Undue Hardship: Policy Responses to Mental Health-Related Accessibility Barriers in Higher Education

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Abstract

In Canada, 1 in 5 students enters post-secondary with a mental health-related challenge. Many students navigate institutional stigma and ableism without adequate services or support. Learning design is rarely inclusive, and accommodations processes are often inaccessible or ineffective in addressing the demand for mental health-related accommodations. Through interviews with seven experts, including student leaders, accessibility staff, and advocates, this capstone applies a multi-criterion policy analysis to identify policy solutions to address barriers to learning. Interventions assessed include: expanding and improving: a) the accommodations process and b) student services, including student-led services, as well as implementing c) universal design for learning (UDL) and d) whole-campus health promotion. It is recommended that interventions be implemented holistically to create more accessible, equitable, and sustainable learning environments.

Keywords: Mental health; Accessibility policy; Disability; Accommodation; Universal design for learning; Post-secondary education

Dedication and Acknowledgements

This work is dedicated to all those whose presence in academia challenges academic norms.

To my partner Leighton, you are the reason I finished this degree. Thank you for always being my voice of reason when the world (or my mind) is unreasonable and for being the first person I want to celebrate with when the world is good.

To my Mama, after all my years in school, our conversations have been where I've learned the most. Thank you for every phone call, mountain walk, and coffee. To my Baba, thank you for taking my childhood questions seriously. You gave me permission to question how we learn and to re-imagine what education could look like. To Sophia, thank you for being the greatest cheerleader any sister could ask for and for letting me be a part of the brilliant and perfect way you look at the world.

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Land Acknowledgement

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I believe that Indigenization, decolonization, and classroom accessibility are interconnected, and I encourage anyone interested in accessible learning to seek out ways to decolonize and Indigenize their pedagogy. I have been lucky to learn about the work of Indigenizing education from local and visiting knowledge keepers. One leader in education is Q’um Q’um Xiiem, also known as Dr. Jo-ann Archibald, who is Stó:lō with St’at’imc ancestry. Q’um Q’um Xiiem is a leader in this work, and I would like to share four of her recommendations for all those in academic communities:

- Learn local, BC, Canadian colonial history.
- Recognize intergenerational impacts.
- Engage in critical self-reflection.
- Use Indigenous stories and perspectives.

I encourage anyone working in education to seek out the wealth of knowledge, stories, and strategies available to make learning safer for Indigenous students and educators and to increase our collective knowledge and capacity to work toward meaningful reconciliation.

Positionality Statement

As a researcher in mental health, accessibility, and education, I approach this topic through the lens of my lived experience as a student navigating academia with mental illness who has had the privilege to hear the stories of many others with similar experiences. I chose this issue as my research focus out of gratitude for the powerful communities of neurodiverse students and students with disabilities I have been a part of - whose hardship in academia is too often overlooked.

I experience mental illness from the perspective of a white settler and cis-gendered woman. The ways in which social identities are interpreted have a profound influence on experiences of mental health or illness and disability. I have not had to navigate much of the stigma and discrimination that others at the intersections of multiple marginalized identities with mental health-related disability experience. I endeavour to apply an intersectional lens throughout this research to address these limitations, but nothing can replace the lived experience of students with diverse experiences of mental health-related disability.

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List of Acronyms

MHD	Mental health-related disability
NEADS	National Educational Association of Disabled Students
PS	Post-Secondary
PSE	Post-Secondary education
PSI	Post-Secondary institution
SWD	Students with disability
SWMHD	Students with mental health-related disability
UD	Universal Design
UDL	Universal Design for Learning

Glossary

Ableism	The belief that people with disabilities are less valuable or worthy of inclusion in society than those without. This concept refers to the social structures and institutions upheld by these beliefs, which are inherently harmful.
Accessible	A service, institution, or other social organization where people with disabilities have the same opportunity of access as do able members of society. In the context of education, accessibility also refers to the equal opportunity for SWDs to be educated as those without.
Accessibility Provider	A staff member at a post-secondary institution who determines student accommodations and provides disability-related supports
Accommodations	Changes made to learning requirements which address access barriers that exist because of social and institutional ableism. Accommodations allow equal opportunity to pursue education.
Disability	Impairment or functional limitation may be physical, mental, intellectual, cognitive, learning, communicatory, or sensory in nature. A disability may be permanent, temporary, or episodic and be evident, visible, non-evident or invisible.
Equity-Deserving	Those who face barriers to safety, opportunities, and public participation due to systemic discrimination and historical inequities
Mental Health-Related Disability	Experiences of limitation in daily activities because of difficulties with an emotional, psychological, or mental health condition
Undue Hardship	The limit of difficulty at which the duty of accommodation does not apply. This includes health, safety, and financial hardship.
Universal Design	The design of environments to make them accessible to the greatest number of people possible by addressing common barriers to participation.
Universal Design for Learning	Designing the teaching and learning environments to make education accessible to the greatest number of people possible

Executive Summary

In 2022, approximately 1 in 5 students entered post-secondary with a mental health-related challenge or disability. However, higher education is not designed to support students with diverse learning needs, and environments are often inaccessible, stigmatizing, and ableist, negatively impacting educational outcomes for this population.

Generally, post-secondary institutions in so-called Canada have not risen to the challenge of providing accessible education to students with mental health-related disabilities (SWMHDs). Through interviews with student organization representatives, advocates, and accessibility staff, this research investigates four policy solutions to increase SWMHDs' access to higher education:

1. improving the accommodations model
2. implementing universal design for learning (UDL)
3. improving student services and support, and
4. addressing stigma and campus culture.

Twelve evaluation criteria were used to assess these options. The key objective of 'increasing access to academia' includes five sub-criteria that measure: access to course content, connection and contribution, awareness, interactions with the medical system, and self-advocacy. Other evaluation criteria are included in the categories of short-term and long-term effectiveness, stakeholder acceptance, cost, and equity impacts.

The Accommodations Model and Universal Design for Learning

Improving accommodations processes and implementing Universal Design for Learning (UDL) are different solutions to the same root issue: academia is not accessible. Students with mental health-related disabilities face unique barriers to learning, and the demand for appropriate academic accommodations is increasing. Accommodations address this issue by improving access through individual coursework alterations. However, the accommodations process is often inaccessible or ineffective for SWMHDs. Therefore, changes must be made to improve the accessibility and efficacy of the accommodations process.

With an increased demand for accommodations and low institutional capacity to support their implementation, increasing provision without changes to learning design is

unlikely to be sustainable. Implementing UDL is a long-term solution that shifts accessibility from the individualized, deficit model of medical accommodations towards an inclusive education model that addresses all students' diverse learning needs.

Findings indicate that immediate changes to the accommodations model can improve accessibility and efficacy and address immediate needs. At the same time, UDL is implemented as a long-term, sustainable solution to accessibility barriers in education.

Student Services/Support and Stigma/Campus Culture

Services and supports have the potential to alleviate the impacts of ableism, inaccessibility, and stigma faced within and outside academia. The need for complex mental healthcare is urgent, and the need for safe and accessible services and student-led support are integral to supporting students. Improvements to student support are necessary to fill critical gaps in the immediate term and to meet complex ongoing needs.

While current services and supports must be improved to meet demand, increasing the capacity of services without addressing root causes is not sustainable. Health promotion is a root-cause, whole-community approach to addressing accessibility barriers, including barriers to services, education, and the social environment.

Findings indicate that increasing capacity and improving student services, especially mental health and student-led supports, should be implemented as soon as possible to meet student needs. Long-term, implementing health promotion in PSIs can increase accessibility through whole-community, systems-level changes and decrease demand for student services emerging from campus culture and academic ableism.

Recommendations

A holistic approach to mental health-related accessibility in post-secondary institutions is recommended. Short-term policy solutions to improve the accommodations model and student services and supports should be implemented to meet the immediate need of students while long-term solutions for UDL and health promotion are implemented sustainably.

The Accommodations Model and Universal Design for Learning

Short-term: Improving the Accommodations Model

- **Increase the capacity of providers**: increase accommodation-related support to students and faculty.
- **Require and support professional development for providers**: mental health awareness, cultural sensitivity, and trauma-informed care.
- **Streamline documentation requirements**: allow more professionals to provide documentation and remove requirements for DSM-5 diagnoses.
- **Clear communication through the accommodations process**: onboarding, outreach, accommodation options, and check-ins.
- **Seek feedback and involvement from students and faculty**: review and improve the accommodations process and implement feedback mechanisms.

Long-term: Implementing Universal Design for Learning

- **Establish a UDL development role** to support professional development and implementation processes.
- **Provide fully supported professional development** in UDL practices.
- **Form or connect with communities of practice** for faculty to share their knowledge, learning process, and tools.
- **Develop co-designed implementation plans** for institutions, departments, or programs based on the capacities and needs of faculty and students.

Student Services and Health Promotion

Short-term: Improving Student Services and Supports

- **Provide and support professional development for all health-related roles**: crisis intervention, cultural sensitivity, and trauma-informed care.
- **Increase mental healthcare capacity**: support complex and ongoing mental healthcare needs.
- **Integrate Universal Design** in all student services and communications.
- **Provide up-to-date funding information** for disability-related funding.
- **Support and amplify student-led organizations**: through funding, dedicated space, and referral.

- **Implement feedback and policy co-design mechanisms**: review and improve services based on consultation or codesign between students and staff.

Long-term: Implementing Health Promotion on Campus

- **Prioritize and support mental health and accessibility** in individual institutions, programs, and classrooms.
- **Engage with Health Promotion-based communities of practice** (ex., BC's Healthy Minds/Healthy Campuses)
- **Designate department leaders** in health promotion.
- **Create diverse leadership committees,** including students, faculty, and staff.
- **Increase opportunities for storytelling, collaboration, and community** throughout the institution and within academia.
- **Increase opportunities for equitable feedback and policy codesign** throughout the institution.

Conclusion

These policy interventions are intrinsically interconnected and interdependent. Based on these findings, it is recommended that each policy solution be implemented holistically to address immediate student needs and to create long-term, sustainable solutions to accessibility barriers for SWMHDs in post-secondary.

Accessibility cannot be retrofitted into ableist structures. Instead, as academia strives to become more equitable, post-secondary institutions must integrate accessibility as a holistic framework that reduces barriers for all members of academic communities and increases opportunities for diverse and historically excluded voices to be heard within and beyond academia.

Chapter 1. Introduction

In so-called Canada, 1 in 5 students enters post-secondary with a mental health-related challenge[1]. For these students, higher education is often perilous. Students are required to navigate institutional barriers of stigma and ableism without sufficient support. In classrooms, learning design is rarely inclusive, and when these students seek accommodations, they often find them inaccessible or ineffective.

This capstone examines accessibility barriers and solutions for students with mental health-related disabilities (SWMHDs) with a grounding in British Columbia's legislation. Recommendations for upstream and downstream policy solutions to increase the accessibility of post-secondary institutions are proposed in relation to the accommodations model, curriculum design, student services and supports, and institutional stigma and culture.

1.1. Population

For this research, the definition of mental health-related disabilities (MHDs) is "those who experience limitations in their daily activities because of difficulties with an emotional, psychological, or mental health condition."[2] The four most common types of MHDs are depression, anxiety, bipolar disorder, and severe stress disorders.[3]

While this research focuses on barriers faced by students with mental health-related disabilities (SWMHDs), this study often refers to students with disabilities (SWDs) more generally for the following reasons: 1. available research may not disaggregate findings by disability types; 2. participants often applied a pan-disability lens to discuss impacts across disability types.

This study focuses on barriers faced by those enrolled in Canadian post-secondary institutions (PSIs) and does not include the numerous barriers for those in pre-enrollment or alums.

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[1] Canadian University Survey Consortium, "2022 First-Year Students Survey Master Report."

[2] Government of Canada, "Accessibility Findings from the Canadian Survey on Disability, 2017."

[3] Government of Canada.

1.2. Conceptualizing Disability

The term *mental health-related disability* was chosen for consistency with the Government of Canada but is not accurate for all persons who experience mental health challenges. While this research uses the term *disability,* members of this population may identify with different terms and conceptualizations of their experiences.

The definition and conceptualization of disability are highly contextual. Institutional policies for accommodation are based on the medical model, where barriers are conceptualized as individual deficiencies. The biopsychosocial model conceptualizes disability as an individual *and* societal experience, wherein barriers are conceptualized as within an individual *and* the social environment. [4]

Whereas the medical model would situate barriers to education solely within the student, the biopsychosocial model supports the perspective that institutional barriers also exist and that institutions are accountable for those barriers. As the biopsychosocial model is widely adopted and informs the framework for the World Health Organization's International Classification of Functioning, Disability and Health, this model will be used when discussing disability.

A complementary philosophy to the biopsychosocial model is the *neurodiversity paradigm*. This philosophy challenges the medical standard of 'normal' cognition and holds that the range of human cognition is a part of human diversity.[5][6] The value in utilizing the neurodiversity paradigm with the biopsychosocial model of disability is its focus on cognition, mental health, and learning. As such, this research grounds itself in the neurodiversity paradigm and biopsychosocial as frameworks to engage with and challenge discriminatory beliefs and cultures within academia. Table 1.1. shows the key differences between these models in the context of education:

[4] Petasis, "Discrepancies of the Medical, Social and Biopsychosocial Models of Disability; A Comprehensive Theoretical Framework."No Reference

[5] Chapman, "Neurodiversity and the Social Ecology of Mental Functions."

[6] Singer, *NeuroDiversity*.

Table 1.1. Models of Disability

Medical Model of Disability	Biopsychosocial & Neurodiversity Models
Variation is disordered	Variation is part of the human experience
Barriers lie within the individual	Barriers lie within the individual & environment
Institutions are not obligated to reduce barriers	Institutions are obligated to reduce barriers

Full and Equal Participation in Education

The Accessible Canada Act states: “all persons must have barrier-free access to full and equal participation in society, regardless of their disabilities”.[7] A guiding principle of this research is that SWMHDs should have such access to participation in higher education. This research considers barrier-free access to PSE to include all aspects of education, including course content, the academic community, and student services, allowing SWMHDs to realize their educational, vocational, and social potential.

[7] Government of Canada, Accessible Canada Act.

Chapter 2. Background

2.1. Mental Health

In 2021, mental health challenges directly impacted approximately 1 in 4 Canadians, a rate that had increased from 1 in 5 before the COVID-19 pandemic.[8] For those experiencing a disability before the pandemic, the social, economic, justice, and health impacts have exacerbated experiences of disability.[9]

Youth with mental health conditions in so-called Canada are nearly 30 percentage points less likely to enroll in PSE than those without.[10] If they do enroll, the nature of their symptoms are often stigmatized in academic environments, particularly where ableist beliefs surrounding excellence and the mind are prevalent. [11][12]

Increasing need for mental health support on campuses and incommensurate provincial and national approaches to funding have led to a "mental health crisis on campuses."[13] Under-resourced counselling and wellness centers often struggle to provide appropriate and effective care to all students, including the specialized care SWMHDs require.[14] Youth are at high-risk for suicidal ideation, for whom suicide is the second-most common cause of death, and up to 90% of people who die by suicide are believed to have a mental illness or substance use issue.[15] As such, SWMHDs experience a high risk of mental health crises and suicidality.

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[8] Statistics Canada, "Survey on COVID-19 and Mental Health."

[9] Statistics Canada, "The Daily — Participants with Long-Term Conditions and Disabilities Report That the Pandemic Is Taking a Toll on Their Mental and Physical Health."

[10] Statistics Canada, "Are Mental Health and Neurodevelopmental Conditions Barriers to Postsecondary Access?"

[11] Condra et al., "Academic Accommodations for Postsecondary Students with Mental Health Disabilities in Ontario, Canada."

[12] Price, *Mad at School*.

[13] Szeto et al., "Increasing Resiliency and Reducing Mental Illness Stigma in Post-Secondary Students."

[14] Priestley et al., "Student Perspectives on Improving Mental Health Support Services at University."

[15] Public Health Agency of Canada, "Suicide in Canada."

