DISMANTLING ABLEISM SURVEY REPORTS

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Dismantling Ableism Survey (DAS): Methodology and Sample Description

Introduction

The Dismantling Ableism: Institutional Action and Accountability Survey (DAS) is one piece of a larger anti-ableism project, entitled Dismantling Ableism for Persons with Disabilities: Institutional Action and Accountability. Funded by a Robbins-Ollivier Award for Excellence in Equity, the project aimed to answer the following questions:

- What is equity when disabled persons and anti-ableism are centered?
- What are the complex ways in which ableism operates across the University of Manitoba community and larger research ecosystem?

The project is composed of 3 pillars. The objective of Pillar A was to utilize research to better understand the diversity within and amongst disabled people at UM through the collection and analysis of disaggregated data. Accordingly, the goals of the survey were:

- To understand the specific ways in which ableism appears across UM (e.g., in work and learning practices and university policies and systems)
- To understand the diversity of experiences within the disability community at UM, including the experiences of those that have chronic health conditions (e.g., how the experiences of disabled persons who identify as 2SLGBTQIA+ differ from those that identify as cis-heterosexual; or how the experiences of disabled staff differ from disabled faculty and student experiences)
- Conduct disaggregated data analysis to inform equitable decision-making

The objective of Pillar B was to aid institutional policy review by developing a comprehensive equity impact assessment tool that centers anti-ableism.

The objective of Pillar C was to develop structures to promote equity for disabled people and produce a report with recommendations to eliminate systemic institutional barriers, incorporating the knowledge acquired through the DAS.

The project is managed by Cade Kuehl (Project Coordinator and Research Assistant); and anchored by Dr. Diane Driedger (Disability Studies), and Dr. Reg Urbanowski (Rehabilitation Sciences) with Distinguished Professor and Vice-Provost (Equity) Dr. Tina Chen serving as the administrative Principal Investigator. Dr. Jennifer Dengate (Director, EDI Research and Projects) oversaw the

development, pre-testing, administration, and analysis of the DAS, in collaboration with Cade Kuehl, Tina Chen, Chris Campbell[1], Kezia Wong[2], and Meisha Monsigneur[3].

Language and Definitions

The DAS used identity-first language ("disabled persons") rather than person-first language ("persons with disabilities") to emphasize the disabling effect of social, environmental, and institutional barriers which hinder disabled individuals' full participation in society, including university life. The survey also referred to "chronic health conditions" to capture the diversity of experiences related to chronic health, such as those who experience illness more intermittently or episodically.

Similarly, some survey questions asked about "difficulties" or "challenges" (e.g., using UM software). The survey was created with the understanding that any reported "difficulties" or "challenges" are directly related to ongoing ableist barriers that impede access and participation.

These language choices were explained in the survey introduction; nevertheless, the project team respects that members of disability and chronic health communities have different language preferences[4]. Wherever possible, language should reflect individual and community preferences. Accordingly, language will vary across contexts.

The project team is grateful for the feedback we received from the survey regarding our language choices. We seek to put this feedback into practice in all future work stemming from the DAS results.

Working Definitions

The DAS was developed and administered using the following working definitions:

Ableism: is the systemically supported assumption that disabled people are inferior, invalid, incompetent, dependent, alien to society, and unable to fulfill social, professional, civil, political, or personal roles. Ableism is a prejudice made on the basis of disability, which favours non-disabled

[1] Chris Campbell (ABD) is a PhD. candidate in the Faculty of Education with extensive expertise in survey project management, including design and administration using Qualtrics. Chris programmed and revised the online questionnaire, including extensive accessibility revisions, and provided invaluable input throughout the survey design, administration, analysis, and reporting stages of the survey project.
[2] Kezia Wong is a Master's student in the Department of Psychology with expertise using SPSS to analyze quantitative data. Kezia performed the statistical analysis of the DAS data, with guidance from two senior project team members.
[3] Meisha Monsigneur is a Master's student in the Department of Psychology with expertise using SPSS to analyze quantitative data. Meisha performed the statistical analysis of the DAS data, with guidance from two senior project team members.
[4] Indeed, several survey respondents objected to the use of identity-first language, instead preferring person-first language.

and neurotypical bodies and minds; and incorrectly defines non-disabled and neurotypical bodies or minds as "normal".

Chronic health condition: any condition, including mental health conditions, that is continuing or that occurs again and again over a long period of time, which in interaction with various barriers, may hinder full and effective participation in society on an equal basis with others[5].

Disaggregating data: means breaking large pieces of data down into smaller, more specific components. Disaggregated analyses allow us to obtain the detailed information that is necessary to create more equitable systems and processes. For this project, disaggregating the data means not just looking for differences between racialized and white disabled students, for example. Instead, it means investigating the diversity of experiences among those who self-identify as racialized (e.g., how the experiences of disabled students who identify as Black may differ from those that identify as Indigenous or South Asian).

Survey Instrument

The DAS consisted of 67 questions[6] covering 17 broad topic areas including, but not limited to:

- The personal impact of ableist institutional attitudes;
- Perceptions of UM's engagement with efforts to dismantle ableism;
- Frequency of experiencing institutional and IT barriers[7];
- Additional costs associated with disability and chronic health identities;
- Accommodations experiences;
- Comfort with sharing disability and chronic health identities; and
- Areas to be immediately addressed by UM.

At the end of each topic section, the survey provided open-ended text boxes, inviting respondents to expand on their experiences and share more.

The questionnaire was reviewed and approved by both the UM Research Ethics Board (REB), Fort Garry campus, and UM's Survey Review Committee (SRC) prior to administration.

Participation in the DAS was entirely voluntary, and respondents did not receive any incentive for their participation.

[5] Adapted from Bernell & Howard (2016).
[6] The 67 questions resulted in a total of approximately 300 individual variables for statistical and qualitative analysis.
[7] The DAS was administered in November-December 2023. As such, the results may not capture recent (and ongoing) accessibility improvements to specific information and communications systems at UM, including the work undertaken to meet the Accessibility for Manitobans Act Information and Communications Standard (AMA-IC) and WCAG 2.1 standards for web content.

Accessibility

Given the goals of the survey and intended sample[8], it was imperative that the online questionnaire be as accessible as possible[9]. The survey was reviewed and pre-tested by several UM community members with both technology accessibility expertise and lived disability experience.

Pre-testers affiliated with the project and those who work with the Office of Equity Transformation as research assistant staff were compensated for their time through regular employee channels (e.g., hours claimed on weekly time sheets). One unaffiliated pre-tester received an honorarium as compensation for their time and labour.

The comprehensive accessibility review and pre-testing of the DAS clearly demonstrates that online surveys can be made more accessible by their designers, proactively reducing many respondent barriers prior to survey administration.

Overall Accessibility Review

Before programming in Qualtrics, the REB- and SRC-approved survey document (Word file) was reviewed for overall accessibility, compatibility with screen readers, and to catch any potentially ableist language. Edits were made throughout the questionnaire, including:

- Removal of forward and backslashes, including simplifying sentence structure by removing all instances of "and/or"
- Breaking up paragraphs of text into bullet points or numbered lists wherever possible
- Front-loading sentences so that the most important information appears at the beginning, rather than the end of a statement[10]
- Ensuring hyperlinks were the only underlined text
- Reserving bold text only for the most important segments of text requiring visual emphasis to properly convey the intent of the question being asked[11,12]
    - Wherever possible, the text prompt "Important:" was used instead, as this conveys emphasis more equitably between screen reader users and non-users
- Adding clarifying explanations to mitigate any offense or harm that may be associated with chosen language

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[8] Members of the UM community who self-identify as disabled and as having chronic health conditions.
[9] The Office of Equity Transformation has committed to applying the survey accessibility lessons learned via the DAS to all future surveys they are involved with.
[10] For example, "I find it mentally or emotionally exhausting to educate others on the topic of accommodations", rather than "Educating others on the topic of accommodations is mentally or emotionally exhausting for me".
[11] The emphasis conveyed by bold text is not effectively translated through screen readers. Accordingly, survey participants not using screen readers might disproportionately benefit from bold text, potentially meaning they would understand questions better than participants using screen readers or other participants identifying with certain visual disabilities and health conditions.
[12] For example, surveys often alternate between positively and negatively phrased questions. To support participants' comprehension and ensure questions are answered accurately, negative terms such as "not" are often bolded.

Once programmed in Qualtrics, the revised online version of the questionnaire was again reviewed for overall accessibility and screen reader compatibility. Following this review, adjustments to the survey formatting and appearance were made wherever possible (e.g., colours[13], font[14], headers[15], and location of text on the screen[16]).

Rank Order Question Pre-test

The final closed-ended question of the survey asked respondents to rank seven broad topic areas to determine which actions would have the biggest immediate impact on the UM community (e.g., improve physical accessibility and infrastructure, and coordinate accommodation and support services, etc.).

To create the most accessible version of this question, the survey programmer created four different formats, consulting Qualtrics guidance for more and less accessible question designs[17]. Options included a matrix format requiring respondents to click radio buttons assigning each topic area a number from one to seven and using arrows to maneuver boxes assigned to each topic area up or down to denote final order of impact, for example.

Again, pre-testers from the UM community and project team tested each version of the rank order question and provided feedback to the survey designers. The version of the question that was most accessible to the greatest number of pre-testers effectively involved breaking the question up into seven progressive questions.

More specifically, respondents were first presented with all seven response options and asked to select the "greatest impact" area. Once selected, this option would disappear from the list of available response choices. Respondents would then be asked a second question (now with only six response options), asking them to choose the second most impactful area, and so on until all seven topic areas were ranked.

Final Questionnaire(s)

Following the accessibility reviews and pre-testing, four complete versions of the final online survey were designed:

- Smaller black text (approximately 11-12 pt. font), white background
- Smaller white text, dark background

[13] To ensure appropriate contrast.
[14] Sans serif fonts (e.g., Aptos, Arial, Calibri, etc.) are relatively more accessible than serif fonts (e.g., Times New Roman), especially for online text content.
[15] Repeating headers were used for matrix format questions, ensuring respondents did not have to scroll to understand which radio button corresponded with each response option (e.g., strongly agree, agree, neither agree not disagree, disagree, strongly disagree, don't know, not applicable, or choose not to answer).
[16] Some text appeared cut off to survey pre-testers, or bumped to the next page of the questionnaire, and needed to be re-located.
[17] As Qualtrics classifies rank order as a relatively inaccessible format overall, pre-testing this question was extremely important.

- Larger black text (approximately 18-22 pt. font), white background
- Larger white text, dark background

Upon clicking the survey link embedded in the email survey invitation, interested participants were taken to a landing page in Qualtrics where they could choose the version of the survey that would be most accessible to them[18].

The four versions of the survey only differed visually, all questions including question format and order were identical across all four versions. Accordingly, following data collection, data from all four versions of the survey could easily be merged to create one final dataset to be cleaned and prepared for analysis.

Anticipating respondents may still encounter technical barriers accessing and completing the survey, the final versions of the questionnaire included a link at the bottom of each page that would direct them to the end of the survey and an open-ended space to describe the specific barriers they had encountered. Responses to the technical feedback question were downloaded by the survey director and will be used to further improve accessibility of future online surveys[19].

Participant Accessibility Feedback

The most frequent barrier participants noted was that the survey required too much time to complete[20], despite the designers' efforts to reduce the impact of the length of the questionnaire prior to administration.

Mindful that participants would all be identifying with different types of disabilities and chronic health conditions, the designers ensured respondents could pause their participation at any point and return to complete the survey up to two weeks later, provided they used the same device and Internet browser. This option was explained in survey introduction. The designers also provided instructions on the survey landing page as to how respondents could re-enter the same version of the survey they had previously been using and continue from the point where they left off (e.g., smaller or larger text on white or dark background).

It is clear from the technical feedback that the option to "pause and return" was not communicated as effectively as it should have been. The designers will explore ways to better reduce the impact of questionnaire length for longer surveys, particularly for respondents identifying as disabled, such

[18] Technically, using this approach resulted in the creation of five separate surveys within Qualtrics. The fifth survey was simply the original version of the online questionnaire that included the landing page, and respondents were taken to the default version (smaller black text on white background) if they did not select any of the other four survey options.
[19] The survey also provided the survey administrators' email contact information so any participants who were prevented from entering or continuing in the survey could receive immediate assistance to begin or resume their participation.
[20] Ultimately, survey length must be balanced with data collection needs, project objectives and commitments, and available resources. Accordingly, it is not always possible or desirable to create a short survey that requires less than 15 minutes of respondents' time, for example.

as more prominently emphasizing pause and return instructions and repeating these instructions throughout the survey (e.g., at the end of topic sections).

Recruitment and Data Collection

The target population for the DAS was any UM community member (student, staff, or faculty) that identifies as disabled or as having chronic health conditions, broadly defined.

Participants were recruited via email invitation, sent through two University of Manitoba mailing lists: all-students and all-employees[21]. In addition to the initial invitation, two follow-up reminders were sent at 1-2 week intervals. The survey was also mentioned in a UM Today story and in a Rady Faculty of Health Sciences online newsletter. Readers of these publications were reminded to check their UM email for the survey invitation and follow-up reminders[22].

Data were collected confidentially through the Qualtrics survey platform over a period of five weeks from November to December 2023. Because the survey included several open-ended text boxes, respondents had the opportunity to voluntarily disclose directly and indirectly identifying details in those spaces. Accordingly, the data collection could not be classified as anonymous.

Interested respondents could also provide their email address for the purpose of receiving copies of the summary results reports following data analysis. Email addresses were collected in a separate Qualtrics survey file and stored apart from the survey data to ensure individual survey responses could not be linked back to any specific email address.

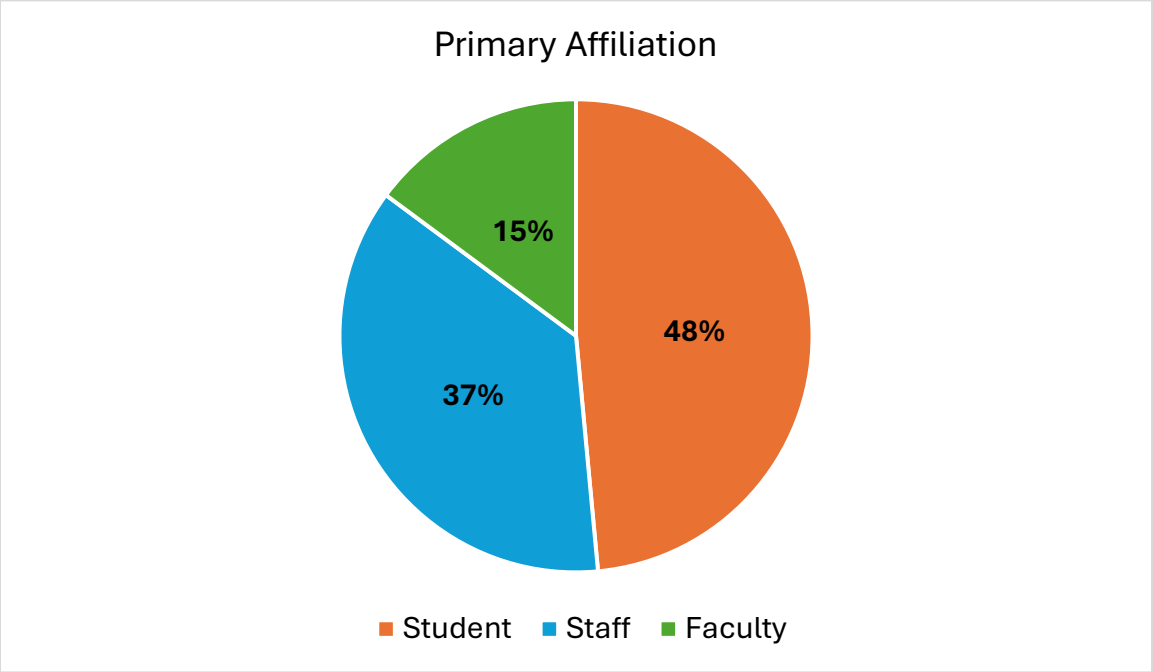
[21] The research team obtained permission from the mailing list managers as part of the Survey Review Committee approval process. The team is also grateful to UM's Marketing and Communications Office (Strategic Communications) for the support they provided regarding the timing and content of the large-scale email invitations.

[22] The survey link was not provided for either the UM Today story or the Rady newsletter to ensure access to the questionnaire was limited to UM community members.

Sample Size and Participant Information

The total sample size for the DAS is 544, after data cleaning. Students make up nearly half of the sample (48%; 73% undergraduate and 27% graduate), followed by staff (37%), and faculty[23] (15%) (see Figure 1 next page). Compared to Office of Institutional Analysis figures[24], students are relatively underrepresented in the DAS sample, staff are overrepresented, and faculty are represented roughly as much in the sample as they are across the UM community[25].

Figure 1: Primary Affiliation



- Most of the sample indicated that Fort Garry is their primary campus (82% students, 72% staff, and 70% faculty)
- The majority of the sample is aged 45 or younger (72%)
- 40% had difficulty meeting their necessary costs (e.g., housing, electricity, water, health care, and food, etc.) in 2022-2023 (44% students vs. 36% faculty and 36% staff)

[23] Totals may exceed 100% due to rounding and the fact that many socio-demographic questions are "select all" format, inviting respondents to choose as many responses as necessary to fully identify.
[24] There may be some discrepancies when comparing such figures, related to differences in institutional definitions and terminology (academic vs. non-academic staff) vs. how the DAS defined student, staff, and faculty when asking respondents to indicate their primary affiliation.
[25] Because it is impossible to know the total number of UM community members who identify as disabled or as having chronic health conditions, it is impossible to calculate a survey response rate.

