ways in which we are constructed and inscribed as subjects. I do not assume the realities of people with disabilities' lives are based solely on the subject positions constructed for them in the

discourses in the DDR. However I am interested in the ways the government discourses position men and women with disabilities because these representations create oppressive norms with which people with disabilities must interact and these have varying effects.

My analysis is also informed by the knowledge that discourses do not exist in isolation. According to Pecheux, 1982 (as cited in Mills, 1997, p. 16), discourses are formed in relation to, or frequently in contrast or opposition to each other. This understanding of the relations of discourse informed my exploration of how the government's dominant discourses interacted with, used and were mediated by the silent or taken for granted dominant discourses of gender, class, race and so on.

While all discourses make truth claims, not all discourses are the same. The institutional and professional support discourses receive affects their legitimacy and authority. A dominant discourse, such as the medical discourse of disability, represents the knowledge about an issue which is legitimized as "true." Dominant discourses tend to appear "natural" and gain their authority by appeals to common sense (Gavey, 1997, p. 54). Counter discourses oppose these dominant truths (Ramazanoglu, 1993, p. 20). St. Pierre (2000) notes that while discourse "works in a very material way through social institutions to construct realities that control both the actions and bodies of people, it can be contested" (p. 486). Despite the institutional authority and structural inequalities which support dominant discourses, they do change over time due to people's individual resistance, changes in social structures and the power of counter discourse especially when it is supported by the activism of social movements (Mills, 1997, p. 88).

Texts and Discourse

My analysis of the DDR Form relies upon Smith's (1990) work on the critical organizing and mediating role of texts to the ruling relations⁵ and the dependency of discourse, bureaucracy and management upon their uniformity across diverse local situations (p. 2, p. 122). Dominant discourses enter the local context of people's lives through various texts. For Smith, (1999) the text is a bridge between the local context and these relations of ruling - offering access to the relations and institutional processes which govern and regulate all of our lives (Smith, 1990, p. 4). The materiality and apparent permanency of written texts makes it easy to forget that discourses are not fixed. However, because meanings are fluid, discourses cannot be completely controlled (Wetherell, 2001).

I gave some consideration to combining discourse analysis with interviewing people with disabilities and/or disability advocates. However, witnessing the stress, panic, and burden the review process was creating for these not always separate groups of people, I decided against this method. I felt that recruitment alone, let alone interviews, would be an additional burden during a time when everyone's resources were stretched to the limit.

Although I was excited about the possibilities of discursive analysis, I also worried about how to keep people with disabilities present as subjects. I wanted to avoid what Smith (1990) suggests most macro-social analyzes do, which is to "construct a textual version of society and social relations which excludes the presence of subjects"

⁵ "the complex of extra-local relations that provide in contemporary societies a specialization of organization, control and initiative." This includes: bureaucracy, administration, management, professional organization, the media and "the complex of discourses, scientific, technical, and cultural, that intersect, interpenetrate and coordinate the multiple sites of ruling" (Smith, 1990, p. 6).

(p. 100). Her conceptualization of the relationship between the local historical settings in which people live their lives and the invisible ruling relations which organize these sites has helped me situate myself as a politically interested researcher, an embodied and situated knower who is a part of the world I am researching. Smith (1999) suggests that to avoid producing people as objects, researchers begin inquiry from the “actual,” that is, the local historical setting in which we all live our lives, in which any text is read or written, and through which each of us participates in the relations which govern, organize, and rule our lives (Smith, 1999, pp. 4-7). This standpoint in the “actual” enables researchers to “look from the margins in” and to produce knowledge that is for people, rather than about them (Smith, 1987, p. 48). She also emphasizes the particular as a “point of entry” into understanding how the ruling relations organize and coordinate our lives (p. 157). I have taken her ideas into my analysis of the discourse in the Ministry’s 23 page DDR Form. While the Form could be analyzed solely as the implementation of the government’s legislative and policy changes, I approach it as the entry point for people with disabilities into this compulsory review process - the text which is read and used by people in their local contexts and which organizes and coordinates their encounter with the state.

I used my research questions and community experience to guide my search for sources which challenged the government’s agenda. As BC’s provincial cross-disability advocacy organization, the BC Coalition of People with Disabilities had a strong public presence throughout the review. Advocates from the Coalition and other individuals were interviewed for articles in the Vancouver Sun, the Province and the Georgia Straight. Bill Tielman, a Georgia Straight columnist at the time, ran a series of columns critical of the

review. These resources also provided additional examples of the Ministry's discourse as did the Auditor General's Report. Other sources of counter discourse were End Legislated Poverty's (ELP)⁶ monthly community newspaper The Long Haul which included information from the BCCPD and letters to the editor from people with disabilities, and the BCCPD's Transition magazine. I also looked at updates on the BCCPD's website and the Creative Resistance website. The Creative Resistance website offers information and resources to individuals and groups working for social justice. This latter site included copies of letters sent by the provincial associations of some of the assessor groups to the Ministry. I also include notes taken during my attendance at the Disability Benefits Forum organized by Vancouver Status of Women and the Anti-Poverty Committee in November, 2002 and notes taken during the BCCPD's Executive Director, Margaret Birrell's information session about the DDR at UBC on November, 26, 2002. Her talk was organized to help recruit volunteer scribes to help people with disabilities fill out the Review Form.

Questions for Textual Discourse Analysis

I approached the analysis of the government's discourse and advocates' counter discourse by developing a series of analytical questions based on my reading of the texts and my understanding of discourse theory. I refined and narrowed the original list of questions as I applied them to the data. The questions enabled me to deconstruct the texts by identifying assumptions, key words and phrases, themes and silences. This deconstructive process illuminated the discourses and their interconnections, the ways in which discourses rely upon one another for their meaning and their power. This

⁶ ELP is a Vancouver-based provincial coalition of 36 BC groups working to end poverty.

deconstructive lens made it possible to see the operation of power and resistance in the review process. These are the questions I used in my data analysis:

1. What are the dominant government discourses in the text? [what are the key words, phrases, themes and metaphors, assumptions and silences in the text]
2. How do the different government discourses rely on, contradict and/or mediate one another? What other dominant discourses do they rely upon/are mediated by?
3. How are people with disabilities positioned by the dominant/government discourses in these texts?
4. What are the effects? [material, regulatory, discursive, disciplinary, normalizing]
5. What are the counter discourses? What discourses do they rely upon/are mediated by?
6. What subject positions do they offer people with disabilities?

Reflexivity and Accountability

Most of the feminist literature I have read on the need for reflexivity and accountability in the research process has focused on the power relations of the researcher/researched relationship in qualitative interview-based research. I want to advocate for the importance of reflexivity and accountability in feminist text-based research projects such as my own. As feminist researchers we cannot escape our implication in the categories and power relations that construct relations of dominance and subordination. This inescapable reality demands reflexivity throughout the research process so that we are accountable for the knowledge claims we make.

Too often situating oneself in the research has been reduced to a simple listing off of identity categories. This can be a meaningless exercise or an apology for the limitations of the research/researcher and any unintentional racism, classism, ableism, or

heterosexism (Alcoff, 1991/1992). Further, it assumes these categories are static and knowable, independent of history and context. Examining my location and position has meant thinking about the implications of the privileges and penalties of my non-disabled White middle class lesbian identity - not in the abstract, but in the context of the ongoing dilemmas of the research process, my political commitment to a feminist anti-oppression politics which includes my alliance work with disability groups, my current university context with its privileges and limitations, and my years of community-based researcher/advocacy work.

Locating myself meant sorting through the differences between community and university-based research projects and their implications for this project. Since I was no longer working with a community organization an important part of this process was defining my relationship to the "disability movement" for this research and claiming a space that acknowledged the realities of both my community history and my new university context.

Examining these layers of identity, politics, and context enabled me to see the strengths and limitations of my positionality. It was important for me to understand the critiques that disabled feminists have made about feminist research that has objectified them. I needed to think about the contradictions and privilege of receiving funding to do research on disability - an under-researched issue because of the systemic barriers and exclusionary practices of academic institutions. I needed to clarify the relationship of my research to the "disability movement" now that my context had changed. These are some examples of how I am implicated in disability - how my non-disabled identity exists in relation to people with disabilities and the structures of domination and subordination

within which we all live and work. While I believed it was politically important that feminist research and theorizing on disability wasn't the responsibility of feminists with disabilities - something only "they" should do, it was important to question this - to re-examine this belief along with my interest and motivation in this particular issue.

While not an "insider," I possess some insider knowledge from my work on collaborative research projects, my connections with people with disabilities and their allies in various organizations, my knowledge of some of the key goals disability advocates are fighting for, and my own commitment to research that would support disability groups' efforts to attain their goals. These, along with my experience using community-based research as a tool for social change, and my involvement in a range of women's issues and community groups were the strengths of my position. They have been an invaluable resource in keeping my research grounded in the material realities and political struggles of people with disabilities/disability advocates.

This kind of reflexivity is important in all research but I have noticed particular dangers in doing text-based policy research that is by definition one step removed from the people one is researching and writing about. One of the pitfalls of discourse analysis is the seductiveness of analyzing language - it is too easy to get lost in the intricacies and structures of grammar and phrasing and lose sight of the larger context in which these discourses occur, the practices they mandate, the realities of people's everyday lives which discourse organizes.

I wanted my research to be accountable to the "disability movement." Because there is no homogenous "disability movement," I had to define this in practical terms. Being accountable has meant deciding to examine my motivation and make it visible and

to keep people with disabilities present as subjects throughout the research process. Keeping people present as subjects has meant considering the material realities of people with disabilities on social assistance and the diversities of their embodiment and social location as I analyzed and critiqued my own and others' assumptions and knowledge claims. It also meant keeping track of the changing research context which included post review developments such as the Auditor General's assessment of the review process, Ministry updates, and updates from disability advocates. At every stage of the research process I tried to pay careful attention to the implications of my analysis and my conclusions for the everyday lives of people with disabilities and for the publicly stated goals of disability advocates.

"Reflexive" text based policy research must go beyond an individualistic accounting of identity to an examination of the implications of one's research context, the implications of the larger political and economic context in which the research takes place, and the subjects of policy live, and the implications of analysis and conclusions for the policy subjects' everyday lives.

Thesis Structure

The thesis is divided into seven chapters. In this chapter I introduced my research by discussing my purpose, motivation and location. I then outlined my research methodology and concluded with some reflections about accountability in feminist text-based research. Chapters Two and Three are a review of the relevant literature. In Chapter Two I review the key ideas, debates, and critiques in the theorizing of disability by critical/feminist disability scholars which inform the disability lens I am using in this study. Chapter Three is a review of the themes and arguments of critical/feminist

disability researchers who have analyzed changes in social assistance policies and practices within the context of welfare restructuring and neoliberal ideology and governance. I also discuss Fraser's ideas about the politics of need interpretation which have informed my analysis. In Chapter Four I situate the review in its broader disability and social assistance policy context. This includes a review of key developments in Canadian disability policies and the understandings of disability which informed them. I also discuss federal social policy changes which affected provincial social assistance programs and provide a detailed look at BC social assistance policies during the past ten years. My analysis of the review in Chapter Five focuses on the discourses in the DDR Form and the MHR's rationale for the review process. In this chapter I identify the Ministry's discursive strategies to legitimize the Form as an apolitical, objective, and neutral information gathering exercise. I argue that these reprivatizing and expert discourses serve to depoliticize the review process and mask its harmfulness to people with disabilities. Rather than a harmless exercise, the Review is a good example of disabling social policy practice. In Chapter Six I look at resistance by analyzing the discursive strategies used by disability advocates and their supporters to challenge and disrupt the review process, and reflect upon what they accomplished. I conclude the study in Chapter Seven by returning to my research questions and findings, and discussing the implications of this study for research, theory, policy and practice.

CHAPTER TWO: CRITICAL/FEMINIST DISABILITY THEORIZING

Introduction

Much like the development of women's studies, race and ethnic studies, and gay and lesbian studies, the rise of the disability movement mobilized the development of critical disability studies in the academy. Prior to the 1980's, most academic research on disability betrayed an individual or medical perspective and was located within medicine, rehabilitation, psychology, social work, and other applied disciplines. According to Linton, Mello and O'Neil (1995) most academic curricula view disability "as a personal medical condition, rather than a social issue, an individual plight rather than a political one" (p. 5). In the specialized applied fields, disability is commonly seen as a problem within the individual that requires "remediation, treatment or intervention to amend or compensate for what is perceived as wrong, missing or dysfunctional" (Linton, Mello, and O'Neill, 1995, p.5). This approach is usually referred to as the individual or medical model of disability.

During the past thirty years activists and scholars in the disability movement(s) and disability studies have challenged the hegemony of this dominant perspective with a counter discourse - the sociopolitical model of disability. At the same time, feminists with disabilities have struggled for visibility in the women's and the disability movements. Academic feminists with disabilities have been the driving force for attention to gender, and increasingly, race, class, and sexuality within critical disability studies, and for the integration of disability into feminist theorizing and research.

One of the troubling gaps in the literature is its overwhelming focus on physical disability. As several researchers (Thomas, 1999; Marks, 1999; Chappell, 1998; Goodley,

2001) have noted, this focus on physical disability marginalizes the experiences and perspectives of people with mental health and cognitive disabilities. When researchers examine “physical disability” but claim to be theorizing “disability” they privilege physical disability as the representative or paradigmatic disability experience. While some recent feminist work addresses gender and cognitive or mental health disabilities (Lindeman, 2001; Nicki, 2001; Carlson, 2001; Gabel, 1999; Wendell, 2001) most of the literature, including the feminist literature, speaks about disability in terms of the disabled body.

While all disability studies scholars share a sociopolitical analysis of disability, their theorizing reflects different disciplines and contexts, and draws upon a range of feminist and social theory. In this chapter I review the key ideas and debates in this counter discourse, paying particular attention to the critiques and contributions of feminist disability scholars whose work informs the critical/feminist disability lens I am using in this research project.

Sociopolitical Discourses of Disability

The British Social Model of Disability

One of the earliest conceptualizations of the sociopolitical discourse of disability was the British social model. Mike Oliver’s (1996) articulation of the social model was strongly influenced by the *Fundamental Principles* document developed by the Union of Physically Impaired Against Segregation (UPIAS) in 1974. The UPIAS document made a distinction between impairment and disability, arguing that disability is imposed on

impairment by the way people with impairments are excluded and isolated from fully participating in society. Thus it is society that disables physically impaired people.⁷

Oliver (1996) writes that he based his binary notion of an individual and a social model of disability on this distinction between impairment and disability. The issue at stake is the source of disablement and disadvantage. The social model contests the individualistic assumption that the cause of disablement is an individual's functional limitations and psychological losses (p. 32). It argues that the source of disablement is "society's failure to provide appropriate services and adequately ensure the needs of disabled people are fully taken into account in its social organization" (Oliver, 1996, p. 32). The social model's absolute distinction between impairment - as neutral biological fact, and disability - a form of oppression - has been a powerful tool for social change because it has enabled activists to shift the focus from disabled people's "limitations" as the source of their disadvantage (Crow, 1996) to the structures, policies, and practices which exclude, marginalize, and discriminate. This understanding of disability as oppression has also shaped British social model theorists insistence on naming people with impairments "disabled people," to reflect disability's social origins.

The US Minority Model of Disability

In the US, critical disability scholars influenced by the civil rights movements, developed a minority model of disability which identified people with disabilities as a disadvantaged group. Hahn (1995) argues that this shift in thinking enabled researchers to see that disabled people shared many of the experiences and obstacles that other minority groups experienced such as high rates of poverty, "welfare dependency," (my quotes) as

⁷ This focus on physical disability has been "extended to include intellectual and sensory impairments (Barnes & Mercer, 1996, p.7).

well as unemployment, housing, transportation, social communication barriers and segregated education (p. 4). However, unlike the social model's focus on structures and political economy, Hahn suggests that the source of disabled people's inequality "can be traced to public attitudes" (p. 4). Irving Zola, (1993) a pioneer in US disability and chronic illness studies, embraced the minority group model, but noted the following key difference. While most ethnic/racial minority group members grow up in the support of a recognized subculture, most people with disabilities grow up in isolation from other people with disabilities (Zola, 1993, p. 167). Zola explored the power of labeling, cultural representation, stereotyping, and the role of the body in disability identity. In his examination of the language of naming and disability identity he argues for a shift to "person with a disability" which conveys a relationship to, but separation from, the totalizing equation of the person with their disability (p. 170). The US and UK approaches to naming reveal different discursive strategies to combat disability oppression. "Disabled people" challenges the source of disability as within the individual while "persons with disabilities" challenges the oppressive notion of disability as totalizing incapacity. One seeks to change the individualistic assumptions of disability while the other challenges stereotyping and erasure. As self-naming is a significant aspect of the political struggle of people with disabilities, I have tried to stay true to the preference of each author. When I speak for myself I will use the phrase "people with disabilities" as this is the term used by disability activists in BC.

Like the social model, the minority model focuses attention on the discrimination people with disabilities face as they try to cope with an environment designed by and for

non-disabled people (Hahn, 1995). However, unlike the social model, the minority model does not rely upon a conceptual distinction between impairment and disability.

Australian feminist disability scholar Helen Meekosha (2004) suggests that differences between the US and the UK disability theories and methods reflect different intellectual traditions, political problems, cultural and national contexts. Her comparison of the two countries highlights the influence of materialist/Marxist theory in the UK emphasis on structural issues and the influence of social psychology and literary studies in the US emphasis on cultural issues. As Meekosha points out, countries on the periphery of the English speaking world (Australia, India, South Africa, Canada and Asia Pacific nations) use a more eclectic approach. She criticizes the US and the UK for failing to “include either the peripheries or the developing world in their analyzes” (p. 731). Meekosha argues, and I agree, that there is a need for a global disability studies project that moves beyond the debates and dialogues between these competing centres (p. 731). As she and other feminists (Thomas, 1999; Wendell, 1996) have argued, cultural, economic, and social relations are all implicated in the disabling and enabling of citizens.

Feminist Critiques

Including Personal Experience

Feminist disability theorists have drawn upon a range of feminist theorizing about experience, identity, difference, and the body to critique and expand critical disability theory. One of the first issues UK feminists focused on was the social model’s neglect of personal experience. Drawing on feminism’s politicization of the “personal,” Morris (1993) raised the need for disabled people to control how their personal experience of disability is represented, including its negative aspects. She argued that denying these

experiences isolates and individualizes them. Crow (1996) questioned the social model's representation of impairment as always irrelevant, neutral, or positive (p.58). She makes a strong case for attention to the difficult aspects of impairment - pain, fatigue, depression, and chronic illness - because they are both a central feature of disabled people's daily lives and make it difficult for many to participate in disability politics. Thomas (1999) notes that while Morris and Crow draw attention to the neglect of disability experience, they actually focus on the negative aspects of impairment. Therefore, they miss what Thomas calls the psycho-emotional effects of disability, in other words, the personal effects of oppression (p. 75). Despite these differences, their critiques contest the relegation of personal experience to the private sphere; the same separate spheres distinction that has marginalized women historically. As Thomas points out, privatizing personal experiences of impairment and oppression negates the social causes of these aspects of disabled people's lives. This abandons these issues to psychology and other disciplines which subscribe to an individual and personal tragedy model of disability (p. 74). Thomas, like many other feminist disability theorists, seeks a theoretical understanding of disability that can encompass both micro and macro issues - experience, identity and oppression.

Illness and Disability

This issue of experience speaks to another tension within British disability studies, the so-called illness/disability divide. In their efforts to de-medicalize disability and challenge the lack of attention to social context in medical sociology some disability scholars (Swain and French, 2000; Oliver 1996) have argued for maintaining a distinction between illness and disability.

Interestingly, I haven't seen this divide in the feminist disability literature (Keith, 1994; Wendell, 1996; Morris, 1993; Thomas, 1999; Thomson, 1997; Meekosha, 1997, 1998, 2002) which, from the early eighties, has included chronic illness in anthologies, research and theorizing. Keith (1994) argues against such either/or distinctions and the creation of a hierarchy between disability and chronic illness within disability studies. De Wolfe (2002) challenges the notion of a fixed boundary between illness and disability, arguing these are unstable categories and often inextricably intertwined. She persuasively argues that excluding people with chronic illness does not challenge the disabled/non-disabled binary so much as shift its boundaries to include only those disabled people who, with accommodation, can function "normally," i.e. like non-disabled people (pp. 264-265). My understanding of disability includes chronic illness. I agree with Keith's (1994) continuum approach to disability experience in which some are stable and well, others are just acquiring conditions, and still others are dealing with progressive conditions (pp. 6-7). People with chronic illness are part of the BC disability movement and many of the people receiving disability assistance live with chronic mental and/or physical illnesses. However, the new criteria which ties eligibility to the need for help with daily living activities will make it harder for some people with chronic and mental illnesses to qualify.

Impairment/Disability

While the social model's distinction between impairment and disability has been politically useful, it is theoretically problematic. Based on her narrative interviews with disabled women, Thomas (1999) argues that the impairment/disability distinction does not hold in disabled women's lived experience. As Corker (1999) points out, disabled

people talk about the complexity of their lives in ways which speak to the spaces between dichotomies such as “health and illness, disability and ‘normality,’ impairment and empowerment, and nature and culture” (p. 633) while the social model’s dichotomization of impairment/disability prevents an exploration of these very spaces (p. 633). Another problem noted by critical disability scholars Hughes and Patterson (1997) is that in making this distinction, the social model, like the medical model it critiques, treats “the body as a pre-social, inert, physical object which is separate from the self” (p. 329).

A key issue at stake in the impairment/disability distinction is the relationship between the material and the social. I have turned to feminists theorists working outside the social model for other ways of thinking about the impaired/disabled body (and mind) and the impairment/disability relationship. While they work within a social constructionist approach, they understand disability as both materially and socially produced, a view I share. I value their understanding of disability as a complex, changing, and context specific reality. While these theorists utilize feminist theorizing about the body, they also critique its exclusion of experiences of illness, disability, and bodily suffering (Wendell, 1996; Meekosha, 1998).

An Interactionist Approach

Wendell’s (1996) feminist approach to disability is premised on her view that the social and the biological are interactive. Therefore, she argues, it is not always easy to separate the biological reality of a disability from its social construction (p. 35). She describes this material-social interaction in terms of how the complex interaction of social factors and bodies affect one’s health and ability to function, as well as the ways in which “social arrangements can make a biological condition more or less relevant to

almost any situation” (p.35). This interactionist approach shapes her analysis of the social/cultural construction of disability which includes not only policies, representations, and societal norms about appearance, pace, performance, and productivity but also wars, poverty, violence, trauma, and other sociopolitical and economic factors that shape embodiment. This is significantly different from social model theorists who would either exclude the social origins of the “impaired body” (and mind) in their understanding of physical disability or argue for a separate social theory of impairment (Oliver, 1996; Abberley, 1987). However, her statement that one cannot always separate the biological and the social implies she sees these as separate prior to their interaction in disability.

Critique of Biological Foundationalism

Schriempf (2001) uses feminist post-structural work on the body, gender, and queer theory to challenge the biological foundationalism of individual, social, and feminist models of disability that apply the sex/gender distinction to impairment/disability. She challenges the bio-social dichotomy by arguing that because the material “is always already social” and the “social is always already material” (p.61,62, 67) the lines between impairment and disability are blurred. Schriempf concludes that “disability and impairment are both always about bodies in social situations and thus always about the material and social conditions of not just one’s body and its abilities but also of one’s environment” (p. 70). While Schriempf convincingly argues for the inseparability of impairment and disability, her interactionist framework insists upon their distinction. Unfortunately, she does not elaborate upon what these distinctions might be - how the “disabled body” differs from the “impaired body.”

Mutually Constitutive Approach

Dyck (1996) uses mutuality rather than interaction in her exploration of the experienced material body and the body as surface of inscription (p.55). This mutually constitutive approach challenges both medical and social model notions of a pre-social, inert and “natural” body while affirming the bodily experiences often rejected in feminist and body theorizing. It also challenges those who argue the body and physical disability are entirely discursively produced. Moss and Dyck (2002) propose “the body in context,” socially constructed and materially present, as a way to hold the tension between the physical body and the processes that ascribe meaning to it. This notion of tension is a particularly useful way of thinking about these mutually constitutive processes without collapsing or resolving them.

Disability as Difference Rather Than Lack

Another issue at stake in this debate has been the biomedical/social model assumption of impairment as lack. Thomson (2004) addresses this issue in her feminist theorizing of disability as “a pervasive cultural system that stigmatizes certain kinds of bodily variations” (p. 76). Drawing on feminist theorizing about race and gender, she argues that disability is not a “natural” state of bodily lack, inadequacy, or misfortune but a “culturally fabricated narrative of the body” (p. 77). As Meekosha (2004) points out, it is this understanding of disability as difference rather than lack, which challenges its assumed inferiority (p. 281). Meekosha (2004) argues that centering difference transcends the social model’s impairment/disability distinction because this understanding of disability includes both the body and the power relations that “judge bodies as normal or not “(p. 728). While Thomson centers the body, her emphasis on

variability along a continuum creates a space for including the cognitive and psychological as well as the physical aspects of bodily life in its conception of disability as difference. This continuum approach is one way that critical/feminist disability scholars have deconstructed the categorization of ability/disability as binary opposites.

Binary Categories

Ability/Disability Binary

Categories are social constructions which constitute people, things, and ideas in terms of their differences. As Minow (1990) points out, these differences are not intrinsic - they are relational. The categorization process conceals the extent to which ability/disability actually depend upon one another for their meaning. It obscures the reality that disability is a matter of degree and context. Furthermore, these relations "are a set of interlocking social arrangements that constitute groups differently *as subordinate and dominant*" (Razack, 1998, p. 136). Within the disability/ability binary, disability is the marked and inferior other of ability. Most government, private, and institutional disability programs are based on and reproduce such dichotomous understandings of ability/disability.

