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POLICY PAPER

Workers with Disabilities and Disability Justice

Please note that this paper deals with the following subjects. Should you need support, the Government of Canada has compiled a list of mental health supports available at this link:

https://www.canada.ca/en/public-health/services/mental-health-services/mental-health-get-help.html

Please take care when reading.

- Ableism
- Ageism
- Derogatory language (either presented as words that are slurs and should not be used or to discuss words that have been reclaimed by some people with disabilities)
- Discrimination against 2SLGBTQIA+ people
- Discrimination and violence against people with disabilities (including situations that end in death)
- Eugenics
- Intimate partner violence
- Medical assistance in dying
- Racism
- Sexism
- State legislated poverty
- Xenophobia

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Workers with Disabilities and Disability Justice

INTRODUCTION

According to the *Canadian Survey on Disability, 2017 to 2022* (CSD), 27% of Canadians aged 15 years and older, or 8 million people, had one or more disabilities.[1] The *Accessible Canada Act* defines disability as, “any impairment, including a physical, mental, intellectual, cognitive, learning, communication or sensory impairment — or a functional limitation — whether permanent, temporary or episodic in nature, or evident or not, that, in interaction with a barrier, hinders a person’s full and equal participation in society.”[2] People can be born with disabilities and/or can acquire a disability at any point in their lives. Disabilities can be permanent, temporary, or episodic.

When thinking about disability, it’s crucial to take an intersectional approach. While a key tenant of Black feminism for centuries, the term intersectionality was coined by civil rights advocate and legal scholar Kimberlé Crenshaw as a critique of feminism and anti-racism to describe the unique forms of discrimination faced by Black women in a specific legal case.[3] In the present day, intersectionality is used as a framework for understanding how connected systems of structures and power interact with multiple categories of social identity to create inseparable forms of inequality, oppression, and discrimination.[4]

No two people with disabilities are exactly alike. Two people with the same disability can experience their disability in different ways due to the severity of their disability, other health factors, the types of support systems they have, etc. Additionally, social categories like age, gender, race, sexual orientation, religious beliefs, etc., interact with disability in different ways. For example, a Black woman with a disability’s experience of being Black, being a woman, and having a disability, is a combination of experience that occurs because of all three social categories.

When people think about disabilities, they often picture someone with a physical disability or a mental disability. However, there are a number of ways to classify different types of disabilities. The CSD sorted data on disabilities into 10 categories: mental-health related, pain-related, seeing, learning, memory, mobility, flexibility, hearing, dexterity, and developmental.

MODELS OF DISABILITY

The way people think about disabilities affects how they feel about disabilities. Broadly speaking, people’s viewpoints can be categorized into different models of disability. The three main models used in Western society are: the moral model, the medical model, and the social model.

Moral Model: believes people are to blame for their disabilities, usually due to a moral failing or religious beliefs (e.g. disability is a punishment for a sin or has been used to mark the person as evil).

Medical Model: looks at how a person with a disability deviates from the norm and seeks to correct or cure the disability so that the person can be "normal".

Social Model: makes a distinction between impairment and disability. Impairment is the attributes or lack of attributes that affect a person's appearance, the function of their mind and/or body, and cause pain and other symptoms. Disability is the discrimination and social oppression created by society and the built environment that excludes people with impairments from society.[5] It was created by sociologist and disability rights activist Mike Oliver. By ratifying the *United Nations Convention on the Rights of Persons with Disabilities*, the Government of Canada has adopted the social model of disability.[6]

While the moral model of disability may sound unbelievable to some, it's still alive in many parts of the world. It's also still used frequently in media, giving the villain of the story an obvious physical disability that's intended to add to the evilness of the character and mark them as an "other".

The medical model of disability has been widely criticized by people with disabilities. While the medical model has made some useful advancements in treating painful symptoms of some disabilities, it doesn't recognize the role social and cultural factors contribute to the experience of disability. Critics of the model point out that money spent researching cures could be better spent implementing universal design and other social interventions that would make society and the built environment better for everyone.

The social model of disability faces its own criticisms. One criticism is that it fails to look at disability intersectionally. It has also been criticized for putting the emphasis on the barriers surrounding physical disabilities (and, to a degree, excluding people with mental disabilities) and not recognizing the effects impairments would still have on many people with disabilities in a barrier free world.[7] That said, the social model of disabilities has still been instrumental in reducing the stigma around disabilities and raising awareness of society's role in creating barriers for people with disabilities.

While the moral, medical, and social models have received the most discussion, other models of disability exist. Some of the more widespread and historically relevant models are described below.

Human-Rights Based Model: sees people with disabilities as individuals and recognizes them as experts on their own lives. It positions people with disabilities as stakeholders who must be part of every decision that affects them and holds the government accountable to work with people with disabilities to eliminate barriers. It also recognizes impairment as a natural aspect of human diversity that can have a great impact on people with disabilities.[8]

Indigenous Models: there is no singular Indigenous model of disability. That said, Indigenous cultures around the world have ancestral stories and traditional teachings about disability, though many cultures don't have a direct translation or a single word for the concept of disability. In many cultures, Indigenous viewpoints on community, responsibility, caretaking, and living a good life conflict with the colonial concept of disability.[9]

Charity Model: similar to the medical model, it views disability as a problem but goes further and believes people with disabilities are helpless and should be pitied. People with disabilities who achieve things are viewed as inspirations and sometimes objectified as inspiration porn (a term created by comedian and disability rights advocate Stella Young).[10] It positions people without disabilities as having a moral obligation to help people with disabilities overcome their tragic circumstances.[11]

Eugenics Model: judges people as either "fit" or "unfit" and believes that anyone who is unfit has undesirable genetic characteristics that should be bred out of the human race. The eugenics movement was alive and well in Canada in the early 20th century. It's worth noting that Tommy Douglas, labour leader and founding leader of the federal New Democratic Party (NDP) initially supported eugenics against people with mental illnesses and disabilities. However, after a trip to Germany in 1936 Douglas rejected eugenics and as the Premier of Saskatchewan rejected eugenic policies, including sterilization.[12] While the eugenics model largely lost popularity after World War II, it's still the basis for some practices that continue in the present day, such as forced sterilization, forced institutionalization, and discriminatory immigration policies. It should be noted that eugenics have been used against people from multiple social categories and not just people with disabilities.[13]

Economic Model: focuses on how disability disrupts a person's ability to work and contribute to the economy. It also looks at how disability financially impacts employers and the state. It is often used by policy makers to determine disability benefits for people with disabilities who engage in paid work.[14]

Radical Model: builds on the Social Model and views disability as a social and political construct. It doesn't distinguish between impairment and disability. It takes an intersectional approach to accomplish its goal of disability justice (as opposed to disability rights which it views as exclusionary towards people who aren't white, straight, and cisgender).[15]

Understanding the approaches the different models take, and the pros and cons of the models can be a helpful starting point for unions beginning to engage in disability justice.

SOCIAL DETERMINANTS OF HEALTH

Social determinants are non-medical social and economic factors that influence health. Some examples are education, housing, employment, food security, income, and the built environment (anything in the physical environment that is created by humans). Factors like prejudice, racism, discrimination, and historical trauma also have an impact on health, particularly for Black, Indigenous, and people of colour (BIPOC), 2SLGBTQIA+ people, and people with disabilities. The following section explores some, but not all, of the social determinants of health that have a significant impact on the health of people with disabilities.

Poverty and Employment

The CSD uses a global severity score that's calculated for each respondent using the number of disability types they have, the level of difficulty experienced in performing certain tasks, and the frequency of activity limitations. The severity scores are broken into four classes (mild, moderate, severe, and very severe) that are often reported as two classes—milder (which encapsulates mild and moderate) and more severe (which encapsulates severe and very severe).[16] However, these labels can be misleading. A so-called mild disability is still a disability. A barrier encountered by someone with a so-called mild disability is still a barrier.

It should be noted that the reports released based on CSD data are not consistent. Some data that was available from the 2017 CSD has not yet been released from the 2022 CSD.

Also, the 2022 CSD asked for respondents to identify their gender but redistributed non-binary respondents into categories of men+ and women+. Desegregated data on race, ethnicity, religious background, etc., is not available at the time of publication. Furthermore, even when reports are published on specific demographics (e.g. women with disabilities) the report does not take an intersectional approach that allows for further disaggregation (e.g. comparing the experiences between Indigenous women with disabilities to 2SLGBTQIA+ women with disabilities and 2SLGBTQIA+ Indigenous women with disabilities). Such comparisons can sometimes be achieved by comparing different reports from Statistics Canada, but data comparing the experiences of people with disabilities who belong to multiple equity-deserving groups is almost non-existent. The CSD is an imperfect measure, but it's still the largest data set we have regarding people with disabilities in Canada.

Using the most recent data from 2022 CSD, we know that people with disabilities have a lower employment rate (62%) than people without disabilities (78%). Between 2016-2021, the employment rate of women with more severe disabilities aged 25 to 34 years decreased from 59% to 43%. People with disabilities are less likely to be employed than people without disabilities across all levels of education and more likely to work part-time jobs than people without disabilities. Additionally, employment rates of people with disabilities decreased as the severity of disability increased.[17] The participation rate—the combined total of people who are employed or unemployed but actively seeking work—of people with disabilities (51%) is significantly lower than the participation rate of people without disabilities (70.1%).[18] Though the data isn't tracked, it's known that some people with disabilities engage in sex work, both online and in person. People with disabilities who are online sex workers report the ability to set their own hours and work from home at their own pace as one of the major draws of the job.[19]

Almost one-quarter (24%) of CSD respondents aged 25 to 64 reported that one of the underlying causes of their condition was work-related (e.g. accidents or injuries at work, stress or violence in the workplace, and exposure to chemicals). Men were more likely than women to report a work-related cause of their condition (30% versus 19%).[20] People with disabilities are slightly more likely to be a member of a union or covered by a collective agreement (32%) than people without disabilities (29%) across all levels of education.[21] That said, there's still a pay gap of 11.6% between the mean annual income of union members with disabilities ($56,600) and union members without disabilities ($64,000). Worse still, the pay gap between non-unionized workers with ($57,400) and without disabilities ($62,800) is only 8.6%. When looking purely at wages, unions appear to be detrimental to workers with disabilities.[22] However, more data is needed to take an intersectional approach and investigate why the rates of unionization and pay are different.

One of the key barriers preventing people with disabilities from participating in the labour market is lack of accessible transportation. Data from the CSD 2017 shows that 24.7% of people with disabilities aged 25 to 64 had difficulty finding work because they didn't have transportation to get to the job. A further 5.8% experienced a barrier looking for work due to lack of specialized transportation.[23]

Unsurprisingly, people with disabilities earn less on average than people without disabilities. Data from the 2019 *Canadian Income Survey* shows that people with disabilities earn about 21.4% less than people without disabilities. Additionally, 30.1% of people with disabilities had employment income that totaled less than $20,000 a year and are underrepresented in higher income brackets. Interestingly, when comparing mean annual earnings, while men with disabilities' mean annual earnings ($48,700) are 24.3% less than men without disabilities' ($64,300), they're higher than women without disabilities' mean annual earnings ($45,100). Women with disabilities earn an additional 13.7% less than women without disabilities (or $38,900).

The pay gap between people with and without disabilities also gets worse when comparing older workers and between workers with higher levels of education. The pay gap between people with and without disabilities was higher between people with some postsecondary education (20.9%) and people with a bachelor's degree or higher (16.0%). While the pay gap between people with and without disabilities was significant (16.6%) between people who worked full-time jobs, people with and without disabilities who worked part-time jobs had similar mean annual earnings.[24]

Canada uses the Market Basket Measure (MBM) to determine poverty thresholds based on the cost of a basket of food, clothing, shelter, transportation, and other items for a family of four that reflects a modest, basic standard of living. A family with a disposable income below the appropriate MBM threshold for the size of the family and the region where they live is deemed to be living in poverty.[25] A criticism of the MBM is that it ignores the extra costs related to disability including but not limited to: treatments/therapies, medical supplies, assistive devices, personal support workers, specialized transportation, and modifications to homes and vehicles.[26] Research in 2018 from the United Nations Department of Economic and Social Affairs estimated that the costs of living with a moderate disability range from 21% to 40% more and the costs of living with a severe disability range from 39% to 70% more.[27]

Working-age adults with more severe disabilities are more than twice as likely to live in poverty (18%) as those without disabilities (7%) and those with milder disabilities (8%). On top of earning less, people with disabilities have added expenses (medication, care giving, specialized transportation, assistive devices, etc.) related to their disability to deal with. 56% of persons with disabilities, nearly 4.5 million people, reported at least one unmet need when it comes to either aids, devices, medication or healthcare services. Three-quarters (73%) of persons with unmet needs (or 3.2 million) cited cost as the reason for those unmet needs.[28]

People with disabilities account for 27% of the population of Canada. Disability Without Poverty's *2024 Disability Poverty Report Card* shows that in 2022, 1,521,000 people with disabilities (16.8% of people with disabilities) aged 15 years and older lived in poverty, indicating that people with disabilities experience poverty at disproportionately high rates. 17.7% of women with disabilities and 15.7% of men with disabilities lived in poverty.

One of the factors contributing to women with disabilities higher rates of poverty is caregiving. Disability Without Poverty's *Shape the CDB* project found that approximately 1/3rd of participants who had a disability was also the caregiver for someone with a disability. Due to the gendered expectations around care, women are more likely than men to be unpaid caregivers.[29] Additionally, data from the 2023 *Labour Force Survey* showed that people with disabilities across all age groups and genders earned less per hour than their counterparts without disabilities. People with disabilities also worked fewer hours per week than people without disabilities.[30]

The 2022 CSD gives us a little data on 2SLGBTQIA+ people with disabilities. Of the 8 million CSD respondents who had one or more disabilities, approximately 8.7% (or 694,090 individuals) reported being a 2SLGBTQ+ person, representing 2.3% of the Canadian population aged 15 years and over. 63.4% of 2SLGBTQ+ people with a disability were between the ages of 15 and 34, compared with 17.8% of the non-2SLGBTQ+ population with disabilities. Mental health related disabilities were the most prevalent form of disability across all age groups, which makes sense since 2SLGBTQIA+ people—particularly transgender, gender-diverse, and Two-Spirit people—face higher rates of harassment and violence than some non-2SLGBTQIA+ populations. 78.5% of 2SLGBTQ+ respondents reported facing one or more barriers to accessibility in the past year. Compared with non-2SLGBTQ+ people with disabilities, the proportion experiencing a barrier overall was higher among both those aged 15 to 24 years and 25 to 34 years among the 2SLGBTQ+ population.[31]

The 2017-2018 *Canadian Community Health Survey* showed that lesbian, gay, and bisexual people aged 18 and higher reported significantly higher rates of mood and anxiety disorders than heterosexual people aged 18 and higher. Women experienced higher rates of mood and anxiety disorders across all sexualities.

	MALE	**FEMALE**
HETEROSEXUAL	8.9%	16.1%
LESBIAN OR GAY	17.3%	27.4%
BISEXUAL	21%	37.1%

Rates of mood and anxiety disorders experienced by heterosexual, lesbian, gay, and bisexual men and women

The report also noted that lesbian, gay, and bisexual people are more likely than heterosexual people to experience discrimination and barriers to employment and career advancement.[32] Of note, bisexual men and women in the workforce earned significantly less than their lesbian, gay, and heterosexual counterparts, with heterosexual men earning the most.[33]

We have some data on Indigenous peoples with disabilities from the 2017 *Aboriginal Peoples Survey*. The survey—now called the *Indigenous Peoples Survey*—was conducted again in 2022-2023, but the data on Indigenous people with disabilities hasn't been released in full at the time of publication. In 2016, Indigenous people accounted for 4.9% of the population of Canada. In 2017, among Indigenous people aged 15 and older, 32% of First Nations (who lived somewhere other than a reserve), 30% of Métis, and 19% of Inuit had at least one disability (compared to 22% of non-Indigenous people aged 15 and older). Indigenous women were more likely to have a disability than Indigenous men across all ages and identity groups.[34]

Data from 2022 tells us that the rate of participation in the workforce of Indigenous people with disabilities was 57.6% compared to 70.5% for Indigenous people without disabilities.

	HAS ONE OR MORE DISABILITIES	**DOES NOT HAVE A DISABILITY**
FIRST NATIONS	55.4%	69.2%
MÉTIS	60.9%	73.1%
INUIT	51.5%	62.9%

Rates of participation in the workforce between First Nations, Métis, and Inuit with and without disabilities.[35]

While the 2022 CSD data released to date doesn't include any information on rates of disability among Black people and people of colour we do have some relevant data from the 2017 CSD. 14.3% of respondents were Black or a person of colour: 4% were South Asian, 2.9% were Chinese, 2.2% were Black, 1.3% were Filipino, and 1% were Latin American. Women were more likely than men to report having a disability. 25.2% of racialized people who were employed reported that they were disadvantaged in employment because of their disability.[36] From the 2023 *Labour Force Survey* we also know that racialized people with disabilities experienced lower rates of employment than racialized people without disabilities. All racialized people with disabilities also experienced lower rates of employment than non-racialized and non-Indigenous people without disabilities.[37]

Housing

It's well established that Canada has a housing crisis. When comparing housing arrangements, data from the CSD 2017 shows that people with disabilities are less likely to live in a private dwelling owned by a member of the household (67.4%) than the total population (71.9%). People with disabilities are also more likely to live in rented dwellings (32.5%) compared to the rest of the population (26.4%).

