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RETALIATION FOLLOWING REQUESTS FOR ACCOMMODATION

An Exploratory Community Consultation on the Experiences of People Living with Multiple Chemical Sensitivity (MCS)

Prepared by

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Community consultation report — not Research Ethics Board-approved research

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Important Note on Scope and Use

This report summarizes an exploratory community consultation convened to understand experiences and identify priorities for future advocacy, policy development, organizational practice, legal reform work, and Research Ethics Board (REB)-approved investigation. The consultation was not designed or conducted as research and did not receive REB approval. It should not be interpreted as a research study, a representative survey, a prevalence estimate, or a legal opinion.

Participant confidentiality has been maintained. Names and identifying details are not included. Quotations are attributed only to participant identification numbers. Province or broad geographic location is used only where needed to demonstrate geographic reach and where it does not create a reasonable risk of identification.

The experiences reported here are the experiences shared by participants. They identify recurring concerns and areas requiring attention; they do not establish legal liability or determine whether any particular act met a legal definition of retaliation, discrimination, harassment, or assault. Those questions require case-specific legal analysis.

Acknowledgements

EHAC-ASEC and ASEQ-EHAQ thank the participants who shared their experiences, concerns, and ideas. Their contributions helped illuminate not only the barriers created by chemical exposures, but also what can happen after a person discloses MCS and asks for accommodation. The organizations also acknowledge the caregivers, advocates, staff, and community members whose ongoing work supports people living with MCS.

Executive Summary

People living with Multiple Chemical Sensitivity (MCS) may require accommodations to access workplaces, healthcare, housing, education, public services, and community life without exposure to fragrances and other environmental chemicals that trigger symptoms. This exploratory bilingual community consultation was convened by EHAC-ASEC and ASEQ-EHAQ to better understand a less examined concern: negative responses and perceived retaliation after a person discloses MCS or requests accommodation.

Participants described experiences across healthcare, employment, housing, neighbourhoods, family relationships, public venues, and community settings. Their accounts varied, but a consistent story emerged. Recognition or disclosure did not necessarily lead to meaningful accessibility or safety. In several cases, requests were ignored, questioned, only partly implemented, or followed by conduct participants perceived as deliberate or knowingly harmful. Participants described increased fragrance use, failure to enforce policies, continued exposure despite advance notice, dismissive responses, and escalating conflict after concerns were raised.

The central message of this consultation is that recognition alone does not ensure accessibility. For some participants, the request for accommodation became a turning point that introduced new barriers. Fear of consequences then discouraged further disclosure and requests. Continued exposure was linked by participants to worsening symptoms, employment loss, reduced healthcare access, housing instability, family strain, avoidance, social isolation, and fear about aging and future care.

Key findings

- Accommodation requests were often made only after extensive self-management and avoidance had failed.
- Participants described retaliation broadly: overt hostility, deliberate or increased exposure, non-enforcement, dismissal, delay, and conduct that discouraged future requests.
- Healthcare barriers were severe and included failed preparation, fragranced providers, disbelief, and avoidance or delay of care.
- Written policies offered little protection when staff lacked training, authority, procedures, or accountability.
- Fear of retaliation functioned as an accessibility barrier by silencing people before a request was made.
- The consequences were cumulative and crossed sectors: health, work, income, housing, relationships, participation, independence, and future security.
- Participants called for education, effective policy implementation, cleaner indoor air, timely complaint responses, accountability, and stronger legal and regulatory protection.

The consultation does not establish how common these experiences are, and it cannot determine whether individual incidents satisfy legal tests. It does, however, identify a coherent pattern that warrants attention. The report recommends immediate improvements in accommodation processes and fragrance-free/lowest-emission policy implementation, alongside structured legal and policy review and future REB-approved research.

This report is intended to stand on its own as a public community document and to serve as a foundation for subsequent work by EHAC-ASEC and ASEQ-EHAQ, including a stronger evidence-informed report on accessibility and legal reform.

1. Background and Purpose

Multiple Chemical Sensitivity (MCS) is associated with adverse symptoms following exposure to low levels of common chemicals encountered in everyday environments. Participants identified fragrances, scented laundry and personal-care products, cleaning agents, air fresheners, smoke, pesticides, solvents, building materials, renovation products, and emissions from equipment as recurring triggers. The resulting barriers can affect access to employment, healthcare, housing, transportation, education, public services, recreation, and family life.