Disability and Chronic Health

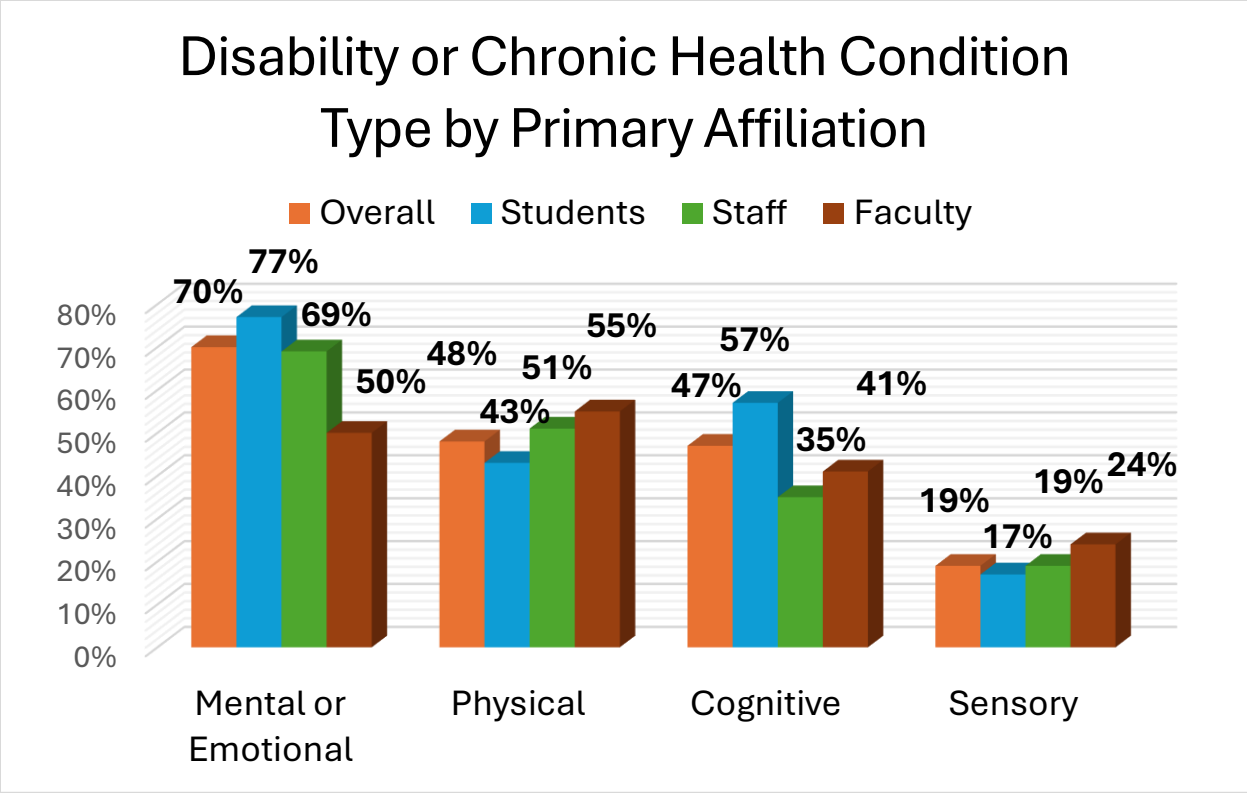
A majority of the DAS sample report their disabilities and chronic health conditions are at least sometimes invisible or hidden, and that they have more than one disability or chronic health condition.

- 63% have chronic health conditions (54% students, 71% staff, and 71% faculty)
    - Respondents aged 45+ are more likely to identify as having chronic health conditions than as disabled or with another disability identity (e.g., temporarily disabled)
- 44% identify as disabled (60% students, 29% staff, 33% faculty)
    - Respondents under the age of 25 are more likely to identify as disabled than as having chronic health conditions or with another disability identity (e.g., temporarily disabled)
- Nearly half of the sample (47%) indicate their disability or chronic health condition is rarely or not at all noticeable to others (47.5% students, 35% staff, and 17.5% faculty)
- 47% indicate it is sometimes noticeable to others (52% students, 37% staff, and 12% faculty)
- Only 10.5% report it is often or always noticeable to others (54% students, 32% staff, and 14% faculty).
- 68% of students who identified as disabled further identified as having multiple disabilities (vs. 63% of faculty and 58% of staff)
- 71% of students who have chronic health conditions have 2+ conditions (vs. 66% staff and 63% faculty)

Mental or emotional and cognitive disabilities and chronic health conditions are the most frequently reported types of disabilities and conditions across the DAS sample (Figure 2 below). Relative to the overall sample, students are overrepresented amongst those identifying with mental or emotional disabilities and conditions (77% vs. 70% overall); and cognitive disabilities and conditions (57% vs. 47% overall).

Staff (51%) and faculty (55%) are more likely to report physical disabilities and conditions relative to the overall sample (48%). Faculty (24%) are also overrepresented amongst those identifying with sensory disabilities and conditions (19% overall).

Figure 2: Disability or Chronic Health Condition Type by Primary Affiliation



Indigenous Identities

- 11% of the sample identifies as Indigenous (12% of students, 12% of staff, and 9% of faculty)
- Indigenous students appear relatively overrepresented amongst the DAS sample compared to their representation across UM overall (9% of all UM students in 2023[26])
- Eight percent of Indigenous respondents further identify as Métis (8% of students and 8% of faculty and staff[27])
- 4% identify as First Nations (Anishinaabeg, Ininew, Anishininewuk, Dakota, Oyate, and Denesuline, etc.) (4% of students and 4% of faculty and staff)
- Respondents specified many additional diverse Indigenous identities, but low case counts prohibit disaggregated reporting

[26] Office of Institutional Analysis (2023)
[27] Combined percentages for certain faculty and staff socio-demographics are provided to better protect privacy and confidentiality.

Non-Indigenous Racialized Identities

- 8% of the sample identifies as biracial or multi-racial (9% of students and 5% of faculty and staff)
- 3% identifies as Black
- 3% identifies as East Asian
- Respondents specified many additional diverse racialized identities, but low case counts prohibit disaggregated reporting
- 76% of the sample identifies as white (77% of students, 74% of staff, and 80% of faculty)

Gender

- 69% of the sample identifies as women **(**65% students, 75% staff, and 69% faculty)
- 10% identifies as non-binary (14% students, and 7% of staff and faculty)
- 6.5% identifies as genderfluid, genderqueer, or another diverse gender (9% of students, and 4% of staff and faculty)
- 4.5% identifies as trans or transgender (7.5% of students)
- 2.5% identifies as agender (4.5% of students)
- 2% identifies as Two Spirit
- Respondents specified many additional diverse genders, but low case counts prohibit disaggregated reporting
- 15% identifies as men (15% of students, 15% of staff, and 19% of faculty)

Sexualities

- 23% of the sample identifies as bisexual or pansexual (30% of students, 19% of staff, and 11% of faculty
- 14% identifies as queer (17% of students, 11% of staff, and 14% of faculty)
- 8% identifies as asexual (9% of students and 6% of faculty and staff)
- 4% identifies as lesbian
- 3% identifies as gay
- Respondents specified many additional diverse sexualities, but low case counts prohibit disaggregated reporting
- 51% identifies as heterosexual (42% of students, 58% of staff, and 64% of faculty)

Additional Sample Details by Primary Affiliation

Students

- 84% full-time students, 10% part-time, and 5% another type of student
- Students are primarily affiliated with the Faculty of Arts (24.5%) and the Faculty of Science (21%). Some other affiliations include the Faculty of Social Work (6%); the Faculty of Education (5.3%); the Faculty of Graduate Studies (5%); and the I.H. Asper School of Business (4%)
- About 1 in 10 are International students
- Approximately two-thirds of students' parents or guardians attended university (63%), and about one-third have not (36%)
- The majority have been studying at UM for 3 years or more (76%). More than one-third (37%) have been studying at UM for 5 or more years
- Most (88%) have never lived in student residence at UM
- More than half of students are under the age of 25 (56%), 39% are between the ages of 25-44 years old, and 6% are aged 45 and older
- 59% of students currently work for pay and 38% do not work for pay. Of those working for pay, more than half work less than 20 hours a week, on average (60%)
- Nearly 1 in 10 students are caregivers to children under the age of 18. Of these, 37.5% have 1 child and 46% have 2 or more children
- 1 in 10 are caregivers to adults aged 18 or older
- 44% of students said it was either difficult or very difficult to meet the costs of their necessary expenses in 2022-2023. About one-quarter (26.5%) said it was easy or very easy to meet the costs of their necessary expenses.

Staff

- 46% of staff respondents work in non-academic units; 28% work in academic units; 8.5% are managers or directors
- 84% have a full-time, on-going, or permanent position; 8% have a full-time, temporary (e.g., limited term) position; and 4.5% have a part-time (permanent, on-going, or temporary) position
- 35% of staff have been working at UM for between 1-5 years (total[28]); 39% have been at UM for 6-15 years; and 13% have been at UM for 16-25 years
- 14% of staff respondents preferred to not provide a response when asked to specify the unit where they work (vs. 2.3% of students and 17.5% of faculty)

[28] Employees were asked how long they have worked at UM in total, including non-consecutive temporary or term positions.

- 12% of staff respondents are primarily affiliated with Rady Faculty of Health Sciences; 8.5% with Max Rady College of Medicine; 6.5% with Student Affairs; 5% with another unit not listed; and 4.5% are affiliated with Information Services and Technology
- 75% of staff work 30-39 hours per week, on average; and 9.5% work 40-44 hours per week on average
- Most (76%) are in non-supervisory positions, but 21% supervise other employees

Faculty

- 22.5% of faculty respondents are assistant professors; 9% are associate professors; 17.5% are full professors; 22.5% are Instructor I, II, or Senior Instructors; and 6% are assistant librarians, associate librarians, or librarians
- Less than one-third have tenure (27.5%), 20% have a probationary appointment, and 34% have an on-going or continuing appointment
- The majority do not currently hold an administrative position (77.5%)
- 17.5% of faculty preferred to not provide a response when asked to specify the unit where they work (vs. 2.3% of students and 14% of faculty)
- 17.5% of faculty are primarily affiliated with the Faculty of Arts, and 13.8% with another area not listed amongst the survey response options
- About one-quarter (26%) work 39 hours or less per week, on average; 27.5% work 40-44 hours per week; and 45% report working 45+ hours per week

Additional Combined Faculty and Staff Demographics

Even though many faculty participated in the DAS, case numbers for faculty often do not meet minimum reporting requirements for some variables[29]. Accordingly, combined percentages for faculty and staff are provided to better protect privacy and confidentiality.

- 51% of faculty and staff are between the ages of 25-44 years old, and 47% are aged 45 and older
- Most faculty and staff are in a relationship (76% vs. 24% not in a relationship)
- 29% of faculty and staff are caregivers to children under the age of 18, whereas 67% are not. Of those that have children under 18, 40% have 1 child and 52% have 2 or more children
- 18% of faculty and staff are caregivers to adults over the age of 18
- 36% of faculty and staff said it was difficult or very difficult to meet the costs of their necessary expenses in the last year, and 33.5% said it was easy or very easy

[29] A minimum of 5 cases is required for reporting; however, more cases are required when the combination of variables in question increases the chances of indirect identification (e.g., faculty + identifies as disabled or as having chronic health conditions + age 45+).

Data Analyses

Both statistical and qualitative analyses were performed on the DAS data. Guided by two senior members of the project team[30], two graduate research assistants conducted statistical analyses using SPSS (v. 28). As written survey responses contain a relatively limited amount of text and offer no chance to ask probing or follow-up questions, the survey director performed a thematic analysis of the data from the open-ended survey questions.

Statistical Analyses

Statistical analyses were conducted to find significant differences between and within groups across important outcome measures (respondents' experiences of ableism and inequities).

Contingency tables were used when both variables were categorical or discrete, including chi-square analyses. Cramer's V was used to measure effect size. V scores range between 0 and 1, with higher scores indicating a stronger association between the variables (e.g., type of disability and whether or not one is currently receiving accommodations). A V score of 0.20 or less suggests a relatively weak association, 0.20-0.60 is a moderate association, and 0.60+ is a strong association.

Differences of means tests were used when the dependent variable was continuous, including independent samples t-test (with Cohen's d to measure effect size) when the independent variable had two categories (e.g., Indigenous or non-Indigenous). A Cohen's d score of +/- 0.20 indicates a small effect, +/- 0.50 indicates a medium effect, and +/- 0.80 or greater indicates a large effect[31].

Analysis of Variance (ANOVA with η^2 to measure effect size[32]) was used when the independent variable had three categories (e.g., Indigenous, non-Indigenous racialized, and white). η^2 scores range from 0 to 1, with higher scores indicating more of the variance in the dependent variable is explained by the independent variable. An η^2 value of 0.01 is a small-sized effect, 0.06 is a medium-sized effect, and 0.14 or higher is a large-sized effect.

Following ANOVA analyses, Tukey's post-hoc comparisons were used to assess the relationship between the three groups that made up the independent variables[33].

Group means for continuous dependent variables (i.e., multi-item index scores) were standardized according to the normal curve, which has a mean of zero and standard deviation of 1. Therefore, mean index scores above zero indicate "above average" experiences and outcomes, whereas scores below zero indicate "below average" experiences and outcomes. "Above average" does not always equate to more positive outcomes and experiences, however (e.g., at times, higher index scores = more negative perceptions and experiences). Instructions regarding the proper

[30] Drs. Tracey Peter and Jennifer Dengate
[31] Cohen's d scores can be positive or negative and do not have an upper limit.
[32] η^2 = eta squared
[33] Post-hoc analyses specify exactly which group means are significantly different from the others and the direction of the difference (e.g., higher or lower).

interpretation of each index is provided alongside statistical results across DAS summary results reports.

Qualitative Analyses

The DAS included 18 open-ended questions to ensure the project team heard directly from respondents regarding the issues that matter most to them and the complexity of their experiences at UM, particularly related to their experiences of intersecting oppressions (e.g., identifying as disabled and with marginalized genders).

While some questions produced "on topic" responses (i.e., respondents focused their written comments on the exact question that was asked), most questions resulted in a wide range of answers that reflected respondents' desire to share whatever was important to them. Accordingly, the qualitative analysis resulted in a mix of both question topic-specific themes (e.g., expansions pertaining to identity sharing preferences) and cross-cutting general themes (e.g., improve physical accessibility).

Cross-cutting Themes

Cross-cutting themes repeat themselves across multiple questions (e.g., calls to expand access to hybrid work and learning opportunities and the need for more education and training). It is important to caution that the re-occurrence of such themes does not necessarily mean that a greater number of respondents made such comments. At least some of the same individuals repeated their comments across several open-ended questions.

Use of Numbers to Identify Themes

Frequent themes and sub-themes were identified based on the number of corresponding comments made by respondents within each open-ended question, as this was a more reliable indicator of relative frequency than comparing across all questions for the reason described above (respondents repeating the same comment across multiple open-ended questions).

During analysis, the total frequency for each theme or sub-theme was calculated and expressed as a numerical tally. Tallies were used to identify the opinions most frequently expressed for each question, which was helpful when respondents' comments concerned dozens of different topics[34]. Tallies also help to contextualize the size of a theme or sub-theme relative to the total number of survey respondents (n = 544)[35] and in relation the totality of the survey results, including statistical findings.

However, numerical "dominance" does not mean that themes associated with only a handful of comments (or even just one or two) are any less important or insightful. The greatest strength of

[34] Indeed, individual comments that were just a sentence or two in length could reference several themes.
[35] In other words, even a very frequently occurring theme may only represent the opinions of 10% of the entire sample (54/544).

qualitative data is that it is highly valid and not subject to arbitrary thresholds that are more common in statistical analysis[36]. Accordingly, the frequency tallies are not provided in presentations of the summary qualitative results. Omitting these tallies also better supports the protection of respondents' privacy and confidentiality.

References

Bernell, S., & Howard, S. W. (2016). Use your words carefully: What is a chronic disease? *Frontiers in Public Health, 4*, 159. https://doi.org/10.3389/fpubh.2016.00159).

[36] For example, statistical test results are not usually accepted as "significant" unless the test coefficient achieves an alpha level below .05.

Dismantling Ableism Survey (DAS): Inequities Identified by Students, Staff, and Faculty

Introduction

The Dismantling Ableism: Institutional Action and Accountability survey (DAS) was administered in November-December 2023 to University of Manitoba (UM) students, faculty, and staff who self-identified as disabled or as having chronic health conditions[1][2].

Disability is not a singular experience, nor are disabled people a homogeneous group. People encounter different barriers and forms of ableism. Moreover, two people with similar impairments will also experience disability differently as personality, circumstance, privilege, and intersectional identities contribute toward their complex identity.

> "Experiences of inequities are particular to the type of chronic health issues [or] disability. When paired with intersectional issues such as race, class, etc., these inequities become more pervasive."

This results report is one in a series highlighting student, staff, and faculty experiences of ableism and inaccessibility at UM. It is intended to diversify understandings of ableism in academia through the presentation of disaggregated results that indicate differences among those who may share one or more broad socio-demographic characteristics such as Indigenous, racialized, or disability identities, gender, or sexuality[3]. We emphasize disaggregated data to acknowledge intersectional marginalization to decenter Whiteness, colonialism, patriarchy, heteronormativity, and cisnormativity within anti-ableism action.

Comparing the experiences of intersectionally marginalized groups is not intended to set these groups in competition with one another or to focus only on barriers and the ways in which they are "disadvantaged", rather than their agency and vast array of achievements and skills. Rather, disaggregated analysis emphasizes experiences and voices that are often overlooked to pinpoint the concrete actions that will have the most widespread positive impacts on the entire UM community.

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[1] The survey was funded by the Robbins-Ollivier Award for Excellence in Equity.

[2] The final sample size for the DAS, after data cleaning, is 544.

[3] For example, do those who identify with cognitive disabilities feel more or less safe at UM than those identifying with physical or sensory disabilities? Do those who identify as disabled and as either bisexual or pansexual encounter more ableist microaggressions than their heterosexual counterparts?

Language

The DAS used identity-first language (disabled persons) rather than person-first language (persons with disabilities) to acknowledge the disabling effect of social, environmental, and institutional barriers which hinder disabled individuals' full participation in society, including university life[4].

Similarly, the survey also used the term "chronic health conditions", broadly defined as any condition, including mental health conditions, that is continuing or that occurs again and again over a long period of time, which in interaction with various barriers, may hinder full and effective participation in society on an equal basis with others[5].

Positionality

Researchers bring their experiences, identities, and biases to their work. The DAS team members identify with various systemically marginalized identities, including disability and chronic health-related identities. These lived experiences are assets, but we recognize that our personal intersections of privilege also influence our work. Our commitment to research quality includes an openness to concerns and criticisms. Please feel free to send feedback on the DAS results to the Office of Equity Transformation at Equity@umanitoba.ca.

This summary highlights some of the unique needs of students, staff, and faculty[6]. Please note these are limited results, stemming directly from select survey questions that were designed to examine the extent of specific institutional barriers and inequities experienced by students, staff, and faculty.

[4] Language choices were explained in the survey introduction; nevertheless, the DAS project team respects that members of disability and chronic health communities have diverse language preferences, including person with a disability, chronically ill, and episodic disability, for example. The team is grateful for all of the feedback we received regarding language and it will inform our work going forward.

[5] Adapted from Bernell, S., & Howard, S. W. (2016). Use your words carefully: What is a chronic disease? *Frontiers in Public Health, 4*, 159. https://doi.org/10.3389/fpubh.2016.00159 and the United Nations.