In Canada, housing is considered "affordable" if it costs less than 30% of a household's before-tax income.[38] Data from the CSD 2017 shows that 25% of people with disabilities lived in unaffordable housing, higher than the 19.7% of the total population that lived in unaffordable housing. Core housing need occurs when a household's residence falls below standards of affordability and suitability (e.g. doesn't have enough bedrooms or needs major repairs) and the median rent of alternative housing in the same community is also unaffordable. 15.9% of people with disabilities were living in households in core housing need (compared to 10.1% of the general population). Men with disabilities were more likely to be in core housing need (16.7%) than women with disabilities (13.6%).[39] Additionally, renters with disabilities (42%) are over-represented in core housing need compared to renters without disabilities (27%).[40]

When looking at suitability of housing, many people with disabilities are forced to live in houses that don't meet their accessibility needs. Results from the CSD 2017 show that 44.9% of people with physical disabilities required at least one type of aid or assistive device or an accessibility feature—such as ramps, raised toilets, walk-in baths or showers, lifts or elevators, grab bars, lowered counters, or automatic doors—within their home. 13% of people with physical disabilities stated they needed aids or assistive devices in their homes but didn't have them.[41]

Data from the *2014 General Social Survey on Victimization* showed that almost half (46%) of all Canadian women who reported having ever experienced homelessness had a disability, as did 37% of men.[42] Research from the Canadian Human Rights Commission found that people with disabilities were four times more likely to experience homelessness than people without disabilities.

People with disabilities were also two times more likely to experience hidden homelessness—defined as people who are temporarily housed but don't have their own accommodations (i.e. staying with friends, family, or strangers). People with disabilities were also more likely to experience homelessness because of violence (53%) compared to people without disabilities (36%).[43] The Canadian Human Rights Commission stated that it has heard from people with disabilities who are applying for Medical Assistance in Dying (MAID) because they can't access housing and the support they need.[44]

Article 19 of the *United Nations Convention on the Rights of Persons with Disabilities* (CRPD) states:

> Parties to the present Convention recognize the equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community.[45]

Despite being a signatory to the CRPD, Canada has no statute that directly enforces the CRPD. When looking at people with disabilities who require extensive care, thousands of younger people with disabilities are forced to live in long-term care (LTC) facilities due to inadequate and underfunded disability supports and home care supports.

RESIDENT AGES	NURSING CARE FACILITIES (NATIONALLY)	COMMUNITY CARE FACILITIES FOR THE ELDERLY (NATIONALLY)
YOUNGER THAN 18	5	0
18 TO 24	140	70
25 TO 44	1,185	555
45 TO 64	11,430	6,235
65 TO 69	9,105	8,120
70 AND OLDER	153,995	220,960

Data from the Nursing and Residential Care Facility Survey (NRCFS), 2020[46]

A 2016 report from Ontario Ombudsman Paul Dubé studied 1,400 complaints about people with developmental disabilities in crisis situations, including being abandoned, abused, unnecessarily hospitalized, and jailed. As a result of the investigation, the Ministry of Community and Social Services helped 20 individuals who had been unnecessarily institutionalized in hospitals secure homes in their communities. The report also advised that housing young adults with developmental disabilities in LTC should be avoided. LTC facilities, "were not developed with the needs of those with developmental disabilities in mind, and are another form of institutionalized care often used as a stopgap solution when more appropriate residential placements are unavailable."[47] As of 2021, 12% of LTC residents in Ontario were under the age of 65.[48]

Being in LTC can negatively impact the mental health of younger people with disabilities. They're forced to live according to a schedule filled with activities designed for people decades older than them who have different needs. It can prevent younger people with disabilities from forming friendships or romantic relationships with people their own age.[49] BIPOC with disabilities and 2SLGBTQIA+ people with disabilities placed in LTC are also isolated from their cultures and communities.

In addition to LTC facilities not being designed to accommodate the needs of young people with disabilities, once in LTC, young people with disabilities may lose access to funding and supports, making it impossible to leave LTC.[50] Direct and individualized funding programs that allow people with disabilities to purchase care and supports, or designate an agency to do that for them, exist at the provincial level. However, these programs are limited and only serve a small percentage of home care clients. Emeritus Co-Director at the Canadian Institute for Inclusion and Citizenship argues that individualized funding and institutionalized care would cost governments approximately the same amount of money.[51] A 2019 review of individualized funding programs for people with disabilities from 1992-2016 in Europe, the U.S., Canada, and Australia found that individualized funding improved quality of life, client satisfaction, and safety:

> Recipients particularly value: flexibility, improved self-image and self-belief; more value for money; community integration; freedom to choose 'who supports you; 'social opportunities'; and needs-led support. Many people chose individualized funding due to previous negative experiences of traditional, segregated, group-orientated supports.[52]

However, it should be noted that direct and individualized funding programs are not universally endorsed. Some have pointed out that under neo-liberalism, consumer choice does not guarantee better outcomes, and that direct and individualized funding could undermine the social safety net.[53] There are also concerns that direct and individualized funding programs could negatively impact workers by turning them into individual contractors as opposed to employees, leading to reduced workers rights, wages, and benefits, and making it difficult to unionize.

Some people with disabilities may prefer living in LTC. Some may prefer a group home setting. Some may prefer home care. And some may prefer a direct or individualized funding model. Above all else, people with disabilities should have the control and right to choose where they live. Social supports must *support* people with disabilities and not contribute to their oppression.

Violent and Fatal Interactions with Law Enforcement

Between 2000 and June 2020, 68% of people who were killed or died during police use of force encounters had a mental illness or substance abuse issue. While the majority of victims were white, Indigenous and Black people (who account for 8.7% of the population) were overrepresented, accounting for 27.2% of the victims. The vast majority of the victims were men.[54]

It's well documented that Indigenous people and Black people are subject to systemic racism, including being racially profiled by police, and are overrepresented in all aspects of the justice system.[55][56][57] Many people with disabilities have conditions or behaviours that put them at higher risk for unnecessary police interaction. People with mental health disabilities may act in ways that draw police attention (e.g. talking to themselves, acting "erratically", etc.). People with movement disabilities may walk with a pronounced gait. People with Autism Spectrum Disorder (ASD) may stim (self-simulation which help people with autism regulate their emotions) in ways that look strange to police (e.g. repeating the same word or action over and over). People with OCD may also have compulsions that looks strange to police (e.g. counting the number of steps taken, walking through a doorway multiple times, etc.). The risk for unnecessary interactions with police for people with disabilities who are Indigenous or Black is even higher due to bias and conscious and unconscious racist beliefs held by police and the criminal justice system.

Once they are interacting with police, people with disabilities can also be more vulnerable than people without disabilities. People who are deaf, hard of hearing, blind, or have low vision may not be able to see or hear cues from police. People with mental health disabilities, particularly when they're experiencing a mental health crisis, may act erratically or not be able to comply with police instructions. People with autism and people with developmental disabilities may not be able to regulate their emotions during interactions with the police.

Tracking (In)Justice, a law enforcement and criminal legal data and transparency project, has documented 2,131 deaths that occurred in custody (police, provincial, federal, and other institutions like hospitals and healing lodges) across Canada.[58] There is no data available about the number of people with disabilities who have died in custody in Canada, though we have some information on individual deaths that have been covered in the news.

One of those deaths was that of Soleiman Faqiri—a 30-year-old man who had schizoaffective disorder—whose 2016 death was ruled a homicide due to, "prone position restraint and musculocutaneous injuries sustained during struggle, exertion and pepper foam exposure in the setting of cardiomegaly and worsening symptoms of schizophrenia". Several workers, including an operations manager and sergeant at the Central East Correctional Centre and a nurse tried to help Faqiri—who was in obvious distress—before the interaction with dozens of corrections workers where Faqiri was killed.[59]

One of the correctional officers who testified at the inquest into Faqiri's death, David Surowiec, stated that 60 policy breaches occurred during the altercation. He cited staffing levels and operational demands as reasons why policies might not be followed. Surowiec also stated that he was not trained in de-escalation nor how to differentiate between restraining someone with mental illness from someone without.[60]

One of the policies not followed was regarding the use of a spit hood on Faqiri. The use of force manual stated that a spit hood may increase the symptoms being experienced during a psychotic episode and directed staff to first attempt to use alternatives on themselves such as protective eyewear or face masks.[61] Surowiec also testified that he received no support from the employer following Faqiri's death and that he has been diagnosed with PTSD and depression as a result of the altercation.[62]

Former Supervising Sergeant Dawn Roselle also testified at the inquiry. Roselle stated that Faqiri's death could have been avoided if a specialized crisis team had been called during the altercation and alluded to chronic understaffing. She also stated that Faqiri never saw a psychiatrist while in custody and was never transferred to a hospital, despite experiencing a psychiatric emergency.[63]

As part of the inquest in Faqiri's death, in 2023 the jury made 57 recommendations to the government of Ontario, the first two being:

1. Develop and issue a public position statement within 60 days of this verdict recognizing that correctional facilities are not an appropriate environment for persons in custody experiencing significant mental health issues.
2. Take immediate steps to ensure that any person in custody experiencing an acute mental health crisis is admitted to hospital for assessment and, when appropriate, treatment, in a therapeutic setting that is suitable, secure, and safe.[64]

OPSEU/SEFPO, the union representing the corrections workers at the Central East Correctional Centre, stated they have been lobbying for similar recommendations to the Ministry of the Solicitor General for years but that the ministry has had virtually no consultation with the union.[65] To date, the government of Ontario has not delivered on either of these recommendations, nor have they acted on most of the other recommendations. But because the recommendations are non-binding, there's no legal pressure on the government to fix the problems.

Faqiri's story is one of an untold number of people with disabilities who have died while in custody. More must be done at all levels of the justice system to ensure people with disabilities are not killed or harmed during interactions with police or while in custody.

Health Care Systems and Health Education

People with disabilities often encounter barriers and discrimination in accessing and interacting with health care systems. Like other Canadians, lack of access to a family doctor is harmful to people with disabilities and results in them not receiving the care or medication they need. People with disabilities who don't have a family doctor are forced to visit a walk-in clinic or emergency room for treatment and may receive lower quality of care due to the often-complex nature of their conditions. In addition to the shortage of family doctors, people with disabilities are often impacted by the shortage of specialist medical practitioners. Long wait times, travel inside and across provinces to access specialists, and the associated costs with that travel are additional impacts on the health and wellbeing of people with disabilities.[66] But accessing care is only part of the struggle.

Data from the 2022 CSD shows that 27.2% of respondents encountered a barrier while communicating in person with medical or health care professionals and 25.1% experienced a barrier communicating over the phone with medical or health care professionals.[67] 20.7% of respondents experienced a barrier related to behaviours, misconceptions, or assumptions about their disability made by a medical or health care professional.[68]

Women (particularly BIPOC women), BIPOC, and gender-diverse people report higher instances of encountering medical gaslighting—particularly when reporting pain symptoms—due to race and gender biases and systemic racism and sexism in medical systems.[69][70] In turn, experiencing racism and sexism in medical systems can lead to patients being misdiagnosed and make their symptoms worse or cause new mental and physical health impacts such as hypertension, chronic stress, depression, and anxiety.[71][72]

In a report from the Department of Justice Canada, *Serious Problems Experienced by People with Disabilities Living in Atlantic Canada*, people with disabilities reported feeling like health care professionals were gaslighting them. People with disabilities felt that health care professionals didn't accept their lived experiences, dismissed their concerns, and made them feel like their symptoms were imaginary. People with disabilities also reported concerns about being labeled a "problem patient" and the impact it would have on their future care.[73]

Sometimes the inverse of the problem can occur where health care professionals believe every health problem is a result of a person's disability. This occurs more frequently when a person has a mental health disability.[74] This is particularly troubling due to the high rate at which disabilities can be comorbid with other disabilities and other health conditions. Data from the World Health Organization (WHO) shows that people with disabilities are at twice the risk compared to people without disabilities of developing conditions such as depression, asthma, diabetes, stroke, obesity, or poor oral health.[75]

Failing to understand a person with disabilities as a person rather than their disability can lead to conditions going untreated and put the patient at risk from other harm. A study of women with disabilities in Northern Ontario, Manitoba, and Nova Scotia found three main barriers when accessing health care: labyrinthine health service systems, assumptions, attitudes, and discriminatory practices, and inadequate sexual health or reproductive services and supports.[76]

Children and youth with disabilities often don't receive the same education around sexuality and sexual health that their peers without disabilities receive.[77] This results in people with disabilities, particularly women and girls with disabilities, being vulnerable to sexually transmitted diseases, unwanted pregnancies, abusive relationships, sexual violence, and intimate partner violence (IPV).

TYPE OF IPV EXPERIENCED SINCE THE AGE OF 15	WOMEN WITH DISABILITIES	WOMEN WITHOUT DISABILITIES
EMOTIONAL, FINANCIAL, OR PSYCHOLOGICAL ABUSE	53.5%	35.6%
PHYSICAL ABUSE	31.8%	17.2%
SEXUAL ABUSE	17.9%	7.3%
TOTAL	55.1%	36.9%

Survey of Safety in Public and Private Spaces, 2018[78]

	PEOPLE WITH DISABILITIES		PEOPLE WITHOUT DISABILITIES	
	MEN	WOMEN	MEN	WOMEN
EXPERIENCED CHILDHOOD SEXUAL ASSAULT BEFORE THE AGE OF 15	5%	14%	2%	7%
EXPERIENCED CHILDHOOD PHYSICAL ASSAULT BEFORE THE AGE OF 15	33%	30%	20%	16%
VICTIM OF A CRIME – PHYSICAL ASSAULT (IN THE PAST 12 MONTHS)	6.6%		3.6%	
VICTIM OF A CRIME – SEXUAL ASSAULT (IN THE PAST 12 MONTHS)	6%		1.4%	

Data from Employment and Social Development Canada[79]

People with disabilities face unique conditions that put them at higher risk for IPV, such as increased reliance on caregivers, communication/language barriers, being perceived as less credible victims, being socialized to have unquestioning compliance, and perceived vulnerability. People with disabilities are often believed to be asexual due to heteronormative ideas about sex and what is considered "natural".[80] Conversely, people with disabilities are also objectified and fetishized.[81] Both sets of beliefs can be dangerous to people with disabilities. Data from Statistics Canada doesn't disaggregated data on women with disabilities and IPV into the 10 categories of disability measured by the CSD. However, some independent studies have found that women with cognitive disabilities or multiple disabilities are at a disproportionately high risk for IPV compared to women with other types of disabilities.[82]

Indigenous women with disabilities experience IPV at significantly higher rates (74%) than Indigenous women without disabilities (46%), non-Indigenous women with disabilities (54%), and non-Indigenous women without disabilities (37%).[83] Data on IPV within different demographics with disabilities hasn't been published by Statistics Canada, but we know from other data that 2SLGBTQIA+ people and women ages 15-24 also experience high rates of IPV.[848586] It stands to reason that 2SLGBTQIA+ people with disabilities and young women with disabilities experience even higher rates of IPV.

It's also worth noting that IPV can cause a person without a disability to develop a disability or cause further disabilities to a person with disabilities. The Disabled Women's Network of Canada (DAWN Canada) has estimated 276,000 women in Canada will experience a traumatic brain injury annually as the result of IPV.[87] Anxiety, depression, PTSD, OCD, and self-destructive behaviours can also be caused by IPV, as well as other physical and mental injuries that can develop into disabilities.[88]

It is often assumed that people with disabilities don't want romantic relationships, sexual relationships, marriage, or to become parents. Prior to and during pregnancy, many people with disabilities receive unsolicited advice from health care professionals, are ignored by health care professionals while they talk to the accompanying parent without disabilities, and have to give birth with equipment that isn't adapted to their disability.[89] Parents and caregivers of people with disabilities can restrict access to information about reproductive health and health care providers. Health care providers may also provide limited information on reproductive health to people with disabilities due to a lack of knowledge or stereotypes about people with disabilities being asexual or nonsexual beings. In some cases, people with disabilities have been sterilized or put on contraceptive medication without their knowledge or consent. Research on people with disabilities experiences with pregnancy care and postpartum care in Ontario found that their care needs were unmet during pregnancy and the postpartum period and that they faced frequent ableism during pregnancy and intrusive surveillance during the postpartum period. A common assumption observed during pregnancy was that participants were unfit to be parents due to their disabilities.[90]

In the past the provincial governments of Alberta and British Columbia enacted legislation to forcibly sterilize people with mental illnesses and disabilities who had been institutionalized. These laws were in effect from 1928-1972 (Alberta) and 1933-1973 (British Columbia). The provincial governments of Saskatchewan, Manitoba, and Ontario all drafted similar legislation, but in all cases, it was defeated before becoming law.[91]

In 1995 a woman named Leilani O'Malley successfully sued the Alberta government for being sterilized without her knowledge as a teenager while she was in the care of the Provincial Training School for Mental Defectives. On the admission form it was noted that O'Malley "seems intelligent" and one doctor attributed her condition to emotional abuse as opposed to a mental disability. But following an IQ test where O'Malley scored low, the provincial Eugenics Board ordered her to undergo a bilateral salpingectomy (removal of both fallopian tubes) during a "routine" appendectomy. O'Malley was only informed she was having an appendectomy and didn't find out she was sterilized until later in life when she was married and attempting to conceive a child. Following the trial, O'Malley was awarded nearly $1 million dollars in damages and legal costs.[92]

O'Malley's trial paved the way for other people with disabilities in Alberta who had been sterilized against their will and/or without their knowledge. 2,832 people with disabilities were sterilized under Alberta's *Sexual Sterilization Act*. 950 of those people launched their own claims against the government of Alberta, resulting in the government issuing a formal apology and $142 million in settlements.[93]

The Supreme Court of Canada's decision in 1986 on *E. (Mrs.) v. E* was a landmark case in advancing the rights of people with intellectual disabilities. The court ruled that Mrs. E could not have her 24-year-old daughter Eve (who had an intellectual disability) sterilized without Eve's consent. The judgement stated:

> Sterilization should never be authorized for non-therapeutic purposes under the parens patriae jurisdiction. In the absence of the affected person's consent, it can never be safely determined that it is for the benefit of that person. The grave intrusion on a person's rights and the ensuing physical damage outweigh the highly questionable advantages that can result from it. The court, therefore, lacks jurisdiction in such a case.
>
> The court's function to protect those unable to take care of themselves must not be transformed so as to create a duty obliging the Court, at the behest of a third party, to make a choice between two alleged constitutional rights – that to procreate and that not to procreate – simply because the individual is unable to make that choice. There was no evidence to indicate that failure to perform the operation would have any detrimental effect on Eve's physical or mental health. Further, since the parens patria jurisdiction is confined to doing what is for the benefit and protection of the disabled person, it cannot be used for Mrs. E.'s benefit.[94]

The ruling ended the long-standing practice of non-therapeutic sterilization of people with intellectual and mental disabilities and affirmed the rights of all people, regardless of cognitive abilities, which cannot be overridden even when a person is in a guardianship. That said, there is evidence that forced and coerced sterilization of women with disabilities still occurs in Canada. In her testimony to the Standing Senate Committee on Human Rights, the CEO of DAWN Canada, Bonnie Brayton, stated that women with disabilities are still vulnerable to coercion and forced sterilization.

