"know what's out there!"

A just recovery from the COVID-19 pandemic for people with disabilities: Descriptive analysis of Canadian survey data

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By

Manisha Pahwa (Lead)
Hazel Dhaliwal
Jocelyn Lee
Syed Mahamad
Em Murdoch

rshop@mcmaster.ca researchshop.mcmaster.ca

Office of Community Engagement McMaster University

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Executive Summary

Emerging research shows that people with disabilities have experienced a worsening of economic and health status, housing conditions, social support, and personal safety during the COVID-19 pandemic. Policy responses to COVID-19 have neglected the needs of people with disabilities, prompting community organizations to advocate for a just recovery that centres disabled people.

In 2021 the Disability Justice Network of Ontario (DJNO) conducted an online, national survey asking people with disabilities about their experiences during the COVID-19 pandemic and what their needs are for a just recovery. The survey collected quantitative and qualitative data in multiple domains, including respondent demographic information, just recovery/quality of life, education and labour force, social services and the justice system, housing, and health care.

This report presents a descriptive analysis of DJNO's survey results for Ontario respondents. By "descriptive analysis", we mean an analysis that stays close to the responses and words of survey participants with little interpretive inference. Each survey question was analyzed on its own. For survey questions with quantitative responses, we tabulated the number and percentage of respondents in each category. For survey questions with qualitative responses, we inductively created and defined categories and codes, counting the number of respondents within each. We analyzed these data for all respondents and then, at the request of DJNO, separately by race/ethnicity. We also made note of responses that mentioned the intersection of gender, disability, and the COVID-19 pandemic.

The results of this survey revealed an urgent and large need for economic, social, housing, and health support for people with disabilities. Liveable social assistance emerged as a cross-cutting issue; without it, people with disabilities find themselves in precarious and worsening housing, social, work, and health circumstances. Guiding principles such as inclusivity need to be salient in new or improved policies oriented to people with disabilities. Disabled people who are racialized and/or non-binary gender face additional challenges at the intersection of their multiple identities of which disability is a part. Housing was a particularly problematic area for disabled people who identified as non-White in this survey. Individuals experiencing or at risk of domestic abuse during the COVID-19 pandemic urgently need support to help emerge safely and enduringly from abusive conditions.

There are a few limitations of our analysis that need to be considered in interpreting these findings. There was a high proportion of non-respondents for some questions, which requires a cautious interpretation of the findings. We aggregated all non-white races/ethnicities into a single category due to the small number of people in individual race/ethnicity categories. This approach made it difficult to discern the distinct experiences and needs of populations of *a priori* interest to DJNO, such as Indigenous disabled people and Black disabled people. Time constraints prevented us from conducting an integrative analysis of the survey's quantitative and qualitative data. We

were also unable to produce data visualizations due to time constraints. Finally, our analysis only used data provided by Ontario respondents. This analysis could readily be replicated on the small numbers of non-Ontario respondents, if needed.

The greatest strength of this descriptive analysis is its policy readiness. The descriptive results stay close to words of respondents. The use of emblematic quotes, taken verbatim from survey responses, narrates in their own words the complex challenges and needs of disabled people for justice in the COVID-19 pandemic. These quotes combined with quantified survey responses show where there are policy gaps and what social institutions need to do to prioritize people with disabilities. Many of these actions would require challenging long-held biases and assumptions about people with disabilities as revealed by the survey responses. The race/ethnicity sub-group analysis and gender observations presented here further enrich our understanding of disabled populations in need of distinct and greater consideration.

Introduction

Overview

This report has been prepared by Research Associates from the McMaster Research Shop at the request of the Disability Justice Network of Ontario (DJNO). It is intended to report on the findings of an online, pan-Canadian survey that the DJNO conducted in 2021 about a just recovery from COVID-19 for people with disabilities in Ontario. Approximately 180 people responded to the survey; most were from Ontario.

Emerging evidence shows that people with disabilities in Canada have been negatively impacted by the COVID-19 pandemic in multiple dimensions. These include unmet needs for mental health and health care (including specialized health care and attendant services), accessible housing, income support, accessible transportation, and access to food/shops/groceries (Abilities Centre, 2020). Social isolation, fear of getting infected with COVID-19, and economic insecurity during the pandemic have been found to contribute to worsened mental health among people with disabilities and chronic conditions (Pettinicchio et. al., 2021). DJNO has also expressed concerns about a “shadow pandemic” of domestic abuse among disabled women. Pre-existing health, social, and economic inequities concerning disabled people have been exposed in the COVID-19 pandemic and there is a growing call to action among disabled communities for a just recovery.

Scope

This report provides the methods, results, and discussion of a descriptive analysis of DJNO’s survey about a just recovery from the COVID-19 pandemic for people with disabilities in Ontario. There were two general types of data collected in the survey:

quantitative (i.e., close-ended or categorical) and qualitative (i.e., open-ended or free text). We conducted a descriptive analysis of the quantitative data by tabulating frequencies and percentages in each response category for each question with categorical responses. We conducted a descriptive analysis of the qualitative data by inductively creating, defining, and counting the number of respondents in codes and categories for each question with open-ended responses. By “descriptive analysis”, we mean reporting directly on or staying close to the actual responses of survey participants. We did not apply any interpretive inferences beyond this, and we did not analyze the data through the lens of theory (e.g., critical disability theory, intersectional theory).

At the outset and midway through this project DJNO stated an interest in race and gender potentially influencing experiences and perspectives. To address DJNO’s interest in these particular areas, we conducted a sub-group analysis by race/ethnicity and made observations about how gender was described in survey responses.

Terms

In this report, the term “disabled people” or “people with disabilities” refers to survey respondents who self-identified as living with one or more disabilities, or of being a caregiver to a person living with one or more disabilities. The term “racialized” refers to survey respondents who self-identified as one or more non-White race or ethnicity. “Gender” is used with an emphasis on the responses that described non-cis hetero experiences. The term “just recovery” refers to a disability-centred response to COVID-19.

Organization

This report is organized as follows:

- **Methodology and limitations:** This section describes in detail the methods that were used to conduct a descriptive analysis of the survey data.
- **Findings:** This section reports on the results of the descriptive analysis, mirroring the major survey domains as well as sections for the race/ethnicity sub-group analysis and gender observations.
- **Discussion:** A high-level interpretation of the results in the context of analysis strengths and limitations.
- **Conclusion:** Final statements about the survey results and how they could inform opportunities for a disability-centred COVID-19 response.

Methodology

The purpose of this methods section is to describe in detail how we analyzed the Disability Justice Network of Ontario’s (DJNO’s) survey data about a just recovery from the COVID-19 pandemic for people with disabilities in Canada. This document provides transparency about how the survey data were analyzed and explains why certain analytical decisions were made over others. These details will support the interpretation of the analysis results and can be referenced by DJNO in potential future analyses of their survey data.

Briefly, the survey contains two different types of data elements:

- Categorical data: These are nominal and ordinal data in the survey. Examples of nominal data include responses to questions about age group, race/ethnicity, and type of disability. Examples of ordinal data include responses to questions with Likert scale options. Categorical data are readily quantifiable and were considered quantitative for the purpose of analysis.
- Open-ended data: These are free text data in the survey. Examples of open-ended data include responses to questions that ask people to describe, in free text boxes, their experiences during the COVID-19 pandemic and what the government should do to support people with disabilities. Open-ended data were ultimately quantized, but were treated as qualitative for the purpose of analysis.

The analytic plan deals separately with categorical and open-ended data. The division of labour on the research team also reflects this distinction: from the beginning of the project to the midterm, two research associates completed the analysis of categorical data and two research associates analyzed the open-ended data. From the midterm of the project to its completion, all four research associates continued and completed the analysis of open-ended data.

The analysis proceeded in four stages:

1. Data cleaning
2. Descriptive analysis of individual survey questions
3. Sub-group analysis
4. Gender observations

Stage 1: Data cleaning

Data cleaning was an essential first step of this research. “Data cleaning” refers to the identification and inclusion of analytically useful parts of the dataset. The purpose of data cleaning was to:

- Become familiar with the survey design/structure and questions
- Identify missing, incomplete, and ineligible survey responses or respondents
- Group data elements by type
- Produce a dataset that is ready for analysis

On January 19, 2022, DJNO provided the research team with a CSV file of all survey results received to date. DJNO also provided the research team with a link to the survey questions on Survey Monkey. The research team converted the CSV file to an XLSX file, which served as the analytic file. The team then identified, counted, and separated categorical questions and their data from open-ended questions and their data. Two analytic (XLSX) files emerged from this step: one containing categorical questions and their responses, and another containing open-ended questions and their responses.

First, the team organized and reformatted the file to be ready for analysis. Next, the research team identified cells with missing, incomplete, and ineligible survey responses or respondents. For each question and each respondent, the research team calculated the proportion of missing and incomplete data. The team removed ineligible survey responses or respondents from the analytic file to ensure their exclusion from analysis. Eligibility was based on responses to the following survey questions:

- 7. According to the World Health Organization, "Disabilities is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations." Using this definition, do you identify as disabled?
- 8. What disabilit(ies) do you have?

Survey participants who responded “no” to question 7 AND who did not select or specify any disability in question 8 were presumed to not be disabled. These individuals and their responses to all survey questions were removed from the analytic file and thus excluded from analyses. Survey participants who responded “no” to question 7, but who selected or specified any type of disability in question 8, were included in the analysis. This ensured that people who had any type of disability, whether or not it agreed with the definition in question 7, were included in our analysis. We also included individuals who responded “no” to question 7 AND who stated that they were a caregiver to a person living with a disability in question 8. We considered caregivers to be proxy respondents for the persons with disability for whom they are caregiving. Survey participants who responded “yes” to question 7 were included, regardless of if or how they responded to question 8.

Open-ended questions and their responses were similarly scanned for completeness and eligibility. The research team identified cells with missing, incomplete, and ineligible survey responses or respondents. Ineligible survey responses were responses that were typos (e.g., a string of letters that do not comprise a word in any language) or responses that were irrelevant to the question or survey. For each question and each respondent, the proportion of missing and incomplete data were calculated. Ineligible survey responses or respondents, previously removed in the cleaning of categorical data, were also removed from the open-ended data analytic file. In addition, in reviewing the open-ended survey data, we came across a small subset of records where the respondents stated they do not have a disability, yet also did not identify as being a caregiver of someone with a disability. Since this research wants to prioritize the perspectives of the disability population, these records were excluded. We then excluded all non-Ontario respondents from the categorical and open-ended analytic files, since DJNO wanted us to analyse Ontario respondent data only in this report.

Stage 2: Descriptive analysis of individual survey questions

The purpose of this stage was to produce a description of the responses to each survey question. For the categorical data, descriptive analysis mainly involved determining the number (N) and % of respondents for all response categories. “No response” was considered a response category. For the purposes of our analysis, we manipulated the data in the following ways:

- For the Likert scale questions (11, 21, 22, 23, 24, 25, 26, 27, 30, 32, 33, 34, 39, and 40), to streamline the way we reported the findings, we converted responses from a five-point scale (strongly disagree, disagree, neutral, agree, strongly agree) into a three-point scale (strongly disagree/disagree, neutral, and agree/strongly agree).
- For survey questions with an “other” box for respondents to write their own response, the research team reviewed each response and deliberated how to best handle it. We either assigned it to the most appropriate existing categorical response option (if it obviously fit); retained it in the “other” category (if it did not obviously fit in existing categories); or, if five or more respondents had the same or a similar response and could not be assigned to an existing response, we created a new category. In instances where responses were retained in the “other” category, the free text responses were reported verbatim in a footnote.
- The demographic questions about race and ethnicity presented numerous challenges due to the types and number of response categories. We found that the response options included approximately a dozen categories of both race and ethnicity, with consequently very few respondents in each category. As there is no consensus in the social sciences literature about how to categorize and distinguish between race and ethnicity, and for the purpose of having sufficient numbers for the sub-group analysis, we collapsed responses into “White”, “non-White”, and “Other” categories.
- The questions about income and education each had numerous response categories. This yielded a small number of respondents in each category (fewer than five respondents). We collapsed categories for each of these questions to increase the number of respondents in each category.

Lastly, we note that for many of the categorical survey questions, respondents were permitted to select one or more response options to each nominal question. Respondents who selected two, three, four, etc. response options to a nominal question were respectively counted twice, thrice, four times, etc. Thus, the tabulations will show that for some questions, the total number of responses exceeds the total number of respondents, and the % of responses exceeds 100%. For these questions, we also created adjunct tables to show the number of respondents who chose two, three, four, etc. responses.

The remainder of our analysis was focused on open-ended data from free text responses to questions (5, 6, 8, 9, 10, 12, 13, 14, 15, 16, 17, 18, 19, 20, 28, 29, 35, 36, 37, 38, and 41). Descriptive analysis of the open-ended data was guided by the framework method (Gale et. al., 2013). Briefly, the framework method is a type of thematic analysis or qualitative content analysis that was originally developed for large-scale policy research. It is an especially useful method for research on multifaceted topics involving teams of researchers and stakeholders with a range of research and practice backgrounds. The framework method involves the development of a matrix of rows (cases), columns (codes), and cells of summarized data. The matrix structure allows researchers to systematically and inductively reduce large volumes of qualitative research findings that can be analyzed by case and by code. The matrix retains context by easily enabling the comparison of data across cases and within cases. The framework method is most commonly used to analyze qualitative data arising from semi-structured interviews due to the method's compatibility with topics of sufficiently narrow scope and the ability to compare and contrast. Over the years, the approach has been applied and adapted for qualitative data arising from different sources and in different contexts, such as health research. We found the framework method to be compatible with the objective and scope of this project, as well as with the topic's interdisciplinary nature and diverse composition of research team members.

The framework method is a "recipe" that produces structured data outputs. The general steps are coding, categorizing, then theming. In the method, these are articulated in seven procedural stages that presume the use of semi-structured interview data. We adapted the framework method for our survey data:

1. Transcription: This step was irrelevant since there was no content to transcribe.
2. Familiarization: Reviewing the survey questions and types of responses (i.e., categorical and open-ended)
3. Coding: Applying paraphrases or labels to interpret passages from open-ended data based on two more researchers independently coding a few responses from each open-ended question.
4. Developing a working analytical framework: Iterative process of building consensus on a set of question-specific codes to apply to all subsequent responses for each open-ended question; grouping codes into categories; defining categories.
5. Applying the analytical framework: Applying all codes and categories to all subsequent open-ended responses.
6. Charting data into the framework matrix: Summarizing data from each open-ended question into categories; including illustrative quotations.
7. Interpreting the data: Making analytic memos throughout the application of the framework method.

