



*Final Report*

# **Housing assistance, social inclusion and people living with a disability**

authored by

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for the

**Australian Housing and Urban  
Research Institute**

Southern Research Centre

November 2011

AHURI Final Report No. 178

ISSN: 1834-7223

ISBN: 978-1-921610-86-8



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<b>Title</b>	Housing assistance, social inclusion and people living with a disability	
<b>ISBN</b>	978-1-921610-86-8	
<b>Format</b>	PDF	
<b>Key words</b>	housing assistance, social inclusion, people, disability	
<b>Editor</b>	Anne Badenhorst	AHURI National Office
<b>Publisher</b>	Australian Housing and Urban Research Institute Melbourne, Australia	
<b>Series</b>	AHURI Final Report; no.178.	
<b>ISSN</b>	1834-7223	
<b>Preferred citation</b>	Tually, S. et al. (2011) <i>Housing assistance, social inclusion and people living with a disability</i> , AHURI Final Report No.178. Melbourne: Australian Housing and Urban Research Institute.	

## **ACKNOWLEDGEMENTS**

This material was produced with funding from the Australian Government and the Australian states and territory governments. AHURI Limited gratefully acknowledges the financial and other support it has received from these governments, without which this work would not have been possible.

AHURI comprises a network of universities clustered into Research Centres across Australia. Research Centre contributions, both financial and in-kind, have made the completion of this report possible.

The authors of this report would like to sincerely thank the people working with people living with disabilities who participated in this study, and those who helped arrange interviews and especially the many people living with disabilities in SA, NSW and Victoria who participated in this study and willingly shared their stories to make this research the rich source of information and insights that it is.

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## **ACRONYMS**

ABI	Acquired brain injury
ABS	Australian Bureau of Statistics
AHURI	Australian Housing and Urban Research Institute
AIHW	Australian Institute of Health and Welfare
COAG	Council of Australian Governments
CRA	Commonwealth Rent Assistance
CRU	Community Residential Unit (Victoria)
CSTDA	Commonwealth State/Territory Disability Agreement
DoH	Department of Housing
DSP	Disability Support Pension (Centrelink)
NAHA	National Affordable Housing Agreement
NDA	National Disability Agreement
NDS	National Disability Strategy
OARS	Offenders Aid and Rehabilitation Service (of South Australia)
PBS	Pharmaceutical Benefits Scheme
SDAC	Survey of Disability, Ageing and Carers (ABS)
WHO	World Health Organisation

## GLOSSARY

- Bedsit** A term commonly used in Australia, the UK and Ireland to refer to a house that has been let out to multiple tenants in the form of non-self-contained single rooms (Department for Communities and Local Government 2011). The tenants share a bathroom/toilet, kitchen, laundry and other facilities. It is a form of dwelling that involves multiple occupation, but does not feature the communal dining configuration of a boarding house.
- Boarding house** A boarding house is a dwelling comprising multiple boarding or lodging units, with shared communal dining and amenities such as on-site kitchen, bathroom and laundry facilities (NSW Department of Housing and Australian Institute of Health and Welfare (AIHW) 2002). Boarding house units consist of a single room or living space. The payment of board gives boarders and lodgers access to shared amenities. Boarding houses are also known as guest houses, hostels and rooming houses (in some states in Australia, rooming houses are differentiated from boarding houses, as these do not provide meals to lodgers).
- Couch surfing** Couch surfing is a form of homelessness and housing insecurity that involves moving frequently from one insecure living arrangement to another, often relying on friends, family and acquaintances for the provision of temporary shelter (MacKenzie & Chamberlain 2008; Uhr 2004). Couch surfers are typically people who are experiencing difficulties in accessing or affording appropriate housing, accommodation and support services.
- Disability** Disability as a social phenomenon and a lived experience varies greatly between individuals and groups within society, depending on a range of factors such as the extent of disability; the source of the disability; the type of impairment, and the interactions between individuals and their physical and social environments (including the extent to which these environments promote accessibility and social inclusion) (Beer & Faulkner 2009). The Australian Bureau of Statistics (ABS) defines disability as 'any limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities. Examples range from hearing loss that requires the use of a hearing aid, to difficulty dressing due to arthritis, to advanced dementia requiring constant help and supervision' (ABS 2004).
- Housing assistance** Housing assistance refers to a range of strategies, services and programs that help individuals who are having difficulties accessing affordable, safe or secure housing (AIHW 2008b). This may include individuals who are income poor and cannot afford privately rented housing; people escaping domestic violence, and people living with a disability or a serious illness that limits their access to suitable housing (AIHW 2008b). Examples of housing assistance in Australia include the provision of social housing such as public and community housing; Commonwealth Rent Assistance (CRA), First Home

Owners assistance and the Supported Accommodation Assistance Program.