Brayton shared stories from women with disabilities whose parents have influenced or made decisions on their daughter's reproductive health without her consent and against her will. Brayton also spoke about how research shows Depo-Provera (a birth control shot) is commonly prescribed to young women with intellectual disabilities in response to family and caregiver concerns about unwanted pregnancy and menstrual hygiene.[95] In their report, the Standing Senate Committee on Human Rights stated forced and coerced sterilization disproportionately affects Indigenous women, Black women, racialized women, people with disabilities, intersex children, and institutionalized persons.[96]

INJURED WORKERS

One category of people who are often overlooked in discussions around disability are injured workers. Injuries acquired at work do not always become disabilities, but a significant number do. Data on injuries that occurred in workplaces under provincial and territorial jurisdiction is difficult to find. But Employment and Social Development Canada produces annual reports of occupational injuries in Canada under federal jurisdiction.

YEAR	NUMBER OF WORK-RELATED DISABLING INJURIES THAT OCCURRED IN WORKPLACES UNDER FEDERAL JURISDICTION
2019	20,850
2020	15,799
2021	16,342
2022	18,131

Data from the 2020 and 2022 Annual Reports - Occupational Injuries in the Canadian Federal Jurisdiction[97][98]

The top five sectors under federal jurisdiction in terms of total disabling injuries reported are:

- Road transportation
- Federal public services, public service departments and crown corporations
- Air transportation
- Postal services and postal contractors
- Communications

Canadian Occupational Safety states that the five most common workplace injuries are: slips, trips, and falls, repetitive stress and overexertion, being struck by or caught in moving machinery, vehicle-related, and fire and explosion-related.[99] Young workers—particularly young men—are at higher risk for injury at work due to lack of training and being employed in riskier jobs than older workers. New workers, regardless of age, and recent immigrant workers are also more likely to be injured at work for similar reasons. Immigrant and refugee workers are also at higher risk due to language barriers and being less able to refuse unsafe work due to their (perceived) status.[100]

In 2017, it was estimated that 1.7 million workers in Ontario (or 24%) were not covered by the *Workplace Safety and Insurance Act*.[101] Given the rise of gig-work and precarious work where delivery drivers and ride-hailing drivers are mostly classified as independent contractors, it's likely that number has increased.[102]

In the 2023 *Trauma and Stress in the Workplace Report* by Mental Health Research Canada, 65% of participants reported that their work threatened their psychological health and 20% responded that their job involves unavoidable risk to psychological harm. In terms of sectors, 74% of first responders said the nature of their work includes unavoidable risk of psychological harm followed by 37% of health care workers and 28% of education workers. In terms of affinity groups, 24% of racialized workers and 24% 2SLGBTQ+ workers stated that the nature of their work includes unavoidable risk of psychological harm (compared to 18% of workers who don't belong to either affinity group). Workers with mood disorders (23%), mental impairment (33%), chronic pain (22%), and physical disabilities (22%) all reported that the nature of their work includes unavoidable risk of psychological harm at higher rates than the average.[103]

An internal audit of Ontario's Workplace Safety and Insurance Board (WSIB) shows that from January to May 2018, only 10 of the 159 claims for work-related chronic mental stress were approved, meaning over 90% of the cases were denied.[104] Legal experts believe the reason for the low rate of approval is due to a 2017 WSIB policy which requires workers making claims for chronic mental stress to meet a higher standard of proof to get compensation than those with other kinds of work-related injuries. The WSIB claimed its policy is modelled on existing policies in British Columbia, Alberta, Saskatchewan, and Quebec.[105] Data released by the WSIB in 2024 shows that chronic mental stress claims are still approved at a much lower rate than any other type of injury.

	CATEGORIES OF INJURIES			
YEAR	**CHRONIC MENTAL STRESS**	**TRAUMATIC MENTAL STRESS**	**PTSD**	**ALL INJURIES**
2017	19%	49%	86%	79%
2018	6%	65%	83%	78%
2019	5%	69%	83%	78%
2020	9%	71%	79%	77%
2021	7%	69%	78%	77%
2022	12%	52%	63%	72%

Data from the WSIB published in the Toronto Star[106]

In addition to the trauma caused by the initial injury, many injured workers report being forced back to work before they're ready. In 2015, the Ontario Federation of Labour (OFL) and the Ontario Network of Injured Workers' Groups (ONIWG) released a report called *Prescription Over-Ruled: Report on How Ontario's Workplace Safety and Insurance Board Systematically Ignores the Advice of Medical Professionals*. The report detailed several issues with Ontario's compensation system such as:

- Inadequate services/inadequate funding for services.
- Ignoring the opinions of treating medical professionals when those opinions are not what WSIB policies want to hear (e.g. pressuring injured workers to return to work when their treating doctor recommends more time to heal).

The report also documented the consequences of not properly funding the recovery of injured workers and giving them enough time to heal. Injured workers are at increased risk of developing mental health conditions and the stress of dealing with WSIB claims can increase the risk even more. Injured workers also reported that their injury had devastating effects on all areas of their life—particularly on their relationships with their families—and in some cases led to substance abuse.[107] It should be noted that WSIB workers have little ability to influence WSIB policy and blame for the harm caused by the WSIB should not be placed on WSIB workers.

A 2022 study on pain prevalence of injured workers in Ontario found that 75% of injured workers reported pain symptoms 18 months after their initial injury. Workers with severe pain symptoms were more likely (33%) to not be currently working at 18 months vs those without pain symptoms (16%) and had poorer self-reported physical and mental health.[108]

The WSIB has also been criticized for policies that deem injured migrant workers as being capable of returning to work too early. In 2023, the Workplace Safety and Insurance Appeals Tribunal issued a decision on a case brought forward by three migrant workers from Jamica who were injured on the job in Canada. The panel found that the existence of systemic racism and the precarious employment status of Seasonal Agricultural Worker Program (SAWP) workers provided relevant context for the interpretation of the evidence. Ultimately, the panel ruled in the workers' favour.[109] In 2024, the WSIB issued an apology and implemented a new *Foreign Agricultural Worker Strategy* that it claims, "emphasizes recovery and return to work in Ontario for foreign agricultural workers".[110] As part of the strategy, the WSIB states it will review all past claims from injured SAWP workers back to 2007. Advocates have criticized the WSIB for not including claims from before 2007 and injured migrant workers employed under other streams of Canada's Temporary Foreign Worker Program.[111]

The above is just a small sample of the systemic issues that injured workers are forced to face. In addition to acquiring a disability through a workplace injury, injured workers are also at risk of aggravating their injury, gaining a new injury, or having their injury turn into a disability due to inadequate care allowed by workers compensation board policies or from being forced back to work without having sufficient time to heal.

DEFINITION OF ABLEISM

Ableism is prejudice, bias, or discrimination against people with disabilities based on the belief that people without disabilities are superior. Ableism has many similarities with the medical model of disability as it reduces people to just their disability and believes that people with disabilities need to be "fixed". Like other types of oppression, ableism comes in different forms.

Structural ableism is barriers to physical structures and infrastructure that prevents people with disabilities from full participation and equal opportunities. E.g. lack of tactile paving to indicate intersections.

Institutionalized ableism is policies, laws, regulations, and practices that exclude people with disabilities from full participation and equal opportunities. E.g. a college policy requiring proof of diagnosis before a student can access disability services and receive an accommodation.

Interpersonal ableism is inflicted by individuals on people with disabilities and can manifest as slurs, microaggressions, bullying, and physical and emotional violence. E.g. a person without disabilities asking a person with a disability if you can pray for them (implying that they need to be fixed).

Internalized ableism occurs when a person with a disability consciously or unconsciously believes the negative messages they hear about disabilities from individuals or society. E.g. someone with a disability who feels like they're a burden when asking for an accommodation.[112]

While not many people would openly admit to being ableist, it's likely that *all* of us have said or done something ableist in our lives and we have all participated in systems with structural and institutionalized ableism. Society as a whole and the built environment are not constructed with the needs of people with disabilities in mind. This is particularly true for people with mental disabilities, invisible disabilities, and episodic disabilities.

Each province has its own human rights code that defines discrimination against people with disabilities. But merely following the human rights code doesn't ensure an environment free from ableism. The mindset behind the charity model of disability—that people with disabilities are pitiable or a source of inspiration for people without disabilities—is ableist. The emphasis employers place on productivity—an arbitrary standard of performance—is ableism.

Other common forms of ableism include:

- Not providing captions on a video
- Talking to a person with a disability as if they're a child
- Questioning how much a person's disability affects them (including questioning whether they have a disability at all)
- Doing a task for a person with a disability without asking them first
- Telling a person with a disability that they don't look like they have a disability

- Ignoring a deaf person and speaking directly to their interpreter
- Saying things like “everyone is a little autistic,” or “everyone is a little OCD”
- Using expressions like “the blind leading the blind”

In their essay Making Space Accessible is an Act of Love for our Communities, writer Leah Lakshmi Piepzna-Samarasinha expands on the effects of ableism, saying:

> Many of us who are disabled are not particularly likable or popular in general or amid the abled. Ableism means that we—with our panic attacks, our trauma, our triggers, our nagging need for fat seating or wheelchair access, our crankiness at inaccessibility, again, our staying home—are seen as pains in the ass, not particularly cool or sexy or interesting. Ableism, again, insists on either the supercrip (able to keep up with able-bodied club spaces, meetings, and jobs with little or no access needs) or the pathetic cripple. Ableism and poverty and racism mean that many of us are indeed in bad moods. Psychic difference and neurodivergence also mean that we may be blunt, depressed, or “hard to deal with” by the tenants of an ableist world.
>
> And: I am still arguing for the radical notion that we deserve to be loved. As we are. As is.[113]

Many instances of ableism occur in the form of microaggressions. The term microaggressions was created by Dr. Chester Pierce in the 1970s to describe the daily insults, insinuations, and dismissals that are inflicted on Black people by non-Black people. He theorized that those microaggressions could wear down a person’s psychological and physical health over time.[114] The concept of microaggressions was brought into the mainstream in 2007 by Dr. Derald Wing Sue who defines microaggressions as:

> The everyday slights, insults, put-downs, invalidations and offensive behaviors that people of marginalized groups experience in daily interactions with generally well-intentioned people who may be unaware of their impact. Microaggressions are reflections of implicit bias or prejudicial beliefs and attitudes beyond the level of conscious awareness.[115]

To be clear, despite the term containing the word “micro”, microaggressions can cause immense and long-lasting physical, psychological, and emotional harm. They’re often referred to as, “death by a thousand cuts”. Some of the most common microaggressions against people with disabilities come in the form of language used to describe people with disabilities.

TERMINOLOGY AND PERSON-FIRST LANGUAGE

When speaking about people with disabilities, the consensus is to use person-first language which emphasizes the whole self and their worth before the disability. Some examples of person-first language are:

- Person with a disability in place of disabled person
- Person who uses a wheelchair in place of wheelchair user

- Person with schizophrenia in place of person who suffers from schizophrenia
- Person who is hard of hearing in place of person who is hearing impaired

Terms like “special needs”, “differently abled”, “impaired”, “suffers from”, and “handicapped” should be avoided as they are widely seen as condescending. Conversely, avoid terms like “normal” and “able-bodied” when talking about people without disabilities. When describing washrooms and parking spots for people with disabilities, refer to them as “accessible”.

Some people with disabilities prefer the term “person living with a disability” opposed to “person with a disability”. However, some people with disabilities dislike including “living” in the description as their disability isn’t something they can separate from their identity. It also doesn’t reflect the experiences of people with temporary or episodic disabilities.[116]

However, many people with disabilities, particularly young people with disabilities, prefer identity-first language over person-first language. This is seen most often in Deaf communities and autism communities.

The Canadian Association of the Deaf states that the Deaf, the deafened, and the hard of hearing are all distinct groups. Using “Deaf” with a capital D refers to people who are, “medically deaf or hard of hearing who identify with and participate in the culture, society, and language of Deaf people, which is based on Sign language. Their preferred mode of communication is Sign.”[117] Deaf cultures can clash with hearing cultures as hearing cultures often view deafness as a problem that should be overcome with medical assistance. Many Deaf people do not identify as having a disability, seeing themselves instead as part of a cultural and linguistic group.[118] Discussions around internalized ableism are a controversial and painful topic in Deaf communities.

Using “deaf” with a lowercase d can be used to refer to people who are medically deaf but don’t necessarily identify with Deaf communities. “Deafened” refers to people who become deaf later in life and may not identify with either the Deaf or hard of hearing communities. And a person who is hard of hearing has hearing loss which ranges from mild to profound and whose usual means of communication is speech.[119] Some individuals prefer person-first language such as “a person who is deaf”, “a person who is deafened”, and “a person who is hard of hearing”.

Similarly, many people in autism communities refer to themselves as “autistic”, “autistic people”, or “autists”. To these individuals, their autism cannot be separated from their identity. As Ly Xīnzhèn Zhǎngsūn writes:

> When we say “person with autism,” we say that it is unfortunate and an accident that a person is Autistic. We affirm that the person has value and worth, and that autism is entirely separate from what gives him or her value and worth. In fact, we are saying that autism is detrimental to value and worth as a person, which is why we separate the condition with the word “with” or “has.” Ultimately, what we are saying when we say “person with autism” is that the person would be better off if not Autistic, and that it would have been better if he or she had been born typical. We suppress the individual’s

> identity as an Autistic person because we are saying that autism is something inherently bad like a disease.
>
> Yet, when we say "Autistic person," we recognize, affirm, and validate an individual's identity as an Autistic person. We recognize the value and worth of that individual as an Autistic person — that being Autistic is not a condition absolutely irreconcilable with regarding people as inherently valuable and worth something. We affirm the individual's potential to grow and mature, to overcome challenges and disability, and to live a meaningful life as an Autistic. Ultimately, we are accepting that the individual is different from non-Autistic people–and that that's not a tragedy, and we are showing that we are not afraid or ashamed to recognize that difference.[120]

It should be noted that while the diagnosis is that of autism spectrum disorder (ASD), it is appropriate to say someone is a person with autism or an autistic person (depending on their preference) as opposed to a person with ASD.

While identity-first language is most commonly found in Deaf communities and autism communities, it should be noted that people with other disabilities may refer to themselves as "disabled" or "a disabled person". When speaking broadly about people with disabilities, person-first language should be used but it's up to each individual to decide what they prefer.

Additionally, unions should aim to have leaders, staff, and members stop using ableist language. Some words like cripple and retard have obvious ties to disability and are widely recognized as derogatory words. But words like lame, crazy, insane, psychopath, hysterical, stupid, dumb, etc. also dehumanize and stigmatize people with disabilities.[121] When criticizing policies and laws, encourage people to think critically about the issues and use precise language instead of using words that have historically been used to tell people with disabilities there is something wrong with them. It should be noted that some people with disabilities have reclaimed the word "crip".[122] The use of the word is contentious in different disability communities for different reasons, but people without disabilities should avoid using the word (the exception being when discussing something that has crip in the name like the #CripTheVote movement or the academic field of crip theory).[123][124]

Other examples of common ableist language are describing oneself as OCD or ADHD (attention deficit hyperactivity disorder) due to a specific behaviour or trait. While many symptoms of OCD and ADHD are experienced by the general population, describing your cleaning habits as OCD or describing your temporary lack of focus as ADHD undermines the severity of the disorders. Similarly, describing yourself or calling someone blind or deaf because they've missed the point or are refusing to listen to you is ableist as it insinuates that people who are blind or deaf are ignorant.[125] Rule of thumb: don't use a person's identity or diagnosis as an insult or a metaphor.

INCREASE IN DIAGNOSIS AND LATE DIAGNOSIS OF DISORDERS AND DISABILITIES

Several news stories in recent years have covered the increase in diagnoses that fall under the umbrella of neurodivergence—a term coined by autistic activist Kassiane Asasumasu which means people whose neurocognitive functioning diverges from dominant societal norms in multiple ways.[126] Particular attention has been given to the apparent rise in diagnoses of ADHD, ASD, and Ehlers-Danlos Syndrome (EDS) (which does not fall under the umbrella of neurodivergence but has been mentioned alongside ADHD and ASD as a “trend” on social media). There has also been increasing attention given to self-diagnosis (meaning a person who diagnoses themselves with a condition based on research and lived experience). Many chalk this up to social media fads—particularly fads that impact children and teenagers—and the perceived benefits one gains from having a disability. While it’s true that more people have been receiving diagnoses and self-diagnosing a number of conditions, it’s a more nuanced topic than it first appears.