EHAC-ASEC and ASEQ-EHAQ have heard repeatedly through community support, public events, accessibility work, and indoor-air-quality initiatives that the barrier is not only exposure itself. People also describe what happens after they explain the risk and ask for changes. Requests that are intended to enable participation may be minimized, resisted, or followed by worsening conditions. In some accounts, the person requesting accommodation believes the response is deliberate retaliation; in others, the harm arises through indifference, non-enforcement, poor preparation, or systemic failure.

The consultation was therefore organized to explore five questions:

- How do people living with MCS understand retaliation in the accommodation context?
- Where do negative responses and perceived retaliation occur?
- How does fear of retaliation affect whether people disclose MCS or request accommodation?
- What consequences follow when accommodation fails or exposure continues?
- What changes do participants believe are needed in policy, practice, law, education, and future investigation?

The consultation was exploratory. Its role was to listen, identify recurring issues, and determine whether further investigation and formal research are required. It was also intended to inform advocacy and future legal reform work without presenting the discussion as legal evidence or research findings.

2. Consultation Approach and Limitations

EHAC-ASEC and ASEQ-EHAQ convened a bilingual online community discussion in June 2026. The session included French- and English-language participation and focused on experiences related to MCS, requests for accommodation, retaliation or feared negative consequences, and priorities for change. Participants were invited to speak from lived experience, caregiving experience, or sustained community-support experience.

Six Canadian participant contributors were assigned identification numbers P001 to P006 for the evidence repository used to prepare this report. One participant also facilitated portions of the discussion and contributed lived and caregiving experience; only the participant's substantive personal and community observations were treated as participant contributions. A contribution from outside Canada was not included in the Canadian participant synthesis used for this report.

Participants were asked three broad sets of questions:

- What motivated them to participate, and what did retaliation mean in the context of MCS?
- Whether fear of retaliation had affected accommodation requests, what had occurred, and how it affected health, work, housing, services, relationships, or well-being?
- What employers, healthcare professionals, service providers, governments, and the public should better understand or change?

The recording and transcript were reviewed to organize participant statements by broad topic. A concise evidence repository was prepared using participant IDs, selected quotations, issue summaries, and proposed report themes. This was a practical documentation and writing process for a community report; it was not a formal qualitative research analysis and should not be described as such.

Confidentiality was maintained in the public report. Names and unnecessary personal identifiers were removed. Quotations were lightly edited only where required for readability, including translation from French into English, removal of filler words, and correction of obvious transcription errors. The intended meaning was preserved. Province or broad location was retained only where it supported the national context without creating undue identification risk.

Limitations

The consultation involved a small, self-selected group and was not intended to represent all people living with MCS. Participation and speaking time varied. The session was exploratory rather than a structured research interview, and some discussion included facilitation, clarification, and community support. Experiences were self-reported and were not independently verified. The report does not determine intent, causation, legal liability, or the legal characterization of any incident. It identifies concerns that merit practical action and more rigorous future inquiry.

3. Findings

Across the consultation, participants described a progression rather than a single type of incident. They first attempted to manage exposure privately. Disclosure and accommodation requests were often made only when participation had become impossible without support. Responses then ranged from support to disbelief, delay, non-enforcement, and conduct perceived as retaliation. Where exposure continued, participants described worsening health, withdrawal, and cumulative loss.

Recognition or disclosure of MCS

↓

Accommodation requested

↓

Support | Disbelief | Delay | Non-enforcement | Perceived retaliation

↓

Continued or increased exposure

↓

Illness and impaired self-advocacy

↓

Loss of access, work, housing security, relationships, or participation

↓

Avoidance and isolation

↓

Fear about the future

Figure 1. Recurring pathway described in the consultation. This is a conceptual summary of participant accounts, not a tested research model.

3.1 Everyday Environmental Barriers and the Turn Toward Avoidance

Before speaking about retaliation, participants described the continuous work of trying to remain safe. Ordinary activities required assessment of products, people, ventilation, routes, timing, and the likelihood that a request would be respected. Fragrance exposure was not limited to perfume or cologne. Participants repeatedly identified scented laundry products, fabric softeners, shampoos, deodorants, candles, plug-in air fresheners, cleaning products, smoke, paint, and residues carried on clothing or equipment.