The result of the framework method is a matrix of codes and categories in columns, cases in rows, and summarized data in cells. Each category typically encompassed two or more closely related codes. Definitions of each category and code were generated inductively based on survey responses to each question. Definitions of categories and codes allowed us to distinguish each code from other closely related codes. Verbatim quotes to exemplify each code were extracted. Minor revisions were made to categories and codes if new data emerged from responses from all survey participants.

We emphasize that our analysis was based entirely on induction; we did not pre-specify categories and codes and their definitions prior to the analysis. This ensured that our analysis stayed sincere to the responses as they were written and intended by survey participants.

Similar to the cell sizes for categorical data analysis, our goal was to ensure that each cell size in the qualitative data analysis framework was 5 or more respondents, to protect the potential identification of survey respondents. Where this was not possible (e.g., unique codes that could not be merged with or subsumed by other codes), an explanation was provided to justify having codes with fewer than 5 respondents.

Stage 3: Sub-group analysis

At the inception of this project, DJNO expressed an interest in conducting a sub-group analysis of racialized groups, with a special interest in survey respondents who identify as Black or persons of colour. Due to the small numbers of survey respondents who identified as Black or persons of colour, we created a “White” race/ethnicity category and merged multiple race/ethnicity categories into a single race/ethnicity category called “non-White/multiracial”. The former category was all people who indicated that they were White and no other race or ethnicity. The latter category was all people who indicated that they were White and some other race or ethnicity, or one or more non-White race or ethnicity. The sub-group analysis of the “non-White/multiracial” category replicated the whole group analysis using the methods described in Stage 2.

Stage 4: Gender observations

At the midterm meeting between DJNO and Research Shop, DJNO expressed an interest in understanding how the COVID-19 pandemic has differentially impacted disabled people on the basis of gender and what this might mean for a just recovery. This interest was motivated by the observation that disabled women have experienced higher rates of sexual and domestic violence during the COVID-19 pandemic (the shadow pandemic). To partly address this interest given the time constraint of our analysis, we searched for open-ended survey responses that mentioned the words “gender”, “women”, “trans”, etc. and extracted the verbatim quotes in which these words were situated. Additionally, we searched gender-related themes such as “abuse”, and extracted verbatim quotes. We provided a high-level commentary about these quotes, which we call “observations”, since they were not examined using any analytic method or systematically found from the survey respondents who identified as non-binary genders.

Limitations

There are a few limitations of our analysis that need to be considered in interpreting these findings. Response rates varied between each question, ranging from 18-100%.

Demographic questions elicited the highest response rates. On average, each survey respondent completed approximately tw-o-thirds of the survey. The high proportion of non-respondents for some open-ended questions is difficult to interpret; non responses may be due to the perceived irrelevance of the question to the survey participant, response options that do not adequately capture the survey respondent's experiences, difficulty understanding the survey question, challenges with the web-based platform, or attrition. For some questions there were small numbers of respondents in certain response categories, which could have been impacted by the proportion of non-respondents for the respective question.

We aggregated all non-white races/ethnicities into a single category due to the small number of people in individual race/ethnicity categories. This approach produced a sufficiently large number for the race/ethnicity sub-group analysis and protected survey respondents from being identified by their survey responses, but also made it difficult to discern the distinct experiences and needs of populations of *a priori* interest to DJNO, such as Indigenous disabled people and Black disabled people.

Time constraints prevented us from conducting an integrative analysis of the survey's quantitative and qualitative data; this would have been applied, for instance, to conduct cross-tabulations between quantitative and qualitative questions within and across domains. We were also unable to produce data visualizations due to time constraints.

Finally, our analysis only used data provided by Ontario respondents. Most survey participants were from Ontario. This analysis could readily be replicated on the non-Ontario respondents, if needed.

Findings

Survey response statistics

The survey was completed by a total of 176 respondents across Canada. As the scope of this report is to elicit perspectives from people with disabilities in Ontario, respondents were excluded from this analysis if they: 1) did not identify as personally disabled or as a proxy/caregiver for a living person who is disabled (N = 21 of 176 respondents), and 2) did not live in Ontario (N = 20 of 176 respondents) during the pandemic. Accordingly, our analysis and the following results are based on the remaining 135 Ontario-based survey respondents who reported having a disability or being a proxy/caregiver to a living person with a disability.

Among these 135 respondents, the range of survey completion was 20% to 100%, with an average of 68%. There were 41 questions in the survey. Ten respondents, or about 7%, responded to every question. The most frequent number of questions answered was 15 of 41 (N = 19; 14%; see Table 3.1). Questions 1, 2, 3, 5, 6, and 7 each had a response rate of 100%, which gathered data on demographic characteristics. Response rates for all other questions in the survey ranged upwards of 18%, with an average of 67% (see Table 3.2). Given the variation in response rates between questions, the number and percentage of participants who provided no response for each question are reported in Appendices 3 and 5.

Demographics of survey respondents

Province/Territory

Participants were asked where they live in Canada. As previously mentioned, participants who stated that they lived outside of Ontario or did not provide their province/territory of residence were excluded from this report. All participants (N = 135; 100%) in this report stated that they currently reside in Ontario (see Table 5.1).

Age

Most participants stated that they were between the ages of 35 to 44 years of age (N = 46; 34%) (see Table 5.2). A large portion of participants were also 25 to 34 years old (N = 31; 23%) and 45 to 54 years old (N = 27; 20%).

Gender Identity

Most survey respondents self-identified as women (N = 81; 60%), followed by men (N = 33; 24%) and non-binary (N = 15; 11%). Participants could select multiple gender identities. Most (N = 126; 93%) self-identified with a singular gender identity, with the remainder (N = 9, 7%) self-identified with two gender identities -- typically selecting an option that is considered under the transgender umbrella.

Income

Most survey respondents were in the lowest annual income bracket of $0 to $24,999 (N = 90; 67%). The next largest group earned $25,000 to $49,999 annually (N = 16; 12%).

Race, ethnicity, and Indigeneity

Only 2% (N = 3) of participants self-identified as Indigenous, with 1% (N = 2) preferring to not disclose. For participants who self-identified as Indigenous, they were given the option to provide their specific Indigenous identity. These participants’ responses were “First Nations” (N = 1; 1%), “Metis and Anishinaabe” (N = 1; 1%), and not specified (N = 1; 1%).

Question 6 asked participants to identify their racial and/or ethnic identit(ies) from a selection of groups. Most (N = 113; 84%) self-identified as white, with most of them (N = 110; 82%) not identifying with any additional racial and/or ethnic group (including multiracial-ethnic). Many of the remaining respondents (N = 19; 14%) identified with a non-white racial and/or ethnic group. The following non-white racial and/or ethnic categories were: Black [including African, African-Canadian, African-American, Afro-Caribbean/West Indian, and Afro-Latinx] (N = 5; 4%), South Asian [e.g., Bangladeshi, Pakistani, Indian, Sri Lankan, Punjabi] (N = 5; 4%), Chinese [including Mainland China, Hong Kong, Macau, and Taiwan] (N = 2; 1%), Indigenous outside of Canada (N = 2; 1%), Arab (N = 1; 1%), Latinx [e.g., Brazilian, Chilean, Columbian, Mexican] (N = 1; 1%), Korean (N = 1; 1%), North African [e.g. Egyptian or Libyan] (N = 1; 1%), and West Asian [e.g., Afghani, Armenian, Iranian] (N = 1; 1%). A few participants (N = 8; 6%) specified they were multiracial-ethnic.

Disabilities

Participants were asked in Question 7 if they self-identified as disabled, and 95% of participants (N = 128) said they did. The remaining participants (N = 7; 5%) who did not self-identify as disabled did specify at least one type of disability in the subsequent question, and therefore their responses were kept for analysis. The most common types of disabilities to be disclosed in Question 8 by participants were: psychological/mental disabilities (N = 76; 56%), physical disabilities (N = 75; 56%), and chronic illnesses (N = 64; 47%). While some participants only specified one type of disability (N = 39; 29%), 71% of participants were found to have two or more types of disabilities (N = 96); most identified having two types of disabilities (N = 36; 27%) or three types of disabilities (N = 35; 26%).

Overall findings: Just recovery and quality of life

Just recovery

When asked to identify important qualities of a just recovery that centres disabled people (Question 9), most respondents identified affordable basic necessities (N=77, 57%), which included requests for livable social assistance (N=65, 48%), affordable, safe, and accessible housing (N=24, 18%), and universal healthcare (N=23, 22%). The following response captures many of these elements: *“1. Increasing money to be able to live with dignity and with as much CHOICE as we can. 2. Being able to have enough money to afford good food to eat, and rent for the going rates, and to be able to live where I want.” (13114327642) (Question 9).* Living different identities, such as being racialized, was also expressed as a barrier to opportunities and accessing opportunities: *“Although I have long term disability pay, it's not enough to keep up with the inflation. I try to apply for new work, but it seems like nowhere wants to give people like me with disabilities a chance […] I feel discriminated in every single way, age, disability, skin color and nothing can be done because I have tried for the past few years.” (13115828685) (Question 41)*.

Half of respondents also expressed considerations for policy formulation (N=69, 51%), which included requests for increased social assistance (N=66, 49%) and re-evaluating eligibility and considerations for support (N=8, 6%).

Another common response was accessibility (N=16, 12%), which included accommodations to make work, school, and other events more accessible (N=10, 7%). In addition, respondents also indicated that a just recovery must include the principles of respect, dignity, and autonomy (N=16, 12%).

Forty-seven respondents did not provide a response to this question (N=47, 35%). The responses described above were reiterated when respondents were asked to share anything else that should be included in the just recovery report that centres disabled people (Question 41).

Question 26 asked respondents about priority populations and triage protocols that state disabled people should receive lesser care in a public health crisis. Most respondents (N=86, 64%) reported that they do not believe in these protocols. A small proportion of respondents (N=5, 3%) indicated they believed in these protocols. Forty-four subjects did not respond to this question (N=44, 33%).

Quality of life

When asked about the impact of the pandemic on quality of life (Question 10), many respondents (N=83, 61%) reported that the pandemic worsened their quality of life. Of those respondents, most stated this was due to financial hardship (N=35, 26%), loss of social cohesion and connections (N=32, 24%), unmet health needs (N=29, 21%), and worsened health status (N=23, 17%). Fear for safety (N=13, 10%), unequal treatment (N=12, 9%), loss or lack of employment (N=8, 6%), and poor accommodation (N=8, 6%). A small proportion of respondents reported an improved or negligible change to quality of life (N=5, 4%). Fifty-one participants did not respond to this question (N=51, 38%).

In Question 36, respondents were asked if they struggled with specific issues during the pandemic. Most respondents indicated they lacked socialization (N=74, 55%) and access to therapy (N=71, 53%). Other issues include food insecurity (N=52, 39%), lack of a savings account (N=52, 39%), lack of access to medication or pain management tools (N=47, 35%), lack of transportation access (N=47, 35%), inability to pay bills (N=42, 31%), inability to pay rent/housing insecurity (N=38, 28%), lack of cleaning and hygiene supplies (N=36, 27%), and lack of internet access (N=21, 16%). Fifty subjects did not respond to this question (N=50, 37%).

“More difficult to access needed services such as doctor appointments. Before the pandemic, I felt like I was making progress with my issues and was able to do more myself, independently without help but the stress and anxiety caused by the pandemic has set me back and I require more help and support from my friends and family than before. But at the same time the pandemic has caused more isolation and has required distancing from those friends and family and so the support I require has had to come from fewer and fewer people in turn causing them more stress. No one is well, everyone is struggling.” (13116563712) (Question 10)

Education and labour force

Accessibility of education system

Almost two-thirds of respondents (N=39, 29%) reported that education systems in Canada were less accessible during the pandemic (Question 12). The two most commonly reported reasons for the decrease in accessibility was a lack of financial support (N=11, 8%) and difficulty with learning in a virtual environment (N=10, 7%). Other reported reasons include health and safety concerns (N=6, 4%), concerns about transportation (N=5, 4%), lack of connection with peers/teachers (N=5, 4%), and being unable to receive accommodations (N=5, 4%). Relatively fewer respondents found that increased access to remote learning made the education systems more accessible during the pandemic (N=15, 11%). Ninety-nine subjects did not respond to the question (N=99, 73%).

One respondent expressed the need for equitable online and in-person learning environments, with an emphasis on access to high-quality educational resources: *"There was little, if any, support for students with IEPs. Having the option to learn online should always be available with access to qualified educators in order to improve access to learning for all. However, assessment and equitable access to resources need to be addressed. The return to physical classes has been less than ideal as well, with schedules that do not meet the needs of students. The education system in general needs an overhaul, with a focus on equity and access to rich resources that support teaching and learning for all." (13114337609) (Question 12)*

Accessibility of labour force

Approximately two-thirds of respondents (N=42, 31%) reported that the labour force in Canada was less accessible during the pandemic (Question 14). When asked why, the two most commonly reported reasons for the decrease in accessibility was difficulty with the job search (N=12, 9%) and health and safety concerns (N=10, 7%). Other reported reasons include lack of accommodations (N=8, 6%), unable to work (N=8, 6%), and lack of financial support (N=5, 4%). Respondents felt that employers do not truly value diversity and inclusion in hiring practices, as expressed by one respondent, *"I don't feel the inclusive and diversity from employers. News always complain about shortage but nowhere wants to hire me." (13115828685) (Question 14)*

A minority of respondents stated that increased access to remote work opportunities made the labour force more accessible during the pandemic (N=12, 9%), but that mandates for returning to in-person work could take away this accessibility: *"More online meetings is more accessible. Working from home. Mandates being enacted for in person meetings, not so much." (13115886066) (Question 14).* In addition, some respondents indicated there was no change in accessibility to the labour force (N=9, 7%). Eighty-seven subjects did not respond to the question (N=87, 64%).

In Question 25, most respondents (N=79, 59%) indicated that the federal government needs to amend the Canada Health Act to include injured workers, while all others that responded were neutral on the matter (N=11, 8%). Forty-five subjects did not respond to the question (N=46, 34%).

Social assistance and the justice system

Amount of social assistance

Most respondents agreed or strongly agreed that the federal government should provide greater funding to support people with disabilities during public health emergencies (N = 102, 65.8%). Nearly 40% (N=62) of respondents experienced housing insecurity due to inadequate social assistance. Most respondents agreed or strongly agreed with advocacy efforts for the federal government to increase social assistance to reach a livable wage (N=99, 63.9%). Most respondents (N = 92, 59.4%) agreed or strongly agreed that the federal government should implement a guaranteed basic livable income (Questions 11, 31, 39, 40).