Social media and the internet have been both beneficial and harmful in the spread of both information and misinformation. Social media and the internet have reduced barriers to accessing information, but that information is largely not moderated and not fact checked. A common rebuttal used when debating someone on the internet is “do your own research”. But doing a Google search, reading the top result, and cherry-picking information that helps your point of view is not research. Media literacy and digital literacy are needed to do quality research and draw conclusions. There’s a difference between reading a study, understanding a study, and knowing how to determine whether the study is scientifically sound. A large segment of the population has a distrust in authority figures and experts for various reasons. In the case of people with disabilities, some of that distrust is warranted due to the history of medical ableism and personal experiences of having been failed by medical systems.

Historically, the diagnostic criteria for many conditions were based off how the condition presented in white, straight, cisgender men and boys. For example, for decades it was believed autism was mainly a disorder that affected males as the traits researchers believed correlated with autism (such as logic and problem solving) were believed to be biologically male traits, and that females had opposing biological traits (such as empathy and being good at developing relationships).[127] The concept of autistic masking or autistic camouflage (a strategy used by some autistic people, consciously or unconsciously, to appear to conform to social norms and hide their autistic traits) wasn’t a focus of academic research until the 2010s. That research has shown that women with autism are more likely to mask than men with autism due to the social expectations and stereotypes placed on women. Women with autism are also more likely to successfully mask than men with autism due in large part to the belief that autism is a male disorder.[128] Other socio-cultural factors, such as white supremacy which positions whiteness as the superior template, and heteronormativity also influence research. Due to these factors, most of the early studies of autism were conducted with white, straight, cisgender boys as the subjects, with criteria for diagnosis and treatment being based on that one demographic.

This led to generations of women, transgender people, gender-diverse people, Black people, Indigenous people, and people of colour being misdiagnosed with something other than autism or not diagnosed at all. Women were more likely to be evaluated for and diagnosed with anxiety, depression, schizophrenia, or borderline personality disorder than autism due to research that points to these being common conditions for women.[129]

Due to white supremacy, implicit bias, western imperialism, and cultural stereotypes, there's often a negative stigma around mental health and disabilities in Black communities and communities of people of colour. Historical and on-going mistreatment and medical racism prevents some Black people and people of colour from seeking an autism diagnosis. When they do seek diagnosis, Black children are more likely to be diagnosed with mood disorders before later being diagnosed with autism.[130] Research has found that white parents don't show the same hesitancy as Black parents about seeking an autism diagnosis for their child—and when they do, white parents use more clinical terms that get medical practitioners on their side and their child referred for an evaluation.

Access to diagnosis is even more difficult for Black women and girls. A review of autism research over a 77-year period (starting in 1943) found that only three studies that focused on Black women and girls (one completed in the U.S., one in South Africa, and one with an unknown research location). Of the three, none of them took an intersectional approach to gender and race.[131]

Likewise, Indigenous people face historic and contemporary oppression but also face unique challenges due to discrimination with medical systems and obtaining an autism diagnosis. A 2022 report from the Canadian Academy of Health Sciences (CAHS) states:

> Colonization and related inter-generational traumas that have been experienced, as well as complexities of accessing care from multiple pan-Canadian and provincial/territorial jurisdictions, are important and unique considerations for Autistic First Nations, Métis, and Inuit peoples and their families. This context exacerbates the existing barriers many Autistic people face, such as access to healthcare and autism diagnosis (especially in rural or remote communities) and culturally-responsive, evidence-informed supports and services, as well as safety concerns.[132]

There is a severe lack of research on autism and Indigenous people in Canada.[133] However, from what research and anecdotal evidence we have, when Indigenous people are evaluated by health care professionals they are often misdiagnosed with the same conditions as women, Black people, and people of colour. However, due to similar presentation and cultural biases, many Indigenous people with autism are misdiagnosed with fetal alcohol spectrum disorders (FASD).[134] The overrepresentation of FASD research on Indigenous people and communities is detrimental to Indigenous people with autism and other disabilities as well as to non-Indigenous people who have FASD but are misdiagnosed due to the racist belief that FASD only affects Indigenous people.[135,136] It should also be noted that increased rates of FASD in Indigenous communities have been used as an excuse to exert surveillance and control over Indigenous women's fertility in the form of forced and coerced contraceptives and sterilization.[137138]

The CAHS report states that what data and research exists on Indigenous people and autism is mainly non-Indigenous led which is not aligned with essential standards, which include Indigenous leadership and data sovereignty. The report also points out that Indigenous cultures typically hold worldviews that promote acceptance of people with autism and include teachings, land-based activities, and therapeutic interaction with animals, art, and music that could help inform and improve on the supports and services used by non-Indigenous autistic people.[139]

Additionally, most autism research focuses on western countries and the associated cultural norms. Cultural differences on what is considered acceptable behaviour may impact on autism recognition. For example, the Diagnostic and Statistical Manual, Fifth Edition (DSM-5) lists “abnormalities in eye contact” as a deficit in nonverbal communication which is one of the categories a person must show persistent deficits in to be diagnosed with autism.[140] However, in some Asian cultures, it’s considered impolite for children to make direct eye contact with adults.[141] BIPOC children who live in western societies are also more likely to learn how to codeswitch—changing the way you talk, look, and behave to align with the dominant social norms and prioritize the comfort of the people around you—as a survival technique from an early age.[142] Codeswitching, combined with autistic masking can make it even harder to identify the symptoms of autism in BIPOC children. Historian Tré Ventour-Griffiths writes:

> However, across transcultural social codes, I have felt pressured into codeswitching out of fear of violence (even if I know I do it badly). Yet, while I codeswitch when I inhabit white spaces, I do so again when speaking and engaging with Black/white neurotypicals.
>
> In the normalisation of neurotypical and white ways of existing, this expectation leaves little room for being autistic while Black. So, many autistic Black people are left to navigate racist and ableist cultures of violence. Aspiring to whiteness and presenting to be neurotypical is in effect repressing ourselves twice over, in our Black and autistic identities.[143]

Underdiagnosis, misdiagnosis, and improper treatment methods can cause extreme physical, physiological, and emotional distress—the effects of which can last for a person’s whole life. Not receiving the correct diagnosis as a child is a barrier to receiving medication, therapy, and accommodations—all of which can shape a person’s life. Research has found that early diagnosis of autism and early intervention is critical for the development of cognitive and language skills.[144] Additionally, high rates of masking have been linked to emotional exhaustion, depression, anxiety, and suicidal thoughts and behaviours.[145]

To this day, women often face a 10-year delay receiving an autism diagnosis from the first time they present to mental health services.[146] And recent research has found that nearly 80% of women with autism are undiagnosed as of age 18.[147] 2020 was the first year where data from the Autism Spectrum Diagnosis Disabilities Monitoring Network found that the prevalence of autism in girls in the U.S. exceed 1%. 2020 was also the first year where the prevalence of autism was higher in 8-year-old Black, Hispanic, and Asian or Pacific Islander children in the U.S. than it was in 8-year-old white children in the U.S.[148]

Gaining access to an evaluation is only part of the struggle. Autism support services are severely underfunded and are disproportionately geared towards children—an obvious problem given what we now know about the prevalence of misdiagnosed and late-diagnosed people with autism. In Ontario, the Centre for Addiction and Mental Health (CAMH) is the only consistent option for adults seeking an autism assessment that’s covered by the Ontario Health Insurance Plan (OHIP). The wait time for an adult autism assessment at CAMH is currently 3+ years. Some provinces don't have any publicly funded hospitals that provide autism assessments for adults.[149] It is possible to get a referral from a family doctor to a psychiatrist for an adult autism assessment, but this option is only available with psychiatrists who work at public hospitals and accept referrals for adult autism assessments. Finding someone who fits these specifications can be an overwhelming and difficult task and relies on the person having a family doctor (or access to one through a walk-in clinic) who can write the referral.

Alternatively, adults seeking an autism assessment can pay a private provider for an assessment. In Canada, the average cost of an autism assessment is between $3000-$5000.[150] Not only is the cost extremely high, when you take into consideration the outdated views on autism that many medical professionals hold, it's understandable why women, transgender people, gender-diverse people, and BIPOC may hesitate to pay that much money. The risk of not being properly assessed and diagnosed is too high for many people.

With this context, it's easier to understand the seemingly sudden increase in autism self-diagnoses. It's true that social media influencers have a vested interest in making content and that social media platforms rarely fact check that content. It's also true that social media algorithms feed users content they think will help keep them on the platform which can create echo chambers. As such, it's almost guaranteed that a portion of people have misdiagnosed themselves with autism.

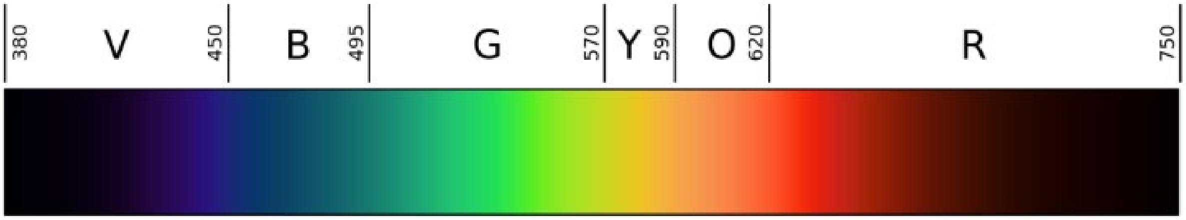
Regardless, it's disingenuous to reduce the increase in diagnoses to teenagers wanting to fit in with their peer group or women hypochondriacs watching one TikTok on autism and self-diagnosing; it's a better understanding of the disability and how previous research was flawed, as well as better screening techniques and more widespread knowledge of traits via access to social media and the internet. It's not that the rate of people with autism has increased but that there are more people that we *know* have autism than we were able to identify before. This also holds true for other disabilities like ADHD, EDS, and other so-called viral trend diagnoses.

There are some children and adults who self-diagnose without putting much effort into researching the disorder or disability. There are also some people on social media who claim to be experts about a condition but whose content spreads misinformation, leading people to self-diagnose incorrectly. Medical professionals are split on the value of self-diagnosis. Some worry that people are self-diagnosing based on individual traits (either temporary or permanent) that can be part of a disorder, but are also common for other conditions or disabilities, delaying the rate at which people seek help, or are common in people without conditions or disabilities. Some are concerned that social media algorithms are creating echo chambers for users that reinforce confirmation bias.[151] Others are more open to the concept of self-diagnosis and understand it as a useful starting point for exploring a professional diagnosis and treatment. Some also like the way social media has fostered community for people who are questioning and self-diagnosing, which is reducing the stigma around trauma, OCD, ADHD, and autism.[152]

It should also be noted that Canada is experiencing a health human resources crisis which may also be contributing to the increase in self-diagnosis. As of January 2025, it's estimated that 6.5 million people in Canada don't have access to a primary care provider.[153] Additionally, many of the specialists required to evaluate and treat some disabilities are not covered by provincial health insurance. Wait times and cost are significant barriers to accessing health services. The Canadian Medical Association has found a direct link between misinformation and negative health outcomes.[154] It is imperative that we resolve the health human resources crisis to improve pathways to diagnosis and treatment for people with disabilities while also combating the systemic ableism, racism, sexism, and transphobia that continues to push individuals towards self-diagnosis.

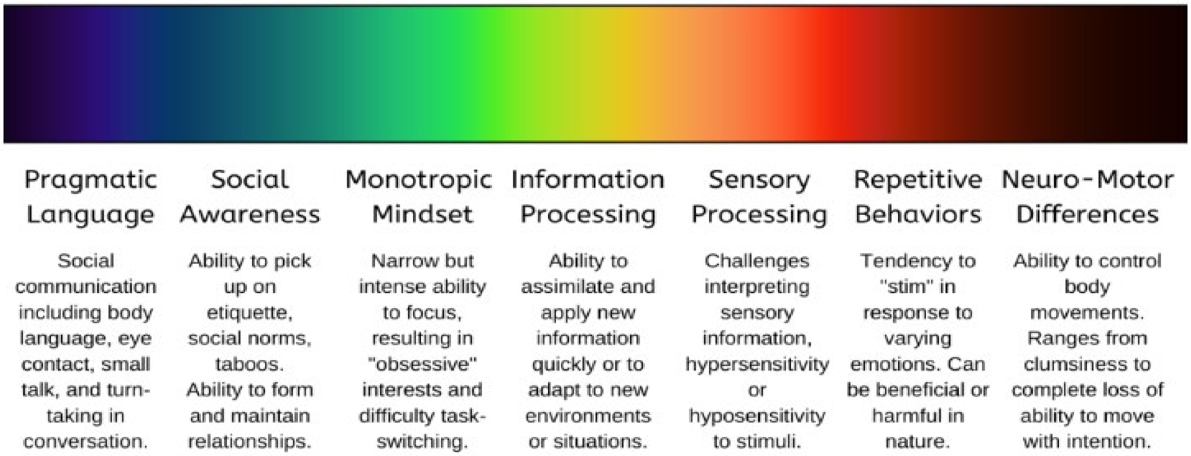
Self-diagnosis is also not universally accepted in disability communities. Some people with disabilities are uninformed on how medical systems and diagnostic criteria have discriminated against people based on gender, race, sexuality, age, etc. Some people with disabilities are also concerned that people who self-diagnose are only doing so to access the limited pool of resources available to people with disabilities. People who self-diagnose are often not looking for anything other than an explanation for why they are the way they are. They may find comfort in speaking to others in disability communities, but by and large they can't access many support services without a diagnosis from a licensed professional. Some people with disabilities also fear that self-diagnosis has led to terminology about disorders and disabilities being minimized and used inappropriately. This is something unions should take note of.

Phrases like, "everyone's a little autistic" contain a fundamental misunderstanding about autism spectrum disorder (ASD). While ASD is a spectrum, it's not a linear scale from a little autistic to severely autistic. Author C.L. Lynch uses the colour spectrum to explain how people misunderstand ASD.



> As you can see, the various parts of the spectrum are noticeably different from each other. Blue looks very different from red, but they are both on the visible light spectrum.
>
> Red is not "more blue" than blue is. Red is not "more spectrum" than blue is.
>
> When people discuss colours, they don't talk about how "far along" the spectrum a colour is. They don't say "my walls are on the high end of the spectrum" or "I look best in colours that are on the low end of the spectrum."

> But when people talk about autism they talk as if it were a gradient, not a spectrum at all.
>
> People think you can be "a little autistic" or "extremely autistic," the way a paint colour could be a little red or extremely red.
>
> In fact, one of the distinguishing features of autism is what the DSM-V calls an "uneven profile of abilities." There's a reason people like to say that "if you have met one person with autism, you've met one person with autism." Every autistic person presents slightly differently.
>
> That's because autism isn't one condition. It is a collection of related neurological conditions that are so intertwined and so impossible to pick apart that professionals have stopped trying.
>
> The autism spectrum looks more like this.



Pragmatic Language	Social Awareness	Monotropic Mindset	Information Processing	Sensory Processing	Repetitive Behaviors	Neuro-Motor Differences
Social communication including body language, eye contact, small talk, and turn-taking in conversation.	Ability to pick up on etiquette, social norms, taboos. Ability to form and maintain relationships.	Narrow but intense ability to focus, resulting in "obsessive" interests and difficulty task-switching.	Ability to assimilate and apply new information quickly or to adapt to new environments or situations.	Challenges interpreting sensory information, hypersensitivity or hyposensitivity to stimuli.	Tendency to "stim" in response to varying emotions. Can be beneficial or harmful in nature.	Ability to control body movements. Ranges from clumsiness to complete loss of ability to move with intention.

> All autistic people are affected in one way or another in most or all of these boxes – a rainbow of traits.
>
> If you only check one or two boxes, then they don't call it autism– they call it something else.[155]

The above graphic is not a complete description of ASD, but it does provide a useful visualization of the spectrum. ASD is a spectrum, but that doesn't mean every person is on the spectrum. It's possible to have one or more of the traits listed in the graphic and not have ASD. Similarly, you can have some traits of ADHD, OCD, bipolar disorder, an anxiety disorder etc. and not have the disorder. You can be hypermobile and not have EDS. Saying, "everyone's a little autistic" or "I'm so OCD about cleaning" downplays the severity of the of the disorder and reduces them to "fun" personality quirks. Disorders, syndromes, and other medical conditions are recognized as disabilities because they impair or *disable* people.

Unions should support members who are seeking diagnosis and/or members who are late diagnosed with disorders and disabilities that present since childhood. They should also be sensitive the shame and stigma that some BIPOC members may feel regarding disabilities and the hesitancy they may feel in seeking a diagnosis or asking for help or an accommodation. Unions should also be aware of the increased understanding of neurodivergence and how that affects the membership, in terms of neurodivergent members seeking accommodations in the workplace as well as how members who provide public services should be aware of how to best support neurodivergent clients.

EPISODIC DISABILITIES, INVISIBLE DISABILITIES, AND BARRIERS TO EMPLOYMENT

To be clear, the worth of a person should not be based on their ability to obtain paid work or to perform so-called productivity. Much of the conversation around people with disabilities focuses on getting them into the workforce. As discussed in earlier sections, many people with disabilities are already in the workforce. Other people with disabilities want to join the workforce but face barriers to doing so. However, some people with disabilities will never be able to join the workforce: that does not make them less valuable members of society. As Dessa Cosma, founder and Executive Director of Detroit Disability Power, says:

> By making paid labor the only kind of real value, we're not only playing into historical and current systems of oppression that devalues certain types of labor, we're also devaluing all of the lovely things that humans do without getting paid. What does that mean for love and friendship and volunteering?[156]

As unions, the focus of our work is on organized labour and workers. However, unions should also pay attention to the perspectives and wisdom of people with disabilities who aren't and will never be part of the labour force.