> *"Now, whenever I leave home, I'm taking a risk."* **— P001**

Participants described avoidance as the most reliable strategy available to them. Avoidance was not presented as a free choice. It meant staying home, declining invitations, sitting apart from others, shortening conversations, leaving venues, postponing care, or giving up activities. One participant reported spending significant personal funds on treatments before concluding that exposure prevention remained the only consistently useful approach.

> *"I've spent money on treatments, but in the end I realized that avoidance is really the only thing that works."* **— P001**

Even outdoor environments were not reliably accessible. Participants described fragranced laundry products carried on clothing, drifting smoke, and emissions from nearby properties. Rural or low-density housing reduced some exposures but did not eliminate windborne contaminants. The practical result was continuing vigilance and reduced spontaneity in daily life.

3.2 Disclosure and Requests for Accommodation as a Turning Point

Participants did not describe accommodation requests as casual preferences. They asked because an environment, service, or relationship had become unsafe or inaccessible. Requests included fragrance-free healthcare visits, enforcement of workplace policies, removal of scented products, smoke-free rules, advance notice of maintenance, safer service practices, and changes to family or visitor products.

Several participants had attempted to explain MCS, provide medical information, or help develop policies. They expected disclosure to improve understanding. Instead, some found that the request altered how they were treated. The shift could be immediate, such as an increase in fragranced products, or gradual, such as disbelief, avoidance, procedural resistance, or reluctance to enforce a policy.

> *"I thought everybody was on board now. But no—it actually got way worse."* **— P004**

The burden of disclosure was intensified by uncertainty. A person could not know whether the response would be supportive, dismissive, or hostile. Participants also described the exhaustion of having to educate others repeatedly and the discomfort of continually pointing out exposures. This made later requests less likely, even when the need remained.

3.3 Retaliation, Perceived Retaliation, and Negative Responses

Participants used the term retaliation broadly. It included overtly hostile conduct, but also actions and omissions that followed a request and made the situation worse. Examples included increased fragrance use, bringing scented candles or sprays into a workplace, refusing to remove air fresheners, ignoring smoke-free requirements, allowing exposure to continue after advance notice, dismissing the person's account, and failing to enforce an existing policy.

Intent could not be independently determined. The important consultation finding is that participants experienced these responses as threatening, punitive, or knowingly dismissive. In some circumstances, they believed people were "testing" whether the disability was real or reasserting control after being asked to change a product or practice.

> *"People started testing me. People were bringing in scent, scented candles—all deliberately."* **— P004**
>
> *"My boss all of a sudden started wearing scented deodorant. To me that was retaliation. It forced me out of there."* **— P003**

Other accounts were less clearly intentional but still harmful. A healthcare provider might acknowledge a sensitivity yet arrive fragranced; venue staff might acknowledge a fragrance-free policy but say nothing could be done; contractors might promise protocols and then fail to follow them. Participants distinguished between accidental exposure and exposure that continued after the risk had been explained.

One participant summarized the familiarity of the problem without describing a single incident:

> *"Retaliation is a familiar word. It's a familiar experience."* **— P005**

3.4 Healthcare Barriers

Healthcare emerged as a severe concern. Participants described fragranced healthcare workers, poor preparation, lack of understanding, dismissal, difficulty obtaining diagnosis or specialist care, and avoidance or delay of medical appointments. Healthcare environments were especially distressing because people often had limited ability to leave, reschedule, or protect themselves during illness, surgery, or urgent care.

P001 described arriving for surgery with a bracelet identifying fragrance sensitivity after having informed staff. The surgeon nevertheless reported wearing perfume that morning. The participant described breathing difficulty and repeated concern about declining oxygen saturation during recovery. The report does not determine the clinical cause of those events; it records that the participant experienced the situation as a serious failure of preparation and accommodation.

> *"When I arrived for surgery, my bracelet identified me as having a perfume allergy. The surgeon said, "I'm sorry, I wore perfume this morning.""* **— P001**

Participants also described disbelief and limited professional knowledge. Some felt their symptoms were treated as psychological or were met with resignation rather than investigation. Others described being unable to access specialized services because of provincial boundaries or capacity. P006 contributed severe healthcare concerns alongside housing and legal issues, reinforcing that healthcare barriers were not incidental but central to the consultation.