**Social inclusion**

Social inclusion is broadly considered to be an ideal condition of full social citizenship (Beer & Maude 2001; Arthurson & Jacobs 2003). It is a concept used to describe the ability of individuals to participate in the formal structures and institutions of the economy, society and state, and to enjoy the benefits of the goods and services produced by mainstream society (Arthurson & Jacobs 2003). Social inclusion is often considered to be the converse of social exclusion, which connotes a reduced capacity to gain access to the goods and services offered by society. People experiencing social exclusion are often subject to the negative impacts of discrimination and/or they are disenfranchised by political, economic or legal structures.

## EXECUTIVE SUMMARY

This Final Report outlines the findings of research addressing two pressing conceptual and policy challenges:

1. What impact does housing assistance have on social inclusion for people with disabilities?
2. How can governments ensure that they maximise the social inclusion benefits from the housing assistance they provide now and into the future?

Investigation of the nexus between housing assistance and social inclusion for people living with a disability is important because of the introduction of a clear whole-of-government social inclusion imperative in government-funded and supported programs. It is also important given the widespread and ongoing concerns about the capacity of the housing system to meet underlying demand for affordable and appropriate housing, especially for vulnerable individuals.

In order to address the overarching research questions, a two-stage methodology was employed.

The first stage of the research involved a literature and policy review to set the context for the research and to highlight what we already know about disability and housing generally. This review and analysis is presented in the Positioning Paper for the project.

For the second stage of the project, reported in this Final Report, primary data were collected from people living with a disability receiving housing assistance and representatives of agencies supporting people living with a disability. Participants in the research had a range of *types* and *levels* of disability, within the target groups of cognitive, psychological, physical/mobility and sensory disability or impairment. Most participants were social housing tenants or private renters in receipt of CRA. Some 98 interviews were conducted with people living with a disability for the research, as well as a small number of focus groups with people living with a disability and service providers. Interviews and focus groups were conducted in three states: NSW, SA and Victoria.

The focus of the data collection for the second stage of the project centred on:

- The current housing situation of people living with a disability, as well as their housing histories and experiences, housing and support needs and the impact of their disability on their housing.
- The general level of social and economic participation of people living with a disability, including their satisfaction with their connectedness to the community, services, employment, family and friends, and their thoughts around their ability to deal with a crisis and have their voice heard.
- The importance of the concept of social inclusion to participants, and their daily life.
- Participants' thoughts around social inclusion/exclusion, satisfaction with their social inclusion outcomes, and perspectives on individual and structural barriers to social inclusion, particularly those who stemming from their disability.
- The role of housing assistance in promoting social inclusion/affecting social exclusion, and the impact of other considerations and issues on social inclusion/exclusion, for example, support needed, social networks, et cetera.

Central to this research was giving a voice to people living with a disability. This voice is clearly represented throughout the rest of this document, and shows the importance of housing assistance for the social inclusion, health and wellbeing of people living with a disability.

In addressing the guiding research questions about the nexus between social inclusion and housing assistance for people living with a disability, the research pays specific attention to the individual level factors identified by participants as shaping their disability and housing (or homelessness) experiences. It also notes how these factors—*type* and *severity* of disability, economic resources and disadvantage, life circumstances and neighbourhood issues and safety concerns—have impacted on, or reinforced, their personal wellbeing and social inclusion/exclusion. The discussion clearly notes that housing is an important part of the life experiences of people living with a disability, and one that can, and has, exerted sometimes contradictory impacts on the life circumstances. For some individuals at some time, it has served as an important resource and stabiliser in their lives, while for others, it has served to constrain their opportunities and limit their capacity for social inclusion. From the discussion, it is evident that many participants are trapped within a complex web of competing pressures, with their wellbeing outcomes and levels of functioning and inclusion in mainstream society and its institutions shaped by factors not always within their control.

On the whole, the research finds that housing assistance has a very substantial impact on the social inclusion of people with a disability in Australia. It has a number of positive impacts:

- Housing assistance provides stability in the lives of people living with a disability who would otherwise be vulnerable to a range of negative circumstances and who may otherwise have no sense of control over their lives.
- Housing assistance helps people with a disability deal with other crises in their lives—health, family relationships, monetary concerns et cetera—and adds to their resilience and independence.
- Housing assistance reduces the exposure of people with a disability to very high housing costs and the risk of eviction. It reduces both vulnerability to homelessness and the experience of (recurrent) homelessness. In the absence of housing assistance, it is almost certain that significantly larger numbers of people living with a disability would experience homelessness, and its most acute manifestation—rough sleeping.
- Housing assistance makes it more likely that people with a disability will enter and remain in paid employment. This has social inclusion benefits both for the individual and broader society.
- Housing assistance, in some instances, can help people with a disability find a voice within their community by equipping them with advocacy skills and providing stability in life, which in turn enables engagement with wider social institutions.