Many of the barriers people with disability experience when participating in the labour force have already been discussed. But much of the research doesn't differentiate between continuous disabilities and episodic disabilities.

Episodic disabilities are unpredictable fluctuating periods and degrees of wellness and disability. Some examples of episodic disabilities are epilepsy, Crohn's disease, fibromyalgia, human immunodeficiency viruses (HIV), endometriosis, post-traumatic stress disorder (PTSD), anxiety disorders, postural orthostatic tachycardia syndrome (POTS), irritable bowel syndrome (IBS), Long COVID, and diabetes.[157] Data from the 2017 CSD shows that 39% of respondents had a continuous disability, 37% had a progressive disability (meaning a disability that worsened over time), and 63% had an episodic disability (categorized by the CSD as recurrent disabilities and fluctuating disabilities).[158]

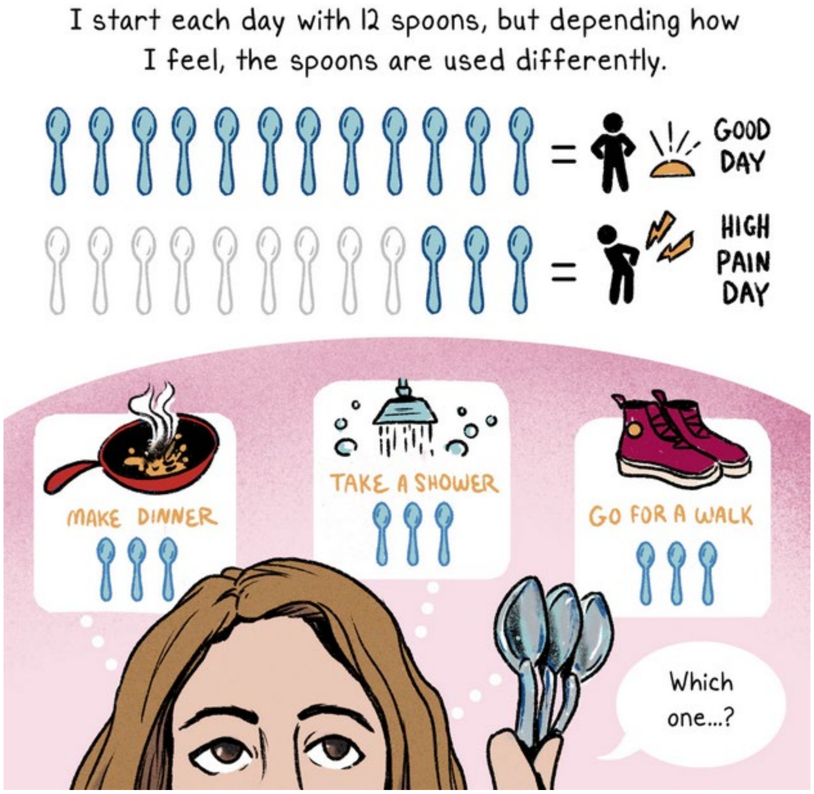
The unpredictable nature of episodic disabilities can make it difficult for a person with an episodic disability to stay in the same job long-term or even hold a job. The periodic ability to work can make it difficult for people with episodic disabilities to access government supports as programs are designed for people with continuous disabilities. Once disability benefits are cut-off during a period of relative wellness, they can be difficult to reobtain, disincentivizing people with episodic disabilities from seeking paid work. While income security is a challenge for most people with disabilities, the unpredictable nature of episodic disabilities and illnesses poses unique challenges in terms maintaining a steady income.[159]

Additionally, because many episodic disabilities are invisible disabilities, a person may look "fine" during a flair-up. In this way, people with invisible disabilities have the privilege of not being immediately recognizable as a person with a disability. But it does create different challenges. Because there is no obvious physical difference between when a person with an episodic disability is relatively well or unwell, employers and co-workers may be suspicious that the worker is faking their disability or using it to get out of doing things they don't want to do.[160] Research has shown that people with episodic disabilities and/or invisible disabilities can be subject to excessive monitoring, scrutiny, and harassment at work.[161] For example, people who have environmental sensitivities or multiple chemical sensitivities (ES-MCS)—people who become very sick when they breathe, touch or ingest many chemicals commonly found in everyday life—report high rates of their disability being disbelieved by health care workers, employers, landlords, friends, and family.[162] This is despite the fact that data from Statistics Canada in 2014 shows that 2.7% of Canadians had MCS and that the Canadian Human Rights Commission has had a policy on environmental health disabilities since 2007.[163][164]

People with episodic and/or invisible disabilities may also be harassed by people who think they're misusing resources meant for people with disabilities such as accessible parking spots, accessible washrooms, priority seats on public transportation, etc.[165] The judgements being passed by others on people with invisible disabilities can result in internalized ableism and make the person feel like they're not "disabled enough".[166]

Believing that people with episodic and/or invisible disabilities are "faking it" or that they can't have a disability because they don't look a certain way are examples of ableism. Invisible disabilities are still disabilities. Episodic disabilities are still disabilities. There is no one way people with disabilities look. Younger people with invisible and/or episodic disabilities in particular often experience ableism due to people conflating youth with perfect health and therefore a lack of disabilities (ignoring the fact that people can have a disability at any age and that people can have excellent health and still have disabilities).[167]

Spoon Theory is used by many people with episodic and/or invisible disabilities. Created by writer and lupus patient advocate Christine Miserandino, Spoon Theory uses spoons as a metaphor for energy and explains how people with disabilities have limited energy resources and also expend more energy on everyday tasks compared to people without disabilities, forcing them to plan their days carefully in order to conserve energy.[168] Spoons are used as a visual representation to show that people with disabilities start the day with a set number of spoons (usually lower than the number of spoons people without disabilities have) and "spend" the spoons on completing different tasks/activities. There's no way to create new spoons once the day's spoons are depleted. Additionally, the number of spoons a person with an episodic disability starts the day with can change depending on whether they're experiencing a flair-up.



Text by Fortesa Latifi. Illustration by Lara Antal.[169]

Often people with disabilities expend a lot of their energy at work. This can come to the detriment of their health and personal lives—which can impact their performance at work in the form of worsening symptoms, or developing mental health conditions or burnout.[170] Work can be tiring for people without disabilities too, but unions should be mindful of the uneven impact of energy use on work and people with disabilities, paying particular attention to the fluctuating levels of energy people with episodic and/or invisible disabilities have. Unions should also be aware of the potential harms that excessive monitoring, scrutiny, and harassment can have on people with disabilities. Research shows that discrimination against people with episodic and/or invisible disabilities impacts worker performance and increases the likelihood of the worker quitting their job or exiting the workforce entirely.[171]

ACCOMMODATIONS

Data from CSD 2017 found that just over 772,000 (or 37.3%) of workers with disabilities aged 25 to 64 required at least one type of workplace accommodation.[172] The most commonly required types of workplace accommodations were: modified work hours (19.3%), modified or different duties (13.7%), special chair or back support (11.4%), modified or ergonomic workstation (10.6), and remote work (8.4%). 59% of workers who required accommodations had all their needs met, 19% had some of their needs met, and 21% had none of their needs met. Of those with at least one unmet need for workplace accommodations: 25% said they did make a request for them to their employer or supervisor but 40% of those requests were refused.[173]

Workplace accommodation data from CSD 2022 shows that the five most commonly required types of workplace accommodations were the same as 2017. What's interesting is while the need for remote work increased to 10.9%, the need for almost all other types of workplace accommodations decreased. This suggests that by accommodating people with disabilities to work remotely the pressure on employers to provide other accommodations decreased significantly.[174] While remote work is an appealing option for many workers with disabilities, unions should be cautious of employers who suggest remote work for all accommodations—particularly if the worker with a disability wishes to remain in the physical office. It's possible that some employers may see remote work as means to escape other ways they could fulfil their duty to accommodate (e.g. renovating the office, reassigning duties, etc.).

Workers with disabilities have reported significant challenges in seeking workplace accommodations. One of the challenges is a lack of understanding on the part of the employer on the duty to accommodate, particularly understanding what qualifies as undue hardship. Under Canadian law, employers must make every reasonable effort to accommodate workers with disabilities. While collective agreements seek to standardize rights for all workers, they can sometimes conflict with the needs of equity-deserving groups like people with disabilities. There is no one-size-fits-all approach to accommodations. Accommodations must be considered individually and assessed on a case-by-base basis due to the unique needs of each person. Two workers with the same disability can need different accommodations.

Employers have a duty to accommodate requests from people who fall into the category of protected grounds under human rights legislation. The specifics around the duty to accommodate vary slightly between provinces and territories but are largely the same. In Ontario, the duty to accommodate is informed by three principles:

1. Respect for dignity
2. Individualization
3. Integration and full participation.[175]

A request for an accommodation does not mean the employer is obligated to accept what the worker requests. However, human rights legislation at the federal, provincial, and territorial levels has strict guidance on what constitutes undue hardship for the employer. To prove undue hardship, the onus is on the employer to prove that the barrier experienced by the person with disabilities is a bona fide occupational requirement. As part of their ruling on *Meiorin*—which was brough to the Supreme Court by the British Columbia Government and Service Employees' Union (BCGEU)—the Supreme Court of Canada has established a test to determine whether the standard that's causing the barrier is a bona fide occupational requirement. The employer could justify the standard by showing:

1. that the employer adopted the standard for a purpose rationally connected to the performance of the job;
2. that the employer adopted the particular standard in an honest and good faith belief that it was necessary to the fulfilment of that legitimate work-related purpose; and
3. that the standard is reasonably necessary to the accomplishment of that legitimate work-related purpose.[176]

Typically, undue hardship only occurs when health and safety is impacted or when there is a significant, provable cost to the employer, though there is some variation between jurisdictions.[177] If the employer fails to accommodate the worker to the point of undue hardship, they may be going against human rights legislation.[178]

During the accommodation process, the worker must outline what hardships they face in their job, but they are not required to disclose their condition(s) or disabilities. In cases where a worker's needs are unclear, the employer has a duty to inquire and ask for documentation such as a doctor's note or a note from other health care providers. If the worker's needs are still unclear, they may be asked to attend an independent medical examination (IME) which are usually provided by health care professionals in the private sector. However, there must be an objective basis for concluding that the initial medical evidence provided is inaccurate or inadequate (e.g. the same health care professional provides multiple notes with conflicting information). IMEs should only be used if there are reasonable grounds and a legitimate need for further evaluation at that specific time, not to second-guess a worker's disability or their request for an accommodation.[179][180]

The employer holds the largest responsibility in the duty to accommodate the worker, but unions also have a duty to participate in the accommodation process. Unions operate on systems of seniority. However, *Central Okanagan School District No. 23 v. Renaud* the Supreme Court of Canada ruled that collective agreements don't supersede human rights. The ruling states:

> A union may become a party to discrimination in two ways. First, it may cause or contribute to the discrimination by participating in the formulation of the work rule that has the discriminatory effect on the complainant – e.g., if the rule forms part of the collective agreement.
>
> Second, a union may be liable if it impedes the reasonable efforts of an employer to accommodate. If reasonable accommodation is only possible with the union's co-operation and the union blocks the employer's efforts to remove or alleviate the discriminatory effect, it becomes a party to the discrimination.[181]

This means that unions also have a duty to accommodate to the point of undue hardship.[182] The worker, the employer, and the union all have a responsibility to participate in discussions around the accommodation. Employers are not obligated to provide the "perfect" accommodation but one that is "reasonable". Conflicts usually occur over disputes as to what constitutes a reasonable accommodation. Unions should recognize the physical, mental, and emotional toll the accommodation process can take on a worker with disabilities and actively support the worker throughout the process.

Another area of confusion in the accommodation process is the jurisdiction of human rights complaints if an accommodation has been denied. A significant number of complaints made to human rights commissions are related to the employment of people with disabilities, and the majority of complaints from people with disabilities are related to employment.

JURISDICTION	PROPORTION AND NUMBER OF DISABILITY -RELATED COMPLAINTS	PROPORTION OF TOTAL COMPLAINTS THAT ARE DISABILITY COMPLAINTS RELATED TO EMPLOYMENT	PROPORTION OF TOTAL DISABILITY COMPLAINTS THAT ARE RELATED TO EMPLOYMENT
CANADIAN HUMAN RIGHTS COMMISSION	52.4% (4538)	44.1%	84.1%
NEWFOUNDLAND AND LABRADOR HUMAN RIGHTS COMMISSION	53.1% (251)	Data not available	Data not available
PRINCE EDWARD ISLAND HUMAN RIGHTS COMMISSION	44.8% (188)	30.5%	68.1%
NOVA SCOTIA HUMAN RIGHTS COMMISSION	64.6% (1109)	51.9%	80.3%
NEW BRUNSWICK HUMAN RIGHTS COMMISSION	36.5% (461)	30.1%	82.6%
COMMISSION DES DROITS DE LA PERSONNE ET DES DROITS DE LA JEUNESSE DU QUEBEC	32.9% (2014)	16.7%	50.8%
HUMAN RIGHTS TRIBUNAL OF ONTARIO	52.3% (11573)	38.2%	73.1%
MANITOBA HUMAN RIGHTS COMMISSION	44.1% (962)	29.0%	65.6%
ALBERTA HUMAN RIGHTS COMMISSION	49.1% (6885)	43.3%	88.1%
NORTHWEST TERRITORIES HUMAN RIGHTS COMMISSION	47.5% (86)	Data not available	Data not available
YUKON HUMAN RIGHTS COMMISSION	48.8% (100)	27.8%	57.0%

Overview of disability complaints related to employment received by human rights jurisdictions across Canada from 2009 to 2016[183]

In some provinces, a worker can file a grievance with their union and a complaint with their provincial human rights commission at the same time. In other provinces, the human rights commission and labour arbitrators hold concurrent jurisdiction over human rights issues in unionized workplaces but will often defer to the grievance process. In Manitoba filing a grievance is the only option for unionized workers.[184]

As unionized workers are often told to pursue human rights issues through the grievance process first, unions should ensure that collective agreements explicitly protect human rights and include clauses related to preventing and resolving harassment and discrimination in the workplace. As stated previously, collective agreements don't supersede human rights. But collective agreements that explicitly protect human rights are stronger and remove hurdles in the grievance process. Unions should also pay attention to advances in disability justice and stay up to date on rulings that involve workers with disabilities and employment. Unions should also be aware that workers with disabilities may need more time to prepare for the grievance than is granted in the collective agreement and work with them to ensure their grievance moves forward. Choosing to file a grievance or a human rights complaint is a big undertaking. The physical, mental, and emotional impacts of filing either complaint may be felt more intensely by people with disabilities.

Another challenge relating to workplace accommodations is that workers without disabilities often lack knowledge about disabilities and the accommodation process.

Some workers without disabilities view accommodations as forms of favouritism or special treatment and it can lead to interpersonal conflicts, harassment, or bullying.[185] Unions must provide education for the entire membership on the differences between equality and equity, and on why diverse workplaces and unions are a strength. Unions should also ensure that all members understand the accommodation process and their legal rights to workplace accommodations. This has the dual benefit of ensuring workers with disabilities (and workers who may acquire a disability in the future) know their rights as well as putting accommodations in perspective for workers without disabilities. Unions can also work with employers to provide regular equity, diversity, inclusion, and accessibility (EDIA) training to reinforce the message that both unions and employers are supportive of workers with disabilities who need accommodations.

Workplace accommodations should be paths to equity, but the process is often long and exhausting for people with disabilities. Even after obtaining a workplace accommodation, they can be ostracised or bullied by their co-workers. But this does not have to be the case. Accommodations are a tool. Creating built environments and workplace policies with universal design eliminates barriers that create the need to ask for an accommodation in the first place.

UNIVERSAL DESIGN

The Centre for Excellence in Universal Design defines universal design as, "the design and composition of an environment so that it can be accessed, understood and used to the greatest extent possible by all people regardless of their age, size, ability or disability."[186] Many things designed for people with disabilities benefit all people. Cut curbs or dropped curbs were designed to assist people who use wheelchairs but benefit parents pushing strollers, travellers rolling suitcases on wheels, and kids pulling a wagon on their paper route. Other examples of universal design that benefit everyone are:

- Automatic doors
- Access ramps
- Closed captions
- Grab bars
- Task lighting
- Slip-resistant flooring
- Flat panel light switches
- Smart devices (e.g. thermostats, air purifiers, air conditioners)
- Text-to-speech programs

The seven principles of universal design are:

1. Equitable use: The design is useful and marketable to people with diverse abilities.
2. Flexibility in use: The design accommodates a wide range of individual preferences and abilities.
3. Simple and intuitive use: Use of the design is easy to understand, regardless of the user's experience, knowledge, language skills, or current concentration level.
4. Perceptible information: The design communicates necessary information effectively to the user, regardless of ambient conditions or the user's sensory abilities.
5. Tolerance for error: The design minimizes hazards and the adverse consequences of accidental or unintended actions.
6. Low physical effort: The design can be used efficiently and comfortably and with a minimum of fatigue.
7. Size and space for approach and use: Appropriate size and space is provided for approach, reach, manipulation, and use regardless of user's body size, posture, or mobility.[187]

Working from a framework of universal design means less work will need to be done in the future to make an environment or product accessible. It also takes the burden of asking for an accommodation off people with disabilities. In their essay *Making Space Accessible is an Act of Love for our Communities*, writer Leah Lakshmi Piepzna-Samarasinha states:

> I've been asked to do disability and access trainings by well-meaning organizations that want the checklists, the ten things they can do to make things accessible. I know that if they do those things, without changing their internal worlds that see disabled people as sad and stupid, or refuse to see those of us already in their lives, they can have all the ASL and ramps in the world, and we won't come where we're not loved, needed, and understood as leaders, not just people they must begrudgingly provide services for.[188]

Universal design can be part of the process of changing our worldview. Unions can implement universal design in several different areas. Apart from union office design, universal design can be used to make communications, websites, policies, and meetings accessible from the outset.