[6] Only high-level results are presented in this summary. There are important differences within the categories of student, faculty, and staff that will be more fully detailed in upcoming results summaries, such as differences between students identifying with cognitive, as opposed to physical or sensory disabilities and chronic health conditions.

What needs to be done?

Overall, DAS respondents told us their experiences would be improved if UM:

- Better acknowledged the considerable diversity of disabilities and chronic health conditions among its community members;
- Improved physical accessibility across its campuses; and
- Created a significantly more inclusive, stigma-free culture.

Students

Student respondents primarily identified as undergraduates. Approximately two-thirds participate mostly via in-person activities and are engaged in paid employment; and three-quarters have been studying at UM for three or more years. Slightly more than half are under 25 years old. One in ten student respondents is a parent or guardian to children under the age of 18, and one in ten provides significant care or support to adults, aged 18 or older. Nearly half (44%) of students experienced difficulty meeting the costs of their necessary expenses, such as food, transportation, and medical care, in 2022-2023.

- Students indicated they need:
    - More inclusive course assessment options (e.g., tests and assignments)
    - More accessible course materials (e.g., access to recorded lectures and sign language or braille translations)
    - More support to complete their degrees or programs as quickly as their non-disabled peers
    - More suitable mentors
    - More scholarship and funding opportunities
- Students reported experiencing barriers[7] at UM significantly more frequently than faculty and staff. Specific barriers that need to be accommodated for students include:
    - Getting to campus
    - Meeting deadlines and due dates
    - Meeting other ableist work expectations (e.g., time spent on work, pace of work, and the amount of work expected to be completed in a given period of time, etc.)
    - Accessing appropriate work or study spaces
- Students perceive they have less social support at UM than faculty and staff[8]. Students indicated they need more opportunities to feel like they are part of a community at UM and

[7] This block of questions asked students how often they encounter the following barriers in a typical month: barriers getting to their campus, barriers getting around campus, barriers related to accessing appropriate work or study spaces, barriers related to a lack of in-person options, barriers related to a lack of hybrid options, barriers related to deadlines or due dates, barriers related to meeting productivity expectations, barriers related to meeting work pace expectations, and barriers related to meeting work hour expectations.
[8] Social support was measured using a three-item index, asking respondents if they "can access social support when they need it", if they "feel part of the UM community", and if they "have opportunities to interact with other disabled people and those with chronic health conditions who are open about their identities".

to interact with other disabled people and people with chronic health conditions who are open about these identities.

- Students are more likely to serve as unpaid experts and educators on disability and accommodations[9] than faculty and staff. Students need this labour to be appropriately recognized and valued.
- Students also indicated they need ableist classroom policies to be eliminated (e.g., inflexible attendance and deadline policies and lack of remote learning options); and need greater access to (and insurance coverage for) a more diverse range of accommodations and support services, such as:
    - Increased support for graduate students[10] with disabilities and chronic health conditions
    - Expanded mental health supports
    - More one-on-one services (e.g., ADHD coaches, disability counsellors, case managers, etc.)
    - More external services (i.e., those not offered by UM)

Staff

The majority of staff respondents are in full-time, permanent or on-going positions. Approximately one-third participate via in-person activities, while 42% are engaged in a mix of remote and in-person activities, and 20% are mostly remote. About half are employed in non-academic units and about 20% have supervisory roles. Approximately 50% have been employed at UM for 6 or more years total.

- Staff indicated they need:
    - Better access to promotion and advancement opportunities
    - More suitable mentors
    - More access to professional and skill development opportunities
- Staff indicated they are less knowledgeable about their accommodations options and perceive more stigma around accommodations than students. Staff need more accommodations support, specifically:
    - More communication about available options and the accommodations process for staff
    - Confidence that applying for and receiving accommodations will not have negative career consequences (e.g., undermine promotion prospects)
- Staff need access to a more diverse range of accommodations and supports[11], such as:
    - Designated mental health days in addition to vacation and sick days
    - More comprehensive benefits for mental health and chronic health conditions

[9] Students are relatively more likely to do such work for their peers and instructors or academic supervisors, than for UM staff.
[10] Student Accessibility Services and Faculty of Graduate Studies are currently working together to improve graduate students' accommodations experiences, specifically.
[11] The DAS was administered prior to the relatively recent increase in mental health care coverage for UM employees announced in early 2024.

- More flexible work arrangements (e.g., expanded hybrid and remote options, 4-day work weeks, and flexible start and stop times)

Faculty

Nearly half of faculty respondents are either instructors or assistant professors. Less than one-third are tenured and less than one-quarter hold administrative positions.

- Faculty indicated they need:
  - More equitable tenure and promotion review processes
  - Better access and support to assume senior leadership roles
  - More suitable mentors
  - More resources to optimally engage with research, teaching, and service[12]
  - Their input to be valued and meaningfully incorporated when they provide disability or chronic health perspectives in service endeavors
- Faculty reported encountering more barriers to accessing and using information and communications technologies than staff and students, overall. Faculty specifically indicate they need more support for[13]:
  - Microsoft Teams
  - UM learning technologies
  - UM software (e.g., Aurora, Banner, and FAST, etc.)
- Faculty indicated they are less knowledgeable about their accommodations options and perceive more stigma around accommodations than students. Faculty reported needing more accommodations support, specifically:
  - Greater access to formal accommodations, including insurance for a more diverse range of support services, especially expanded mental health coverage[14]
  - Better communication about available options and the accommodations process for faculty
  - Greater access to hybrid teaching options
  - Confidence that applying for and receiving accommodations will not have negative career consequences

[12] Optimal engagement would also mean engagement that can be sustained over time, including but not limited to appropriate work pace, mode (e.g., remote, hybrid, or in-person), and tasks, for example.
[13] The DAS was administered in November-December 2023. As such, the results may not capture recent (and ongoing) accessibility improvements to specific information and communications systems at UM, including those undertaken to meet the Accessibility for Manitobans Act Information and Communications Standard (AMA-IC), and WCAG 2.1 standards for web content.
[14] The DAS was administered prior to the relatively recent increase in mental health care coverage for UM employees announced in early 2024. Faculty and staff also highlighted the need for accommodations to be centralized so that they are not affected by unit-level considerations such as budgets and priorities.

Dismantling Ableism Survey (DAS): Mental and Emotional Health-Related Results

Introduction

The Dismantling Ableism: Institutional Action and Accountability survey (DAS) was administered in November-December 2023 to University of Manitoba (UM) students, faculty, and staff who self-identified as disabled or as having chronic health conditions[1][2].

Disability is not a singular experience, nor are disabled people a homogeneous group. People encounter different barriers and forms of ableism. Moreover, two people with similar impairments will also experience disability differently as personality, circumstance, privilege, and intersectional identities contribute toward their complex identity.

> "Experiences of inequities are particular to the type of chronic health issues [or] disability. When paired with intersectional issues such as race, class, etc., these inequities become more pervasive."

This results report is one in a series highlighting student, staff, and faculty experiences of ableism and inaccessibility at UM. It is intended to diversify understandings of ableism in academia through the presentation of disaggregated results that indicate differences among those who may share one or more broad socio-demographic characteristics such as Indigenous, racialized, or disability identities, gender, or sexuality[3]. We emphasize disaggregated data to acknowledge intersectional marginalization to decenter Whiteness, colonialism, patriarchy, heteronormativity, and cisnormativity within anti-ableism action.

Comparing the experiences of intersectionally marginalized groups is not intended to set these groups in competition with one another or to focus only on barriers and the ways in which they are "disadvantaged", rather than their agency and vast array of achievements and skills. Rather, disaggregated analysis emphasizes experiences and voices that are often overlooked to pinpoint the concrete actions that will have the most widespread positive impacts on the entire UM community.

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[1] The survey was funded by the Robbins-Ollivier Award for Excellence in Equity.

[2] The final sample size for the DAS, after data cleaning, is 544.

[3] For example, do those who identify with cognitive disabilities feel more or less safe at UM than those identifying with physical or sensory disabilities? Do those who identify as disabled and as either bisexual or pansexual encounter more ableist microaggressions than their heterosexual counterparts?

Language

The DAS used identity-first language (disabled persons) rather than person-first language (persons with disabilities) to acknowledge the disabling effect of social, environmental, and institutional barriers which hinder disabled individuals' full participation in society, including university life[4].

Similarly, the survey also used the term "chronic health conditions", broadly defined as any condition, including mental health conditions, that is continuing or that occurs again and again over a long period of time, which in interaction with various barriers, may hinder full and effective participation in society on an equal basis with others[5].

Positionality

Researchers bring their experiences, identities, and biases to their work. The DAS team members identify with various systemically marginalized identities, including disability and chronic health-related identities. These lived experiences are assets, but we recognize that our personal intersections of privilege also influence our work. Our commitment to research quality includes an openness to concerns and criticisms. Please feel free to send feedback on the DAS results to the Office of Equity Transformation at Equity@umanitoba.ca.

This summary focuses on some of the experiences of DAS respondents who identify with mental or emotional health-related disabilities or chronic health conditions.

Mental and Emotional Health

- Overall, 70% of DAS respondents identified with a mental or emotional health-related disability or chronic health condition[6]:
    - 77% of student respondents
    - 69% of staff respondents
    - 50% of faculty respondents

[4] Language choices were explained in the survey introduction; nevertheless, the DAS project team respects that members of disability and chronic health communities have diverse language preferences, including person with a disability, chronically ill, and episodic disability, for example. The team is grateful for all of the feedback we received regarding language and it will inform our work going forward.

[5] Adapted from Bernell, S., & Howard, S. W. (2016). Use your words carefully: What is a chronic disease? *Frontiers in Public Health, 4*, 159. https://doi.org/10.3389/fpubh.2016.00159 and the United Nations.

[6] This does not mean they only identified with a mental or emotional health-related disability or chronic health condition. Respondents were invited to select all the types of disabilities and health conditions necessary for them to fully identify, including physical, sensory, and cognitive. As respondents could choose multiple responses, the overall total for this question does not equal 100%.

- Most of those who identify with a mental or emotional health-related disability or health condition (75%+) identify specifically as having a **"chronic health condition**", as opposed to "disabled" or "another disability identity"
- Most (75%+) describe their disability or chronic health condition as **sometimes, rarely, or not at all noticeable to others**[7]
- Many identify with mental or emotional health-related disabilities or health conditions **in addition to another type of disability or chronic health condition** (e.g., cognitive, physical, or sensory, such as ADHD and anxiety or depression)[8]

Experiences at UM

Compared to those who identify with physical, sensory, and cognitive disabilities and chronic health conditions, DAS respondents that identify with mental and emotional health-related disabilities or health conditions:

- Are more satisfied with their current participation at UM[9]
- Feel UM is more engaged with efforts to dismantle ableism[10]; and
- Perceive UM to be safer for those with disabilities and chronic health conditions, overall[11].

However, these respondents indicate their experiences at UM would be improved by the following:

- **Greater overall inclusion** (i.e., recognize and de-stigmatize mental and emotional health related disabilities and health conditions across UM)
    - Those with mental or emotional health-related disabilities and conditions are the least comfortable with sharing their disability and chronic health identities at UM[12].
- **Greater inclusion regarding accommodations**, specifically:
    - Clarify and communicate formal and informal accommodations options for mental and emotional health-related disabilities and chronic health conditions
    - Students[13] and faculty and staff[14] that identify with mental or emotional health-related disabilities and conditions are less likely to be receiving needed accommodations than their counterparts who identify with cognitive, physical, or sensory disabilities and chronic health conditions

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[7] With respect to the overall sample (any type of disabilities or health conditions), 47% describe their disability and health identities as "sometimes noticeable" (52% students, 37% staff, and 12% faculty); and 47% describe their identities as "rarely or not at all noticeable" (47.5% students, 35% staff, and 17.5% faculty). Just 10.5% of the sample describes their identities as "often or always noticeable" (54% students, 32% staff, and 14% faculty).

[8] With respect to the overall sample (any type of disabilities or health conditions), 68% of students who identified as disabled further identified as having multiple disabilities (vs. 63% of faculty and 58% of staff). Similarly, 71% of students with chronic health conditions have 2+ conditions (vs. 66% staff and 63% faculty).

[9] $F\ (2, 526) = 8.76$, $p =<.001$, $\eta^2 = 0.03$

[10] $F\ (2, 503) = 5.8$, $p =<.01$, $\eta^2 = 0.02$

[11] $F\ (2, 486) = 4.1$, $p =<.05$, $\eta^2 = 0.02$

[12] $F\ (2, 517) = 4.9$, $p =<.01$, $\eta^2 = 0.02$

[13] $X^2\ (4, 221) = 11.1$, $p =<.05$, $V = 0.16$

[14] $X^2\ (4, 188) = 12.8$, $p =<.05$, $V = 0.19$. Faculty and staff were combined into one group for this statistical test.

- **Review of student and employee policies**
    - Understand the impact that classroom attendance, assignment and test deadlines, and employee leave and absence policies have on those with mental and emotional health-related disabilities and chronic health conditions
- **Expanded employee benefits** (e.g., provide designated mental health days and more coverage for a wider range of mental health care and support services)

Noticeability Matters

Most DAS respondents who identified with mental or emotional health-related disabilities and conditions indicated these identities were only sometimes, rarely, or not at all noticeable to others[15]. Related to this, many actively **"mask"** their identities – only choosing to share them with a few trusted individuals at UM, if they share them at all.

"Mental illness is invisible. Most people mastered the art of hiding it."

Respondents also described unique barriers associated with relatively less noticeable disabilities and chronic health conditions[16], including:

- Feeling less "legitimately" disabled vs. more noticeable disabilities and chronic health conditions[17];
- Not being believed when they say they have a disability or chronic health condition or need accommodations; and
- Having to "prove" to others that they have a disability or chronic health condition.

The qualitative data suggests such attitudinal barriers particularly affect students who need accommodations for less noticeable and mental or emotional health-related disabilities and conditions, as illustrated by the following quotes:

"What are the requirements [for registering with Student Accessibility Services]? Embarrassed. Feel like I should be sicker or more disabled, that it is only for the visibly disabled."

"It takes so long to process and mental health is not enough reason for them to give me accommodations."

"I am just embarrassed because 'depression isn't an excuse' you know?"

"I am scared to apply, because my disabilities are not apparent, I may be denied."

[15] DAS respondents used terms such as "hidden" and "invisible" to describe their disabilities and chronic health conditions. The survey specifically asked respondents if their disabilities or chronic health conditions were more or less "noticeable to others", which is why we use that particular language.
[16] Any type of less noticeable disability or chronic health condition, including but not limited to mental and emotional health.
[17] This feeling is related to respondents' belief that UM generally thinks of disabilities and chronic health conditions as noticeable to others, physical, and continuous, rather than "hidden", "invisible", or episodic.

Desire for Expanded Mental and Emotional Health Supports

When asked what types of accommodations and supports they would like to have, DAS respondents[18] strongly emphasized the need for more robust mental health support options, services, and benefits, noting that current services do not meet the existing demand for mental health care[19]. Respondents need:

- Greater access to high-quality doctors, counsellors, and counselling services (especially expanded access to one-on-one mental health care)
- More mental health supports, including a **culture of greater respect** where mental health care needs receive as much recognition as physical health care needs
    - Expand insurance and health benefits to better cover chronic health condition care and mental health care
    - Provide designated mental health days, in addition to sick and vacation days

[18] All respondents, not limited to those who identified with mental or emotional health-related disabilities and chronic health conditions.
[19] The DAS was administered prior to the relatively recent increase in mental health care coverage for UM employees announced in early 2024.

Dismantling Ableism Survey (DAS): Experiences of those Identifying with Systemically Marginalized Genders

Introduction

The Dismantling Ableism: Institutional Action and Accountability survey (DAS) was administered in November-December 2023 to University of Manitoba (UM) students, faculty, and staff who self-identified as disabled or as having chronic health conditions[1][2].

Disability is not a singular experience, nor are disabled people a homogeneous group. People encounter different barriers and forms of ableism. Moreover, two people with similar impairments will also experience disability differently as personality, circumstance, privilege, and intersectional identities contribute toward their complex identity.

> "Experiences of inequities are particular to the type of chronic health issues [or] disability. When paired with intersectional issues such as race, class, etc., these inequities become more pervasive."

This results report is one in a series highlighting student, staff, and faculty experiences of ableism and inaccessibility at UM. It is intended to diversify understandings of ableism in academia through the presentation of disaggregated results that indicate differences among those who may share one or more broad socio-demographic characteristics such as Indigenous, racialized, or disability identities, gender, or sexuality[3]. We emphasize disaggregated data to acknowledge intersectional marginalization to decenter Whiteness, colonialism, patriarchy, heteronormativity, and cisnormativity within anti-ableism action.

Comparing the experiences of intersectionally marginalized groups is not intended to set these groups in competition with one another or to focus only on barriers and the ways in which they are "disadvantaged", rather than their agency and vast array of achievements and skills. Rather, disaggregated analysis emphasizes experiences and voices that are often overlooked to pinpoint the concrete actions that will have the most widespread positive impacts on the entire UM community.

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[1] The survey was funded by the Robbins-Ollivier Award for Excellence in Equity.

[2] The final sample size for the DAS, after data cleaning, is 544.

[3] For example, do those who identify with cognitive disabilities feel more or less safe at UM than those identifying with physical or sensory disabilities? Do those who identify as disabled and as either bisexual or pansexual encounter more ableist microaggressions than their heterosexual counterparts?

Language

The DAS used identity-first language (disabled persons) rather than person-first language (persons with disabilities) to acknowledge the disabling effect of social, environmental, and institutional barriers which hinder disabled individuals' full participation in society, including university life[4].

Similarly, the survey also used the term "chronic health conditions", broadly defined as any condition, including mental health conditions, that is continuing or that occurs again and again over a long period of time, which in interaction with various barriers, may hinder full and effective participation in society on an equal basis with others[5].

Positionality

Researchers bring their experiences, identities, and biases to their work. The DAS team members identify with various systemically marginalized identities, including disability and chronic health-related identities. These lived experiences are assets, but we recognize that our personal intersections of privilege also influence our work. Our commitment to research quality includes an openness to concerns and criticisms. Please feel free to send feedback on the DAS results to the Office of Equity Transformation at Equity@umanitoba.ca.

This summary explores the intersection of gender and disability and chronic health identities, regarding experiences of ableism at UM. In this summary, we strive to highlight the experiences of minoritized gender respondents, which refers specifically to respondents who identify with systemically marginalized genders[6] (e.g., trans or transgender, non-binary, agender, genderfluid, genderqueer, or another diverse gender identity, etc.).