When asked about how low social assistance rates have impacted the respondents quality of life, 43 (32%) reported reduced affordability, 12 (9%) reported increased dependence on others, and 14 (10%) reported worsened overall health outcomes. Reduced affordability appeared in several areas including difficulties with affording nutritious food options (N=30, 22%); housing (N=19 (14%); other expenses such as entertainment, clothing and technology (N=15, 11%); out of pocket health care expenses (N=11, 8%); and transportation costs (N=5, 4%). One participant stated, *"I can't afford adequate or healthy groceries. The last week of the month means eating carbs and super low-quality food…I can't afford a number of recommended or prescribed therapy, including mental health therapy needed" (13146230453) (Question 35)*.

Participants have highlighted some barriers since the start of the pandemic that have made it increasingly difficult to solely rely on social assistance. Eighteen respondents (13%) stated that social assistance has not kept pace with the increased cost of living. Six respondents (4%) noted increased costs for delivery of goods. Also, twelve respondents (9%) reported reduced access to supports and services. One respondent explained the barriers they faced and stated, *"Local food banks shuttered. Harder to contact case worker. Food/grocery delivery costs too high. Increased costs at grocery store" (13113754238) (Question 37).*

Access to social assistance

A notable number of respondents (N = 48, 36%) felt that social services were less accessible since the start of the pandemic in Canada. Some (N = 11, 8%) expressed that online or remote services did not provide adequate communication when compared to in-person services. Some (N = 11, 8%) expressed reduced accessibility to the same case worker and reduced availability of case workers. One respondent stated, *“My social assistance worker routinely does not answer phone or email and there is often no avenue to get the supports I need” (13115594058)*. Others (N=8, 6%) reported going through difficult processes to access services or delays such as increased wait times to access services. A few respondents (N = 6, 4%) experienced communication problems over the phone. As one respondent stated, social services, *“are dependent on a stable internet connection, access to the internet, a phone, time to wait on hold, and electricity - things that are not often available to us” (13148130448) (Question 16)*. However, a small group of respondents (N = 14, 10%) felt that social services became more accessible since the start of the pandemic, with a subset (N = 11, 8%) attributing this to accessible online or remote services and communication (Question 16).

Justice system

When asked if the Canadian justice system has become more or less accessible since the start of the pandemic, 22 (16%) participants responded less accessible, 4 (3%) participants responded more accessible, 7 (5%) participants responded no change, and 11 (8%) participants responded there is no justice. Some reasons for the justice system to become less accessible included unaffordable legal fees, a backlog in scheduling which has caused rushed hearings and increased wait times, and online hearings that require unaffordable technology. One participant wrote, *“because of cuts, people in poverty haven’t had real access to legal aid and not everyone can afford technology”*. Other participants felt the justice system’s online mode made hearings more accessible. Some reported feeling disappointed by the justice system as it never was in the favour of people with disabilities (Question 15).

Housing

Accessible housing

The survey results affirm that accessible housing is important to sustaining a good quality of life (N = 21, 16%). More specifically, some respondents indicated that their quality of life has been negatively impacted by the inflexibility of property designs (e.g., not wheelchair-friendly) (N = 8, 6%). Being located far from facilities, essential services, and support systems has further restricted accessibility (N = 9, 7%), in addition to a lack of cleanliness observed in properties afflicted by mould or pest infestations (N = 9, 7%). One respondent asserted, *“If I had an accessible home, I would be using a wheelchair as needed to reduce pain and fatigue. If I weren't in a mouldy apartment, my general health and cognitive function would improve. And if I weren't in a bachelor [apartment], I'd have space to actually move my body” (13132692617) (Question 28)*.

Affordable housing

Lack of affordable housing also appears to have negatively impacted quality of life (N = 25, 19%). Some respondents reported spending most of their income on housing (N = 16, 12%), while others expressed concern that inflation or increasing cost of living expenses is making it difficult to pay for housing (N = 10, 7%). While some respondents were able to afford secure housing (N = 13, 10%), others fear losing their rental properties due to external circumstances (N = 5, 4%). Moreover, participants notably skewed low in confidence in being able to access affordable alternative housing if they need to move outside of their current home or living situation (Figure 5.2). In fact, most respondents shared that they have at least once experienced housing insecurity due to low social assistance rates (N = 56; 41%; Table 5.10).

As such, there is largely consensus in the belief that all disabled Canadians should have the right to an accessible and affordable home (N = 87; 64%; Table 5.23). In view of this, all participants agreed or strongly agreed that the federal government needs to provide greater funding for accessible, affordable housing (N = 86; 64%; Table 5.22). The pandemic, in particular, has greatly impacted access to stable housing, leading potentially to a loss of autonomy and sense of dignity (N = 5, 4%), a negative impact on overall health (N = 8, 6%), and a dependence on others (N = 12, 9%), with one respondent stating, *“I moved home during the pandemic because I couldn't get help” (13135991976) (Question 28)*.

Health care

Access to health care

When participants were asked about how healthcare systems in Canada have become more or less accessible to them during the pandemic, most respondents said healthcare became less accessible (N = 74; 55%). A notable theme amongst respondents who felt healthcare was less accessible was that virtual appointments were inadequate to in-person visits (N = 19; 14%). Notably though, most participants who found healthcare systems in Canada to be more accessible (N = 20; 15%) felt that the option to book virtual appointments was a helpful alternative to in-person visits (N = 18; 13%). One respondent explained that virtual appointments both improve accessibility since some appointments *“would be dangerous or arduous to attend in person”*, and reduce accessibility due to virtual appointments feeling *“impersonal, rushed, and often miss elements of examination that are only possible in person”* (13115594058) *(Question 13)*. Respondents who found healthcare to be less accessible cited additional factors. Some cited an increase in wait times for accessing healthcare (N = 14; 10%), as well as specialists and/or resources being less available (N = 14; 10%). Others felt communicating via phone can be problematic (N = 12; 9%). Some (N = 11; 8%) mentioned appointments delays or cancellations. A smaller portion (N = 8; 6%) mentioned avoiding healthcare centres to avoid contracting COVID-19, and a few (N = 5; 4%) cited resistance to support persons attending appointments as a factor for inaccessibility (Question 13).

Participants were also asked on how often they or their loved ones accessed medical support in relation to their disabilit(ies). Most (N = 32; 24%) stated that they accessed medical support less than once a month. Some (N = 12; 9%) said they did access medical support at least once per month, while others (N = 22; 16%) mentioned accessing support a few times per month. Few (N = 10; 7%) stated that they accessed support at least once per week, and a few respondents (N = 7; 5%) accessed support every day. Contrastingly, a few respondents (N = 7; 5%) mentioned never going to access medical support, or said they did access medical support at times but it was very inconsistent (including some of these respondents cited COVID-19 as the reason why they went inconsistently) (Question 17).

Affording health care

Participants were asked whether they paid for any healthcare expenses out of pocket, or a loved one paid for their healthcare expenses. The majority said they or a loved one paid out of pocket for healthcare services (N = 61, 45%). One participant stated they had to ask for help from friends and family, and found it *“incredibly stressful and makes me feel inferior to need to ask for money all the time”* (13124539005). Of those who paid out of pocket, the most common expense that was mentioned was medications (N = 34; 25%). Many participants also paid for specific treatments such as mental health therapy (N = 13; 10%) or physiotherapy (N = 12; 9%) out of pocket. Some (N = 11; 8%) mentioned the expense of medical devices or supplies being out of pocket for them. Others (N = 7; 5%) brought up other general medical treatments outside of mental health therapy and physiotherapy. A small group (N = 5; 4%) mentioned paying for medical assessments or lab tests out of pocket and a few respondents (N = 5; 4%) reported paying for direct care from a specialized healthcare professional (Question 18).

When participants were asked separately on if they themselves or their loved ones paid for any assistive devices out of pocket, most (N = 51; 38%) said that they or their loved ones paid out of pocket all or some of the time (Question 20).

A majority of respondents (N = 88, 65%) agreed or strongly agreed that the federal government needs to provide greater funding for pharmaceuticals and create universal pharmacare (Table 5.13.) [Question 21]. A majority of respondents (N = 90, 67%) agreed or strongly agreed that the federal government should modify the Canada Health Act and include assistive devices. There were 45 subjects (33%) who did not respond to this question (Question 22). Among the participants, many agreed or strongly agreed that the federal government should increase funding for home care (N = 88, 65%). Additionally, participants rarely chose feeling neutral about this matter (N = 2, 1%). There were 45 subjects (33%) who did not respond to Question 23. When asked whether the federal government should increase funding for palliative care, the majority strongly agreed (N = 75; 56%), some agreed (N = 10, 7%), and a few responded feeling neutral (N = 5; 4%). There were 45 subjects (33%) who did not respond to this question (Question 24).

Home and long-term care

When participants were asked how home care or personal support workers impact their quality of life in Canada, 16 (12%) responded it positively impacts their quality of life while 18 (13%) responded it negatively impacts their quality of life. Participants (N = 5; 4%) reasoned that these services helped maintain their autonomy and dignity while other participants (N = 5; 4%) reasoned these services helped maintain hygiene. For instance, one participant stated, *"It is imperative that the needs of disabled and elderly people are met humanely and with dignity."* (13114337609) Unfortunately, participants did not elaborate on how it negatively impacted quality of life (Question 19).

A majority of participants (N = 53; 39%) answered 'no' when asked whether they considered living in a long-term care home due to disability, income or accessibility to housing. However, 15 participants answered 'maybe' (11%) and 9 participants answered 'yes' (7%). One participant explained their family members used long-term care due to disability. The respondent stated, *"Yes, my aunt had multiple sclerosis and needed care beyond what we could provide" (13114337609) (Question 29).*

Regardless of income status, the majority of respondents (N = 87, 64%) agreed or strongly agreed that people with disabilities have the right to age without moving into an institution. One respondent (1%) felt neutral about this topic. There were 47 subjects (35%) who did not respond to this question (Question 32).

Medical assistance in dying

There was a variation in responses when respondents were asked whether they are in agreement with the changes made to medical assistance in dying. A notable number of respondents disagreed or strongly disagreed (N = 64; 47%) as Bill C-7's expansion still does not include those suffering due to social determinants of health. Conversely, a portion of respondents (N = 15, 11%) agreed or strongly agreed as the bill now includes people with disabilities who are not terminally ill. There were 12 respondents (9%) who neither agreed or disagreed. There were 44 subjects (33%) who did not respond to this question (Question 27).

Race/ethnicity sub-group analysis

A subgroup analysis of the survey responses was undertaken to evaluate potential differences in attitudes, beliefs, and/or experiences between people with disabilities who identify as White versus non-White. Among the 135 respondents, 110 respondents identified as White (81%), 19 respondents identified as non-White (14%), and 6 respondents preferred not to disclose their race and/or ethnicity (4%). Given that the overall average response rate was only 67%, subgroup comparisons were further restricted by the small number of respondents across multiple response categories for each question. For example, we found zero responses for non-White respondents for many questions. Caution must be exercised in the following interpretation of findings.

Demographics

Over half (57%) of White respondents identified as women, 27% as men, 10% as non-binary, 4% as trans, 1% as two-spirit, and 5% as “other.” Comparatively, 74% of non-White respondents identified as women, 16% as men, 16% as non-binary, and 11% as Two-Spirit (Table 5.3.2). Overall, non-White respondents reported more than one gender identity more often than White respondents (Table 5.3.4).

A higher percentage of non-White respondents were younger than 25 years old, at 16%, compared to 5% for White respondents. Most non-White respondents were either 25-34 years old or 45-54 years old, whereas White respondents were often found to be between the ages of 35 and 44 (Table 5.2.1). White and non-White respondents mostly earned $0-$24,999 annually. Only a small percentage (5%) of White respondents earned an annual income of $100,000 and up (Table 5.4.1).

Affordability and accessibility to goods and services

All survey respondents expressed low confidence regarding their ability to access affordable alternative housing if needed. However, a greater percentage of non-White respondents (63%) reported having no confidence *at all* compared to the survey’s White respondents (46%) (Table 5.20.1). On the other hand, non-White respondents reported experiencing less housing insecurity due to low social assistance rates than their White counterparts (Table 5.10.1). White respondents also reported experiencing food insecurity (42%) more frequently than non-White respondents (16%), which could be due to a difference in question-specific response rates (Table 5.11.1). White respondents also mentioned their struggles with access to therapies (55%) more so than non-White respondents (37%). However, these responses for Question 36 reflect what the COVID-19 pandemic specifically impacted in their level of access to resources. It is probable that both White and non-White respondents were already experiencing difficulties with accessing resources such as therapies before the COVID-19 pandemic began.

The pandemic has worsened access to education for all respondents. Overall, White respondents shared these hindrances more openly (N = 30; 27%) compared to non-White respondents (N = 2; 11%). Being unable to receive accommodations in the education system appears to have been a greater issue for non-White respondents (N = 2; 11%). Healthcare systems were also less accessible, although a greater percentage of non-White respondents reported having to avoid healthcare centres to reduce risk of becoming infected with COVID-19 (N = 3; 16%). Labour force and social services access was equal among White and non-White respondents (N = 35, 32% and N = 37, 34%, respectively). One-third 34% (N = 37) of White respondents signalled that low social assistance rates have reduced affordability compared to 21% of non-White respondents (N = 4), particularly with respect to the cost of food (N = 26, 24% of White respondents versus N = 2, 11% of non-White respondents). Interpretation of these results must be taken with considerable discretion, given the uneven and small sample sizes of the dataset when clustered by race and/or ethnicity, namely of the non-White subgroup.

Gender observations

A just recovery plan for people with disabilities post-pandemic entails promoting diversity and inclusivity. A respondent mentioned *“a system where there are representatives from all walks of life, not white, male cisgender, wealthy, educated neoliberals”.* This system would include people with disabilities that belong to the LGBTQ+ group.

The theme of abuse was apparent across genders including non-binary, multigender, and woman. Due to financial difficulties faced in affording housing during the pandemic, people with disabilities stated feeling forced to live in households with abusive relations whether a family member or partner. For example, one respondent expressed feeling trapped in an abusive relationship, stating *“I had no way to leave because I had no income”.* Furthermore, one respondent stated a power imbalance in a past relationship, where the ex-partner was dominating and powerful; this participant expressed fear in how power imbalances can influence their ability to secure professional employment post-pandemic.

People with disabilities who were trans, non-binary, and queer shared their experiences in healthcare falling short from expectations. In terms of affordability, out-of-pocket healthcare expenses for gender-affirming care are difficult to endure. One respondent expressed an unmet need for supportive services that aid in gender transition. Furthermore, respondents expressed discomfort when people working in healthcare and education made assumptions about the lived experiences of people with disabilities. For example, one respondent mentioned an experience with a physician during the pandemic, where the professional did *“not ask appropriate questions”* and made assumptions.