The consequence was not merely an unpleasant visit. Participants described postponing care, avoiding healthcare unless essential, and entering appointments with fear that accommodation would fail. This converts an environmental barrier into an access-to-care barrier.

3.5 Workplace Retaliation and Loss of Employment

Workplace accounts provided the clearest examples of perceived retaliation following disclosure. Participants described supervisors and co-workers failing to follow policies, increasing fragrance use, introducing scented products, or treating the request as a challenge to authority. Management non-compliance was particularly damaging because it signalled that the policy would not be enforced.

P003 described helping create a scent-free policy and then experiencing non-compliance by management. She linked the resulting exposures to leaving her job and relocating. P004 described providing medical documentation and expecting support, only to perceive an increase in scented products and "testing" by colleagues. These accounts show how an accommodation process can fail not only through inadequate adjustments but through a deterioration in the work environment after disclosure.

> *"We created a scent-free policy. The worst people who didn't get it were the management."* **— P003**

Employment consequences included early retirement, resignation, lost income, relocation, and reduced capacity to volunteer or re-enter community life. Some participants believed pursuing workers' compensation or other remedies would be futile because causation would be difficult to prove and the process itself would require substantial energy.

3.6 Policies Without Implementation or Enforcement

A repeated distinction was made between a written policy and an effective accommodation system. Participants described policies that were displayed or acknowledged but not explained, monitored, or enforced. Staff sometimes lacked authority or procedures to respond. Visitors and members of the public could remain fragranced without consequence. Managers themselves sometimes ignored the policy.

> *"It was supposed to be fragrance-free, but they told me there was nothing they could do."* **— P001**
>
> *"No scent means no scent."* **— P004**

Participants emphasized that "fragrance-free" must include more than perfume. Scented laundry products, fabric softeners, shampoos, body sprays, deodorants, cleaning products, and air fresheners can remain significant sources of exposure. Policies that do not define expectations, cover procurement and maintenance, communicate with visitors, and establish a response process may provide reassurance on paper while leaving the environment unchanged.

The consultation therefore points to implementation as a distinct accessibility obligation: leadership, education, planning, procurement, communication, response procedures, and accountability must operate together.

3.7 Housing, Neighbourhoods, and Fear of Losing a Safe Home

Housing was described as both a refuge and a site of unavoidable exposure. Participants reported smoke, fragrances, cleaning products, maintenance contamination, scented visitors or care workers, and emissions drifting between units or across property boundaries. Some had moved repeatedly in search of a safer home. Others feared that speaking up would provoke escalation or jeopardize housing relationships.

P004 described becoming silent after perceived retaliation and feared that redevelopment could leave her without a unit she could safely occupy. P006 described living in housing intended in part for people with multiple chemical sensitivity while still being affected by smoking, fragranced neighbours, and contractors who did not follow promised protocols. She hesitated to raise the issue because prior complaints about other conduct had made matters worse.

> *"I don't know how to handle it, because if it's not done super, super delicately, it will cause massive retaliation."* **— P006**

Participants also raised the absence of clear, timely remedies when airborne contaminants cross unit or property boundaries. This issue is especially difficult because the affected person cannot fully control the air entering a home, yet may face uncertain legal or administrative protection. Aging intensified the concern. Participants questioned how they would safely access seniors' residences, assisted living, or long-term care if fragrance-free and lowest-emission practices were unavailable.

> *"I'm 65 now. One day I may have to live in a residence. What am I going to do?"* **— P001**

3.8 Family Relationships, Caregiving, and Social Isolation

Family experiences ranged from strong support to disbelief and exclusion. Some family members changed laundry and personal-care products, helped identify sources, and treated accommodation as a shared responsibility. These examples showed that practical support is possible and can reduce both exposure and emotional burden.

Other participants described years of conflict, tolerating exposure to preserve relationships, or withdrawing from gatherings because requests were not respected. P004 described the tension between caring for an elderly parent who smoked and protecting her own health. P003 described the pain of family members not understanding her limitations and eventually becoming unable to continue attending gatherings.