2.2. Employment

In their 2021 report, The Canadian Human Rights Commission (CHRC) cited employment as a top priority for persons with disabilities.[16] Canadians with disabilities are less likely to be employed than those without (59% vs 80%), and those who are employed are more likely to have lower labour market outcomes than their non-disabled peers.[17] These factors are exacerbated by the gender wage gap and other social factors that limit employment opportunities. [18] Canadians with disabilities are more likely to live in poverty, particularly those with more severe disabilities, who were 18 percentage points more likely to be living in poverty than those without any disabilities.[19]

Educational attainment is a significant factor in employment rates for all Canadians, including those with disabilities. [20] Particularly for those with more severe disabilities, rates of employment increase significantly as education increases. For example, among women with more severe disabilities, employment jumps from approximately 29% to 58% with a university credential.[21]

2.3. Disability in Post-Secondary

People with disabilities are twice as likely not to finish PS than those without.[22] A 2020 survey found that approximately 60% of Canadians with a disability reported they had not achieved the level of education they aspired to – a rate nearly 20 percentage points higher than those without a disability. [23] In addition, youth with disabilities are less

[16] Canadian Human Rights Commission, "Stronger Together."

[17] Statistics Canada, "A Demographic, Employment and Income Profile of Canadians with Disabilities Aged 15 Years and over, 2017."

[18] Statistics Canada.

[19] Statistics Canada.

[20] Statistics Canada.

[21] Statistics Canada.

[22] Berrigan, Scott, and Zwicker, "Employment, Education, and Income for Canadians with Developmental Disability."

[23] Rubab Arim, "A Profile of Persons with Disabilities among Canadians Aged 15 Years or Older, 2012."

likely to attend post-secondary than those without, with rates of enrollment decreasing as the severity of disability increases.[24][25]

The number of PS students who report having a disability is increasing yearly. According to CUSC data, in 2013, 9% of first-year students reported having a disability, with 4% reporting a mental health-related disability.[26] In 2019, approximately 1 in 4 first-year PS students reported a disability or impairment, accelerating to 1-in-3 in 2022, with 20% of all students reporting a mental health-related disability or impairment.[27]

The 'invisibility' and episodic nature of MHDs, combined with the prevalence of stigma and lack of mental health awareness, create unique barriers within the learning and social environments of academia for SWMHDs.[28][29] As there is limited disaggregated data and significant overlap within disability (approximately 60% of youth aged 15 to 24 years had more than one disability type), the following section can serve as an overview of barriers faced by SWMHDs.[30]

Despite a more significant proportion of SWDs, they are likelier to have a lower GPA and to fail or drop courses than students without disabilities.[31] The barriers SWDs face often result in them taking fewer courses, taking longer to finish their studies, having their studies interrupted, or discontinuing their studies.[32]

Roughly 40% of SWDs reported social exclusion and 27% experienced bullying.[33] Graduate students with disabilities (GSWDs) were more likely to rate their experience negatively than those without (21% versus 32%) and were less likely to be satisfied with their research experience, professional development, coursework,

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[24] Rubab Arim.

[25] Max and Waters, "Breaking Down Barriers."

[26] Canadian University Survey Consortium, "2013 First-Year University Student Survey Master Report."

[27] Canadian University Survey Consortium, "2019 First Year Survey Master Report."

[28] Harrison, "Episodic Disabilities and Post-Secondary Education."

[29] Statistics Canada, "Are Mental Health and Neurodevelopmental Conditions Barriers to Postsecondary Access?"

[30] Statistics Canada, "A Demographic, Employment and Income Profile of Canadians with Disabilities Aged 15 Years and over, 2017."

[31] Parsons et al., "Accommodations and Academic Performance."

[32] Rubab Arim, "A Profile of Persons with Disabilities among Canadians Aged 15 Years or Older, 2012."

[33] Clarke, "A Mental Health Snapshot of the 2016 CGPSS Data."

interactions, and programs.[34] SWDs also report greater student debt at both the undergraduate and graduate levels.[35] In 2017, a quarter (26%) of Canadians with disabilities had an unmet disability-related need due to cost.[36] Financial need has been identified as a factor in the high rate of SWDs terminating their education.[37]

Disability does not only impact students. Approximately 7% of college and university professors, faculty, teachers, or researchers report a disability.[38] However, rates of disability among academics are likely underreported; this population was more than 20 percentage points more likely to experience harassment and discrimination compared to those without disabilities and less likely to receive funding.[39][40]

People with disabilities are frequently over-researched but under-represented as knowledge producers.[41] When marginalized persons are excluded from higher education, educational systems perpetuate the exclusion of diverse ways of knowing from academia.[42] The result excludes ways of learning, teaching, and knowing from academic communities, disciplines, and shared social knowledge.

2.4. Intersectionality

Disability is not homogenous, and experiences of disability are influenced by social positionality. In so-called Canada, 14% of persons (15 and older) with a disability are a visible minority.[43] In addition to interpersonal and systemic racism within Canadian society, for students who are members of a visible minority, the challenges of acquiring

[34] Clarke, "Comparison of Graduate Students with and without Disabilities Using 2016 CGPSS Data."

[35] NEADS, "Landscape of Accessibility and Accommodation in Post-Secondary Education."

[36] Statistics Canada, "A Demographic, Employment and Income Profile of Canadians with Disabilities Aged 15 Years and over, 2017."

[37] NEADS, "Landscape of Accessibility and Accommodation in Post-Secondary Education."

[38] Statistics Canada, "Selected Population Characteristics of Postsecondary Faculty and Researchers by Region, Role, and Employment Status."

[39] Statistics Canada, "Unfair Treatment, Discrimination or Harassment among Postsecondary Faculty and Researchers."

[40] Statistics Canada.

[41] Lillywhite and Wolbring, "Undergraduate Disabled Students as Knowledge Producers Including Researchers."

[42] Gold, "Scholars on the Margins, or Marginalized Scholars?"

[43] Statistics Canada, "The Visible Minority Population with a Disability in Canada."

accommodations and navigating PSE are often exacerbated by stigma, racism, and bias.[44] Socioeconomic status is a predictor of students' ability to benefit from the accommodations process and other PS barriers.[45] Students from wealthier backgrounds were more successful navigating the accommodations process due to financial support and "cultural and social capital that mitigate the stigma associated with disability."[46]

Students also face the intersecting barriers of disability and gender. People who identify as non-binary or transgender experience greater mental health-related challenges *and* barriers to accessing medical services.[47] On campuses, women with disabilities were found to experience sexual violence at a rate nearly double (15% vs 8%) those without.[48] There is significant co-morbidity between MHDs and substance use.[49] As the onset of MHDs is commonly in adolescence, youth with MHDs who use substances are at increased risk of fatal or non-fatal overdoses due to the unregulated drug poisoning emergency.[5051]

While the scope of this research restricts a broader analysis, it should be noted that ethnicity, sexuality, religion, and other axes of marginalization all have unique relationships with disability and mental health.

Indigeneity

Indigenous peoples in so-called Canada are at higher risk of disability than non-Indigenous Canadians and face greater barriers in meeting disability-related needs within the healthcare system, where discrimination and stigma contribute to medical harm.[52] However, disability is not a fixed term universally, nor does it exist independently

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[44] Statistics Canada.

[45] Waterfield and Whelan, "Learning Disabled Students and Access to Accommodations."

[46] Waterfield and Whelan.

[47] Navarro et al., "Health and Well-Being among Non-Binary People."

[48] Statistics Canada, "Students' Experiences of Unwanted Sexualized Behaviours and Sexual Assault at Postsecondary Schools in the Canadian Provinces, 2019."

[49] NIDA, "Common Comorbidities with Substance Use Disorders Research Report."

[50] *NIDA.*

[51] Wyton, "Campus Life Is Returning. Will Toxic Drug Deaths Increase Too?"

[52] Turpel-Lafond, "In Plain Sight."

of culture, social positionality, or individual experience. The models of disability used and cited in this research are derived from the same Western ontologies that serve colonialism and the settler state. As such, when this research refers to 'disability,' it does so with the recognition that no model should be assumed to fully describe Indigenous experiences by non-Indigenous researchers.

In 2016, just over 10% of Indigenous peoples in so-called Canada aged 25-64 had obtained university degrees, compared with nearly 30% of settler Canadians. Because of ongoing colonial legacies of residential institutions and medical systems, Indigenous youth with disabilities entering PSIs face systemic barriers that may be intertwined with community, ancestral, or personal trauma.[53] Robin Wall Kimmerer describes the tension between colonial educational structures and Indigenous ways of knowing in her collection of essays on the relationship between Indigenous wisdom and western science, *Braiding Sweetgrass*. Kimmerer describes her first day of college:

> "It was happening all over again, an echo of my grandfather's first day at school when he was ordered to leave everything—language, culture, family—behind. The professor made me doubt where I came from and what I knew and claimed that this was the right way to think. Only, he didn't cut my hair off".[54]

Two Calls to Action from the Truth and Reconciliation Commission have been identified to inform this research and to investigate how potential policy solutions might impact Indigenous students:

> 23.iii. Provide cultural competency training for all health-care professionals.
> 62.ii Provide the necessary funding to post-secondary institutions to educate teachers on how to integrate Indigenous knowledge and teaching methods into classrooms.[55]

While this research is limited in scope, the intersection of disability, education, and Indigeneity allows for an opportunity to engage with opportunities to challenge colonial educational systems.

The "In Plain Sight" report has been included as it contains the lived experiences of Indigenous peoples and their interactions with BC's medical system. In citing this report, I do not intend to promote the views of Turpel-Lafond, rather, I intend to amplify the voices of participants who shared their stories.

[53] Winder, "Post-Secondary Education (PSE) Indigenous Students' Perspectives."

[54] Kimmerer, *Braiding Sweetgrass*.

[55] Truth and Reconciliation Commission of Canada, "Truth and Reconciliation Commission of Canada: Calls to Action."

2.5. Accommodations in Post-Secondary Institutions

Access to accommodations is a significant factor in academic success for SWDs. The loss of accommodations in the transition period from high school to PS is correlated with lower GPAs and higher rates of dropped and failed courses.[56] Accommodations are changes to the learning environment, curriculum or equipment that aim to meet the accessibility-related needs of students without changing core learning requirements.[57] Table 2.1. shows examples of accommodations that may be used by SWMHDs depending on institutional policies:

Table 2.1. Examples of accommodations*

Barrier	Examples	Potential Accommodation
Medication side effects	Drowsiness, fatigue, blurred vision, hand tremors, slowed response time	Exams begin/end by a certain time Extended testing periods
Time pressure and task limits	Difficulty managing assignments and meeting deadlines; inability to multi-task	Deadline extensions Early availability of syllabus/course materials
Limits to stamina	Difficulty sustaining energy all day	One test/exam per day Priority registration
Social limits	Difficulty getting along, contributing to group work, and reading social cues	Alternatives to group work Pre-arranged breaks
Environmental stimuli limits	Inability to block out sounds, sights or odors that interfere with focus; limited ability to tolerate noise/crowds	A reduced-distraction testing environment preferential seating
Severe anxiety	Anxiety that results in someone being emotionally and physically unable to complete tests/assignments	Alternatives to traditional tests Written assignments in lieu of oral assignments and vice versa
Concentration challenges	Restlessness, shortened attention span; difficulty understanding/recalling verbal directions	Notetaker Recorded lectures

Source: Original table by author. Information drawn from the following sources: Souma, A., Rickerson, N., & Burgstahler, S. (2012); DO-IT (n.d.).[58]

[56] Parsons et al., "Accommodations and Academic Performance."

[57] British Columbia Ministry of Advanced Education, "The Disability Services Framework."

**I'm very thankful to Marguerite Pigeon for helping me to format this table*

[58] Souma, Rickerson, and Burgstahler, "Academic Accommodations for Students with Psychiatric Disabilities"; DO-IT, "Accommodating Students with Psychiatric Disabilities."

Accommodations are determined on a ‘case-by-case’ basis. Providers determine ‘reasonable’ accommodations through analysis of medical documentation, the impact of the disability, and essential course or program outcomes.[59] A request is considered unreasonable if it imposes “undue hardship” on faculty regarding *health, safety,* and *cost.* This threshold emerges from the *Canadian Human Rights Act*.[60] In so-called BC, *The Disability Services Framework* serves as a general guideline.[61]

2.6. Legislation

The rights of SWDs to full inclusion in educational institutions are protected under international, federal, and provincial legislation. In 2010, so-called Canada ratified the United *Nations Convention on the Rights of Persons with Disabilities* (CRPD) ensuring equality under the law and non-discrimination for persons with disabilities, including access to education. [62][63] Federal laws protecting people with disabilities are the *Canadian Human Rights Act* and the *Canadian Charter of Rights and Freedoms*. [64][65]

Following the federal *Accessible Canada Act* in 2019, the 2021 *Accessible British Columbia Act* was passed, requiring certain organizations – including post-secondary institutions - to establish accessibility committees responsible for developing accessibility plans that remove barriers for persons with disabilities.[66] Plans are to be completed as of September 2023 and should incorporate principles of inclusion, adaptability, diversity, collaboration, self-determination, and universal design. [67]

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[59] British Columbia Ministry of Advanced Education, “The Disability Services Framework.”

[60] Government of Canada, Canadian Human Rights Act 1976-77, c. 33, s. 1.

[61] British Columbia Ministry of Advanced Education, “The Disability Services Framework.”

[62] United Nations, “Convention on the Rights of Persons with Disabilities.”

[63] United Nations.

[64] Government of Canada, Canadian Human Rights Act 1976-77, c. 33, s. 1.

[65] Government of Canada, Canadian Charter of Rights and Freedoms, Part 1 of the Constitution Act, 1982, being Schedule B to the Canada Act 1982 (UK), c 11.

[66] Government of Canada, Accessible Canada Act.

[67] Government of Canada.

2.7. Conclusion

An increasing rate of SWMHDs face barriers to accessing PSE which negatively impacts their educational attainment and employment. Additionally, intersectional experiences of disability result in additional barriers for students experiencing marginalization in other ways. The accommodations model, based on human rights legislation, is the primary approach to supporting SWMHDs within educational environments.

Chapter 3. Methodology

The questions that guided this research were: 1. What are the barriers to accessing education for students with mental health-related disabilities, and 2. What solutions to these barriers exist? These questions shaped the scope of the literature review and interview questions.

Findings from a literature review and experts' interviews comprised the data for this multi-criteria policy analysis. The literature review provided an overview of upstream and downstream access barriers and solutions. The literature review was used to develop a framework for policy solutions (i.e., potential policy options) and interview questions and to determine criteria for analysis. The literature review search included combinations of the terms: “accessibility,” “disability,” “post-secondary,” “higher education,” “stigma,” “universal design,” “accommodations,” “mental health,” “psychiatric disability,” and related terms. In addition, Canadian contexts were utilized where available. The search engines used were the Simon Fraser University Library search engine, Google, and Google Scholar.

The study Principal Investigator (PI) (MT) conducted interviews with participants between December 5th and 28th, 2022. A list of potential interviewees was based on personal contacts, web searches, and recommendations. Participants were required to be over 19 years of age and not currently experiencing a mental health crisis. Student interviewees were required to lead or have led student disability groups and were given an honorarium of $30.

Of the seven participants, one was a former advocate working nationally to support students with disabilities, and two were present or former executives of student-led disability support organizations at post-secondary institutions. Three worked with provincial organizations in mental health. One was an accessibility provider at a post-secondary institution. The contributions of those with disclosed disabilities are directly quoted more frequently to amplify their perspectives.

All participants were provided with and reviewed a consent form with the PI before interviews and provided written or verbal consent. All interviews were conducted 1:1 except one interview, which included three participants from one organization. All interviews lasted approximately 1 hour and were held over zoom. All interviewees were

given questions based on the interview guide (Appendix A). While some participants were asked targeted questions about specific options based on their expertise, each had an opportunity to comment on all potential policy options.

Interview data were analyzed through thematic analysis.[68] Interviews provided feedback, nuance, and details for the policy solutions. Most interview data were analyzed within the framework of the four policy options, while intersectional findings and other impacts were analyzed across all options.

This study received ethics approval from Simon Fraser University.

[68] Braun and Clarke, "Using Thematic Analysis in Psychology."

Chapter 4. Literature Review

Based on a review of the current literature, two upstream and two downstream approaches were identified to have potential to address accessibility barriers and increase access for students with mental health-related disabilities (SWMHDs). The following table shows the four approaches:

Table 4.1. Policy approaches to address accessibility barriers

Downstream Approaches	Upstream Approaches
1. improving the accommodations model 3. improving student services and supports	2. implementing universal design for learning 4. addressing stigma and campus culture

4.1. Improving the Accommodations Model

Operating within the medical model of disability, the accommodations model assumes the responsibility to reduce barriers lies with the student rather than the institution. Access to accommodations is unequal, and factors such as power dynamics, student ethnicity and socioeconomics impact supports and outcomes.[69][70] For those who acquire accommodations, ongoing self-advocacy required of students to legitimize their needs as they interact with the medical system, accessibility providers, and faculty may significantly impact academic success, mental health, and overall well-being.[71] The following are barriers to accessing accommodations which may emerge in this process.