Methodological Note

The gender question on the DAS invited respondents to select all the genders that apply to them. To conduct statistical comparisons, the gender variable was recoded into three categories – women, men, and minoritized genders. However, this artificial re-grouping does not necessarily mean respondents only selected the gender corresponding with the category of the same name. It is possible that respondents who selected a minoritized gender (e.g., trans) also selected another gender, such as woman, for example.

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[4] Language choices were explained in the survey introduction; nevertheless, the DAS project team respects that members of disability and chronic health communities have diverse language preferences, including person with a disability, chronically ill, and episodic disability, for example. The team is grateful for all of the feedback we received regarding language and it will inform our work going forward.

[5] Adapted from Bernell, S., & Howard, S. W. (2016). Use your words carefully: What is a chronic disease? *Frontiers in Public Health, 4*, 159. https://doi.org/10.3389/fpubh.2016.00159 and the United Nations.

[6] "Woman" and "man" can also be marginalized gender identities in particular contexts. For the purposes of the DAS results, however, "woman" and "man" are considered majoritized gender identities.

Accordingly, respondents in the minoritized gender group identify with at least one non-man or non-woman gender. Because some overlap between the three categories remains, the statistical results should only be considered one piece of evidence describing differences in men, women, and minoritized gender respondents' experiences.

Gender

The DAS sample is characterized by considerable gender diversity, particularly amongst students.

- 10% identifies as non-binary[7] (14% students, and 7% of staff and faculty)
- 6.5% identifies as genderfluid, genderqueer, or another diverse gender (9% of students, and 4% of staff and faculty)
- 4.5% identifies as trans or transgender (7.5% of students)
- 2.5% identifies as agender (4.5% of students)
- 2% identifies as Two Spirit
- Respondents specified many additional diverse genders other than woman or man, but low case counts prohibit disaggregated reporting
- 69% of the sample identifies as women (65% students, 75% staff, and 69% faculty)
- 15% identifies as men (15% of students, 15% of staff, and 19% of faculty)

Descriptives and Intersecting Marginalized Identities

Minoritized gender respondents in the DAS sample are significantly more likely to:

- Be under 25 years of age (52%), compared to women (24%) and men[8] (22%)
- Identify as disabled (41%), compared to men (29%) and women[9] (24%)
- Identify with cognitive disabilities and chronic health conditions (73%) than men (44%) and women[10] (43%)
- Indicate their disability or chronic health condition is sometimes noticeable to others (56%) than women (46%) and men[11] (42%)
- Identify with marginalized sexualities besides bisexual or pansexual[12] (57.5%) than men (18%) and women[13] (14%)
- Participate in work or studies at UM mostly or fully in-person (66%), compared to men (54%) and women[14] (44%)

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[7] The total sample size for the DAS is 544.
[8] X^2 (4, 517) = 46.4, p =<.001, V = 0.21
[9] X^2 (4, 507) = 13.9, p =<.01, V = 0.12
[10] X^2 (4, 513) = 32, p =<.001, V = 0.18
[11] X^2 (4, 518) = 14.9, p =<.01, V = 0.12
[12] They are also more likely to identify as bisexual or pansexual than men and women, but cell counts are very unevenly distributed, prohibiting detailed reporting for both results.
[13] X^2 (4, 503) = 127.6, p =<.001, V = 0.36
[14] X^2 (4, 516) = 14.4, p =<.01, V = 0.12

Experiences at UM

"As an intersex individual who is currently managing sexuality-gender related condition, I can say for sure that it difficult to share my condition. I did a few times, and I could feel and see the distancing from the person(s) I spoke with. [...] In my opinion, many people fear [or] discriminate against what they do not understand: an impulsive culture shock based of sexuality [or] gender differences."

Respondents identifying with minoritized genders:

- Are less satisfied with their level of participation at UM than women and men[15]
- Feel less safe (personally) than women and men[16]
- Perceive their primary campus to be less safe for disabled people in general than women and men[17]
- Perceive less equity than women and men (student-specific finding)[18]
- Perceive more negative attitudes toward disability at UM than women and men[19]
- Perceive UM to be less engaged with dismantling ableism than women and men[20]
- Experience institutional barriers more often than women and men (e.g., getting around campus and accessing appropriate work or study spaces, etc.)[21]
- Report more IT barriers than women and men[22]
- Experience significantly more in-person ableist microaggressions than women and men (e.g., someone assumed they needed help or that their disability impacted all their capabilities, etc.)[23]
- Experience more exclusion, incivility, and harassment in-person than women and men (e.g., excluded within one's home unit or across UM in general)[24]
- Perceive more additional costs associated with disabilities and chronic health conditions than women and men (report they do more unpaid labour, specifically)[25]
- Report more emotional exhaustion than women and men[26]

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[15] $F (2, 520) = 5.4$, $p =<.01$, $\eta^2 = 0.02$
[16] $F (2, 508) = 7.1$, $p =<.001$, $\eta^2 = 0.03$
[17] $F (2, 482) = 9.9$, $p =<.001$, $\eta^2 = 0.04$
[18] $F (2, 252) = 3.4$, $p =<.05$, $\eta^2 = 0.03$
[19] $F (2, 521) = 3.1$, $p =<.05$, $\eta^2 = 0.01$
[20] $F (2, 497) = 4.0$, $p =<.05$, $\eta^2 = 0.02$
[21] $F (2, 521) = 7.8$, $p =<.001$, $\eta^2 = 0.03$
[22] $F (2, 520) = 7.4$, $p =<.001$, $\eta^2 = 0.03$. The DAS was administered in November-December 2023. As such, the results may not capture recent (and ongoing) accessibility improvements to specific information and communications systems at UM, including those undertaken to meet the Accessibility for Manitobans Act Information and Communications Standards (AMA-IC), and WCAG 2.1 standards.
[23] $F (2, 498) = 3.7$, $p =<.05$, $\eta^2 = 0.02$
[24] $F (2, 495) = 8.9$, $p =<.001$, $\eta^2 = 0.04$
[25] $X^2 (4, 492) = 19.7$, $p =< .001$, $V = 0.14$
[26] $F (2, 521) = 8.0$, $p =<.001$, $\eta^2 = 0.03$

- Report more negative interactions with their peers than women and men (student-specific finding)[27]

[27] F (2, 229) = 6.6, p =<.01, η^2 = 0.06

Dismantling Ableism Survey (DAS): Experiences of those Identifying with Systemically Marginalized Sexualities

Introduction

The Dismantling Ableism: Institutional Action and Accountability survey (DAS) was administered in November-December 2023 to University of Manitoba (UM) students, faculty, and staff who self-identified as disabled or as having chronic health conditions[1][2].

Disability is not a singular experience, nor are disabled people a homogeneous group. People encounter different barriers and forms of ableism. Moreover, two people with similar impairments will also experience disability differently as personality, circumstance, privilege, and intersectional identities contribute toward their complex identity.

> "Experiences of inequities are particular to the type of chronic health issues [or] disability. When paired with intersectional issues such as race, class, etc., these inequities become more pervasive."

This results report is one in a series highlighting student, staff, and faculty experiences of ableism and inaccessibility at UM. It is intended to diversify understandings of ableism in academia through the presentation of disaggregated results that indicate differences among those who may share one or more broad socio-demographic characteristics such as Indigenous, racialized, or disability identities, gender, or sexuality[3]. We emphasize disaggregated data to acknowledge intersectional marginalization to decenter Whiteness, colonialism, patriarchy, heteronormativity, and cisnormativity within anti-ableism action.

Comparing the experiences of intersectionally marginalized groups is not intended to set these groups in competition with one another or to focus only on barriers and the ways in which they are "disadvantaged", rather than their agency and vast array of achievements and skills. Rather, disaggregated analysis emphasizes experiences and voices that are often overlooked to pinpoint the concrete actions that will have the most widespread positive impacts on the entire UM community.

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[1] The survey was funded by the Robbins-Ollivier Award for Excellence in Equity.

[2] The final sample size for the DAS, after data cleaning, is 544.

[3] For example, do those who identify with cognitive disabilities feel more or less safe at UM than those identifying with physical or sensory disabilities? Do those who identify as disabled and as either bisexual or pansexual encounter more ableist microaggressions than their heterosexual counterparts?

Language

The DAS used identity-first language (disabled persons) rather than person-first language (persons with disabilities) to acknowledge the disabling effect of social, environmental, and institutional barriers which hinder disabled individuals' full participation in society, including university life[4].

Similarly, the survey also used the term "chronic health conditions", broadly defined as any condition, including mental health conditions, that is continuing or that occurs again and again over a long period of time, which in interaction with various barriers, may hinder full and effective participation in society on an equal basis with others[5].

Positionality

Researchers bring their experiences, identities, and biases to their work. The DAS team members identify with various systemically marginalized identities, including disability and chronic health-related identities. These lived experiences are assets, but we recognize that our personal intersections of privilege also influence our work. Our commitment to research quality includes an openness to concerns and criticisms. Please feel free to send feedback on the DAS results to the Office of Equity Transformation at Equity@umanitoba.ca.

This summary explores the intersection of sexualities and experiences of ableism. We strive to highlight the experiences of two groups: bisexual or pansexual respondents, and respondents identifying with additional minoritized sexualities.

Methodological Note

The sexualities question on the DAS invited respondents to select all the sexualities that apply to them. To conduct statistical comparisons, the sexualities variable was recoded into three categories – heterosexual, bisexual or pansexual, and additional minoritized sexualities. Overall, 23% of the DAS sample identifies as bisexual or pansexual, which enabled us to make bisexual or pansexual its own category for statistical comparison. Accordingly, for the purpose of this report, "additional minoritized sexualities" refers specifically to respondents who identify with non-bisexual or pansexual minoritized identities such as gay, lesbian, queer, Two Spirit, and asexual, etc.

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[4] Language choices were explained in the survey introduction; nevertheless, the DAS project team respects that members of disability and chronic health communities have diverse language preferences, including person with a disability, chronically ill, and episodic disability, for example. The team is grateful for all of the feedback we received regarding language and it will inform our work going forward.

[5] Adapted from Bernell, S., & Howard, S. W. (2016). Use your words carefully: What is a chronic disease? *Frontiers in Public Health, 4*, 159. https://doi.org/10.3389/fpubh.2016.00159 and the United Nations.

This artificial re-grouping does not necessarily mean respondents only selected a sexuality corresponding with the category of the same name. It is possible that respondents who selected an "additional minoritized sexualities" (e.g., queer) also selected another sexuality, such as bisexual, for example[6].

Accordingly, respondents in the additional minoritized sexualities group identify with at least one non-bisexual or pansexual minoritized sexuality. Because some overlap between the three categories remains, the statistical results should only be considered one piece of evidence describing differences in the experiences of heterosexual, bisexual or pansexual, and additional minoritized sexuality respondents.

Sexualities

The DAS sample is characterized by considerable sexual diversity, particularly amongst students.

- 23% of the sample identifies as bisexual or pansexual (30% of students, 19% of staff, and 11% of faculty
- 14% identifies as queer (17% of students, 11% of staff, and 14% of faculty)
- 8% identifies as asexual (9% of students and 6% of faculty and staff)
- 4% identifies as lesbian
- 3% identifies as gay
- Respondents specified many additional diverse sexualities, but low case counts prohibit more detailed reporting
- 51% identifies as heterosexual (42% of students, 58% of staff, and 64% of faculty)

Descriptives and Intersecting Marginalized Identities

Most bisexual or pansexual respondents in the DAS sample:

- Are aged 25-44 (59%)
- Identify as having chronic health condition(s) (63%)
- Identify with cognitive disabilities and chronic health conditions (62%) than heterosexual respondents[7] (36%)
- Indicate their disabilities or chronic health conditions are sometimes noticeable to others (53%)
- Are more likely to identify with non-woman and non-man genders than heterosexual respondents[8]
- Participate in work or studies at UM mostly or fully in-person (about 53%) in contrast to a mix of both in-person and remote (about 33%), and mostly or fully remote (13%)

[6] Because the variable has a "select all that apply" format, the possibility cannot be fully ruled out.
[7] X^2 (4, 496) = 32, p =<.001, V = 0.18
[8] X^2 (4, 503) = 127.6, p =<.001, V = 0.36

Most respondents identifying with additional minoritized sexualities in the DAS sample:

- Are aged 25-44 (45%)
- Identify as having chronic health condition(s) (53%)
- Identify with cognitive disabilities and chronic health conditions (61%) than heterosexual respondents[9] (36%)
- Indicate their disabilities or chronic health conditions are sometimes noticeable to others (53%)
- Are more likely to identify with non-woman and non-man genders than heterosexual respondents[10]

Experiences at UM

Compared to heterosexual respondents, bisexual, pansexual, and additional marginalized sexuality respondents:

- Are less satisfied with their level of current participation at UM[11]
- Perceive UM to be less engaged with efforts to dismantle ableism[12]
- More often experience institutional barriers (e.g., getting to campus, getting around campus, and accessing appropriate work or study spaces)[13]
- Perceive their primary campus to be less safe for themselves (personally)[14]
- Perceive their primary campus to be less safe for disabled people in general[15]
- Perceive more additional costs associated with disability and chronic health identities (report they do more unpaid labour, specifically)[16]
- Experience more in-person ableist microaggressions[17]
- Experience more in-person exclusion, incivility, and harassment[18]
- Report more emotional exhaustion[19]

[9] X^2 (4, 496) = 32, p =<.001, V = 0.18
[10] X^2 (4, 503) = 127.6, p =<.001, V = 0.36
[11] F (2, 504) = 10.1, p =<.001, η^2 = 0.04
[12] F (2, 481) = 7.5, p =<.001, η^2 = 0.03
[13] F (2, 493) = 7.1, p =<.001, η^2 = 0.03
[14] F (2, 493) = 7.1, p =<.001, η^2 = 0.03
[15] F (2, 465) = 11.7, p =<.001, η^2 = 0.05
[16] X (4, 478) = 33.8, p =<.001, V = 0.19
[17] F (2, 482) = 6.0, p =<.01, η^2 = 0.02
[18] F (2, 481) = 7.1, p =<.001, η^2 = 0.03
[19] F (2, 505) = 6.5, p =<.01, η^2 = 0.03

Dismantling Ableism Survey (DAS): Experiences of Those with Less Noticeable Disabilities and Chronic Health Conditions

Introduction

The Dismantling Ableism: Institutional Action and Accountability survey (DAS) was administered in November-December 2023 to University of Manitoba (UM) students, faculty, and staff who self-identified as disabled or as having chronic health conditions[1][2].

Disability is not a singular experience, nor are disabled people a homogeneous group. People encounter different barriers and forms of ableism. Moreover, two people with similar impairments will also experience disability differently as personality, circumstance, privilege, and intersectional identities contribute toward their complex identity.

> "Experiences of inequities are particular to the type of chronic health issues [or] disability. When paired with intersectional issues such as race, class, etc., these inequities become more pervasive."

This results report is one in a series highlighting student, staff, and faculty experiences of ableism and inaccessibility at UM. It is intended to diversify understandings of ableism in academia through the presentation of disaggregated results that indicate differences among those who may share one or more broad socio-demographic characteristics such as Indigenous, racialized, or disability identities, gender, or sexuality[3]. We emphasize disaggregated data to acknowledge intersectional marginalization to decenter Whiteness, colonialism, patriarchy, heteronormativity, and cisnormativity within anti-ableism action.

Comparing the experiences of intersectionally marginalized groups is not intended to set these groups in competition with one another or to focus only on barriers and the ways in which they are "disadvantaged", rather than their agency and vast array of achievements and skills. Rather, disaggregated analysis emphasizes experiences and voices that are often overlooked to pinpoint the concrete actions that will have the most widespread positive impacts on the entire UM community.

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[2] The final sample size for the DAS, after data cleaning, is 544.

[3] For example, do those who identify with cognitive disabilities feel more or less safe at UM than those identifying with physical or sensory disabilities? Do those who identify as disabled and as either bisexual or pansexual encounter more ableist microaggressions than their heterosexual counterparts?

Language

The DAS used identity-first language (disabled persons) rather than person-first language (persons with disabilities) to acknowledge the disabling effect of social, environmental, and institutional barriers which hinder disabled individuals' full participation in society, including university life[4].

Similarly, the survey also used the term "chronic health conditions", broadly defined as any condition, including mental health conditions, that is continuing or that occurs again and again over a long period of time, which in interaction with various barriers, may hinder full and effective participation in society on an equal basis with others[5].

Positionality

Researchers bring their experiences, identities, and biases to their work. The DAS team members identify with various systemically marginalized identities, including disability and chronic health-related identities. These lived experiences are assets, but we recognize that our personal intersections of privilege also influence our work. Our commitment to research quality includes an openness to concerns and criticisms. Please feel free to send feedback on the DAS results to the Office of Equity Transformation at Equity@umanitoba.ca.

This summary explores experiences of ableism at UM related to differences in disability "noticeability". Specifically, we emphasize the experiences of those DAS respondents who indicated their disabilities or chronic health conditions are either "not at all or rarely noticeable to others", or "sometimes noticeable to others", as compared to those whose disabilities and chronic health conditions are "often or always noticeable to others".

Methodological Note

Much of the data that references the experiences of those who identify with less noticeable disabilities and chronic health conditions are qualitative. As such, this report presents numerous quotes to describe respondents' experiences in their own words. Many of these quotes have been edited for the limited purposes of:

- Redacting potentially identifying details; and
- Increasing accessibility and generally improving clarity for all readers (e.g., adding missing punctuation and removing forward slashes, etc.).

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[4] Language choices were explained in the survey introduction; nevertheless, the DAS project team respects that members of disability and chronic health communities have diverse language preferences, including person with a disability, chronically ill, and episodic disability, for example. The team is grateful for all of the feedback we received regarding language and it will inform our work going forward.

[5] Adapted from Bernell, S., & Howard, S. W. (2016). Use your words carefully: What is a chronic disease? *Frontiers in Public Health, 4*, 159. https://doi.org/10.3389/fpubh.2016.00159 and the United Nations.

Any additions or deletions to quotes are framed with square brackets[6]. The content and intended message of each of the quotes remains intact.

Broaden Understanding

Highlighting the experiences of DAS respondents identifying with less noticeable disabilities and chronic health conditions is especially important because one of the most frequently occurring themes observed during qualitative analysis was respondents' assertion that UM's understanding of disability is biased toward physical and more noticeable disabilities, overall.

Respondents further explain that such bias marginalizes:

- Less noticeable disabilities and chronic health conditions, especially **cognitive and mental or emotional health-related** disabilities and conditions[7]
- And all types of disabilities and chronic health conditions whose effects are **episodic or intermittent**, rather than continuous (e.g., flare-ups of chronic pain or intense periods of anxiety or depression, etc.)[8]

"Invisible impairments and health conditions are often not given the same depth of understanding as those with visible impairments."