> *"I had to tolerate many exposures just to be around them."* **— P004**

Isolation was both an outcome and a protective strategy. Participants stopped attending events, reduced contact, stayed home, or positioned themselves apart from others. Peer connection was therefore especially important. P005 described joining partly for a "group hug" and to learn from the perseverance of others. Participants spoke about validation as a way of recovering confidence after repeated disbelief.

3.9 Fear, Impaired Self-Advocacy, and Procedural Inequality

Fear operated before, during, and after an accommodation request. Participants anticipated ridicule, conflict, job loss, worsening exposure, damaged relationships, or housing consequences. This meant that some requests were never made. Others were delayed until symptoms or barriers became severe.

A particularly important issue was the expectation that people advocate effectively while symptomatic. Exposure-related cognitive difficulty, fatigue, respiratory distress, and anxiety could impair concentration and communication at the exact moment a person had to explain the problem, challenge a decision, or preserve evidence. P003 articulated this procedural disadvantage clearly:

> *"When I had to go in and talk to that manager, I got brain fog. You can't do a good job of representing yourself."* **— P003**

Complaint and accommodation systems that depend on immediate, sustained, technically precise self-advocacy may therefore be inaccessible in practice. Fear and symptom-related impairment can silence the person and then be mistaken for lack of evidence, lack of urgency, or acceptance of the situation.

3.10 Cumulative Loss and Fear About the Future

Participants rarely described a single event with a single consequence. They described accumulation: repeated symptoms, lost work, treatment costs, relocation, reduced healthcare, strained relationships, shrinking participation, and uncertainty about future care. The loss was physical, social, economic, and civic.

For some, the greatest consequence was not one exposure but the narrowing of life. Volunteering, exercise, public events, travel, family gatherings, and ordinary errands became uncertain or impossible. Participants described grief, exhaustion, fear, and the sense that there was nowhere to go without risk.

At the same time, participants expressed hope that authoritative information, stronger policy, cleaner air, effective accommodation, and legal accountability could change the trajectory. Their recommendations focused not only on individual disputes but on preventing the conditions that allow repeated harm.

4. Discussion

The consultation began with retaliation, but the discussion revealed a broader accessibility problem. Participants were not describing only interpersonal conflict. They were describing systems that often remain inaccessible after a disability-related need has been disclosed. The central insight is therefore that recognition alone does not ensure accessibility.

Across sectors, the same sequence appeared: a person encounters exposure, attempts private avoidance, discloses MCS, requests accommodation, and receives a response that may be supportive, delayed, incomplete, dismissive, or perceived as retaliatory. If the environment does not change, exposure continues. Health and self-advocacy may worsen, and the person withdraws. The eventual absence of the person can hide the original barrier: the workplace, clinic, residence, or event may appear problem-free because the person who could not safely participate is no longer present.

This pattern matters for accessibility practice. A duty or commitment to accommodate cannot be evaluated only by whether a policy exists or a request was acknowledged. The relevant question is whether the person can actually access and use the environment or service safely and with dignity. Implementation, monitoring, response, and protection from negative consequences are part of meaningful access.

The accounts also suggest that retaliation should be understood functionally as well as intentionally. Formal legal definitions may require specific elements and vary by jurisdiction. A community accessibility analysis can nevertheless examine whether a response discourages a person from asserting rights, worsens exposure after a request, penalizes participation, or creates fear of future requests. This functional lens does not decide legal liability; it helps identify where systems may be producing exclusion.

Healthcare deserves particular attention because the power imbalance is substantial and the consequences of avoidance can be serious. A person may be ill, cognitively impaired, sedated, dependent on staff, or unable to leave. Advance planning that fails at the point of care can therefore create both immediate risk and long-term avoidance. Similarly, housing barriers can be continuous because home is not an optional environment and neighbouring emissions may be outside the resident's control.

The consultation further highlights procedural accessibility. People may be expected to document events, negotiate solutions, educate decision-makers, and pursue complaints while experiencing the symptoms caused by the disputed exposure. Processes that are slow, adversarial, or dependent on repeated self-advocacy can compound the original barrier. Timeliness and support are therefore not merely administrative conveniences; they may determine whether a remedy has any practical value.