Awareness of Support

Student awareness of disability-related supports in post-secondary (PS) is often low.[72] The National Educational Association of Disabled Students (NEADS) has identified that educating SWDs about options allows students to make informed

[69] Freedman, Dotger, and Song, "Encountering Ableism in the Moment."

[70] Waterfield and Whelan, "Learning Disabled Students and Access to Accommodations."

[71] Easterbrook et al., "The Legitimization Process of Students with Disabilities in Health and Human Service Educational Programs in Canada."

[72] Toutain, "Barriers to Accommodations for Students with Disabilities in Higher Education."

decisions regarding their academics, particularly as significant differences between the K-12 and PS accommodations processes may limit access.[73]

The Medical System

To receive accommodations, students typically meet with a medical specialist (either on or off campus) to acquire paperwork that 'legitimizes' their needs.[74] As a result, students are required to identify their experiences as a medical issue, even if this does not align with their self-perception. For SWMHDs, this typically requires psychiatrist's assessment, which can be a costly and lengthy process; as of 2022, the wait time for a psychiatric evaluation in so-called BC could be more than a year.[75][76] Accommodations are often not available in the interim, and students may have to delay their education or attempt their coursework without accommodations.[77] Additionally, medical professionals typically do not receive training recommending accommodations, so paperwork does not guarantee effective learning changes.[78]

Accessibility Provision

The relationship between students and accessibility providers is often regarded by students as bureaucratic and lacking in self-determination.[79] The term 'gatekeeping' is often used to describe this model, designed to filter 'qualified'' students based on medical classification.[80] Compounding this lack of self-determination, NEADS reports

[73] Toutain; NEADS, "Landscape of Accessibility and Accommodation in Post-Secondary Education."

[74] British Columbia Ministry of Advanced Education, "The Disability Services Framework."

[75] NEADS, "Landscape of Accessibility and Accommodation in Post-Secondary Education."

[76] Truth and Reconciliation Commission of Canada, "Truth and Reconciliation Commission of Canada: Calls to Action."

[77] Broffman, "Academic Accommodations for College Students with Psychiatric Disabilities."

[78] Harrison, Holmes, and Harrison, "Medically Confirmed Functional Impairment as Proof of Accommodation Need in Postsecondary Education."

[79] Broffman, "Academic Accommodations for College Students with Psychiatric Disabilities."

[80] NEADS, "Landscape of Accessibility and Accommodation in Post-Secondary Education."

that students are subject to the biases of providers which can negatively impact outcomes.[81]

The policies and procedures of providers are not currently standardized or enforced in so-called Canada, although NEADS has proposed guidelines that aim to standardize and improve the model.[82] NEADS' publication "Enhancing Accessibility in Post-Secondary Education Institutions" includes promising practices for the onboarding process, communications, feedback processes on the efficacy of accommodations, inclusive design of services, procedural flexibility and clarity, professional development, and mentorship opportunities.[83] Potential improvements to the accommodations model are hindered by a chronic underfunding of accessibility services relative to the increasing demand, as such, staff are often limited in the support they can provide. [84]

Faculty

Students report that the power disparity between faculty and students is a barrier to implementing accommodations.[85] Additionally, there is a lack of whole-institution training in accessibility, including for faculty, on how to approach accommodation-related conversations with students.[86]

Faculty may perceive accommodations as detrimental to academic integrity; however, these perceptions were not supported by the literature.[87][88] Concerning disability and academic ethics, recent scholarship advances the "*ethical imperative for educators to ensure that they develop and present learning materials in ways that empower students to learn*" as part of a whole-community approach to academic

[81] NEADS.

[82] NEADS, "Enhancing Accessibility in Post-Secondary Education Institutions."

[83] NEADS.

[84] Sokal, "Five Windows and a Locked Door."

[85] Hutcheon and Wolbring, "Voices of 'Disabled' Post Secondary Students."

[86] NEADS, "Landscape of Accessibility and Accommodation in Post-Secondary Education."

[87] NEADS.

[88] Pagaling, Eaton, and McDermott, "Academic Integrity."

ethics.[89] This view is unified with the differentiated teaching approach found in universal design for learning.

4.2. Implementing Universal Design for Learning

Student populations are becoming increasingly learning-diverse. However, despite multidisciplinary research demonstrating that individuals process and deliver information differently, syllabus development, instruction, and assessments are not commonly developed with diverse learners in mind.[90]

While multiple models for inclusive and accessible instruction exist, Universal Design for Learning (UDL) is the most common. UDL applies the framework of Universal Design - accessible design for any environment - to learning environments.[91] By providing multiple means of engagement, representation, and action and expression (see Appendix B for a detailed description of principles), UDL aims to support as many learners as possible while honouring the essential requirements of the course, program, or discipline.[92][93] Based on decades of research in neuroscience, psychology, and education, UDL supports a spectrum of learning styles by embedding variations for intaking information and demonstrating understanding within the curriculum.[94]

UDL has been identified as barrier-reducing for SWMHDs, as it can pre-emptively address MH-related instructional, testing, setting, and timing/scheduling barriers that students currently rely on accommodations for.[95]

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[89] Pagaling, Eaton, and McDermott.

[90] Schreiner, Rothenberger, and Sholtz, "Using Brain Research to Drive College Teaching."

[91] CAST, "About Universal Design for Learning."

[92] NEADS, "Landscape of Accessibility and Accommodation in Post-Secondary Education."

[93] CAST, "About Universal Design for Learning."

[94] CAST, "Universal Design for Learning Guidelines Version 2.2."

[95] Fovet, "Exploring the Potential of Universal Design for Learning with Regards to Mental Health Issues in Higher Education."

Equity and UDL

UDL improves learning experiences for culturally or linguistically diverse students or those who experience academic consequences stemming from structural barriers[96]. Models such as Integrated Multicultural Instructional Design can expand UDL principles to increase safety in classroom culture and curriculum design.[97] UDL has been used to increase Indigenous teaching practices through curriculum co-creation with Indigenous students to incorporate storytelling, inclusive participation design, and photovoice.[98]

Implementing UDL

The primary critique of UDL is its implementation challenges. Faculty in PS do not typically receive UDL training and support in integrating UDL principles is generally not available, nor is support for transitioning curriculum, including technological support. Faculty may perceive that implementing UDL will increase their workload or require technological expertise.[99] Additionally, faculty may have a philosophical disagreement with UDL.[100] Although numerous case studies have demonstrated efficacy, research into student outcomes is lacking, and no standardization of what UDL should look like or how it should be measured has been widely adopted.[101]

An ecological approach which accounts for the complexity of institutional systems would likely be a beneficial approach to implementing UDL.[102] This approach accounts for the variability of institutions and necessitates shared ownership over UDL initiatives

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[96] Chita-Tegmark et al., "Using the Universal Design for Learning Framework to Support Culturally Diverse Learners"; Rao, "Universal Design for Learning and Multimedia Technology."

[97] Couillard and Higbee, "Expanding the Scope of Universal Design."

[98] Fovet, "Universal Design for Learning as a Tool for Inclusion in the Higher Education Classroom."

[99] Fovet, "Developing an Ecological Approach to the Strategic Implementation of UDL in Higher Education."

[100] Fovet.

[101] Gidden and Jones, "Examining the Impact of Universal Design for Learning (UDL) on Minimizing Academic Accommodations in Post-Secondary."

[102] Fovet, "Developing an Ecological Approach to the Strategic Implementation of UDL in Higher Education."

which could involve “accessibility services, other student services units, teaching and learning departments, instructional designers, faculty and senior administration.”[103]

4.3. Comparing the Accessibility Model to UDL

The accommodations model operates on the assumption that the number of people requiring changes to the learning environment is small enough that providers and faculty can provide this on a case-to-case basis. However, as the number of students requiring accommodation increases each year, the model of individual exemption risks becoming unsustainable. Conversely, Universal Design for Learning (UDL) pre-emptively accounts for the variability of learning styles, which decreases the need for individual accommodations and therefore reduces the need for self-advocacy and unwanted interactions with the medical system, accommodations, and faculty.

4.4. Improving Student Services and Supports

Supports that address the unique barriers faced by SWMHDs are essential to student well-being within ableist social and academic systems. Both whole-system and targeted improvements are identified to increase access. Whole-system approaches include inclusive design for all student services, while targeted approaches focus on mental healthcare and student-led support.

Access to Student Services Overall

NEADS identifies that student services staff “consistently identified a lack of professional development around working with students with disabilities.”[104] No standard for accessibility training was identified; however, professional development would likely include training in universal design, disability and accessibility competency, and culturally-sensitive trauma-informed practices.[105]

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[103] Fovet.

[104] NEADS, “Landscape of Accessibility and Accommodation in Post-Secondary Education.”

[105] NEADS.

Mental Healthcare for Students

Proposed improvements to mental healthcare on campuses that address the needs of SWMHDs include increased capacity to shift from reaction to proactive initiatives, address wait times, increase awareness of services, and provide more accessible hours and drop-in services for crisis intervention.[106] In addition, professional development includes culturally-sensitive trauma-informed and crisis-intervention training with a policy review informed by these lenses.[107] Providing disability-specific supports such as counsellor-led support groups also addresses the unique needs of students otherwise not represented in other offered supports.[108]

Student-Led Supports

The role of peer support in supporting persons with mental health challenges is effective at reducing symptom distress and hospitalization, improving social support and quality of life, and capacity-building.[109] It has also been shown to reduce the need for costly services.[110] Therefore, NEADS recommends funding peer support groups and mentorship networks to support the specific needs of SWDs.[111]

4.5. Addressing Stigma and Campus Culture

Stigma experienced by students in PSE is cited as a significant barrier to academic well-being and success. Students may experience stigma in their interactions with student services and administration, during the accommodations process, and with other students.[112] Stigma prevents students from accessing services that would benefit them, including accessing accommodations.[113] SWMHDs often perceive that their

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[106] Priestley et al., "Student Perspectives on Improving Mental Health Support Services at University."

[107] Priestley et al.

[108] Centre for Innovation in Campus Mental Health, "Stepped Care for Post-Secondary Campuses."

[109] "Stepped Care 2.0 Toolkit."

[110] Cyr et al.

[111] NEADS, "Landscape of Accessibility and Accommodation in Post-Secondary Education."

[112] Toutain, "Barriers to Accommodations for Students with Disabilities in Higher Education."

[113] Toutain.

academic careers are jeopardized if they disclose to faculty, and biases against students who use accommodations create additional barriers. [114][115] Additionally, the stigma of disability and disclosure can compound with institutional barriers related to other marginalized social positions.

Health Promotion in Post-Secondary Institutions

The health promotion approach in PS is a whole-campus strategy that seeks to improve mental wellness in PS communities. *The Okanagan Charter*: *An International Charter for Health Promoting Universities and Colleges* guides health promotion on campuses in so-called BC.[116] The Charter's Action Framework for Higher Education includes the following calls to action:

- Embed health in all campus policies.
- Create supportive campus environments.
- Generate thriving communities and a culture of well-being.
- Support personal development.
- Create or re-orient campus services.[117]

The charter describes health promotion as a positive, proactive approach that empowers institutions to employ social and environmental levers to influence the health of academic and broader communities (see Appendix C).

4.6. Comparing Improvements to Student Services and Supports to Addressing Stigma and Campus Culture

Improving student services and support addresses the immediate access barriers and critical needs of students impacted by academic and societal ableism. Health promotion addresses cultural and organizational barriers that cause and exacerbate barriers faced by SWDs. Health promotion is expected to decrease the need for reactive student support, particularly within mental health services.

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[114] Max and Waters, "Breaking Down Barriers."

[115] Pardy, "Head Starts and Extra Time."

[116] "Okanagan Charter."

[117] Truth and Reconciliation Commission of Canada, "Truth and Reconciliation Commission of Canada: Calls to Action."

4.7. Conclusion

Improving the accommodations model and student services and supports by addressing the lack of resources, knowledge and stigma, and unnecessary barriers caused by systemic barriers and academic ableism. Implementing UDL and health promotion address these systemic barriers by integrating inclusive learning and health in all aspects of the PS experience.

Chapter 5. Interview Findings

The following chapter is a thematic analysis of five semi-structured interviews with seven interviewees on the feasibility, nuances, and impacts of the following policy options identified in the literature review:

1. Improving the accommodations model.
2. Implementing universal design.
3. Improving student services and supports.
4. Addressing stigma and campus culture.

Participants often preferred to speak to issues of disability in a pan-disability approach rather than to focus on MHDs. As such, responses to questions often addressed the needs of students with disabilities generally and, most commonly, reflected the needs of those with hidden disabilities.

Table 5.1. shows the represented social positions of participants:

Table 5.1. Interview Participants

Participant Code	Position	Disclosed Disability/ Neurodiversity
Rep.1	Past student representative & advocate (Canada)	Yes
Rep.2	Current student representative (BC)	Yes
Rep.3	Past student representative (BC)	Yes
Provider	University accessibility provider (BC)	No
Advocate1	Mental health advocate (BC)	No
Advocate2	Mental health advocate (BC)	No
Advocate3	Mental health advocate (BC)	No

5.1. Improving the Accommodations Model

Participants identified several barriers and potential solutions with the accommodations model, including capacity, documentation, provider knowledge, communication, and disclosure-related challenges with faculty.

Increased Demand and Low Capacity

Participants reported that while the demand for accessibility services in academia is increasing, the capacity of centers and staff to provide services is often limited.

Nationally, there is a backlog of students accessing accommodations, with as many as 50-100 additional individuals enrolled in some institutions. Within this increase in demand is a dramatic increase in invisible and mental health-related accommodations proportionate to other accommodations:

> "When I first started, there were relatively few students in the center who were being accommodated around mental health. … the mental health needs of students, and in terms of accommodation, has risen dramatically" (Provider).

Not enough time, people, or resources exist to provide effective services as providers struggle to support students in an increasingly complex learning environment with a *"greater range of accommodation needs"* (Provider). Additionally, participants raised concerns about how accessibility providers will navigate incoming COVID-19 long-haulers with unknown and inconsistent symptoms, framing the problem as '*uncharted grounds for post-secondary for years to come'* (Rep.1).

The Gatekeeping Model

As described by participants, the frameworks employed by accessibility providers to provide accommodations in so-called BC are informed by human rights legislation, case law, and professional insights. The duty to accommodate is interpreted to arise when medical documentation is provided. Then, thresholds developed by providers will determine who is eligible based on that documentation:

> "there's typically a threshold then in terms of who can access or, you know, accommodate issues based on disability… you know 'this counts, this meets the standards, this doesn't meet the standard' '" (Provider).

Once the student meets the institution's requirements, faculty must accommodate them to the point of undue hardship. These guidelines are complicated by the nature of mental health symptoms which can be hidden and unpredictable compared to other disabilities.

The perception of accessibility services by some students is of *"fan institution not to provide students with accommodations but to provide as few students as possible with accommodations"* (Rep.2). This gatekeeping function is seen to serve the interests of academic institutions wherein a significant percentage of students might be eligible for accommodations:

> “I think that there's a very real sense in the institution that if everybody who experienced something like anxiety were allowed to access accommodations, then everybody would be getting accommodations - and where would we be then?” (Rep.3).

Medical Documentation

All participants reported that medical documentation is a significant barrier to SWMHDs' access to accommodations. Despite barriers, documentation was also perceived through an institutional lens to legitimize accommodations. Particularly in the case of conflict resolution, the presence of clear policies and standards and a rigorous process were identified as tools for enforcement.

> “That's why having standards on accommodations are important because you need them in those circumstances… you really need to be able to say, ‘hey, we have a rigorous process’ (Provider).

For mental health-related accommodations, specialized assessments can take years to acquire and be prohibitively expensive. Students with pre-existing accommodations from high school or other institutions often find their documentation no longer sufficient and are required to acquire new assessments.

Some need for documentation and standardization in accommodation provision was acknowledged by multiple respondents. However, respondents also recognized that these processes should be supportive:

> “I understand that there is a need for this documentation… we can do it in a way that is helping you through this process and making you feel understood and safe” (Rep.3).