Some respondents expressed opportunities for policy change, such as *“paid professional development opportunities … that are not paternalistic”*. Also, to help mitigate abuse, another respondent expressed the need for a system where financial supports are calculated on an individual basis rather than a household basis. In this way, people with disabilities can have the opportunity to escape abusive relationships if they are empowered financially.

Discussion

This survey asked people with disabilities in Canada what they would want from a just recovery from the COVID-19 pandemic. A prominent theme echoed across the survey was providing increased social assistance to support the increased cost of living. Survey respondents reported that preexisting economic hardship was intensified during the COVID-19 pandemic, leading to poorer quality of life and health outcomes. Another study validates these findings: finances was found to be the greatest stressor among people with disabilities since previously unmet financial needs continued to be unmet during the COVID-19 pandemic (Abilities Centre, 2020; Pettinicchio et al., 2021). During the pandemic people with disabilities have struggled to meet the rising costs of safe and accessible housing, food, out of pocket healthcare expenses, and other expenses such as transportation, delivery of goods, entertainment, clothing, and technology. Our findings indicate that low social assistance has affected the ability to afford housing the most with some respondents expressing heightened fears of losing their rental units. Another study showed accessibility to housing among people with disabilities to be a concern prior to the pandemic that worsened during the pandemic (Abilities Centre, 2020). Our findings also support the need to provide accessible housing, which includes wheelchair friendly designs and housing locations close to facilities, services, and support systems. Overall, these results express a dire need to reform social assistance for people with disabilities in Canada and provide additional financial support during public health emergencies.

In this survey we found that health and home care during the COVID-19 pandemic was eliminated, worsened, or difficult to afford or access. Our findings indicate that specialists and healthcare resources were less available. Another study corroborates these findings as access to general or specialized healthcare significantly worsened during the pandemic for people with disabilities (Abilities Centre, 2020). Moreover, our study revealed medications to be the most expensive out of pocket healthcare expense. Respondents expressed their support for increased government funding for pharmaceuticals, thereby encouraging a universal pharmacare plan in Canada. In addition, respondents expressed favourability for home care and personal support workers as it allowed them to maintain their autonomy and dignity as well as maintain hygiene. Most respondents did not want to live in long term care homes and believed they had a right to age without moving to such institutions. Our findings indicated a strong push to enhance government funding models for home care services. Additionally, in terms of attitudes toward healthcare laws, Bill C7’s expansion was appreciated by many, but some respondents still felt it falls short. There is still a gap in Bill C7 whereby people with disabilities who are suffering due to social determinants of health (e.g., access to a livable income, housing, food, medication, etc.) are neglected. Also, healthcare triage schemes were not favoured as they were biased against people with disabilities by assuming that they should have lesser care.

Survey results regarding education and employment were mixed. Respondents experienced difficulties funding education. Virtual education and employment benefitted those who were able to possess and use the requisite technologies, but were barriers for people who did not have, could not afford, or could not use these technologies. For the labour sector, responses reinforced the difficulty in finding jobs and many had health and safety concerns. Our findings about changes in employment induced by COVID-19 were similar to those found in another study among people with disabilities, which found that one-third of respondents had a reduction in hours or were laid off during the pandemic (Abilities Centre, 2020).

Accessing social services became more challenging for survey respondents during the pandemic. Many respondents indicated an interruption in social services when case workers changed or were not available. Another study found that case management significantly worsened during the pandemic (Abilities Centre, 2020). For the justice system, respondents shared inherent barriers such as extremely high legal fees and the inability to afford technology for online hearings.

During the COVID-19 pandemic there has been an increase in the prevalence of domestic violence. This is the “shadow pandemic” and while not directly asked about in the survey, we found a number of responses that revealed the presence of the shadow pandemic among people with disabilities. Some survey respondents who identified as non-binary, multigender, or woman reported being stuck in abusive relationships due to financial reasons. This reflected an increased dependence on others such as a partner or parents due to financial reasons. Additionally, trans, non-binary, and queer people reported difficulties in affording out of pocket gender affirming care that reflected the broader difficulty of pursuing out of pocket healthcare expenses.

A number of policy options in each of the above domains could be pursued under the framework of a just recovery for people with disabilities. Results from this survey suggest that potential policies need to promote a decent standard of living by ensuring that people with disabilities have access to adequate income, social and health supports and opportunities. The Government of Canada has published a plan to enhance information about community support services and accessibility, e.g., by providing support staff, sighted guides, and interpreters at social service sites (Government of Canada, 2022). A whole of government approach is needed for a just recovery given the different levels of jurisdiction involved (e.g., health care, which is at the provincial level in Ontario) and given the need for coordination across government departments. Similar, previously conducted research shows that people with disabilities would like policies and practices that promote diversity, inclusivity, dignity, respect, and autonomy. Some of these principles were expressed directly by survey respondents and many were implicit in the survey responses. A just recovery that centers disabled people could identify and flesh out guiding principles that could be the basis for policy change.

Conclusion

From the perspective of people with disabilities, the study aimed to examine what a just recovery plan post-pandemic should entail. Social assistance, healthcare services, educational opportunities, job opportunities, justice services and other social services, are all aspects in our society which are not meeting expectations for people with disabilities. These findings are useful in identifying the barriers that persisted and were exacerbated during the pandemic, thereby reinforcing a need for social and economic policy reform in the post-pandemic era that centers the experiences of people with disabilities.

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Appendices

1. Survey codebook
2. Survey completion statistics
3. Demographic characteristics of survey respondents
4. Race/ethnicity of survey respondents
5. Response distribution for categorical (close-ended) questions
6. Codes, categories, definitions, and counts by open-ended question

Appendix 1: Survey codebook

#	Question/Variables	Response Options	Codes	Question Type
1	Where in Canada do you live?		1=Alberta 2=British Columbia 3=Manitoba 4=New Brunswick 5=Newfoundland and Labrador 6=Nova Scotia 7=Ontario 8=Prince Edward Island 9=Quebec 10=Saskatchewan 11=Northwest Territories 12=Nunavut 13=Yukon	One response (radio button)
2	How old are you?		1=Under 18 2=18-24 3=25-34 4=35-44 5=45-54 6=55-64 6=65+	One response (radio button)
3	What is your gender identity?	Woman	0=No 1=Yes	Multi-select (checkboxes)

3		Man	0=No 1=Yes	Multi-select (checkboxes)
3		Non-Binary	0=No 1=Yes	Multi-select (checkboxes)
3		Trans Masc	0=No 1=Yes	Multi-select (checkboxes)
3		Trans Femme	0=No 1=Yes	Multi-select (checkboxes)
3		Two-Spirit	0=No 1=Yes	Multi-select (checkboxes)
3		Other (please specify)	0=No 1=Yes	Multi-select (checkboxes)
3		Other (please specify)	Free-text	Open-Ended
4	What is your approximate annual income? income		1=$0-$24,999 2=$25,000-$49,999 3=$50,000-$74,999 4=$75,000-$99,999 5=$100,000-$124,999 6=$125,000-$149,999 7=$150,000-$174,999 8=$175,000-$199,999	One response (radio button)

			9=$200,000 and up	
5	1. Do you identify as Indigenous?(proof of Indigenous identity is not required for the purposes of this survey)	No	0=No 1=Yes	Multi-select (checkboxes)
5		Prefer not to answer	0=No 1=Yes	Multi-select (checkboxes)
5		Yes (please self-identify)	0=No 1=Yes	Multi-select (checkboxes)
5		Please self-identify	Free-text	Open-Ended
6	How do you identify racially and/or ethnically?	Arab	0=No 1=Yes	Multi-select (checkboxes)
6		Black (including African, African-Canadian, African-American, Afro-Caribbean/West Indian, Afro-Latinx)	0=No 1=Yes	Multi-select (checkboxes)

6		Chinese (including Mainland China, Hong Kong, Macau, and Taiwan)	0=No 1=Yes	Multi-select (checkboxes)
6		Filipino/a	0=No 1=Yes	Multi-select (checkboxes)
6		Indigenous outside of Canada (e.g., Nahualt, Maya, Quechua, Aymara, Mapuche, etc.)	0=No 1=Yes	Multi-select (checkboxes)
6		Indo-Caribbean/West-Indian, Indo-African, Indo-Fijian	0=No 1=Yes	Multi-select (checkboxes)
6		Japanese	0=No 1=Yes	Multi-select (checkboxes)
6		Korean	0=No 1=Yes	Multi-select (checkboxes)
6		Latinx (e.g., Brazilian, Chilean, Columbian, Mexican)	0=No 1=Yes	Multi-select (checkboxes)
6		North African (Egyptian, Libyan)	0=No 1=Yes	Multi-select (checkboxes)
6		Pacific Islanders or Polynesian/Melanesian/Micronesian (e.g., Cook Island MÄori, Hawaiian MÄâ€™oli, Fijians, Marquesan, Marshallese,	0=No 1=Yes	Multi-select (checkboxes)

		Niuean, Samoans, Tahitian MÄâ€™ohi, Tongan, New Zealand MÄori)		
6		South Asian (e.g., Bangladeshi, Pakistani, Indian, Sri Lankan, Punjabi)	0=No 1=Yes	Multi-select (checkboxes)
6		South East Asian (e.g., Cambodian, Malaysian, Thai, Vietnamese)	0=No 1=Yes	Multi-select (checkboxes)
6		West Asian (e.g., Afghani, Armenian, Iranian, Iraqi, Israeli, Jordanian, Lebanese, Palestinian, Syrian, Yemeni)	0=No 1=Yes	Multi-select (checkboxes)
6		White (including European, White-Canadian/American/ Australian/South African)	0=No 1=Yes	Multi-select (checkboxes)
6		Multiracial/ethnic (with at least one parent in a non-White group above)	0=No 1=Yes	Multi-select (checkboxes)
6		Prefer not to answer	0=No 1=Yes	Multi-select (checkboxes)
6		Prefer to self identify:	0=No 1=Yes	Multi-select (checkboxes)

6		Self identify	Free-text	Open-Ended
7	According to the World Health Organization, "Disabilities is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations." Using this definition, do you identify as disabled?		0=No 1=Yes	One response (radio button)
8	What disabilit(ies) do you have?	Physical	0=No 1=Yes	Multi-select (checkboxes)
8		Intellectual	0=No 1=Yes	Multi-select (checkboxes)
8		Learning	0=No 1=Yes	Multi-select (checkboxes)
8		Hearing	0=No 1=Yes	Multi-select (checkboxes)
8		Neurological	0=No 1=Yes	Multi-select (checkboxes)
8		Developmental	0=No 1=Yes	Multi-select (checkboxes)

8		Psychological/Mental	0=No 1=Yes	Multi-select (checkboxes)
8		Chronic Illness	0=No 1=Yes	Multi-select (checkboxes)
8		Visual	0=No 1=Yes	Multi-select (checkboxes)
8		Other (please specify)	0=No 1=Yes	Multi-select (checkboxes)
8		Other (please specify)	Free-text	Open-Ended
9	We are experiencing a pandemic and economic recession that has led to a national public health crisis. How we rebuild after this crisis will define our next chapter as a country. What are two, or more if you wish, important qualities of a Just Recovery that centres disabled people		Free-text	Open-Ended
10	How has this pandemic impacted your quality of life as a Disabled person in Canada?		Free-text	Open-Ended
11	The Federal Government needs to provide greater funding for supporting disabled people during Public Health Emergencies (for example, the COVID-19 pandemic)		1=Strongly Agree 2=Agree 3=Neutral 4=Disagree 5=Strongly Disagree	One response (radio button)

12	How have education systems in Canada been made more or less accessible to you since the beginning of the pandemic?		Free-text	Open-Ended
13	How have healthcare systems in Canada been made more or less accessible to you since the beginning of the pandemic?		Free-text	Open-Ended
14	How has the labour force in Canada been made more or less accessible to you since the beginning of the pandemic?		Free-text	Open-Ended
15	How has our justice system in Canada been made more or less accessible to you since the beginning of the pandemic?		Free-text	Open-Ended
16	How have other social services in Canada been made more or less accessible to you since the beginning of the pandemic?		Free-text	Open-Ended
17	How often do you or your loved ones access medical support in relation to your disabilit(ies)?		1=Every day 2=A few times a week 3=About once a week 4=A few times a month 5=Once a month 6=Less than once a month 7=Other (please specify)	One response (radio button)

17		Other (please specify)	Free-text	Open-Ended
18	Do you or your loved ones pay for any of your healthcare out of pocket? If yes, what types of costs occur, and what impact do these costs have?		Free-text	Open-Ended
19	Does access to home-care or personal support workers impact your quality of life in Canada? Please explain your answer.		Free-text	Open-Ended
20	Do you or your loved ones pay for any of your assistive devices out of pocket?		0=No 1=Yes	One response (radio button)
20		Other (please specify)	Free-text	Open-Ended
21	The Federal Government needs to provide greater funding for Pharmaceuticals and create Universal Pharmacare		1=Strongly Agree 2=Agree 3=Neutral 4=Disagree 5=Strongly Disagree	One response (radio button)
22	The Federal Government needs to amend the Canada Health Act to include Assistive Devices		1=Strongly Agree 2=Agree 3=Neutral 4=Disagree 5=Strongly Disagree	One response (radio button)

23	The Federal Government needs to provide greater funding for Home Care		1=Strongly Agree 2=Agree 3=Neutral 4=Disagree 5=Strongly Disagree	One response (radio button)
24	The Federal Government needs to provide greater funding for Palliative Care		1=Strongly Agree 2=Agree 3=Neutral 4=Disagree 5=Strongly Disagree	One response (radio button)
25	The Federal Government needs to amend the Canada Health Act to Injured Workers		1=Strongly Agree 2=Agree 3=Neutral 4=Disagree 5=Strongly Disagree	One response (radio button)
26	I believe in the efficiency of triage protocols (protocols which state that in a public health crisis, disabled people should receive lesser care)		1=Strongly Agree 2=Agree 3=Neutral 4=Disagree 5=Strongly Disagree	One response (radio button)
27	In 2021, the Federal Government expanded access to assisted suicide to include disabled people who are not terminally ill, but who suffer due to disability. This Bill C-7 expansion did not account for disabled people who are suffering due to social determinants of health (access to a livable income, housing, food, medication,		1=Strongly Agree 2=Agree 3=Neutral 4=Disagree 5=Strongly Disagree	One response (radio button)

	etc). Knowing this, do you agree with the expansion of medical assistance in dying for disabled people who are not terminally ill?			
28	In what ways does access to (or lack of access to) accessible, affordable, housing impact your quality of life in Canada? Please explain your answer.		Free-text	Open-Ended
29	Have you or a loved one explored living in a Long Term Care home for reasons related to disability, income, and access to housing supports? If so, please explain		Free-text	Open-Ended
30	How confident are you that you could access affordable alternative housing if you needed to move outside of your current home or living situation?		1=Extremely confident 2=Very confident 3=Somewhat confident 4=Not so confident 5=Not confident at all	One response (radio button)
31	Have you ever experienced housing insecurity due to low social assistance rates?		0=No 1=Yes	One response (radio button)