Thomson's (1997) analysis of the ability/disability binary system notes how this binary functions in much the same way as other dualistic systems such as gender and race, by erasing ambiguities and constructing impermeable boundaries (p.34). When ability/disability are constructed as completely dichotomous, people with disabilities are perceived as radically Other. Davis challenges ability/disability's impermeable boundaries by arguing that (1995) the disability category is extraordinarily unstable and begins to break down when you scrutinize the broad and heterogeneous group of people

who makes up the disabled (p. xv). Echoing Thomson's perspective of disability as difference, he notes that most people have some sort of physical or mental difference, although only some impairments/differences will be categorized as a disability. Davis argues that the term disabled obscures the fact that disability is neither a fixed nor static category, "but one which expands and contracts to include "normal," (i.e. non-disabled), people as well" (p. xv). Thomson (1997) challenges this fixed notion of disability by pointing to the dynamic and contingent nature of, for example, physical impairments which tend to fluctuate at different times in people's lives or from one day to the next, and which are affected by various external factors (pp. 13-14). Marks (1999) notes how psychology research has disrupted taken for granted ideas about relatively fixed states of mind and sharp distinctions between "sane" and "mad." Instead, this research reveals a continuum of experience in which mental states emerge out of a complex constellation of relational, contextual, and constitutional factors (p. 19). I understand disability as neither fixed nor static, but fluid, culturally and historically specific, and shaped by social context. While I support this deconstructive approach because it allows one to see the ability/disability binary difference as relational and to denaturalize disability, as Thomson notes, it threatens to mask the binary's material and historic effects and erase "the social categories we analyze and claim as significant" (Thomson, 1997, pp. 22-23). She suggests a useful approach to this dilemma is to understand the constructionist/essentialist polarities as theoretical strategies, rather than opposing truths, which can be used for specific goals. In this way deconstruction can be an effective critical tool for understanding difference without losing the specificities of identity, experience, and history (Thomson, 1997, p 23).

Normal/Abnormal Binary

Ability/disability secure their meaning through a series of other interdependent binaries such as capacity/incapacity; dependence/independence, and perhaps most powerfully, the normal/abnormal binary. All of these contrasting differences construct disability as a totalizing identity. Davis (1995) argues that this totalization is so powerful that once a person is labeled disabled, the label tends to overwhelm their abilities, capacities, and other aspects of identity. And it masks the point of reference, the norm from which one assesses who is “normal” (Minow, 1990). My review of the critical/feminist disability literature has convinced me of the critical role that the normal/abnormal binary plays in the dominance of individual/medical discourses which construct disability as deficit and lack. These discourses rely on taken for granted cultural and scientific norms of appearance, function, behaviour and valued activities - norms which Davis (1995) points out, are determined by non-disabled people. Assumptions of normal/abnormal minds and bodies inform the standards and criteria used to assess people with disabilities for inclusion or exclusion in government and other programs and services, and play a significant part in the reproduction of disability as physical and mental inferiority.

In this project I am relying on the work of disability scholars who have exposed normalcy as a social construction. Davis (1997) denaturalizes normalcy by providing an historical account of the development of Western notions of the norm. He describes how 19th century European beliefs in biological determinism and the new science of statistics, which developed in the context of European colonialism and imperialism, shaped this

idea and its application to the human body, contributing to the idea of a normative and a deviant body.

Amundson (2000) challenges taken for granted assumptions of normalcy as biological fact by contesting what he calls the doctrine of "*functional determinism*" which he argues is based on a notion of "*normal function*" (p. 103). Drawing a comparison between shifts in conceptualizations of race to the present view of biologists that race does not exist, Amundson argues for a similar shift in the taken for granted biological understanding of disability. He disrupts the supposedly "natural" biological categories into which human diversity is divided, by arguing that just as the concept of race is a social myth, a way of "managing diversity" so is the concept of "normal function" (p. 103). He cites an array of scientific research which highlights developmental flexibility, disassociates typicality from normality, identifies the reality that few people are anatomically usual, and disputes equivalencies between frequency, normality, and health to support his argument that normal function does not exist (pp. 103-105). His work is important not only because it challenges so-called scientific "facts" about disability, but also because the concept of normal function is regularly assumed in assessment tools. Amundson's analysis of a health index tool demonstrates how its scales of mobility and physical activity are biased towards typical modes of functioning. As a result, they actually measure barriers in the environments while identifying them as personal attributes (pp. 107-108).

Wendell's (1996) critique of normativity focuses on "normalized expectations" about the pace of life and work, performance, and individual productivity and "normal" adult control of mind and body. A belief in normalcy denies the immense variation of

human bodies and minds and, I would argue, it also contributes to a rejection of illness, suffering, and pain as “abnormal” experiences. To effectively challenge disablism requires breaking through non-disabled culture’s denial of physical and mental variation, distinguishing the typical and the usual from the “normal,” and acknowledging that illness, disability, and aging are not “abnormal” but common human experiences which need to be integrated into the policies and practices of social, political, economic and cultural life. The power of the normal/abnormal binary in securing the meaning of disability is this implicit equivalence of disability with the “abnormal.”

Dependence/Independence Binary

Disability scholars have also challenged the dependence/independence binary which valorizes independence and constructs people with disabilities as dependent burdens. Hughes (2001) critiques the medical model’s understanding of dependency as the result of biological deficits which restrict functioning and ability. He argues that as products of social worlds we are all interdependent, that our lives, regardless of our level of “ability” are marked by some amount of dependency (p. 25). Interdependency troubles the binary and problematizes the notion of independence. Hughes adds that the meaning of dependency is not universal but rather contingent upon its cultural, social, economic, and historical context. As Wendell (1996) points out, the contemporary meaning of independence is shaped by normative expectations of what an adult can do without help. For example, hiring someone to do your gardening or housecleaning does not undermine independence, whereas hiring someone to help you feed, dress, or bathe yourself does. Morris (1991) challenges the totalizing nature of the binary which makes it difficult to see the ways in which disabled people not only receive care and support but

provide it as well. The association of disability with helpless dependency makes the often reciprocal nature of relationships between disabled and non-disabled people invisible.

As Morris (1991) recounts, the independent living movement has challenged non-disabled notions of independence that rest on assumptions of physical and emotional autonomy. Disability activists have argued for a new meaning of independence that is not linked to one's capacity to care for oneself but rather to "being able to choose when and how care takes place" (Brisenden, 1989, p.8 as cited in Morris, 1991, p. 140). The independent and community living movements have fought for the rights of people with disabilities to live on their own rather than in an institution or with their parents, and for the right to make their own decisions rather than have their lives controlled by professionals. While noting the advantages of the movement's emphasis on independence in societies where this characteristic is so highly valued, Wendell draws on feminist critiques of western ideals of autonomy and independence to draw attention to the negative effects on the self worth of people who "cannot live without a great deal of help from others" (p. 145). She also warns how this ideal of independence can be used against people with disabilities by demanding unrealistic goals or as a way to rationalize refusing services. Wendell's cautions are timely given the neoliberal emphasis on economic independence and self-reliance in BC's new social assistance policy for people with disabilities.

Exclusions in Disability and Feminist Theorizing

Socially constructed identity categories such as ability/disability not only create a hierarchy of difference, they mask internal differences within each category of the binary (Riley, 2000 as cited in Scott, 2003 p. 5). One of the strongest contributions feminist

disability scholars have made to disability theorizing is their use of feminism's theorizing of difference to critique the exclusions in both disability and feminist theorizing.

Early feminist work on disability highlighted the exclusion of disabled women's experiences, issues, and perspectives from both the disability and the women's movement agendas (Fine & Asch, 1981; Deegan, 1981; Weiss, 1985; Toews, 1985; Lloyd, 1992; Morris, 1993). This early work identified issues such as sexuality, sterilization, parenting and violence that neither movement was addressing. Disabled feminists drew attention to the ableism of non-disabled feminists who could only see disabled women's disability, not their gender (Israel & Odette, 1993; Keith, 1992; Morris, 1993; Keith & Morris, 1995). Some (Lloyd, 1992; Blackwell-Stratton et al, 1988; Thomas, 1999) challenged this othering by emphasizing the commonalities disabled women had with other women, noting the specificities or differences within this overall sameness. Others (Fine & Asch, 1988) compared the situation of women with disabilities to men with disabilities and to non-disabled women as a way to emphasize their greater disadvantage. Morris (1993) has critiqued the focus on disabled women's greater or "double disadvantage" for reproducing stereotypes of disabled women as helpless or passive victims while Lloyd (1992) critiqued double disadvantage for its additive approach. Drawing upon Black feminist thought, she argues for the understanding of disabled women's oppression as the intersection and simultaneity of gender and disability. However, her intersectional analysis neglects other aspects of disabled women's identity. Razack (1998) challenges the additive approach to difference in her analysis of sexual assault and developmental disability. She argues that seeing women with disabilities as doubly or triply oppressed induces pity and a politics of rescue, rather than the respect that leads to a questioning of

complicity and the ways in which interlocking systems of oppression place women in different and hierarchical relations to one another (p.132).

Following the shift to gender as an analytical category within feminist theorizing, feminist disability theorists (Keith, 1992; Morris, 1993; Crow, 1996; Wendell, 1996; Meekosha, 1997, 1998; Thomas, 1999; Garland-Thomson, 2002) analyzed the gendered nature of disability. For example, Thomas' (1999) narrative interviews with disabled women illustrate the ways in which disability is a gendered experience, inflected by race, class, sexuality, and age. She argues that just as each of our lives are shaped by gender, experiences of ableism are also refracted through gendered locations and relations (p. 26). This focus on gender has challenged the privileging of male experience as representative in disability studies.

However, the feminist focus on gender and disability has also obscured the differences among disabled women and, at times, implied that disability is always the key difference between disabled and non-disabled people (Thomas, 1999). As noted earlier, the disability category represents an extremely heterogeneous group of women and men with diverse identities. Fine and Asch (1988) were among the first feminists to critique the way researchers treated disability as a unitary concept in which not only gender, but race, class, and sexuality were irrelevant. But as Meekosha (1998) argues, disabled embodiment can only be understood in its historical, cultural, and class contexts along with the gendered and/or racialized body (p. 176).

Feminist disability researchers (Thomson, 1997; Humphrey, 1999; Vernon, 1998; Razack, 1998; Meekosha, 1997; Carlson, 2001; Meekosha, 2005) have been at the forefront of exploring the intersection of gender and disability with race and class, or

sexuality. Davis (1995) and Meekosha (1997, 2005) have noted the influence of race, class, and gender on the likelihood and nature of impairment, as well as the degree to which one is disabled by it. The focus on disability as a unitary concept has contributed to the racialization of disability as White despite the fact that as Davis (1995) notes, people who are poor tend to be born with more disabilities and to acquire more disabilities and globally, people of colour make up a disproportionate number of the poor (p.161). Meekosha's (2005) feminist examination of the intersections of race and disability in Australian society points out how disability became the rationale for eugenic policies that became the means for excluding different races, religions, and cultural groups from immigrating and for policies aimed at the gradual elimination of the country's indigenous people (p.6) One of the critical exclusions Meekosha (2004) notes in the Australian disability literature, which is also true of Canada, is the "almost totally unexplored space of Indigenous disability" (p. 731). Meekosha (2005) begins to address this absence by exploring the causes of impairment in indigenous communities such as economic and environmental conditions, cultural dislocation and colonization. She discusses the problematic nature of the disability concept for indigenous communities, noting that the major, and at times competing, indigenous interpretations of disability stress the political implications of this labeling in terms of eroding community solidarity and cultural identity (p.10).

In Canada, one of the effects of colonization has been the separation of First Nations people into on-reserve status "Indians" governed by the federal Indian Act and off-reserve non-status "Indians" whose access to health and social services is covered by provincial governments. These artificial distinctions have "led to fragmented policies

and a patchwork of supports and services, where these are available at all” (Federal Task Force on Disability Issues, 1996, p. 20). Many women and men living on reserve must leave their home community to access health and social services. However, they are often unable to do so because the overlap and lack of collaboration between provincial and federal governments makes them ineligible for many provincially funded programs. While a number of federal government reports⁸ have identified the need to address these jurisdictional issues, a recent (Durst and Bluechartd, 2001) study of urban Aboriginal people with disabilities once again reiterates its urgency.

Feminist disability theorists continue to struggle for the integration of disability as a category of analysis in feminist theorizing (Keith, 1992; Morris, 1993; Keith & Morris, 1995; Meekosha and Dowse, 1997; Samuels, 2002; Thomson, 2004). Writing in 2002, Samuels discusses the still radical nature of using disability as a category of analysis because it has yet to be seen as a legitimate position from which to address literature, philosophy and the arts (p.58). Thomson (2004) argues for the integration of disability into feminist theorizing so it is part of all feminist explorations of culture and representation. She suggests this integration calls for a re-imagining of established knowledge that would deepen and challenge feminist theory (p. 75). Thomson (2004) further argues that disability is not only of concern to women with disabilities or confined to a few key topics, but that like gender, disability inflects cultural institutions and practices, social identities, political positions, historical communities and can “strengthen our understanding of how multiple systems (of race, class, sexuality, gender, and disability) intertwine, redefine, and mutually constitute one another” (p. 76) As a

⁸ The Obstacles Report, Canada, 1981; Completing the Circle, Canada, 1993

feminist doing disability work, I want to bring a feminist perspective to my analysis of disability and a disability perspective to my analysis of feminist research and theorizing.

Critical/Feminist Disability Lens

As I reviewed the critical/feminist disability literature's theorization of disability I noticed that different theorists analyzed it as an experience, an identity, a form of oppression or a constructed category. In much the same way that my work with disability groups raised my awareness of ableism, my encounter with this rich and rapidly expanding literature unsettled and expanded my understanding of the issues at stake in the theorizing of disability. Immersing myself in these theoretical debates and critiques has been an important part of this project and strengthened my analysis of the Review and its texts.

As my review of the literature makes clear, disability is a slippery concept because it holds so many meanings and is the subject of such contestation and debate. While I initially tried to find a new definition of disability that could hold the various meanings I was ascribing to it, I found that each definition created its own exclusions. Challenging this need/desire to redefine disability I describe my understanding of disability's meanings rather than circumscribe it in yet another definition. In the next section I discuss the key ideas and concepts about disability that form the critical/feminist disability framework I am using in this study.

My understanding of disability encompasses disability as identity, experience and a socially constructed category of difference. When I refer to disability experience I include physical, mental, and cognitive experiences of embodiment that are shaped by the mutually constitutive nature of the material and social. This understanding of disability

experience includes chronic illness. I see disability experience and identity as shaped by the interaction of power relations, by cultural and historical context, by social location and embodiment. Contrary to social model theorists, when I talk about disability oppression I prefer to use the term ableism rather than disability to represent the structural barriers and systemic practices which oppress people with disabilities. I use hegemonic ability to name the dominance of able-bodied/minded beliefs, practices and attitudes which are taken for granted by non-disabled people and perpetuate ableism.

My theoretical framework also relies upon an understanding of disability/ability as a socially constructed category of difference much like gender and race. Such categorization constructs disability identity as the dichotomous and unequal other of ability. Drawing upon the ideas of those scholars who challenge this binary, I understand disability/ability as variations or differences in embodiment that exist along a continuum. Ability/disability are matters of degree and context - fluid and dynamic - rather than fixed and completely separate. However, while these categories need to be deconstructed to challenge the notion of an essential disability identity or experience, I hold this in tension with the importance of disabled peoples' histories and current realities of segregation, exclusion, and marginalisation that shape disability experience and identity.

My analysis also relies heavily upon the deconstructive work of the critical/feminist disability scholars mentioned above who challenge normative notions of independence, function, character, pace, and expectations. I see the independence/dependence and abnormal/normal binaries as supporting a totalizing view of disability as incapacity, dependence, abnormality, loss, deficit, and limitation - the

individual/medical model of disability which activists have been contesting for over thirty years.

While disability is the key category I am exploring in this project, I draw upon feminist critiques of difference to hold the tension between using disability as a key category of analysis while not reproducing disability as a unitary concept in my work. Although the DDR approached disability as though gender, race, and so on were irrelevant, I am interested in how they inform this process and its effects. I do not see the experiences of disabled women as one of double or triple disadvantage. I rely upon Razack's critique that this notion leads to pity and rescue rather than respect, to think through the implications of activist and government discourse in a context dominated by individual/medical discourses of disability, and in which people with disabilities are either invisible or represented as heroic figures or objects of pity.

In the following chapter I review the work of critical/feminist disability scholars whose analysis of recent policy changes for people with disabilities on social assistance in Canada, Australia, and Britain has informed my research. I end the chapter by reviewing some key concepts from Fraser's analysis of welfare state discourse that I have used to analyze the Review.

CHAPTER THREE: WELFARE RESTRUCTURING AND DISABILITY

The changes to social assistance policy for people with disabilities, which I explore in this project, are part of the broader welfare restructuring processes that have occurred in most western industrialized countries during the past twenty years. In this chapter I review the themes and arguments of the critical/feminist disability researchers whose work on this issue has been a springboard for my own thinking and analysis of BC's disability designation review. While the details of the policy changes in Canada, Australia and Britain differ, the parallels in discourse, ideology and implications for people with disabilities are striking.

Although she does not address disability issues per se, I have also found Nancy Fraser's analysis of welfare state discourse a useful resource. I conclude the chapter with a discussion of her ideas about the politics of need interpretation, which have informed my analysis.

Britain's Welfare to Work Disability Policies

Mark Hyde (2000) and Alan Roulstone (2000), critical disability scholars from the United Kingdom, examine the policy changes affecting disabled people under the Labour Government's new welfare to work programme for those on "out of work" disability benefits - the New Deal for Disabled People.

Hyde (2000) argues that the New Deal employment policy which "encourages" labour force participation is intertwined with social security changes which "discourage" dependence on welfare by tightening eligibility requirements so that it is harder to qualify. At the same time, the government offers positive financial incentives to "encourage" disabled people into unpaid or low paid work. He also analyzes how

government administrative practices intertwine with policy by showing how the Benefits Integrity Project - a massive review of Disability Allowance recipients - has been replaced by a practice of "active case management," a more rigorous (intrusive) approach to assessing (monitoring), which reflects the Labour government's desire to target resources to those who are in the greatest need. Hyde argues that these changes will not only perpetuate disabled people's exclusion from paid work, but intensify the social exclusion and material deprivation of some groups of disabled people.

His analysis of the broader ideological and economic forces driving the government's welfare reform agenda offers a complex and comprehensive way to think about the broader context of welfare reform in the UK and here in Canada. He considers three explanatory frameworks for these changes: (1) they reflect a fundamental shift in state ideology from provider of unconditional support for "entitlements," to enforcing the "obligations" of citizenship, especially the obligation to work (p.333); (2) they are a form of fiscal policy driven by government concerns with budget constraints and other fiscal pressures (p. 334-335) and (3) they are best understood as labour market policy meant to address concerns about the negative impact of the welfare state on the nation's economic efficiency by reducing the work ethic, undermining productivity, and reducing international competitiveness (pp. 335-336). Hyde concludes that all three provide relevant insights: welfare restructuring has been shaped by fiscal and labour market concerns which have been legitimized by an ideological shift in responsibility from the state to the individual (p. 337).

Roulstone's (2000) analysis focuses on language, specifically, the gap between government rhetoric and reality. He notes the changes in government discourses that

embraced the social model's emphasis on barriers to its new emphasis on welfare dependency. Roulstone argues that the ideological function of the New Deal's rhetoric of dependency is to obscure the power relations of employment exclusion by focusing on the so-called "dependent individual" (p. 428). He points out that despite government rhetoric about a "new deal" between disabled people, employers, and the state, there is nothing to address the many employment barriers disabled people actually face. This places the responsibility for inclusion with the disabled individual and employment adviser (p. 433). While Roulstone and Hyde do a good job of naming the economic and ablest limitations of the labour market, they neglect to point out that employment power relations are also gendered, racialized, heterosexist and agist.

The CHST's Impact on Women with Disabilities in Canada

While Hyde and Roulstone focus on people with disabilities, Shirley Masuda's 1998 qualitative research study for Status of Women Canada investigates the devastating effects of the federal government's introduction of block funding for social assistance, health, and education and its accompanying funding cuts on the lives of women with disabilities.⁹ Shirley Masuda was a disability activist and researcher with DAWN Canada, the key feminist organization for women with disabilities in Canada. While her research report for Status of Women Canada is not in the academic literature, I wanted to include it because DAWN Canada has been at the forefront of researching the lives of women with disabilities in Canada and because at a policy level the lives and interests of women with disabilities tend to be invisible under the people with disabilities approach. According to Masuda, 62% of women with disabilities live below the poverty line

whether they are working or not, and 60% rely either partially or completely on the welfare system (pp. 1- 2). Her report identifies the effects focus group participants have noticed in Financial Assistance/Disability Benefits, Home Care, Institutional Care, Health Care and Education/Employment - and makes recommendations for change. One of the report's gaps is the limited attention it pays to the impact of race, ethnicity, class, and sexuality on women with disabilities' experiences of these cuts. Masuda's research makes the effects of welfare restructuring referred to in Roulstone's and Hyde's research visible. The overwhelming conclusion is that CHST block funding and cuts have devastated an already inadequately funded and functioning system. Her report highlights women's fears of being cut off welfare, their fear and hopelessness about the future, regional inequalities, and the implications for women's safety, health, and psychological well-being. In addition, the report points out how binary understandings of disability and the medical model translate into welfare criteria that make it almost impossible for women to maintain their benefits while they take training or education programs (p.27). Masuda's participants describe a situation similar to the UK welfare reforms: changes to the definition of disability making it harder to qualify, inadequate benefits, and increased surveillance, scrutiny, reassessments, and harassment. While she does not develop this point, Masuda reports that her participants frame this denial of their basic needs and their difficulties accessing medical care as an erosion of their human rights (p.3).

⁹ In 1996 the federal government introduced the Canada Health and Social Transfer (CHST) which shifted transfer payments to the provinces from a 50/50 cost-shared arrangement to block funding for social assistance, health and education. For a more detailed explanation see Chapter Four.

The Legislative and Policy Attack on Disabled People in Australia

Australian feminist disability researcher Helen Meekosha's (2000) conference paper uses a human rights and discourse lens to analyze her country's legislative and policy attacks on disabled people. The notion of human rights she works with extends beyond legislation to the issues raised by Masuda's participants, the provision of "services and activities in the community" (p.5). Meekosha situates Australian changes within a global context of International Human Rights covenants and a global disability movement that increasingly uses human rights to further its goals. At the same time she problematizes the ability of human rights legislation to effect the social transformations disabled people seek. In particular she draws on Minow's (1990) critique of the two track legal system which offers one track of self-determination and participation for those who satisfy criteria of rational thought and independence, and a second track of special treatment and quite often, social and political exclusion for various others (Minow, 1990, p. 146, as cited in Meekosha, 2000, p. 2). She also cites Thornton's (2000) critique of the individualistic nature of anti-discrimination legislation's complaint mechanism with its burden of proof on the complainant. Meekosha argues that despite advances for disabled people in Australia during the 1980's and 1990's, there is an increasing return to medical and economic discourses of disability to justify their harsh treatment and discrimination (p. 3). This return, she argues, has been facilitated by the government's economic rationalist ideology which favours minimum state intervention, reduced support to people in need, the freeing up of market restraints, and the rhetoric of mutual obligation (pp. 8, 12).

Like Roulstone, her critique highlights the ideological nature of the government's language of "mutual obligation" and "welfare dependency." Her analysis of the government's welfare reform documents points to the coercive nature of "mutual obligation" which sanctions those who are unable to meet them. One of the key points she makes in this paper is the lack of social recognition for disabled people. She challenges the state's right to impose obligations on disabled people in the absence of their social recognition as citizens. Her critique of "welfare dependency" draws attention to its inherent ableism, which demeans and devalues disabled peoples' efforts to survive in a disabling social and physical environment (p.12). Her analysis also reveals a textual silence about the differences among disabled people, particularly gender and ethnicity. This is an important point because it challenges most governments' one size fits all policy approach which fails to recognize the impact of embodiment, social location, and positioning on disability experience.

Ableness, Citizenship and Welfare Restructuring in Canada

In her conference paper, Canadian feminist geographer Vera Chouinard (2002) uses the concepts of citizenship and ableness to analyze the implications of neoliberal governance and welfare policy reforms for disabled women and all citizens. Drawing upon feminist theorizing of marginalization, exclusion and the critique of the 'universal' male subject, Chouinard defines citizenship as a "site of positive and negative differencing processes" which involve multiple and at times conflicting dynamics of inclusion and exclusion (p.2). While citizenship is a useful lens with which to examine and contest processes of exclusion and marginalization, as she does here, it is also a

problematic concept for Aboriginal people to embrace because the notion of Canadian citizenship rests upon their colonization.

Chouinard defines the concept of “ableness” as “a regime of power and privilege” that codes the normatively valued citizen subject as “able” (p. 3). She argues that under neoliberal governance, ableness is more than not having an impairment. The “able citizen” not only embodies the ability to see, hear, walk, and talk but to be productive, employed, and therefore not a financial burden. Chouinard suggests that neoliberal regimes have linked ability and citizenship so that the more social supports are eroded, the more this expanded notion of “ableness” becomes an important condition of citizenship for everyone. In the neoliberal context, everyone is expected to strive towards these ideals of ableness and independence.

Chouinard’s analysis of welfare restructuring emphasizes its disciplinary and regulatory aspects. She argues that the “hollowing out” of the welfare state is as much about new disciplinary regimes of citizenship as it is about funding cuts and changes to social assistance programs (p. 4). These include regulatory practices which actively and harshly discipline those who are least able to meet the increasingly strict criteria of ability and independence and political discourses which suggest that people have lapsed into a cycle of dependency and need to be disciplined “‘back into’ the paid work ethic” (pp. 4, 6).

Chouinard applies this citizenship/ableness lens to the development of Ontario’s two workfare programs - one for the able, Ontario Works Benefit and one for the disabled, Ontario Disability Supports Program (ODSP). She argues that setting up the two programs signaled that welfare recipients with verified impairments and illnesses

would not be judged as harshly for their “dependency” on state resources. She also points out that because the ODSP assumed disability no longer meant total inability to work, disabled people judged “able to work” were now disciplined into normative constructions of citizenship. For example, disabled people who could finish their paperwork without assistance from government employees had their applications for ODSP fast-tracked. As Chouinard argues, not only does this practice imply that the more able disabled deserve a quicker response to their claims on programs resource, it also reinforces ablest assumptions that doing work in disabled ways is by definition less productive.

Chouinard suggests that the political objective of the Ontario Works Benefit workfare program is to discipline individuals who depend on the government for income support into economic self-sufficiency through paid employment. Like the welfare programs in Britain and Australia, and here in BC, the program’s language shifts responsibility for employment from state agencies to the individual. The silence about employment barriers and structural disadvantage represents people in economic need as having only themselves to blame, which exempts state agencies from any responsibility.

Chouinard concludes that the harsh welfare policies of Ontario’s Harris government discipline everyone to conform to norms of ableness and independence. They punish the “apparently able” by making it harder to qualify and maintain benefits, by policing and punishing fraud, and through compulsory workfare schemes (p. 5). They subject the more able disabled to parallel processes, while those disabled people who must remain on ODSP face more cuts in services, tighter eligibility requirements, and deepening poverty.