COVID-19 AND DISABILITY

The COVID-19 pandemic radically changed the work arrangements of millions of people around the world. A survey of Canadians with disabilities and their experiences with COVID-19 found that from February to April 2020, 1/3 of participants experienced temporary or permanent job loss or reduced hours.[189] Data from CSD 2017 showed that 37% of people with disabilities aged 15 to 64 relied solely on employment income and 30% of people with disabilities relied exclusively on non-employment income. The aforementioned survey found that from February to April 2020, 45% of people with disabilities reported relying solely on non-employment income. Overall, 61% of participants reported a major or moderate impact from COVID-19 on at least one type of financial obligation or essential need.[190]

The number of people with disabilities living in poverty actually decreased to 14.7% in 2020 due to federal pandemic income benefits such as the Canadian Emergency Response Benefit (CERB) and one-time top-ups to programs including the Disability Tax Credit (DTC) and the Canada Child Benefit (CCB). However, some provinces and territories clawed back some or all CERB payments through provincial disability benefit programs.[191] Additionally, many other Canadians with disabilities didn't qualify for CERB or the Canada Recovery Benefit (CRB). Eligibility for CERB and CRB required that recipients had lost their job due to COVID-19 and that they made $5,000 or more in the year prior to losing that job. Many workers with disabilities did not meet the $5,000 threshold, and income from the Canada Pension Plan Disability benefit (CPPD) did not count as eligible income for CERB or CRB even though other income replacement payments did.[192]

In May 2016 approximately 7.1% of Canadians worked remotely for most of their job. Data from Statistics Canada shows that in 2019, 39% of Canadian jobs could be done remotely. That prediction came true when, due to recommendations from medical professionals and researchers on how to stop the spread of COVID-19, governments instituted lockdowns and social distancing protocols. In April 2020 data from the Labour Force Survey shows that 40% of Canadians worked remotely for most of their job.

During the pandemic, many existing inequalities in Canadian society and in the world of work were exposed. The future of work was widely debated and, in February 2021 it was reported that 90% of workers who were forced to work remotely due to the pandemic reported accomplishing at least as much work per hour at home as they did in the office. However, as lockdowns and social distancing protocols were lifted, employers began to recall workers to the physical workplace. The number of Canadians who worked remotely for most of their job decreased to 30% in January 2022 and 20% in January 2023.[193]

What's interesting is the workplace accommodation requests to work remotely from workers with disabilities. In 2017, 8.4% of workers with disabilities required an accommodation to work remotely, but 30.4% of those accommodations were not granted. In 2022, the number of workers with disabilities who required an accommodation to work remotely rose to 10.9% but only 19.3% of those were denied.[194] This could indicate that many employers had it within their power to grant accommodations to work remotely prior to the pandemic but chose not to. It could also indicate that, after spending a period of time where all or most of their workers worked remotely, it's now harder for employers to justify why a worker with a disability can't be accommodated to work remotely.

During the pandemic, people with disabilities reported being unable to access health services for their conditions. A survey found that the most common health service disruption reported was for regular medical or dental services (51%), followed by physiotherapy, massage therapy or chiropractic treatments (37%), regular medical testing (34%), and counselling services (18%).[195] From April 2020 to March 2021, approximately 360,000 (or 16%) fewer surgeries were performed across Canada than in 2019–2020. In 2021–2022, surgery volumes were lower than pre-pandemic levels by approximately 10% (227,000) due to successive waves of COVID-19 and worker shortages.[196]

Prior to the pandemic, a significant number of people with disabilities reported feeling socially isolated and lonely. As we know, people with disabilities face an increased risk of IPV—a risk that increased more during the pandemic due to lockdowns and social distancing protocol, as well as people doing their best to individually stop vectors of transmission after protocols were lifted (e.g. not going to visit their friend who has a compromised immune system).[197] A study of participants in Nova Scotia, New Brunswick, Ontario, Alberta, and British Columbia found that people with disabilities experienced poor physical health (59.2%) and poor mental health (63.7%) at higher rates than people without disabilities (30.1% and 49.2% respectively) during the pandemic.[198] In particular, Black people and people of colour with disabilities reported having worse overall health (54%) and worse mental health (61%) since the start of the pandemic compared to other people with disabilities.[199] People with disabilities have largely been left out of COVID-19 recovery planning. As previously discussed, people with disabilities have lower rates of employment and earn less than people without disabilities. Without savings to fall back onto, people with disabilities face a worse outcome in terms of finances, housing, and health.[200]

For many people with disabilities, the current model of “living with COVID” means living a life of isolation. As social distancing and mask policies were dropped, the risk factors for people with disabilities—particularly people with compromised immune systems—significantly increased. A study of 35,519 hospitalizations for COVID-19 in Canada found several chronic diseases and disabilities are associated with excess risk of death from COVID-19. In particular, people with Down syndrome aged 51 and older had 8.5 times the risk of dying from COVID-19.[201] A 2022 study published in the Canadian Medical Association Journal found that patients with a disability who were admitted to hospital with COVID-19 had longer stays (across all age groups) and elevated readmission risk than those without disabilities.[202] One of the authors of the study, Hilary Brown, highlighted some of the social determinants of health that put people with disabilities at higher risk of being exposed to COVID-19 such as living in poverty, living in LTC and group homes, and requiring home care services.[203]

People with disabilities across the country reported being unable to access food, personal protective equipment (PPE), and adequate sanitation in LTC during the pandemic.[204] Approximately 1,650 trained military personnel were deployed in response to provincial calls for help to care for residents in LTC in Ontario and Quebec. The report by the Canadian Armed Forces highlighted the deplorable living conditions of the five Ontario LTC facilities military personnel were deployed to and highlighted understaffing, lack of training, and general underfunding—all of which have been pointed out by unions for years—as some of the contributing factors.[205] The report from the Canadian Armed Forces on the LTC facilities military personnel were deployed to in Quebec came to similar conclusions.[206] As previously discussed, thousands of people with disabilities under the age of 65 are currently living in LTC facilities.

Post COVID-19 Condition (better known as Long COVID) is defined as symptoms of COVID-19 persisting for more than 12 weeks after the infection.[207] More than 200 symptoms have been identified with impacts on multiple organ systems and varying levels of physical, mental, and cognitive impairment.[208] The most common symptoms are extreme fatigue, brain fog, memory and concentration issues, body pain, shortness of breath and an elevated heart rate.[209] Research shows that people of all ages can develop Long COVID and people who had mild or asymptomatic cases of COVID-19 can still develop Long COVID.[210] The affects of Long COVID can be temporary or permanent.

COVID-19 and Long COVID are causing a massive number of people acquire disabilities. In 2022, Dr. Sami Schalk tweeted:

> Because of COVID-19 and a lack of access to health care, the majority of people are going to be disabled soon, if they aren't already. Many of the hundreds of millions of people who got the virus are now disabled, living with long COVID. Many others are living with PTSD, depression, and deep grief from the strain (a totally inadequate word) of living through fascism, mass death, and economic and climate crisis.[211]

Dr. Schalk received a lot of backlash for her tweet, but there was truth in what she said. Research published in 2024 has found that approximately 400 million people worldwide had or currently have Long COVID. The condition is estimated to have an annual economic impact of approximately $1 trillion, equivalent to about 1% of the global economy. Additionally, it's unknown how many people acquired a disability as a result of COVID-19 directly that isn't Long COVID.

Canada stopped tracking COVID-19 cases nationally, but data from an article published in the Canadian Medical Association Journal found that by March 2023, 76% of the population had detectable antibodies as a result of infections.[212] Data from Statistics Canada shows that 3.5 million Canadian adults (or 11.7% of the adult population) have experienced long-term symptoms, from a COVID-19 infection. Of that 11.7%, 79.3% had been experiencing symptoms for six months or more and 42.2% had symptoms for one year or more. 21.7% of Canadians with Long COVID reported being often or always limited by their symptoms on a daily basis.[213] Every COVID-19 infection poses a risk of developing Long COVID, and studies have shown that multiple COVID-19 infections greatly increases the risk for developing Long COVID.[214] The belief that COVID-19 is now a mild virus that only causes cold-like symptoms undermines the fact that every COVID-19 infection increases the risk of acquiring a disability. Scientists have equated repeated COVID-19 infections with playing Russian roulette.[215]

As of June 2023, about 600,000 adults in Canada had missed time from work or school due to longer-term symptoms and/or Long COVID. On average they missed 24 days. About 100,000 adults were unable to return to work or school because of their longer-term symptoms.[216]

Additionally, many of the symptoms of Long COVID are episodic, making it difficult for people with Long COVID to access disability supports.[217]

The impact of COVID-19 vaccines on preventing Long COVID are mixed, but most studies indicate they provide partial protection against developing Long COVID.[218] However, testimony from people with disabilities shows that vaccine clinics often weren't accessible to people with disabilities and there was a lack of specialized transportation for people with disabilities to get to the vaccine clinics.[219]

Canadian research has shown that women are more likely to contract COVID-19 than men due largely to the gendered aspects of labour. Women—particularly BIPOC and immigrant women—are more likely to work frontline jobs in health care, education, LTC, and retail, putting them at higher risk for exposure to COVID-19. Additionally, PPE tends to be designed to fit cisgender men, meaning women often must make do with PPE that doesn't fit them properly. Women are also more likely to be responsible for unpaid labour, such as grocery shopping, caring for sick relatives, and child care duties, all of which increase women's risk of exposure. As mentioned above, repeat exposures to COVID-19 increase the risk of developing Long COVID, meaning women are more likely to develop Long COVID than men.

Research also shows that people with disabilities are more likely to contract COVID-19 than people without disabilities. People with disabilities that compromise their immune systems obviously have a heightened risk of contracting COVID-19. Some people with disabilities are unable to wear masks or respirators due to medical or sensory issues. People who are blind, Deafblind, or have low vision use their hands more often to read braille and interpret the world around them. People with learning and intellectual disabilities may not be able to understand and/or follow preventative measures. People who are Deaf, deafened, or hard of hearing may need others around them to use non-medical masks with clear windows or remove their masks to communicate when sign language is not an option. This is not an exhaustive list, but it illustrates some of the ways people with specific disabilities are put at higher risk. Additionally, people with disabilities who live in LTC or other group living facilities are at higher risk for exposures to COVID-19, as are people with disabilities who interact regularly with health care workers or home care workers. In one Canadian study, 28.3% of adults with a disability reported Long COVID symptoms, compared to 16.3% of adults without a disability.[220]

The COVID-19 pandemic impacted nearly all aspects of the lives of people with disabilities. Pre-existing inequalities were made worse. A significant number of people acquired a disability because of COVID-19. People with disabilities are still at an increased risk for contracting COVID-19 and developing Long COVID. Disability advocate Marya Bangash summarized the feeling of many Canadians with disabilities, "If you want me to live with COVID, you have to make it livable for me."[221]

ACCESSIBLE CANADA ACT

In 2019, the federal government passed the *Accessible Canada Act* (ACA). While advertised to make the whole of Canada accessible by 2040, the ACA only covers areas that fall under federal jurisdiction and has hopes of inspiring other jurisdictions to follow their lead. People with disabilities, disability rights and justice organizations, and allies raised concerns about the power and scope of the ACA prior to it being passed. In 2018, the Council of Canadians with Disabilities wrote an open letter to the federal government which included 9 recommendations and was co-signed by 92 disability organizations.[222]

In 2024, 5 years into the 21 years that culminate in 2040, the federal government released the *Accessible Canada Roadmap* and allowed public feedback until January 2025. As the AODA Alliance pointed out in their brief to multiple House of Commons standing committees on the 5 Year Review of the ACA:

> The ACA has failed to require real progress on removing and preventing disability barriers. We do not believe the Federal Government could produce an impressive list of major disability barriers that the ACA caused to be removed over the past five years. Some federally-regulated organizations have no doubt taken some action to remove some disability barriers, but not because of any ACA requirements.
>
> The ACA is far too weak. It does not require a single disability barrier to ever be removed or prevented. It gives people with disabilities no substantive rights, but it gives the Federal Government and federally-regulated organizations many loopholes.
>
> It requires federally-regulated organizations to make accessibility plans, but it does not require those plans to be strong and effective. It does not require those plans to be effectively implemented.
>
> The long, complicated and convoluted ACA is incredibly hard to decipher, even for experts. For non-experts, it is impenetrable. Its implementation and enforcement are excessively bureaucratized and wastefully splintered among three federal agencies, the Canadian Human Rights Commission, the CRTC and the CTA. Each has a poor record on effectively enforcing accessibility for people with disabilities. The ACA's fragmented enforcement is confusing, bureaucratic and, ultimately, ineffective.[223]

One thing the federal government has done to make the 2040 deadline a reality is contract AccessNow—an accessibility technology company whose goal to make communities easier to navigate for people living with disabilities—to undertake Mapping Our Cities For All (MOCA). To date, MOCA has mapped 14,000 locations in Vancouver, Calgary, Ottawa, and in 17 towns in rural Alberta using over 126,000 data points.

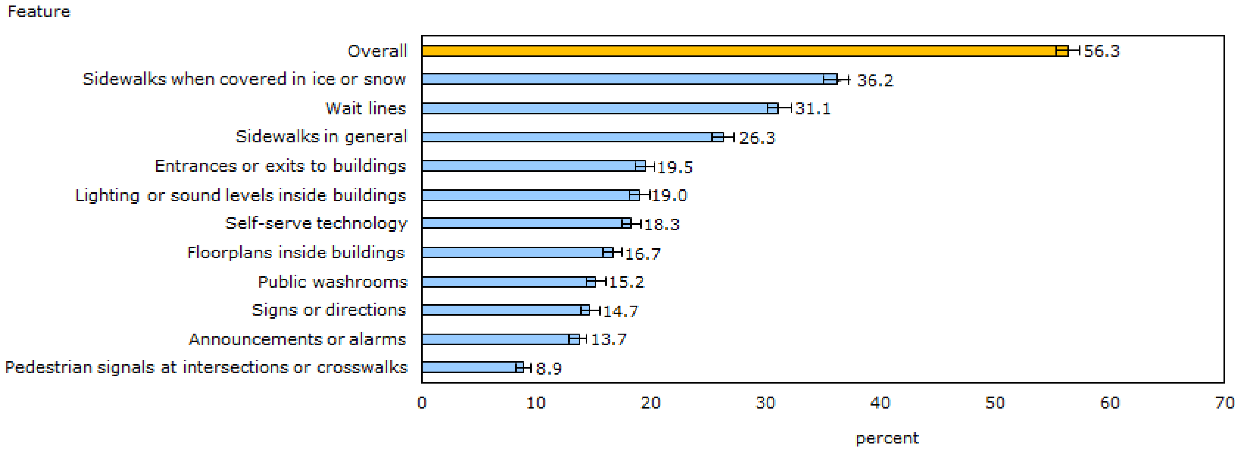
CITY	NUMBER OF PLACES MAPPED	PERCENTAGE OF PLACES PERCEIVED ACCESSIBLE
VANCOUVER	4,367	48.5%
CALGARY	5,381	35%
OTTAWA	3,099	53%

Data from Mapping Our Cities For All, 2023

While MOCA is only a snapshot of accessibility across Canada, it's clear that areas under federal jurisdiction are not on track to meet the 2040 goal. One of the key findings from MOCA was that certain sectors address accessibility better. At least 50% of the businesses in five sectors were perceived as accessible: health and personal care stores, real estate, finance and insurance, clothing and accessories, and sporting goods stores. Conversely, fewer than 35% of the businesses in the following sectors were rated accessible: professional, scientific, and technical services, repair and maintenance, personal and laundry services, and educational services. MOCA recommended investigating sector-specific disparities to gain insight for crafting targeted policy interventions.[224]

Some data from Statistics Canada gives us further insight on the scope of the problem. In the 2022 CSD, 56.3% of respondents stated they encountered a barrier to accessibility in public spaces.

Chart 1
Barriers to accessibility in public spaces, persons with disabilities, aged 15 years and over, by feature, Canada, 2022



Note: The overall calculation includes persons who experienced barriers with at least one of these features. The categories include persons who were deemed to have experienced a barrier if they encountered it "at least sometimes" in the last 12 months.
Source: Statistics Canada, Canadian Survey on Disability, 2022.

People with disabilities who are women, immigrants, elderly, and have a lower income were all more likely to experience a barrier in public spaces.[225] And among Canadians with disabilities aged 15 and older who considered themselves housebound, 17.8% said it was due to the unavailability of specialized transportation.[226]

The task of making Canada accessible by 2040 is a large undertaking. However, it's also a potential source of job creation to which unions should pay attention. Across the country, buildings will need to be renovated, aids and devices will need to be created and installed, technology and programs will need to be adapted, translators will need to translate a massive amount of material into braille, inspectors will need to be hired to ensure the ACA is enforced, and so much more. Additionally, people with disabilities should be hired to continue the work of MOCA and point out barriers. There is incredible potential within the 2040 goal to ensure work for unionized workers or to organize non-unionized workers. A 2018 report from the Conference Board of Canada found that improvements to workplace access would allow 550,000 Canadians with disabilities to work more, increasing GDP by $16.8 billion by 2030.[227] If nothing else, governments should be interested in making Canada accessible for the gains to the GDP.