"There are measures put into place to help certain disabilities but not all disabilities, even when brought up as a concern. Disabled students seem to have to put in much more time, effort, and resources into advocating for themselves when in need than necessary. There isn't much talk about students with 'invisible' disabilities."

"I find that unseen disabilities and chronic health conditions are treated differently than physical ones. My experience taking and returning from medical leave for mental health reasons was handled very differently to a colleague who went on medical leave for [physical health reasons]."

Descriptives

- Nearly half (47%) of DAS respondents indicate their disabilities or chronic health conditions are **rarely or not at all noticeable** to others (47.5% students, 35% staff, and 17.5% faculty)
- Similarly, 47% indicate their disabilities or chronic health conditions are **sometimes noticeable** to others (52% students, 37% staff, and 12% faculty)

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[6] For example, [or] or [and]. The symbol [...] signifies that a relatively large portion of a sentence has been removed from the original quote.

[7] This does not mean that less noticeable disabilities and chronic health conditions are limited to cognitive and mental or emotional health disabilities and conditions. Certain physical and sensory conditions may also be relatively less noticeable to others or become more noticeable episodically.

[8] These quotes are in response to a question that asked respondents to comment on "how disabilities are thought of at UM".

- Only 10.5% report their disabilities or chronic health conditions are **often or always noticeable** to others (54% students, 32% staff, and 14% faculty)[9]
- Overall, 70% of all DAS respondents identify as having a **mental or emotional health-related** disability or chronic health condition (77% students, 69% staff, 50% faculty)
- 47% of all DAS respondents identify as having a **cognitive** disability or chronic health condition (57% students, 35% staff, 41% faculty)[10]

Noticeability Matters

The DAS results indicate that experiences of ableism can vary according to how noticeable individuals' disabilities and chronic health conditions are to others, which reinforces the importance of disaggregated data analysis[11].

For example, compared to those whose disabilities and chronic health conditions are less noticeable to others, those whose disabilities are "often or always noticeable to others" report experiencing significantly more:

- Ableist microaggressions both in-person[12] and virtually[13]; and
- In-person exclusion and harassment[14].

But those whose disabilities and chronic health conditions are more noticeable also report feeling significantly more comfortable sharing their disability identities at UM than their counterparts whose disabilities and chronic health conditions are less noticeable[15].

DAS respondents with less noticeable disabilities and chronic health conditions describe some different experiences of ableism[16] that involves:

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[9] Totals exceed 100% because respondents could select more than one response to the question, if they wished.

[10] In comparison, 48% of all respondents identify as having a physical disability or chronic health condition (43% students, 51% staff, 55% faculty); and 19% identify as having a sensory disability or chronic health condition (17% students, 19% staff, 24% faculty).

[11] The DAS questions asked, "how noticeable is your disability or chronic health condition to others?", which is why we use "noticeability" in this report. Respondents used a variety of terms to describe their personal experiences including "hidden" and "invisible".

[12] $F (2, 511) = 10.8$, $p =<.001$, $\eta^2 = 0.04$.

[13] $F (2, 467) = 4.8$, $p =<.01$, $\eta^2 = 0.02$.

[14] $F (2, 509) = 7.4$, $p =<.001$, $\eta^2 = 0.03$. Post-hoc tests indicate respondents who identify as having "often or always noticeable" disabilities and chronic health conditions experience significantly more in-person exclusion and harassment than those whose disabilities are "not at all or rarely noticeable to others", specifically.

[15] $F (2, 524) = 5.4$, $p =<.01$, $\eta^2 = 0.02$.

[16] This does not mean that respondents with less noticeable disabilities and chronic health conditions do not experience any microaggressions, exclusion, or harassment. Unfortunately, they are still impacted by such behaviours, but the DAS data indicates they report these experiences significantly less often than respondents with more noticeable disabilities and chronic health conditions. Likewise, those with more noticeable disabilities and chronic health conditions can also be questioned about the "legitimacy" of their disabilities and conditions and feel like others do not believe them.

- **Not being believed** when they say they are disabled or need accommodations; and
- Feeling like their disabilities and chronic health conditions are somehow "**less legitimate"** than other types of disabilities and chronic health conditions, which is also related to respondents' perception of institutional bias toward more noticeable, physical, and continuous disabilities and chronic health conditions.

Impact on Participation and Identity Sharing

DAS respondents indicate that having less noticeable, including episodic, disabilities and chronic health conditions affects how they participate at UM as students and employees, and how they share (or choose not to share) their identities with others.

Participation at UM:

> Sometimes [noticeable to others]. I have gone weeks at a time with a flare-up of my physical illness where I can't get out of bed, and I have to call in sick. However, during midterms [or] times of heavy workload, **I had to manage the flare-up by going to school and dealing with it. This meant taking exams when I feel dizzy, disoriented, [or] out-of-it.**

> Yes [noticeability of disability affects my participation at UM] in the sense that my chronic health conditions are considered "invisible" I feel as though it is often frowned upon when I am not able to output the same amount of work as my peers, **it is assumed that I am just being lazy rather than struggling to function**. In reality, it takes everything I have just to get here in the morning.

> In some instances, I have been **more aggressively 'pushed' to participate** in learning activities [or] specific situations despite my objections [and] concerns [regarding] triggering my mental health conditions, likely because my conditions are NOT particularly apparent or visible.

Identity Sharing:

> The issue for me isn't so much sharing with instructors that I am disabled, but rather **convincing them that my disability is valid** because they seem to all think that ADHD just means I should be hyper and not that I have extreme sensory and task initiation issues [...].

> I feel because my disabilities are invisible to fairly invisible, that **I need to "play up" my fatigue for it to be taken seriously**. Overall, I expect that if I were more open, that I would receive a great deal of unconscious stigma as a result [...].

> I don't feel comfortable disclosing my mental health condition **fearing negative judgment regarding my competence for my role**. I think others may feel the same and this is the biggest challenge to build a supporting peer community.

Many individuals described:

- "Masking" their identities, the effort required to mask, and the impact masking can have on individuals' well-being and participation, as a result:

"Not noticeable [to others] because I've gotten good at masking. But masking itself takes a huge toll causing fatigue and contributing to multiple cases of burn out each year."

"I adapt to social situations through masking my autistic traits. I can maintain masking fairly effectively, and it does not largely limit me from engaging with learning activities in the first place. However, masking is draining and limits the amount of learning activities I can participate in each day."

- And the importance of having access to remote work and learning options, and appropriate absence and leave benefits:

"Most often, my chronic health condition is not noticeable to others. I am less likely to participate or might change how I participate if [or] when my chronic health condition is noticeable to others. For example, I might take time off 'sick' or I might work from home or virtually."

Impact on Accommodations

Many DAS respondents who identify with less noticeable disabilities and chronic health conditions expressed uncertainty as to what their accommodations options are, and some are unsure if they can receive any accommodations at all[17]:

"I am unsure what supports would be helpful for me, as my pain and symptoms are very unpredictable."

"[I] don't think an eating disorder counts."

Statistical analyses further indicate that:

- Respondents who identify with "rarely or not at all noticeable" disabilities and chronic health conditions are **less likely to feel comfortable applying for accommodations** than respondents who identify with "sometimes noticeable" and "often or always noticeable" disabilities and chronic health conditions[18]
- Respondents who identify with "rarely or not at all noticeable" and "sometimes noticeable" disabilities and chronic health conditions are significantly more likely to agree that **needing**

[17] These quotes are in response to the question "why aren't you receiving or applying for accommodations?". It was asked only of those respondents who indicated they require (or are unsure if they require) accommodations to fully participate at UM.

[18] More specifically, 48% of "rarely or not at all noticeable" respondents disagree that they are comfortable applying for accommodations, compared to 40% of "sometimes noticeable" respondents, and 32% of "often or always noticeable" respondents. X^2 (4, 526) = 9.6, p =<.05, V = 0.10.

or applying for accommodations will hurt their studies or career than respondents who identify with "always or often noticeable" disabilities and chronic health conditions[19]

- Students who identify with "rarely or not at all noticeable" disabilities and chronic health conditions **perceive significantly more stigma around accommodations**, as compared to their peers whose disabilities and chronic health conditions are "often or always noticeable to others"[20]
- Students who identify with "rarely or not at all noticeable" disabilities and chronic health conditions are marginally[21] more likely to say they have **not registered with Student Accessibility Services** (31.5%) than their peers who identify with "often or always noticeable" (21%) and "sometimes noticeable" disabilities and chronic health conditions (18%)

A More Inclusive Understanding

Thus, many DAS respondents call on UM to commit to a more inclusive understanding of what disability and chronic health conditions are and all the ways they are experienced by students, staff, and faculty members. Such a commitment must also include an understanding of how exactly disability and chronic health diversity can manifest across UM campuses (e.g., intermittent or extended absences from class or work, and seeking temporary accommodations rather than continuous ones, etc.).

An insufficient understanding of disability and chronic health diversity may result in members of the UM community being **denied needed accommodations and being subjected to ableist microaggressions and discriminatory behaviour** (e.g., "you look too healthy to be disabled"):

> Sometimes I have asked professors for extensions as per my Student Accessibility Services accommodations and they have told me **I don't seem like I need them**. It feels as though my mental health experience has to be visible to them in order for them to grant them.
>
> Many of the faculty are warm, understanding, and well aware of how to help or at least how to listen, ask questions and provide support. Others are less aware of cognitive disabilities or have a narrow understanding of what they are and respond with **denial and reassurance that you are fine and are more than capable**.
>
> Yes, they aren't visible so when I tell people I struggle **they don't believe there is an actual issue and that I'm making it up** because they can't physically see something I struggle with.

[19] More specifically, 59% of "rarely or not at all noticeable" respondents agreed that applying for accommodations would be harmful, compared to 54% of "sometimes noticeable" respondents, and 31% of "often or always noticeable" respondents. $X^2(4, 469) = 10.8$, $p =<.05$, $V = 0.11$.

[20] $F(2, 528) = 4.1$, $p =<.05$, $\eta^2 = 0.02$

[21] This result is only significant at the .10 alpha level, meaning there is a relatively greater chance (10%) that we have wrongly concluded there is a relationship between students' degree of disability "noticeability" and whether or not they have registered with SAS, as compared to results that are significant at the .05 alpha level or less.

Dismantling Ableism Survey (DAS): Student Accommodations Experiences at UM

Introduction

The Dismantling Ableism: Institutional Action and Accountability survey (DAS) was administered in November-December 2023 to University of Manitoba (UM) students, faculty, and staff who self-identified as disabled or as having chronic health conditions[1][2].

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Positionality

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The following results highlight some of the experiences of student respondents who need or are currently receiving accommodations.

Who needs accommodations?

- More than two-thirds (68%) of students[6] require an accommodation to fully participate at UM
- Another 20% of students are unsure if they require accommodations
- Students who identify as having **multiple disabilities and chronic health conditions** are more likely to require accommodations than students who identify as having one disability or chronic health condition (80% vs. 59%[7])

[4] Language choices were explained in the survey introduction; nevertheless, the DAS project team respects that members of disability and chronic health communities have diverse language preferences, including person with a disability, chronically ill, and episodic disability, for example. The team is grateful for all of the feedback we received regarding language and it will inform our work going forward.

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[6] The results in this report refer only to those UM students who participated in the Dismantling Ableism Survey, not all UM students.

[7] X^2 (2, 149) = 7.1, p =<.05, V = 0.22

- Students identifying with **cognitive disabilities** are more likely to require accommodations (76%) than students identifying with physical or sensory disabilities (61%), and mental or emotional health-related disabilities (47.5%[8])
- Students identifying with **mental or emotional health-related disabilities or chronic health conditions** are more likely to be **unsure** as to whether they require an accommodation (25%), as compared to students identifying with cognitive (19%) and physical or sensory disabilities and chronic health conditions (18%[9])

Whose needs are not currently being met?

- **Graduate students** who need accommodations are less likely than their undergraduate counterparts to be receiving them[10] (40% vs. 28%[11])
- Students identifying with **mental or emotional health-related disabilities** are less likely to be receiving needed accommodations (55%) than students with physical or sensory disabilities (36%) and students with cognitive disabilities (26%[12])
- Only 1/3 of students currently receiving accommodations indicate their needs are being **met or exceeded** by their instructors or academic supervisors
- 1/3 of students have been **denied** an accommodation at some point[13]

Why are students denied accommodations?

Students who have been denied accommodations were invited to expand on the circumstances surrounding these denials. Students described:

- Feeling that their expertise regarding their own needs was challenged or ignored
- Barriers related to the existing accommodations process and system, including application deadlines, and available resources and supports to fulfill accommodations requests
- Denials or delays related specifically to the need to obtain official medical documentation or approvals
- Concern that the wider UM culture views accommodations as an unfair advantage
- Instances where instructors denied accommodations requests, including those approved by Student Accessibility Services; or engaged in other ableist conduct (e.g., downplaying the seriousness of students' disabilities or deciding that honoring accommodations would enable students' disabilities)

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[8] X^2 (4, 256) = 21.5, p =<.001, V = 0.21

[9] X^2 (4, 256) = 21.5, p =<.001, V = 0.21

[10] Student Accessibility Services and Faculty of Graduate Studies are currently working together to improve graduate students' accommodations experiences, specifically.

[11] X^2 (2, 215) = 7.9, p =<.05, V = 0.19

[12] X^2 (4, 221) = 11.1, p =<.05, V = 0.16

[13] This includes both formal and informal accommodation requests.

What is the impact of being denied?

Students described the following consequences of accommodations denials:

- Continuing to struggle through classes unnecessarily
- Dropping classes, affecting future workloads and graduation timelines
- Extra time and effort spent self-advocating or challenging denials
- Distress, burnout, and feeling unwelcome at UM
- Feeling discouraged from requesting accommodations again in the future

Next steps

Two concrete actions recommended by students to improve their accommodations experiences include[14]:

- Better educating the UM community, including instructors, on the wide range of disabilities and chronic health conditions students identify with (e.g., cognitive and mental health disabilities), accommodation options and processes at UM, and accessible course design
- Implementing reporting mechanisms and consequences for ableist conduct

[14] Students, faculty, and staff offered a wide variety of suggestions regarding the types of supports they would like to have. These suggestions will be fully detailed in future results summaries. The two actions highlighted here were selected because they appear particularly relevant to preventing students from being unfairly denied accommodations.

Dismantling Ableism Survey (DAS): Staff and Faculty Accommodations Experiences at UM

Introduction

The Dismantling Ableism: Institutional Action and Accountability survey (DAS) was administered in November-December 2023 to University of Manitoba (UM) students, faculty, and staff who self-identified as disabled or as having chronic health conditions[1][2].

Disability is not a singular experience, nor are disabled people a homogeneous group. People encounter different barriers and forms of ableism. Moreover, two people with similar impairments will also experience disability differently as personality, circumstance, privilege, and intersectional identities contribute toward their complex identity.

> "Experiences of inequities are particular to the type of chronic health issues [or] disability. When paired with intersectional issues such as race, class, etc., these inequities become more pervasive."

This results report is one in a series highlighting student, staff, and faculty experiences of ableism and inaccessibility at UM. It is intended to diversify understandings of ableism in academia through the presentation of disaggregated results that indicate differences among those who may share one or more broad socio-demographic characteristics such as Indigenous, racialized, or disability identities, gender, or sexuality[3]. We emphasize disaggregated data to acknowledge intersectional marginalization to decenter Whiteness, colonialism, patriarchy, heteronormativity, and cisnormativity within anti-ableism action.

Comparing the experiences of intersectionally marginalized groups is not intended to set these groups in competition with one another or to focus only on barriers and the ways in which they are "disadvantaged", rather than their agency and vast array of achievements and skills. Rather, disaggregated analysis emphasizes experiences and voices that are often overlooked to pinpoint the concrete actions that will have the most widespread positive impacts on the entire UM community.

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[1] The survey was funded by the Robbins-Ollivier Award for Excellence in Equity.

[2] The final sample size for the DAS, after data cleaning, is 544.

[3] For example, do those who identify with cognitive disabilities feel more or less safe at UM than those identifying with physical or sensory disabilities? Do those who identify as disabled and as either bisexual or pansexual encounter more ableist microaggressions than their heterosexual counterparts?

Language

The DAS used identity-first language (disabled persons) rather than person-first language (persons with disabilities) to acknowledge the disabling effect of social, environmental, and institutional barriers which hinder disabled individuals' full participation in society, including university life[4].

Similarly, the survey also used the term "chronic health conditions", broadly defined as any condition, including mental health conditions, that is continuing or that occurs again and again over a long period of time, which in interaction with various barriers, may hinder full and effective participation in society on an equal basis with others[5].

Positionality

Researchers bring their experiences, identities, and biases to their work. The DAS team members identify with various systemically marginalized identities, including disability and chronic health-related identities. These lived experiences are assets, but we recognize that our personal intersections of privilege also influence our work. Our commitment to research quality includes an openness to concerns and criticisms. Please feel free to send feedback on the DAS results to the Office of Equity Transformation at Equity@umanitoba.ca.

The following results highlight some of the experiences of staff and faculty respondents who need or are currently receiving accommodations.

Who needs accommodations?

- 43% of staff and faculty respondents need an accommodation to fully participate at UM
- Another 37% are unsure if they require accommodations
- Staff and faculty who are **mostly or fully remote** are more likely to require an accommodation (65%), as compared to those with hybrid work arrangements (41%) and those who mostly work in-person[6] (35%)
- Those that have **multiple disabilities** are more likely to require accommodations than those with one disability[7] (67% vs. 47%)
- Staff and faculty who describe their disability or chronic health condition(s) as **"sometimes noticeable"** more likely to be **unsure** if they require accommodations (42%) than those

[4] Language choices were explained in the survey introduction; nevertheless, the DAS project team respects that members of disability and chronic health communities have diverse language preferences, including person with a disability, chronically ill, and episodic disability, for example. The team is grateful for all of the feedback we received regarding language and it will inform our work going forward.

[5] Adapted from Bernell, S., & Howard, S. W. (2016). Use your words carefully: What is a chronic disease? *Frontiers in Public Health, 4*, 159. https://doi.org/10.3389/fpubh.2016.00159 and the United Nations.

[6] X^2 (4, 255) = 13.2, p =<.05, V = 0.16

[7] X^2 (2, 91) = 9.2, p =<.05, V = 0.32

whose disabilities or chronic health conditions are "rarely or not at all" (33%) and "often or always noticeable to others" (29%)[8]

Whose needs are not currently being met?