Britain's Disability Living Allowance Form

Shildrick and Price (1999) use the tools of postmodernism in their feminist Foucauldian analysis of Britain's Disability Living Allowance (DLA) Form which assesses disabled people's needs for "personal care" or help "getting around"(p. 435). While they situate the Form within the context of welfare state agencies' demands to know the intimate details of welfare applicants' lives, they neglect the broader context of welfare restructuring the other researchers in this chapter have described. Their rationale for focusing on disabled women in particular is also problematic. Because they see disability as conceptually linked to the disablement of the female body in western culture, they argue that female disablement is the "further marginalization of the already marginal" (p. 434). This centres gender as the primary form of oppression and leads to an additive approach in which disabled women are "doubly disabled."

Despite these and other criticisms, it is the only other critique of a disability form I have come across and offers some relevant insights. Shildrick and Price's analysis draws on Foucault's understanding of medicine as a disciplinary regime and his explorations of how its external gaze is complicated through techniques of self-surveillance and confession. The DLA Form includes 28 pages of detailed self-analysis which requires a disabled woman to direct a critical gaze towards the minutiae of her bodily functioning and to "confess" the intimate details of its inadequacies (pp. 435-436). This demand for intimate details compels a normalizing judgment or gaze directed at oneself. To qualify for benefits each disabled woman must produce herself as a disabled subject.

Shildrick and Price point out that the Form's focus on individual functioning privileges the individual's so-called "failings" over social and environmental barriers (p. 435). And while self-assessment is a large part of the Form, they also note its limitations as a non-authoritative discourse which must be confirmed by two health professionals. They argue that the self-certification techniques exemplified in the DLA Form are not a lessening of authoritarian control but rather its dispersal. This procedure shifts responsibility for a successful claim away from the state agencies to the individual woman who is more easily blamed for her failure to monitor her own functioning. Lastly, they argue that this demand to know is an expression of power/knowledge in which the applicant is controlled by continuous surveillance and the demand for intimate and personal details, rather than external coercion (p. 436). While I agree that surveillance and demand for information are insidious disciplinary regimes that control disabled women, I would also argue that it is not that surveillance and demand to know replace external coercion, but rather that they mask it.

One of the gaps in this literature is attention to the resistance of disability activists to these changes in disability policy. This research project makes a contribution to addressing this absence by exploring the discursive strategies disability advocates used to successfully resist the review.

The Politics of Need Interpretation

As mentioned earlier, although she does not address disability issues, Nancy Fraser's (1989) feminist analysis of the contested nature of needs discourse and its politicizing/depolicitizing tendencies has been a useful resource for my analysis of the review's discourses of concealment and resistance.

One of the questions I had going into this project focused on the possibilities of resistance during a crisis such as the review. Fraser addresses this issue as she outlines the dilemma facing feminists who she argues, must both oppose any cuts to welfare benefits and yet, because these benefits tend to reproduce, rather than challenge structural inequalities, must also find ways to intervene at the ideological level (p. 145). She suggests that since talk about people's needs is the key language in which political claims are made and contested, and inequities challenged in welfare capitalist societies, needs discourse is a strategic focus for feminist action (p. 145). Fraser problematizes the taken for granted quality of most needs talk which assumes that peoples' needs are somehow obvious and beyond debate. As she argues, this hides the reality that how needs are defined and interpreted, by whom, and in whose interests is a site of political contestation (p. 164). Her critique of the welfare system highlights its depoliticizing tendencies to treat people's needs as unproblematic and redefine them in ways which substitute managing need satisfaction for the "politics of need interpretation."

Fraser's analysis makes the contested character of needs discourse visible. She describes needs talk "as a site of struggle where groups with unequal discursive and non-discursive resources compete to establish as hegemonic their respective interpretations of legitimate needs" (p. 166). At stake is the power to define people's needs and therefore what would best satisfy them. This struggle over need interpretation occurs within what Fraser calls the social – a discursive space of conflict over competing discourses about peoples needs.

Fraser's analysis of the three major categories of competing needs discourses is important because it highlights the things feminists and other social movement activists

need to pay attention to in our engagement with the state. Oppositional needs talk offers alternative interpretations that “challenge, displace and/or modify” the dominant ones (p. 166). Reprivatization discourses try to depoliticize these oppositional discourses by arguing these needs are personal, family, or economic issues, not political ones. They seek to “exclude, defuse and/or co-opt” oppositional discourses (p. 166). Expert discourses translate politicized needs into administrable ones (p. 174). This process also tends to depoliticize because the translation process decontextualizes people’s needs, removing their social group specificity and oppositional meaning (p. 174). This rewriting process repositions the people whose needs are to be met as individual “cases” and potential recipients of services rather than members of social groups. Fraser’s analysis has been particularly helpful for my project because she makes the struggle over peoples needs visible by focusing on the interactions among these competing discourses and interests.

Summary

In this chapter I reviewed the research of critical/feminist disability researchers whose work analyzes the changes in social assistance policies and practices for people with disabilities. This literature situates welfare policy practices such as the review in the larger context of neoliberal ideology and governing practices which has been the driving force behind welfare restructuring in western countries. One of the key issues that this research makes visible is the shift from state to individual responsibility for the employment, independence, and inclusion of people with disabilities that has taken place. Government discourses of welfare dependency, mutual obligation, and independence reflect this shift and obscure existing power relations. Another key issue is the lack of

attention to the many barriers facing people with disabilities in new social policies and practices such as the DLA Form which compels people with disabilities individual to scrutinize the minute details of their inabilities.

My review highlights how welfare restructuring processes lead to remarkably similar practices as governments increase surveillance, tighten eligibility rules, reduce benefits, and make cuts to services which increases the fear, hopelessness and poverty of people with disabilities who rely on government financial assistance to meet their daily needs. As Meekosha notes, these policies mark a regressive return to medical and economic discourses of disability. Chouinard's analysis makes the ideological link between social assistance policies for people with and without disabilities visible. As neoliberal governments expand the meaning of ableness beyond embodiment to include productivity and independence of state funding, ableness and independence have become new requirements for claiming citizenship for disabled and non-disabled people.

I end the chapter by discussing Fraser's analysis of needs discourse which problematizes the taken for granted quality of needs talk and makes visible its contested nature.

In the next chapter I outline the historical disability policy and recent social policy context in which the BC government's changes to social assistance policy have taken place.

CHAPTER FOUR: HISTORICAL, POLITICAL, AND ECONOMIC CONTEXT

Introduction

As part of the changes to BC's social assistance policies for people with disabilities, the review has two relevant policy contexts - disability policy and social policy. I begin the chapter by outlining some key issues in the development of Canadian disability policy. Next, I examine the consequences of the federal government's neoliberal social policies for provincial social assistance programs. In the last section of the chapter, I analyze key changes to BC's social assistance policies for people with disabilities and non-disabled people during the past ten years.

Historical Disability Policy Context

Chrichton and Jongbloed (1998), (Jongbloed, 2003) suggest that disability policy, like all Canadian social policy, has developed incrementally in response to changing values, socioeconomic conditions, and demands. Their analysis of late 19th and 20th century Canadian disability policy development argues that different models of disability - law and order, medical and economic, and socio-political - have shaped disability policy during three distinct time periods. This framework tends to oversimplify the continuing influence of these frameworks on contemporary disability policy debates. However, it draws attention to how incremental policy development has resulted in a mix of programs based on different, and at times, contradictory beliefs, criteria, and goals. This makes it hard for people with disabilities to get the services and supports they need as they may qualify for one program but not another.

Segregation Model of Disability

One of the first Canadian disability policy initiatives was the creation of asylums in the early 1800's for people who were mentally ill or handicapped (Boyce et al, 2001, p. 11). While the initial goal was to return people to their communities, by the end of the 19th century, most asylums provided lifetime custodial care (Boyce et al, 2001).

Chrichton and Jongbloed (1998) suggest that disability policies during the late 19th and early 20th century reflected a "law and order" approach which viewed people with mental illness or handicap as dangerous and disruptive and recommended their institutionalization for their own and society's protection (p. 97). Surprisingly, their analysis neglects the influence of eugenic beliefs on early 20th century institutionalization policies. McLaren (1990) shows how concerns with improving the "race" and fears of race degeneration led eugenic thinkers to advocate for segregation through institutionalization to control the reproduction of people deemed "unfit." The "unfit" category was very broad and included people with mental illness or handicap as well as people who were poor, new immigrants, and those whose behaviour was deemed immoral.

Segregation was also a strong theme in the development of Canadian education policy. As provincial governments made schooling compulsory during the 1920's, disabled children were either excluded or segregated into separate classes on the basis of eugenic arguments (Boyce et al, 2001). Segregation more accurately captures this era's approach to disability policy than "law and order," which speaks primarily to the jailing of people with mental illness during the early 1800's. While no longer dominant, this

segregation paradigm continues to inflect contemporary debates about disability issues and policy.

Medical and Economic Models of Disability

Jongbloed (2003) suggests that medical and economic models of disability shaped the development of rehabilitation and income maintenance policies and programs from 1910 to 1970. Rehabilitation programs based on the medical model focused on individual physical and psychological adjustment to impairment. However, medical, vocational, and social rehabilitation programs also reflected economic concerns with reducing the costs of disability by increasing peoples' employability and returning them to work (Chrichton and Jongbloed, 1998, p. 122).

Income Security Policies and Programs

Income security programs have also relied on both perspectives. According to Bickenbach (1993), most North American income support programs are designed to address peoples' loss of productive capacity, wage-earning capacity, or employability (pp. 70-71). At the same time, these programs define disability in biomedical terms as an impairment of a certain severity and duration (Bickenbach, 1993, p. 71). Policy makers continue to use the medical verification of impairment as a supposedly politically neutral and objective way to test eligibility and to prevent and detect fraudulent claims (Bickenbach, 1993, p. 72).

The first provincial income support programs were workers' compensation programs paid for by employer contributions. Starting with British Columbia in 1902, worker's compensation programs were gradually introduced in each province (Boyce et al 2001, p. 12). But the many people whose disabilities were not connected to their job

had to rely on municipal programs or charity organizations for some limited income support. It was only after World War II, that provincial governments began providing small pensions to those who could not work (Jongbloed & Chrichton, 1990, p. 26).

Rehabilitation Policies and Programs

The first rehabilitation policies and programs were part of the federal government's response to the needs of veterans injured during World War I. (Segsworth, 1920; Kidner, 1918; Todd, 1918 as cited in Boyce et al 2001, p. 13). These rehabilitation programs eventually expanded to include disabled workers covered by provincial workers' compensation programs. After World War II the new Department of Veterans Affairs provided more programs and services to help veterans reintegrate into daily life. It was veterans within government and in newly formed community organizations who became key advocates for the expansion of these rehabilitation and vocational training programs to people with disabilities who weren't eligible for either veterans or workers compensation programs (Boyce et al, 2001, p. 18). In 1954 the federal government's Disabled Persons Allowance Act provided a vocational rehabilitation program and allowance for people 18 and older with total and permanent disabilities without other resources (Chrichton and Jongbloed, 1998, p. 121). In 1961, the Vocational Rehabilitation of Disabled Persons Program provided funding for people with disabilities who weren't war veterans to return to the work force. (Boyce et al, 2001, p. 18; Chrichton & Jongbloed, 1998, p. 121).

This early history of rehabilitation and income support policies demonstrates some important themes in the origins of disability as a category in government social policy. First, the disability category was gendered. Given the make-up of the military and

the labour force, most recipients of veterans and workers compensation programs would have been men. This gendered history helps to explain the difficulties women with disabilities have had accessing traditional rehabilitation and vocational programs. Second, as Hahn (1985 as cited in Jongbloed, 2003) notes, veterans and workers were seen as deserving recipients of government assistance because they had become disabled while serving the nation's economic, political, and military interests. They were not held responsible for their inability to work. However, being blameless and deserving did not translate into generous benefit rates. One can still see the influence of the English Poor Law principle¹⁰ of least eligibility in the federal government's decision to set veteran's pension rates to the low income of an untrained labourer (Boyce et al, 2001, p.14). This principle continues to influence the setting of social assistance rates at well below the poverty line.

Canada/Quebec Pension Plan

In 1965, the federal government established the Canada/Quebec Pension Plan (C/QPP) as a national social insurance system based on compulsory work force contributions which included a pension for workers who became permanently disabled and were therefore unable to return to work (Jongbloed, 2003, p. 204). In 1966, the federal government introduced the Canada Assistance Plan (CAP). Developed in the context of the "war on poverty" (Morel, 2002), the CAP shifted social assistance to an entitlement model which extended federal-provincial cost sharing for a range of health, education, and social services, including programs for people with disabilities (Morel, 2002; Jongbloed, 2003). The CAP funding guidelines created national standards for

¹⁰ [the relief recipient's] situation on the whole shall not be made really or apparently so eligible [desirable] as the situation of the independent labourer of the lowest class. English Poor Law

accessing welfare and a guaranteed appeal process if assistance was denied. According to Jongbloed and Chrichton (1990), the goal was to develop a consistent national welfare structure that would guarantee social assistance to people on the basis of need rather than the moralistic notion of whether one was deserving (p. 30). Many conservative provinces saw this goal in conflict with maintaining a strong work ethic (Jongbloed and Chrichton, 1990). While its religious roots link work with morality and good character, and idleness with sin, the work ethic's contemporary manifestation ties economic success to individual character, effort, and merit-based educational qualifications (Beder, 2000, p.87). One sees the influence of work ethic ideology in the dominance of discourses which stigmatize social assistance recipients as lazy and dependent people who lack initiative, and in policies which provide benefits well below the poverty line to discourage fraud and "encourage" people to get back to work as quickly as possible.

Under CAP funding, provincial social service departments administered disability benefits through their social assistance programs (Chrichton and Jongbloed, 1998). Currently, four provinces, British Columbia, Alberta, Ontario and New Brunswick, have developed separate social assistance programs for people with disabilities. As provincial governments of the 1980's instituted policies to "encourage" non-disabled recipients to see their situation as temporary, some policy makers felt that people with disabilities who could not work should receive higher income and other benefits because they would be long term recipients (Chrichton and Jongbloed, 1998, p. 145). Because disability was defined in terms of unemployability, a woman or a man with a disability who could work part-time was not seen as disabled.

Commissioners 1834 as cited in Swanson, 2001, p. 29).

Sociopolitical Model of Disability

From the 1970's onward, disability activists have used a sociopolitical understanding of disability to critique the disabling attitudes, structures and systems that marginalize and exclude people with disabilities. Advocates have fought against institutionalization, for greater control over resources, the removal of environmental and systemic barriers, and the development of adequate supports for daily living in the community (Chrichton and Jongbloed, 1998). Jongbloed and Chrichton (1998) suggest that the sociopolitical model has shaped all disability policy from the 80's onwards. While it has definitely shaped transportation and housing policies, as Jongbloed (2003) notes, income and employment policies continue to focus on individual limitations and lack of skills, functional capacity, and cost savings rather than systemic discrimination, lack of good job opportunities, and employer practices (p. 206). As a result, many people with disabilities who would like to work cannot access decent paying jobs and live in poverty on disability pensions and social assistance. As Bickenbach (1993) points out, a critical reason for this lack of progress is the dominance of the economic model which assesses these changes as too costly.

No Coordinated Disability Income System

There is no coordinated, comprehensive disability income system in Canada. What does exist is a patchwork of programs and services that is complex, unwieldy and often inadequate (Federal Task Force on Disability Issues, 1996, p. 73). The current system not only reflects existing social and economic inequities, it creates new ones. Program eligibility and level of income support depend on age, the cause of disability, and labour force experience (Federal Task Force on Disability Issues, 1996, p. 74). The

income of a person who is not working depends on whether they become disabled at work or in a car accident, contributed to CPP before disability, or are a veteran. Many women and men aren't eligible for these programs and must rely on social assistance programs whose benefits fall well below the poverty line. This reflects the earlier mentioned belief that social assistance rates should be kept low to "encourage" people to work, while also discouraging deception and fraud. While a national income system was recommended in the federal government's 1981 Obstacles Report and again in the 1996 Report of the Federal Task Force on Disability Issues, there is little evidence of political will to take on the complex federal, provincial and territorial negotiations that would be required to achieve consensus. Jongbloed (2003) argues that the private insurance industry and the legal profession pose another barrier to the development of equitable income policies for people with disabilities as they "benefit financially from the current system and oppose the move to a comprehensive scheme" (p. 207).

The Need for a Comprehensive System of Disability Supports

In recent years, disability activists have lobbied for a comprehensive system of disability supports which would separate eligibility for income programs from eligibility for disability-related supports. The Federal Provincial Territorial Unison 2000 Report identifies the importance of accessibility, portability and individual focus in the development of a comprehensive disability supports system (p. ix). Disability advocates have argued that this separation would make it easier for people on disability social assistance who are able to and want to work, to enter/re-enter the work force because they would not lose funding for these essential supports. Separating income and disability supports also benefits people who do not qualify for social assistance, as it guarantees

entitlement to the aids and personal assistance they need to access and maintain employment.

Federal Neoliberal Policy Context

During the past twenty years, advocacy efforts to change disability income policies have taken place within the steady erosion of the welfare state as many western governments have adopted neoliberal ideologies and governing practices to respond to economic restructuring, globalization, and the need for deficit reduction (Brodie, 1996; Evans and Wekerle, 1997). In Canada, concerns with deficit and debt reduction have been the justification for “policy by stealth.” (Brodie, 1996) Without public debate or discussion, the federal government has implemented major policy shifts in its budgets or as mere changes in regulation (Grey, 1990, p. 32 as cited in Brodie, 1996, p. 131).

In 1990 the federal government set a limit on “shareable CAP cost increases in the three wealthiest provinces (British Columbia, Alberta, and Ontario) at 5% which resulted in the loss of several billion dollars of income” (Vaillancourt, 1997, p. 19 as cited in Morel, 2002, p. 22). While BC and Ontario were most affected, all three provinces responded by cutting their social assistance budgets. During this period the federal government also restructured the unemployment insurance program. The new employment insurance programs’ restrictive criteria resulted in a drop in eligible recipients from 74% in 1989 to 36% in 1997, “(and disproportionately affected women)” (Canadian Labour Congress, 1999 as cited in Klein and Long, 2003, p. 14). These federal policy changes created a situation which increased the numbers of unemployed people turning to provincial social assistance at the same time provinces were cutting their social assistance budgets (Klein and Long, 2003).

In 1994, the federal government's green paper Improving Social Security in Canada, presented an individualized approach to reforming the social welfare system that focused on 1) individuals' need for job skills and 2) income support that fosters independence and initiative (ISSC, 1994, p. 10 as cited in Brodie, 1996, p. 136). As Swanson (2001) notes, despite the paper's acknowledgement that economic conditions cause poverty, the solutions focused on changing the individual to fit the economy. A third focus, affordability, emphasized the need for a commitment to end waste and abuse (ISSC, 1994, p. 10 as cited in Brodie, 1996, p. 136). The green paper's demeaning references to income assistance recipients as "dependents" reflected the government's neoliberal analysis of the structural problems of poverty and unemployment as individual problems of "welfare dependency."

In February, 1995 Finance Minister Paul Martin used the debt crisis and budget process to halt consultations on social security and to "shift federal responsibility for social welfare, health care, and post-secondary education onto the provinces" (Brodie, 1996, p. 139). The budget for that year set a timeline for phasing out the CAP and the Established Financing Program (EFP). These programs were replaced by a new block funding program called the Canada Health and Social Transfer (CHST) (Brodie, 1996). The CHST consolidated federal transfer payments for health, education and social services into one lump sum payment (Masuda, 1998). It also set federal contributions at a fixed amount. This radical change in funding structure and the cuts that accompanied it, had a huge impact on provincial social assistance programs. The elimination of the CAP effectively ended the federal government's ability to maintain national standards for social assistance as a condition of cost-shared funding. The elimination of the CAP meant

the loss of the right to adequate levels of income support, the right to assistance when in need, and the right to receive assistance without being forced to participate in training or work programs (Klein and Long, 2002, p. 13). This made it possible for provincial governments to introduce more restrictive eligibility criteria and welfare to work policies to deal with the cuts to transfer payments and budget deficits (Klein and Long, 2003).

While the welfare system has been rightly criticized as paternalistic, bureaucratic, and intrusive, the CAP entrenched a national commitment to income support as a socio-economic citizenship right for anyone who needed it. The loss of these rights did not arouse much resistance beyond anti-poverty and women's groups. One reason for this lack of protest was the success of neoliberal discourses in reducing citizens' expectations of government programs while increasing the obligations of the individual in the new globalized economy (Brodie, 1996; Morel, 2002). Another, was the mainstream media's relentless poor-bashing throughout the 1990's which stereotyped poor people as lazy, uneducated and unwilling to work and thus responsible for their own poverty (Swanson, 2001, p.2).

The dominance of this discourse created a climate of intense hostility towards people on welfare which helped to shift public attention away from the policies and structures that were creating unemployment and increasing poverty (Swanson, 2001, p. 7).

Theret (1999) argues that by eliminating CAP funding and standards while simultaneously increasing demand for assistance through its overhaul of the employment insurance program, the federal government created pressure on the provinces to reduce or narrowly target benefits. By increasing federal funding for "active employment policies"

it encouraged the provinces to implement welfare to work policies (Theret, 1999, p. 74 as cited in Morel, 2002, p. 24) [*Translation*]. These changes replaced the right to assistance on the basis of need with the obligation to participate in employment-related activities in order to receive assistance. While these policies were initially targeted to “apparently able” people expected to work, they are influencing social assistance programs for people with disabilities.

BC’s Social Assistance Policies

The changes to BC’s social assistance policy began in 1996 when the NDP government replaced the Guaranteed Available Income for People in Need (GAIN) with the BC Benefits Program. This new social assistance policy included separate legislation for children, youth, people with disabilities, and adults over 25. While the GAIN Act’s preamble had included a commitment to alleviating poverty, neglect and suffering, the new preamble talked “about self-sufficiency, individual responsibility, training, and financial accountability” (Swanson, 2001, p. 118). This change in ideology was accompanied by funding cuts and punitive regulations. For example, welfare rates for single women and men were cut from \$546 to \$500 a month and their allowable assets were reduced to \$500 (Swanson, 2001; CCPA, 2000). Hardship and crisis grants were cut, as were earnings exemptions, while single parents were now forced to look for work once their youngest child turned seven (Swanson, 2001; CCPA, 2000). The right to assistance to anyone in need was eroded by a new rule which required applicants from outside the province to wait three months to apply (Swanson, 2001).¹¹

While things were much worse for people on general assistance, the NDP’s new Disability Benefits Program was a great improvement over the old GAIN for the

Handicapped legislation. Beginning with its preamble, which indicated the government's commitment to a social safety net, to treating people with fairness, dignity, and sensitivity, and to supporting their inclusion and integration into the mainstream community (BC Coalition, 2005, p. 4), these improvements were the result of years of struggle by disability activists.

One of the most important changes in the new legislation was the new definition of disability. Mental health groups had first raised concerns that the GAIN definition of "handicap" was discriminatory because it focused on physical disability and the functions a person could perform (Birrell, November 26, 2002). The BCCPD, the BC Association for Community Living (BCACL) and the Canadian Mental Health Association (CMHA) formed an Ad Hoc group to lobby for changes to the definition (Loxton, 2001). One of their arguments for this change was that BC lagged behind other provinces in which 18-20% of their social assistance recipients qualified for disability social assistance while in BC the rate was only 12% (Birrell, November 26, 2002). Gaining political support for these changes was challenging because they would increase the number of eligible recipients and thus government spending. (Birrell, November 26, 2002).

While the GAIN criterion of an "apparently permanent" disability had made it difficult for people with cyclical disabilities such as multiple sclerosis to qualify, the new definition focused on the duration of a disability (Analysis of changes, 2002b). It also removed the old stigmatizing requirement that an individual had to be "permanently unemployable" in order to qualify (Loxton, 2001). In addition, the definition added an innovative qualifying criterion that recognized people with disabilities' "unusual and continuous monthly expenditures for transportation, or for special diets, or for other

¹¹ This out of province rule was later rescinded.

unusual, but essential and continuous needs” (Beatty, 1998, p. British Columbia, para. 2). This meant that people who did not need assistance with daily living tasks could now qualify on the basis of these extra costs. The new expanded definition was a significant victory for disability activists (Loxton, 2001). It meant that thousands of people with mental health disabilities and physical disabilities such as chronic fatigue would now receive the higher income of \$771,¹² plus the health benefits and subsidized bus pass that came with the Disability Benefits 2 category. These changes were the first step in Ad Hoc’s overall objective which to “eventually remove disability benefits from the general welfare system and put in place a new human rights/human resources model of disability support” (Loxton, 2001, p. 30).

In 1997, the NDP government created another disability category within its general social assistance program which offered a benefit of \$596¹³ plus health benefits and a subsidized bus pass. To qualify for the new Disability Benefits 1 category, an individual’s medical condition had to last at least six months and require ongoing extra costs or the need for ongoing assistance with daily living tasks which they could not fund from other sources (Beatty, 1998, British Columbia, para. 3). As was the case with Disability Benefits 2, this new benefit recognized the additional costs that come with managing a temporary illness or disability and granted access on this basis.

Immediately after the Liberals were elected in 2001 they implemented their promised tax cuts. Soon after, they declared a structural deficit which provided a rationale for their radical program of restructuring, privatization, and drastic cuts to social services and community-based groups. The following January, the government

¹² By 2002 this had increased to \$786.

¹³ By 2002 this had increased to \$608.

announced massive changes to provincial welfare programs. These changes included a budget cut of 581 million dollars (or 30%) to the Ministry of Human Resources over three years, the loss of 459 full-time equivalent positions and the closure of 36 welfare offices across the province. (Klein & Long, 2003, p. 8). While the NDP cuts and tightened eligibility rules for non-disabled people had been punitive and harmful, the changes to come would be even more devastating.

In April, the government introduced its new social assistance legislation - Bill 26, *Employment and Assistance* and Bill 27, *Employment and Assistance for People with Disabilities*. Though separate Acts, they are linked by ideology and practice as Ministry of Human Resources Minister Murray Coell indicated when he introduced Bill 26 to the BC Legislature in 2002.

This act and a companion act for people with disabilities will help the Ministry of Human Resources carry out its mandate to redefine income assistance in Canada. (p. 2813).