Reducing the complexity of requirements was one identified solution to the medical documentation barrier. A recent human rights case against York University was described which resulted in the removal of the psychiatric diagnosis requirement from the accommodations process. Some PSIs, such as the University of New Brunswick require only a standard doctor’s or service provider’s note and do not require a diagnosis: “*They don't need the details.… It still requires some medical notation, but it's not as invasive” (Rep.1).*

Other solutions include establishing in-house assessment processes (for example, assessments within the faculty of education). This solution has been shown to reduce drop-out rates and wait times. Or to provide interim accommodations while students acquire paperwork. Interim accommodations would be equivalent in quality to those they would receive *with* completed paperwork to ensure no lapse in access.

Mental Health Literacy of Accessibility Providers

Participants report significant differences in how “physical” and MHDs are received and accommodated, with physical accommodations being easier to access compared to MH-related accommodations:

> “As soon as I had this temporary physical disability, then all of a sudden, all these doors were opened… But when I asked for them for the mental health issue, it was like, well no. We can't really get that to you” (Rep.3).

Students seeking accommodations for MHDs report negative experiences with accessibility staff, including that staff do not take mental health barriers seriously: *“It's a very common refrain that I hear that [accessibility providers are] insensitive and standoffish” (Rep.2).* A need for professional development in mental health literacy was identified as academic accommodations are ineffective if they do not align with symptoms or medication side effects.

Transparency and Communication

Participants identified the “bureaucratic wall” with students lacking access to information regarding what accommodations are available and how to access them. Instead of withholding information, approaching students with an *“assumption of good faith”* would mean making students aware of available accommodations. A more iterative relationship between students and providers was identified by one participant who described a potential appointment:

> “Here are the possible accommodations, do you know which of these would work for you?... Let's explore what has worked in the past, what could work for you” (Rep.3).

Participants stressed that information about accessibility services should be communicated clearly to all incoming students. Each incoming student should know how to access this service, whether they are eligible, how the institution defines disability, what accommodations might be available to them, and what kind of documentation they will need to access them.

Participants noted that, because of issues with the model, figuring out what accommodations work for a student can take years. Onboarding practices for students seeking accommodations could be improved by offering confidential drop-in meetings. In addition, participants raised the idea of arranging meetings between incoming and more

senior students who are registered with accessibility services to share stories, skills, and support:

> “So, if you find that shared sense of belonging, that's a great starting point to help a) beat back that impostor syndrome, and b) just help a student find a sense of self [as] early as possible” (Rep.1).

Participants also identified an opportunity for centers to connect students with other campus supports such as mental health services, financial services, or other services, particularly when access barriers are preventing students from accessing these services on their own.

Self-Advocacy and Faculty Dynamics

The disclosure and self-advocacy process was reported as emotionally difficult and academically risky: “if you were to disclose your disability or appear incompetent, that you would be basically shooting yourself in the foot, you would be ruining your own future prospects in academia” (Rep.3). Asking for accommodations from faculty was identified as a primary barrier for students. Students are often required to educate or justify as they advocate for themselves, particularly where faculty lack personal contact with the disability community. Students often face misunderstandings of their conditions or denial of accommodations.

Participants shared that outcomes to disclosure are highly dependent on the level of willingness and knowledge of faculty. The accommodations process assumes not only that students know what they need for each assignment, class, and academic situation but that they have the ongoing capacity to ask for it.

Participants identified a range of responses when approaching faculty with legitimized accommodations, from faculty who offer formal and informal accommodations to registered students to those who resist all accommodations. Participants provided mixed insights into the third group, with some reporting resistance as rare and some as common. Identified reasons for resistance were: 1. Lack of understanding of disability, 2. Lack of understanding about the accommodations process, 3. Philosophical disagreement, and 4. Potential for an increased workload. Faculty who lack disability-related knowledge, particularly of hidden disabilities, may not understand the purpose of accommodations and have concerns about implications for

academic fairness. A lack of knowledge of the *"policy and the process"* of accommodations may also cause resistance in faculty (Provider).

Some faculty "*philosophically just don't agree*" with accommodations due to concerns about academic freedom and the use of accommodations by students; one participant described the response as*: "who are you to tell me that this person needs this, you know, where's my academic freedom? This is how I teach a course… They just don't believe in it"* (Provider). The potential for an increased workload may also cause resistance in faculty.

Participants identified that institutional anxieties of academic dishonesty are often prioritized over the needs of SWDs:

> "It was more about what the *institution* needs and about trying to prevent cheating than it was about recognizing the needs of this one particular student who might need to show their knowledge in a slightly different way" (Rep.3).

Participants identified an assumption that accommodations give students an unfair advantage, particularly when a lack of knowledge of invisible disability exists, and that SWDs are dishonest when asking for accommodations. The result of this is feelings of *"disempowerment and of denial or feeling misunderstood or misrepresented in a way… because, like, I'm not here to cheat" (Rep.3).*

5.2. Implementing Universal Design for Learning

All participants identified universal design for learning (UDL) as a desired and effective approach to increasing access to learning for SWDs:

> "UDL is really designed to meet over 90% of the learning population. Whereas other models… they've got one mindset in mind, one way of teaching, one way of instruction, one way of feedback, one way of testing" (Rep.1).

The essential difference between UDL and traditional curriculum is: *"a disabled student can pass the course and isn't punished for being disabled*" (Rep.2). Status quo curriculum design, one participant remarked, is fair competition only in theory, but *"in a world where disability is very common,"* SWDs are likely to face disproportionate barriers (Rep.2).

Conversely, UDL practices would allow SWDs to participate in otherwise inaccessible spaces. Additionally, UDL *"takes away from the stigma"* of accommodations

due to lower rates of use as accessible learning becomes *"a natural part of the university infrastructure" (Rep2; P).* Participants highlighted the value of UDL in minimizing the increasing need for accommodations:

> "If we just applied principles of good universal design, if everything was just accessible, and we had really good universal design, then an accommodation to some degree might never be necessary" (Provider).

With increased UDL, accessibility services could shift towards consultancy and supporting students, taking a more developmental approach, and working on *"greater issues"* (Provider). Participants suggested that accessibility providers could shift to learning strategy and assistive technology support for faculty. This may include providing frameworks, ideas, easy-to-adopt solutions, and standards that would allow faculty to improve their pedagogy without significantly increasing their workload.

When discussing recent perceptions of universal design for learning, participants reported an increase in "openness" among faculty due to COVID-19 adaptations to learning, as well as an increased societal focus on equity, diversity, and inclusion. When discussing barriers to implementing UDL, participants perceived that although there was low resistance to the concept, complexity was an institutional barrier:

> "I think the principles or *idea* of universal design. I don't think you get a lot of resistance. It's the 'what does that mean? And what does that look like on the ground?'… in an institution as complex as a large university" (Provider).

Participants recommended that the implementation of UDL include workshops and communities of practice for professors and were described as a long-term strategy to increase capacity in departments that *"creates a steady process of systematic change":*

> "They slowly start building capacity among themselves. There's power in that. And then there's power in the fact that they may go back to their department… and they share it with others" (Rep.2).

Respondents report that many faculty are informally implementing elements of UDL already. Interpersonal examples included visiting students taking tests in alternative examination rooms and showing empathy in their interactions. Participants highlighted interactive polling apps to allow participation, automatic captioning, and varying lecture speaking rates as inclusive practices. Hybrid learning was the most identified example of inclusive course design, negating the need for multiple forms of accommodations.

Equity and UDL

Safety for SWDs relates to the safety of other marginalized groups in academia. Responding to the question of whether classroom safety is related to accommodations, one respondent noted that they were not the same but that they are interrelated.

> "If I'm comfortable flexing to people's individual needs and giving them accommodations, then from an intersectional perspective, it then makes sense that I would *also* be okay with understanding their unique needs and respecting them for it" (Rep.2).

UDL was identified as supporting the learning experiences of those from *"complex walks of life"* even if they do not qualify or have the means to acquire accommodations (Rep.1). Respondents found that due to the high cost of assessments and low financial support, "the biggest metric on access to accommodations has most to do with class" (Rep.2). UDL also addresses many of the hidden barriers for those whose families did not attend PSE, those who learn differently, and those with imposter syndrome. UDL was identified as helpful for the specific barriers faced by international students with culture change and language differences.

5.3. Improving Student Services and Supports

Participants identified two complementary approaches to increase mental wellness on campus through student services: making services more accessible through universal design and responding to critical needs through mental health and peer-support services.

Making Services More Accessible

Students entering PS often lack knowledge of institutional structures, available services, and disability-related processes. This process holds particular risk for students with mental health-related disabilities as their transition can exacerbate pre-existing conditions. Participants suggested making onboarding interviews available to all students where their needs can be identified and where information and contacts can be provided:

Using multiple forms of communication with students was identified to reach all types of learners on campus, particularly international students:

> "I would love to see communication in multiple forms… you know, how to sign up for courses, to how to find your classroom, how to make friends, you know, all those things that people wonder about" (Rep.3).

In addition to increasing forms of communication, making online and in-person spaces accessible and welcoming, increasing overt inclusion, and emphasizing representation were reported as potential ways to improve services. Finally, participants identified leadership by Humber College and George Brown College in integrating whole-institution UDL[118][119].

Responding to Critical Needs

Students with mental health-related disabilities frequently rely on their institution's mental health services. However, participants noted that while mental health services are crucial to addressing the unique needs of SWMHDs, students often feel unsupported when they "*really needed it*" or that staff put them *"in a situation that was worse"* (Rep.3). Issues identified by participants were the under-resourcing of mental health supports, stigma experienced by patients – particularly at the front desk, and a fear of the center's handling of crises:

> "There's a sort of gatekeeping, you know, having to get through the front office and the front desk and try to find a way to talk to the person who actually would understand and help you" (Rep.3).

Student-Led Disability Organizations

Participants described how SWDs-led organizations (independent of accessibility providers) provide resources and support for students not offered by their institution. Participants stressed that dedicated staff is essential to the functioning of this organization, without which *"it would not get done" (Rep.2).* Not all institutions have or support these organizations. However, the address the "de*ep need"* for support (Rep.2).

Supports include referral to other supports, help with bureaucracy, and providing advocacy when needed. Staff responsibilities include administration, communications, center upkeep (if applicable), and grant-seeking/sponsorship/bursaries. Providing a

[118] Humber College, "Accessible Education."

[119] George Brown College, "Leveraging a UDL Mindset."

dedicated physical space allows for community-building, resource sharing, and support for students who are often facing barriers to accessing their campuses.

Additional Supports

The barriers of cost to SWDs were repeatedly raised by participants. Making financial aid services more accessible and increasing referral to disability-eligible grants were concrete steps identified by participants. One participant noted that *"Financial aid officers at Universities across the country are not really sharing … the bursaries offered or the scholarships"* that SWDs would be eligible for (Rep.1).

5.4. Addressing Stigma and Campus Culture

Participants discussed how ableism manifests within academia as barriers to learning and identified a health-promotion approach to reduce ableist barriers.

Ableism

Respondents identified the insidious and systemic nature of ableism in academia: "*I think the whole way this institution is set up, and it's like any university, it's an ableist institution*" where if SWDs "want something different from everyone else" they must *prove* they deserve it (Rep.3). Ableist beliefs include the assumption of non-disability of academic community members and the subsequent 'opt-in' model of accommodations. The nature of invisible disabilities means these barriers are often unknown to, and therefore unaddressed by, the PS community:

> "Because we live in an ableist society, there's kind of a generic assumption that everybody's not disabled. And so, when you navigate the world as a person with a hidden disability, the people that you interact with are going to just make that assumption that you are not disabled" (Rep.3).

Respondents identified that these invisible barriers extend beyond classrooms, embedded in the structures and cultures of institutions. In addition to systemic ableism, respondents identified *internalized* ableism as a barrier. Particularly when students do not recognize their own needs as valid. While past efforts to ameliorate social barriers for SWDs have been stigma-based, respondents noted that a health-focused, whole-community approach is more effective.

Respondents identified a lack of overall will by institutions to address ableism within academia. While some departments were identified as having greater accessibility (such as communications) or lesser accessibility (such as the sciences, business, and math), there is a lack of overall commitment to accessibility.

Health Promotion Approaches

A health-promotion approach addresses upstream impacts on students with disabilities and shifts policy opportunities beyond accessibility services by focusing on whole-campus wellness. Participants identified Healthy Minds/Healthy Campuses (HM/HC) as a community of practice providing resources for health promotion. A health promotion approach addresses issues raised by respondents, including institutional awareness, belonging, and power imbalances (see Appendix D for framework).

Dialogue and Storytelling

Awareness is increased by creating spaces for storytelling and dialogue between community members with and without disabilities. Providing safe and non-judgemental spaces for sharing lived experiences is viewed as an antidote to shame and stigma:

> "If we can break down that [chain] by creating the space for dialogue, I think that would be one way to address stigma" (Advocate1).

Sharing experiences of disability on campus and disability-related policies and practices are viewed as trust-forming between students, faculty, and staff. Indigenous ways of teaching and knowing are identified as a potential framework for sharing stories within a community.

Community-Building and Peer-ness

Participants discussed how relationships and community building increase a sense of belonging. Growing opportunities for interaction - including collaborative work and study projects and clubs - between students, faculty, and other academic community members is seen as an antidote to the isolation SWDs face. Within a health-promotion approach, the goal is greater "peer-ness" among community members instead of traditional rigid hierarchies of academia. Community-building practices were identified as more promising than professional development in addressing stigma and campus culture and institutional awareness:

> "Not just like, 'let's make a mandatory professional development module for instructors that teaches them about mental illness', but that it would

> have actual people with lived experience talking about what it was like for them" (Rep.3).

Power imbalances between SWDs and the broader academic community are addressed by increasing opportunities for student voices to be heard within various areas of the institution. This includes increasing effective feedback processes for institutional policies and shared decision-making across the institution where feasible. In addition to a wellness approach, a process *that "involves and engages everyone equally"* in the processes of feedback and co-design in institutional policy processes is identified as addressing attitudes and beliefs:

> "This is why administrations do have to really ask themselves, 'what are we actually doing to be inclusive in this whole process of who makes decisions for our community, and who's being impacted by them?'" (Advocate3).

Leadership Committee and Policy Review

Participants raised the idea of having a leadership committee who can review policies. Participants identified that the group's diversity should reflect the institution's diversity. This approach requires receptivity to the lived and living experiences of SWDs to inform the campus policies that impact their studies, where SWDs often feel unable to confront unfair or inaccessible procedures.

Topics for this committee might include institutional philosophies, management systems, and student services. One example raised by a participant is the process of requesting a medical exemption in a course withdrawal (a process familiar to many students with disabilities), described as "traumatizing" and demeaning" and where strangers judge whether "your experience was valid or seemed *difficult enough*, based on some standard of difficult" (Rep.3). Reviewing this policy with a health-promotion lens would be one example of an opportunity to address the lack of "compassion and humaneness" within the process.

5.5. Additional Themes

Responsibility

One theme that participants raised was that of shifting responsibility from student advocacy and labour to institutional responsibility, including *"will"* from the institution and accountability:

> “There needs to be someone whose job it is… there's this sort of burden on disabled individuals in the system to be *constantly* giving their own time and energy to advocate over and over again for things that just don't seem to happen” (Rep.3).

Capacity of Institutions

Smaller campuses were identified as advantageous for building community relationships because *“they have the capacity to do so”* due to reduced complexity, fewer barriers, and greater interaction (advocate2). However, community building on larger campuses was seen as more difficult but possible, particularly where higher administration is supportive. Meanwhile, larger campuses were seen as more likely to offer more professionalized and dedicated accommodations support.

Chapter 6. Policy Options

Based on the literature review, the following four options were developed and shared with participants during the interview process. Participants discussed these options and provided depth and complexity. Based on these findings, four policy approaches were developed.

6.1. Option 1: Improving the Accommodations Model

As demand for accommodations increases, particularly among students with mental health-related disabilities (SWMHDs), there is a need to address the capacity of accessibility providers while improving the accessibility and efficacy of the accommodations process. For the most part, accommodations are a downstream solution responding to a lack of support. Improving the accommodations model includes the following changes in addition to increased capacity to provide SWDs and faculty with effective accommodations support.

Increasing Accessibility of the Accommodations Process

The accommodations process should integrate more accessible practices as identified in the literature review and interviews. Accessibility provision should include:

- Sufficient capacity to support students' accessibility needs and to assist faculty with accommodations processes (outlined below).
- Culturally safe and trauma-informed services that encompass knowledge of mental health-related accommodations and barriers in academia (see table 2.1 for examples).
- Early outreach procedures to all new students aligning with UD principles.[120]
- A list of potential accommodations accessible to all students.
- Drop-in sessions for students to ask accessibility-related questions.
- A streamlined and equitable documentation process (outlined below).
- Onboarding programs for incoming and opportunities for mentoring and connection between incoming and more experienced SWDs.[121]

[120] Whereas universal design for learning (UDL) is the application of universal design (UD) to the learning environment, UD can increase access in any environment.