32	All disabled Canadians deserve the choice to age in place (without moving into an institution) regardless of income.		1=Strongly Agree 2=Agree 3=Neutral 4=Disagree 5=Strongly Disagree	One response (radio button)
33	The Federal Government needs to provide greater funding for accessible, affordable housing		1=Strongly Agree 2=Agree 3=Neutral 4=Disagree 5=Strongly Disagree	One response (radio button)
34	All disabled Canadians should have the right to an accessible and affordable home.		1=Strongly Agree 2=Agree 3=Neutral 4=Disagree 5=Strongly Disagree	One response (radio button)
35	Social Assistance rates in all provinces across Canada are below a livable wage. In what ways have low social assistance rates impacted your quality of life in Canada? Please explain your answer.		Free-text	Open-Ended
36	Since the start of the pandemic, have you struggled with any of the following issues as a disabled person in Canada?	None of the above	0=No 1=Yes	Multi-select (checkboxes)
36		Food insecurity	0=No 1=Yes	Multi-select (checkboxes)

36		Inability to pay rent/ housing insecurity	0=No 1=Yes	Multi-select (checkboxes)
36		Inability to pay bills	0=No 1=Yes	Multi-select (checkboxes)
36		Lack of internet access	0=No 1=Yes	Multi-select (checkboxes)
36		Lack of transportation access	0=No 1=Yes	Multi-select (checkboxes)
36		Lack of a savings account	0=No 1=Yes	Multi-select (checkboxes)
36		Lack of cleaning supplies and hygiene supplies	0=No 1=Yes	Multi-select (checkboxes)
36		Lack of socialization	0=No 1=Yes	Multi-select (checkboxes)
36		Lack of medication or pain management tools	0=No 1=Yes	Multi-select (checkboxes)
36		Lack of therapy (physiotherapy, occupational therapy, psychiatrics etc)	0=No 1=Yes	Multi-select (checkboxes)
36		Other	0=No 1=Yes	Multi-select (checkboxes)

36		Other (please specify)	Free-text	Open-Ended
37	What are some barriers that you have experienced since the beginning of the pandemic that has made relying on social assistance more difficult?		Free-text	Open-Ended
38	How have social assistance departments become more or less accessible to you during the course of this pandemic?		Free-text	Open-Ended
39	The Federal Government needs to advocate for social assistance rates that equal a livable wage		1=Strongly Agree 2=Agree 3=Neutral 4=Disagree 5=Strongly Disagree	One response (radio button)
40	The Federal Government needs to implement a guaranteed basic livable income		1=Strongly Agree 2=Agree 3=Neutral 4=Disagree 5=Strongly Disagree	One response (radio button)
41	Is there anything else that you would like to share with DJNO to include in our Just Recovery report which centres disabled people?		Free-text	Open-Ended

Appendix 2: Survey completion statistics

Table 2.1. Summary statistics for rate of survey completeness for a 41-question survey completed by 135 respondents.[a]

Range of survey completeness	**Minimum**	20% (8 out 41)
	Maximum	100% (41 out of 41)
Average survey completeness		69%

[a]Standalone “N/A” responses were considered non-responses in assessing survey completeness.

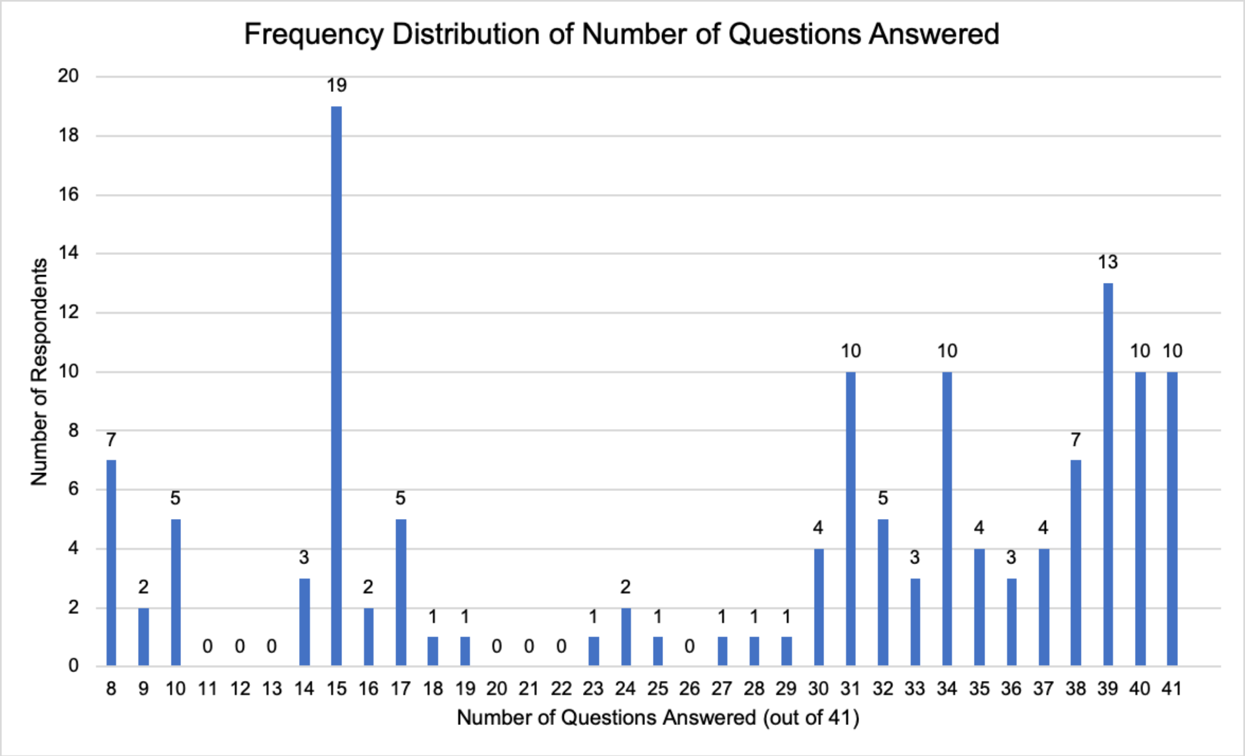

Figure 2.1. Frequency distribution of the number of questions answered by 135 survey respondents.

Table 2.2. Summary statistics for question completeness[a] across a 41-question survey completed by 135 respondents.

Range of question completeness	**Minimum**	18%
	Maximum	100%
Average question completeness		67%

[a]Standalone “N/A” responses were considered non-responses in assessing question completeness.

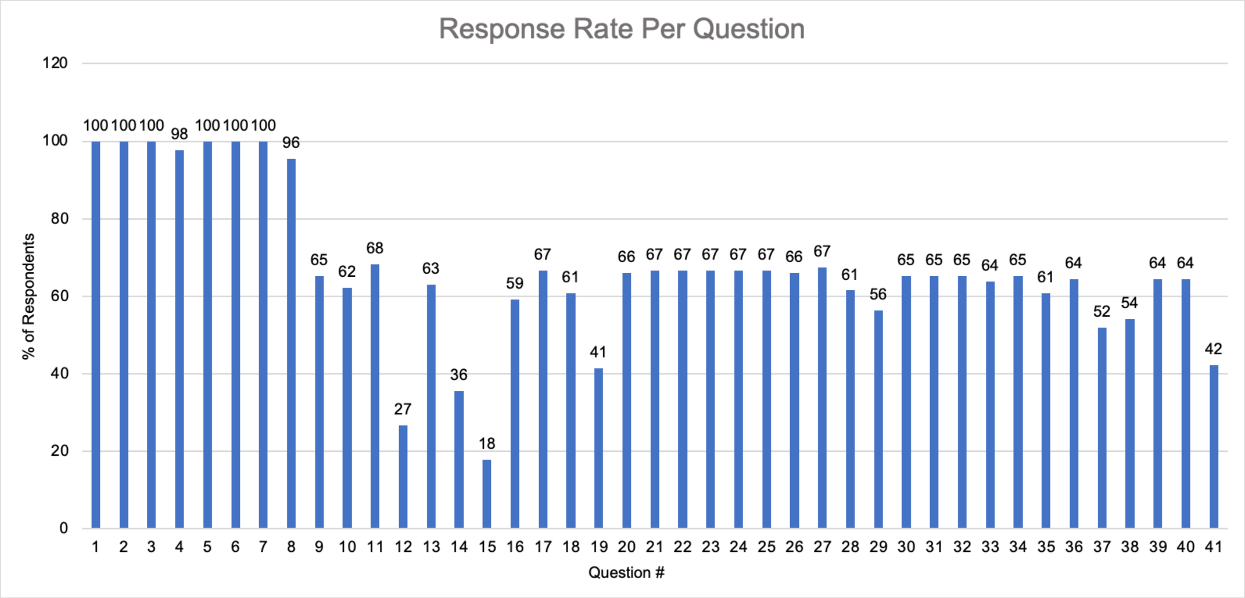

Figure 2.2. Response rate per question of the 41-question survey (N = 135).

Appendix 3: Demographic characteristics of survey respondents

Table 3.1. Response distribution for Question 1: “Where in Canada do you live?”

Response	# of Respondents	% of Respondents
Ontario	135	100%

Table 3.2. Response distribution for Question 2: “How old are you?”

Response	# of Respondents	% of Respondents
< 25 years old	9	7%
25-34 years old	31	23%
35-44 years old	46	34%
45-54 years old	27	20%
55-64 years old	17	13%
> 64 years old	5	4%
Total	135	100%

Table 3.2.1. Race/ethnicity sub-group analysis for Question 2: “How old are you?”[a]

Response	# of White Respondents	% of White Respondents	# of Non-White Respondents	% of Non-White Respondents
< 25 years old	5	5%	3	16%
25-34 years old	25	23%	5	26%
35-44 years old	42	38%	2	11%

45-54 years old	21	19%	5	26%
55-64 years old	14	13%	3	16%
> 64 years old	3	3%	1	5%
Total	110	100%	19	100%

[a] 6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

Table 3.3.1. Response distribution for Question 3: “What is your gender identity?”[a]

Response	# of Respondents	% of Respondents
Woman	81	60%
Man	33	24%
Non-Binary	15	11%
Trans	6	4%
Two-Spirit	4	3%
Other[b]	5	4%
Total	144	107%

[a] Individuals who responded in more than one category were counted more than once (see Table 5.3.2). Total % of responses is based on a denominator of 135 respondents.

[b] Other responses (N = 5) were: "agender, femme", “multigender", “she/they”, and “still working on that.” N = 2 selected a categorical response and specified an "other" gender identity. N = 3 only specified gender identity in "other."

Table 3.3.2. Race/ethnicity sub-group analysis for Question 3: “What is your gender identity?”[a]

Response	# of White Respondents	% of White Respondents	# of Non-White Respondents	% of Non-White Respondents
Woman	63	57%	14	74%

Man	30	27%	3	16%
Non-Binary	11	10%	3	16%
Trans	4	4%	1	5%
Two-Spirit	1	1%	2	11%
Other[b]	5	5%	0	0%
Total	114	104%	23	121%

[a] 6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

Table 3.3.3. Number of gender identities disclosed by respondents.

# of Gender Identities	**# of Respondents**	**% of Respondents**
One (1)	126	93%
Two (2)	9	7%
Total	135	100%

Table 3.3.4. Race/ethnicity sub-group analysis for number of gender identities disclosed by respondents.[a]

Response	**# of White Respondents**	**% of White Respondents**	**# of Non-White Respondents**	**% of Non-White Respondents**
One (1)	106	96%	15	79%
Two (2)	4	4%	4	21%
Total	110	100%	19	100%

[a] 6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

Table 3.4. Response distribution for Question 4: “What is your approximate annual income?”

Response	# of Respondents	% of Respondents
$0-24,999	90	67%
$25,000-$49,999	16	12%
$50,000-$74,999	14	10%
$75,000-$99,999	6	4%
$100,000 and up	6	4%
No response	3	2%
Total	135	100%

Table 3.4.1. Race/ethnicity sub-group analysis for Question 4: “What is your approximate annual income?”[a]

Response	# of White Respondents	% of White Respondents	# of Non-White Respondents	% of Non-White Respondents
$0 - $24,999	74	67%	12	63%
$25,000 - $49,999	11	10%	4	21%
$50,000 - $74,999	12	11%	2	11%
$75,000 - $99,999	5	5%	1	5%
$100,000 and up	5	5%	0	0%
No response	3	3%	0	0%

Total	110	100%	19	100%

[a]6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

Table 3.5. Response distribution for Question 5: “Do you identify as Indigenous? (Proof of Indigenous status is not required for the purposes of this survey)”[a]

Response	**# of Respondents**	**% of Respondents**
No	130	96%
Yes (please self-identify)	3	2%
Prefer not to say	2	1%
Total	135	100%

[a]Other responses were (N = 3): “First Nations”, and “Metis and Anishinaabe.” N = 1 did not provide any specific Indigenous identity.

Table 3.6. Response distribution for Question 7: “According to the WHO, "Disabilities is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations." Using this definition, do you identify as disabled?”

Response	**# of Respondents**	**% of Respondents**
Yes	128	95%
No	7	5%
Total	135	100%

Table 3.6.1. Race/ethnicity sub-group analysis for Question 7: “According to the WHO, "Disabilities is an umbrella term, covering impairments, activity limitations, and participation restrictions. An impairment is a problem in body function or structure; an activity limitation is a difficulty encountered by an individual in executing a task or action; while a participation restriction is a problem experienced by an individual in involvement in life situations." Using this definition, do you identify as disabled?”[a]

Response	# of White Respondents	% of White Respondents	# of Non-White Respondents	% of Non-White Respondents
Yes	104	95%	18	95%
No	6	5%	1	5%
Total	110	100%	19	100%

[a] 6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

Table 3.7.1. Response distribution for Question 8: ”What disabilit(ies) do you have?”[a,b]

Response	# of Responses	% of Responses
Psychological/Mental	76	56%
Physical	75	56%
Chronic Illness	64	47%
Neurological	41	30%
Learning	27	18%
Developmental	24	20%
Hearing	13	10%
Intellectual	12	9%
Visual	9	7%
Total	341	253%

[a] Individuals who responded in more than one category were counted more than once (see Table 5.7.2). Total % of responses is based on a denominator of 135 respondents.
[b] N = 7 responded “no” to Question 7 (see Table 5.6) but provided at least one response to Question 8.