The new legislation and regulations embodied the government's belief in employment as the route to independence and outlined its expectations for active participation in employment-related activities. All disabled and non-disabled people became subject to a new appeal process which reduced the options for external review of Ministry decisions. All new applicants had to complete and document a three week job search before they could apply for benefits, although an exemption was possible on the grounds of undue hardship. The new legislation gave the Minister authority to require employment plans from any recipient assessed as employable, and the power to penalize those who did not comply. The Minister's decision to amend, suspend, or cancel an

employment plan was final, with no right to appeal (Employment and Assistance for People with Disabilities Regulation, 2002)

There were also significant differences between the Bills. Bill 26 mandated more cuts to employable individuals and couples over 55, and to single parents. Punitive regulations forced single parents to look for work once their youngest child turned three, eliminated earnings exemptions, and capped crisis grants. The two most radical changes were 1) the introduction of a two year time limit which restricts single people expected to work, to two years of assistance in any five year period and 2) the introduction of a two year independence test which requires new applicants to prove they have been financially independent for the past two years. These changes effectively ended welfare as an economic right for people in British Columbia (Klein and Long, 2003, p. 9).

Bill 27 created a new definition of disability for the new Person with Disabilities (PWD) category focused on the way an individual's impairment restricts their ability to perform daily living activities. This marked the Ministry's return to a functional definition of disability¹⁴ which, according to disability advocates, was worse than the old GAIN definition they had fought so hard to change (Birrell, November 26, 2002). The new definition eliminated unusual and continuous costs as a valid criterion. This affected the eligibility of people who do not need help with daily living tasks, but have ongoing disability-related expenses - people who are HIV positive or have soft tissue injuries for example ("Analysis of Changes," 2002a). The duration of a cyclical disability was increased from one to two years. The need for assistance to perform daily living activities no longer contained a reference to "within a reasonable period of time" (Beatty, 1998,

¹⁴ A functional definition assesses an individual's ability/inability to perform certain physical and mental functions.

British Columbia, para. 2). This meant that people who try to do things for themselves, despite the difficulty and amount of time it takes, might not qualify ("Analysis of Changes," 2002a). In addition, the PWD designation was no longer permanent. The permanent designation provided people with some financial stability and security. Without it "most PWD recipients will have their disability status reviewed every 2-5 years" (Loxton, 2003, p. 3). With each review they will have to prove they are disabled enough to qualify through time consuming, intrusive, and stressful reassessments. The preamble's commitments to people's security, dignity and integration were gone, presumably because they are incompatible with the Ministry's ideology of independence, employment, and personal responsibility. As BCCPD advocate May McIntyre (2002) wrote, "the removal of the Preamble says volumes about the status of citizenship for people in BC who happen to have a permanent disability" (p. 11). In keeping with its new philosophy of encouraging people with disabilities to be as independent as possible, the Ministry increased the earnings exemption from \$200 to \$300 and then to \$400 a month.

While the Ministry did not cut the \$786 monthly benefit rate for the PWD category, by tightening the eligibility requirements it restricted access, and raised fears that many people receiving DB2 benefits would no longer qualify. These fears were heightened for thousands when the government began its massive designation review in October, 2002. Anyone who no longer qualified could apply for the new Persons with Persistent and Multiple Barriers to employment (PPMB) category which had replaced the old Disability Benefits 1. Although the Ministry was going to set the benefit for this category at \$510, disability advocates convinced them to increase it to the old DB1 level of \$608 per month and to maintain the health benefits and subsidized bus pass (BCCPD,

2002). However, the new eligibility requirements were more restrictive. To qualify one needs to have received assistance for 12 out of the past 15 months. This means that anyone who has been working and gets sick will not qualify ("Changes to disability," 2003). The PPMB criteria increased the duration of a medical condition from six months to one year, and likely to last for two years ("Changes to disability," 2003). In keeping with its employment focus, the Ministry eliminated the extra costs and need for assistance criteria. The new criteria focus on an individual's ability to work and include an employability screen which assesses each applicant's barriers to employment ("Changes to disability," 2003).¹⁵

With these new guidelines in place, the Ministry began to review the approximately 12,000 people on DB1 Benefits. While the Disability Designation Review was a massive and very public undertaking, this case by case review was largely invisible to the general public. Each person on DB1 received a letter from the Ministry which advised them to meet with their caseworker to explore the barriers restricting their ability to look for or maintain employment. Filling out the employment screen was part of this process. Disability advocates challenged the Ministry's employability screen's 15 questions which assigned the greatest number of assessment points for the following barriers: number of times and length of time on social assistance, English as a second language, limited work experience and less than grade 10 level of education (MHR Employability Screen). Because the screen did not include any questions about medical condition many people with disabilities faced disqualification. This would leave them eligible for regular assistance at \$510 a month with no health benefits or bus pass and

¹⁵ "The screen asks questions about level of education, language skills and time spent on income assistance. It has no questions about an applicant's medical condition. A minimum of 15 out of a possible

subject to the new two year time limit rule. In January, 2003 the Ministry amended the PPMB designation by modifying the criterion, “people with an illness or disability that had lasted for one year, was likely to continue or reoccur frequently for at least two years,” with the phrase, “and in itself meant they could not work” (PPMB Fact Sheet, 2003). This made it possible for people who did not get the necessary 15 points on the employability barriers screen to qualify based on a medical report from their doctor. “However, people who do not score 15 points on the Screen must prove their medical condition precludes their ability to work or seek work” (“Change to disability, 2003, p. 7). It’s hard to know for sure how many people on DB1 did not qualify for PPMB. Unlike the Ministry’s statistical reports for PWD recipients, which include statistics from the old DB2 program, the PPMB statistics begin with the new program.

While the changes to Bill 26 and Bill 27 created one legally recognized category for people with disabilities on social assistance, it is important to remember that there are many people with disabilities who do not qualify for Bill 27’s PWD benefits and are receiving PPMB or regular income assistance. The boundaries between the two Bills are much more permeable than they first appear. Any Ministry comments about changes or improvements for “people with disabilities” on social assistance refer only to those people who are able to meet the new PWD eligibility criteria. The people who don’t qualify are invisible as “people with disabilities” in the Ministry’s discourse and statistics and must try to survive on \$608 or \$510 a month. For a city the size of Vancouver these amounts are only 32% and 38% of the poverty line (Klein & Long, 2003, p.20)¹⁶

21 points must be scored to “pass” the screen and thus be eligible for PPMB” (Transition, March 2003, p.6)

¹⁶These figures are based on Statistics Canada before-tax Low Income Cut-Offs (LICOs) in 2002, for cities of 500,000+ people.

Making it harder to qualify for the PWD level of benefits doesn't change what people need to maintain their health and manage their disability. And while the Ministry increased the PWD benefit to \$856 in 2005, this amount is still well below the poverty line, and benefits only those able to meet the more restrictive criteria.

Given what researchers (Davis, 1995) and activists know about the links between poverty, illness and disability, forcing anyone to live on \$510 a month for a long period of time with no health benefits, or forcing them to accept any job no matter how unsafe or exploitative in the name of "independence" is disabling. Surviving on \$608 a month makes it difficult to find safe housing and to eat properly which will only increase the severity of some people's illness or disability, making them eligible for the PWD benefit once their health has worsened. A certain percentage of these women and men will become ill or disabled because of these policies - creating new clients for the PPMB or PWD category. The tightened eligibility requirements, punitive regulations, and cuts to health benefits make it almost impossible for people with disabilities on regular social assistance to survive with any dignity and maintain their health.

Summary

In this chapter, I began my analysis of the DDR by situating this aspect of the BC government's changes to social assistance policy in its larger historical and contemporary disability and neoliberal social policy context. This discourse/policy link is critical to understanding the meaning and implications of the government's discursive strategies. I described the two policy contexts that meet in the provincial disability social assistance policies and practices - federal social policy changes which have affected provincial social assistance programs - and the development of Canadian disability policy. My

review of disability policy development highlights its incremental nature and the influence of very different understandings of disability - segregation, medical, economic, and sociopolitical - which have resulted in programs with often contradictory goals and criteria which make it difficult for people with disabilities to access the services they need. While the sociopolitical model of disability has influenced some changes in transportation and housing, income security policies continue to be guided by medical and economic discourses of disability which focus on an individual's limitations and cost rather than systemic discrimination and barriers.

I then described the neoliberal social policy context in which people with disabilities have been struggling. This included the federal changes in ideology and practice that affected provincial social assistance programs across the country: the focus on individual's welfare dependency; CAP funding cuts to the provinces; the loss of national welfare standards with the loss of CAP and the shift to the CHST; and changes to federal unemployment insurance program. I then narrowed my focus to BC's social assistance policies. I discussed the regressive changes the NDP made to general income assistance and the progressive changes they made to social assistance for people with disabilities. My discussion of the Liberal government's radical changes to social assistance in Bills 26 and 27 emphasized their ideological and practical links. I noted how the regressive changes to the definition of disability will force some people to drop down to PPMB or possibly general assistance. I argued that these changes which force people to change categories will not only have serious consequences for their financial resources, their health and well-being, it will also make them invisible as people with disabilities in the government discourse. I concluded the chapter by arguing that given the

established links between poverty, illness, and disability - the ideological and material changes in Bills 26 and 27 which legislate greater poverty for people with and without disabilities on social assistance are literally disabling.

In the following chapter I critically analyze the government's discursive strategies during the DDR by analyzing its primary text, the 23 page Re-assessment Form and the MHR rationale for the review.

CHAPTER FIVE: DECONSTRUCTING THE DDR FORM AND THE MINISTRY'S RATIONALE

I am a disabled person that received the 23 page review at the beginning of October and chose to put it aside until I was able to deal with it. I have now finished my portion and suffering the aftermath. I am sure I speak for many of us when I say that I was left feeling totally defeated (as I have with many MHR experiences). Most of us are continually trying to improve our circumstances, only to consistently run into MHR brick walls. I have always chosen to focus on the things I can do, not what I can't do, and to believe that I will someday become independent of the government and be able to financially support myself with a home-based business; in ten years of trying to access funding there has been none available and I have been unable to get around MHR regulations. After being forced to look at every detail and limitation of my disabilities, it now seems hopeless.

Carolyn Hurn, The Long Haul, March 2003

In this chapter I deconstruct the discourses that legitimize and authorize the DDR Form and the review process as an apolitical, neutral, objective and by implication - harmless - information-gathering exercise. By examining the Form's discursive themes of medical knowledge, authority, expertise and disability; independence; and normalcy, I expose the Form's taken for granted, hegemonic, and disabling assumptions. These assumptions rely upon and reproduce a notion of disability as deficiency, limitation, lack, dependence, and abnormality, thereby positioning people with disabilities as incapable "others" of non-disabled people. Contrary to the Ministry's claims of fairness and impartiality, this analysis brings the power relations between the state and people with disabilities on social assistance into view.

According to Dorothy Smith (1990, 1999) texts such as the Review Form are part of the standardized means of organizing, governing, and regulating people's behaviour in modern capitalist industrialized countries. These texts mediate the ruling relations which govern all of our lives (Smith, 1999). While many people with disabilities would have known about the Liberal government's changes to the definition of disability in Bill 27, it was the arrival of the Ministry's letter of re- assessment in the first week of October,

2002 that compelled their entry into the review process. The Form is the key text the Ministry used to coordinate and organize the review process. It provided each person under review with a standardized set of instructions on how to complete and submit the Form. Any individual under review who hoped to qualify for the new “Persons With Disabilities” (PWD) designation, and thus maintain their DB 2 level of benefits, had to follow the Form’s directions and complete it by the government deadline.¹⁷ The Form mandated a sequence of activities that involved not only the almost 19,000 women and men with disabilities under review, but countless doctors and health professionals whose expertise the MHR Form required. The review also mobilized many disability/community advocates around the province who informed, supported, and guided people through this arduous and stressful process.

The Form and its Discursive Themes

The DDR Form is an extremely formal and authoritative looking government document (see APPENDIX A)¹⁸. Its legal authority is indicated on page one by the reproduction of the provincial insignia, the identification of the laws that authorize the Ministry to collect this information, and the laws that dictate with whom it can be shared. The Form’s impersonal and clinical language suggest an impartiality and objectivity which adds to its authority (Davis, 2002). The Form’s language along with its lack of visible authorship, mask the fact that this is a government document carefully crafted by various people for a specific purpose - determining eligibility and thereby access to the new PWD category.

¹⁷This deadline was originally set at January 15th but under pressure from disability groups and their supporters, the government later extended this to March 15th, 2003.

¹⁸ This sample PWD application form is essentially the same as the DDR Form used during the review.

The Review Form is long. Its 23 pages are divided into three Sections that must be filled out in sequence. Each Section offers detailed instructions to applicants, physicians, and health professionals. Section One is three pages and the only optional section in the Form. It asks for basic personal information, a description of an applicant's disability, and how their disability affects their life and their ability to take care of themselves. The individual or their legal representative may complete this Section. The five-page Physician Report in Section Two asks for information such as an individual's medical diagnosis, their health history, the degree and course of their impairment, their functional skills, restriction of daily living activities, and how long and how often the doctor has seen them. The purpose of the Physician Report

is to provide information to the Ministry about the client's physical or mental impairments associated with diagnosed medical conditions relevant to this review of eligibility for continuation of a **Person with Disabilities (PWD)** designation. The emphasis is on how the medical conditions and impairment affect the Client's ability to perform Daily Living Activities... p. 6)

Section Three contains an eight page Assessor Report, which must be completed by a designated health professional (a medical practitioner, a registered psychologist, a registered nurse or registered psychiatric nurse, an occupational therapist, a physical therapist or a social worker). This Section requires an assessment of such things as the effects of impairment on: an individual's ability to communicate; their physical ability; their mental and emotional functioning; and the amount and kind of help they need with daily living activities. "The purpose of the Assessor Report is to document the Client's impairments and their impact on performance of Daily Living Activities" (p.13). Both Reports state that "the Review Form is not intended to assess employability or vocational abilities (pp. 6,13).

Medical Discourses

Medical Authority and Objective Knowledge

The Review Form privileges medical authority and legitimacy. As Wendell (1996) notes, medicine is an institution with significant cognitive and social authority. Much of medicine's cognitive authority comes from its association with science. Despite theoretical work that demonstrates how all knowledge is constructed within situated historical and cultural contexts, scientific knowledge tends to be seen as asocial, universal, and objective (Fosket, 2000). Because medical knowledge is derived from science, it gains much of its authority and legitimacy from scientific knowledge's universal and objective status.

Medicine's social authority comes from this cognitive authority along with the status, connections, and positioning of medical professionals in powerful institutions (Wendell, 1996). In North America, medical authority extends into other institutions such as government, the courts, and insurance companies. These institutions first turned to medicine for verification of disability because they sought an objective means of validating people's claims of illness or disability (Stone, 1984). In Canada, most benefit programs for people with disabilities, including social assistance, require medical validation of impairment.

The instructions to the Physician's Report in Section 2 direct doctors to provide information about impairments associated with diagnosed medical conditions. Doctors are required to select the specific diagnoses from a list of numbered diagnostic codes. While these diagnoses are a form of "social labeling" (Engelhardt, 1986, p. 185 as cited in Wendell, 1996) the use of medical language lends this lengthy list the authority of

objective scientific fact. Furthermore, these instructions conceal the critical importance of medical diagnosis to accessing the PWD benefit. Because medical diagnosis is a typical requirement for government disability benefits, it is safe to assume that everyone under review already had such a diagnosis. However, because the Form will also be used to assess new PWD applicants, anyone without a medical diagnosis will automatically be ineligible. This requirement grants biomedical knowledge an authority that overrides an individual's lived experience and embodied knowledge. In legitimizing the inclusion and exclusion of women and men with disabilities into the PWD category on the basis of medical diagnosis, the Ministry relies on a taken for granted assumption that getting a medical diagnosis is an unproblematic matter of science, rather than a complex social process that often reflects and exacerbates existing social inequities. As feminist research on women's experiences with the health care system has documented, individual and systemic sexism, racism, heterosexism, ableism and classism can make it difficult for women to get a diagnosis.

The MHR draws on medical knowledge's legitimacy as objective scientific knowledge in the Form's language and design. The questions for people with disabilities to fill out are qualitative. While some of the questions for doctors and health professionals are also qualitative, most are quantitative survey questions with checkboxes and scales. This use of specialized clinical language and quantitative survey questions lends an aura of scientific objectivity to the Ministry's request for doctor's and health professionals' expert opinions.

Unbiased Professional Expertise

The discourse of professionalism mediates discourses of medical authority and objectivity to bolster the legitimacy and credibility of doctors and assessors' opinions as unbiased experts. By the discourse of professionalism I refer to dominant beliefs about which groups of people are seen as credible sources of expert knowledge. Most professionals undergo university education and training to gain mastery of a specialized body of knowledge that is the source of their expertise (Mullaly, 1997). Professional membership is controlled through university program requirements and testing, accreditation processes, professional associations, and regulatory boards (Mullaly, 1997).

Bill 27 and its revised disability designation criteria give doctors and health professionals the legitimate authority to complete the Review Form.¹⁹ The criteria state that in a doctor's opinion the persons' impairment must last two years or longer and, in the opinion of a health professional, (which may also be the person's doctor) the impairment must significantly restrict the person's ability to perform daily living activities so that they require help (pp. 7, 13). Their assessments of impairment and functioning are the expert and objective "validation device" (Stone, 1984) the Ministry uses to grant access to the PWD category and its benefits. In this way they are positioned by the State as powerful gatekeepers on the basis of their professional credentials and expertise. While community/disability advocates, support workers, and others may have had as much, if not more contact with the women and men under review, they are not seen as credible assessors. One of the critical issues here is that because professional expertise and credibility are based on specialized training and a body of knowledge,

professional opinions tend to be viewed as unbiased and neutral. While advocates and other community workers may have considerable knowledge and experience, they are not seen as neutral and unbiased. This concern with objective knowledge is evident in the Auditor General's Report (2003/2004) which lists some of the weaknesses that Ministry officials saw in the previous legislation and its administration. One concern was the lack of specific qualifications for assessors so that one didn't have to be a health professional to assess a person's impairments. This concern speaks to issues of professional credibility and expertise but also to the Ministry's understanding of disability as a medical issue.

Discourses of professionalism, medical authority, and objectivity inform the requirement for physicians and assessors to verify their respective reports and attachments contain their "findings and considered opinion" (pp. 12, 22). The word "findings" lends an aura of scientific research and credibility to their assessment while "considered opinion" alludes to their professional and unbiased expertise. Doctors are also asked for their credentials and for the length of time and frequency of contact with their patient. Assessors are asked for this information and to document the specific approaches and information sources they used for their assessment. On the one hand, these requests for information and documentation can be read as a way for the government to prevent fraudulent applications. On the other hand, they can be interpreted as an evaluation of the assessor's credibility and objectivity. Given the Form's emphasis on "objective" medical knowledge, it is likely that medical tests and professional assessments would have greater credibility than interviews with family, friends, or community service organizations. These discourses of medical authority, objective

¹⁹ As indicated in the Auditor General's Report, under the old legislation assessors did not have to be health professionals. Mental health workers, clerics, advocates, teachers could fill in the Form (personal

knowledge, unbiased expert opinion and professionalism contribute to the Form's, and thus the Review's, appearance of neutrality, objectivity, and fairness.

Disability as Individual Inability, Deficit, Limitation and Lack

Discourses of medical authority and objective knowledge support the continuing cultural dominance of the medical discourse of disability as individual inability, deficit, limitation, and lack. This discourse has two aspects. First, it assumes that disability is an individual medical issue rather than a social one - a characteristic that exists solely within a woman or a man's mind/body. Thus an individual's impairment is seen as the source of their limitations or restrictions. This medicalized understanding of disability is mediated by the discourse of individualism. Within the biomedical context, the discourse of individualism supports an understanding of human health as the internal property of separate and independent human organisms (Morgan, 1998, p. 100). The individual is the primary health subject and the target of healthcare interventions in what Morgan terms "context-stripping ways" (p.100). As a result, systemic factors of race, gender, class, sexuality, and disability are either ignored or seen as biological differences that may usefully predict health and illness. As medicalized subjects, people with disabilities are seen primarily as people with medical problems who need cure or rehabilitation, rather than diverse individuals who face discrimination, exclusion, marginalization based on their embodiment. To protest the medicalization of disability is not to deny that people with disabilities may have a variety of medical needs. It is the individualistic, decontextualized, and reductive focus of medical discourse and the medicalization of their lives that disability activists have challenged.

This individualistic perspective ignores the context in which people live, the impact of disabling environmental barriers, social attitudes, and social practices on any individual experience of disability. For example, in Section One the heading is Disabling Condition and the two client questions ask the person being reviewed to describe “your” disability and its impact on your life, which assumes that the source of disablement is located solely in people’s bodies/minds. In Sections 2 and 3, many of the questions assume it is possible to assess a person’s functional skills and abilities independent of their context. For example, Section 3, page 19 asks health professionals to evaluate the impact of mental impairment on the person’s social functioning as if this would not be affected by poverty, housing, personal support and so on. These kinds of questions treat disability experience as a property of the person rather than an interaction between one’s embodiment and the social, cultural, and physical environment. Systemic factors are irrelevant to the Review Form’s focus on functional assessment. However, the reality is that people with disabilities are differently situated. As much critical/feminist disability research and experience reveals, disability experience does differ according to diversity of embodiment and social location. By ignoring this, the Ministry did not anticipate the diverse challenges and barriers the women and men under review would face to complete the Form by the government’s imposed deadline. It also ignored the larger context of inequitable allocation of healthcare resources within communities and between them. By treating everyone under review in the same way, the review reproduced existing inequities and assumed an equitable health care system and diagnostic processes unaffected by discrimination and privilege.

The second aspect of the medical discourse of disability is its view of disability as inability, deficiency, limitation, and lack. This understanding rests upon a notion of disability as a taken for granted biological fact rather than a socially produced medical understanding or in Rosemary Garland-Thomson's (2004) words, "as something that is wrong with someone" (p. 77). This understanding of disability is reflected in assessment questions which ask: "What are the person's limitations in lifting?" (p.10); "Are there any significant deficits with **cognitive and emotional function**?" (p.10) (bold in original). "Does the impairment directly restrict the person's ability to perform Daily Living Activities?" "For each item indicate to what degree the client's mental impairment or brain injury restricts or impacts his/her functioning?" (p. 16). For motivation the examples include: lack of initiative; loss of interest; for emotion: excessive or inappropriate anxiety or depression and for impulse control: inability to stop doing something or failing to resist doing something (p. 16). Not only are these vague and open to broad interpretation, they focus entirely on inability, lack, and limitation.

The Ministry's application of the medical discourse of disability throughout the Review Form is disabling because it compels each person under review to present their experience of disability through a lens of incapacity in order to re-qualify and maintain their benefits. It forces them, no matter what their individual situation may be, to advocate for their disabilities with doctors and health professionals. It is discouraging, demoralizing, and disabling for women and men with disabilities to be forced to represent themselves as physically or mentally unable, limited, and as lacking as possible to get the financial assistance and benefits they need and to which they are entitled. While individuals may relate to their positioning as medicalized and incapable subjects in varied

ways, the Form's discourses reproduce dominant power relations which position people with disabilities as subordinate to non-disabled people. This narrowing of the category in the Ministry's interest of targeting disability social assistance to those "most in need" created a situation whereby people with disabilities were forced to choose between subjecting themselves to the most disabling representation of their individual situation or risk losing benefits. The Ministry's use of medical discourse re-entrenches medicine's institutional authority to decide if someone is impaired/disabled. This authority is so taken for granted that it is difficult to make visible that it is in fact a "political decision to screen people's social needs through medical values and authority" (Sherwin, 1992, p. 194 as cited in Wendell, 1996, p. 132).

Discourse of Independence

Challenging the hegemony of social, cultural, and medical discourses that represent people with disabilities as dependent has been a critical area of struggle for disability activists who have constructed a notion of independence that does not mean being able to do everything by oneself, but rather, being able to make choices about how one will live.

The Review Form's questions rely on taken for granted hegemonic assumptions to construct independence as the ability to perform an activity without the help of a person, a guide animal, a technical device, or a longer time than is typical. These assumptions are disabling because they presume a normative able person as the standard for defining and assessing independence. Assessment of need for assistance is a key category in the Assessor Report Section. For example in Section Three B-3, Mobility and Physical Ability, health professionals are asked to "Indicate the assistance required

related to impairment(s) that directly restrict the client's ability to manage in the following areas." The areas include: "walking indoors, walking outdoors, climbing stairs, standing, lifting, and carrying and holding" (p. 15).

Although the word dependence never appears in the Form, it doesn't need to. By equating independence with the ability to function without any help, the need for help automatically signifies dependence. The Ministry didn't have to use independence as a response category. It could just as easily have constructed a different question which read: What kinds of assistance does this individual need to walk indoors? None, periodic, continuous, an assistance device, no assistance but takes longer than typical. While the answers would not differ, this shift in language does challenge the normative representation of ability as independence and disability as dependence.

The Form constructs women and men with disabilities as people who need help with daily living activities. When the need for help signifies dependence, it becomes more difficult for people with disabilities who require such assistance with daily living activities to be perceived as independent. At issue here is the kind of assistance that gets defined as "help." In industrialized societies much of the help that people who conform to dominant positions of ability, race, gender, sexuality and class receive is taken for granted (Wendell, 1996). It is only when members of subordinate groups need a kind or amount of "help" that differs from dominant needs, that it becomes socially visible as "help" and its recipients labeled socially dependent (Wendell, 1996, p. 42). For example, many non-disabled people will view a disabled person's need for a personal assistant to help them get dressed as a sign of helpless dependence. Western discourses of liberal humanism and individualism place a high value on the independent and autonomous

(male) subject (Hughes, 2001). The result is a devaluation of people who are seen as dependent or lacking in autonomy. People who need help with activities such as bathing, dressing, feeding or toileting are seen as particularly dependent and devalued (Wendell, 1996). However, as disability advocates have argued, it isn't one's limitation or one's need for assistance, but **the lack of assistance** (my emphasis) that creates dependence for people with disabilities. This notion of dependency as a social relation challenges the dominant moral and psychological understandings of dependency as an individual character trait (Fraser & Gordon, 1994).

Because the Ministry's new criteria is targeted to those "most in need," people filling out the Form cannot be sure they will be "dependent enough" to meet the new disability criteria. According to the Ministry's definition, the more help they need, the less independent they are. Just as medical discourse requires people to present themselves as unable as possible, the discourse of independence requires them to present themselves as dependent as possible.

Discourse of Normalcy

The Review Form is permeated by assumptions of normalcy which operate in different ways. First, the Form uses a medical definition of impairment as the "loss or abnormality of psychological, anatomical or physiological structure or function causing a restriction in the ability to function independently, effectively, appropriately or for a reasonable duration" (p. 8). The definition of impairment as abnormality isn't possible without an unspoken standard of "normal" function and structure. Such a standard assumes impairment is a universal biological condition, rather than the social product of history, culture, and context. This medical definition of impairment dichotomizes the

continuum of human variation and biological difference into two unequal categories, normal and abnormal. Most bureaucratic and administrative definitions of disability rest on such assumptions of normalcy.