[121] Humber College's Transitions To Success program is an excellent example of onboarding SWDs raised in the interviews.

- Referral to services outside of accessibility services and assistance in contacting these services when needed.
- Opportunities to review the efficacy of accommodations to ensure accommodations are working for students.
- Ongoing feedback processes to seek input on policies and procedures.

Reducing the Complexity of the Documentation Process

Currently, the need for legitimacy and standardization to enforce accommodations in cases of faculty resistance requires some documentation from students. However, to address the inequities and barriers of the medical system, accessibility providers should revise documentation requirements to (1) increase the number of eligible medical professionals who can provide documentation (for example, allowing counsellors to fill out documentation) and (2) not require a DSM-5 diagnosis (The University of New Brunswick Fredericton requirements are an example of a documentation process with reduced complexity; their form is included in Appendix E).

Providing Faculty Support

Providing practical information on accommodations and how faculty can navigate the accommodations process in a way that is harm-reducing would benefit faculty lacking requisite knowledge in disability and accessibility procedures. This information could be provided when faculty are informed that a student in their class is registered with accessibility services and could also be available on the institution's website. As part of their role, providers should be available to provide support to faculty who have questions regarding the accommodation of students.

Increasing Mental Health Knowledge and Safety

Due to the highly stigmatized nature of MHDs, accessibility providers must have a knowledge of MHDs and associated academic barriers to determine appropriate accommodations (see table 2.1). In addition, providers must receive training to ensure safer interactions with students. No review of training options has been conducted for this analysis, however, training for providers should address mental health awareness, cultural sensitivity, and trauma-informed care to address current barriers.

6.2. Option 2: Implementing Universal Design for Learning

Implementing UDL addresses the root cause of inaccessible learning design and allows for the greatest access to course content while decreasing the need for accommodations. In this option, faculty are supported through resources and professional development to incorporate UDL into their pedagogy. As each institution's needs differ, significant attention, including robust research, should be given to the implementation of UDL, as outcomes may vary considerably depending on the institution. Despite this, the following starting points were identified in this research.

Establishing a UDL Development Role

Establishing a supportive role (or *roles* for larger institutions) to consult with stakeholders, support UDL leaders, promote UDL, assist in course design, and provide resources to begin the implementation process. This role could also support UDL in student services. As the number of accommodations decreases with an increase in UDL, accessibility providers could increase their consulting role and provide these services.

Institution-Led Implementation

As identified in the literature review, one-size-fits-all UDL policies are unlikely to have uptake within institutions with distinct organizational structures, sizes, histories, budgets, and other unique characteristics. The supportive role could employ approaches such as the *ecological approach* to UDL, which involve a whole-institution lens to identify barriers and opportunities to implementing UDL to benefit the planning process.

Offering Professional Development in UDL

Providing professional development training to support faculty interested in UDL would increase the capacity of faculty already interested in or implementing inclusive methods. Participants identified the importance of group-based learning and accountability mechanisms in building departmental capacity. Faculty must be supported in this learning process, such as by employing teaching releases for UDL training.

6.3. Option 3: Improving Student Services and Supports

As demand for student services by students with disabilities (SWDs) increases, there is a need to address the capacity and accessibility of institutional services. This option is a downstream response to societal and academic barriers, which includes the following changes.

Improve Mental Health Services

As with accessibility services, increasing the capacity of mental health services addresses the high demand for services and the low capacity faced by student services. Feedback and codesign mechanisms with students on the accessibility and safety of mental healthcare on campus should also be established to ensure effective change.

Campus mental healthcare must have the capacity to address complex and ongoing mental healthcare needs, and staff who provide mental health-related services to SWMHDs must have the training to address potential crisis-related care. Training includes those who provide administrative services in any health-related setting and should address cultural sensitivity, trauma-informed care, and crisis intervention As staff are often required to acquire training without sufficient time and resources, staff should be adequately supported in undertaking this training.

These recommendations are based on the priorities of participants in this research and do not provide an exhaustive analysis of mental health services in PSIs. For more improvements to mental healthcare in PSE for all students, please see the National Standard of Canada's Mental Health and Wellbeing for Post-Secondary Students.[122]

Implement Universal Design within Student Services

This option includes implementing universal design (separate from *universal design for learning* because universal design is not limited to the learning environment) in student services. Making student services accessible to all students includes communicating information in multiple formats and bolstering onboarding supports to

[122] Canadian Standards Association, "Mental Health and Well-Being for Post-Secondary Students."

ensure all students have adequate information entering their institution. Establishing a designated, temporary role to provide UD resources would increase capacity for student services. This role would allow service providers to improve services quickly and allow for capacity-building over time. Once capacity exists within student services to provide inclusive services, this role could shift to supporting UDL in course design.

Increase Awareness and Provide Financial Support

Financial services should ensure that SWDs are aware of all available disability-focused grants and scholarships and should offer support to SWDs to also apply for non-disability-focused funding.

Support Student Organizations

Student-led services - in the form of disability-focused student organizations – should be financially supported through the institution. An organization requires funding for staff members, supplies, and student initiatives. In addition, a student organization benefits from an accessible, dedicated physical space on campus.

6.4. Option 4: Addressing Stigma and Campus Culture by Increasing Health Promotion on Campus

Ableism in academia is a whole-institution problem that no individual policy change can solve. However, addressing stigma and campus culture through a health-promotion approach is an upstream solution that can impact ableism throughout the academy. The policy option of health promotion includes the following changes.

This option includes an institutional commitment to health promotion and the designation of department leaders to enact these principles. In so-called BC, Healthy Minds / Healthy Campuses (HM/HC) is a leader in campus health promotion and similar communities of practice can be found nationally and internationally.[123] The following sections describe relevant aspects of health promotion.

Create Leadership Committees and Initiatives

[123] Canadian Health Promoting Campuses, “Network.”

Utilizing the principles of EDI, institutions should support and resource a diverse group of students, faculty, and staff (including individuals with MHDs) to lead health promotion on campus. Student members should be provided honoraria, and faculty and staff should be sufficiently supported in these roles. The committee should lead efforts to (1) increase opportunities for collaboration between faculty and students and (2) create spaces for disability-related dialogue and storytelling among community members, including opportunities for these sessions to inform institutional policies.

Increase Feedback Processes and Policy Co-Design

The institution should increase opportunities for ongoing student feedback on the provision of services and institutional policies. Increase opportunities for co-design of service provision and policy development and revision. Institutions should prioritize these opportunities in mental health and accessibility services.

Chapter 7. Criteria and Measures

The literature review and interview findings determined twelve evaluation criteria in five categories. The primary objective of this research is to increase access to academia, the secondary categories of stakeholder acceptance, effectiveness, cost, and equity impacts are included below. Below is a discussion of each criterion.

7.1. Increase Access to Academia

The primary objective of this policy analysis is to address barriers and thereby increase access for students with mental health-related disabilities in post-secondary. Four measurements of increased access were drawn from research findings.

Increase Access to Course Content

A greater likelihood of access to course content for SWMHDs is the first criterion. For this criterion, a significant increase in accessibility of course content results in a ‘good’ rating, and some increase results in a ‘moderate’ rating. No change results in a ‘poor’ rating.

Decrease Unwanted Interaction with the Medical System

Unwanted interaction with the medical system is identified as a significant barrier to accessing accommodations. This includes the documentation process for accommodations, administrative medical documentation (such as the medical withdrawal process), and negative interactions with on-campus healthcare.

For this criterion, significantly fewer unwanted interaction points with the medical system result in a ‘good’ rating, and fewer have a ‘moderate’ rating. No policy options are expected to result in greater interaction. Therefore, no change in unwanted interaction results in a ‘poor’ rating.

Decrease Need for Self-Advocacy

The need for self-advocacy is identified as a barrier to accessing accommodations with service providers and faculty and seeking student services. For

this criterion, a decreased need for self-advocacy is measured in fewer processual requirements and/or increased capacity to address disability-related needs in faculty and staff.

For this criterion, significantly fewer requirements for self-advocacy in institutional processes result in a ‘good’ rating, while fewer requirements result in a ‘moderate’ rating. No policy options are expected to result in greater self-advocacy. Therefore, no change results in a ‘poor’ rating.

Increase Opportunities for Connection and Contribution

Limited social and academic involvement was identified as a significant concern for SWMHDs. Therefore, this criterion measures opportunities for SWMHDs to contribute to academic and social communities. Greater academic involvement means the ability to contribute within classrooms and research collaborations, while greater connection means opportunities to participate in academic, social, and community life.

For this criterion, a significant increase in opportunities for academic contribution and social connection results in a ‘good’ rating and a moderate increase results in a ‘moderate’ rating. Options with fewer opportunities than other options result in a ‘poor’ rating.

Increase Knowledge of Disability

As knowledge of disability was identified as a priority of SWDs, this criterion measures whether knowledge of disability is increased.

For this criterion, solutions expected to increase knowledge within and beyond the institution receive a “good” rating. Solutions expected to increase knowledge within multiple areas of the institution receive a “moderate” rating. Solutions expected to result in increased knowledge in limited areas of the institution receive a “poor” rating.

7.2. Effectiveness

Short-Term Efficacy

This criterion measures how options meet immediate needs for services and support for SWMHDs. Options that are expected to allow PSIs to meet or exceed needs in the short term receive a ‘good’ rating. Those expected to meet *some* needs receive a ‘moderate’ rating. Options not expected to meet needs receive a ‘poor’ rating.

Sustainability

This criterion addresses the increasing demands for support within PSE and measures how options will meet demand in the future if the trend continues to increase. Options that are expected to allow PSIs to meet future demand fully receive a ‘good’ rating. Options expected to meet demand somewhat receive a ‘moderate’ rating. Options not expected to meet demand in the future receive a ‘poor’ rating.

7.3. Stakeholder Acceptance

Faculty and accessibility providers were identified as primary stakeholders due to their high level of interaction with SWMHDs in accommodations and learning processes.

Acceptance by Faculty

This criterion addresses concerns that some options may increase faculty workloads and the risk of low uptake for professional development. Solutions that require faculty to make no changes to their learning design for individuals or classrooms receive a “good” rating. Solutions requiring some changes receive a “moderate” rating. Solutions that require significant changes from faculty receive a “poor” rating.

This criterion does not measure perceptions of academic integrity. The belief that accommodations or universal design for learning are unethical, is not substantiated.[124] Therefore, this perception is measured indirectly in the criterion *Increased Knowledge of Disability*.

[124] Pagaling, Eaton, and McDermott, “Academic Integrity.”

Capacity of Accessibility Staff

Accessibility providers were identified as primary stakeholders due to the high level of interaction between SWMHDs in the accommodation processes. A significant barrier identified for accessibility providers is capacity as the need for and complexity of - accommodations increases.

For this criterion, solutions that require no additional capacity result in a “good” rating. Solutions requiring some additional capacity receive a “moderate” rating. Solutions requiring significantly greater capacity receive a “poor” rating.

7.4. Cost

As this research has not undertaken a formal costing of policy options, this criterion measures the estimated costs of options relative to one another. Additional roles, training, and other resources are considered in this comparison.

Options expected to incur the lowest costs receive a ‘good’ rating, while options expected to incur the highest receive a ‘poor’ rating.

7.5. Equity Impacts

The proposed policy options have implications for all academic community members. The following are measures of impacts on groups selected based on findings from this research.

Impacts on Equity-Deserving Groups

This category measures whether it is expected that equity-deserving groups on campus, overall, will benefit from policy options. As identified in the literature review and interview findings, accessibility measures in education often have positive impacts on other marginalized groups who face barriers to education. As such, the impacts of policies on those who face marginalization are considered in this section.

As identified in the literature review, academia is a colonial space. As such, this criterion also measures whether any policies might benefit Indigenous students, including opportunities for Indigenous ways of knowing and learning in higher education

and professional development. These measures are drawn from The Truth and Reconciliation Commission's 94 Calls to Action.[125]

For this criterion, solutions expected to result in the greatest positive impacts for equity-deserving groups receive a "good" rating. Solutions expected to have some positive impacts receive a "moderate" rating. Solutions expected to result in no positive impacts receive a "poor" rating.

Impacts on Faculty and Staff with Disabilities

The literature review showed that members of academic communities with disabilities often face significant barriers in their academic careers due to inaccessible environments. This criterion measures whether policies might impact the access of non-student community members to their working environment.

For this criterion, solutions expected to positively impact faculty and staff with disabilities receive a "good" rating. Solutions expected to have no impacts receive a "moderate" rating. Solutions expected to result in negative impacts receive a "poor" rating.

[125] Truth and Reconciliation Commission of Canada, "Truth and Reconciliation Commission of Canada: Calls to Action."

Chapter 8. Evaluation

The following section evaluates the policy options using the criteria and measures drawn from the literature review and interviews. The complete matrix can be found in Appendix F.

8.1. Increasing Access to Academia for Students with Mental Health-Related Disabilities

The primary objective of this analysis is to address barriers and, thereby, increase access for students with mental health-related disabilities (SWMHDs) in post-secondary (PS).

Increase Access to Course Content

	Option 1: Accommodations	Option 2: UDL	Option 3: Student Services	Option 4: Health Promotion
Increase Access to Course Content	Moderate	Good	Poor	Poor

Option 2 is expected to result in the greatest improvement in course access, and the likelihood of course completion as universal design for learning is estimated to meet the needs of most learners. As a result, both registered and unregistered SWMHDs would be significantly more likely to have access to course content without accommodations. Therefore, this option receives a ‘good’ rating.

Option 1 is expected to allow for a greater number and higher quality of accommodations for students who register with their institution’s providers as barriers are significantly reduced. However, this option only benefits students who register with these services. Further, while accommodations would be more accessible, they would not be barrier-free. Therefore, this measure receives a ‘moderate’ rating.

Neither Option 3 nor Option 4 are expected to significantly improve access to course content and receive a ‘poor’ rating.

Decrease Unwanted Interaction with the Medical System

	Option 1: Accommodations	Option 2: UDL	Option 3: Student Services	Option 4: Health Promotion
Decrease Unwanted Interaction with the Medical System	Moderate	Good	Moderate	Poor

Option 2 is expected to significantly decrease contact with the medical system as many accommodations – and the medicalized process of acquiring them - would no longer be required for most students. This option receives a ‘good’ rating.

Reducing the complexity of documentation requirements in Option 1 would result in fewer points of contact with the medical system, particularly specialists, as students could acquire documentation from multiple service providers familiar with their needs. Although reduced, some degree of interaction with the medical system would be required for most students in the process of acquiring accommodations. This option receives a ‘moderate’ rating.

Option 3 includes crisis intervention and culturally-sensitive trauma-informed training within mental health services. Improving mental health literacy is expected to decrease the likelihood that interactions between students and staff will be negative. This option also receives a ‘moderate’ rating.

Although the long-term impacts of Option 4 would likely improve interactions within on-campus medical settings, because the option is not expected to result in immediate changes in unwanted medical system interactions and does not impact accommodations documentation, this option receives a ‘poor’ rating.

Decrease Need for Self-Advocacy

	Option 1: Accommodations	Option 2: UDL	Option 3: Student Services	Option 4: Health Promotion
Decrease the Need for Self-Advocacy	Moderate	Good	Moderate	Poor

Option 2 is expected to significantly decrease the need for self-advocacy due to the decrease in the need for accommodations-related processes and greater awareness of diverse learning styles. While this option does not decrease the need for self-advocacy in accessing student services, this option receives a ‘good’ rating.

In Option 1, professional development in mental health literacy among accessibility providers and a more accessible accommodation process is expected to reduce the need for self-advocacy. As SWMHDs would still be required to advocate for themselves with faculty and to access student services, this option receives a ‘moderate’ rating.

Option 3 is expected to decrease the need for self-advocacy for students seeking services – particularly in mental health services - on campus. The availability of student-led support would also provide direct advocacy. As SWMHDs would still be required to advocate for themselves throughout the accommodations process, this option also receives a ‘moderate’ rating.

Option 4 is expected to decrease the need for self-advocacy over time as awareness of accessibility increases within the institution. While this option has the widest impact, the effects are not expected to be immediate. As a result, this option receives a ‘poor’ rating.