- Only 30% of staff and faculty who need (or are unsure if they need) accommodations are currently receiving them
- 81.5% of staff and faculty identifying with **mental or emotional health-related disabilities** who need accommodations are **not** receiving them, as compared to staff and faculty with cognitive disabilities (75%) and physical or sensory disabilities who need accommodations[9] (52.5%)
- 25% of staff and faculty who need (or unsure if they need) accommodations have been denied an accommodation at some point[10]
- Those who work **mostly or fully remotely** are marginally more likely to have been denied accommodations (37.5%) than those who work mostly or fully in-person (24%) and those with hybrid work arrangements[11] (19%)

Why are staff and faculty denied accommodations?

When invited to expand on accommodations denials, many staff and faculty described:

- Inconsistent access to work-from-home arrangements, including insecure temporary remote work arrangements (e.g., no commitment that a current remote work agreement would continue or actions that undermine current arrangements, such as denying equipment requests)
- Institutional factors overriding employees' needs and medical experts' recommendations (e.g., supervisors' authority or perceived favourtism, financial limitations, and UM policies)

I have been granted a temporary accommodation situation that is working very well for me and allows me to participate fully in my work [with limited exceptions]. However, the temporary nature of the accommodation is very stressful for me - I feel like I will have to quit when the accommodation ends. I can't imagine going back to working without accommodations now that I understand how much more manageable work can be with them.

[8] X^2 (4, 254) = 13.9, p =<.01, V = 0.17
[9] X^2 (4, 188) = 12.8, p =<.05, V = 0.19
[10] This includes both formal and informal accommodations.
[11] X^2 (2, 181) = 5.0, p =<.10, V = 0.17. These results are only significant at the .10 alpha level, indicating there is a 10% chance we have wrongly rejected the null hypothesis that there is no relationship between type of work participation and being denied accommodations.

What is the impact of being denied accommodations?

- Negative impacts on personal well-being
- Having to devote time and energy to additional unpaid labour (e.g., continuing to pursue accommodations following denials and other self-advocacy efforts)
- Out-of-pocket costs to fund one's own accommodations

[It feels] invalidating, [they are] concerned more with avoiding precedents [or] hassle than the appropriateness of accommodation or my wellbeing.

Dismantling Ableism Survey (DAS): Indigenous Participants' Experiences

Introduction

The Dismantling Ableism: Institutional Action and Accountability survey (DAS) was administered in November-December 2023 to University of Manitoba (UM) students, faculty, and staff who self-identified as disabled or as having chronic health conditions[1][2].

Disability is not a singular experience, nor are disabled people a homogeneous group. People encounter different barriers and forms of ableism. Moreover, two people with similar impairments will also experience disability differently as personality, circumstance, privilege, and intersectional identities contribute toward their complex identity.

> "Experiences of inequities are particular to the type of chronic health issues [or] disability. When paired with intersectional issues such as race, class, etc., these inequities become more pervasive."

This results report is one in a series highlighting student, staff, and faculty experiences of ableism and inaccessibility at UM. It is intended to diversify understandings of ableism in academia through the presentation of disaggregated results that indicate differences among those who may share one or more broad socio-demographic characteristics such as Indigenous, racialized, or disability identities, gender, or sexuality[3]. We emphasize disaggregated data to acknowledge intersectional marginalization to decenter Whiteness, colonialism, patriarchy, heteronormativity, and cisnormativity within anti-ableism action.

Comparing the experiences of intersectionally marginalized groups is not intended to set these groups in competition with one another or to focus only on barriers and the ways in which they are "disadvantaged", rather than their agency and vast array of achievements and skills. Rather, disaggregated analysis emphasizes experiences and voices that are often overlooked to pinpoint the concrete actions that will have the most widespread positive impacts on the entire UM community.

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[1] The survey was funded by the Robbins-Ollivier Award for Excellence in Equity.

[2] The final sample size for the DAS, after data cleaning, is 544.

[3] For example, do those who identify with cognitive disabilities feel more or less safe at UM than those identifying with physical or sensory disabilities? Do those who identify as disabled and as either bisexual or pansexual encounter more ableist microaggressions than their heterosexual counterparts?

Language

The DAS used identity-first language (disabled persons) rather than person-first language (persons with disabilities) to acknowledge the disabling effect of social, environmental, and institutional barriers which hinder disabled individuals' full participation in society, including university life[4].

Similarly, the survey also used the term "chronic health conditions", broadly defined as any condition, including mental health conditions, that is continuing or that occurs again and again over a long period of time, which in interaction with various barriers, may hinder full and effective participation in society on an equal basis with others[5].

Positionality

Researchers bring their experiences, identities, and biases to their work. The DAS team members identify with various systemically marginalized identities, including disability and chronic health-related identities. These lived experiences are assets, but we recognize that our personal intersections of privilege also influence our work. Our commitment to research quality includes an openness to concerns and criticisms. Please feel free to send feedback on the DAS results to the Office of Equity Transformation at Equity@umanitoba.ca.

The following results highlight some of the experiences of Indigenous respondents.

Indigenous Identities

- Overall, 11% of the survey sample identifies as Indigenous (12% of students; 12% of staff; and 9% of faculty)
    - Indigenous representation among the survey sample appears to exceed Indigenous representation among UM students (9% in 2022-2023[6]) and employees[7]
- 8% of Indigenous survey participants further identify as Métis (8% of students and 8% of faculty and staff), and 4% identify as First Nations (Anishinaabeg, Ininew, Anishininewuk, Dakota, Oyate, and Denesuline, etc.) (4% of students and 4% of faculty and staff)

[4] Language choices were explained in the survey introduction; nevertheless, the DAS project team respects that members of disability and chronic health communities have diverse language preferences, including person with a disability, chronically ill, and episodic disability, for example. The team is grateful for all of the feedback we received regarding language and it will inform our work going forward.

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[6] Office of Institutional Analysis

[7] Choosing to share one's Indigenous identities is a highly personal decision, influenced by a number of factors. Accordingly, Indigenous identities may be present across UM to a greater degree than is reflected by official institutional statistics.

- Many additional Indigenous identities were specified, but low case counts prohibit the reporting of these identities to protect privacy and confidentiality[8]
- The majority of Indigenous respondents are 25-44 years old (53%), 24% are aged 45+, and 23% are under the age of 25
- The majority are neither parents nor guardians of children under the age of 18 (71%), nor do they provide significant support to adults over the age of 18 (83%)
- Nearly half of Indigenous respondents mostly or fully work or study at UM in-person (48%), while 21% are mostly or fully remote and 31% participate via a mix of both in-person and remote activities

Disability and Chronic Health

- Indigenous respondents are relatively **more likely to identify as having chronic health conditions** (61%) than as disabled or with another disability identity
- More than half indicate their disabilities or chronic health conditions are **only sometimes noticeable to others** (55%)
- Indigenous respondents are **more likely to identify with cognitive disabilities** and health conditions than physical, sensory, or mental or emotional health-related disabilities; and they are significantly more likely than non-Indigenous respondents to identify with cognitive disabilities and health conditions (66% vs. 45%[9])
- More than 75% of Indigenous respondents identify with **multiple disabilities and chronic health conditions**; and Indigenous respondents are significantly more likely than non-Indigenous respondents to identify as having two or more chronic health conditions[10]

Experiences at UM

Systemic ableist barriers are disproportionately negatively impacting members of the UM community who identify as both Indigenous and as having disabilities and chronic health conditions, among other identities.

Indigenous survey respondents are significantly[11] more likely than non-Indigenous respondents to:

- Feel unsatisfied with their current level of participation at UM
- Feel less safe personally and believe their campus is less safe for disabled people and those with chronic health conditions in general

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[8] Even though 5 individuals is a common minimum standard for statistical reporting, the combination of identities (e.g., Indigenous and disabled, or Indigenous and a faculty member, etc.) increases the risk of unintentional identification. Accordingly, we increased our minimum case threshold to better protect individuals' privacy and confidentiality.

[9] X^2 (2, 509) = 10.3, p =<.01, V = 0.14

[10] X^2 (1, 324) = 5.3, p =<.05

[11] Refers to t-test and ANOVA results of multi-item indices that achieved statistical significance at the .05, .01, or .001 alpha levels.

- Feel less comfortable about sharing their disability and health identities at UM
- Believe UM is less engaged with dismantling ableism (e.g., taking responsibility for systemic barriers and taking action to dismantle these barriers)

- Personally experience negative impacts of ableist attitudes (e.g., feel they must work harder to prove they belong at UM or feel pressure to downplay the impact of their disability, etc.)
- Experience more institutional barriers, overall (e.g., barriers getting to campus, finding suitable work or study spaces, barriers related to a lack of hybrid work or study options, etc.)
- Experience more information and technology (IT) barriers, overall[12]
- Experience more ableist microaggressions both in-person and virtually (e.g., others assume respondents need help or that all their capabilities are affected by their disability and health identities)
- Experience more exclusion and mistreatment both in-person and virtually
- Experience more emotional exhaustion
- Encounter more inequities (e.g., access to professional development and skills training and promotion and advancement opportunities) (this finding is specific to Indigenous staff vs. non-Indigenous staff only)

How to Move Forward

The ableist barriers experienced by Indigenous survey participants are inseparable from the on-going impacts of intersecting oppressions, such as colonization and homophobia and transphobia, as described by one student survey participant:

> "I am currently experiencing mental health issues related to Indigenous intergenerational trauma generational [e]ffects and now it's hard for me to attend in person events."

- Less than half of Indigenous respondents (45%) identify as heterosexual
- About one-quarter (23%) of Indigenous respondents indicated a gender other than man or woman; and the majority identified either as women or with a systemically marginalized genders[13] (e.g., Two Spirit[14], transgender, or agender, etc.)
- Nearly two-thirds of Indigenous respondents experienced difficulties meeting their necessary costs in 2022-2023 (e.g., food, housing, transportation, and medical care, etc.)

[12] The DAS was administered in November-December 2023. As such, the results may not capture recent (and ongoing) accessibility improvements to specific information and communications systems at UM, including the work undertaken to meet the Accessibility for Manitobans Act Information and Communications Standard (AMA-IC), and WCAG 2.1 standards.
[13] Respondents could choose multiple answers for the gender and sexualities questions so totals for these variables can exceed 100%.
[14] Two Spirit was a response option for both the gender and sexualities questions.

and Indigenous respondents are significantly more likely than non-Indigenous respondents to have reported such difficulties (64.5% vs. 36%[15])

As such, **actions that address intersectional systemic inequities are necessary** for every Indigenous student, staff, and faculty member to fully excel at the University of Manitoba.

Immediate Actions

Overall, Indigenous participants told us that the following actions would make the greatest impact toward dismantling ableism at UM:

1. Coordinate accommodations and support services (21% ranked #1)
2. Ensure disabled people and those with chronic health conditions are valued members of the UM community (19% ranked #1)
3. Improve physical infrastructure and accessibility (16% ranked #1)

[15] X^2 (2, 506) = 20.2, p =<.001, V = 0.20

Dismantling Ableism Survey (DAS): Perceptions and Impacts of Ableism at UM – Overall Univariate Findings

Introduction

The Dismantling Ableism: Institutional Action and Accountability survey (DAS) was administered in November-December 2023 to University of Manitoba (UM) students, faculty, and staff who self-identified as disabled or as having chronic health conditions[1][2].

Disability is not a singular experience, nor are disabled people a homogeneous group. People encounter different barriers and forms of ableism. Moreover, two people with similar impairments will also experience disability differently as personality, circumstance, privilege, and intersectional identities contribute toward their complex identity.

> "Experiences of inequities are particular to the type of chronic health issues [or] disability. When paired with intersectional issues such as race, class, etc., these inequities become more pervasive."

This results report is one in a series highlighting student, staff, and faculty experiences of ableism and inaccessibility at UM. It is intended to diversify understandings of ableism in academia through the presentation of disaggregated results that indicate differences among those who may share one or more broad socio-demographic characteristics such as Indigenous, racialized, or disability identities, gender, or sexuality[3]. We emphasize disaggregated data to acknowledge intersectional marginalization to decenter Whiteness, colonialism, patriarchy, heteronormativity, and cisnormativity within anti-ableism action.

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[1] The survey was funded by the Robbins-Ollivier Award for Excellence in Equity.

[2] The final sample size for the DAS, after data cleaning, is 544.

[3] For example, do those who identify with cognitive disabilities feel more or less safe at UM than those identifying with physical or sensory disabilities? Do those who identify as disabled and as either bisexual or pansexual encounter more ableist microaggressions than their heterosexual counterparts?

Language

The DAS used identity-first language (disabled persons) rather than person-first language (persons with disabilities) to acknowledge the disabling effect of social, environmental, and institutional barriers which hinder disabled individuals' full participation in society, including university life[4].

Similarly, the survey also used the term "chronic health conditions", broadly defined as any condition, including mental health conditions, that is continuing or that occurs again and again over a long period of time, which in interaction with various barriers, may hinder full and effective participation in society on an equal basis with others[5].

Positionality

Researchers bring their experiences, identities, and biases to their work. The DAS team members identify with various systemically marginalized identities, including disability and chronic health-related identities. These lived experiences are assets, but we recognize that our personal intersections of privilege also influence our work. Our commitment to research quality includes an openness to concerns and criticisms. Please feel free to send feedback on the DAS results to the Office of Equity Transformation at Equity@umanitoba.ca.

This summary describes:

- Respondents' **personal experiences**, including experiences of ableism, at UM (e.g., barriers encountered on campus, and additional costs and unpaid labour associated with having disabilities or chronic health conditions, etc.);
- **Perceptions of institutional ableism across UM** (e.g., how committed respondents believe UM is to dismantling ableism and how they believe disabilities are thought of at UM, etc.); and
- The **impacts of ableism** including respondents' views on safety and identity sharing at UM, and their level of emotional exhaustion.

Methodological Notes

This summary presents select univariate findings to give readers a sense of the DAS sample's overall scores on key measures (i.e., the combined responses of all students, staff, and faculty who completed the DAS).

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[5] Adapted from Bernell, S., & Howard, S. W. (2016). Use your words carefully: What is a chronic disease? *Frontiers in Public Health, 4*, 159. https://doi.org/10.3389/fpubh.2016.00159 and the United Nations.

- Univariate analyses produce results for individual variables or survey questions (e.g., perception of safety), whereas bivariate analyses involve two variables and can identify differences between groups (e.g., undergraduate vs. graduate students' perceptions of safety). As such, this report does not include statistical comparisons
- **Univariate results can obscure important group differences**. For example, univariate analyses may show that, overall, most DAS respondents "never" or "rarely" experienced ableist microaggressions in the last year. However, this does not mean everyone had this experience. Bivariate analyses identify which groups experienced significantly more (or fewer) ableist microaggressions than others
    - Results highlighting statistically significant bivariate differences between groups in the DAS sample are presented in the remaining results reports (e.g., results specific to respondents with marginalized genders or sexualities, and respondents who identify with mental or emotional health-related disabilities or chronic health conditions)
- Group-specific results are presented in this summary only when survey questions were designed to take primary affiliation into account (e.g., equity questions created to be relevant to the unique experiences of students, staff, and faculty)
- Unless otherwise noted, "agree" stands for all of those who agreed and strongly agreed with the statement in question; and "disagree" stands for all of those who disagreed and strongly disagreed.

1. Personal Experiences at UM

Participation at UM

- Less than two-thirds of respondents (61%) are satisfied with their current level of participation at UM
- 42% indicate that accessibility barriers prevent their desired level of in-person participation
- Only 23% indicate that accessibility barriers prevent their desired level of remote participation

Access to Social Support at UM

- Only one-third of respondents (33%) say they can access social support at UM when they need it
- More than one-third (39%) do **not** feel like a part of the UM community
- Less than one-quarter (21%) have opportunities to interact with other disabled people and people managing chronic health conditions who are open about their identities at UM

Barriers Experienced in a Typical Month

Overall, respondents generally indicated they "never" or "rarely" experienced the various barriers highlighted in the DAS[6]. Nevertheless, the following barriers are experienced at least "sometimes" by DAS respondents in a typical month:

- Getting to their campus (57%)
- Getting around their campus (38%)
- Accessing appropriate study or work spaces (55%)
- Barriers related to a lack of in-person options (37%)

And barriers related to work methods and expectations were even more common:

- Barriers related to a lack of hybrid options (63%)
- Meeting deadlines or due dates (69%)
- Meeting productivity expectations (72%)
- Meeting work pace expectations (66%)
- Meeting weekly work hour expectations (66%)

IT-Related Barriers

Generally, respondents found it "easy" to access or use various IT and communications systems. Yet, respondents encountered the most barriers in the following four areas:

- UM Intranet (SharePoint) (34% difficult to access or use)
- Various UM software (e.g., Aurora, Banner, etc.) (29% difficult to access or use)
- UM websites (26% difficult to access or use)
- UM learning technologies (22% difficult to access or use)

Regarding virtual meeting platforms, Zoom was rated best for large and small group meetings (only 7% found it difficult, overall). Teams and Webex were rated more difficult (17% found both of these options difficult, overall).

It is important to note that the DAS was administered in November-December 2023. As such, the results may not reflect recent (and ongoing) efforts to improve accessibility for specific information and communications systems at UM, including the work undertaken to meet the Accessibility for Manitobans Act Information and Communications Standard (AMA-IC), and WCAG 2.1 standards.

[6] This block of questions asked respondents how often they encounter the following barriers in a typical month: barriers getting to their campus, barriers getting around campus, barriers related to accessing appropriate work or study spaces, barriers related to a lack of in-person options, barriers related to a lack of hybrid options, barriers related to deadlines or due dates, barriers related to meeting productivity expectations, barriers related to meeting work pace expectations, and barriers related to meeting work hour expectations.

Additional "Expert" Labour

Generally, respondents indicated their various interactions on campus were neutral or somewhat positive[7]. However, numerous students, faculty, and staff indicated they perform extra labour involving educating others on disability and accommodations, and that they are expected to be an expert on these topics.

- About one-quarter to one-third of students perform the additional labour of educating others and serving as an expert on disability and accommodations across their various interactions (e.g., peers and instructors or supervisors)
- Relatively more students report doing this work than faculty and staff (about one-quarter or fewer faculty and staff report doing this kind of work)
- The vast majority (75%+) of students that do this work find these roles mentally and emotionally exhausting; and students indicate they more often do this work for their peers, and instructors or academic supervisors, as opposed to staff at UM

Ableist Microaggressions Experienced in the Last Year

Respondents generally indicated they "never" or "rarely" experienced various ableist microaggressions in-person in the past year.

The two microaggressions respondents experienced most often **in-person** were:

- Someone downplayed the effects of your disability (15% often or very often)
- You were told you look "too healthy" to be disabled (13% often or very often)

Similarly, respondents generally indicated they "never" or "rarely" experienced various ableist microaggressions in the past year online.