It should also be noted that even if Canada is fully accessible by 2040, millions of people with disabilities who are alive now will not be alive to witness that reality. Governments, businesses, and organizations should be doing everything in their power to make Canada fully accessible as soon as possible. The fact that there is no longer a Minister of Diversity, Inclusion and Persons with Disabilities, or indeed any minister responsible for any of those items individually, does not bode well for making Canada accessible by 2040.[228]

CANADA DISABILITY BENEFIT

The Canada Disability Benefit (CDB)—originally advertised to support the financial security of persons with disabilities—is a new federal initiative aiming to reduce poverty and support the financial security of working-age people with disabilities.[229][230] In June 2024, the government published draft regulations of the CDB and invited feedback from the public until September 2024. The final regulations were published March 2025 and it's expected that the CDB will begin accepting applications in June 2025, with the first payments being delivered in July 2025.

While the CDB is much needed, NUPGE echoed the concerns of disability justice organizations and people with disabilities during the public consultations. The primary criticism is the low amount provided by the CDB: a maximum amount of $200 per month (or $2,400 a year). For reference, as of March 2025, the average monthly rent cost in Canada was $2,088.[231]

In addition to the low dollar amount, the CDB has income thresholds. The benefit will be reduced by 20 cents for every dollar of income that is above $23,000 (if the beneficiary is single) or $32,500 (if the beneficiary is married or has a common-law partner). If both members of a couple are beneficiaries, the benefit will be reduced by 10 cents for each person for every dollar of the couple's income that is above $32,500. Though claiming the CDB is designed to support the financial security of working-age people with disabilities, the working income exemption does little to benefit workers with disabilities. If the beneficiary is single, a maximum of $10,000 will be exempted from the calculation of their income (a maximum of $14,000 if the beneficiary is married or has a common-law partner).[232] As previously mentioned, Canada uses the Market Basket Measure (MBM) to determine poverty thresholds in different regions across Canada. Using the most recent MBM thresholds, $23,000 is below the poverty threshold of every major city in Canada.[233]

As previously discussed, approximately 1.5 million people with disabilities live below the poverty line in Canada. However, *Budget 2024* only estimated 600,000 people would be eligible for the CDB.[234] Former Minister of Diversity, Inclusion and Persons with Disabilities Kamal Khera stated that once the CDB is fully mature in 2027-28 it will only lift 25,000 workers with disabilities and 15,000 of their family members out of poverty each year.[235] Based on those numbers, it will take 60 years to lift the current 1.5 million people with disabilities out of poverty or 24 years to lift the estimated 600,000 people with disabilities who are eligible for the CDB out of poverty.

Beyond the low amount of the benefit, concerns have been raised about the CDB application process. The CDB has been restricted to people with disabilities aged 18 to 65. Additionally, eligibility is restricted to people with disabilities who are eligible for the Disability Tax Credit (DTC). The DTC has long been criticized for the confusing and costly application process (medical practitioners are allowed to charge a fee for completing their part of the application). Rabia Khedr, National Director of Disability Without Poverty, and Senator Judith G. Seidman have stated that people who are part of marginalized groups face unique barriers when applying for the DTC:

> For instance, individuals with mental health conditions or episodic disabilities frequently fail to meet the DTC's rigid and outdated criteria, even though these conditions often create significant barriers to daily life and employment. Similarly, racialized and newcomer Canadians may face systemic barriers in accessing medical care, further complicating their ability to qualify.

Khedr and Senator Seidman have also pointed out that the DTC was never designed as a tool to determine eligibility for social benefits. Additionally, many people with disabilities don't file taxes because they lack taxable income. And if the applicant lives with their spouse or common-law partner, the partner must also file their taxes for the applicant to be eligible. Using the DTC as part of the eligibility criteria for the CDB prevents the people with disabilities who need the CDB most from accessing it. [236]

It would create fewer barriers for people with disabilities, and be far more cost effective, to work with the provinces and territories to automatically enroll anyone receiving provincial or territorial disability benefits. This suggestion, along with increasing the amount of the benefit, was included in the hundreds of comments the government received on the draft regulations but was ignored.[237]

The last of the main concerns with the CDB is the potential for the provinces and territories to clawback the CDB from people with disabilities who receive provincial or territorial disability benefits. As of March 2025, only seven provinces and territories have committed to no clawback of the CDB (British Columbia, Saskatchewan, Manitoba, Nunavut, Quebec, Nova Scotia, and Newfoundland and Labrador). The Yukon, the Northwest Territories, Ontario, and New Brunswick have yet to issue a statement on clawbacks.[238] And Alberta has declared they will keep Assured Income for the Severely Handicapped (AISH) payments at their current level but clawback the amount given by the CDB.[239]

To be clear, provincial and territorial disability benefits also fall short of meaningful support for people with disabilities. In 2020 the Organisation for Economic Co-operation and Development (OECD) found that Canada only spends 0.8% of its GDP on public spending on incapacity (which includes disability support benefits).[240]

PROVINCE OR TERRITORY NAME	PROVINCIAL OR TERRITORIAL SUPPORT PROGRAM	SUPPORT PROGRAM MONTHLY AMOUNT	MBM POVERTY THRESHOLD (OF MAJOR CITIES)	GAP BETWEEN SUPPORT AMOUNT AND POVERTY LINE
BRITISH COLUMBIA	BCEA-Disability Assistance Branch	$1,483.4	$2,294.25 (Vancouver)	$810.85
ALBERTA	Assured Income for the Severely Handicapped	$1,863	$2,264.29 (Edmonton)	$401.29
SASKATCHEWAN	Saskatchewan Assured Income for Disability	$1,064	$2,098.04 (Regina)	$1,034.04
MANITOBA	Manitoba Supports for Persons with Disabilities	$1,166	$2,088.71 (Winnipeg)	$922.71
ONTARIO	Ontario Disability Support Program	$1,188.67	$2,050.67 (Hamilton)	$862
QUEBEC	Basic Income Program/ Social Solidarity Program	$1,548 (B.I.P) $1,205 (S.S.P)	$1,888.79 (Montreal)	$340.79 (B.I.P), $683.79 (S.S.P)
NEW BRUNSWICK	Extended Benefits Program	$907	$2,002.29 (Moncton)	$1,095.29
NOVA SCOTIA	Employment Support and Income Assistance	$950	$2,149.88 (Halifax)	$1,199.88
PRINCE EDWARD ISLAND	AccessAbility Supports	$1,426.67	$2,095.33 (Charlottetown)	$668.66

NEWFOUNDLAND AND LABRADOR	Income Support	$1,083	$2,090.29 (St. John’s)	$1,007.29
YUKON	Social Assistance Program	$1,522.42	$2,215.17 (Whitehorse)	$692.75
NORTHWEST TERRITORIES	Income Assistance Program	$2,123.92	$2,540.46 (Yellowknife)	$416.94
NUNAVUT	Income Assistance Program	$769	Federal government has yet to determine	

Data from Disability Without Poverty’s *Disability Statistics by Province*, 2024[241]

The CDB regulations state, “the Minister of Employment and Social Development has provided persons with disabilities from a range of backgrounds with meaningful and barrier-free opportunities to collaborate in the development and design of the annexed Regulations”.[242] What it fails to state is that the government did not incorporate any of the recommendations they heard from people with disabilities. As it stands, the CDB will fail to make any meaningful difference in the lives of people with disabilities.

MEDICAL ASSISTANCE IN DYING (MAID) AND DISABILITY

Medical Assistance in Dying (MAID or MAiD) is a process that allows people to be able to receive assistance from a medical practitioner in ending their life. In 2015 the Supreme Court of Canada ruled in *Carter v Canada (AG)* that, “prohibition on physician-assisted dying infringes the right to life, liberty and security of the person in a manner that is not in accordance with the principles of fundamental justice.”[243] In 2016, Bill C-14 or *An Act to amend the Criminal Code and to make related amendments to other Acts (medical assistance in dying)* was passed at the federal level.[244]

Initially, in addition to age and the ability to consent, the criteria for MAID eligibility included a “grievous and irremediable medical condition” which was defined as a person who has all of the following:

- they have a serious and incurable illness, disease or disability;
- they are in an advanced state of irreversible decline in capability;
- that illness, disease or disability or that state of decline causes them enduring physical or psychological suffering that is intolerable to them and that cannot be relieved under conditions that they consider acceptable; and
- their natural death has become reasonably foreseeable, taking into account all of their medical circumstances, without a prognosis necessarily having been made as to the specific length of time that they have remaining.[245]

The original MAID requirements are now known as Track 1 MAID.

A legal challenge was brought against the Attorney General of Canada regarding the provision around a person's natural death being reasonably foreseeable. In 2019, the Superior Court of Quebec ruled in *Truchon c. Procureur général du Canada* that the reasonably foreseeable natural death requirement infringed upon rights to life, liberty, and security of person in the *Canadian Charter of Rights and Freedoms*.[246]

In response, in 2021 the federal government passed further legislation which repealed the provision that required a person's natural death be reasonably foreseeable in order for them to be eligible for MAID.[247] The revised requirements are now referred to as Track 2 MAID. Currently, people whose only medical condition is a mental illness are not eligible for MAID. The program was originally set to be expanded to include mental illness as the sole medical condition in March 2024 but was delayed until March 2027.[248]

In 2023, 19,660 Canadians applied for MAID. 15,343 people received MAID, 2,906 people died before receiving MAID, 915 people were deemed ineligible, and 496 people withdrew their requests. A total of 9,619 reported their racial, ethnic or cultural identity when making their request for MAID. 95.8% of respondents were white, indicating that MAID may be less accessible to BIPOC. Of the respondents who received MAID and identified as Indigenous, 80 identified as First Nations, 36 identified as Métis, and 23 identified as both First Nations and Métis. Health Canada states that fewer than five people identifying as Inuit received MAID in 2023, and that fewer than five people who identified as Indigenous received MAID under Track 2, but they don't provide the actual number.[249] It's unknown how many of the Indigenous people who used MAID had disabilities.

There are also issues in the data on the number of people with disabilities that accessed MAID due to inconsistencies in data collection. In 2023, 3,633 people who accessed MAID self-identified as having a disability. 3,423 of those people were eligible under Track 1 MAID and 210 were eligible under Track 2 MAID. Women who self-reported having disabilities were more likely to access MAID under both tracks compared to men. In terms of people who self-identified as having disabilities and required disability support services, 68.4% of people who accessed MAID under Track 1 and 75.7% of people who accessed MAID under Track 2 reported requiring disability support services.[250]

There is no data specific to people with disabilities regarding why they chose to access MAID. But data on the motivation of all people who accessed MAID in 2023 is available.

REPORTED NATURE OF SUFFERING	EXPERIENCED BY PERCENTAGE OF PEOPLE WHO ACCESSED MAID UNDER TRACK 1	EXPERIENCED BY PERCENTAGE OF PEOPLE WHO ACCESSED MAID UNDER TRACK 2
LOSS OF ABILITY TO ENGAGE IN MEANINGFUL ACTIVITIES	95.5%	96.3%
LOSS OF ABILITY TO PERFORM ACTIVITIES OF DAILY LIVING	87.4%	83.1%
LOSS OF DIGNITY	64.8%	70.4%
INADEQUATE PAIN CONTROL OR CONCERN ABOUT IT	54.4%	58.5%
PERCEIVED BURDEN ON FAMILY, FRIENDS, OR CAREGIVERS	45.1%	49.2%
LOSS OF INDEPENDENCE	52.8%	39.1%
INADEQUATE CONTROL OF OTHER SYMPTOMS OR CONCERNS ABOUT IT	41.8%	31.2%
EMOTIONAL DISTRESS, ANXIETY, FEAR, OR EXISTENTIAL SUFFERING	38.5%	35%
LOSS OF CONTROL OF BODILY FUNCTIONS	33.4%	32.2%
ISOLATION OR LONELINESS	21.1%	47.1%
OTHER	3.6%	4.8%

Data from the Fifth Annual Report on Medical Assistance in Dying in Canada, 2023[251]

Arguments for and against Track 1 and Track 2 MAID and the proposed expansion scheduled for 2027 have divided communities of people with disabilities. When the federal government was debating Track 2 legislation, over 200 disability organizations opposed the legislation and warned the government of the threat it posed to people with disabilities.[252] Tim Stainton, Director Emeritus of the Canadian Institute for Inclusion and Citizenship at the University of British Columbia, has described MAID as, “probably the biggest existential threat to disabled people since the Nazis’ program in Germany in the 1930s.”[253] In September 2024 a coalition of disability rights organizations—Inclusion Canada, the Council of Canadians with Disabilities (CCD), Indigenous Disability Canada (IDC/BCANDS), and DAWN Canada—as well as two individuals who have been harmed by Track 2 MAID filed a Charter challenge with the Ontario Superior Court of Justice.[254]

In March 2025 the United Nations Committee on the Rights of Persons with Disabilities issued a scathing critique of Canada’s current MAID system. In particular, the committee took issue with Track 2 MAID stating:

> (a) The federal government did not challenge the Quebec Truchon decision which fundamentally changes the whole premise of medical assistance in dying when natural death is reasonably foreseeable to a new program that establishes medically assisted dying for persons with disabilities based on negative, ableist perceptions of the quality and value of the life of persons with disabilities, including that 'suffering' is intrinsic to disability rather than the fact that inequality and discrimination cause and compound 'suffering' for persons with disabilities;
>
> (b) The concept of 'choice' creates a false dichotomy by setting up the premise that if persons with disabilities are suffering, it is valid for the State Party to enable their death, with safeguards not guaranteeing the provision of support, and ableist assumptions deemphasising the myriad of support options for persons with disabilities to live dignified lives, and the systemic failures of the State Party to address the social determinants of health and well-being, such as poverty alleviation, access to healthcare, accessible housing, prevention of homelessness, prevention of gender-based violence, the provision of community-based mental health supports and employment supports;
>
> (c) Evidence from the Ontario Office of the Chief Coroner and federal government data indicating that Track 2 MAiD is disproportionately accessed by women with disabilities and persons with disabilities in marginalised situations, and there is an upward trajectory of persons with disabilities killed through Track 2 MAiD;[255]

Regardless of individual perspectives on the use of MAID, as discussed in other sections, Canada is failing people with disabilities by not adequately addressing social determinants of health. Author Jeremy Appel summarized the situation:

> I've come to realize euthanasia in Canada has become the ultimate neoliberal policy — we'll starve you of the funding you need to live a dignified life, demand you pay back pandemic aid you applied for in good faith, and if you don't like it, well, why don't you just kill yourself?
>
> The problem with my previous perspective was it held individual choices as sacrosanct. But people don't make individual decisions in a vacuum. They're the product of social circumstances, ones often out of their control.[256]

WORKING WITH ORGANIZATIONS THAT CATER TO PEOPLE WITH DISABILITIES

Unions should be cautious when engaging with organizations that focus on people with disabilities. Most of the organizations do good work and are led by people with disabilities or valued allies. But some organizations are highly contentious in disability communities. Autism Speaks is the largest autism research organization in the world but is strongly disliked by many people with autism. The dislike stems from:

- Their mission statement listing finding a "cure" for autism until 2016
- Their adverse impact on autism research (funding studies on the link between vaccines and autism until at least 2010, and not issuing a statement that vaccines do not cause autism until 2015)

- Its endorsement of the controversial Applied Behaviour Analysis (ABA) therapy
- Spreading misinformation and harmful stereotypes about autism through their short film *I Am Autism* and through other sources
- A lack of people with autism on their board and in management positions.[257]

More recently, organizations like Autistics for Autistics Ontario (A4A) have raised concerns over some of the projects Autism Speaks sponsors being used for eugenic purposes.[258] This is not to say that everything Autism Speaks has done is negative, but the opinions of people with disabilities and organizations led by people with disabilities must be considered when unions are looking to amplify the work of organizations that work with people with disabilities.

IMPACT OF THE TRUMP ADMINISTRATION ON PEOPLE WITH DISABILITIES AND GLOBAL HEALTH

Given the substantial impact of United States policy on Canada and the rest of the world, it should be noted that U.S. President Trump has ordered several changes that severely harm people with disabilities. Trump's pick for the Secretary of the Department of Health and Human Services (HHS), Robert F. Kennedy Jr., is a lawyer with no medical or public health training. He does however have experience with anti-vaccine advocacy, and is labeled as one of the Disinformation Dozen—a group of twelve people who are responsible for approximately 65% of anti-vaccine content on Facebook and Twitter.[259] Research has also shown that RFK Jr.'s organization, Children's Health Defense, was one of two buyers that accounted for the majority (54%) of anti-vaccine advertising content on Facebook for multiple months.[260]

In addition to his incorrect beliefs about vaccines (such as believing vaccines cause autism and that no vaccine is safe or effective) RFK Jr. has also spread scientific racism (by claiming that Black people have better immune systems that white people and should therefore be on different vaccine schedules) and misinformation about COVID-19, fluoride in drinking water, chronic disease in children, bird flu, and other topics related to health.[261][262] He has also attacked the Centers for Disease Control (CDC) directly, calling it a "cesspool of corruption" that harms children in a way he likened to "Nazi death camps".[263]

Under RFK Jr.'s order the CDC, the Prevention and the Food and Drug Administration (FDA), and the National Institutes of Health (NIH) have enacted massive job cuts.[264] Under the executive order creating the Make America Healthy Again Commission, RFK Jr. has been directed to, "assess the prevalence of and threat posed by the prescription of selective serotonin reuptake inhibitors, antipsychotics, mood stabilizers, stimulants, and weight-loss drugs."[265] Mental health disability activists have warned about this directive in relation to RFK Jr.'s promise on the campaign trail (when he was a candidate for the Republican nomination for president) to create "wellness farms" or drug rehabilitation farms for people to "get off" legal and illegal drugs.[266] RFK Jr. has ordered the elimination of the Administration for Community Living—which helps people with disabilities and older adults live independently—though he claims some responsibilities will be transferred to other agencies.[267]

On April 10, 2025, RFK Jr. announced that the U.S. government will “pinpoint the cause of autism by September”. In response to RFK Jr.’s statement, Trump suggested that, “there’s got to be something artificial out there that’s doing this, maybe it’s a shot. But something’s causing it”.[268] It should be noted that the 1998 paper by Andrew Wakefield that claimed there was a link between the measles, mumps, and rubella (MMR) vaccine and autism was redacted in 2010 after it was discovered that some of the research was funded by lawyers acting for parents who were involved in lawsuits against vaccine manufacturers.[269] Vaccine skepticism increased following the publication of Wakefield’s paper, leading to an increase of MMR vaccine injury claims and decrease in MMR vaccination rates in multiple countries.[270][271] Australia and countries in Europe and North America have all had outbreaks of mumps and measles since Wakefield’s paper was published, despite both diseases being nearly completely eradicated in Western countries prior to the 1990s.[272][273] Further research—that was conducted ethically and scientifically—has consistently shown there is no proof that vaccines cause autism.[274]

It should also be noted that in December 2024, former President Joe Biden signed a five-year extension of the Autism Collaboration, Accountability, Research, Education and Support Act (or Autism CARES Act), which includes $1.95 billion dollars to fund projects related to autism.[275] Additionally, the NIH already spends more than $300 million dollars yearly researching autism.[276] People with autism and medical experts have expressed doubt at RFK Jr.’s claim to find the cause of autism by September, pointing out the cuts to staffing and research grants enacted by RFK Jr. will hurt research efforts.[277][278] RFK Jr. has also hired David Geier—a researcher who has been disciplined for practicing medicine without a license and has written several papers (that have been debunked and retracted) which spread misinformation about vaccines—as a senior data analyst at the HHS. Given all of the above, there is concern that RFK Jr. will simply announce that vaccines cause autism in September.[279][280] Should that happen, the effects on vaccine research and the health of the general population would be disastrous.