Table 3.7.2. Race/ethnicity sub-group analysis for Question 8: ”What disabilit(ies) do you have?”[a]

Response	# of White Respondents	% of White Respondents	# of Non-White Respondents	% of Non-White Respondents
Psychological/ Mental	61	55%	12	63%
Physical	60	55%	11	58%
Chronic Illness	55	50%	7	37%
Neurological	34	31%	5	32%
Learning	19	17%	6	26%
Developmental	18	16%	4	21%
Hearing	12	11%	0	0%
Intellectual	10	9%	0	0%
Visual	8	7%	0	0%
Total	277	252%	45	237%

[a] 6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

Table 3.7.3. Number of disabilities disclosed by respondents.

# of Disabilities	# of Respondents	% of Respondents
One (1)	39	29%
Two (2)	36	27%
Three (3)	35	26%

Four (4)	12	9%
Five (5)	13	10%
Total	135	100%

Table 3.7.4. Race/ethnicity sub-group analysis for number of disabilities disclosed by respondents.[a]

Response	# of White Respondents	% of White Respondents	# of Non-White Respondents	% of Non-White Respondents
One (1)	32	29%	6	32%
Two (2)	31	28%	4	21%
Three (3)	26	24%	7	37%
Four (4)	10	9%	1	5%
Five (5) or more	11	10%	1	5%
Total	110	100%	19	100%

[a] 6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

Appendix 4: Race/ethnicity of survey respondents

Table 4.1. Response distribution for Question 6: “How do you identify racially and/or ethnically?”[a,c]

Response	# of Responses	% of Responses
White (including European, White-Canadian/ American/Australian/South African)	113	84%
Multiracial/ethnic (with at least one parent in a non-White group above)[b]	8	6%
South Asian (e.g., Bangladeshi, Pakistani, Indian, Sri Lankan, Punjabi)	5	4%
Black (including African, African-Canadian, African-American, Afro-Caribbean/West Indian, Afro-Latinx)	5	4%
Chinese (including Mainland China, Hong Kong, Macau, and Taiwan)	2	1%
Indigenous outside of Canada (e.g., Nahualt, Maya, Quechua, Aymara, Mapuche, etc.)	2	1%
Arab	1	1%
Latinx (e.g., Brazilian, Chilean, Colombian, Mexican)	1	1%
Korean	1	1%
North African (e.g., Egyptian, Libyan)	1	1%
West Asian (e.g., Afghani, Armenian, Iranian, Iraqi, Israeli, Jordanian, Lebanese, Palestinian, Syrian, Yemeni)	1	1%

Prefer not to answer	6	4%
Total	146	108%

[a]Individuals who responded in more than one category were counted more than once (see Table 4.3). Total % of responses is based on a denominator of 135 respondents.
[b]N = 8 self-identified as multiracial/ethnic in the survey responses. N = 2 additional respondents specified multiple racial/ethnic identities but did not self-identify as multiracial/ethnic.
[c]Other responses (N = 3) were: “Assyrian”, “First Nations”, and “Magyar.” N = 2 selected a categorical response and specified an "other” racial/ethnic identity. N = 1 only specified racial/ethnic identity in “other.”

Table 4.2. Racial and/or ethnic identity (white or non-white) disclosed by respondents.

Racial and/or Ethnic Identity	# of Respondents	% of Respondents
White only [excluding multi-racial/ethnic]	110	81%
Non-white	19	14%
Prefer not to answer	6	4%
Total	135	100%

Table 4.3. Number of racial and/or ethnic identities disclosed by respondents.

# of Racial and/or Ethnic Identities	# of Respondents	% of Respondents
One (1)	120	89%
Two (2)	7	5%
Three (3)	2	1%
Prefer not to say	6	4%
Total	135	100%

Appendix 5: Response distribution for categorical (close-ended) questions

Table 5.8. Response distribution for Question 17: ”How often do you or your loved ones access medical support in relation to your disabilit(ies)?”

Response	# of Respondents	% of Respondents
Less than once a month	32	24%
A few times a month	22	16%
Once a month	12	9%
At least once a week	10	7%
Never or inconsistently due to COVID	7	5%
Every day	7	5%
No response	45	33%
Total	135	100%

Table 5.8.1. Race/ethnicity sub-group analysis for Question 17: ”How often do you or your loved ones access medical support in relation to your disabilit(ies)?[a]

Response	# of White Respondents	% of White Respondents	# of Non-White Respondents	% of Non-White Respondents
Less than once a month	28	25%	3	16%
A few times a month	17	15%	3	16%
Once a month	11	10%	1	5%
At least once a week	8	7%	1	5%

Never or inconsistently due to COVID	6	5%	1	5%
Every day	4	4%	2	5%
No response	36	33%	8	42%
Total	110	100%	19	100%

[a] 6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

Table 5.9. Response distribution for Question 20: ”Do you or your loved ones pay for any of your assistive devices out of pocket?"

Response	**# of Respondents**	**% of Respondents**
Yes	51	38%
No	34	25%
Does not use assistive devices	4	3%
No response	46	34%
Total	135	100%

Table 5.9.1. Race/ethnicity sub-group analysis for Question 20: ”Do you or your loved ones pay for any of your assistive devices out of pocket?"[a]

Response	**# of White Respondents**	**% of White Respondents**	**# of Non-White Respondents**	**% of Non-White Respondents**
Yes	40	36%	7	37%
No	29	26%	4	21%

Doesn’t use assistive devices	4	4%	0	0%
No response	37	34%	8	42%
Total	110	100%	19	100%

[a] 6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

Table 5.10. Response distribution for Question 31: ”Have you ever experienced housing insecurity due to low social assistance rates?”

Response	# of Respondents	% of Respondents
Yes	56	41%
No	32	24%
No response	47	35%
Total	135	100%

Table 5.10.1. Race/ethnicity sub-group analysis for Question 31: ”Have you ever experienced housing insecurity due to low social assistance rates?”[a]

Response	# of White Respondents	% of White Respondents	# of Non-White Respondents	% of Non-White Respondents
Yes	46	42%	5	26%
No	26	24%	6	32%
No response	38	35%	8	42%
Total	110	100%	19	100%

[a] 6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

Table 5.11. Response distribution for Question 36: “Since the start of the pandemic, have you struggled with any of the following issues as a disabled person in Canada?”[a]

Response	# of Responses	% of Responses
Lack of socialization	74	55%
Lack of access to therapy (physiotherapy, occupational therapy, psychiatrics, etc.)	71	53%
Food insecurity	52	39%
Lack of a savings account	52	39%
Lack of access to medication or pain management tools	47	35%
Lack of transportation access	47	35%
Inability to pay bills	42	31%
Inability to pay rent/housing insecurity	37	27%
Lack of cleaning supplies and hygiene supplies	36	27%
Lack of internet access	21	16%
No response	50	37%
Total	530	393%

[a] Individuals who responded in more than one category were counted more than once. Total % of responses is based on a denominator of 135 respondents.

Table 5.11.1. Race/ethnicity sub-group analysis for Question 36: “Since the start of the pandemic, have you struggled with any of the following issues as a disabled person in Canada?”[a]

Response	# of White Respondents	% of White Respondents	# of Non-White Respondents	% of Non-White Respondents
Lack of socialization	64	58%	8	42%
Lack of access to therapy (physiotherapy, occupational therapy, psychiatrics, etc.)	60	55%	7	37%
Food insecurity	46	42%	3	16%
Lack of a savings account	43	39%	6	32%
Lack of access to medication or pain management tools	40	36%	4	21%
Lack of transportation access	40	36%	5	26%
Inability to pay bills	36	33%	4	21%
Inability to pay rent/housing insecurity	31	28%	3	16%
Lack of cleaning supplies and hygiene supplies	32	29%	2	11%
Lack of internet access	18	16%	2	11%

No response	40	36%	9	47%
Total	450	409%	53	279%

[a] 6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

Table 5.12. Response distribution for Question 11: “The Federal Government needs to provide greater funding for supporting disabled people during public health emergencies (for example, the COVID-19 pandemic).”

Response	# of Respondents	% of Respondents
Agree to strongly agree	89	66%
Neutral	0	0%
Disagree to strongly disagree	3	2%
No response	43	32%
Total	135	100%

Table 5.12.1. Race/ethnicity sub-group analysis for Question 11:“The Federal Government needs to provide greater funding for supporting disabled people during public health emergencies (for example, the COVID-19 pandemic).”[a]

Response	# of White Respondents	% of White Respondents	# of Non-White Respondents	% of Non-White Respondents
Agree to strongly agree	72	65%	13	68%
Neutral	0	0%	0	0%
Disagree to strongly disagree	2	2%	1	5%
No response	36	33%	5	26%

Total	110	100%	19	100%

[a] 6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

Table 5.13. Response distribution for Question 21: ”The Federal Government needs to provide greater funding for pharmaceuticals and create universal pharmacare.”

Response	**# of Respondents**	**% of Respondents**
Agree to strongly agree	88	65%
Neutral	2	1%
Disagree to strongly disagree	0	0%
No response	45	33%
Total	135	100%

Table 5.13.1. Race/ethnicity sub-group analysis for Question 21: ”The Federal Government needs to provide greater funding for pharmaceuticals and create universal pharmacare.”[a]

Response	**# of White Respondents**	**% of White Respondents**	**# of Non-White Respondents**	**% of Non-White Respondents**
Agree to strongly agree	72	65%	12	63%
Neutral	1	1%	1	5%
Disagree to strongly disagree	0	2%	0	0%
No response	37	34%	6	32%
Total	110	100%	19	100%

[a] 6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

Table 5.14. Response distribution for Question 22: ”The Federal Government needs to amend the Canada Health Act to include assistive devices.”

Response	# of Respondents	% of Respondents
Agree to strongly agree	90	67%
Neutral	0	0%
Disagree to strongly disagree	0	0%
No response	45	33%
Total	135	100%

Table 5.14.1. Race/ethnicity sub-group analysis for Question 22: “The Federal Government needs to amend the Canada Health Act to include assistive devices.”[a]

Response	# of White Respondents	% of White Respondents	# of Non-White Respondents	% of Non-White Respondents
Agree to strongly agree	73	66%	13	68%
Neutral	0	0%	0	0%
Disagree to strongly disagree	0	0%	0	0%
No response	37	34%	6	32%
Total	110	100%	19	100%

[a] 6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

Table 5.15. Response distribution for Question 23: ”The Federal Government needs to provide greater funding for home-care.”

Response	# of Respondents	% of Respondents

Agree to strongly agree	88	65%
Neutral	2	1%
Disagree to strongly disagree	0	0%
No response	45	33%
Total	135	100%

Table 5.15.1. Race/ethnicity sub-group analysis for Question 23: ”The Federal Government needs to provide greater funding for home-care.”[a]

Response	**# of White Respondents**	**% of White Respondents**	**# of Non-White Respondents**	**% of Non-White Respondents**
Agree to strongly agree	71	65%	13	68%
Neutral	2	2%	0	0%
Disagree to strongly disagree	0	0%	0	0%
No response	37	34%	6	32%
Total	110	100%	19	100%

[a] 6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

Table 5.16. Response distribution for Question 24: ”The Federal Government needs to provide greater funding for palliative care.”

Response	**# of Respondents**	**% of Respondents**
Strongly agree	75	56%
Agree	10	7%

Neutral	5	4%
Disagree to strongly disagree	0	0%
No response	45	33%
Total	135	100%

Table 5.16.1. Race/ethnicity sub-group analysis for Question 24: ”The Federal Government needs to provide greater funding for palliative care.”[a]

Response	# of White Respondents	% of White Respondents	# of Non-White Respondents	% of Non-White Respondents
Strongly agree	62	56%	10	53%
Agree	8	7%	2	11%
Neutral	3	3%	1	5%
Disagree to strongly disagree	0	0%	0	0%
No response	37	34%	6	32%
Total	110	100%	19	100%

[a] 6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

Table 5.17. Response distribution for Question 25: ”The Federal Government needs to amend the Canada Health Act to Injured Workers.”

Response	# of Respondents	% of Respondents
Strongly agree	66	49%
Agree	13	10%

Neutral	11	8%
Disagree to strongly disagree	0	0%
No response	45	33%
Total	135	100%

Table 5.17.1. Race/ethnicity sub-group analysis for Question 25: ”The Federal Government needs to amend the Canada Health Act to Injured Workers.”[a]

Response	# of White Respondents	% of White Respondents	# of Non-White Respondents	% of Non-White Respondents
Agree to strongly agree	64	58%	12	63%
Neutral	9	8%	1	5%
Disagree to strongly disagree	0	0%	0	0%
No response	37	34%	6	32%
Total	110	100%	19	100%

[a] 6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

Table 5.18. Response distribution for Question 26: ”I believe in the efficiency of triage protocols (protocols which state that in a public health crisis, disabled people should receive lesser care).”

Response	# of Respondents	% of Respondents
Somewhat to strongly agree	5	4%
Neither agree nor disagree	3	2%
Somewhat to strongly disagree	83	61%

No response	44	33%
Total	135	100%

Table 5.18.1. Race/ethnicity sub-group analysis for Question 26: “I believe in the efficiency of triage protocols (protocols which state that in a public health crisis, disabled people should receive lesser care).”[a]

Response	# of White Respondents	% of White Respondents	# of Non-White Respondents	% of Non-White Respondents
Somewhat to strongly agree	4	4%	1	5%
Neither agree nor disagree	2	2%	1	5%
Somewhat to strongly disagree	68	62%	11	58%
No response	36	33%	6	32%
Total	110	100%	19	100%

[a] 6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

Table 5.19. Response distribution for Question 27: ”In 2021, the Federal Government expanded access to assisted suicide to include disabled people who are not terminally ill, but who suffer due to disability. This Bill C-7 expansion did not account for disabled people who are suffering due to social determinants of health (access to a livable income, housing, food, medication, etc). Knowing this, do you agree with the expansion of medical assistance in dying for disabled people who are not terminally ill?”