Because this was not REB-approved research, these observations should be treated as consultation-based insights and hypotheses for further examination. They are nonetheless sufficiently coherent to guide immediate organizational improvements and to justify structured legal, policy, and research work.

5. Implications for Accessibility, Policy and Legal Reform

The experiences shared in this consultation point to several questions that should shape future work by EHAC-ASEC, ASEQ-EHAQ, governments, legal advocates, human rights bodies, accessibility organizations, healthcare systems, employers, and housing providers.

5.1 From Recognition to Enforceable Access

Recognition of MCS as a disability or accommodation need is important, but participants' experiences indicate that recognition can be ineffective without operational duties, accessible procedures, and protection after disclosure. Future policy and legal review should examine the full accommodation pathway: notice, assessment, interim protection, implementation, monitoring, enforcement, and remedy.

5.2 Retaliation as an Accessibility Barrier

Fear of retaliation can prevent a person from requesting accommodation at all. Negative treatment after disclosure can also force withdrawal before a complaint is resolved. Future reform work should examine whether existing anti-reprisal protections are understood, accessible, timely, and broad enough to address disability-related accommodation across employment, healthcare, housing, public services, and other settings.

5.3 Environmental Accessibility and Source Control

Participants repeatedly sought control of preventable sources rather than exceptional treatment. Fragrance-free and lowest-emission practices, smoke control, safer procurement, advance notice, and contractor protocols can reduce barriers before an individual request becomes necessary. Legal and policy work should therefore consider environmental accessibility as both an individual accommodation issue and a proactive systems-design issue.

5.4 The Home and Air Crossing Boundaries

Neighbouring emissions raise difficult questions at the intersection of disability rights, housing law, nuisance, public health, condominium or tenancy governance, and property rights. Participants described limited practical remedies when smoke or fragrance entered their homes. This area warrants focused legal analysis, comparative jurisdictional review, and consultation with housing and human rights experts.

5.5 Procedural Accommodation and Timely Remedies

Complaint systems should account for cognitive impairment, fatigue, communication difficulty, limited finances, and the health consequences of delay. Future reform proposals should consider assistance with documentation, accessible communication, interim measures, non-adversarial early resolution, protection from further exposure, and remedies that arrive before employment, housing, or healthcare access is lost.

5.6 Evidence Needed for Reform

This consultation provides a narrative foundation, not a legal evidentiary record. A strong future legal reform report should combine lived experience with applicable statutes, regulations, policies, tribunal and court decisions, professional standards, indoor-air-quality evidence, accommodation guidance, and comparative approaches. It should also distinguish among intentional retaliation, harassment, failure to accommodate, adverse-effect discrimination, policy non-compliance, negligence, and broader regulatory gaps.

Future REB-approved research could examine the prevalence, settings, forms, timing, and consequences of retaliation following MCS accommodation requests; the effectiveness of current complaint mechanisms; and the organizational practices that prevent escalation. The present report helps define those questions.

6. Recommendations

The following recommendations are proportionate to an exploratory community consultation. They identify immediate practical actions and priorities for formal policy, legal, and research development.

1. Establish clear accommodation pathways

Organizations should provide a written, respectful, and timely process for receiving MCS-related accommodation requests, identifying immediate protective measures, assessing needs, implementing solutions, and following up. The process should identify responsible decision-makers and should not require the individual to repeatedly restart the explanation.

2. Protect people from negative consequences after disclosure

Employers, healthcare organizations, housing providers, educational institutions, and service providers should communicate that retaliation, harassment, deliberate exposure, and obstruction of accommodation are unacceptable. Concerns raised after disclosure should be documented and reviewed promptly, with interim measures to prevent continued harm.

3. Move fragrance-free policies from paper to practice

Policies should define fragranced products broadly, address staff, visitors, procurement, cleaning, maintenance, renovations, and contractors, and include education, signage, response procedures, and accountability. Leadership must model compliance.

4. Prioritize healthcare accessibility

Healthcare systems should develop advance-notice and point-of-care protocols for patients with MCS, including fragrance-free staff preparation, safer waiting and treatment arrangements, chart alerts that trigger action, and escalation procedures when accommodation cannot be delivered as planned.