Increase Opportunities for Connection and Contribution

	Option 1: Accommodations	Option 2: UDL	Option 3: Student Services	Option 4: Health Promotion
Increase Opportunities to Connect and Contribute	Poor	Moderate	Good	Moderate

Option 3 is expected to improve opportunities for connection and contribution primarily through the availability of student community and support through the disability-focused student organization. Due to the potential for connection and contribution with other students with disabilities, this option receives a ‘good’ rating.

Option 2 increases the likelihood that students can contribute to the classroom learning environment and connect with other community members. However, unlike option 4, these opportunities are limited to the classroom. This option receives a ‘moderate’ rating.

Option 4 is expected to provide the greatest opportunity for contribution and connection across students, faculty, and staff, as community-building and peer-leadership are critical aspects of health promotion. However, because this option is contingent on uptake from community members to engage with health promotion, this option receives a ‘moderate rating.

Option 1 is expected to provide opportunities for connection between incoming and current or former SWDs during the onboarding period. However, compared to other options designed to support ongoing opportunities, this option’s opportunities for connection are limited. As a result, this option receives a ‘poor’ rating.

Increased Knowledge of Disability

	Option 1: Accommodations	Option 2: UDL	Option 3: Student Services	Option 4: Health Promotion
Increased Knowledge of Disability	Poor	Moderate	Moderate	Good

Option 4 is expected to increase awareness of disability and accessibility within the institution as increasing awareness of mental health and wellness is foundational to HM/HC. Therefore, this option receives a ‘good’ rating.

Options 2 and 3 both increase awareness of accessibility through UD but lack a whole-campus approach. Each option receives a moderate’ rating.

Option 1 is expected to have the lowest impact on disability awareness as knowledge sharing outside accessibility services is limited to faculty. This option receives a ‘poor’ rating.

8.2. Effectiveness

Short-Term Efficacy

	Option 1: Accommodations	Option 2: UDL	Option 3: Student Services	Option 4: Health Promotion
Short-term efficacy	Good	Poor	Good	Poor

Options 1 and 3 require changes that address the immediate needs of SWMHDs. In both options, many of the recommended changes to the accommodations process can be undertaken in a short time frame. Other aspects of these policies, such as professional development and capacity building, are also expected to be feasible in a shorter time scale than Options 2 and 4. Therefore, both options receive a “good” rating.

Options 2 and 4 require are considered long-term approaches. While short-term changes *can* be made by individuals within PSIs through changes to curricula and health-promotion practices, these options receive a “poor” rating.

Sustainability

	Option 1: Accommodations	Option 2: UDL	Option 3: Student Services	Option 4: Health Promotion
Sustainability	Poor	Good	Moderate	Good

Option 2 is expected to build UDL capacity in the long term through training initiatives, developmental supports, and communities of practice. A curriculum designed with the principles of UDL can be replicated each time a course is taught, unlike individual accommodations which must be obtained, communicated, and arranged each semester, requiring greater collective involvement from students, providers, and faculty. This option received a ‘good’ rating.

Option 4 is expected to address the campus culture-related needs of SWMHDs through health promotion initiatives and procedures. As these long-term changes address systems, biases, and beliefs within academic environments which contribute to social determinants of health, these changes are expected to relieve pressure on downstream campus services. This option receives a ‘good’ rating.

Option 3 is expected to meet demands in most student services and supports, including in student-led supports. However, ongoing and increasing demand for mental healthcare are unlikely to be met through this option. As a result, this option receives a ‘moderate’ rating.

Option 1 is not expected to meet long-term demands for accommodations at the current rate of increase. As a result, this option receives a ‘poor’ rating.

8.3. Stakeholder Acceptance

This section measures the acceptance by faculty and accessibility providers based on capacity and increased workload.

Acceptance by Faculty

	Option 1: Accommodations	Option 2: UDL	Option 3: Student Services	Option 4: Health Promotion
Acceptance by Faculty	Poor	Poor	Good	Moderate

Option 3 is not expected to require any increase in faculty capacity or require uptake. Therefore, this option receives a ‘good’ rating.

Option 1 requires not only an increased number of accommodations but also an increased complexity of accommodations addressing MHDs. While this option includes increased support to faculty in the accommodations process, additional time and learning will be required, particularly for those who are less practiced in accommodating MHD-related disabilities. This option receives a ‘poor’ rating.

Option 4 is expected to increase the workload of faculty who volunteer to participate in Leadership Committees and other health promotion initiatives. Additionally, potential changes made due to health promotion-based institutional policy reviews may include requirements for faculty. As any significant time commitments would be voluntary, this option receives a moderate rating.

Option 2 requires the greatest time investment from faculty due to professional development and course design. Although support in the form of a UDL Development Role and institutional support through teaching release would be available, this option relies on the uptake of faculty to engage with provided supports and opportunities for professional development in UDL. As a result, this option receives a ’poor’ rating.

Capacity of Accessibility Staff

	Option 1: Accommodations	Option 2: UDL	Option 3: Student Services	Option 4: Health Promotion
Capacity of Accessibility Staff	Poor	Moderate	Good	Good

Both Options 3 and 4 necessitate some additional labour for accessibility providers. Option 3 requires implementing UD service provision along with other student services. Option 4 requires responses to feedback systems on policies and procedures. While some additional capacity is required in response to these changes, compared to other options, these options receive a ‘good’ rating.

For Option 2, no increased capacity would be required for accessibility providers to provide accommodations as need is anticipated to decrease. However, if providers assist in UDL development, there is anticipated to be a period of overlapping responsibilities. For this reason, this option receives a ‘moderate’ rating.

Option 1 results in the greatest requirements for accessibility staff, including the need for a higher number and greater complexity of accommodations, professional development, and increased student and faculty support services. Due to the increased need for capacity, this option receives a ‘poor’ rating.

8.4. Cost

	Option 1: Accommodations	Option 2: UDL	Option 3: Student Services	Option 4: Health Promotion
Cost	Moderate	Poor	Poor	Good

Option 4 requires funding for health-related initiatives, honoraria for students and support for faculty and staff on the leadership committee. Compared to other options, option 4 is the least costly option and receives a ‘good’ rating.

Option 1 requires funding due to increased demand for accommodations, student and faculty support, and professional development. Communication with faculty would likely increase with an increase in accommodations. Relative to other options, this option receives a ‘moderate’ rating in cost.

Option 2 requires funding for professional development, including teaching release. Establishing a UDL Development role would likely require funding an additional role until accommodations decrease. As a result, this option receives a ‘poor’ rating.

Option 3 requires funding for a student organization (including one staff), inclusive design support staff, professional development training, and supports for students. This option receives a ‘poor’ rating.

8.5. Equity Impacts

Impacts on Equity-Deserving Groups

	Option 1: Accommodations	Option 2: UDL	Option 3: Student Services	Option 4: Health Promotion
Impacts on Equity-Deserving Groups	Poor	Good	Moderate	Good

Option 2 and Option 3 are most likely to benefit equity-deserving groups.

Option 2 addresses the learning needs of those not currently supported in classrooms and is likely to increase classroom safety. Further, UDL has also been identified to increase opportunities for Indigenous ways of teaching and knowing in the classroom. International students from equity-deserving groups are also expected to experience fewer language and cultural-related barriers in the classroom. Therefore, this option receives a ‘good’ rating.

Option 4 addresses power dynamics and hierarchies that contribute to inequities on campus and increases opportunities for community-building. As with Option 2, this option is expected to have a positive impact on equity-deserving groups across the institution. Therefore, this option receives a ‘good’ rating.

Option 3 increases the safety of mental health services through culturally-sensitive trauma-informed training along with UD in other services. This option addresses Call to Action 23 iii. This option receives a ‘moderate’ rating.

While Option 1 is expected to make the accommodations process safer and more equitable through training, support, and changes to the documentation process, it supports only those registered as SWDs. Because of the lower relative number of students impacted, this option receives a ‘poor’ rating.

Impacts on Faculty and Staff with Disabilities

	Option 1: Accommodations	Option 2: UDL	Option 3: Student Services	Option 4: Health Promotion
Impacts on Faculty and Staff with Disabilities	Poor	Moderate	Moderate	Good

Option 4 is expected to have the greatest possible impact as it addresses the high rates of stigma and discrimination faced by faculty with disabilities within academia. While this option requires involvement within leadership committees, involvement is optional and supported by the institution. This option receives a ‘good’ rating.

While option 2 provides institutional support and UDL development support, the capacity to engage in professional development training and curriculum design may negatively impact faculty who experience accessibility barriers. However, increased awareness of accessibility within the institution and more acceptance of diverse teaching methods is expected to benefit faculty. This option receives a ‘moderate’ rating.

Option 3 also provides institutional support for staff. However, the capacity to engage in professional development and UD implementation may negatively impact staff who experience accessibility barriers. This option receives a ‘moderate’ rating.

Option 1 is expected to have a negative impact on faculty with disabilities compared to other options, as faculty would be required to accommodate a greater number of students with a greater complexity of needs. While faculty would have some support through accessibility providers, this support is not expected to offset the increased workload. Therefore, this option receives a ‘poor’ rating.

Chapter 9. Discussion and Recommendations

9.1. Discussion

The following is a discussion of how each policy approach addresses barriers faced by students with mental health-related disabilities (SWMHDs) and the strengths and limitations of these options based on the multicriteria policy analysis.

Option 1: Accommodations Model

Option 1 is expected to increase access to academia by addressing access to 'course content,' 'medical interactions', and 'self-advocacy.' The short-term effectiveness of this option is expected to be good but is expected to be unsustainable in the long term. This option has the lowest expected stakeholder acceptance and moderate cost compared to other options. However, there are limited benefits for equity-deserving groups and higher burdens for disabled faculty and staff.

Option 2: Universal Design for Learning

Option 2 is expected to significantly increase access by addressing all key objectives. The long-term efficacy of this option is expected to be good but likely ineffective in the short term. While stakeholder acceptance for this option is expected to be good for providers, it is expected to be low for faculty with expected uptake barriers. However, Option 2 is expected to benefit equity-deserving groups significantly.

Option 3: Student Services and Supports

Option 3 is expected to increase access by addressing most key objectives except for 'access to course content.' This option is expected to have good short-term efficacy but only moderate sustainability. The stakeholder acceptance for this option is good compared to other options but benefits to impacted groups are moderate compared to other options.

Option 4: Campus Culture and Stigma: Health Promotion

Option 4 increases access through ‘connection/contribution’ and ‘increasing knowledge’ but does not address most key objectives. This option is expected to be a long-term approach with poor short-term efficacy. Stakeholder acceptance is moderate compared to other options, but option 4 is expected to be the most cost-effective option. This option is also expected to have the greatest benefit to impacted groups.

9.2. Recommendations

The inaccessibility of academia is a complex problem; no single option can unravel ableist social and academic structures.

Options 1 and 2 have the greatest positive impact to curriculum and barriers related to the accommodations processes. However, these options do not impact broader, community-focused objectives beyond the classroom. These objectives are met through options 3 and 4 which do not address curriculum and accommodation-based barriers.

Implementing Options 1 or 3 addresses critical short-term needs but is neither sustainable nor likely to benefit other impacted groups. Options 2 and 4 are necessary, long-term changes to the institutional and pedagogical culture that benefit impacted populations, but neither meets the short-term needs of students.

It is recommended that institutions consider both a short-term and long-term approach to accessibility in post-secondary: implementing Options 1 and 3 in the short term and Options 2 and 4 as long-term solutions. The policy approaches presented in this analysis work holistically to address the problem of access in academia (see the Policy Roadmap in Appendix G).

Chapter 10. Implementation Considerations

Due to the barriers of stigma and ableism within academia, accessibility for students with mental health-related disabilities (SWMHDs) should be a publicly stated priority for post-secondary institutions (PSIs).

Implementing the policy options holistically, institutions should implement improvements to the accommodations model and student services and supports should be implemented as soon as possible. Plans for implementing health promotion and universal design for learning (UDL) should be determined with stakeholder involvement, including the accessibility committees required by the Accessible BC Act. Implementing health promotion and UDL as long-term institutional goals and determining responsibility and ownership of initiatives within the institution is essential to move policy forward. Reasonable goal-setting for these initiatives can help ensure that chosen approaches are effective. The size of institutions is a factor in how policy approaches are implemented. Sourcing feedback from SWMHDs and other members of the institution's community on priorities and existing barriers and strengths can help determine approaches to meet community needs.

Determining the best path forward for implementation requires consultation between stakeholders and shared ownership of work across the institution. For UDL, participants report significant variability of faculty acceptance and capacity between departments and individuals. As such, as institutions determine what approach will be most efficacious for their institutions, faculty engagement to determine barriers, interests, and perspectives is essential.

Where professional development is required, efforts should be made to source training led by persons with lived experience of marginalization. An evaluation plan should be determined with involvement from the institutions' accessibility committee, according to the Accessible BC act, to seek feedback from all members of the academic community on the efficacy of policies.

Chapter 11. Limitations

This study has several limitations. First, due to the complexity of options, the limited scope of this research, and the variability of post-secondary institutions, options serve as policy *approaches* which often lack detail. As institutions have unique cultures, sizes, budgets, and other factors determining implementation, it is impossible to recommend an overarching implementation structure or account for unique variables.

The perspectives of faculty are underrepresented in this analysis. Adding faculty perspectives would have enriched the discussion of accommodations and universal design for learning (UDL). Similarly, this research would also have benefited from hearing the perspectives of campus mental health practitioners. Further research would benefit from these insights.

The number and characteristics of interviewees did not allow for representativeness in perspectives from persons with disabilities. This research would have benefited from representation from a greater number of social intersections. Additionally, while there is a high degree of overlap between disability types and although experts often choose to apply a pan-disability lens, a greater focus on the unique barriers of students with mental health-related disabilities would have strengthened the analysis. Finally, the scope of this research prevented a deeper analysis of the systemic, historical, and social relationships that impact SWMHDs, including a deeper analysis of intersectional factors.

Chapter 12. Conclusion

Post-secondary institutions are not designed to support students with mental health-related disabilities, and current accommodations and student supports are not enough to meet the needs caused by institutional barriers. Implementing these policies in ways that are holistic, effective for individual institutions, and integrate community feedback processes is essential for a sustainable and long-term approach to accessibility for students with mental health-related disabilities in post-secondary.

Improving accommodations addresses the critical and increasing need of students. However, there needs to be a more sustainable approach to learning accessibility. Implementing universal design for learning shifts accessibility towards an inclusive model that recognizes the diverse learning needs of all students. However, UDL will take time to implement. As institutions integrate UDL practices, improvements to the accommodations model can ameliorate the barriers that UDL can erase.

Improving student services addresses the critical and increasing need for mental healthcare, increases the accessibility of other supports, and supports students through student-led organizations. This option is a downstream solution to societal and academic ableism, particularly in mental health services. However, continuing to increase the capacity of reactive services is not sustainable. Implementing health promotion is more likely to meet community members' needs and reduce the need for specialized support. Health promotion will not meet the immediate needs of students, which is why improvements to student support are necessary to fill critical gaps in the immediate term.

The accessibility of higher learning is essential for equitable education, not only for students with mental health-related disabilities but for all students who experience marginalization within academia. The diversity of minds and perspectives in society must be reflected in the diversity of scholars, decision-makers, and leaders who can graduate from higher learning. By failing to support students with diverse minds and experiences, institutions miss an opportunity not only to empower people with lived experience to reach their potential but also to model how we can create environments and address social problems in ways that are healthy and inclusive for all members of our communities.

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Appendix A. Interview Guide

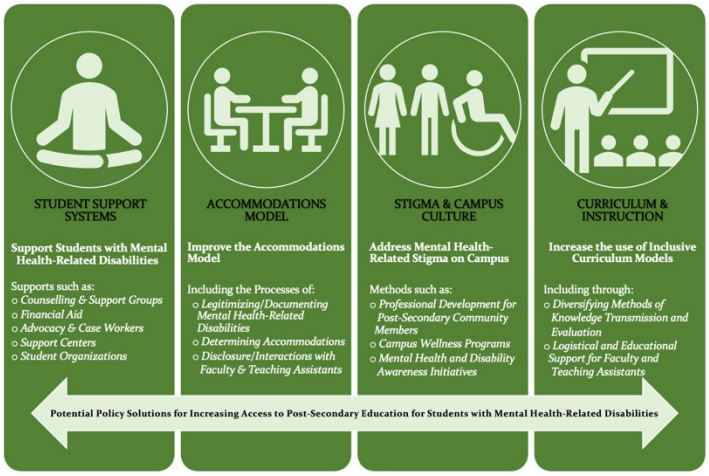
Policy Issue: There are too many accessibility barriers in post-secondary education for people with mental health-related disabilities

Information Objectives

- *Which policy solutions should be implemented to improve accessibility for this population?*
- *What are the benefits and challenges of these solutions?*
- *What are the impacts on stakeholders and other equity-deserving groups?*

Working Definition of Mental Health-Related Disability:
"Those who experience limitations in their daily activities because of difficulties with an emotional, psychological, or mental health condition" (definition borrowed from Statistics Canada).