However, as mentioned in Chapter Two, disability scholars have challenged this medical perspective. Amundson (2001) in particular has challenged the biological reality of normal and abnormal function by arguing that this categorization reflects a functional determinism based on social myth rather than biological fact. He suggests that calling a typical or average member of a species “normal” assumes a blueprint in the developmental process that simply does not exist.

And, as Stone’s (1984) disability policy analysis has shown, decisions about what constitutes a legitimate medical impairment are a matter of judgment rather than fact. Research studies have shown a wide discrepancy in how impairments are determined (Stone, 1984).

The medical definition of impairment also assumes non-disabled norms of independent, effective, and appropriate functioning. I’ve already discussed the use of independence to signify normative ability. Because discourses of normalcy mediate the discourse of independence, dependence on others for personal care challenges taken-for-granted ideas about what it means to be a “normal” adult: it isn’t “normal” to need help with such activities.

I want to focus on appropriateness because it is a key norm in the Form’s questions on mental impairment in Section Three. Here assessors are asked to evaluate people’s social functioning by indicating “the support/supervision required, as related to restrictions in the following areas: Daily decision-making, interacting, relating &

communicating with others” (p.19). The relevant categories under this heading include appropriate social decisions, interacts appropriately with others, and able to deal appropriately with others. Different disabilities violate different social and cultural norms of appearance, behavior, and performance. The norm of appropriateness is only used in questions about mental impairment. While appropriate behaviour is not defined, the Review Form provides some guidance to assessors. Appropriate social decisions include: “avoiding situations dangerous to self or others, using good social judgment” (p.19). Interacts appropriately with others includes: “understands and responds to social cues; problem solves in social context” (p. 19). An ability to deal appropriately with others’ demands is not elaborated. Each of these examples is rather vague and open to wide clinical interpretation. The history of mental health practice is filled with examples of people who have been institutionalized for transgressing dominant gender and sexual norms under the guise of “inappropriate social behaviour.” While the vagueness may provide greater latitude for a person trying to meet the criteria and maintain their benefits, there is a cost in how one must represent oneself. In the context of the Form, appropriate behaviour signifies “normal” social functioning which in turn, constitutes inappropriate behaviour as “abnormal” social functioning; or, in other words - mental impairment. To have a mental impairment is to need assistance to behave in “socially appropriate ways.”

Many of the Form’s assessment categories are based on ablest norms. In Section Three B. 2, which assesses the ability to communicate, health professionals are asked to assess the person’s level of ability in speaking, writing, reading and hearing as good, satisfactory, poor, or unable. These categories exclude alternate forms of communication

such as sign language, Braille, and bliss boards²⁰ and yet again reproduces disability as inability. A person who identifies as Deaf may not be able to speak or hear, but this doesn't mean they are unable to communicate. If a person decides to answer "good" to challenge the Form's assumptions about these categories, they may not qualify for benefits. Once again the question could have been phrased quite simply as, how do you communicate, followed by an inclusive list of examples. My point is that the "unable" category is disabling and unnecessary. Similarly, the modes of movement used to assess mobility and physical ability exclude the use of a wheelchair or scooter. People are assessed according to their ability to walk, climb stairs, stand, lift, carry, and hold according to non-disabled standards of amount of time and need for assistance. Such normative standards assume that people who use wheelchairs are not independent. The categories also assume a static disability experience, which isn't true for many people whose experience can change from one day to the next. It is important to remember that the disability category is a large and heterogeneous one. Some of the people under review may be very ill, others may be living with chronic pain, fatigue, or mental health that varies from day to day. Others may live with precarious health, while many people's physical and mental experience may be relatively stable. However, this variability should not be misconstrued, nor used as a justification for increasing the frequency of assessment of people who qualify. Activists have protested the loss of the permanent disability designation in the new legislation because it will subject people to increased stress, surveillance, and assessment as they are asked to continually prove they are "really" disabled.

²⁰ A communication tool for people who are non-verbal.

The purpose of the Form is to provide the Ministry with the information about how the person's impairments affect their ability to perform daily living activities. These daily living activities include the following categories: personal care, basic housekeeping, shopping, meals, paying rent and bills, medications, transportation and social functioning. Each of these categories is further divided into a number of tasks the Ministry assumes an able person could do without assistance and in a reasonable amount of time. These pre-determined categories and tasks are choices that also reflect cultural and gender norms. For example, childcare is missing from the list of daily activities. This omission reflects gendered norms that shape which daily living activities are deemed essential to assess disability. They also reflect sexist and ableist assumptions about the childcare capacities of people with disabilities. Researchers have noted that women with disabilities are consistently constructed as unable to adequately care for their children because of their need for assistance with tasks that violate ablest norms of independence (Keith & Morris, 1995).

The discourse of normalcy marks people with disabilities as abnormal, inferior and other. Taken for granted ablest norms about structure, function, and behaviour as well as independence and appropriateness, shape the social attitudes, structures, policies and practices that exclude, marginalize, and disable people with disabilities.

Discussion

Appearance of Fairness and Impartiality

Medical discourse, knowledge, and authority legitimize the Form as a "fair and impartial" way for the Ministry to gather the information it will use to assess people with disabilities' eligibility for the new PWD category. In this way, the Form functions in

Foucauldian terms as a “technology of power,” the means by which power conceals its operation (Shore & Wright, 1997). The Form is not a voluntary request for information, but a compulsory institutional procedure for collecting information and producing authoritative “knowledge,” about poor people with disabilities on social assistance. While the Disability Benefits 2 program also required medical verification of disability, this review compelled people with disabilities to submit to a more detailed scrutiny of their mental and physical functioning to keep their benefits.

The Form contradicts Bill 27’s supposed goals. The more the questions deconstruct the person’s health and well being into very specific aspects of functioning, the more dependent the answers become on specialized medical knowledge, professional expertise, and opinion. While the Ministry insists the goal of Bill 27 is to increase people with disabilities’ “independence,” the Review Form increases their dependency on medical knowledge, expertise and professional opinion to access PWD benefits. People must be as incapable, dependent, and abnormal as possible to qualify, but once they receive assistance they are expected to be as economically independent as possible.

People on social assistance have always been subjected to surveillance (Fraser, 1989) to prove their worthiness and deservingness. The intrusive scrutiny of people’s functioning, needs for assistance, appropriateness, and normalcy is a form of surveillance which, under the guise of fairness and impartiality, establishes a visibility through which it is possible to differentiate and judge (Foucault, 1979, p.184). The Form’s scrutinizing of people’s functioning produces the details needed to determine their inclusion or exclusion in the new PWD category - not only whether a person is “really disabled,” but whether they are “disabled enough” to meet the new criteria. But these details do not

make the women or men more visible, nor their needs; only the specificities of their inabilities and incapacities. This "knowledge" is then recorded in each person's file. While the Form may appear relatively harmless in comparison to other experiences of state oppression such as sterilization, institutionalization, and segregation it is a powerful example of disabling social policy practice. It is disabling for people to be forced to represent themselves as physically or mentally unable, limited, and lacking as possible to get the financial assistance they need to live. This creates a bizarre no-win situation whereby improving health and ability may lead to loss of eligibility and the very financial supports that made these improvements possible. During the review process disability advocates encouraged men and women to base their answers on their worst day as they feared some people might lose their benefits because they understandably wanted to focus on their abilities and capacities, rather than their inabilities and incapacities. Just because the government had come up with yet another administrative definition of disability, people's needs for a livable income hadn't changed. The Form is disabling because it re-medicalizes disability, in seeming obliviousness to thirty years of disability activism, thereby reinscribing disability as absence, lack, incapacity, abnormality, inappropriateness, and dependence.

In the Ministry's August, 2003 news release, which outlined the results of the DDR, then Minister of Human Resources Murray Coell stated:

This long-overdue review was about fairness. It ensures persons with disabilities receive the assistance they are eligible for - the third highest rate among Canadian provinces - and assures taxpayers that their tax dollars are going to those who are truly eligible.

The Ministry needed to manage the review in a way that would minimize negative publicity and widespread opposition (Wendell, 1996). Its consistent stance of "fairness

and impartiality” was made in response to harsh criticism from those who saw the review as a cost-cutting exercise on the backs of poor people with disabilities. Fairness and impartiality imply a process uninfluenced by personal beliefs and ideology. However, the government’s ideological agenda is very much in evidence in Minister Coell’s comments. In this context fairness to people with disabilities means ensuring they get the assistance they are eligible for - not that they are entitled to or need - but eligible for. Since it is the Ministry who changed the definition to restrict eligibility, its concern with fairness to people with disabilities has a punitive subtext, ensuring people do not get something they no longer deserve. According to the Ministry, the deserving people with disabilities are those who are “disabled enough” to meet the new criteria. The Minister’s comment about the benefit rate supports the government’s claim to fairness in terms of its financial generosity. However, this claim obscures the reality that while it may be third highest in the country, it is still well below the poverty line. The Minister goes on to say that fairness means assuring taxpayers that their tax dollars are going to those who are “truly eligible.” This statement speaks to the Liberal government’s ideological positioning of citizens solely in economic terms. The Minister speaks about taxpayers, rather than citizens, who need assurance about how their “hard-earned” money is being spent. Fairness here means accountability to taxpayers. Neoliberal governments have successfully co-opted communities’ calls for government accountability in consultation and decision-making, transforming it into a focus on the bottom-line and an ever increasing amount of paper work to justify an ever-decreasing amount of government funding. These last comments are a subtle form of “poor-bashing” (Swanson, 2001) which position poor people and taxpayers as two mutually exclusive groups. Fairness

means policing one group on behalf of the other. "Truly eligible" is a polite way of implying the government must ensure people are not lying or pretending to get something they do not deserve. Yet, it is the government who has changed the criteria, creating a new group of people who need to be investigated in case they are no longer "disabled enough" to be "truly eligible." The Minister's concerns about fairness are more about protecting the public purse than protecting the rights and meeting the needs of people with disabilities.

Erasing Differences

As I mentioned earlier, the Form's textual uniformity is central to its coordinating role in the review. It also supports the Ministry's claims of fairness and impartiality. Fairness is an important value in discourses of Canadian identity that portrays "us" as a fair and compassionate nation. This discourse masks the stratification of Canadian society along gender, race, class, disability, age, and sexuality lines. In the Canadian liberal context fairness is usually interpreted as a commitment to treating everyone the same, which, of course, assumes that everyone is equally situated. The Form's uniform text, deadlines, and requirements - its one size fits all approach - has the appearance of fairness because everyone must supply the same kind of information within the same time-frame. However, because people with disabilities are not equally situated, treating everyone the same reproduces pre-existing inequalities of gender, race, and so on. As a result the review process neglected the impact of diverse embodiment, social location and geography on an individual woman or man's ability to get the Form completed by deadline. The Ministry ignored the impact of ill health, mental and physical disability, access to transportation, literacy, English as a second language, access to advocacy and

community services, and the well-documented shortage of family doctors when it set the original January 15th deadline.

Another example of the Ministry's neglect of difference is the erasure of gender in the Form. The Form's brief personal information section does not include a question about gender. This is unusual for a government document, given the influence of feminist activists and policy makers who have developed gender-lens policy tools for government departments. This absence speaks to the well-documented tendency of non-disabled researchers and policy makers to treat disability as a unitary identity. To many non-disabled people, disability is such a totalizing identity that gender, race, and sexuality are rendered invisible. Another influence is the Ministry's belief in a medical discourse of disability. When disability is understood to be a matter of individual biology, gender seems irrelevant.

However, in a gender-stratified society, women's experiences are inevitably gendered (Brodie, 1996). Disabled women have struggled for years to have their voices heard and their issues addressed by government, the disability and the feminist movements. DAWN has documented women with disabilities' higher poverty and unemployment rates; their harder time finding work, accessing rehabilitation services, employment programs, safe housing and other services. Race, class, sexuality, and age also affect each woman's experience of these issues.

The Ministry's decision about whom to review and whom to exempt is another example of the gendered implications of the review. A leaked Ministry document questioned the "subjective nature" of the diagnosis of disabilities such as fibromyalgia, chronic fatigue, soft tissue injuries, and back pain. The document questioned whether

these were “real” disabilities - meaning of course, whether people’s claims of pain and fatigue “real.” This suggests that officials believed that people were feigning these symptoms and therefore taking advantage of a benefit they did not deserve, or they believed that the symptoms were psychosomatic, and thus in their minds, rather than their bodies. Discourses of psychosomatic illness are themselves heavily gendered and frequently applied to women who have physical symptoms the institution of medicine cannot yet explain. The BCCPD noted that the review also seemed to target people suffering from depression, learning disabilities, and some forms of arthritis (Klein and Long, 2003, p.33). As researchers have documented, many of these disabilities such as chronic fatigue, fibromyalgia, arthritis, and depression are more prevalent among women (Roman & Salmon, 2003). In contrast to the Form’s appearance of “gender neutrality,” the review’s targeting of these invisible disabilities as “real” disabilities is heavily gendered.

The review was not only gender but race neutral as well. The women and men who rely on disability social assistance are those who are unable to work because of health and/or employment/educational barriers and exclusions. People who rely on disability income assistance have no other means of financial support. It is people who were earning a low income who are most likely to have to turn to income assistance when they become disabled. Research suggests that women, people of colour and people with disabilities are the majority of low income people, although without further research it is difficult to know the race and class backgrounds of the women and men who rely on disability social assistance in BC. However, at the time of the review everyone on disability social assistance was receiving \$786 per month which means that whatever

their backgrounds, all were now living in poverty. The review was an attack on the most economically disadvantaged women and men with disabilities in the province.

Guise of Neutrality and Objectivity

Defining disability is not a neutral process but an exercise of power with material and social consequences (Wendell, 1996). Definitions determine not only who will be included, but excluded. While the Review Form relies on medical discourses and health professionals, it was the government, not doctors nor health professionals, who had the power to change the definition of disability. It was Ministry officials who designed the Form and determined the assessment criteria. The Auditor General's report indicates that a Ministry review team and twenty two external professionals were invited to review the Form and it was pilot-tested with groups of physicians, health professionals, and ministry adjudicators. However, people with disabilities were excluded from these processes, presumably because they were not considered "neutral" experts on their own lives.

This masking of the political under the guise of neutrality is a key feature of modern power (Shore & Wright, 1997). The Form's appearance of neutral objectivity depoliticizes the review (Fraser, 1989). Its medical discourses privatize disability as an individual medical issue and treats assessment as a neutral process of unbiased expert knowledge and professional opinion. Similarly, the Ministry's stance that the review was necessary because there was not enough information in people's files depoliticizes the review as a bureaucratic exercise - a purely administrative matter. However, it was a political decision to change the disability designation criteria and to review everyone at once. According to the Auditor General's Report, while the Ministry considered several options, it decided to fast track the review because "it believed it had to act quickly to

meet the intent of the new Act” (2003/2004, p. 18). The report concludes that the decision had more to do with concerns about the program’s growth rates in 2000/2001 and 2001/2002 and the Ministry’s notion that these were due to “a softening of the eligibility rules in 1996 and questionable assessor reports” (p. 19). Based on this assumption the Ministry expected anywhere between 6, 177 and 9,750 recipients might have their disability status rescinded (Auditor General, 2003/2004, p. 18).

The Auditor General’s Report outlines some of the weaknesses government and Ministry officials identified in the Disability Benefits Program Act which motivated them to draft new legislation. Some of these so-called weaknesses included: the inclusion of unusual and continuous expenditures as a disability criteria, which wasn’t the case in any other province, the permanence of disability status with no ongoing requirement for review, the inadequacy of the previous 11 page application to make eligibility decisions and the fact that assessors did not need to be health professional (p. 12). In addition, Treasury Board had expressed concerns about costs going back to 1998.²¹ The last reason noted in the Auditor Generals’ Report is that

...Ministry research showed that indiscriminately granting disability status to clients who really should not qualify increases their dependence on assistance. Not granting this status to such clients reduces their dependence without harming their health (p. 12).

The Report offers no details about who did this research nor the basis for their shocking conclusions. Not only do these conclusions contradict the research which documents the link between poverty and illness/disability, it justifies this increased threat to people’s health and their ability to find safe and secure housing and proper nutrition in the name of getting rid of their dependence. While outrageous, this research does reveal

the Ministry's assumptions that the Disability Benefits Program, which had expanded the definition was granting disability benefits indiscriminately, i.e. to people who didn't really need them. While it is hard to understand how any research could conclude that increasing people's poverty would not affect their health, this research supports the Ministry's new emphasis on as much independence as possible for people who qualify for the PWD category.

Most in Need

"Most in need" is another key phrase the Ministry used to rationalize the review. According to the Minister, "What we wanted to do was make sure we are targeting funds today and funds in the future to those people who are most in need" (McInnes, 2002a, p. B6). This phrase is commonly used by neoliberal governments concerned about the need for fiscal restraint to control deficit and debt (Brodie, 1996).

In this case, the Ministry uses the positive language of providing something to those most in need to mask the reality that they are in fact trying to cut this program by changing the eligibility criteria. As neoliberal governments focus their resources on those they define as "most in need," attention shifts away from those people whose needs are now relegated to the "least in need" category. In this shift, both the people and their needs tend to disappear from view. This is exactly what has happened to people with disabilities who have been receiving benefits under the PPMB category, whose benefits are now being reviewed every two years. According to the BCCPD (2005), many are not making it through the review process.

²¹Costs did increase because the Disability Benefits Program Act addressed the exclusion of people with mental health disabilities under GAIN for the Handicapped.

The Ministry's targeting of programs to those "most in need" assumes that who needs what is somehow obvious and unproblematic. According to the Ministry's definition of disability, the "most in need" are people with severe impairments who need help with daily living activities. However this definition owes more to economic and political considerations than the needs of people with disabilities on social assistance who were not consulted. It was operationalized in the Form and put into practice in the Review. As my analysis and discussion make visible, the discursive strategies the Ministry used to target resources to those it deems "most in need" individualizes and pathologizes people with disabilities and subjects them to a coercive self-scrutiny, increasing surveillance, and control (Brodie, 1996).

I want to end this section by returning to Carolyn Hurn's description of her experience which opened the chapter. Hurn describes the impact of being reviewed, of how demoralizing and defeating it is for people with disabilities struggling to improve their lives to be subjected to a process which forces them to list all they cannot do. She also reminds us that this experience of feeling defeated is not new. It is a common feature of many of her experiences with the Ministry and the regulations which make it impossible for people with disabilities to improve their lives. The welfare system's regulations are based on the system's assumptions and interpretations of what people with disabilities such as Carolyn Hurn need. These interpretations do not reflect the lived experience and expert knowledge of people with disabilities because they are not consulted. Hurn's letter is a critique of the review and the Ministry which speaks to the "epistemic violence" (Razack, 1998) of government practices and processes that force

women and men with disabilities to “prove” their disability according to hegemonic standards of normalcy determined by non-disabled people.

Summary

In this chapter I used a variety of theoretical resources to identify and deconstruct the discourses of the Form and the Ministry’s rationale for the review. Drawing upon Fraser’s analysis of the depoliticizing tendencies of the welfare state I showed how the Ministry’s use of expert discourses of medical knowledge, authority, and unbiased professional opinion attempt to legitimize and depoliticize the Form and thus the Review as a neutral, objective, and therefore harmless bureaucratic information gathering exercise. My analysis challenges this depoliticization. I argue that the Review is a powerful example of a disabling social policy practice that does great harm to people with disabilities. The Form’s discourses of normalcy, independence, and disability as individual incapacity force people with disabilities to represent themselves as incapable, dependent, and as abnormal as possible in order to re-qualify and maintain the benefits they need to survive. This positioning of people with disabilities is demoralizing, disabling, and oppressive, not neutral and objective.

The Form’s discourses rely on and reproduce disability as an individual, medical issue which ignores the realities of disabling environments, social structures, policies and practices on disability experience. The Review’s one size fits all approach actually reproduces barriers and exclusions that exist because not all people with disabilities on social assistance are equally situated.

Using Smith and Foucault I described the Form’s coordinating and organizing role as a compulsory institutional procedure used to organize and mediate people with

disabilities encounter with the state. Here I argued that this compulsory self scrutiny was in itself disabling as it did not make people's needs more visible, only the specificities of their inabilities. The Ministry's discourses of neutrality, fairness, and impartiality shift attention away from the fact that it was a political decision to change the definition of disability and initiate such a large scale review.

I also challenged the Ministry's rationale that the Review was a fair and impartial process designed to ensure services were going to those "most in need." Using Fraser's analysis of the politics of need interpretation I problematized the Ministry's targeting of resources to those who are "most in need" as though who is most in need is somehow obvious. And I exposed the way in which the positive language of providing something masks what is essentially a funding cut. I also showed how this focus on those who are "most in need" simultaneously creates a "least in need" category who disappear from public view.

While the discourses the Ministry mobilized throughout the review have the institutional authority of government, law, and medicine the review's legitimacy and rationale were fiercely contested by disability advocates and their supporters. In the next chapter I analyze and discuss these discourses of resistance to the DDR.

CHAPTER SIX: DISCOURSES OF RESISTANCE

I have been an advocate for 20 years, but deep down I am still a person on “welfare” who is scared that it will be taken away and I will not be able to survive.

gisele guay, (The Long Haul, October 2002)

The passing of Bills 26 and 27 marked a radical shift in BC’s social assistance policy from a culture of entitlement “towards a culture of personal responsibility, self-reliance and employment” (Coell, 2002, p. 2813). Like other neoliberal western governments, this shift in the culture of social assistance reflected an ideological shift in responsibility from the state to the individual. While Bill 26 seemed designed to punish people on regular assistance for welfare dependency by providing sanctions to “encourage” them to become independent through employment, Bill 27 encouraged people with disabilities to be as (economically) independent as possible by participating in paid or unpaid employment. As mentioned previously, Bill 27 also created a new disability category with more restrictive qualifying criteria. The Ministry’s subsequent review of people’s disability designation became a key site of struggle for disability advocates’ resistance to these policy changes.

In this chapter I analyze the discourses that disability advocates and their supporters used to contest and disrupt the review and celebrate what they were able to accomplish under incredible duress. Not only did they guide thousands of people through the review process, but the vast majority of people who were reviewed (98%) were given PWD status and kept their benefits. While disability advocates won this struggle, they did so at great cost and some risk, and the “welfare wars” continue. I end the chapter by discussing some of the Ministry’s more recent administrative attacks on people with disabilities.

As noted earlier, Bills 26 and 27 became law on September 30, 2002. The following week thousands of people on DB2 received letters notifying them that their disability status was being reviewed to see if they met the criteria for the new PWD benefit. It takes a lot of work for poor people on social assistance to qualify and maintain their benefits (Fraser, 1989). Every time the MHR decides to change its definition of disability, people with disabilities have to go through the exhausting physical and emotional effort of "proving" their disability all over again. As one woman noted in her letter to the editor of End Legislated Poverty's community newspaper, The Long Haul

A lot of us received a lifetime disability designation under the old GAIN Act where we had to prove unemployability. Some of us went through an arduous ordeal within the past year to obtain the old Level 2 Disability (DBII) status, so it has been shocking, to say the least, to have had to be reviewed. (Hurn, 2002, p. 2).

The first priority for disability advocates was to provide the information and support that people needed to get their DDR Forms filled out on time. This was an enormous challenge which strained the resources of the community agencies and advocacy groups whose funding had just been slashed by the Liberal government. At the Disability Benefits Forum I attended in Vancouver in November, 2002, one mental health advocate talked about how the government had created a crisis of massive proportions because there were not enough resources for people with mental illness. Other speakers talked about the impact of the review on already over-stretched health services and workers' inability to do anything else but support their clients through this process. The message was clear. The review was diverting scarce community resources and re-organizing the work of advocates in small, under-funded community groups, as well as doctors and health assessors who were coping with the resource limitations of the health care system.

In addition to guiding people through this process, disability advocates and their supporters used mainstream and community newspapers, radio, television and the Internet to challenge and resist the review and make its implications visible to the general public. My analysis of the discursive strategies used by disability advocates and their supporters to challenge and disrupt the review focuses on textual sources in Vancouver's mainstream and community newspapers and the Internet (see Chapter One, pp. 11-12). In the following section I present my analysis and discussion of four key oppositional discourses that disability advocates and their supporters used to oppose the Ministry's attempts to depoliticize the review as a fair, impartial, and harmless information gathering accountability exercise.

Counter Discourses

Exposing the Ministry's Hidden Agenda

This discourse exposed what the Ministry's discourse and rationale were designed to conceal. As Margaret Birrell, Executive Director of the BCCPD commented to Vancouver Sun reporter Craig McInnes, (2002)

The new rules appear to be designed to cut the numbers of people receiving benefits by restricting the definition of disabled in a way that makes it difficult for people with mental illnesses to qualify. They're on target to do what they want to do. Ten thousand will be off January 15. (p. B6).

These statements challenge the Ministry's rationale for the review. By linking the review to the Ministry's restrictive changes to the definition of disability, Birrell offers an alternative rationale - a hidden agenda to drastically reduce the numbers of people claiming disability assistance. In the context of the Liberals' massive cuts to social programs, government layoffs, and office closures - all of which broke many of their campaign promises, this counter discourse had great legitimacy.

It was further supported by a leaked Ministry memo that speculated on the thousands of people who were expected to lose their eligibility during the review. The leaked memo forced the government to try to defuse the situation by publicly denying that there were any targets. This was a significant victory. Not only did it put the Ministry on the defensive, but once the targets were publicly denied, it became more difficult to cut thousands of people off. Although it was in the government's financial interest and in keeping with its neoliberal ideology to reduce the numbers of people eligible for PWD benefits, it obviously didn't want to be seen as doing so. While the Ministry's communications director publicly denied "a dollar target for saving from reducing disability benefits," he also had to admit that "the 2002 budget projected a 30-percent savings in overall social-assistance costs, including disability benefits and welfare" (Tieleman, 2002, p. 18). BCCPD advocates were able to use this 30 percent budget target to counter the Ministry's denials. As BCCPD's Co-Director of Advocacy Access, Robin Loxton, noted, in the same Georgia Straight article,

The government is very clear - it's cutting 30 percent over three years. You just have to do the math. If they send out 18,000 letters and you look at the adjudication rate in the past, about 50 percent will be rejected (Tieleman, October, 2002, p.19).

This hidden agenda discourse effectively linked the Ministry's new definition of disability and the review to the Ministry's need to cut its budget. Disability advocates used this discourse to disrupt the government's depoliticization of the review as a neutral administrative procedure by accusing the Ministry of concealing the review's real purpose - to save money at the expense of people with mental health and other disabilities. As mentioned in the previous chapter, ministry officials consistently denied that the review was about saving money, even when the Auditor General's Report

(2003/2004) concluded that the reason for the Ministry's decision to review everyone within the original three-month time frame was "the potential cost savings associated with the anticipated number of ineligible recipients" (p. 21).