5. Improve housing protection and governance

Housing providers should address smoke, fragranced products, maintenance emissions, contractor practices, and inter-unit transfer through policies, ventilation and source-control measures, communication, and timely response. Governments and legal organizations should examine gaps affecting airborne contaminants crossing residential boundaries.

6. Make complaint and resolution processes accessible

Processes should permit support persons, flexible communication, additional time where required, assistance with documentation, and early non-adversarial resolution. Interim protection should be available where delay could cause continued exposure, loss of work, loss of care, or housing instability.

7. Expand authoritative education

Governments, professional bodies, healthcare educators, employers, human resources professionals, housing providers, first responders, unions, and disability organizations should provide accurate education on MCS, environmental accessibility, fragrance sources, accommodation, and the harms of disbelief or retaliatory conduct.

8. Integrate environmental accessibility into broader accessibility planning

Accessibility plans, procurement standards, building operations, emergency planning, public events, transportation, and service design should consider indoor air quality, preventable chemical exposures, and source control rather than relying only on individual requests.

9. Undertake a focused legal and policy review

ASEQ-EHAQ and EHAC-ASEC should develop a separate legal reform report drawing on lived experience, legal analysis and emerging evidence with qualified legal partners. It should map protections and gaps across federal, provincial, and territorial human rights, accessibility, employment, occupational health and safety, healthcare, housing, tenancy, condominium, public health, and anti-reprisal frameworks.

10. Conduct future REB-approved research

A subsequent research project should use an approved protocol, purposive recruitment across jurisdictions and sectors, accessible participation methods, and a clear analysis plan. It should examine retaliation and non-retaliatory accommodation failure separately, while documenting consequences, remedies sought, outcomes, and promising practices.

11. Continue meaningful lived-experience leadership

People living with MCS and caregivers should be involved in designing policies, training, research, legal reform priorities, and evaluation. Engagement should be accessible, confidential, and structured so that participation does not require repeated exposure or excessive self-advocacy.

12. Develop practical tools for immediate use

EHAC-ASEC and ASEQ-EHAQ should translate this report into concise tools: an accommodation checklist, a retaliation documentation guide, a healthcare preparation form, a housing communication template, and a short briefing for decision-makers. These tools should clearly state that they are informational and not legal advice.

7. Conclusion

Participants in this exploratory consultation described what can happen after a person with MCS identifies an environmental barrier and asks for accommodation. Some experienced support. Others described disbelief, delay, policy non-enforcement, continued or increased exposure, and conduct they perceived as retaliation. The consequences extended beyond symptoms to employment, healthcare, housing, relationships, participation, independence, and hope for the future.

The most important message is simple: recognition alone does not ensure accessibility. An accommodation right or policy has limited value if the request itself exposes the person to hostility, worsening conditions, procedural disadvantage, or fear. Meaningful accessibility requires prevention, implementation, accountability, timely remedy, and protection after disclosure.

This report does not claim to establish prevalence, causation, or legal liability. It records community experiences and identifies a coherent agenda for action. Organizations can improve practice now. Governments and legal partners can examine gaps in protection. Researchers can build an REB-approved evidence base. People with lived experience can continue to shape solutions.

The participants' stories therefore serve two purposes. They support immediate efforts to make environments safer and more inclusive, and they provide a foundation for stronger future work on policy and legal reform. EHAC-ASEC and ASEQ-EHAQ will use this consultation to advance that work while preserving confidentiality and respecting the limits of the consultation.

Appendix A. Consultation Questions

- What motivated you to join the discussion, and what does retaliation mean to you in the context of MCS?
- Have you hesitated to request accommodation because of fear of retaliation or negative consequences? What occurred and how did it affect your health, work, education, housing, access to services, relationships, or well-being?
- What should employers, healthcare professionals, housing and service providers, governments, and the public better understand about retaliation and accommodation for people living with MCS?
- What changes would help prevent retaliation, improve accommodation, and create more accessible environments?

Appendix B. Suggested Next Products

- Legal reform report and jurisdictional map.
- Policy brief for governments and human rights/accessibility bodies.
- Organizational implementation guide for fragrance-free and lowest-emission policies.
- Healthcare accommodation protocol and patient preparation tool.
- Housing and neighbour-exposure legal/policy scan.
- REB-approved research protocol on retaliation following accommodation requests.