Visual Aid for Interview



INTRODUCTION

INVITATION AND STUDY PURPOSE

- *You are being invited to take part in this study because of your expertise or experiences with students with mental-related disabilities in post-secondary education. For the purposes of this study, mental-related disabilities is defined as "those who experience limitations in their daily activities because of difficulties with an emotional, psychological, or mental health condition" (definition borrowed from Statistics Canada).*
- *The purpose of this study is to identify and assess potential policy responses to accessibility barriers for this population. We are inviting people who have knowledge in this area to help us.*

YOUR PARTICIPATION IS VOLUNTARY

- *Your participation is completely voluntary.*
- *You will be fully supported in not answering questions or in ending the interview at any time.*

STUDY PROCEDURES

- *This session will involve one interview lasting between 30-60 minutes.*
  - *If we go over time, I will ask your permission before continuing.*
- *During this interview, I will ask you about your views on how to best address accessibility barriers in education.*
- *If you are comfortable, the interview will be voice recorded.*
- *You are more than welcome to opt out of recording at any time.*
- *If you enter the research and then decide to withdraw, all data collected from you will be destroyed.*

INTERVIEW GUIDE

Introduction

1. Could you describe your work and how you interact or have interacted with students with mental health-related disabilities?
2. What would you say, in your experience, is the main barrier to learning for students with mental health-related disabilities?

Part 1. Policy Solutions: Overall

If we could take a look at the image I sent to you: as I described, these are four areas I've identified from the literature as possible solutions to the problem of access for these students.

3. When you look at these four categories, do you have any thoughts about which stand out to you as promising, problems you see, or any initial feedback?
   → *Follow-ups based on the choice of model:*

If Participant Chooses Inclusive Education Models: Potential Follow-Up Questions
If it stands out positively → Why does that solution stand out to you? → Can you describe how you envision PSE with a more inclusive curriculum design and how that would differ from the current education model? → What benefit do you foresee of implementing this? How would an inclusive curriculum impact the learning experiences of students with mental health-related disabilities? → Do you think this change would impact other equity-deserving populations in PSE? → If so, which populations and how? → How would you envision the steps of implementing a more inclusive curriculum? → What, if any, challenges do you foresee? → Do you think faculty or administrators would face challenges or benefits from these changes?
If stands out negatively → Can you talk me through the challenges or drawbacks you foresee? → Could anything be done to mitigate these?

If Participant Chooses Student Support Systems: Potential Follow-Up Questions
If stands out positively → Why does that solution stand out to you? → Can you describe broadly how you envision PSE with more student supports and how that would differ from the current model of education? → What does an ideal student support network look like to you for this population? → What kinds of supports do you think are most important? → What kinds of supports do you wish there were more of? → What benefit do you foresee of implementing this? How would more supports impact the learning experiences of students with mental health-related disabilities? → Do you think this change would impact other equity-deserving populations in PSE? → If so, which populations and how? → How would you envision the steps of implementing more supports? → What challenges do you foresee?
If stands out negatively → Can you talk me through the challenges or drawbacks you foresee? → Could anything be done to mitigate these?

If Participant Chooses Accommodations Processes: Potential Follow-Up Questions
If stands out positively → Why does that solution stand out to you? → Can you describe how you envision an improved or alternate accommodations model and how that would differ from the current model? → What does an ideal accommodations process look like to you for a student with a mental health related disability? → Would you change anything about the legitimization or documentation process? → What about the process of determining which accommodations are available to students? → What about the process of requesting accommodations from faculty or TAs? → Any more broadly, what do you envision the role of a disability services center to be? → What benefit do you foresee of changing the model? How would a different model impact the learning experiences of students with mental health-related disabilities? → Do you think this change would impact other equity-deserving populations in PSE? → If so, which populations and how? → How would you envision the steps of implementing these changes? → What challenges do you foresee? → Do you think faculty or administrators would face challenges or benefits from these changes?

If stands out negatively
- ➔ Can you talk me through the challenges or drawbacks you foresee?
- ➔ Could anything be done to mitigate these?

If Participant Chooses Stigma and Culture: Potential Follow-Up Questions

If stands out positively
- ➔ Why does that solution stand out to you?
- ➔ Can you describe broadly what a PSI without stigma looks like to you? How would it be different from the status quo?
- ➔ What measures would you like to see taken to address stigma in PSE?
  - ➔ Is there anything you think doesn't work that has been used in the past?
- ➔ What benefit do you foresee of implementing this? How would addressing stigma impact the learning experiences of students with mental health-related disabilities?
- ➔ Do you think this change would impact other equity-deserving populations in PSE?
  - ➔ If so, which populations and how?
- ➔ How would you envision the steps of addressing stigma?
- ➔ What challenges do you foresee?

If stands out negatively
- ➔ Can you talk me through the challenges or drawbacks you foresee?
- ➔ Could anything be done to mitigate these?

Part 2. Individual Policy Solutions

(Not all policy options need to be examined by each interviewee: tailor to expertise)

I'd like to go through some of the other options with you.

4. What is your opinion of increasing the use of inclusive curriculum design to improve access for this population?

Inclusive Education Models: Potential Follow-Up Questions

If positive
- ➔ Can you describe broadly how you envision PSE with more inclusive curriculum design and how that would differ from the current model of education?
- ➔ What benefit do you foresee of implementing this? How would inclusive curriculum impact the learning experiences of students with mental health-related disabilities?
- ➔ Do you think this change would impact other equity-deserving populations in PSE?
  - ➔ If so, which populations and how?
- ➔ How would you envision the steps of implementing more inclusive curriculum?
- ➔ What challenges do you foresee?
  - ➔ Do you think faculty or administrators would face challenges or benefits from these changes?

If negative
- ➔ Can you talk me through the challenges or drawbacks you foresee?
- ➔ Could anything be done to mitigate these?

5. What is your opinion of increasing or improving student support systems to address this problem?

Student Support Systems: Potential Follow-Up Questions

If positive
- ➔ Can you describe how you envision PSE with more student support and how that would differ from the current education model?
- ➔ What does an ideal student support network look like for this population?
  - ➔ What kinds of support do you think are most important?
  - ➔ What kinds of supports do you wish there were more of?
- ➔ What benefit do you foresee of implementing this? How would more support impact the learning experiences of students with mental health-related disabilities?
- ➔ Do you think this change would impact other equity-deserving populations in PSE?
  - ➔ If so, which populations and how?
- ➔ How would you envision the steps of implementing more support?
- ➔ What challenges do you foresee?

If negative
- ➔ Can you talk me through the challenges or drawbacks you foresee?
- ➔ Could anything be done to mitigate these?

6. What is your opinion of improving the accommodations model?

Accommodations Processes: Potential Follow-Up Questions
If positive ➔ Can you describe how you envision an improved or alternate accommodations model and how that would differ from the current model? ➔ What does an ideal accommodations process look like for a student with a mental health-related disability? ➔ Would you change anything about the legitimization or documentation process? ➔ What about the process of determining which accommodations are available to students? ➔ What about the process of requesting accommodations from faculty or TAs? ➔ Any more broadly, what do you envision the role of a disability services center to be? ➔ What benefit do you foresee of changing the model? How would a different model impact the learning experiences of students with mental health-related disabilities? ➔ Do you think this change would impact other equity-deserving populations in PSE? ➔ If so, which populations and how? ➔ How would you envision the steps of implementing these changes? ➔ What challenges do you foresee? ➔ Do you think faculty or administrators would face challenges or benefits from these changes?
If negative ➔ Can you talk me through the challenges or drawbacks you foresee? ➔ Could anything be done to mitigate these?

7. What is your opinion of addressing stigma in PSE?

Stigma and Culture: Potential Follow-Up Questions
If positive ➔ Can you describe broadly what a PSI without stigma looks like to you? How would it be different from the status quo? ➔ What measures would you like to see taken to address stigma in PSE? ➔ Is there anything you think doesn't work that has been used in the past? ➔ What benefit do you foresee of implementing this? How would addressing stigma impact the learning experiences of students with mental health-related disabilities? ➔ Do you think this change would impact other equity-deserving populations in PSE? ➔ If so, which populations and how? ➔ How would you envision the steps of addressing stigma? ➔ What challenges do you foresee?
If negative ➔ Can you talk me through the challenges or drawbacks you foresee? ➔ Could anything be done to mitigate these?

Conclusion

8. Are there any final comments or thoughts you would like to share with me before we end the interview?

Figure A1. Interview Guide

Appendix B. Universal Design for Learning Guidelines and Questions

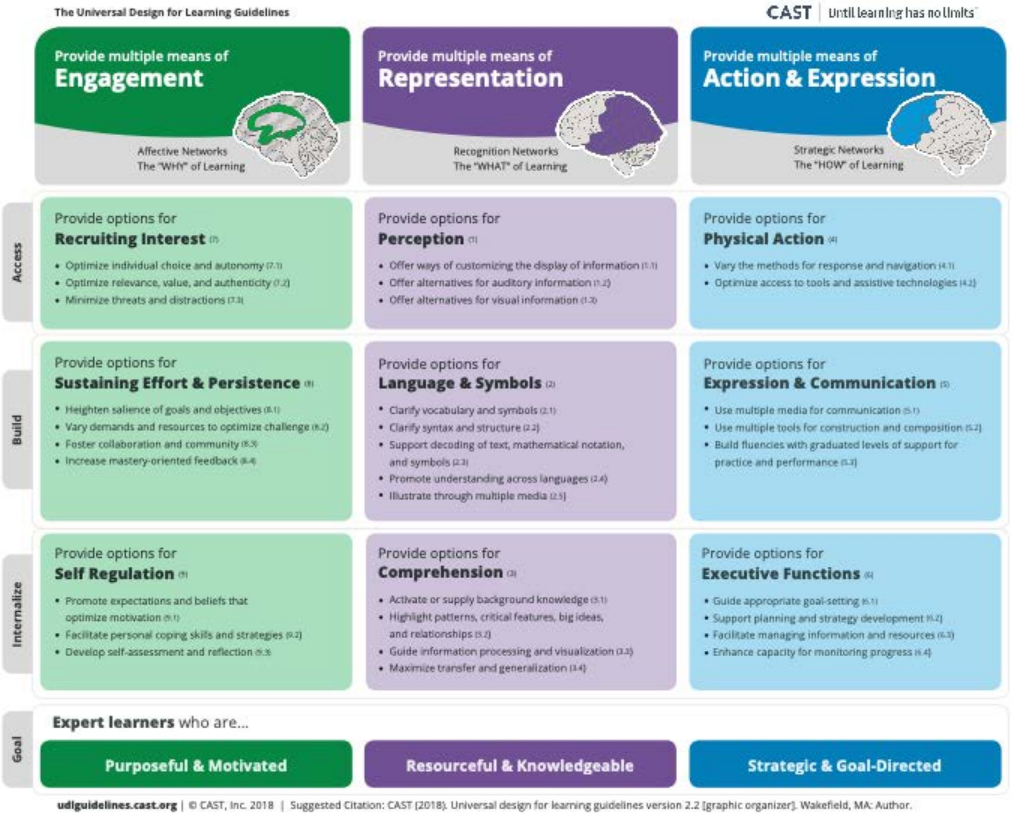


Figure B1. CAST Universal Design for Learning Guidelines
Source: CAST (2018). Universal Design for Learning Guidelines version 2.2. Retrieved from http://udlguidelines.cast.org

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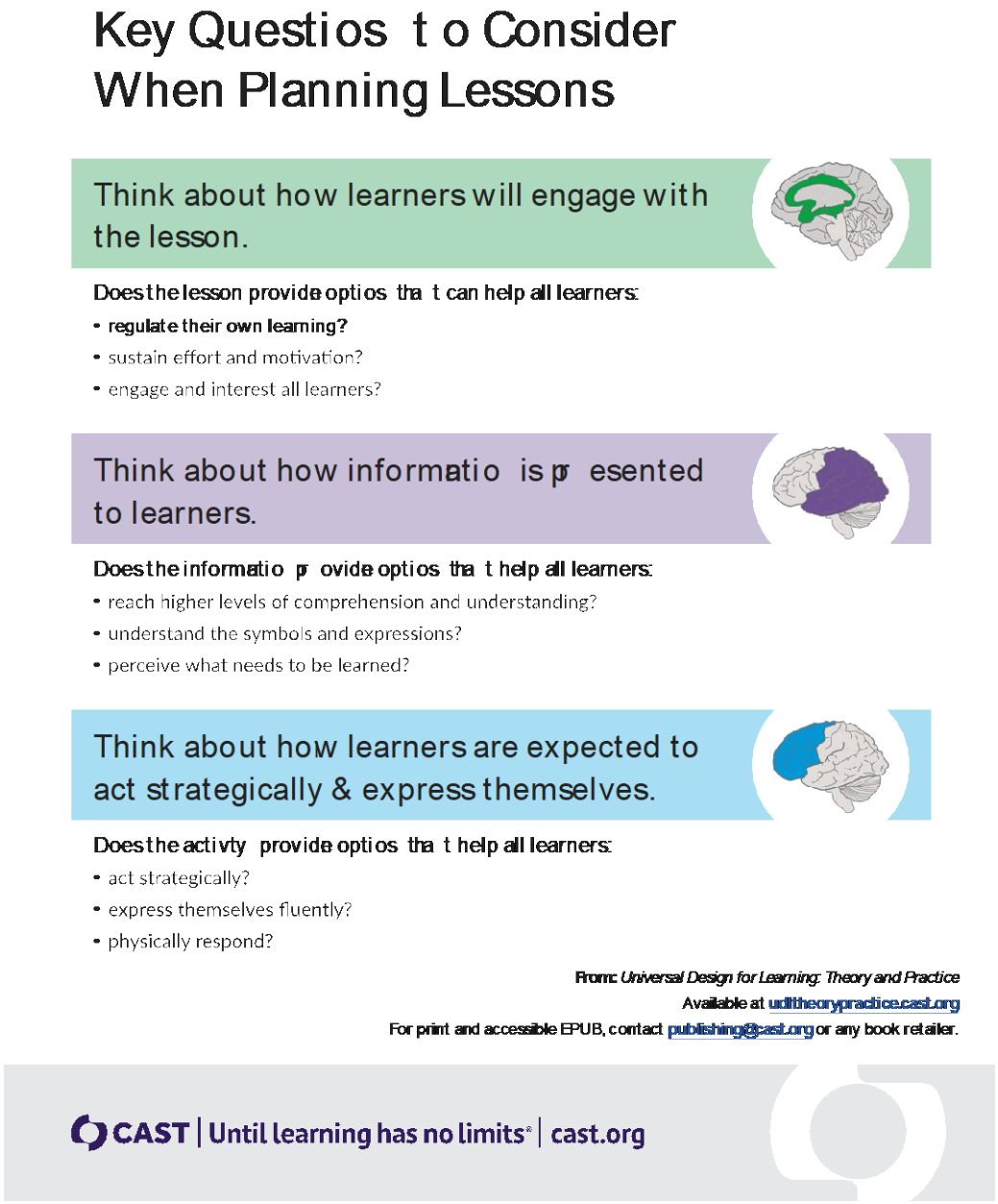


Figure B2. CAST Universal Design for Learning Key Questions to Consider When Planning Lessons

Source: CAST (2020). Key questions to consider when planning lessons. Wakefield, MA: Author. (Reprinted from Universal design for learning: theory and practice, by Meyer, A., Rose, D.H., & Gordon, D., 2014, Author). Retrieved from http://www.cast.org/products-services/resources/2020/udl-guidelines-key-questions-planning-lessons

Appendix C. Okanagan Charter: Key Principles for Action

“KEY PRINCIPLES FOR ACTION

The following are guiding principles for *how* to mobilize systemic and whole campus action.[10]

- **Use settings and whole system approaches**

  Use holistic settings and systems as the foci for inquiry and intervention, effectively drawing attention to the opportunities to create conditions for health in higher education. Set an example for health promotion action in other settings.

- **Ensure comprehensive and campus-wide approaches**

  Develop and implement multiple interconnected strategies that focus on everyone in the campus community.