Exposing the Review's Harmfulness

Fear, Panic, and Despair

If the government's hidden agenda was to kick people off of disability benefits to cut costs, this oppositional discourse made the harm – the devastating human costs of this agenda - visible. This discourse focused on the impact of the review on people with disabilities and held the government accountable. It made the panic, confusion, fear, stress, and despair the review process had created visible.

Advocates for the disabled say the letters are causing panic among many of the people who get disability benefits. "People are terrified. There is great concern." said Jan Harder, who was waiting Thursday to hear whether her son, who is schizophrenic, is being reassessed. (McInnes, 2002a, p. B6).

BCCPD's advocates were worried that people with mental illness were being targeted by the change back to a functional definition of disability. Because so many people with mental health disabilities were being reviewed (one third of the total) they highlighted the effects on members of this group. In an interview with then Georgia Straight columnist Bill Tieleman, Robin Loxton noted,

...even the stress of being reassessed, let alone the possibility of losing their benefits, is hurting people with disabilities. I had a man in here in tears who has been on disability since 1981. He's never been able to work in his entire life. He can't deal with people, and even coming to the coalition office was an enormous challenge, Loxton said. His mental health has taken a downturn since getting this reassessment letter. (Tieleman, 2002, p. 12).

For some people with mental health disabilities, the fear of losing their benefits was overwhelming. One mental health advocate talked about people receiving the Form,

and freezing, not opening their mail, not calling their doctor, just giving up (Disability Benefits Forum, November, 2002). Tom McGregor, Co-director of BCCPD's Advocacy Access Program, used the Ministry's own concerns with saving money to show that the review was creating a harmful situation that would require more expensive interventions: "Many of them will end up in acute care in hospital, and that's a hell of a lot more expensive than \$786 a month in disability benefits." (Tieleman, 2002, p.19).

People's fears were more than justified. Given the radical changes in Bills 26 and 27, their health, safety, and well-being were at stake. Carolyn Hurn's letter to the editor of the Long Haul speaks to the material consequences of not meeting the new eligibility criteria, "It is devastating and scary to think we could lose the roof over our head, life-saving medications, food and transportation to medical appointments, all very basic needs" (p. 2). Although they were receiving the highest level of social assistance benefits available, at \$786 per month they were well below the poverty line. As I noted in Chapter Four, if an individual couldn't meet the new PWD criteria they might qualify for the PPMB benefit of \$608 per month along with a subsidized bus pass, health benefits and a smaller earnings exemption. The loss of the PWD benefit represents a loss of \$178 dollars per month which equals a 33% decrease in monthly income. This is a huge loss for anyone but even more devastating for someone with such a low income to start. The threat of dropping down to regular social assistance was frightening - a meager \$510 a month, with no bus pass, no health benefits and no earnings exemption. As Jan Harder put it, "Five hundred a month means you eat in the soup kitchen and live in a hotel room in the Downtown Eastside...." (McInnes, October 4, 2002a, p. B6). Even more

devastating, the threat of homelessness became very real with the Ministry's new time limit rule.

Researchers have noted that not only are people with disabilities more likely to be poor but that poverty increases the likelihood of illness and disability (Davis, 1995, Raphael, 1999, Raphael, 2003, Sieppert, Linde, & Rutherford, 2003). It isn't hard to imagine how the lack of proper nutrition, safe housing, transportation and some resources to maintain one's health added to the stress of trying to survive on \$510 a month would make an illness or disability worse. The consequence of such a policy is to increase the likelihood that people who were initially denied the PWD or PPMB benefit because the government changed the definition for political reasons, might become eligible because of the effects of a greater degree of poverty and insecurity on their physical and mental health. As the thirty-six Vancouver doctors argued in their letter to the editor of the Vancouver Sun (2002), the review was designed to systematically disqualify people, despite research that shows that "social determinants - i.e. decent housing and a stable income - are the best predictors of an individual's overall health" (as cited in Doctors protest, 2003, p. 5). They further argued that it was unconscionable for the Ministry to ask them to participate in a process that compromised their professional responsibility to advocate for their patients' health (Vancouver Sun, 2002 as cited in Doctors protest, 2003, p. 5). The social and cultural construction of disability is not just a discursive but a material issue. When poverty is known to increase the likelihood of illness and disability, then policies which force anyone to live on \$510 without health benefits are literally disabling.

Suicide

The threat of losing their benefits created such despair that some people receiving Disability Benefits 2 saw death as their only option. In November, 2002, an article in the Province (2002) newspaper reported the suicide of Arne Ristvedt, a 54 year-old grandfather who couldn't work because of chronic back pain and knee pain, and who had fought for years to get on disability and find an apartment of his own (Bermingham, 2002, p. A.33). The article quoted his suicide note "I can't take the bull[...] from the government. Sue the government for pain" (p. A.33). It goes on to note that there have been reports of a similar suicide on Vancouver Island and an attempted suicide in Surrey. The same article also highlighted the calls the BCCPD and Vancouver Crisis Centre were receiving from people who were suicidal. As the Crisis Centre's Richard Cramer noted, "[they say] what's the point of living, if they are dealing with the extra burden" (p. A33). Bill Tieleman (2002) also wrote about the anguish some people were feeling (2002, p. 19). He described a Vancouver man diagnosed with schizophrenia who committed suicide soon after he found out that he would be reassessed. While the man's friend, Peter Norris, notes that the review was not the only cause of his friend's despair, he is clear that his friend was feeling threatened by the review which "added to his burdens" (Tieleman, 2002, p. 19). It seems safe to assume that the media coverage of Arne Ristdvedt's death and the fear of more publicity, had some influence on what the Ministry did next. The following week, "just minutes before a press conference that was called by disability advocates to demand an extension of the January 15th deadline...." (McInnes, 2002, p. B.5), the provincial government announced that it would be exempting over 5,000

people²² with mental illness under review and extending the deadline from January to March 15.th This announcement ended the review process for thousands of people with mental illness, many of whom were experiencing some of its most devastating effects. And it safeguarded their status and benefits in the Ministry's new "PWD," category, a level of benefits they had had great difficulty accessing until the Disability Benefits Program Act came into effect in 1996. In response to why the Ministry was able to exempt the very people whose files had apparently lacked the necessary information, a Ministry spokesman stated that "a review of the forms returned so far showed that virtually all of those people who cited mental disorders who had qualified under the new rules" (McInnes and Reevely, 2002, p. B.5). While this was good news for people with mental health disabilities, the devastating harm the process had created could not be undone.

By making the devastating consequences of the review visible, disability advocates and their supporters challenged the legitimacy of the Ministry's power to disqualify thousands of people.

Exposing the Barriers

By making the barriers to completing the Form visible, disability advocates and their supporters further undermined the review's credibility. Not only was the review punitive and harmful, it was unworkable. This was due to the complexity of the Form and the tight deadline. As Robin Loxton noted, "The reassessment forms have stunned the whole disability community. There's almost a feeling of disbelief among people when

²² While first reports estimated 5,000 people with mental health disabilities were exempted this figure was later raised to over 6,000 in the Auditor General's Report.

they realize all of what's involved; it a very complicated process.” (Tieleman, 2002, p. 12).

One of the biggest barriers people with disabilities' faced was lack of access to doctors, health assessors, and community advocates. The original January 15th deadline created a huge burden of work for everyone involved - people with disabilities, doctors, health assessors, and community advocates. The Ministry's lack of awareness of the consequences of trying to review everyone at once reveals the hegemony of ablest norms and assumptions combined with an appalling ignorance of the barriers people with disabilities face on a day to day basis.

The BC Association of Social Workers partnered with several of the professional associations named as qualified health assessors to lobby the Ministry to address the barriers - to extend the deadline, increase funding for support services and develop adequate outreach strategies for all applicants. Their argument for extending the deadline centred on people's lack of access to doctors, assessors, and advocates. Their advocacy letters to the Ministry described the reality of health care in BC in which 100,000 people cannot find a family doctor. They noted the burden the short timeline created for people with disabilities who had to try to find a doctor taking new patients and then have enough contact so that the doctor could complete Section 2 (BCASW lobbies, 2002).

However, even if people did have access to a doctor, BCCPD's advocates worried that with the increase in the physician's report from one page to five, many doctors wouldn't have time fill them in. This was particularly true for the poorer areas of Vancouver where “clinics have literally hundreds of patients with disabilities” (Tieleman, 2002, p. 19). That the Ministry did not think about this when they developed the Review

process demonstrates their ignorance of the realities of poverty for people with disabilities on social assistance. This would be even more of an issue for those people with disabilities who had to rely on their doctor to also complete the eight page assessor report. Given the lack of family doctors this was an incredible strain on doctors and the health care system. The Vancouver doctors who protested the review in their letter to the Vancouver Sun estimated that the time commitment to complete the Form would be at least one hour. It is admirable that these doctors did not want to participate in a review that was creating such harm and designed to disqualify people. While the BCCPD welcomed their protest, they asked the doctors to continue participating. Unless all BC doctors refused to participate, the review would continue. If these doctors didn't participate it would be much harder for people with disabilities to get their Forms completed by the deadline which meant they would be cut off according to the letter the Ministry sent to everyone being reviewed (Margaret Birrell, November 26, 2002).

Another barrier was the uneven distribution of health professionals across the province, which again affected individuals access to a designated assessors. In the Long Haul, the Brain Association (2003) criticized the list of qualified assessors for being too narrow and excluding Case Managers who coordinate clinical and community-based services for people living with a brain injury

The acceptable list of health professionals who qualify as an assessor is narrow and will not benefit those people living with the outcome of acquired brain injury and who are not connected to a family physician or other qualified assessor. ...In the majority of instances, a Case Manager is able to provide a much more comprehensive assessment of how a brain injury has impacted an individual's life. (p. 10).

The Assessor's Professional Associations also identified the various access barriers for people with mental health problems, literacy problems and socially isolated women and men who needed help from community advocacy and support services whose resources were stretched very thin. As Robin Loxton noted, "There's not enough resources to help everyone fill out their reassessment forms on a one-to one basis, even with additional help. But community groups are trying to designate resources to assist clients through this process" (Georgia Straight, Nov. 7-14, p. 12)

As the March 15th deadline approached, 3,000 people had yet to return their Forms. The Vancouver Sun reported on BCCPD's news conference at which Jane Dyson called "on the ministry to stop this process and admit it had been a huge error and to rescind the 23-page form that doctors and health assessors are finding extremely difficult to complete" (Morton, 2003, p. B.5). Tom McGregor argued that going ahead would cruelly punish the people most likely to have trouble completing the process by the March 15th deadline - "people with the greatest level of cognitive impairment, the people who are most isolated and the most vulnerable" (Morton, 2003, p.B.5). He added that these would be people experiencing severe depression and people living in the Downtown Eastside of Vancouver.

In this same article the Ministry's disingenuous ignorance of these barriers, of the lack of access to doctors and health assessors, and the diminishment of the Ministry's complicity in the Form is evident in spokesman Richard Chambers' defensive response to the concerns BCCPD advocates raised about the Form.

The client is being asked to fill out two questions. ...What is the nature of the disability. And how does this disability interfere or affect your ability to carry out normal daily activity. That's what we're asking the client to do. (Vancouver Sun, March 13, 2003, p. B5).

A Waste of Time and Money

Disability advocates and their supporters used the Liberal government's concerns with fiscal restraint and cost savings to critique the review as a waste of time and money.

During the review, the Vancouver doctors' letter to the editor challenged the government's decision, in an era of limited health care resources, "to ask physicians to spend more than 18,000 hours, at a minimum cost of \$2.34 million dollars, defending our patients' disability designations." (Vancouver Sun, 2002, as cited in Transition, 2003, p. 5).

In the end, the review cost the Ministry of Human Resources almost five million dollars, valuable resources which could have gone to support people with disabilities. As the Auditor General's Report noted, this figure does not include the costs to other government ministries, nor to the community groups who provided information and support during the review (Auditor General Report, 2003/2004, p. 35).

The disability movement's campaign against the Ministry's cost-cutting agenda review was an amazing success. Not only were disability advocates able to get almost 5,000 people with mental health disabilities exempted from the review process, in the end only 400 people lost their disability designation. Forty people appealed and were reinstated. Three hundred and fourteen people dropped down to PPMB or regular assistance. Only forty-six people had their cases closed.

This low figure contradicts the March, 2003 article in the Vancouver Sun, in which Ministry spokesman Richard Chambers is quoted as saying that "just over half of those citing physical disorders are qualifying" (Morton, 2003, p. B. 5) which is what advocates had predicted. Sometime between March and August 2003, the Ministry must

have decided to back off, because only 360 people did not qualify for the new PWD category. Georgia Straight columnist Bill Tieleman speculated that that the protest of people with disabilities and their advocacy groups, some sympathetic media coverage, and the threat of a legal challenge if thousands lost their designation, played a role.

While I do not want to minimize the material implications and health consequences for these 360 individuals, nor the cost to people with disabilities, community advocates and the disability movement, given the Liberal government's record of cuts, the fact that 360 rather than over 9,000 people did not qualify was an amazing accomplishment for people with disabilities and disability advocates. The resistance to the review forced the Ministry to back down. The thousands of women and men who qualified maintained their benefits and thus their housing, nutrition, and safety. (Auditor General Report, 2003/2004, p. 36). When the review's results were publicized, it was easy to use the Ministry's rhetoric of fiscal responsibility against it. In an era of fiscal restraint it was wasting money: As BCCPD's Margaret Birrell commented, "In a nutshell, this has been a complete waste of time and money, and what it's done to people with disabilities and their families is unspeakable and unconscionable." (Tieleman, 2003, p.14). BCCPD's Jane Dyson used the ministry's rhetoric of accountability to taxpayers to argue that the review "has clearly been a costly failure, both financially for taxpayers and emotionally for the community of people with disabilities," ("Majority of recipients," 2003, p. 7).

Given the low numbers of people who lost their benefits, the Ministry had to rationalize why it had put people with disabilities, advocates, doctors and health professionals through such a stressful, harmful, burdensome, and ultimately unnecessary

process. The Minister's August 11th, 2003 press release emphasized that these results were expected, a comment meant to challenge the persistent idea that the review's hidden agenda was to cut thousands of people, and that "for the first time in over 10 years we have certainty that public resources are going to those most in need" (Ministry of Human Resources, 2003). This attempt to justify the review by blaming the previous government's poor administrative practices was weak and easily challenged. "It is astounding that the Minister would undertake a lengthy and costly process when he has stated that he already knew the result - the vast majority of people would qualify," said Margaret Birrell of the BCCPD. (Majority of recipients, 2003 p.7).

Discussion

Disability advocates' discourses of resistance challenged the Ministry's ability to disqualify thousands of people by attacking the review's legitimacy, the Ministry's credibility, motivation, rationale, and the human and financial costs to people with disabilities and to taxpayers. They exposed the Ministry's hidden motives and illuminated the harm to individuals and the disability community as a whole, as well as the barriers that made the whole process a chaotic, confusing mess, and ultimately a waste of time and money. Combined they made an effective, multi-layered challenge to the Ministry's redefinition of the disability category to achieve its own neoliberal political and economic goals. These counter discourses put the Ministry on the defensive. Its rhetoric of fairness, impartiality and accountability were attempts to defuse the challenges of disability advocates counter discourse.

One of the central tensions in this political struggle was the Ministry's use of dominant discourse to depoliticize the review as a harmless bureaucratic exercise, a

matter for experts to determine through objective and neutral assessment. These counter discourses repoliticized the review by making the individual and collective harm visible, by identifying the barriers, by using the government's rhetoric of fiscal constraint to critique the Ministry for wasting money, and by consistently linking the review to the Ministry's changes to the definition of disability and its need to cut costs.

These oppositional discourses also created subject positions for people with disabilities. While the Form positioned people with disabilities as incapable "others", these discourses positioned people with disabilities as unfairly targeted, threatened, frightened, stressed, and victimized by the Ministry's cost cutting agenda. These repoliticizing discourses constituted people with disabilities as a community under siege by their own government who lacked the access to support, resources, doctors, health professionals, and advocates they needed to get through the Review.

How the Counter Discourses Are Heard

One of the things I was interested in exploring when I began this project was what was possible in terms of resistance during a time of crisis. As Fraser (1989) notes, one of the dilemmas of the welfare wars is the need to oppose any cuts to already inadequate welfare programs which reproduce inequalities. While disability advocates were able to draw attention to some elements of the political economy driving the review, their first priority was to ensure that as many people as possible received the support they needed to get the Form in on time in order to maintain their designation and its benefits. However much anyone would have liked to see the review dismantled, their strategies of resistance could not jeopardize the financial support which people so desperately needed. Their resistance to the review's threat to people's designation was incredibly successful and

deserves to be celebrated. They prevented thousands of people from losing their benefits, particularly women and men with mental health disabilities who had only been able to access this level of benefits since the changes to the definition of disability in the 1996 Disability Benefits Act. Their efforts prevented a grave injustice, increased poverty, individual suffering, and I would argue - given the suicidal calls received during the review - likely some deaths as well. However, the cost of the review to individuals, advocates, groups, and the disability movement has been very high.

One way to understand a little more about how these counter discourses functioned is to examine some of the factors that influenced how they were heard. Razack (1998) argues that histories, social relations, and conditions that structure groups unequally in relation to one another *shape what can be known, thought, and said* (p. 10). She further suggests that how we “hear” and how we “tell” our experience are culturally produced and historically specific, and influenced by subject positions, context, and dominant discourses of gender, race, disability, class, and sexuality (Razack, 1993, 1998). In the following section I explore how the political context in which disability advocates’ counter discourses are situated and dominant narratives of disability influence how these discourses may be heard, particularly by non-disabled people.

Context

The Liberals implementation of their tax cuts resulted in their declaring a structural deficit which became the justification for their massive cuts to social programs, government layoffs, and privatization. This was the immediate political context within which disability advocates discourses of resistance were situated. Virtually every community had been affected by cuts to legal aid, social assistance, and health care -

including the loss of acute, long-term care, and psychiatric beds. Other changes included the cancellation of the tuition freeze for post-secondary education, a twenty three percent cut to the Ministry of Children and Family Services, funding cuts to poverty, disability and women's groups, the elimination of the Ministry of Women's Equality, the Ministry of Multiculturalism and the Human Rights Commission and a 35% cut to the Ombudsman's Office. The Child Care BC Program which provided before and after school care was eliminated and the government canceled the not yet implemented universal day care program. These cuts were accompanied by the closure of hospitals, courthouses, probation offices, and welfare offices, and massive layoffs within the public service (Caledon Institute of Social Policy, 2002, pp. 1-7).

The government's actions mobilized widespread protests across the province and expanded the active opposition from traditional advocacy groups to a wide range of citizens concerned about the loss of so many services. During these protests the Liberal government was routinely portrayed as cruel, heartless, and mean-spirited for attacking the poorest, the most disadvantaged, and the most vulnerable people in the province. The widespread negative public reaction to the government's neoliberal agenda provided a broad, supportive political context for disability advocates' discourses of resistance. Given their own experience, it was easy for many people to believe advocates' claims that the Ministry had a hidden cost-cutting agenda and that the review was doing great harm.

Discourse of Pity

The discourse of pity is a dominant discourse that mediates how discourses of resistance are heard and interpreted. Razack (1998) argues that non-disabled people are

heavily invested in this discourse of pity which leads to a politics of rescuing and saving unfortunate and tragic victims, rather than respect and an examination of the ways in which non-disabled norms and assumptions transform a mental or physical condition into a situation of disadvantage or vulnerability. Discourses of pity individualize and privatize disability as a personal issue that focuses attention on individuals and feeds administrative and therapeutic solutions (Fraser, 1989), versus an analysis of the barriers and systemic exclusions that create disadvantage.

One of the dilemmas for anyone doing disability work is the small discursive space that advocates and allies have to try to draw attention to the oppression of people with disabilities without reinscribing people with disabilities as incapable. Advocates cannot control how their counter discourse will be mediated by taken for granted understandings of disability as an individual medical issue and a personal tragedy. The dominance of this discourse makes it difficult to draw attention to the impact of oppressive practices without reproducing disability as totalizing incapacity. While this is an issue for all marginalized groups, it is particularly problematic for disability because of widely accepted and taken for granted ablest assumptions and norms which naturalize disability as biological deficit, deficiency, and lack.

During the protest against the Liberal's massive cuts I noticed how frequently people with disabilities, poor people, and women and children were described by many community advocates, politicians and media as "our" most vulnerable people or citizens. The same people were much less frequently referred to as the most disadvantaged and marginalized. While these cuts did create a condition of increased vulnerability for many people, I am concerned about the implications of this use of vulnerable in relation to

people with disabilities. While disadvantaged and marginalized reflect a social relation - that people are being disadvantaged or marginalized by someone or something, the problem with the use of vulnerability is that it leaves the issue of vulnerable to what and why unanswered. To describe people as vulnerable implies that it is a fixed characteristic rather than a transitory state (Campbell, 2002, as cited in Words matter, 2002, p. 20). People are vulnerable at different times. The use of words like vulnerable or unfortunate to describe people with disabilities is necessarily inflected by dominant cultural and medical narratives of disability that mark people with disabilities as either heroic or tragic, and as we saw in the previous chapter, as incapable. These discourses influence how counter discourses about people with disabilities will be heard by non-disabled people. They can inadvertently reinforce totalizing assumptions of people with disabilities as completely unable or as tragic victims. While I am not suggesting non-disabled people never use this word, I am agreeing with disability advocates who have argued for greater sensitivity and selectivity in its use because it focuses on the individual, rather than the conditions which create the vulnerability (Campbell, 2002, as cited in Words matter, 2002, p. 21).

A similar critique can be applied to the use of the word unfortunate. For example, after the release of the Auditor General's review of the DDR, Vancouver Sun columnist Vaughn Palmer wrote a generally sympathetic article in which he concluded that the Liberal government deserved the blame for the review's "waste of tax dollars and for adding to the suffering of some of our most unfortunate citizens" (p. A3). His use of unfortunate with citizen is an interesting juxtaposition. While citizen recognizes that people with disabilities have rights, responsibilities, and entitlements, the use of

unfortunate echoes the discourse of pity. Describing disabled citizens as unfortunate focuses on individual embodiment and “what happened to them” rather than drawing attention to poverty, inaccessible spaces, the organization of work, ablest norms of productivity and performance which exclude people with disabilities. That Vaughan Palmer was attempting to write a column in support of people with disabilities, only highlights the struggle advocates and allies face to repoliticize disability (Fraser, 1989). The discourse of pity is deeply intertwined with taken for granted notions of disability as a personal and private, rather than a political issue.

This discourse of pity runs through the welfare system. People with disabilities have generally been seen as the “deserving poor” because they are seen to be in need of assistance through no fault of their own. However there is a cost to this construction of their identity in this notion of deservedness. This discourse of pity runs through the welfare system. People with disabilities have generally been seen as the “deserving poor” because they are seen to be in need of assistance through no fault of their own. However there is a cost to this construction of their identity in this notion of deservedness. People with disabilities do not want charity, they want rights, equity, and adequately funded services which will allow them to participate in their communities (Campbell, 2002, as cited in Words matter, 2002, p. 21).

Telethons and fundraisers which have traditionally relied upon the discourse of pity to raise funds have also contributed to this intertwining of pity, charity, deservedness, and disability.

These discourses of pity point to the discursive constraints facing disability advocates during the review crisis. While the immediate political context supported

disability advocates counter discourses, the discourse of pity and the dominant discourse of disability were constraints. They influenced how the discourse of harm might be heard by non-disabled people in ways that reinscribed disability as an individual rather than a sociopolitical issue. While people with disabilities cannot control how they may be heard, they are the experts on their own lives. They have knowledge about their situation and their needs that is not available to non-disabled people (Wendell, 1996). As Wendell (1996) argues, any culture that stigmatizes disability would rather ignore and suppress, and I would add, devalue their knowledge, rather than make the changes necessary to integrate it (p. 75).

The Future

While disability advocates won the battle, the “welfare wars” continue. As Robin Loxton’s (2003a) comments make clear, the next PWD reviews will be done in private on a case-by-case basis.

And, this is just the first round of change. We know the government will review people’s disability status every 2-5 years. As such, this is just the first review of many, and the community is in a constant state of anxiety about the future. It is frightening to think that the “new era” in this province will mean that so many disadvantaged citizens are facing such hardship and desperation. (p.3).

Advocates have already seen the consequences of this privatization of the assessment process happen to people receiving the old DB1 benefit. While the DDR was taking place, each of the 12,000 people on DB1 had their eligibility for the new PPMB program individually reviewed by their case workers. Then, in 2004 the Ministry changed the PPMB adjudication process by shifting the responsibility for qualifying decisions from local to regional offices. According to the BCCPD, the timing of this shift was significant because it happened after the program’s second anniversary, and people on the

benefit have to re-apply every two years. They report that many of the people reviewed have been denied benefits. This shift from local to regional decision-making means that the people who make the assessment decisions do not know the people with disabilities whose files they are reviewing. With this shift comes the loss of important knowledge that caseworkers have about “the reality of applicant’s situations that are in the details of living with their disability” (BCCPD, 2005). The issues at stake here revolve around the credibility of different kinds of knowledge. While this more anonymous approach may appear to lend the process greater objectivity, as my analysis of the DDR Form made clear, this positivist approach translates into oppressive results for people with disabilities.

The loss of the permanent designation means that the threat of losing the PWD benefit and its meager resources is now something all people with disabilities must live with. If, as I, and many other critical/feminist disability scholars argue, disability is dynamic not static, why shouldn’t this occur? To say that disability is a fluid experience is not the same as saying that someone has a disability one day and not the next - the fluidity happens within the overall experience of disability. The loss of the permanent designation is problematic because of the nature of the assessment, the work it requires, and the material consequences of not meeting the criteria. As I argued in the previous chapter, assessments are designed by non-disabled people according to ablest norms of performance, productivity, function, and behaviour. They do not take social location, context, or environmental barriers into account. Being reviewed every two to five years subjects women and men with disabilities to an intrusive scrutiny and monitoring process that requires them to “prove” over and over again that they are disabled enough to qualify

for this higher level of social assistance support and benefits. These proof giving processes are stressful, disempowering, and disabling because to prove disability one must prove one's inability - one's inadequacy, deficiency, inferiority, abnormality, dependence, and limitations in relation to the hegemonic "structures of normalcy" (Titchkosky, 2001, *Coming Out*, para 4).