Additionally, thousands of pages have been removed from the CDC website, many of which contained vital public health data sets that are used around the world.[281] On March 28, 2025, Dr. Peter Marks—a hematologist and oncologist—resigned (after being given the choice to resign or be fired) from his position as Director of the Center for Biologics Evaluation and Research (CBER) within the FDA. In his resignation letter, Dr. Marks criticized RFK Jr. for spreading misinformation about vaccines and emphasized the dangers to public health of undermining confidence in established vaccines.[282]

Fred Trump III, Trump’s nephew, claims that in 2017 following a meeting with disability rights activists, Trump said, “those people, the costs. Why don’t they just die?”. Fred Trump III also claims that in 2020, when he asked his uncle for money to help pay for his son William’s medical care related to disability, Trump replied, “maybe you should just let him die”. Trump has acknowledged but not denied the claims.[283]

Regardless of whether the claims are true or not, Trump has been doing significant damage to people with disabilities by terminating diversity, equity, and inclusion (DEI) programs in the federal government, spreading the lie that anyone hired through a DEI program does not have merit, and that DEI programs are discriminatory and wasteful.[284] Through Elon Musk's so-called Department of Government Efficiency, Trump has also enacted staffing cuts at the Department of Veterans Affairs.[285] Trump and Musk frequently use the words "retard" and "retarded" as an insult, emboldening others to do the same.[286] Trump has also ordered the Department of Education to be dismantled, leaving students with disabilities without Individualized Education Programs (IEPs), accommodations, and a guarantee of a meaningful education. The words "disability" and "accessibility" have been listed as grounds to flag or reject grant applications at the National Science Foundation.[287] And the Department of Justice, which enforces the *Americans with Disabilities Act* (ADA), has begun stripping protections from the ADA under the guise of lowering the cost of living, stating, "avoiding confusion and reducing the time spent understanding compliance may allow businesses to deliver price relief to consumers."[288]

This is only the tip of the iceberg in terms of the rollback of disability rights in the U.S. Trump has been in office for just over 100 days and already people with disabilities, disability organizations, and allies are overwhelmed with the rapid rate at which Trump is harming people with disabilities and other equity-deserving communities. It's speculated that the speed at which Trump is moving is an extension of the "flood the zone" tactic Steve Bannon, former head of Breitbart News and former chief strategist for Trump, boasted about using during Trump's 2016 election campaign.[289] The premise of the tactic is to saturate the news ecosystem with misinformation which overwhelms the media's ability to separate fact from fiction. As a result, media publishes conflicting stories on the same event, creating distrust in media and eroding one of the core aspects of democracy. This tactic was pioneered by Russian President Vladimir Putin of whom writer Sean Illing says, "used the media to engineer a fog of disinformation, producing just enough distrust to ensure that the public can never mobilize around a coherent narrative".[290]

People with disabilities in the U.S. are facing a direct threat to their existence. Additionally, by slashing programs and jobs at the CDC, FDA, and other government agencies, millions of Americans are at risk of acquiring a disability due to lack of research, health information, and policies. The FDA will be forced to do fewer food and drug inspections which will erode safety.[291] The Division of HIV Prevention has been gutted.[292] Medical studies relying on grants from the NIH will not be completed.[293] Dr. Georges Benjamin, executive director of the American Public Health Association, said, "they seem to be on a quest to totally destroy the infrastructure of the nation's public health system. It's amazing that they are looking to cut the parts of our health system that give the best value for prevention and wellness".[294] Dr. Ashish Jha, the dean of the Brown University School of Public Health, said:

> We rely on our CDC for things like tracking down disease outbreaks. We rely on NIH for research into new treatments and tests and vaccines. At this moment, whether those will continue to be effective has really been put into question. We don't know what the implications of all of this will be. I'm worried that what we're going to see is more people getting sick, more disease outbreaks and infrastructure that is going to be less and less capable of responding to those threats.[295]

In addition to the job loss and potential economic crisis created by the U.S. tariffs against Canada, the majority of medical device imports to Canada come from the U.S (35%). Following the U.S., Canada imports 17% of its medical devices from China, 7% from Mexico, and 5% from Germany.[296] The U.S. is also Canada's main trading partner for pharmaceuticals, accounting for 64% of exports and 29% of imports in 2020.[297] Under the current Trump administration, there is a genuine threat to Canada's sovereignty and democracy. Political experts warn that Trump's goal of making Canada the 51st U.S. state and the way he speaks about Canada echo how Putin speaks about Ukraine.[298] The U.S. tariffs against Canada are an attack on Canada's economy. Canada cannot passively accept the tariffs, but the U.S. tariffs on Canada and the retaliatory Canadian tariffs on the U.S. will have a financial impact on people in Canada, particularly people with disabilities who are more likely to need medical devices and pharmaceuticals and who are also more likely to have lower incomes and/or live in poverty compared to people without disabilities.

Canada is not immune to the policies and misinformation coming out of the U.S. Cuts to the U.S. federal agencies will have a direct impact on the health of people living in Canada and the rest of the world. A significant portion of vaccine research is conducted in the U.S. and/or funded by the U.S. government. Millions of dollars of funding for global health organizations have been slashed.[299] As we well know, diseases don't stop at human-made boarders. Though Canadian tourism to the U.S. has slowed after Trump's threat of tariffs against Canada, there is still a great deal of cross-border travel which has the potential to spread diseases that are no longer being tracked in the U.S. Experts in epidemiology, immunology, and infectious diseases warn that another pandemic is inevitable.[300] The attack on U.S. public health has the potential to speed up our trajectory towards the next pandemic. In 2019, Canada imported 53.0% of face masks of textile materials from the U.S. and 26.4% from China. In the age of U.S. tariffs and U.S. threats to Canadian sovereignty, it's unknown how these factors will affect Canada during the next pandemic.

CONCLUSION

Anyone can acquire a disability at any point in their lives. The pandemic demonstrated that the federal government is capable of mobilizing to quickly distribute funds to Canadians who are struggling. So why is that same speed not used to assist people with disabilities? Why does the ACA not require sectors under federal jurisdiction to be accessible until 2040? Why will the CDB only lift 25,000 workers with disabilities out of poverty annually? Where are the investments in indoor air filtration; a technology that we know plays a significant role in reducing the transmission of COVID-19 and other airborne pathogens? Why are disability support payments allowed to be less than poverty thresholds?

People with disabilities are one of several equity-deserving groups whose lives governments at all levels have significant power to improve. People with disabilities are a large part of the population of Canada. We know that as of 2022, 8 million Canadians aged 15 years and older had a disability in Canada—that's 27%—and the number would be even higher if it included children with disabilities.

Even if they don't track the demographic data, it's statistically likely that unions represent large numbers of workers with disabilities. Making unions stronger for people with disabilities makes the union stronger for everyone. Given the way disability interacts with all parts of a person's life, unions have a responsibility to take part in disability justice.

As writer Leah Lakshmi Piepzna-Samarasinha says in their essay *Making Space Accessible is an Act of Love for our Communities*:

> Love in action is when we strategize to create cross-disability access spaces. When we refuse to abandon each other. When we, as disabled people, fight for the access needs of sibling crips. I've seen able-bodied organizers be confused by this. Why am I fighting so hard for fragrance-free space or a ramp, if it's not something I personally need?
>
> When disabled people get free, everyone gets free. More access makes everything more accessible for everybody. And once you've tasted that freedom space, it makes inaccessible spaces just seem very lacking that kind of life-saving, life-affirming love. Real skinny. Real unsatisfying. And real full of, well, hate.
>
> Why would you want to be part of that?[301]

WHAT CAN UNIONS DO?

Above all else, listen to people with disabilities and adhere to the principles of "nothing about us, without us". The burden of ending ableism and making the world accessible is not on people with disabilities, but they must be included in all matters that relate to them. Unions should make sure they engage with people who have different types of disabilities and who belong to multiple equity-deserving groups and ensure intersectionality is a guiding framework.

This is not a complete list of what unions can do, but it serves as a starting point for several areas. Some of the actions recommended for unions to do internally can also apply to actions unions can take during collective bargaining and in employer relations.

Actions Within Unions

- Do an internal EDIA audit of the union and union practices, policies, and procedures (followed by routine reviews).
- Implement EDIA training that emphasizes the lived experience of people with disabilities for union staff, elected positions, and members.
- Embrace universal design and plain language in all aspects of the union.
- Create accessible materials in a variety of formats (e.g. accessible PDFs, audio recordings of collective agreements, accessible websites and social media, etc.).
- Demonstrate to the membership that unions will fight for workers with disabilities, particularly on discrimination and accommodations.
- Go beyond boilerplate language of inclusivity in job postings (e.g. only list the core job functions and bona fide occupational requirements, advertise the job in physical and

online spaces that people with disabilities visit, note ways in which the job/workplace is already accessible, offer the interview questions in advance of the interview, etc.).
- Host educational sessions on disability and the duty to accommodate.
- Foster solidarity between members with and without disabilities.
- Ensure that scent free policies are in place and followed in union buildings and workplaces.
- Provide sector specific training on bias, systemic ableism, and their intersections with other experiences of oppression.
- Create a code of conduct and anti-oppression policy.
- Share resources like the **Job Demands and Accommodation Planning Tool (JDAPT)** and the **Job Accommodation Network (JAN)** with members.
- Audit in-person and online union meetings and events for accessibility.
- Ensure members with disabilities are represented on all committees and working groups.
- Embody equity, as opposed to equality, understanding that different members have different needs, and therefore must be treated differently for there to be an equality of outcome.

Collective Bargaining and Employer Relations

- Engage with the employer on the importance of universal design, particularly as a tool to reduce the number of individual accommodations the employer must respond to.
- Bargain for flexible work arrangements (including flexible hours, remote work, and hybrid work).
- Engage with the employer on ongoing EDIA training in the workplace, particularly as a tool for retention of workers with disabilities.
- Ensure people with disabilities are included in designing workplace emergency policies and evacuation plans.
- Work with employers to create accommodations for members with disabilities and members who are caregivers for people with disabilities (and work to raise awareness with members that their union can assist them with the accommodation process). Emphasize that accommodations cannot take a one-size-fits-all approach.
- Encourage employers to create disability management programs and plans. This should be done in consultation with workers with disabilities, disability organizations, and the union (e.g. **CSA Z1011:20, Work disability management system**).
- Prior to bargaining, engage with members with disabilities and include their needs in bargaining proposals (e.g. increased amount of sick leave benefits everyone, but particularly workers with disabilities).
- Strengthen anti-discrimination clauses in collective agreements to include specific protections for members with disabilities.
- Push employers to enact monitoring mechanisms so workers can provide feedback on whether they have the tools and supports they need to produce quality work.
- Work with the employer to evaluate which positions are held by members with disabilities and assist members with disabilities in advancing their careers.

- Ensure employers are adequately training workers on occupational health and safety and go beyond legal requirements for training.
- Press employers to look seriously at reducing stress in the workplace.
- Include mental health coverage in collective bargaining.
- Work with employers to provide sector specific training for members on how to better serve people with disabilities.
- Encourage public service employers to create resources for people with disabilities on their rights when accessing specific public services (e.g. health care).
- Encourage public service employers to adopt trauma-informed care as part of their services.
- Push employers to ensure all policies are looked at with a disability justice lens.

Lobbying and Advocacy

- Advocate for more intersectional research on disabilities.
- Lobby governments to modify disability support programs to be more responsive to the changing circumstances of people with episodic disabilities.
- Lobby to integrate human rights values into workers compensation systems.
- Lobby the federal government to nationalize home care services.
- Lobby governments to increase disability support payments and reduce employment income claw backs.
- Lobby governments to ensure funds for housing are only being given to projects that comply with the principles of universal design.
- Lobby the federal government to ensure Statistics Canada creates reports that look at disability intersectionally and also includes intersectional data on disability in other reports (e.g. Labour Force Reports, Canadian Community Health Survey, etc.).
- Lobby the federal government to publish a plan with timelines on how it will enact and implement regulations related to the *Accessible Canada Act*.

RESOLUTION #20 IMPROVING CANADA AND OUR UNIONS FOR PEOPLE WITH DISABILITIES

The 2022 Canadian Survey on Disability (CSD) showed that 27.0% of Canadians aged 15 years and older, or 8 million people, had one or more disabilities that limited them in their daily activities.

The 2022 CSD showed that 62.0% of working-age adults (25 to 64 years of age) with disabilities were employed, compared with 78.0% of persons without disabilities. People with disabilities who are working are often underemployed in lower-paying jobs that have less stability, fewer benefits, and limited chances for career growth.

41.0% of low-income Canadians have disabilities. 16.5% of people with disabilities in Canada live in poverty—that's more than 1.5 million people. The financial impact of having a disability is felt harder by people who are discriminated against due to their gender, sex, sexual orientation, race, ethnicity, citizenship status, and religion.

Anyone can acquire a disability at any time.

Though it is no longer a pandemic, COVID-19 is still prevalent in our society and is still causing people to develop disabilities. Research has found that even a mild or asymptomatic case of COVID-19 can cause long-term damage to the immune system, brain, lungs, heart, kidneys, and blood vessels. It also elevates the risk of heart attack, stroke, diabetes, organ failure, dementia, epilepsy, and more. The risk of developing a disability or severe health condition after a COVID-19 infection is somewhat reduced for people who are fully vaccinated and regularly obtain booster shots, but it is not eliminated.

Post COVID-19 condition (also known as long COVID) is a condition where the symptoms of COVID-19 persist for more than 12 weeks after the infection. The Public Health Agency of Canada reported that, by October 2022, 15.0% of adults who got COVID-19 experienced long COVID. 47.0% reported having symptoms for 1 year or longer. 21.0% reported their symptoms often or always limited their daily activities. And 74.1% of those who were employed or attending school missed work or school due to their symptoms on average, missing an estimated 20 days each.

Accommodations help everyone. Ramps and curb cutouts help people with strollers, carts, luggage, and wagons. Doors that can be opened with one hand assist people who are younger, older, or weaker, and anyone carrying things. However, universal design—the design of products and environments to be usable by all people, to the greatest extent possible, and without the need for adaptation or specialized design—should be the standard.

The Canada Disability Benefit (CDB) pays a maximum of $2,400 per month. The average cost of a 1-bedroom apartment in Canada in the month of June 2024 was $1,929. $2,400 a month will not lift the majority of people with disabilities out of poverty. To qualify for the CDB, prospective recipients must qualify for and receive the federal Disability Tax Credit (DTC), even if a person is already approved for disability benefits provincially. The DTC has a low uptake rate: it's estimated that only 40% of working-aged adults with qualifying disabilities are currently enrolled in the DTC. This is due to lack of awareness of the program, a burdensome application process (for which medical practitioners may charge a fee up to $300), and confusing eligibility criteria. The criteria are especially confusing and restrictive for people with episodic disabilities and for people who fall under the DTC category of having a disability related to "mental functions." In addition to the CDB, the DTC is also the gateway to the Child Disability Benefit and Registered Disability Savings Plans.

Medical Assistance in Dying (MAID) is reportedly being accessed by people with disabilities due to failures of our health care and social welfare systems. This trend is predicted to continue as governments privatize more public services. In 2022, the most cited sources of suffering by individuals requesting MAID were the loss of the ability to engage in meaningful activities followed by the loss of the ability to live their daily life.

Therefore, the National Union of Public and General Employees will

Continue the Special Workers with Disabilities Committee as the Workers with Disabilities Committee and ensure that the committee meets at least once a year.

Develop a tool kit that enables Components to undertake accessibility audits of their meeting and event spaces.

Share best practices regarding collective bargaining for people with disabilities with Components.

Ensure all NUPGE communications and publications use alt text and tags where appropriate.

Lobby the federal government to raise the Canada Disability Benefit amount and make the Canada Disability Benefit easier to access.

Lobby the federal and provincial governments to properly fund public health care and other public services that people with disabilities rely on.

Lobby the federal government to expand the *Pharmacare Act* and create a comprehensive essential medicines list to ensure broad and effective coverage.

Encourage Components to lobby provincial governments to expand public health care to include mental health services.

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