Response	# of Respondents	% of Respondents
Somewhat to strongly agree	15	11%
Neither agree nor disagree	12	9%
Somewhat to strongly disagree	64	47%

No response	44	33%
Total	135	100%

Table 5.19.1. Race/ethnicity sub-group analysis for Question 27: ”In 2021, the Federal Government expanded access to assisted suicide to include disabled people who are not terminally ill, but who suffer due to disability. This Bill C-7 expansion did not account for disabled people who are suffering due to social determinants of health (access to a livable income, housing, food, medication, etc). Knowing this, do you agree with the expansion of medical assistance in dying for disabled people who are not terminally ill?”[a]

Response	# of White Respondents	% of White Respondents	# of Non-White Respondents	% of Non-White Respondents
Somewhat to strongly agree	14	13%	1	5%
Neither agree nor disagree	10	9%	2	11%
Somewhat to strongly disagree	50	45%	10	53%
No response	36	33%	6	32%
Total	110	100%	19	100%

[a] 6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

Table 5.20. Response distribution for Question 30: ”How confident are you that you could access affordable alternative housing if you needed to move outside of your current home or living situation?”

Response	# of Respondents	% of Respondents
Very to extremely confident	5	4%
Somewhat confident	4	3%

Not so confident	13	10%
Not confident at all	66	49%
No response	47	35%
Total	135	100%

Table 5.20.1. Race/ethnicity sub-group analysis for Question 30: ”How confident are you that you could access affordable alternative housing if you needed to move outside of your current home or living situation?”[a]

Response	**# of White Respondents**	**% of White Respondents**	**# of Non-White Respondents**	**% of Non-White Respondents**
Very to extremely confident	4	4%	1	5%
Somewhat confident	4	4%	0	0%
Not so confident	12	11%	0	0%
Not confident at all	51	46%	12	63%
No response	39	35%	6	32%
Total	110	100%	19	100%

[a] 6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

Table 5.21. Response distribution for Question 32: “All disabled Canadians deserve the choice to age in place (without moving into an institution) regardless of income.”

Response	**# of Respondents**	**% of Respondents**
Agree to strongly agree	87	64%

Neutral	1	1%
Disagree to strongly disagree	0	0%
No response	47	35%
Total	135	100%

Table 5.21.1. Race/ethnicity sub-group analysis for Question 32: “All disabled Canadians deserve the choice to age in place (without moving into an institution) regardless of income.”[a]

Response	# of White Respondents	% of White Respondents	# of Non-White Respondents	% of Non-White Respondents
Agree to strongly agree	70	63%	13	68%
Neutral	1	1%	0	0%
Disagree to strongly disagree	0	0%	0	0%
No response	39	35%	6	32%
Total	110	100%	19	100%

[a] 6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

Table 5.22. Response distribution for Question 33: ”The Federal Government needs to provide greater funding for accessible, affordable housing.”

Response	# of Respondents	% of Respondents
Agree to strongly agree	86	64%
Neutral	0	0%

Disagree to strongly disagree	0	0%
No response	49	36%
Total	135	100%

Table 5.22.1. Race/ethnicity sub-group analysis for Question 33: ”The Federal Government needs to provide greater funding for accessible, affordable housing.”[a]

Response	# of White Respondents	% of White Respondents	# of Non-White Respondents	% of Non-White Respondents
Agree to strongly agree	69	63%	13	68%
Neutral	0	0%	0	0%
Disagree to strongly disagree	0	0%	0	0%
No response	41	37%	6	32%
Total	110	100%	19	100%

[a] 6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

Table 5.23. Response distribution for Question 34: ”All disabled Canadians should have the right to an accessible and affordable home.”

Response	# of Respondents	% of Respondents
Agree to strongly agree	87	64%
Neutral	1	1%
Disagree to strongly disagree	0	0%
No response	47	35%

Total	135	100%

Table 5.23.1. Race/ethnicity sub-group analysis for Question 34: ”All disabled Canadians should have the right to an accessible and affordable home.”[a]

Response	# of White Respondents	% of White Respondents	# of Non-White Respondents	% of Non-White Respondents
Agree to strongly agree	70	63%	13	68%
Neutral	1	1%	0	0%
Disagree to strongly disagree	0	0%	0	0%
No response	39	35%	6	32%
Total	110	100%	19	100%

[a] 6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

Table 5.24. Response distribution for Question 39: ”The Federal Government needs to advocate for social assistance rates that equal a livable wage.”

Response	# of Respondents	% of Respondents
Agree to strongly agree	86	64%
Neutral	1	1%
Disagree to strongly disagree	0	0%
No response	48	36%
Total	135	100%

Table 5.24.1. Race/ethnicity sub-group analysis for Question 39: ”The Federal Government needs to advocate for social assistance rates that equal a livable wage.”[a]

Response	# of White Respondents	% of White Respondents	# of Non-White Respondents	% of Non-White Respondents
Agree to strongly agree	69	63%	13	68%
Neutral	1	1%	0	0%
Disagree to strongly disagree	0	0%	0	0%
No response	40	36%	6	32%
Total	110	100%	19	100%

[a] 6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

Table 5.25. Response distribution for Question 40: ”The Federal Government needs to implement a guaranteed basic livable income.”

Response	# of Respondents	% of Respondents
Agree to strongly agree	80	59%
Neutral	5	4%
Disagree to strongly disagree	2	1%
No response	48	36%
Total	135	100%

Table 5.24.1. Race/ethnicity sub-group analysis for Question 39: ”The Federal Government needs to advocate for social assistance rates that equal a livable wage.”[a]

Response	# of White Respondents	% of White Respondents	# of Non-White Respondents	% of Non-White Respondents
Agree to strongly agree	64	58%	12	63%

Neutral	4	4%	1	5%
Disagree to strongly disagree	2	2%	**e**0	0%
No response	40	36%	6	32%
Total	110	100%	19	100%

[a]6 respondents who preferred not to disclose their race and/or ethnicity were excluded from the sub-group analysis.

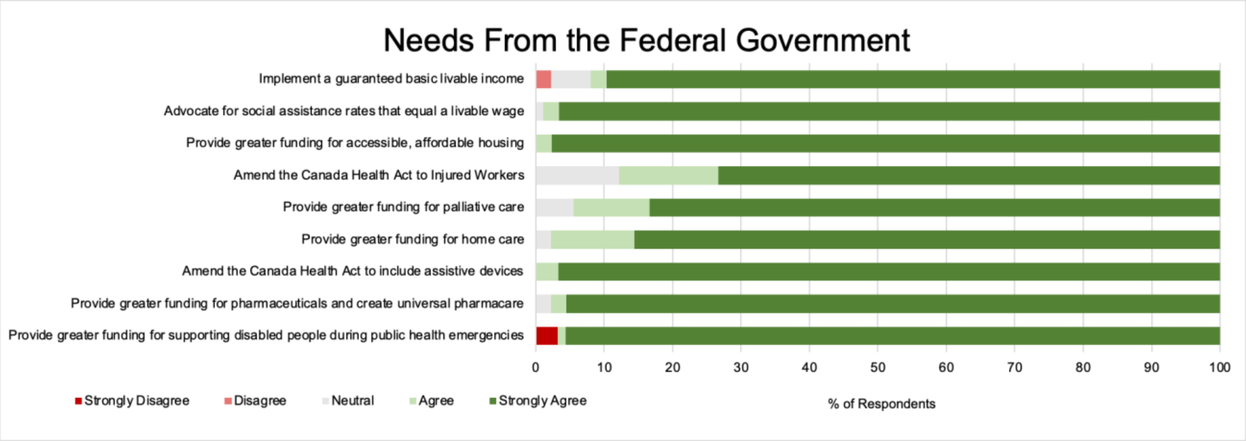

Figure 5.1. Distribution of respondents' levels of agreement regarding perception of needs from the federal government (Questions 11, 21, 22, 23, 24, 25, 33, 39, and 40). Distribution does not include respondents that left these questions blank.

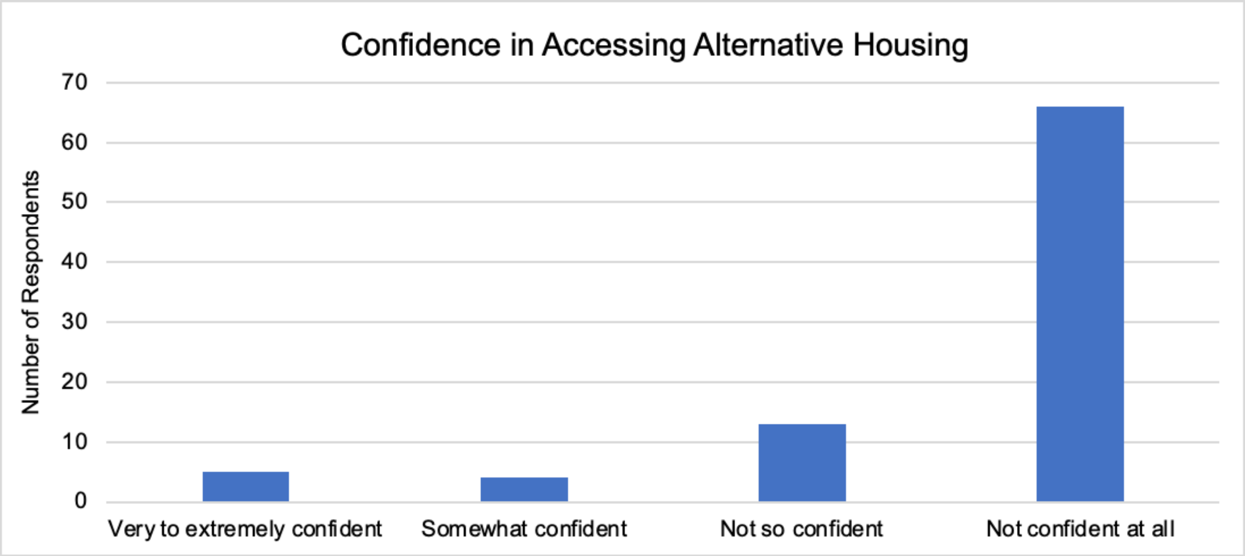

Figure 5.2. Distribution of respondents' self-reported confidence levels in being able to access alternative housing if moving outside their current home or living situation was necessary (Question 30). N = 47 (35%) provided no response.

Appendix 6: Codes, categories, definitions, and counts for open-ended survey questions

Table 6.1. Codes and categories for Question 9: “We are experiencing a pandemic and economic recession that has led to a national public health crisis. How we rebuild after this crisis will define our next chapter as a country. What are two, or more if you wish, important qualities of a Just Recovery that centres disabled people.”

Category: Affordable basic necessities (N = 77)		
Definition: People with disabilities should be able to afford their basic needs, such as food, shelter, healthcare, and transit.		
Codes	**Definition**	**N**
Livable social assistance	The social assistance provided to people with disabilities should be sufficient to afford their basic needs.	65
Affordable, safe, and accessible housing	Safe and accessible housing should be affordable for people with disabilities.	24
Universal healthcare	Healthcare services and resources, including pharmacare, dental care, mental health care, home care, and safe supply, should be accessible and affordable for people with disabilities.	23
Social assistance that facilitates autonomy	The social assistance provided should allow people with disabilities to have autonomy.	10
Affordable transit/transportation	Transportation should be affordable for people with disabilities.	8
Assistance with acquiring healthy food	Healthy food should be made affordable for people with disabilities.	8
Category: Accessibility (N = 16)		

Definition: People with disabilities should be able to access all necessary services, goods, and resources without systemic barriers.		
Codes	**Definition**	**N**
Accommodations to make work, school, and events accessible	Accommodations should be made to ensure people with disabilities can participate in work, school, and other events.	10
Category: Respect, dignity, and autonomy (N = 16)		
Definition: People with disabilities should be respected, valued, included by society and have the autonomy to make their own decisions.		
Category: Considerations for policy formulation (N = 69)		
Definition: Factors to consider when creating fair policies for people with disabilities.		
Codes	**Definition**	**N**
Increase social assistance	The amount of social assistance should be kept up to date with inflation to ensure it provides a livable wage and allows people with disabilities to afford their basic needs.	66
Eligibility and considerations for support	Eligibility criteria for support should be based on the individual and not be contingent on factors, such as household or marital status.	8

Table 6.2. Codes and categories for Question 10: “How has this pandemic impacted your quality of life as a disabled person in Canada?”

Category: Worsened quality of life (N = 83)
Definition: The participant indicated that aspect(s) of their life have worsened as a result of the pandemic.

Codes	**Definition**	**N**
Financial hardship	Accessing or affording basic necessities, such as food, rent/housing, and healthcare has been more difficult. Cost of living has been rising without accompanying financial supports or wage increases, leading to reliance on savings.	35
Loss of social cohesion and connections	The pandemic has increased feelings of loneliness and isolation due to the inability to go out and see family and friends. Lack of social interaction has resulted in a loss of friends, sense of community, and social skills, affecting mental health.	32
Unmet health needs	Access to health-benefiting supports and services (e.g., doctor's appointments and mental health care) has reduced while delays to medical treatments and access to health benefits have increased with long waitlists.	29
Worsened health status	The pandemic has negatively affected physical and/or mental health (e.g., chronic pain/illness, physical disabilities, depression, stress, anxiety, suicidal thoughts, weight fluctuations, psychological distress).	23
Fear for safety	The participant shares concern over risk of COVID-19, which has affected their ability to leave the house and feel safe outside/in public settings. Access to personal protective equipment or sanitizing supplies to stay safe has been limited.	13
Unequal treatment	People with disabilities are treated unfairly or unequally compared to people without disabilities, perpetuated by ableism and stigmatization. Concerns are not taken as seriously.	12

Loss or lack of employment	Being unable to work due to illness or any other undisclosed reason, losing employment during the pandemic, or being concerned over job precarity has worsened quality of life.	8
Poor accommodation	There is inflexibility or insufficiency in providing adequate accommodations in workplaces, schools, or other institutions.	8
Category: Improved quality of life to negligible change (N = 5)		
Definition: The participant indicated that aspect(s) of their life have improved as a result of the pandemic.		

Table 6.3. Codes and categories for Question 12: “How have education systems in Canada been made more or less accessible to you since the beginning of the pandemic?”

Category: Less accessible (N = 39)		
Definition: The participant expressed that education systems have become less accessible since the beginning of the pandemic.		
Codes	**Definition**	**N**
Lack of financial support	The participant mentioned difficulty with covering the financial costs of attending an education program, such as tuition fees, electronic devices (i.e., laptops), internet access; or expressed frustration regarding the lack of funding provided by educational institutions and/or governmental aids (i.e., loans, grants).	11
Difficulty with learning in virtual environment	The participant mentioned struggling with the ability to properly utilize virtual learning tools, or simply engaging with course content in a virtual setting.	10

Health and safety concerns	The participant mentioned concerns about their personal health and safety being at-risk due to in-person learning activities, or regarding health provisions at educational institutions.	6
Concerns about transportation	The participant mentioned general concerns and/or difficulties regarding the use of public transportation options and/or private modes of transportation (i.e., driving).	5
Lack of connection with peers/teachers	The participant mentioned feelings of frustration about not being able to adequately connect with their peers and/or instructors during the pandemic.	5
Unable to receive accommodations	The participant mentioned experiencing some difficulty with obtaining educational accommodations from instructors and/or administration members.	5
Category: More accessible (N = 18)		
Definition: The participant expressed that education systems have become more accessible since the beginning of the pandemic.		
Codes	**Definition**	**N**
Increased access to remote learning	The participant mentioned that they found remote learning options to be beneficial to their educational experience.	15

Table 6.4. Codes and categories for Question 13: “How have healthcare systems in Canada been made more or less accessible to you since the beginning of the pandemic?”