There have also been many more administrative changes that have made accessing financial and health benefits more difficult. While people used to be able to get a disability benefits application form from Ministry offices and community agencies, the PWD application forms are only available from MHR offices after the applicant has undergone a financial eligibility test. Advocates from the BCCPD are hearing that people who left the Disability Benefits Program and are returning to the Employment and Assistance for Person with Disabilities Program have to complete the 23 page application form (McGregor, 2003a, p. 10). In order to reduce the money spent on health benefits, the Ministry is no longer paying for essential dental services that are above the cost of basic dental coverage (Loxton, 2003b, p. 19). Other cuts to benefits include a lack of funding for scooters because the new PWD legislation doesn't consider mobility outside the home a basic need. Orthotics are only provided if they will provide basic mobility, prevent surgery, or are needed post surgery (McGregor, 2003b, p. 17). And, the new legislation restricts the extra \$40 per month for a high protein diet to people with specific health conditions (Dyson, 2003, p. 13).

The privatizing and individualizing of the review process and these never ending administrative cuts make it more difficult to challenge the Ministry's actions because they happen to one person at a time. It is harder to raise public awareness and outrage

about these cuts and a review process that happens behind closed doors. While activists will continue to closely monitor such changes, it does mean that a lot of the movement's energies must be devoted to preventing further losses and working to regain those things which have been eliminated.

However, disability advocates at the BCCPD are also involved in a project that focuses on people with disabilities' human rights. The Poverty and Human Rights Project and the BCCPD are working together to see if the changes to disability benefits in the new legislation and regulations violate government commitments to people with disabilities guaranteed under International and domestic human rights laws (Brodsky & Dyson, 2003, p. 19). One of the critical issues this project addresses is the overwhelming silence about poverty in the Ministry's neoliberal discourse of welfare dependency, independence, employment, and active participation.

Contradictions

According to then Minister of Human Resources Murray Coell, (2002) the goals of Bill 27 were "greater independence for people with disabilities, including security of income, enhanced well-being and full participation as citizens" (p. 2920). My analysis of the review highlights the contradictions between these goals and the Ministry's policy changes and practices. To recap, these changes to the legislation included a return to a regressive functional definition of disability, the loss of the permanent disability designation, the replacement of the DB1 benefit with the PPMB and its tighter eligibility requirements, the three week waiting period for new applicants, a new appeal process which will make it harder to win appeals, an increase from one to two years duration for people with cyclical disabilities to qualify for the PWD benefit, and the imposition of the

two year time limit for those people with or without disabilities who rely on regular income assistance.

If this were not enough, the DDR review put thousands of people with disabilities through a stressful, frightening, harmful, and ultimately unnecessary review process which consumed the time, energy, and efforts of countless community advocates and health professionals across the province. As my analysis shows, contrary to its stated goals the review and the continual re-assessment are increasing people with disabilities' dependence on health, medical, and ministry professionals for assessment, and on informal supports by cuts to home care and other services. The new legislation subjects people with disabilities to increasing amounts of work to maintain their benefits and coerces them into an oppressive positioning to access the PWD benefit. The Ministry's stated goals co-opt the disability communities' demands for increased participation, independence, and employment by translating independence into an expectation that people with disabilities will participate in paid or unpaid work, rather than the definition of independence as defined by people with disabilities - greater control over decisions in their lives. Real participation would involve input into the program and not being coerced into paid or unpaid work as an expression of active citizenship.

The new legislation offers little attention to or acknowledgement of the many systemic barriers to education and employment for people with disabilities. In targeting resources to those whom the government has decided are most in need, and thus most deserving, by tightening the eligibility requirements of PWD benefits, by reducing health benefits, by putting people through a harmful and ultimately unnecessary review, by insisting on a highly medicalized, intrusive and ablest application process, the Ministry

has actually reduced the security of income, well-being, and full participation of many people with disabilities.

In the next chapter I revisit my research questions and conclusions, and discuss the implications of my project for research, theory, policy and practice.

CHAPTER SEVEN: CONCLUSION

I began my work on this thesis with a desire to analyze and understand what was happening to people with disabilities on social assistance so I could challenge it. I wanted to know how the Liberal government was using discourse to rationalize and justify its oppressive social assistance policies and practices. My community work has taught me the importance of understanding the state and how it works to avoid co-optation, and to see those spaces and opportunities for change that do exist. I wanted my research to produce an analysis that would be useful not only to myself, but to other advocates and allies working on disability issues in both the university and the community.

One of the critical points in the research process was the troubling of my own unexamined assumptions and understanding about the meaning of disability. I want to stress this aspect of the research process here because I came in as an ally quite confident of my awareness of the barriers and exclusions people with disabilities often face in their daily lives. During the research process I began to see my own unexamined assumptions about disability. My struggle to understand what was at stake in the debates about the meaning of disability and to see the hegemonic normalcy that structures people with disabilities' lives strengthened my ability to see the ablest assumptions and norms in the review. This struggle to learn and unlearn has been a critical piece of my ally work.

I began my project with the following research questions:

1. What are the dominant discourses used to rationalize BC's Disability Designation Review?
2. What power relations between the state and people with disabilities were constituted by these discourses?

3. How did disability advocates and their allies disrupt and challenge the government's discourses? What did they accomplish?

Key Findings

My research analyses the struggle facing people with disabilities who must rely on social assistance under neoliberalism. I approached the review as terrain of political struggle over the interpretation of people's needs - who needs what and who has the power to decide (Fraser, 1989). The Ministry's new social assistance legislation redefined people's needs. It decided that people on general income assistance needed to end their welfare dependency through employment, while people with disabilities needed "as much independence as possible" through their active participation in paid or unpaid work.

My analysis of the review confirms what other researchers have discovered about the changes to disability social assistance policies under neoliberal ideology and governing practices. As in other western countries, BC's welfare changes have been shaped by an ideological change in responsibility from the state to the individual. According to this rationale, people with disabilities' problem is their lack of independence, not poverty, the organization of work, employment and educational barriers, and conceptual oppression around who is normal. The silence about poverty in neoliberal discourse is deafening.

The details of welfare reform in BC - tighter eligibility requirements, active case management, increased monitoring and surveillance, inadequate benefits, and application forms which focus on functional inabilities rather than social and environmental barriers - are remarkably similar to those in Britain and Australia. Discourses of welfare dependency, mutual obligation, active participation, and independence co-opt disability

communities' discourse and obscure the power relations of employment, social assistance, and the state. The similarities highlight the dominance of neoliberal ideology and governing practices and the devastating effects they are having on people with disabilities in many western countries.

Situating the review within its broader historical and social context, I highlighted the significance of the loss of the CAP and federal changes to unemployment insurance for the disability movement's ongoing struggle to improve income support for people with disabilities.

My analysis of the Ministry's discursive strategies and rationale confirms and delineates the ways in which dominant discourses are used to legitimize and depoliticize policy practices such as the review. The Ministry used expert and reprivatizing medical discourses to depoliticize the review as a neutral, objective and thus harmless information gathering exercise. These medical discourses justified the Form's intrusive scrutiny of people with disabilities' behavior and functioning as necessary knowledge required to assess eligibility. My deconstruction of the objectivity and neutrality of the medical discourse and the Form's ablest assumptions of independence, normalcy, and disability challenge this depoliticization. I argue that the review - as a compulsory institutional procedure that positions people with disabilities as unable, incapable, abnormal and dependent - is hardly neutral. It is disabling. It constructs an oppressive subject position for people with disabilities that they must assume in order to qualify for the benefits they need to survive. This subjection is a violence against the people with disabilities who were forced to represent themselves according to the Ministry's ablest construction of disability which determines who is "normal." The Form's focus on functional assessment

ignores the significance of systemic barriers, policies, and practices in the construction of disability experience.

My research addresses a gap in the critical disability welfare literature about the resistance of people with disabilities to welfare restructuring. Disability advocates repoliticized the review by making its devastating effects visible, by linking it to the Ministry's changes to the definition of disability and its need to cut costs, and by challenging the systemic barriers that made the deadline so unworkable. My analysis of the discourses of resistance highlights the success of the resistance: 98% of people retained their PWD status. It also shows the extremely high costs of the review for individuals, advocates, families, and the disability movement as a whole. The review's credibility and legitimacy was so successfully challenged, that the Ministry backed away from its cost cutting agenda.

While the review is over the "welfare wars" continue through various administrative policies and cutbacks which make it more difficult for people to access and maintain their benefits. Administrative changes to the review practices of the PPMB program indicate that many people are losing their benefits when they are reviewed.

Implications for Research, Theory, Policy and Practice

Research

All research has inherent limitations as it reflects the interpretation of the researcher who brings the strength and limits of history, identity, context, knowledge, and perspective. Discourse analysis offers particular insights into the state and how it works and into the struggle facing people with disabilities under neoliberalism. But it cannot do everything. I have tried to be careful about the knowledge claims I have made using this

particular method of textual analysis. I reiterate the partiality of all knowledge not as an excuse for the inevitable limitations of my analysis, but as a reminder of the nature of any research process. There is much to be learned about this event in BC's history and as I moved through the research process I saw several possibilities for future research.

My approach to this research project was inspired, in part, by Dorothy Smith's method of institutional ethnography which guided how I approached the Form as a point of entry into the ruling relations that coordinate, govern and organize people with disabilities' on social assistance lives. I would like to see a research project explore the review by using this institutional ethnographic method which assumes that each of us is an "expert practitioner" in our daily lives (Smith, 1987). This means that the research process would begin with the expert knowledge of people with disabilities on social assistance who were reviewed. The research would inquire into their experience of disability, their dealings with the Ministry, their perspectives on the Form and the material and other effects of the review. This is knowledge that can only be gained by interviewing them. While my research is in solidarity with people with disabilities, it only documents aspects of their experience that were represented in the media as part of the resistance to the review. It does not capture the complexities of their experiences. This institutional ethnographic method would also include the perspectives of advocates, assessors, physicians, and ministry bureaucrats which would also provide the details and perspectives that are not available from public media. My analysis of the Ministry's discursive strategies shows how critical discourse analysis can be used to unpack the dominant assumptions, norms, and values of the review and challenge their depoliticizing effect. It also reveals the role of text-based discourses in coordinating and

organizing the relations of ruling. Combining qualitative interviews with people with disabilities, advocates, health professionals and ministry bureaucrats with my discourse analysis would offer a more complex picture of how the review worked that could inform future advocacy strategies.

As I analyzed the discourses of resistance I found myself wondering how disability advocates around the province would have described their sense of the constraints and possibilities, their strategies and what they learned, what they accomplished and the cost. I would like to see a qualitative research project explore these issues. While my research focuses on advocates from the BCCPD who spoke out in the media, there were many more advocates throughout the province who were involved. It would be useful to learn more about the specifics of how the review worked in rural areas and the longer term implications of the review on communities and community groups in both urban and rural areas.

It would also be useful to have a national study that compared the impact of the loss of CAP funding and the changes to social assistance programs for people with disabilities in BC, Alberta, Ontario and New Brunswick - the four provinces with separate disability social assistance programs. A national study could document the similarities and differences among the provinces and their effects on people with disabilities. This national perspective could be used to lobby for changes that would benefit people with disabilities across the country.

As I reviewed the Form I kept thinking about the need for research that explored the possibilities of assessing people with disabilities for benefits that would not subject them to such disempowering, oppressive, and pathologizing processes.

I also see the need for an action research project that would document what happened to the people on DB1 who were reviewed during 2002. This project could explore how many people were able to re-qualify and the impact of the recent administrative changes to the assessment process. It is also important to document what happened to the people who did not qualify for PPMB. Did they qualify for regular assistance and if so, how are they coping and surviving almost three years later? What has been the impact on their health? Have any of them re-applied for PWD assistance and been accepted? What have their dealings with the Ministry been like?

There were 314 people who dropped down from PWD to PPMB or general assistance as a result of the review. I wonder who they were and what has happened to them as a result of losing their designation. While it might be difficult to track them down, I think it would be worthwhile to document their experiences.

Lastly, I see the need for research that documents people with disabilities' experiences with the Ministry's employment services and programs. Are people on disability social assistance being pressured into paid or volunteer work? Are they expected to participate in pre-employment services or employment programs? Are they being asked/encouraged/pressured to sign employment plans? What has been the experience of people who have participated in these employment programs, and so on. This project would provide important information about how this aspect of the program is being put into practice and identify problem areas requiring monitoring and change.

Theory

In Chapter One I argued for the importance of including disability as a category of analysis in feminist research and the value of feminist theorizing for disability issues.

Most of the feminist welfare research I have come across during my research treats women and disability as separate categories and does not incorporate disability into its analysis. My research demonstrates what is gained when research about welfare issues uses a critical/feminist disability lens that troubles the ability/disability binary. It takes a critical disability lens to see that people with disabilities may be receiving social assistance under the PWD, the PPMB and the general social assistance categories. This insight makes it possible to see how the government's redefinition of disability erases some people with disabilities from government discourse as they and their needs are rendered invisible under these other categories.

A feminist approach to disability research challenges the notion of a unitary disability identity. While my research does not focus on the experiences of women with disabilities, it acknowledges the importance of social location in disability experience by paying attention to how issues of gender, race, and class influence the review. Without this attention to difference, disability research may reproduce gender, race, and sexuality inequities.

Policy

There are a number of policy implications arising from this research. Social assistance policies for people with disabilities need to be grounded in the knowledge, experience, and expertise of people with disabilities. Disability policy and practice needs to be guided by an understanding of disability as a socio-political issue so it can address the ablest social context which shapes people with disabilities' abilities and disabilities. This includes an understanding of disability experience as an interaction of embodiment, social location, and environmental factors. Policies that are guided by medical discourse

will only continue to individualize and pathologize people with disabilities as dependent, abnormal, and incapable.

As Fraser (1989) indicates in her theorizing of the welfare system as a juridical, administrative, and therapeutic state apparatus, the state typically determines peoples' needs in the absence of dialogue with those directly affected. People with disabilities are the experts on their lives. They need to give direction to the policy making processes that shape social assistance policy for people with disabilities, rather than always having their needs mediated by professionals and bureaucrats. In this particular case, disability advocates can also play an important role both in the needs discourse and in the monitoring of policy making and consultation processes for ablest assumptions. The participation of people with disabilities/disability advocates would also make visible the diverse needs, experiences, and barriers that women and men with disabilities face. This acknowledgement of diversity challenges the one size fits all orientation of the review and most government policy processes. While this democratization of the policy-making process is not likely to happen given the current neoliberal ideology, it is something to be struggled for.

Bill 27 has co-opted disability advocates' demands for greater participation for people with disabilities in all aspects of community life, by imposing active participation in paid or unpaid work as an expectation for all PWD recipients. I think it is important in this neoliberal context, which has attempted to reduce citizen's expectations of government, for disability advocates and their allies to challenge this co-optation by demanding meaningful participation in the policy-making process.

There are a number of specific policy changes I would like to support. As I noted earlier, social assistance policies which force anyone to live on \$510 a month with no bus pass, health benefits, or earnings exemption are literally disabling. So, the first policy change I would like to see is a substantial increase in the social assistance rates for everyone on social assistance, but especially people on general assistance. I would also like to see people on general assistance receive a subsidized bus pass, extended health benefits and the same \$500 earnings exemption currently available to people on PPMB and PWD.

I support the BCCPD's calls for new disability legislation that would restore the preamble from the Disability Benefits Program which "anchored the provision of BC's disability benefits within a respectful framework" (BC Coalition, 2005, inclusion, para 1). Other recommendations in their call for new legislation are a change to the definition that would restore the old criterion of extra costs associated with a disability. This more inclusive definition was designed to include people with mental health disabilities who may not need assistance with daily living activities. Other recommended policy changes would be to restore the permanent disability designation, increase disability rates, and replace the PPMB category with the Temporarily Excused (from seeking employment) category but to raise the benefit amount to match the PPMB rate (BC Coalition, 2005, Replace the, para, 4). This category requires only a doctor's letter and has no waiting period. One of the reasons for this change is that many people with permanent disabilities become stuck in this benefit which is geared toward people with a temporary condition (BC Coalition, 2005, Replace the para 2).

In Chapter Five I suggested some changes to the Form that challenged its assumptions of people with disabilities as dependent and unable. However these minor changes do not challenge the Form's positivist ideology, nor the functional definition of disability which the Form operationalizes. BCCPD's advocates are lobbying for a Form that is "shorter and easier to complete for both recipients and health care professionals." (Loxton and Dyson, 2005). In solidarity with these demands I would like to use what I have learned from my analysis to advocate for a simple, short, qualitative Form that does not medicalize, objectify, or disable - that expands the criteria for assessors to allow women and men with disabilities to select the person who can best speak to their day to day experience of living with a disability. A qualitative Form would acknowledge people with disabilities' knowledgeability and create a space for both the individual and the "assessor" to describe the person's disability experience in a way that does not require women and men with disabilities to represent themselves as completely incapacitated. The Form could provide space to document what individuals need to maintain their health and independence, and the impact of the lack of community resources and other barriers on their health and well-being. I would like to see a disability application Form that values experiential and embodied knowledge as credible knowledge, that takes into account the realities of people's lives and the specificities of their situation, and that moves beyond a reductive focus on abstract notions of structure and function that assess the worthiness of people's claims by adding up how many blocks they can walk unaided, how long they can remain seated, their cognitive and emotional deficits, or their need for help to feed and dress themselves.

Practice

This section is more difficult to write. I find myself still integrating the implications of this project for my practice. What I can say is that I know from my experience of doing equity work on campus during the course of this research project, that it has affected how I listen to people in positions of power, what I expect of them, and my understanding of how institutions work.

This research has been an act of resistance for me, a way to challenge the neoliberal and ablest discourses of the review and to document the invisible violence of this institutional procedure. It has given me a very close look at the devastating impact of neoliberal ideology on people with disabilities in BC. And of course the review is but one of many hundreds of examples of the impact of this ideology on people and communities.

My application of Fraser's (1989) work to the DDR review has been particularly useful because it has given me a framework which helps me to see the common and repetitive elements in political struggles. When I first came across Fraser's description of the politicizing and depoliticizing effects of oppositional, expert and reprivatizing discourses, it spoke not only to my sense of what was happening in the review, but to my experience in other struggles as well. Understanding the work these discourses perform has made it easier for me to recognize, and challenge institutional attempts to modify, displace or co-opt demands for change. Fraser's analysis of the moments of struggle over needs, makes it possible to more easily predict institutional responses and therefore to anticipate, plan, and respond.

It also highlights the fact that these struggles are ongoing and long term. All gains can be lost as disability and so many other community advocates saw when the BC

Liberals implemented their agenda of cuts and privatization in 2002. This knowledge means that gains, while they need to be celebrated, cannot be taken for granted. They need to be monitored.

What is needed to support sustainability over the long term in this neoliberal context is a good question, though not one I can answer. I have been noticing how the continual loss of “organizational memory” is a barrier to sustainability as skills, histories, and strategies are not passed on. And I know that systemic change requires the collaboration of many allies who can contribute to struggles in a variety of ways.

While I have seen language as an important strategy in my anti-violence and disability work, my analysis of the review has developed my understanding of discourse as not just words, but actions and interventions. It has sharpened my ability to hear the silences in any discourse and the taken for granted assumptions and norms dominant discourses rely upon. I find myself automatically listening to all public discourse with this deconstructive lens.

Final Thoughts

One of the reasons I returned to university after so many years of community work was my desire for time to think about and strengthen my understanding and analysis of the interlocking nature of oppression and the intersectionality of identities. I wanted to explore these issues with others, challenge my own thinking and ask new questions. I wanted to be able to make connections between oppressions without collapsing them - and to articulate what I knew but didn't yet have language for.

I also wanted more analytical resources with which to think about the implications of the shift to the right during the nineties and the federal government's downloading of

social programs to the provinces. These changes along with their accompanying discourses of deficit and debt had resulted in community groups spending most of their/our time trying to compete for ever scarcer resources to keep our organizations going, or being forced by the state into collaborations and partnerships driven by lack of funding.

My course work, campus activism, connections with students, staff, and faculty, and the thinking and struggles I have faced in this thesis and my life during the past few years, have developed my ability to think about and see the complexities and the specificities of identity, experience, history, and context in my analysis of the disability review, as well as the other social justice issues I am involved with on campus and in the community.

As I have been writing this last chapter I have been re-reading Sherene Razack's (1998) work on disability and anti-essentialism. I feel a sense of coming full circle as this is the work I was reading as I began the master's program. I return to this text with a deeper understanding of what Razack means by our need to move beyond a politics of inclusion to a politics of anti-subordination in which we are accountable for the ways in which we are implicated in the domination of others. Razack argues that when we see difference as residing in the person versus the social context we are able to ignore our role in producing it. A politics of anti-subordination in terms of disability politics asks what conditions transform a situation of physical and mental difference into one of disadvantage? People with disabilities do not need rescuing or pity, they need respect and solidarity in their struggle against the structures that create poverty, marginalization, and exclusion and the hegemony of ablest norms and assumptions that shape disabling

practices and processes such as the DDR. In that struggle for a politics of anti-subordination I find myself returning to the following questions: Who is describing and assessing the realities of whom, how do we hear these descriptions and what relations do they secure? (Razack, 1998, p. 169).

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APPENDIX A



**BRITISH
COLUMBIA**

Ministry of
Human Resources

PERSONS WITH DISABILITIES DESIGNATION APPLICATION INTRODUCTION

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the *Employment and Assistance for Persons With Disabilities Act*. The collection, use and disclosure of personal information is subject to the provisions of the *Freedom of Information and Protection of Privacy Act*. If you have any questions about the collection, use or disclosure of this information, please contact your local Employment and Assistance Centre.

The purpose of this form is to collect the information necessary to determine eligibility for the Person with Disabilities designation under the *Employment and Assistance for Persons with Disabilities Act*.

This Application has three Sections:

- Section 1: **Applicant Information** (for completion by the Applicant) - The term "Applicant" used throughout the form means a client who is applying for the Person with Disabilities designation.
- Section 2: **Physician Report** (for completion by the Applicant's Physician) - References to "Physician" in this application have the same meaning as "Medical Practitioner".
- Section 3: **Assessor Report** (for completion by a health professional)

PLEASE DO NOT TAKE THIS BOOKLET FORM APART - PLEASE KEEP TOGETHER

Instructions for completion

1. The above sections of the Application Form need to be completed in the order listed.
2. The Applicant is to complete Section 1, Applicant Information, sign the Declaration, and take the form to his/her physician for completion of the Physician Report.
3. The Applicant's Physician is to complete Section 2, Physician Report, and return the Application Form to the Applicant.
4. The Applicant will then take the form to a Health Professional (as defined in Section 3) for completion of Section 3, Assessor Report.
5. The Health Professional is to complete Section 3, Assessor Report, and return the Application Form to the Applicant.
6. Applicant - please review the checklist at the end of this booklet to ensure your application is complete.
7. The Applicant will then mail the application to the Health Assistance Branch, Ministry of Human Resources using the enclosed self-addressed envelope.

Office Use Only

The following must be signed in order for the application to be processed

The Applicant is in receipt of Income Assistance or would qualify for assistance under the *Employment and Assistance for Persons With Disabilities Act* if found eligible for the Person with Disabilities (PWD) designation.

Ministry Signing Authority (Print Name)	Signature
Employment and Assistance Centre Stamp	Date Signed (YYYY MM DD)

HR2583 (03/01/20)

Page 1 of 23

Sample



BRITISH
COLUMBIA

Ministry of
Human Resources

PERSONS WITH DISABILITIES
DESIGNATION APPLICATION
SECTION 1
APPLICANT INFORMATION

You may have someone help you complete this Section of the Application.

Important Note: You **MUST** sign the "Declaration" on page 5 of this form in order for your application to be processed.

A - PERSONAL INFORMATION			
Last Name	First Name	Middle Name	Date of Birth (YYYY MM DD)
Personal Health Number		Social Insurance Number (optional)	Telephone Number
Street Address		City	Postal Code

Do you need help completing this application?

☐

Yes

☐

No

If yes, what help do you need?

B - DISABLING CONDITION

This section provides you with an opportunity to describe your disability and the impact it has on your life. You are not required to complete this section. If you do not complete this Section, your application will be considered based on information provided in the Physician and Assessor Sections of this Application.

☐

I choose not to complete this self-report. (Please proceed to Declaration on page 5)

Note - If more space is required, you may attach additional pages.

1. Please describe your disability.

B - DISABLING CONDITION (cont'd)

2. How does your disability affect your life and your ability to take care of yourself?

Sample

B - DISABLING CONDITION (cont'd)

C - DECLARATION AND NOTIFICATION

I, _____, am applying for designation as a person with disabilities as set out in the *Employment and Assistance for Persons with Disabilities Act* and I declare that the information provided in Section 1A and 1B is true and complete. I understand that I will have the opportunity to review completed Section 2, Physician Report and Section 3, Assessor Report before submitting the completed designation application form to the Ministry of Human Resources. I understand that the BC government may verify the information in Section 1A, Section 2 and Section 3, as necessary to determine and confirm my eligibility for the designation.

*Applicant Signature _____

Witness Signature _____

Date Signed (YYYY MMM DD) _____

Witness Name (Please Print) _____

Witness Address & Telephone _____

* If the Applicant is incapable of signing this Application, it may be signed by a person who has legal authority to act on behalf of the Applicant as applicable under provisions of relevant BC legislation, for example, a committee, or a person with an enduring power of attorney. If you are signing on behalf of the Applicant, you must state your legal authority to act on behalf of the Applicant and you must attach proof of that legal authority (for example, a copy of the court order naming you as Committee) to this Application.

My legal authority to act for the applicant is _____

NOTE: Proof of Committee, Power of Attorney and/or Parent/Guardian status must accompany this Application.



BRITISH
COLUMBIA

Ministry of
Human Resources

PERSONS WITH DISABILITIES
DESIGNATION APPLICATION
SECTION 2
PHYSICIAN REPORT

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the *Employment and Assistance for Persons With Disabilities Act*. The collection, use and disclosure of personal information is subject to the provisions of the *Freedom of Information and Protection of Privacy Act*. If you have any questions about the collection, use or disclosure of this information, please contact your local Employment and Assistance Centre.

This section is to be filled out by a physician registered and licensed to practice in British Columbia. The Physician completing this Section of the application may also complete Section 3, Assessor Report.

The purpose of the Physician Report is to provide information to the ministry about the applicant's physical or mental impairments associated with diagnosed medical conditions relevant to this application for a **Person with Disabilities (PWD)** designation. The emphasis is on how the medical conditions and impairment affect the Applicant's ability to perform Daily Living Activities as defined in the *Regulations* pursuant to the *Employment and Assistance for Persons with Disabilities Act*. This Application is **not** intended to assess employability or vocational abilities.