Again, the most frequently experienced **remote** microaggression was:

- Someone downplayed the effects of your disability (8% often or very often)

Exclusion, Incivility, and Harassment

Most respondents indicate they are "never" or "rarely" excluded or mistreated **in-person** at UM:

- Excluded or left out in your home department or unit (87% never or rarely)
- Excluded or left out at UM in general (86% never or rarely)
- Heard insulting, derogatory, or offensive language or remarks (82% never or rarely)
- Experienced hostile or intimidating behaviours (88% never or rarely)

[7] "Somewhat" refers to the fact that respondents only usually "agree" that they had positive interactions (e.g., were treated with respect), but they did not "strongly agree".

Similarly, most respondents indicate they are "never" or "rarely" excluded or mistreated when they are **remote or virtual**.

- Excluded or left out in your home department or unit (90%+ never or rarely)
- Excluded or left out at UM in general (90%+ never or rarely)
- Heard insulting, derogatory, or offensive language or remarks (90%+ never or rarely)
- Experienced hostile or intimidating behaviours (90%+ never or rarely)

Degree, Program, or Career Progression

- Nearly two-thirds (64.5%) feel "behind others"
- Less than one-third (29%) feel "on track with others"
- Only 6% feel like they are "ahead" of others

2. Perceptions of Institutional Ableism at UM

Attitudes toward Disabilities at UM

DAS respondents' perceptions of attitudes toward disability at UM are relatively poor, overall, with more than half indicating negative perceptions, such as:

- 59.5% agree that "UM practices and policies treat disabilities as individual medical problems"
- 54% agree that "UM employees treat disabilities as individual medical problems"
- Less than half (46%) agree that "disabled people are seen as capable of handling the demands of academia"
- 53% agree that "disabilities thought of negatively, as issues needing to be 'fixed'"
- 72% agree that "UM would rather keep things the same than make significant change to increase equity for disabled people"
- Only 21% agree that "others at UM are well-informed about disabilities and disability-related issues"

Higher percentages of respondents assert UM expects disabled people as part of the community, but welcoming people with disabilities and chronic health conditions is insufficient if ableism persists across the institution.

- 78% agree that "UM expects disabled people to be present in-person
- 66% agree that "UM expects disabled people to be present virtually"
- Less than one-third (29%) believe that "UM does **not** welcome disabled people as members of the community"

UM's Commitment to Dismantling Ableism

- Only 20% agreed that "UM understands how many barriers still exist for disabled people"
- Only 27% agreed that "UM acknowledges the systemic impact of barriers on disabled people"
- Only 21% agreed that "The University is taking responsibility for eliminating these barriers at UM"
- Only 22.5% agreed that "The University is taking action to dismantle these barriers"

Ongoing Inequities

Student-Identified Inequities

Overall, student respondents indicated they experience ongoing inequities including, but not limited to:

- "Assessment options in my classes are too limited for me" (56% agree)
- "Class materials are adequately accessible for me" (45% agree)
- "It is taking significantly longer for me to complete my degree or program than my non-disabled peers" (62% agree)
- "It is challenging to find suitable mentors" (57% agree)

Staff-Identified Inequities

Staff also identified ongoing inequities with career implications:

- "I have as much access to professional and skill development opportunities as my non-disabled co-workers" (68% agree)
- "It is challenging for me to find suitable mentors" (42% agree)
- "I have as much access to promotion and advancement opportunities as my non-disabled co-workers" (44% agree)

Of those that said they do not have as much access to promotion and advancement as their non-disabled co-workers, 63% agreed that "attitudes toward my disability and disability in general have prevented me from accessing or pursuing promotion or advancement opportunities at UM".

Faculty-Identified Inequities

Faculty perceive the most inequity around the tenure and promotion (T&P) process and leadership opportunities:

- 64% agree T&P is biased against disabled faculty
- 63% feel like senior leadership roles are not a realistic option for them

The percentage results indicate several other areas still needing serious improvement, for example:

- 55% feel that faculty do not have as much access to accommodations at UM as others
- 52% say it is difficult to find suitable mentors
- Slightly less than 40% indicate they receive sufficient resources to reach their functional capacity to conduct their research and teach their classes

Faculty were also asked a series of questions regarding service work which, again, indicates specific areas needing attention:

- Only 50% agree they "receive enough resources and support to fully engage with my [service] commitments"
- Only 13% agree that "when asked to provide a disability or chronic health perspective, my input is valued and meaningfully incorporated"
- Less than half (43%) feel that "the service I do is producing meaningful change"

But there are also some relatively more encouraging findings regarding service:

- 68% **disagree** that "because I am disabled or managing chronic health conditions, I receive excessive service requests"
- 84% **disagree** that they are "mostly seen as an expert on disability or chronic health in my service work"

Additional Costs

Survey respondents assert there are additional costs that accompany disability and chronic health identities at UM.

- About half (49%) agree they must "spend a lot more money" to be a student or employee at UM because they have a disability or chronic health condition
- More than half (58%) agree they must "do a lot more unpaid labour" to be a student or employee at UM[8] because they have a disability or chronic health condition

[8] Compared to their respective non-disabled counterparts (students, faculty, and staff).

3. Impacts of Ableism

Personal Impact of Ableist Attitudes at UM

- 41% of respondents agree that they "feel that others think I'm faking my disabilities or chronic health conditions"
- 37% of respondents agree that "others question my intelligence or competence because I am disabled or have chronic health conditions"
- 59% of respondents feel they "must work harder than others to prove I belong at UM"
- 78% of respondents "feel pressure to downplay the impact of my disabilities or chronic health conditions"

Perceptions of Safety

Nearly half of respondents (48%) consider their primary campus to be safe or very safe for themselves, personally. When asked how safe various areas on campus are (e.g., libraries, offices, classrooms, etc.), respondents tended to either say they were neutral or leaned toward "safe".

Respondents personally felt **the least safe**:

- Getting to campus (18% unsafe or very unsafe)
- In recreational and active living spaces (17.5% unsafe or very unsafe)

Respondents are relatively less optimistic about how safe their campuses are for others with disabilities, however.

- Only 28.5% consider their primary campus to be safe for disabled people and those with chronic health conditions, in general

Respondents assert the most dangerous experiences for those with disabilities and chronic health conditions, in general, are:

- Getting to campus (37% unsafe or very unsafe)
- Getting around campus (33.5% unsafe or very unsafe)

Sharing Identities

Overall, respondents express concern about sharing their disability and chronic health identities at UM:

- Nearly half (45.5%) do not think it is safe for people to share their identities at UM
- 76% would only feel comfortable sharing with a few select individuals
- 75% are worried that sharing would negatively affect their career or studies

In addition, more than half (58.5%) indicate they have had to share their identities with someone at UM when they would rather **not** have.

Emotional Exhaustion

Unfortunately, DAS respondents agree that they are burned out and exhausted, overall. Moreover, about half of respondents link these feelings to ableism at UM:

- 86% “feel drained from my work or studies”
- 83.5% feel “used up at the end of the work or school day”
- 78% feel “burned out from my work of studies”
- 57% feel “frustrated by the ableist barriers I encounter in my career, degree, or program”
- 49% are “exhausted by the ableist barriers I encounter at UM in general”

Dismantling Ableism Survey (DAS): Qualitative Results

Introduction

The Dismantling Ableism: Institutional Action and Accountability survey (DAS) was administered in November-December 2023 to University of Manitoba (UM) students, faculty, and staff who self-identified as disabled or as having chronic health conditions[1][2].

Disability is not a singular experience, nor are disabled people a homogeneous group. People encounter different barriers and forms of ableism. Moreover, two people with similar impairments will also experience disability differently as personality, circumstance, privilege, and intersectional identities contribute toward their complex identity.

> "Experiences of inequities are particular to the type of chronic health issues [or] disability. When paired with intersectional issues such as race, class, etc., these inequities become more pervasive."

This results report is one in a series highlighting student, staff, and faculty experiences of ableism and inaccessibility at UM. It is intended to diversify understandings of ableism in academia through the presentation of disaggregated results that indicate differences among those who may share one or more broad socio-demographic characteristics such as Indigenous, racialized, or disability identities, gender, or sexuality[3]. We emphasize disaggregated data to acknowledge intersectional marginalization to decenter Whiteness, colonialism, patriarchy, heteronormativity, and cisnormativity within anti-ableism action.

Comparing the experiences of intersectionally marginalized groups is not intended to set these groups in competition with one another or to focus only on barriers and the ways in which they are "disadvantaged", rather than their agency and vast array of achievements and skills. Rather, disaggregated analysis emphasizes experiences and voices that are often overlooked to pinpoint the concrete actions that will have the most widespread positive impacts on the entire UM community.

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[1] The survey was funded by the Robbins-Ollivier Award for Excellence in Equity.

[2] The final sample size for the DAS, after data cleaning, is 544.

[3] For example, do those who identify with cognitive disabilities feel more or less safe at UM than those identifying with physical or sensory disabilities? Do those who identify as disabled and as either bisexual or pansexual encounter more ableist microaggressions than their heterosexual counterparts?

Language

The DAS used identity-first language (disabled persons) rather than person-first language (persons with disabilities) to acknowledge the disabling effect of social, environmental, and institutional barriers which hinder disabled individuals' full participation in society, including university life[4].

Similarly, the survey also used the term "chronic health conditions", broadly defined as any condition, including mental health conditions, that is continuing or that occurs again and again over a long period of time, which in interaction with various barriers, may hinder full and effective participation in society on an equal basis with others[5].

Positionality

Researchers bring their experiences, identities, and biases to their work. The DAS team members identify with various systemically marginalized identities, including disability and chronic health-related identities. These lived experiences are assets, but we recognize that our personal intersections of privilege also influence our work. Our commitment to research quality includes an openness to concerns and criticisms. Please feel free to send feedback on the DAS results to the Office of Equity Transformation at Equity@umanitoba.ca.

This summary explores some of the results from the qualitative analysis of the open-ended survey questions where respondents were invited to expand on their experiences at UM. Specifically, this report describes the themes identified in the analysis of two questions:

- Expansions on how respondents believe "disabilities and chronic health conditions are thought of at UM"; and
- Expansions on comfort and discomfort with sharing disability and chronic health identities at UM.

[4] Language choices were explained in the survey introduction; nevertheless, the DAS project team respects that members of disability and chronic health communities have diverse language preferences, including person with a disability, chronically ill, and episodic disability, for example. The team is grateful for all of the feedback we received regarding language and it will inform our work going forward.

[5] Adapted from Bernell, S., & Howard, S. W. (2016). Use your words carefully: What is a chronic disease? *Frontiers in Public Health, 4*, 159. https://doi.org/10.3389/fpubh.2016.00159 and the United Nations.

Methodological Note

Not every DAS respondent answered the open-ended questions featured in this brief report. Still, the two featured questions generated hundreds of comments. Accordingly, while the thematic results are based on a portion of the DAS sample, they represent the experiences and opinions of at least half the DAS sample. This note is not intended to diminish the experiences and opinions of those who responded to the open-ended questions[6], it is only included to provide readers with necessary methodological context to interpret the results.

This report also presents numerous quotes to describe respondents' experiences in their own words. Many of these quotes have been edited for the limited purposes of:

- Redacting potentially identifying details; and
- Increasing accessibility and generally improving clarity for all readers (e.g., adding missing punctuation and removing forward slashes, etc.).

Any additions or deletions to quotes are framed with square brackets[7]. The content and intended message of each of the quotes remains intact.

Ableism Upheld

When asked how they believe "disabilities and chronic health conditions are thought of at UM", those that responded to the question largely indicated that:

- Disabilities and chronic health conditions are, at best, an afterthought, institutional actions are largely performative and symbolic, and UM is generally resistant to structural change.

> Unless you're actively talking about the impact of a condition (which can easily get you labelled as a complainer or squeaky wheel), it will not be addressed (or it will be forgotten and expectations, workload, etc. will all slip back to standards for neurotypical and otherwise abled people). It appears that the University's assumption is that all staff are abled and otherwise conform to normative standards, and that exceptions may or may not be made on a case-by-case basis.

> Anytime I have gotten someone to listen to the concerns I have raised, I have been expected to take on the task of 'fixing' it myself off the side of my desk. This tells me everything I need to know about the UM's perspective on disabilities and chronic health conditions: they are an afterthought, and they are not a community issue.

[6] Indeed, the greatest strength of qualitative data is that it is highly valid and not subject to arbitrary thresholds for determining "significance".
[7] For example, [or] or [and]. The symbol [...] signifies that a relatively large portion of a sentence has been removed from the original quote.

Persons with disabilities are an afterthought at the UM and policies are only followed to maintain the bare legal minimum. Disability is the least understood, respected, and supported issue at the UM and even then, it is not understood at an intersectional level.

I really don't know how these topics are thought about by the university. It might be something that is talked about in passing in a UM Today article or an email from the President, but I don't see anything that stands out to me that UM is making changes and strides towards making acceptable and reasonable changes for those with disabilities and chronic mental health conditions.

UM is so rigid and bureaucratic in the foundations of its structure, something as unique as the spectrum of disability and chronic health conditions doesn't feel like it's really supported. At the end of the day UM is resistant to change and feels like students and staff are just student numbers and employee numbers.

- Too much hostility and stigma around disabilities, chronic health conditions, and accommodations remains, creating fear and uncertainty.

My own peers have called people with mental health conditions "crazy" which discourages me from speaking about my own experiences. And note that making people attending ableism seminars doesn't do anything if they are not willing to recognize and change their own actions, it just makes them mad at disabled people [and] people with chronic conditions that they need to "learn about them" which is a "waste of time" [...].

I'm sick of the consistent jokes and judgment or people joking about pretending to have a disability for it to be funny. It's really, really difficult. Hearing students constantly joke about being autistic and laugh it off is really offensive.

I feel that everyone knows the proper talking points when push comes to shove, but there is absolutely still stigma against disabilities and chronic health conditions.

I had to answer "I don't know" to many of these questions, because I have not disclosed my disabilities to my co-workers or management due to the extreme stigma surrounding neurodivergent disabilities [...]. I have no way of knowing for sure whether the U of M is a safe employer to disclose [...] to, so I choose not to take the risk of disclosing unless or until I require significant accommodations in order to do my job.

I think the fear for me is that I will be punished if people were to really find out [about a cognitive disability identity]. I fear being found out.

- Support and inclusion for people with disabilities and chronic health conditions are inconsistent, varying significantly from individual-to-individual and unit-to-unit.

I feel as though as I had a majorly great experience in [unit] because of the essence of the work we do. [...] I do not believe this is true for all departments across the campuses. I see a lot of lived experiences in groups on social media that students may feel [that] profs are not accommodating or easily accessible or understanding. These are all parts of accessibility.

I feel as though the campus administration and President and Deans do acknowledge the impact, however there are also experiences I have with certain professors that have made me feel extremely ostracized from the non-disabled students.

Like all nuanced topics, chronic health conditions are thought of very differently by individuals and the range of acceptance and accommodation varies by person, and unit, and while I think the University can make a meaningful shift, I don't know that full acceptance, understanding, and responsibility can be accomplished.

- There is a relatively narrow institutional understanding of disability and chronic health conditions, marginalizing mental health and hidden or less noticeable disabilities and chronic health conditions, in particular.

The lack of understanding and awareness of the impact of mental and cognitive disabilities for students is atrocious! Too many decision-makers are in positions where they do not validate or believe the impact of these disabilities (whether chronic, permanent or temporary) have on students.

For learning disabilities, I feel overall UM does a good job with accommodating and educating. For physical (or even mental health) is where UM lacks. Both in understanding and offer accommodations.

Chronic health conditions are not highly recognized as a disability and seem to be dismissed.

I don't think UM thinks of body size accommodations at all-- there are many spaces on campus where I would not be able to find a seat that worked for me. I do think there is a desire to become more accessible in other ways.

- The onus is on the individual – disabilities and chronic health conditions are treated as individual “problems”.

The impression I receive is that my mental health is my own problem and a distant and subordinate consideration to even the whims of policy, let alone any cognizant need.

I have not seen any evidence of any acknowledgement by UM and a lack of knowledge of where I could turn to for assistance. I am simply expected to deal with it on my own with an occasional nod of empathy from staff.

It is definitely seen as an individual's "problem" over the community's.

Impact on Identity Sharing

Given respondents' overall perception of "how disabilities and chronic health conditions are thought of at UM", it's understandable that many are not comfortable sharing these identities with others at UM. Many of those that responded to the question asking how comfortable they are sharing disability and chronic health identities feel:

- It is necessary to share their identities to defend themselves, avoid or pre-empt negative consequences, or explain behaviour

Sharing is up to the person themselves, but in certain situations leaving the question of "well WHY aren't they doing X" open is more damaging than telling someone about the disability [or] chronic health condition.

To avoid suspicion and judgment from instructors, I've often had to disclose my chronic health condition or learning disabilities. It's dehumanizing [...].

Sometimes I feel like I want to share to explain or defend myself in a way. Since people do not understand autism or know that I am autistic, they may see how I can't understand or interpret something properly as rude or selfish when, really, I'm just autistic. I feel like I want to share but I don't want to feel like I'm using it as an excuse, and I don't want to get unfairly judged by people.

I have had to share it with my boss to help explain absences.

I didn't want to share some of my issues with HR, but it was that or look like a terrible employee. My HR rep was very professional about and has not made me feel negatively about it, but I'd rather not have gone through that at all.

- It is necessary to share identities in order to receive accommodations, even when individuals would rather not share the details

I have had to be open about certain issues in the course of applying for and using accommodations. I hesitate to say whether it is safe for people to disclose in general - it might depend on the disability and its impacts on the specific things others expect the person to do. These days, people realize they are supposed to be sensitive to disability issues, so most will not react negatively to the news; however, some might react negatively to the disability itself (e.g., "I know she has a health condition, but why can't she do XYZ?").

Honestly the way you receive accommodations at the U of M requires you to prove your disability. For this reason, I've felt like I have to tell every professor or staff member I ask for help with the exact reason I need accommodations. I feel like I might not receive them if I don't convince them I'm disabled enough. This hasn't happened, but it is a worry.

I have had to share my diagnosis a few times when I would have preferred not to. During the acute part of my illness when I first started my treatments, and also in order to receive an [accommodations-related assessment] - a doctor's note was required which disclosed the clinic and the doctor indicated my diagnosis.

Many also described:

- A negative reaction upon sharing with others, including:
    - Others downplaying the seriousness of respondents' disabilities or need for accommodations
    - Instances where the information was "used against" the individual later

As someone with hidden disabilities who otherwise occupies locations of privilege, I do not share. When I have shared, I get reactions that convey that folks think I am gaming the system. This, in turn, negatively affects people's perspectives of me. Better they think I have comments of low productivity than untrustworthy.