- **Use participatory approaches and engage the voice of students and others**

  Set ambitious goals and allow for solutions and strategies to emerge through use of participatory approaches to engage broad, meaningful involvement from all stakeholders, including students, staff, faculty, administrators and other decision makers. Set priorities and build multilevel commitments to action.

- **Develop trans-disciplinary collaborations and cross-sector partnerships**

  Develop collaborations and partnerships across disciplines and sectors, both within the campus community and with local and global partners, to support the development of whole campus action for health and the creation of knowledge and action for health promotion in communities more broadly.

- **Promote research, innovation and evidence-informed action**

  Ensure that research and innovation contribute evidence to guide the formulation of health enhancing policies and practices, thereby strengthening health and sustainability in campus communities and wider society. Based on evidence, revise action over time.

- **Build on strengths**

  Use an asset-based and salutogenic approach to recognize strengths, understand problems, celebrate successes and share lessons learned, creating opportunities for the continual enhancement of health and well- being on campus.

- **Value local and indigenous communities' contexts and priorities**

  Advance health promotion through engagement and an informed understanding of local and indigenous communities' contexts and priorities, and consideration of vulnerable and transitioning[11] populations' perspectives and experiences.

- **Act on an existing universal responsibility**

  Act on the “right to health” enshrined in the Universal Declaration of Human Rights to ensure health promotion action embodies principles of social justice, equity dignity and respect for diversity while recognizing the interconnectedness between people’s health and health determinants, including social and economic systems and global ecological change.”

Okanagan Charter: Key Principles for Action

Source: “Okanagan Charter: An International Charter for Health Promoting University and Colleges.” Kelowna, BC, 2015. Retrieved from https://bp-net.ca/program/the-okanagan-charter/.

Appendix D. Healthy Minds Healthy Campuses Framework for Post-Secondary Student Mental Health

Figure 2: Framework for Post-Secondary Student Mental Health

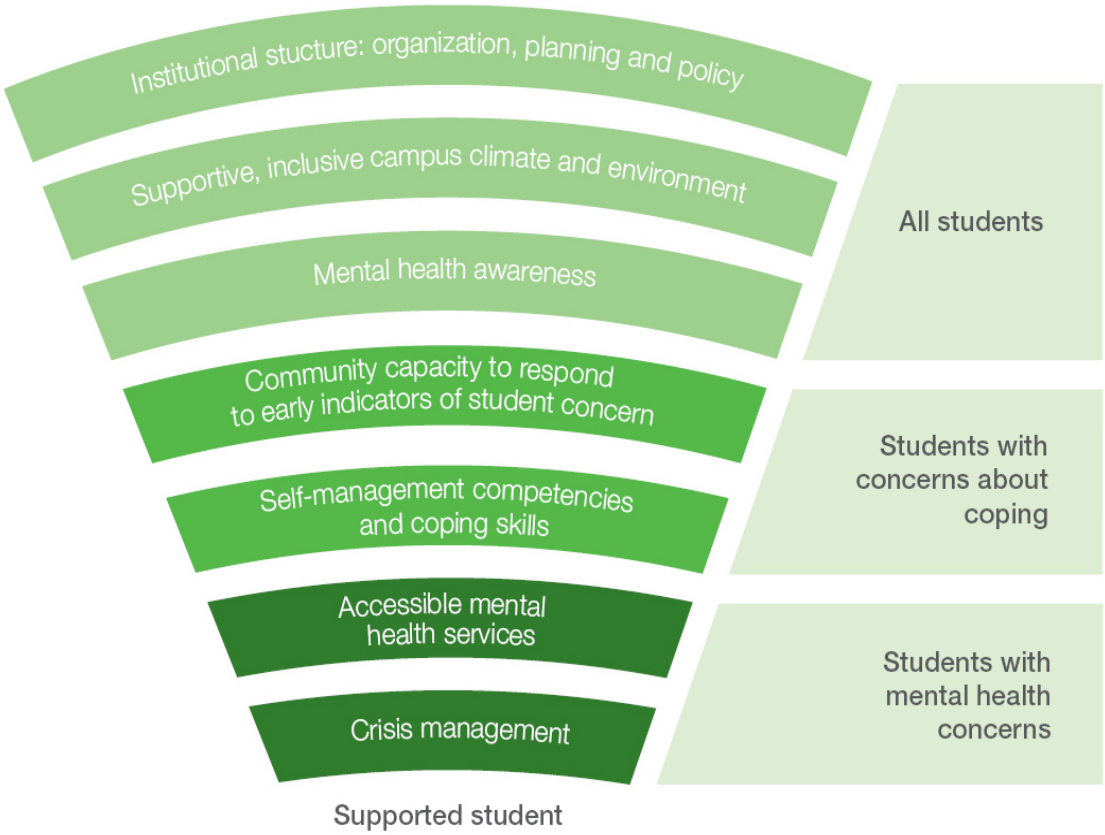
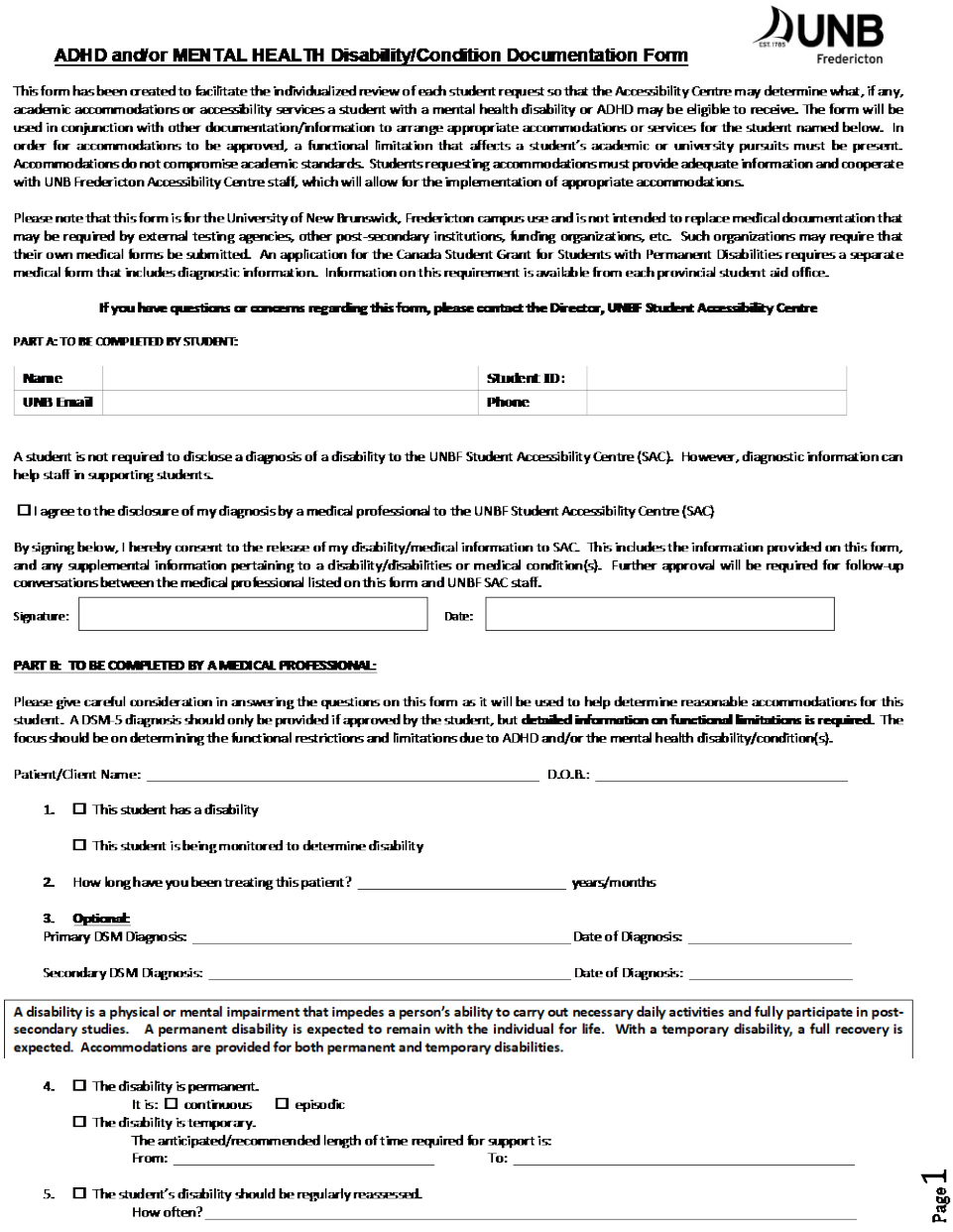


Figure F1: Framework for Post-Secondary Student Mental Health

Source: Canadian Association of College & University Student Services and Canadian Mental Health Association. (2013). *Post-Secondary Student Mental Health: Guide to a Systemic Approach*. Vancouver, BC. Retrieved from https://healthycampuses.ca/wp-content/uploads/2014/09/The-National-Guide.pdf.

Appendix E University of New Brunswick Fredericton ADHD/Mental Health Accommodations Documentation Form



ADHD and/or MENTAL HEALTH Disability/Condition Documentation Form

UNB Fredericton

This form has been created to facilitate the individualized review of each student request so that the Accessibility Centre may determine what, if any, academic accommodations or accessibility services a student with a mental health disability or ADHD may be eligible to receive. The form will be used in conjunction with other documentation/information to arrange appropriate accommodations or services for the student named below. In order for accommodations to be approved, a functional limitation that affects a student's academic or university pursuits must be present. Accommodations do not compromise academic standards. Students requesting accommodations must provide adequate information and cooperate with UNB Fredericton Accessibility Centre staff, which will allow for the implementation of appropriate accommodations.

Please note that this form is for the University of New Brunswick, Fredericton campus use and is not intended to replace medical documentation that may be required by external testing agencies, other post-secondary institutions, funding organizations, etc. Such organizations may require that their own medical forms be submitted. An application for the Canada Student Grant for Students with Permanent Disabilities requires a separate medical form that includes diagnostic information. Information on this requirement is available from each provincial student aid office.

If you have questions or concerns regarding this form, please contact the Director, UNBF Student Accessibility Centre

PART A: TO BE COMPLETED BY STUDENT:

Name		**Student ID:**	
UNB Email		**Phone**	

A student is not required to disclose a diagnosis of a disability to the UNBF Student Accessibility Centre (SAC). However, diagnostic information can help staff in supporting students.

☐ I agree to the disclosure of my diagnosis by a medical professional to the UNBF Student Accessibility Centre (SAC)

By signing below, I hereby consent to the release of my disability/medical information to SAC. This includes the information provided on this form, and any supplemental information pertaining to a disability/disabilities or medical condition(s). Further approval will be required for follow-up conversations between the medical professional listed on this form and UNBF SAC staff.

Signature: _____ Date: _____

PART B: TO BE COMPLETED BY A MEDICAL PROFESSIONAL:

Please give careful consideration in answering the questions on this form as it will be used to help determine reasonable accommodations for this student. A DSM-5 diagnosis should only be provided if approved by the student, but **detailed information on functional limitations is required.** The focus should be on determining the functional restrictions and limitations due to ADHD and/or the mental health disability/condition(s).

Patient/Client Name: _____ D.O.B.: _____

1. ☐ This student has a disability

   ☐ This student is being monitored to determine disability

2. How long have you been treating this patient? _____ years/months

3. **Optional:**
   Primary DSM Diagnosis: _____ Date of Diagnosis: _____

   Secondary DSM Diagnosis: _____ Date of Diagnosis: _____

A disability is a physical or mental impairment that impedes a person's ability to carry out necessary daily activities and fully participate in post-secondary studies. A permanent disability is expected to remain with the individual for life. With a temporary disability, a full recovery is expected. Accommodations are provided for both permanent and temporary disabilities.

4. ☐ The disability is permanent.
   It is: ☐ continuous ☐ episodic
   ☐ The disability is temporary.
   The anticipated/recommended length of time required for support is:
   From: _____ To: _____

5. ☐ The student's disability should be regularly reassessed.
   How often? _____

Page 1

Figure D1: University of New Brunswick Fredericton: ADHD and/or MENTAL HEALTH Disability/Condition Documentation Form

Source: University of New Brunswick: Student Services Fredericton Retrieved from https://www.unb.ca/fredericton/studentservices/_assets/documents/accessibility/mental-health-medical-form.pdf

Appendix F. Policy Matrix

		Option 1: Accommodations	Option 2: UDL	Option 3: Student Services	Option 4: Health Promotion
Increase Access to Academia	Increase Access to Course Content	Moderate	Good	Poor	Poor
	Decrease Unwanted Interaction with the Medical System	Moderate	Good	Moderate	Poor
	Decrease the Need for Self-Advocacy	Moderate	Good	Moderate	Poor
	Increase Opportunities to Connect and Contribute	Poor	Moderate	Good	Good
	Increase Knowledge of Disability	Poor	Moderate	Moderate	Good
Effectiveness	Short-term efficacy	Good	Poor	Good	Poor
	Sustainability	Poor	Good	Moderate	Good
Stakeholder Acceptance	Acceptance by Faculty	Poor	Poor	Good	Moderate
	Capacity of Accessibility Staff	Poor	Moderate	Good	Good
Cost	Cost	Moderate	Poor	Poor	Good
Equity Impacts	Impacts on Equity-Deserving Groups	Poor	Good	Moderate	Good
	Impacts on Faculty and Staff with Disabilities	Poor	Moderate	Moderate	Good

Figure G1: Complete Policy Matrix

Appendix G. Policy Implementation Roadmap

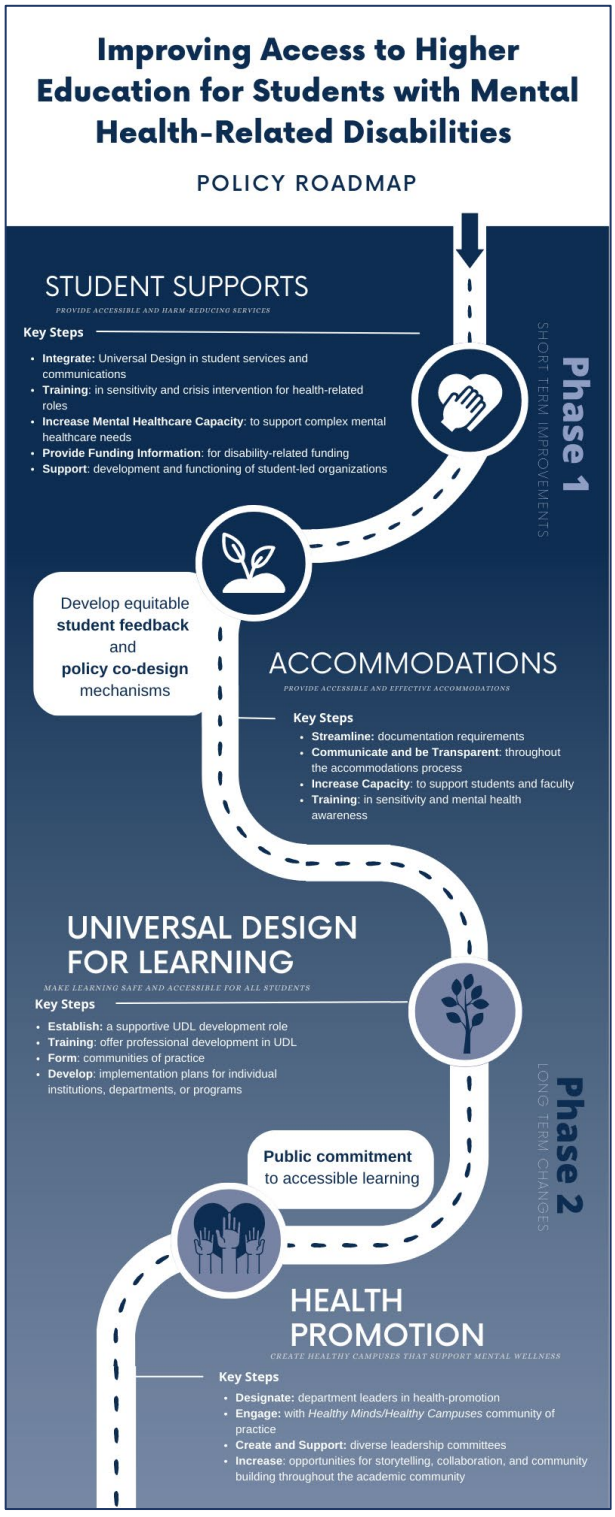


Figure H1: Policy Implementation Roadmap: Improving Access to Higher Education for Students with Mental Health-Related Disabilities