Category: Less accessible (N = 74)

Definition: Healthcare services and systems were more difficult to access for people with disabilities during the pandemic.		
Codes	**Definition**	**N**
Virtual appointments are not adequate replacements for in-person visits	The inability to have in-person visits prevents people with disabilities from receiving comprehensive health care.	19
Increased wait times	The increased wait times makes health care systems less accessible for people with disabilities.	14
Specialists and/or resources are less available	Specialists and resources beyond primary care are less available for people with disabilities.	14
Communicating by phone can be problematic	Healthcare services that transitioned to phone appointments and require scheduling by phone are less accessible due to the barriers of communicating by phone that people with disabilities experience (e.g., inconsistent access to a phone, lack of comfort communicating by phone).	12
Delayed/cancelled appointments	Appointments have been delayed or cancelled due to the pandemic, preventing people with disabilities from accessing healthcare services.	11
Avoid healthcare centres to avoid COVID-19	To reduce their risk of contracting COVID-19, people with disabilities avoid healthcare centres.	8
Resistance to support persons attending appointments	Healthcare services that expressed resistance to having support persons attend appointments deterred people with disabilities from attending their appointments.	5
Category: More accessible (N = 20)		

Definition: Healthcare services and systems were easier to access for people with disabilities during the pandemic.		
Codes	**Definition**	**N**
Option of virtual appointments is helpful	The option of virtual appointments facilitates greater access to some healthcare services, which some people with disabilities prefer.	18

Table 6.5. Codes and categories for Question 14: “How has the labour force in Canada been made more or less accessible to you since the beginning of the pandemic?”

Category: Less accessible (N = 42)		
Definition: The participant expressed that the labour force has become less accessible since the beginning of the pandemic.		
Codes	**Definition**	**N**
Difficulty with job search	The participant mentioned experiencing challenges with finding suitable jobs, whether that is due to a lack of accessible job opportunities, experiences with discrimination during the hiring process, or general distress associated with the job search process.	12
Health and safety concerns	The participant mentioned concerns about their personal health and safety being at-risk due to in-person work duties, or regarding health provisions by their current/prospective employer.	10
Lack of accommodations	The participant mentioned experiencing some difficulty with obtaining accommodations from their prospective or current employer.	8
Unable to work	The participant mentioned having an inability to work during the pandemic.	8

Lack of financial support	The participant mentioned a lack of support provided by the government due to unemployment during the pandemic.	5
Category: More accessible (N = 13)		
Definition: The participant expressed that the labour force has become more accessible since the beginning of the pandemic.		
Codes	**Definition**	**N**
Increased access to remote work	The participant mentioned that they found remote working options to be beneficial.	12
Category: No change (N = 9)		
Definition: The participant did not express the labour force becoming more or less accessible since the beginning of the pandemic.		

Table 6.6. Codes and categories for Question 15: “How has our justice system in Canada been made more or less accessible to you since the beginning of the pandemic?”

Category: Less accessible (N = 22)		
Definition: The participant expressed that the justice system has been made less accessible since the beginning of the pandemic.		
Codes	**Definition**	**N**
Scheduling backlog	Backlog in the legal system due to COVID-19 has resulted in lengthy wait times and/or rushed hearings.	7
Dysfunction with law enforcement	Negative interaction(s) with police or security have made the justice system less accessible.	6

High legal fees	Legal aid/services have been unaffordable.	5
Category: No change (N = 7)		
Definition: The participant expressed that the justice system has not changed since the beginning of the pandemic.		
Category: No justice (N = 11)		
Definition: The participant expressed that there is a lack of justice altogether.		
Codes	**Definition**	**N**
Lack of due process	Disabled people are not treated equally or fairly in the justice system.	7

Table 6.7. Codes and categories for Question 16: “How have other social services in Canada been made more or less accessible to you since the beginning of the pandemic?”

Category: Less accessible (N = 48)		
Definition: Other social services were more difficult to access for people with disabilities during the pandemic.		
Codes	**Definition**	**N**
Online/remote services and communication not adequate replacements for in-person services	In-person visits are necessary to adequately provide social services to people with disabilities.	11
Change in case worker or case worker availability	The accessibility to social services suffered due to changes in case worker or case worker availability during the pandemic.	11

Convoluted process or delays in accessing services (e.g., increased wait times)	The process to gain access to social services for people with disabilities can be nonsensical and unintuitive at times.	8
Communicating by phone is problematic	The primary way of communicating with social service workers during the pandemic was by phone, however because people with disabilities may not have consistent access to a phone and ‘playing phone tag’ became common, social services were less accessible.	6
Category: More accessible (N = 14)		
Definition: Other social services were easier to access for people with disabilities during the pandemic.		
Codes	**Definition**	**N**
Online/remote services and communication have been helpful	The option of online/remote services is more accessible and online communications (e.g., email) is preferable to some people with disabilities.	11

Table 6.8. Codes and categories for Question 18: “Do you or your loved ones pay for any of your healthcare out of pocket? If yes, what types of costs occur, and what impact do these costs have?”

Category: Pays for healthcare services out of pocket (N = 61)		
Definition: The participant discloses that they or their loved ones do pay for healthcare services/resources out of pocket.		
Codes	**Definition**	**N**

Medication	The participant (or their loved ones) pays for prescribed substances, including marijuana for medical use, as well as other medications that do not require a prescription from a licensed medical professional.	34
Mental health therapy	The participant (or their loved ones) pays for mental health treatments outside of prescribed medications; typically administered by a psychiatrist, psychologist, or other licensed mental health professional.	13
Physiotherapy	The participant (or their loved ones) pays for treatment(s) to restore, maintain, and improve their physical mobility and functioning, including massage therapy and acupuncture.	12
Medical devices/supplies	The participant (or their loved ones) pays for medical devices or supplies that are defined under the Food and Drugs Act, which "covers a wide range of products used in the treatment, mitigation, diagnosis or prevention of a disease or abnormal physical condition" (i.e., hearing aids, splints, heart monitors), as well as associated supplies for cleaning or repairs.	11
Medical treatments	The participant (or their loved ones) pays for general treatments to combat a disease or disorder carried out by a licensed physician or dentist (excluding physiotherapy and mental health therapy).	7
Assessments/lab tests	The participant (or their loved ones) pays for medical assessments or laboratory tests, such as blood tests or diagnostic assessments.	5
Specialized professional	The participant (or their loved ones) pays for the direct care from a specialized healthcare professional specifically for their disability/condition (i.e., podiatrist).	5

Category: Does not pay for healthcare services out of pocket (N = 25)
Definition: The participant discloses that they or their loved ones do not pay for healthcare services/resources out of pocket (and is typically using healthcare services that are covered by OHIP or private insurance).

Table 6.9. Codes and categories for Question 19: “Does access to home-care or personal support workers impact your quality of life in Canada? Please explain your answer.”[a]

Category: Positive impact on quality of life (N = 19)		
Definition: The participant indicated that home-care or personal support workers positively impacted their quality of life.		
Codes	**Definition**	**N**
Autonomy and dignity	The participant indicates that home-care or personal support workers helps them maintain independence and avoid institutionalization.	5
Hygiene	The participant indicates access to home-care or a personal support worker helps them maintain personal and/or house hygiene.	5
Category: Negative to no impact on quality of life (N = 18)		
Definition: The participant indicates home-care or personal support workers negatively impacted or had no impact on their quality of life.		

[a] Not applicable (N = 26): Participants may have expressed an opinion or statement on whether access to home-care or personal support workers would impact their quality of life, but indicated that they either do not have a need or access to these services at this time.

Table 6.10. Codes and categories for Question 28: “In what ways does access to (or lack of access to) accessible, affordable, housing impact your quality of life in Canada? Please explain your answer.”

Category: Lack of accessibility (N = 21)

Definition: Lack of accessibility is one factor leading to a poorer quality of life. This includes having property designs which make living difficult, lack of cleanliness within properties, and the locations of these properties lack proximity to supportive services.		
Codes	**Definition**	**N**
Lack of proximity to facilities and support systems	The property is not close to essential services (e.g., grocery stores, pharmacy) and is not close to support systems (e.g., family).	9
Property lacking cleanliness	The property is infested with mould, mice, or bugs.	9
Inflexibility in property design	The property is not wheelchair friendly or lacks an elevator.	8
Category: Lack of affordability (N = 25)		
Definition: Lack of affordability is one factor leading to a poorer quality of life. This includes not having enough money to pay for monthly housing expenses or having increased expenses due to inflation.		
Codes	**Definition**	**N**
Majority income spent on housing	Majority of monthly budget is spent on supporting one’s housing needs.	16
Inflation or increased expenses	Increased living expenses is making it difficult to financially manage paying for housing.	10
Category: No change to quality of life (N = 18)		
Definition: Affordable and accessible housing is not a problem.		
Codes	**Definition**	**N**

Able to afford house	Are financially secure to afford housing.	13
Fear of losing house	Due to external circumstances out of one’s control, many people with disabilities are afraid to lose their rental properties.	5
Category: Dependence on others (N = 12)		
Definition: To obtain affordable and accessibility housing, people with disabilities depend on others such as a partner, parents, or friends.		
Category: Negative impact on overall health (N = 8)		
Definition: Lack of accessibility and affordability is leading to poor physical and mental health outcomes.		
Category: Autonomy or dignity missing (N = 5)		
Definition: Lack of affordable and accessible housing leads to less power to make decisions that align with one’s preferences. Limited housing options also undermines the dignity of people with disabilities.		

Table 6.11. Codes and categories for Question 29: “Have you or a loved one explored living in a Long-Term Care home for reasons related to disability, income, and access to housing supports? If so, please explain.”

Category: Yes (N = 9)
Definition: The participant has explored living in a long-term care home for reasons related to disability, income, and access to housing supports.
Category: No (N = 53)
Definition: The participant has not explored living in a long-term care home for reasons related to disability, income, and access to housing supports.
Category: Maybe (N = 15)

Definition: The participant has considered exploring living in a long-term care home for reasons related to disability, income, and access to housing supports.

Table 6.12. Codes and categories for Question 35: “Social Assistance rates in all provinces across Canada are below a livable wage. In what ways have low social assistance rates impacted your quality of life in Canada? Please explain your answer.”

Category: Reduced affordability (N = 43)		
Definition: A lack of social assistance leads to reduced affordability in affording a house, food, transportation, out of pocket healthcare expenses, and additional living expenses. As a result, this leads to a poorer quality of life.		
Codes	**Definition**	**N**
Food	People with disabilities face difficulties in accessing adequate nutritious daily meals.	30
Housing	People with disabilities face difficulties in accessing affordable housing.	19
Extra expenses	People with disabilities face difficulties in accessing additional living expenses including but not limited to entertainment, clothing, and technology.	15
Out-of-pocket healthcare expenses	People with disabilities face difficulties in accessing out of pocket health care expenses (e.g., dental, vision, rehabilitation devices, medications etc.)	11
Transportation	People with disabilities face difficulties in accessing affordable transportation.	5
Category: Worsened health (N = 14)		
Definition: A lack of social assistance leads to worsened physical and mental health outcomes for people with disabilities.		
Category: Dependence on others (N = 12)		

Definition: A lack of social assistance forces people with disabilities to depend on others for living support.

Table 6.13. Codes and categories for Question 37: “What are some barriers that you have experienced since the beginning of the pandemic that has made relying on social assistance more difficult?”

Category: Increased cost of living (N = 18)
Definition: The increased cost of living during the pandemic has made relying on social assistance more difficult for people with disabilities.
Category: Reduced access to supports and services (N = 12)
Definition: Reduced access to departments and workers during the pandemic makes it difficult for people with disabilities to receive an adequate amount of social assistance.
Category: Increased costs for delivery of goods (N = 6)
Definition: Due to the pandemic, delivery is preferred over in-store purchasing, however these unexpected delivery costs make it difficult for people with disabilities to rely on social assistance.

Table 6.14. Codes and categories for Question 38: “How have social assistance departments become more or less accessible to you during the course of this pandemic?”

<table>
<tr><th colspan="3">Category: Less accessible (N = 29)</th></tr>
<tr><td colspan="3">Definition: Social assistance departments were more difficult to access for people with disabilities during the pandemic.</td></tr>
<tr><td>Codes</td><td>Definition</td><td>N</td></tr>
</table>

Communicating by phone is problematic	The primary way of communicating with social assistance department workers during the pandemic was by phone, however because people with disabilities may not have consistent access to a phone and ‘playing phone tag’ became common, the social assistance department was less accessible.	15
Online/remote services and communication not adequate replacements for in-person services	In-person visits are necessary to adequately provide services related to social assistance to people with disabilities.	10
Change in case worker or case worker availability	The accessibility to the social assistance department suffered due to changes in case worker or case worker availability during the pandemic.	9
Category: More accessible (N = 7)		
Definition: Social assistance departments were easier to access for people with disabilities during the pandemic.		
Codes	**Definition**	**N**
Online/remote services and communication have been helpful	The option of online/remote services is more accessible and online communications (e.g., email) is preferable to some people with disabilities.	7

Table 6.15. Codes and categories for Question 41: “Is there anything else that you would like to share with DJNO to include in our Just Recovery report which centres disabled people?”

Category: Respect, dignity, and autonomy (N = 11)
Definition: People with disabilities should be respected, valued, included by society and have the autonomy to make their own decisions.
Category: Livable social assistance (N = 10)

Definition: The social assistance provided to people with disabilities should be sufficient to afford their basic needs.
Category: Eligibility and considerations for support (N = 6)
Definition: Eligibility criteria for support should be based on the individual and not be contingent on factors, such as household or marital status.
Category: Universal healthcare (N = 5)
Definition: Healthcare services and resources, including pharmacare, dental care, mental health care, home care, and safe supply, should be accessible and affordable for people with disabilities.
Category: Affordable, safe, and accessible housing (N = 5)
Definition: Safe and accessible housing should be affordable for people with disabilities.