Some professors treat you differently [and] act like they're annoyed with accommodations or make comments that people abuse them.

There is a lot of misunderstanding and misinformation regarding certain disabilities, so while trying to share my conditions to reduce stigmatization, I often hesitate and sometimes regret doing it.

This happened more than once, I shared it with higher management. It was used against me.

- Worry about the impact of sharing, including:
    - Career concerns and others "seeing me differently", for example

If I share my disabilities with some people at the positions of power, I might not get jobs from them in the future. Because they might think that it will be difficult for them to accommodate my needs.

My colleagues would see me differently if they knew.

I do have concerns. [It] may not impact my current position to share my chronic health condition identity but could impact opportunities for advancing my career.

> Having an "invisible disability" has afforded me the privilege of not having to share this aspect of my identity when I don't want to, although I have had to around the process of accessing accommodations. I do fear that I would be treated differently if I was more open about my disability, mostly because I don't perceive a great deal of understanding about neurodiversity at the UM generally.
>
> For a few of my courses, before I registered with [Student Accessibility Services], I had to disclose to my professors about my disability. I worried that even if I didn't need an accommodation for their class, it would impact my performance. I worried that they would think I was less capable and less intelligent as my peers simply because of my mental health conditions.

Positive Experiences

Yet, several respondents also describe positive experiences around identity sharing:

> I don't feel any stigma regarding talking about my disability with people. I think generally people are very accepting especially on campus
>
> I have only every felt included, students are mindful of me as I wear [an assistive device] which is visible - my [additional disability is not noticeable] but I have not had any untoward aggression or rudeness directed to me.
>
> The UM is a great environment for me, my supervisor and co-workers are always doing their best and anything that comes up is either addressed or managed by assuming good intentions. If people look for problems, they'll find them, of course, but most staff and students don't want to be insulting, exclusionary or demeaning.
>
> I often share my disabilities with my students as I have received positive feedback for doing so.

Positive feelings about identity sharing were often tied to individuals, individual teams, or individual units across UM that:

- Are supportive of their disabled peers and co-workers;
- Have pursued education related to disability, chronic health, and ableism;
- Are engaged with anti-ableism efforts; or
- Include other individuals with disabilities and chronic health conditions[8].

> I am very fortunate to have such an understanding supervisor and people on my team who deal with the same or similar [types of] disabilities. I truly don't know what I would do if my boss wasn't so understanding and ready to offer suggestions if I say I'm experiencing a

[8] This point illustrates the importance of creating environments wherein others feel comfortable sharing their disability and chronic health identities and providing opportunities to get to know others who are open about these identities.

> challenge. I've never, ever been made to feel bad about the things I struggle with at this job. I have at previous jobs, so the support here is really amazing.
>
> At the U of M I have shared (some of my conditions) with a few folks and they still treat me with respect and consideration. Again - I think I'm very fortunate to be in the team that I'm in. It's all-inclusive, non-judgmental and accepting.
>
> It's very important for leaders to be proactive about educating themselves and explicitly stating their support for disabled staff and willingness to accommodate. In my years at the university, I have only made a disclosure to one supervisor, because they were upfront about creating a safe space [...] as well as willingness to learn.
>
> Most of my experiences in talking to people about my disabilities has been fine - although this is likely because most of the people I've talked to in relation to this are also disabled in some way.

Overall, respondents' comments emphasize that **individuals must have control** over whether or not (and with whom) they share their identities across UM, including how much detail they provide:

> [...] I also tend to only share certain aspects of my conditions, but that can sometimes spiral into giving more information than I would prefer, and in some ways, I feel like I've been designated an unofficial spokesperson for disabled folks of all kinds.

"Moving in a Good Direction"

The totality of the qualitative data demonstrates that there is considerable diversity in experiences of ableism among DAS respondents[9]. But, on balance, respondents who provided written answers describe more negative experiences than positive, indicating that:

- UM is still characterized by systemic ableism

> While they [UM] expect that students with disabilities will be on campus, and have initiatives to support their learning, such as [Student Accessibility Services], much of the focus is on physical barriers, and even then, only to a minimal standard. There is little being done to address systemic and institutional ableism and barriers. Where barriers are addressed, they are somewhat performative.
>
> It's truly a toss-up whether you get someone (e.g., an instructor) who is ableist or not and there doesn't seem to be a safe, effective way to submit a complaint about them. So ultimately it feels like UM may have some policies in place and may signal that is trying not to be ableist and welcoming to disabled peoples, but they can be toothless when it comes to actually changing the deeply rooted ableism in my faculty at least.

[9] The data generated from all 18 open-ended questions, beyond the two specific questions detailed earlier in this report.

It is so frustrating to see the same systemic issues and barriers ignored year-after-year. I have personally raised concerns over and over and over again around the ways in which the University's physical layout, policies, procedures, programs, and services are not accessible, and no one will listen [...].

- Ableism intersects with additional oppressions at UM such as colonialism, ageism, racism, sexism, homophobia and transphobia, and classism, for example

Ageism very much intersects with disability-related microaggressions; sometimes it's hard to tell if I'm being dismissed because of traits of my (invisible but sometimes noticeable) disability, or because I'm a young professional.

Because my condition is often invisible, the harassment and exclusion that does involve me is more often on the basis of gender (as a woman in a man-centric program) than ability. I don't feel I like an outsider due to disability necessarily.

Financially, I have noticed many inequities for people with disabilities [and] chronic conditions. I had to choose between going back to school or work, as I am not fit to do both and financially, I am suffering and having to use some of my student aid to pay my rent.

If at all anything discriminatory happens towards me, it's most likely because of my color and not because of my disability (which is not visible).

- There is still much work to be done to dismantle ableism at UM and create an inclusive work and learning environment, but efforts are intensifying

I think the UM is moving in a good direction, but more still needs to be done. There isn't a lot of clarity on some of the way[s] to deal with chronic health issues or mental health. I'm nervous about disclosing too much to my supervisors because I fear how they would react. I know they can't fire me for having problems, but will I be valued, promoted, etc. the same as someone who doesn't have any issues[?] That is something I wrestle with quite a bit.

I think the fear for me is that I will be punished if people were to really find out. I fear being found out. In general, it seems like most people at UM are overworked and trying to pretend to manage. Keeping up with appearances is generally what makes it seem less safe to be open about my condition. **I do think compared to other workplaces UM is doing a lot to start the conversations and make it safer for people to speak out about their condition**. [...] While most of my colleagues are kind and supportive there is something that seems like a facade most of the time and distractions from real, deeper work of creating safe and inviting environments.

What We Learned: Respondent Recommendations from the Dismantling Ableism Survey (2023)

Introduction

The Dismantling Ableism: Institutional Action and Accountability survey (DAS) was administered in November-December 2023 to University of Manitoba (UM) students, faculty, and staff who self-identified as disabled or as having chronic health conditions[1,2].

Disability is not a singular experience, nor are disabled people a homogeneous group. People encounter different barriers and forms of ableism. Moreover, two people with similar impairments will also experience disability differently as personality, circumstance, privilege, and intersectional identities contribute toward their complex identity.

> "Experiences of inequities are particular to the type of chronic health issues [or] disability. When paired with intersectional issues such as race, class, etc., these inequities become more pervasive."

This results report is one in a series, specifically highlighting student, staff, and faculty recommendations for reducing the ableism and inaccessibility they have experienced at UM.

Language

The DAS used identity-first language (disabled persons) rather than person-first language (persons with disabilities) to acknowledge the disabling effect of social, environmental, and institutional barriers which hinder disabled individuals' full participation in society, including university life[3].

Similarly, the survey also used the term "chronic health conditions", broadly defined as any condition, including mental health conditions, that is continuing or that occurs again and again over a long period of time, which in interaction with various barriers, may hinder full and effective participation in society on an equal basis with others[4].

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[2] The final sample size for the DAS, after data cleaning, is 544.

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[4] Adapted from Bernell, S., & Howard, S. W. (2016). Use your words carefully: What is a chronic disease? *Frontiers in Public Health, 4*, 159. https://doi.org/10.3389/fpubh.2016.00159 and the United Nations.

Positionality

Researchers bring their experiences, identities, and biases to their work. The DAS team members identify with various systemically marginalized identities, including disability and chronic health-related identities. These lived experiences are assets, but we recognize that our personal intersections of privilege also influence our work. Our commitment to research quality includes an openness to concerns and criticisms. Please feel free to send feedback to the Office of Equity Transformation at Equity@umanitoba.ca.

DAS Respondent Recommendations

Overall, DAS respondents indicated the following three overarching actions would have the greatest immediate impact on members of the University of Manitoba (UM) community who identify as disabled, including having chronic health conditions:

1. Coordinate accommodations and support services
2. Improve physical infrastructure and accessibility
3. Ensure disabled people and those with chronic health conditions are valued members of the UM community

Respondents offered several other suggestions to increase accessibility, equity, and reduce the stigma and ableism they are currently experiencing. Unsurprisingly, many of respondents' additional recommendations correspond to the above three overarching actions and they are grouped accordingly below. Respondent recommendations that fall outside of the three main action items appear separately in their own categories.

Disaggregated statistical analyses[5] and qualitative analyses suggest that, overall, implementing the recommendations detailed in this document would be especially impactful in reducing barriers for those with disabilities and chronic health conditions who also identify as (or as having):

- Students (especially Bannatyne students)
- Indigenous
- Multiple disabilities or chronic health conditions
- Cognitive disabilities or chronic health conditions
- Mental or emotional health-related disabilities or chronic health conditions
- Disabilities and chronic health conditions that are less noticeable to others
- Systemically marginalized genders
- Systemically marginalized sexualities
- Financial difficulties
- Caregiver or significant support roles for adults aged 18+

[5] See the DAS Methodology and Sample Description for more details on exact statistical and qualitative analyses procedures.

We also note in-text when certain actions would be particularly beneficial to specific individual groups (e.g., faculty).

1. Accommodations and Support Services

Overall, most DAS respondents who currently receive accommodations praise the efforts of those working in accommodations and support services, such as Student Accessibility Services, Student Advocacy, and Employee Wellness, for example. However, these respondents and respondents who need but are currently not receiving accommodations[6], including those who have been denied accommodations, also assert that both student and employee accommodations services need specific improvements.

- Review and revise existing student and employee accommodations registration processes, emphasizing:
    - A proactive approach that removes the burden on applicants;
    - The expertise of accommodations applicants, rather than the requirement for medical or expert assessment and documentation; and
    - Greater schedule flexibility.
        - Some students indicated the requirement to apply for certain accommodations two weeks in advance was a barrier for them
- Reconsider "all-or-nothing" approach to accommodations and offer smaller or shorter-term accommodations, including those for temporary and intermittent or episodic disability and chronic health needs
- Expand access to counselling services, including one-on-one and in-person services for students and employees[7]
- Better communicate accommodations options and processes to students and employees, clarifying[8]:
    - The circumstances under which mental and emotional health-related disabilities and less apparent disabilities and chronic health conditions (e.g., intermittent or episodic disabilities) qualify for accommodations; and
    - Who has decision-making power regarding overriding or denying approved accommodations.

[6] In addition to being asked if they need accommodations to fully participate at UM, respondents were also asked if they are currently receiving accommodations, and reasons why respondents may not be currently receiving needed accommodations (e.g., prefer informal accommodations arrangements vs. applying for formal accommodations). According, it was possible to identify respondents who need but are not currently receiving accommodations. The accommodations section of the survey was explicitly designed to identify such nuanced differences for the purpose of identifying specific issues requiring the development of targeted recommendations.

[7] The DAS was administered prior to the relatively recent increase in mental health care coverage for UM employees announced in early 2024.

[8] DAS respondents indicated these two issues are ongoing sources of confusion, affecting their decision to applying for accommodations.

Student-Specific Needs

Student respondents to the DAS made the following suggestions regarding student accommodations and supports:

- Improve the Student Accessibility Services test booking website
- Expand the student note-taker program (e.g., include more graduate-level courses) and consider paid positions to ensure note-takers are available to meet accommodations needs
- Expand graduate students' access to accommodations and support services

Employee-Specific Needs

- Increase employee access to accommodations and support services, including:
    - Clarifying the process for accessing the centralized accommodations fund for employee accommodations
- Reconsider the use of the term "wellness" in Employee Wellness to better communicate the unit's role in providing accommodations and accessibility to faculty and staff who identify as disabled and as having chronic health conditions

2. Physical Infrastructure and Accessibility

- Continue to remove physical accessibility barriers, including but not limited to[9]:
    - Barriers getting to UM campuses (e.g., access to affordable bus passes and parking[10]);
    - Barriers getting around UM campuses;
    - Barriers to accessing appropriate work and study spaces; and
    - Barriers to accessing remote and hybrid work and learning.
- Barriers related to ableist productivity expectations also remain problematic for DAS respondents, including:
    - Inflexible deadlines and due dates;
    - How fast they are expected to complete work; and
    - How many hours of work they are expected to complete each week.
- Ensure accessible spaces and seating consider body size diversity
- Ensure accessible spaces consider sensory sensitivities (e.g., lighting, sound, and access to quiet rooms[11], etc.)
- Improve safety across UM campuses, especially regarding getting to campus and in recreation and active living spaces

[9] Respondents specified many other barriers that have also been identified as part of the recent accessibility audit including ensuring elevators and accessible door buttons are all operational and expanding the number of private, all gender, accessible washrooms, for example.
[10] Especially parking, accessibility, and safety at the Bannatyne campus.
[11] Respondents note that quiet spaces would also support anyone needing a place to rest during the day.

3. Ensuring Disabled People are Valued Members of the UM Community

- Change the existing institutional culture that reinforces ableism and stigma (particularly around receiving accommodations) that compound the effects of ableism, particularly for those who identify with multiple systemically marginalized identities
    - Recognize and support a diverse range of disabilities and chronic health conditions, especially those that are mental or emotional health-related and those that are only sometimes apparent to others (i.e. intermittent or episodic disability)
    - Take a person-centered approach to disability and chronic health
- Increase access to social support at UM, including opportunities for those with disabilities and chronic health conditions to build communities and relationships with each other and the wider UM community
- Continue to provide education and training around disability, chronic health, and ableism to all members of the UM community to reduce stigma and discrimination
    - Students indicate education focused on the following topics is especially needed:
        - The diverse range of disabilities and chronic health conditions, including mental and emotional health-related disabilities and health conditions, and less apparent, intermittent, or episodic disabilities and health conditions;
        - Accommodations responsibilities[12], options, and processes at UM;
            - Clearly emphasizing that accommodations do not constitute "unfair advantages"
        - Inclusive course design, teaching, and assessment; and
        - Workshops designed to support students with disabilities and chronic health conditions (e.g., effective study techniques for ADHD).
- Implement and communicate clear processes to address and report ableist conduct, including accountability procedures
    - Students and staff would especially benefit from the development of reporting and accountability procedures

4. Continue to Make Information Technology More Accessible

The DAS was administered in November-December 2023. As such, the results may not capture recent (and ongoing) accessibility improvements to specific information and communications systems at UM, including the work undertaken to meet the Accessibility for Manitobans Act Information and Communications Standard (AMA-IC), and WCAG 2.1 standards.

- Streamline UM's information systems and technologies
    - Faculty would especially benefit from IT support

[12] Including the legal responsibility to provide accommodations, as outlined in the Accessibility for Manitobans Act.

- Review strategic operating procedures for the IT procurement and review processes. IT testing and review of new and existing systems and software must include disabled people and those that have chronic health conditions[13]
    - DAS respondents report fewer barriers to accessing and using Zoom, as compared to Microsoft Teams and WebEx, for example
- Student and employee training and support must be more attentive to the needs of disabled people and those that have chronic health conditions to ensure they can continue to learn and work optimally during periods of IT-related change, such as beginning training earlier
    - Students would especially benefit from test-taking program tutorials well in advance of tests or exams, specifically
- Consider the impact of IT changes on those experiencing greater financial difficulties (e.g., those who cannot afford or choose not to own a smartphone)

5. Improve Equity-Based Practices

- When people with disabilities and chronic health conditions serve as experts on disability, chronic health, or accommodations at UM, this labour must be appropriately recognized, valued, and possibly compensated
    - Students with disabilities and chronic health conditions would especially benefit from valuing their expertise
- Promote and support Universal Design for Learning (UDL) more widely
    - Students would especially benefit from improving equity in the following ways:
        - Expanded course assessment options
        - More accessible course materials
        - Greater time flexibility to complete course requirements
- Increase staff access to professional and skills development
- Increase staff access to promotion and advancement opportunities
- Support faculty with disabilities and chronic health conditions to pursue senior leadership, if they are interested in these roles
- Improve access to suitable mentors for students, staff, and faculty who identify as disabled or as having chronic health conditions
- Prioritize workload equity including considering options for greater time flexibility to support employees who have disabilities or chronic health conditions (e.g., flexible start and stop times, 4-day work weeks, part-time roles, etc.)
- Reassess resource allocation to ensure disabled faculty, including those with chronic health conditions, can optimally and sustainably engage in research, teaching, and service activities

[13] A user testing process is currently being developed.

6. Conduct Policy Reviews using the Comprehensive Equity Impact Assessment Tool

Disaggregated analyses demonstrated that student, staff, and faculty respondents are negatively impacted by a number of UM policies. Accordingly, UM should undertake a review of existing policies for impacts stemming from intersectional systems of oppression including, but not limited to, the following:

- Classroom policies: including, but not limited to, attendance and absence policies
- Student accommodations: to address any existing gaps that may result in certain students not receiving needed accommodations (e.g., students who are at particular stages of their programs or graduate students[14])
- Staff absence and leave policies
- Employee accommodations: to address any existing gaps that may result in certain employees not receiving needed accommodations (e.g., sessional instructors)
- Tenure and Promotion guidelines including, but not limited to, appropriately recognizing the contributions of faculty with disabilities and chronic health conditions who serve as experts on disabilities, chronic health, and accommodations
- Work-from-home policies: to ensure consistent and equitable access across the institution
- Employee benefits: to assess the need for additional or expanded benefits, especially for mental and emotional health supports offered both internally and externally to UM[15]
    - DAS respondents emphasized the need for designated mental health days, specifically
- Student benefits: to assess the need for additional or expanded benefits, especially for mental and emotional health supports and more comprehensive one-on-one supports (e.g. ADHD coaches, case managers, and disability counsellors, etc.) both internal and external to UM

[14] Student Accessibility Services and Faculty of Graduate Studies are currently working together to improve graduate students' accommodations experiences, specifically.
[15] The DAS was administered prior to the relatively recent increase in mental health care coverage for UM employees announced in early 2024.