Please answer all questions completely as this will assist the Ministry of Human Resources, Health Assistance Branch, in determining whether the Applicant meets the criteria for designation as a person with disabilities.

The contents of this report are confidential, but are subject to the following conditions:

- the report will be shared with the applicant;
- the report will be shared with the Health Professional completing Section 3 of this Application;
- the report will be shared with the Employment and Assistance Appeal Tribunal if an appeal is initiated regarding eligibility for the Person with Disabilities (PWD) designation; and
- the report may be reviewed by a health professional consulting with the Ministry of Human Resources.

Fee

Payment of fees for completion of the Physician Report is provided through the Medical Services Plan. Payment will be made in accordance with the rate established by the Ministry of Human Resources provided that:

1. The Application process has been initiated by the Ministry of Human Resources Employment and Assistance Centre as indicated by the Office stamp and signature on the cover page of this Application; and
2. The Physician has fully completed Section 2 of the Application.

Please keep a copy of the completed Section 2 of this form until such time as you receive payment for your fee.

Physicians having questions regarding this application may contact the Health Assistance Branch,
Ministry of Human Resources at 1-888-356-6564

PROGRAM DEFINITIONS

Designation of Persons with Disabilities (PWD)

Following is an extract of the section in the *Employment and Assistance for Persons With Disabilities Act* that sets out the criteria for designation as a person with disabilities.

2(1) In this section:

"assistive device" means a device designed to enable a person to perform a daily living activity that, because of a severe mental or physical impairment, the person is unable to perform;

"daily living activity" has the prescribed meaning;

"health professional" means a person who is authorized under an enactment to practice the profession of:

- (a) a medical practitioner,
- (b) a registered psychologist,
- (c) a registered nurse or registered psychiatric nurse,
- (d) an occupational therapist,
- (e) a physical therapist, or
- (f) a social worker.

2(2) The minister may designate a person who has reached 18 years of age as a person with disabilities for the purposes of this ACT if the minister is satisfied that the person has a severe mental or physical IMPAIRMENT that

- (a) in the opinion of a medical practitioner is likely to continue for at least 2 years, and
- (b) in the opinion of a health professional
 - (i) directly and significantly restricts the person's ability to perform DAILY LIVING ACTIVITIES either
 - (A) continuously, or
 - (B) periodically for extended periods, and
 - (ii) as a result of those restrictions, the person requires help to perform those activities.

2(3) For the purposes of subsection (2),

- (a) a person who has a severe mental impairment includes a person with a mental disorder, and
- (b) a person requires help in relation to a daily living activity if, in order to perform it, the person requires
 - (i) an assistive device,
 - (ii) the significant help or supervision of another person, or
 - (iii) the services of an assistance animal.

2(4) The minister may rescind a designation under subsection (2).

TO BE COMPLETED BY THE APPLICANT'S PHYSICIAN ONLY

A - DIAGNOSES				
Specify diagnoses related to the Applicant's impairment using the diagnostic codes below. "Impairment" is a loss or abnormality of psychological, anatomical or physiological structure or function causing a restriction in the ability to function independently, effectively, appropriately or for a reasonable duration. Please include additional information as required.				Date of onset, if known
	Diagnostic Code	Specific Diagnosis (e.g. location of paralysis, type of respiratory or heart condition, type of hepatitis, etc.)	Month	Year
1.				
2.				
3.				
4.				
5.				
Comments:				

DIAGNOSTIC CODES

Infectious and parasitic diseases

- 1.0 Other
- 1.1 HIV
- 1.2 AIDS
- 1.3 Hepatitis
- 1.4 Hepatitis C

Neoplasms

- 2.0 Neoplastic disorders - other
- 2.1 Lip, oral cavity & pharynx
- 2.2 Digestive organs & peritoneum
- 2.3 Respiratory & intrathoracic organs
- 2.4 Bone, connective tissue, skin and breast
- 2.5 Genitourinary organs
- 2.6 Leukemia

Endocrine, nutritional and metabolic diseases, and immunity disorders

- 3.0 Endocrine disorders - other
- 3.01 Immune disorders - other
- 3.02 Metabolic disorders - other
- 3.1 Thyroid disorders
- 3.2 Diabetes

Diseases of the blood and blood-forming organs

- 4.0 Other diseases of the blood
- 4.1 Anemia
- 4.2 Hemophilia

Mental disorders

- 5.0 Other mental (please specify)
- 5.1 Delirium, dementia & amnesic & other cognitive disorders
- 5.2 Schizophrenia & other Psychotic disorders
- 5.3 Mood disorders
- 5.4 Developmental disability
- 5.5 Anxiety disorders
- 5.6 Somatoform disorders
- 5.7 Personality disorders
- 5.8 Substance-related disorders
- 5.9 Pervasive developmental disorders
- 5.10 Eating disorders

Diseases of the nervous system & sense organs - Neurological

- 6.0 Neurological disorders - other
- 6.1 Epilepsy
- 6.2 Brain tumors
- 6.3 Parkinson's disease
- 6.4 Cerebral palsy
- 6.5 Paraplegia
- 6.7 Quadraplegia
- 6.9 Other paralysis
- 6.10 Myasthenia Gravis
- 6.11 Muscular dystrophy
- 6.12 ALS
- 6.13 Alzheimer's disease
- 6.14 Huntington's chorea
- 6.15 Friedreich's Ataxia
- 6.16 Multiple sclerosis

Conditions of the nervous system & sense organs - Sensory

- 7.00 Sensory disorders - other
- 7.01 Blindness
- 7.02 Visually impaired
- 7.03 Deafness
- 7.04 Hearing impaired
- 7.05 Organic speech loss

Diseases of the circulatory system

- 8.0 Cardiovascular - other
- 8.1 Ischemic heart disease
- 8.2 Recurrent Arrhythmias
- 8.3 Valvular heart disease
- 8.4 Congenital heart disease
- 8.5 Cardiomyopathy
- 8.6 Chronic venous insufficiency
- 8.7 Peripheral arterial disease
- 8.8 Cerebral vascular accident

Diseases of the respiratory system

- 9.0 Respiratory disorders - other
- 9.1 Cystic fibrosis
- 9.2 COPD
- 9.3 Asthma
- 9.4 Emphysema

Diseases of the digestive system

- 10.0 Digestive disorders - other
- 10.1 Peptic ulcer
- 10.2 Chronic liver disease
- 10.3 Cirrhosis
- 10.4 Crohn's disease
- 10.5 Colitis

Diseases of the genitourinary system

- 11.0 Genitourinary disorders - other

- 11.1 Kidney disease

Diseases of the skin and subcutaneous tissue

- 12.0 Skin disorders - other
- 12.1 Psoriasis

Diseases of the musculoskeletal system and connective tissue

- 13.0 Musculoskeletal system - other
- 13.1 Lupus
- 13.2 Rheumatoid arthritis
- 13.3 Arthritis
- 13.4 Osteoporosis
- 13.5 Ankylosing spondylitis
- 13.6 Degenerative disc disease
- 13.7 Scoliosis
- 13.8 Fibromyalgia
- 13.9 Scleroderma

Congenital anomalies

- 14.0 Congenital anomalies - other
- 14.1 Chromosomal abnormalities
- 14.2 Fetal alcohol syndrome
- 14.3 Thalidomide syndrome
- 14.4 Spina Bifida

Injury and poisoning

- 15.0 Injury and poisoning - other
- 15.1 Traumatic brain injury
- 15.2 Amputations

Other conditions

- 16.0 Other
- 16.1 Chronic fatigue syndrome
- 16.2 Sleep apnea
- 16.3 Environmental sensitivities

B. HEALTH HISTORY

1. Please indicate the severity of the medical conditions relevant to this person's impairment. How does the medical condition impair this person? Test results and other reports or findings may be used here where appropriate.

Sample

2. Height and Weight (if relevant to the impairment)

Height: _____

Weight: _____

3. Has the applicant been prescribed any medication and/or treatments that interfere with his/her ability to perform daily living activities?

☐ Yes ☐ No

If yes, please explain:

Sample

If yes, what is the anticipated duration of the medications/treatments:

Sample

4. Does the applicant require any prostheses or aids for his/her impairment? ☐ Yes ☐ No

If yes, please explain:

Sample

Sample

Sample

C - DEGREE AND COURSE OF IMPAIRMENT

1. Is the impairment likely to continue for two years or more from today? ☐ Yes ☐ No
What is the estimated duration of the impairment and are there remedial treatments that may resolve or minimize the impairment?

Please explain:

D - FUNCTIONAL SKILLS

Note: For the purposes of questions #1 and #2, "unaided" means without the assistance of another person, assistive device or assistance animal

1. How far can this person walk unaided on a flat surface?
☐ 4+ blocks ☐ 1 to 3 blocks ☐ Unknown
☐ 2 to 4 blocks ☐ Less than 1 block ☐ Not at all
2. How many stairs can this person climb unaided?
☐ 5+ steps ☐ 2 to 5 steps ☐ None ☐ Unknown
3. What are the person's limitations in lifting?
☐ No limitations ☐ 2 to 7 kg (5 to 15 lbs) ☐ No lifting
☐ 7 to 16 kg (15 to 35 lbs) ☐ Under 2 kg (Under 5 lbs) ☐ Unknown
4. How long can this person remain seated?
☐ No limitation ☐ 1 to 2 hours ☐ Unknown
☐ 2 to 3 hours ☐ Less than 1 hour
5. Are there difficulties with communication other than a lack of fluency in English? ☐ Yes ☐ No
If yes, what is the cause: ☐ Cognitive ☐ Motor ☐ Sensory ☒ Other

Comments:

6. Are there any significant deficits with cognitive and emotional function? ☐ Yes ☐ No ☐ Unknown
If yes, check those areas where the deficits are evident and provide details below:

- | | |
|--|---|
| <input type="checkbox"/> Consciousness (orientation, confusion) | <input type="checkbox"/> Emotional disturbance (e.g. depression, anxiety) |
| <input type="checkbox"/> Executive (planning, organizing, sequencing, calculations, judgement) | <input type="checkbox"/> Motivation (loss of initiative or interest) |
| <input type="checkbox"/> Language (oral, auditory, written comprehension or expression) | <input type="checkbox"/> Impulse control |
| <input type="checkbox"/> Memory (ability to learn and recall information) | <input type="checkbox"/> Motor activity (goal oriented activity, agitation, repetitive behaviour) |
| <input type="checkbox"/> Perceptual psychomotor (visual spatial) | <input type="checkbox"/> Attention or sustained concentration |
| <input type="checkbox"/> Psychotic symptoms (delusions, hallucinations, thought disorders) | <input type="checkbox"/> Other (specify) _____ |

Comments:

E - DAILY LIVING ACTIVITIES

Note: If you are completing the Assessor Report, Section 3, in addition to this Physician Report, do not complete this page, (Part E)

Does the impairment directly restrict the person's ability to perform Daily Living Activities?

☐ Yes ☐ No ☐ Unknown

If yes, please complete the following table:

Daily Living Activities	Is Activity Restricted? (check one) If yes, describe extent of restriction in "comments" below			If yes, the restriction is: (check one)	
	Yes	No	Unknown	Continuous ¹	Periodic ²
Personal self care	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Meal preparation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Management of medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Basic housework	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Daily shopping	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility inside the home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mobility outside the home	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Management of finances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Social functioning** - daily decision making; interacting, relating and communicating with others (this category only applies for persons with an identified mental impairment or brain injury): If yes, please provide details	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

* If "Periodic", please explain:

** If Social Functioning is impacted, please explain:

Please provide additional comments regarding the degree of restriction:

What assistance does your patient need with Daily Living Activities? ("Assistance" includes help from another person, equipment and assistance animals.) Please be specific regarding the nature and extent of assistance required.

¹ Continuous assistance - refers to needing significant help most or all of the time for an activity.

² Periodic assistance - refers to the need for significant help for an activity some of the time as would be the case where a person required help due to the episodic nature of the impairment.

F - ADDITIONAL COMMENTS

Please provide any additional information that you consider relevant to an understanding of the significance of the person's medical condition, the nature and extent of this person's impairment and the impact these have on his/her daily functioning (e.g., hospitalization related to the impairment.)

G - FREQUENCY OF CONTACT

How long has the Applicant been your patient?

Prior to today, how often have you seen the Applicant in the past 12 months?

☐ 0 ☐ Once ☐ 2 - 10 ☐ 11 or more

Comments:

H - CERTIFICATION

I, _____, am a physician registered with the College of Physicians and Surgeons of British Columbia and licensed to practice clinical medicine in BC.

☐ I am a General Practitioner

☐ I am a specialist in _____

Medical Practitioner Number: _____

This report (and attached documents) contains my findings and considered opinion at this time.

Signature

Date (YYYY MMM DD)

Telephone

Fax

E-mail Address (optional)

Print / Stamp Address



**BRITISH
COLUMBIA**

Ministry of
Human Resources

**PERSONS WITH DISABILITIES
DESIGNATION APPLICATION
SECTION 3
ASSESSOR REPORT**

The personal information requested on this form is collected under the authority of and will be used for the purpose of administering the *Employment and Assistance for Persons With Disabilities Act*. The collection, use and disclosure of personal information is subject to the provisions of the *Freedom of Information and Protection of Privacy Act*. If you have any questions about the collection, use or disclosure of this information, please contact your local Employment and Assistance Centre.

This Assessor Report is to be completed by one of the following health professionals: Medical Practitioner, Registered Psychologist, Registered Nurse or Registered Psychiatric Nurse, Occupational Therapist, Physical Therapist or Social Worker.

The purpose of the Assessor Report is to document the Applicant's impairments and their impact on performance of Daily Living Activities as defined in the *Regulations* pursuant to the *Employment and Assistance for Persons With Disabilities Act*. The Application is not intended to assess employability or vocational abilities.

This section should be completed by a health professional having a history of contact and recent experience with the applicant. **Please complete this section based on your knowledge of the Applicant, observations, clinical data and experience.**

Please answer all questions completely as this will assist the Ministry of Human Resources, Health Assistance Branch, in determining whether the applicant meets the criteria for designation as a person with disabilities.

The contents of this report are confidential but are subject to the following understandings:

- the report will be shared with the applicant;
- the report may be shared with the Physician completing Section 2 of this application;
- the report will be shared with the Employment and Assistance Appeal Tribunal if an appeal is initiated regarding eligibility for the Persons with Disabilities (PWD) designation; and
- the report may be reviewed by a health professional consulting with the Ministry of Human Resources.

Fee

Payment will be made in accordance with the rate established by the Ministry of Human Resources provided that:

1. The Application process has been initiated by the Ministry of Human Resources Employment and Assistance Centre as indicated by the Office stamp and signature on the cover page of this Application; and
2. The Health Professional has fully completed Section 3 of the Application.

Fees for physicians completing this section are paid through the Medical Services Plan. Other Health Professionals completing this section may submit an invoice in the amount of \$75 to the Ministry of Human Resources at the following address (please use tear-off invoice on page 23):

Ministry of Human Resources
Health Assistance Branch
PO Box 9971 Stn Prov Govt
Victoria, B.C. V8W 9R5

Please keep a copy of the fully completed Section 3 of this form until such time as you receive payment for your fee.

Assessors having questions regarding this application may contact the Health Assistance Branch.

Ministry of Human Resources at 1-888-356-6564

PROGRAM DEFINITIONS

Designation of Persons with Disabilities (PWD)

Following is an extract of the section in the *Employment and Assistance for Persons With Disabilities Act* that sets out the criteria for designation as a person with disabilities.

2(1) In this section:

"assistive device" means a device designed to enable a person to perform a daily living activity that, because of a severe mental or physical impairment, the person is unable to perform;

"daily living activity" has the prescribed meaning;

"health professional" means a person who is authorized under an enactment to practice the profession of:

- (a) a medical practitioner,
- (b) a registered psychologist,
- (c) a registered nurse or registered psychiatric nurse,
- (d) an occupational therapist,
- (e) a physical therapist, or
- (f) a social worker.

2(2) The minister may designate a person who has reached 18 years of age as a person with disabilities for the purposes of this ACT if the minister is satisfied that the person has a severe mental or physical IMPAIRMENT that

- (a) in the opinion of a medical practitioner is likely to continue for at least 2 years; and
- (b) in the opinion of a health professional
 - (i) directly and significantly restricts the person's ability to perform DAILY LIVING ACTIVITIES either
 - (A) continuously, or
 - (B) periodically for extended periods; and
 - (ii) as a result of those restrictions, the person requires help to perform those activities.

2(3) For the purposes of subsection (2),

- (a) a person who has a severe mental impairment includes a person with a mental disorder; and
- (b) a person requires help in relation to a daily living activity if, in order to perform it, the person requires
 - (i) an assistive device,
 - (ii) the significant help or supervision of another person, or
 - (iii) the services of an assistance animal.

2(4) The minister may rescind a designation under subsection (2).

A - LIVING ENVIRONMENT1. Does the Applicant live ☐ Alone? ☐ With Family, Friends, or Caregiver? ☐ In a Care Facility?

Comment:

B - MENTAL OR PHYSICAL IMPAIRMENT*"Impairment" is a loss or abnormality of psychological, anatomical or physiological structure or functioning causing a restriction in the ability to function independently, effectively, appropriately or for a reasonable duration.*

1. What are the applicant's mental or physical impairments that impact his/her ability to manage Daily Living activities? (brief summary)

2. Ability to Communicate

Please indicate the level of ability in the following areas:

Speaking

Reading

Writing

Hearing

Comments:

3. Mobility and Physical AbilityIndicate the assistance required related to impairment(s) that directly restrict the applicant's ability to manage in the following areas. Check all that apply.

Walking indoors

Walking outdoors

Climbing stairs

Standing

Lifting

Carrying and holding

Comments:

¹ Periodic assistance - refers to the need for significant help for an activity some of the time as would be the case where a person required help due to the episodic nature of the impairment.² Continuous assistance - refers to needing significant help most or all of the time for an activity.

C - DAILY LIVING ACTIVITIES						
Indicate the assistance required related to impairment(s) that directly restrict the applicant's ability to manage in the following areas. <u>Check all that apply.</u>	in dependent	Periodic assistance ³ from another person	Continuous assistance ⁴ from another person or unable	Uses Assistive device (Explain)	Takes significantly longer than typical (describe how much longer)	Explain / Describe
Personal Care						
1. Dressing						
2. Grooming						
3. Bathing						
4. Toileting						
5. Feeding self						
6. Regulate diet ⁵						
7. Transfers (in/out of bed)						
8. Transfers (on/off of chair)						
Basic Housekeeping						
1. Laundry						
2. Basic Housekeeping						
Shopping						
1. Going to and from stores						
2. Reading prices and labels						
3. Making appropriate choices						
4. Paying for purchases						
5. Carrying purchases home						
Additional comments (including a description of the type and amount of assistance required and identification of any safety issues):						

³ Periodic assistance - refers to the need for significant help for an activity some of the time as would be the case where a person required help due to the episodic nature of the impairment.

⁴ Continuous assistance - refers to needing significant help most or all of the time for an activity.

⁵ For example, issues related to eating disorders characterized by major disturbances in eating behaviour.

C - DAILY LIVING ACTIVITIES (cont'd)

Indicate the assistance required related to impairment(s) that directly restrict the applicant's ability to manage in the following areas. Check all that apply.

	Independent	Periodic assistance from another person	Continuous assistance from another person or unable	Uses Assistive device (Explain)	Takes significantly longer than typical (describe how much longer)	Explain / Describe
Meals						
1. Meal planning						
2. Food preparation						
3. Cooking						
4. Safe storage of food (ability, not environmental circumstances)						
Pay Rent and Bills						
1. Banking						
2. Budgeting						
3. Pay rent and bills						
Medications						
1. Filling/Refilling prescriptions						
2. Taking as directed						
3. Safe handling and storage						
Transportation						
1. Getting in and out of a vehicle						
2. Using public transit (where available)						
3. Using transit schedules and arranging transportation						
Additional comments (including a description of the type and amount of assistance required and identification of any safety issues): <hr/> <hr/> <hr/> <hr/>						

C - DAILY LIVING ACTIVITIES (cont'd)

Social Functioning Only complete this if the Applicant has an identified mental impairment, including brain injury.

Indicate the support/supervision required, as related to restrictions in the following areas:	Independent	Periodic Support/Supervision	Continuous Support/Supervision	Explain / Describe (include a description of the degree and duration of support/supervision required)
Appropriate social decisions (incl. avoiding situations dangerous to self or others, good social judgement)				
Able to develop and maintain relationships				
Interacts appropriately with others (e.g., understands and responds to social cues, problem solves in social context)				
Able to deal appropriately with unexpected demands				
Able to secure assistance from others				
Other (specify) _____				
<p>Describe how the mental impairment impacts the applicant's relationship with his/her:</p> <ul style="list-style-type: none"> immediate social network (partner, family, friends) <ul style="list-style-type: none"> <input type="checkbox"/> good functioning - positive relationships: assertively contributes to these relationships <input type="checkbox"/> marginal functioning - little significant participation/communication: relationships often minimal and fluctuate in quality <input type="checkbox"/> very disrupted functioning - aggression or abuse: major withdrawn: often rejected by others <p>Comments: _____</p>				
<ul style="list-style-type: none"> extended social networks (neighbourhood contacts, acquaintances, storekeepers, public officials, etc.) <ul style="list-style-type: none"> <input type="checkbox"/> good functioning - positive interacts in community: often participates in activities with others <input type="checkbox"/> marginal functioning - little more than minimal acts to fulfil basic needs <input type="checkbox"/> very disrupted functioning - overly disruptive behaviour: major social isolation <p>Comments: _____</p>				
<p>If the applicant requires help, as indicated above, please describe the support/supervision required which would help to maintain him/her in the community.</p> <p>_____</p> <p>_____</p>				
<p>Additional Comments (including identification of any safety issues):</p> <p>_____</p> <p>_____</p>				

D - ASSISTANCE PROVIDED FOR APPLICANT

Assistance provided by other people

The help required for daily living activities is provided by:

- | | | |
|----------------------------------|---|---|
| <input type="checkbox"/> Family | <input type="checkbox"/> Health Authority Professionals (e.g., Nurse) | <input type="checkbox"/> Community Service Agencies |
| <input type="checkbox"/> Friends | <input type="checkbox"/> Volunteers | <input type="checkbox"/> Other |

Comments: _____

If help is required but there is none available, please describe what assistance would be necessary.

Assistance provided through the use of Assistive Devices

What equipment or devices does the Applicant routinely use to help compensate for his/her impairment?

Check (✓) appropriate item(s):

- | | | | |
|--|---|---|--|
| <input type="checkbox"/> Cane | <input type="checkbox"/> Lifting device | <input type="checkbox"/> Feeding device | <input type="checkbox"/> Communication devices |
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Hospital bed | <input type="checkbox"/> Breathing device | <input checked="" type="checkbox"/> Interpretive services |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Prosthesis | <input type="checkbox"/> Commode | <input type="checkbox"/> Toileting aids |
| <input type="checkbox"/> Manual Wheelchair | <input type="checkbox"/> Splints | <input type="checkbox"/> Urological appliance | <input type="checkbox"/> Bathing aids |
| <input type="checkbox"/> Power Wheelchair | <input type="checkbox"/> Braces | <input type="checkbox"/> Ostomy appliance | <input type="checkbox"/> Other |
| <input type="checkbox"/> Scooter | | | <input type="checkbox"/> Specially designed adaptive housing |

Please provide details on any equipment or devices used by the applicant:

If equipment is required but is not currently being used, please describe the equipment or device that is needed:

Assistance provided by Assistance Animals

Does the applicant have an Assistance Animal? ☐ Yes ☐ No

If yes, please specify either the nature of the assistance provided by the animal or the need:

E - ADDITIONAL INFORMATION

Please provide any additional information that may be relevant to understanding the nature and extent of the applicant's impairment and its effect on daily living activities.



F - APPROACHES AND INFORMATION SOURCES

What approaches and information sources did you use to complete this form:

- ☐ office interview with applicant. _____
- ☐ home assessment _____
- ☐ other assessments (specify) _____
- _____
- ☐ file/chart information (specify) _____
- _____
- ☐ family/friends/caregivers (specify) _____
- ☐ other professionals (specify) _____
- ☐ community services (specify) _____
- ☐ other (specify) _____

[illegible]

G - FREQUENCY OF CONTACT

1. Is this your first contact with the applicant? ☐ Yes ☐ No

2. How long have you known this applicant? _____

3. How often have you seen this person in the last year?

☐ Once ☐ 2 - 10 times ☐ 11 or more times

4. Briefly describe the type and duration of the program or services you or your organization are providing or have provided to the applicant.

H - CERTIFICATION

I, _____, am a _____ practicing in
British Columbia. (enter professional discipline)

I am registered with a professional regulatory body ☐ Yes ☐ No

Name of regulatory body: _____

My registration number is: _____

I am employed by:

☐ self-employed; private practice ☐ A Health Authority

☐ Other employer (please specify) _____

This report (and attached documents) contains my findings and considered opinion at this time.

Signature

Date (YYYY MMM DD)

Telephone

Fax

E-mail Address (optional)

Print / Stamp Address

CHECKLIST

APPLICANT CHECKLIST

- ☐ Have you completed Section 1, Applicant Information?
- ☐ Have you read and signed the declaration, Section 1C?
- ☐ Has the Physician Report, Section 2, been completed and signed?
- ☐ Has the Assessor Report, Section 3, been completed and signed?
- ☐ Did you keep a photocopy for your records?
- ☐ Did you remember to include any additional information you want considered?
- ☐ Has proof of legal authority to act on behalf of the applicant been attached?
- ☐ Do you wish to be notified when your application is received by Health Assistance Branch?
If so, please check here and complete the form below
- ☐ Using the enclosed self-addressed envelope, please mail your completed application to:

Health Assistance Branch
Ministry of Human Resources
PO Box 9999 Str Prov Govt
Victoria, B.C. V8W 9W9

CONFIRMATION OF APPLICATION RECEIVED BY HEALTH ASSISTANCE BRANCH

Your Application was received on:

Name
Address
City/Town
Postal Code

HR0283 (03/01/99)

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ASSESSOR'S INVOICE

Invoice No.	Invoice Date		
Applicant Name	Applicant DOB	Personal Health Number	
Date of Service	Description of Service	Completion of PWD Assessors Section \$75.00	
Make cheque payable to:			
Supplier Name			
Address		Postal Code	Telephone
Supplier Signature			

Sample

**Ministry of Human Resources
Health Assistance Branch
P.O. Box 9971 Stn Prov Govt
Victoria, B.C. V8W 9R5**