There are a number of steps governments can and should take to ensure that the social inclusion benefits arising from housing assistance to people with a disability are maximised:

- First and foremost, the provision of additional social housing will advance the wellbeing and social inclusion of persons with an impairment across Australia. Additional supply, targeted to this vulnerable group within society, will have significant positive impacts.

- Social housing provision for people with a disability should avoid creating areas of concentration of people with a disability. While acknowledging that the demand for social housing exceeds supply and the need of many people living with a disability for urgent assistance, grouping large numbers of people with a disability in one location has negative effects. The supply of social housing needs to be spread across a range of locations and neighbourhoods as much as possible.
- The housing occupied by people with a disability needs to meet the circumstances of the individual and their household as closely as possible. This includes modifications to the dwelling and on-going maintenance where the disability may require on-going attention. A pertinent example here is for dwellings where a wheelchair user resides.
- Housing assistance for people with a disability should focus on providing accommodation in places with good access to public transport in order to facilitate access to both services and employment.
- Housing assistance programs can and should be used as a vehicle for delivering training and community development programs that help people with a disability find their voice.

Additionally, it is clear that *much more needs to be done to improve outcomes for people living with a disability accommodated in the private rental market*. Lessons can clearly be learned here from existing private rental support programs assisting people living with a disability specifically, such as that offered by Karingal in Geelong, as well as those assisting other vulnerable groups. Directing more resources to agencies to deliver such assistance for people living with a disability, however, should not be at the expense of further investment in social housing. It is clear that this is the best option for many people with severe disabilities and impairments, and particularly those needing specific disability-related modifications to a dwelling. The reality remains, which we still have a long way to go in developing a private rental market responsive to the disability-related needs of tenants.

Regardless of the tenure focus of assistance, the findings of this small scoping study also highlights the immediate need for supports for people living with a disability, including housing assistance, *to concentrate on sustaining tenancies*. Social inclusion outcomes for tenants will remain sub-optimal if actions to sustain tenancies are not promoted. This is clearly a concern for those with mental health issues in particular.

People with a disability and their households remain one of the most disadvantaged groups within society. Housing assistance, and especially access to social housing, is one measure that governments can take to substantially improve their wellbeing and degree of social inclusion within broader society. People with a disability should remain a priority group in the housing allocation processes of social housing providers and more attention should be paid to the interface between health services and housing.

# 1 INTRODUCTION

This Final Report outlines the findings of research addressing two pressing conceptual and policy challenges:

1. What impact does housing assistance have on social inclusion for people with disabilities?
2. How can governments ensure that they maximise the social inclusion benefits from the housing assistance they provide now and into the future?

Investigation of the nexus between housing assistance and social inclusion for people living with a disability is important, as the election to office of the Labor Government in 2007 has seen significant reform of housing and disability policy, as well as the introduction of a clear whole-of-government social inclusion imperative in government-funded and supported programs. It is also clearly the case that housing, as an institution, is seen as the conduit for dealing with an increasing and complex range of non-shelter issues for tenants—the majority of whom are vulnerable in the market and suffering acknowledged multiple disadvantages. These non-shelter issues, for example, include desegregation; facilitation of links to necessary services and supports and the community generally, as well as to employment and education opportunities; three of the four pillars of the social inclusion focus of government—learn, work, engage and have a voice.

The rich insights provided in this report are also important, given the widespread and ongoing concerns about the capacity of the housing system to meet underlying demand for affordable and appropriate housing. There are separate but related concerns over the capacity of the housing system to cater for the diverse and increasingly complex needs of many people living with a disability. This includes people with a psychiatric disability. Moreover, and as discussed in the Positioning Paper for this project (Tually & Beer 2010), housing research has not developed a full understanding of the links between housing assistance and social inclusion for the general population, let alone for people with a disability. This research is an important addition to the limited body of literature around disability and housing generally, providing useful and significant insights and perspectives of broader (housing and social) policy relevance. It is also timely given government and community-sector preferences for understanding and promoting the role housing does and should play in determining a range of non-shelter outcomes for households, and in shaping social inclusion outcomes for all Australians.

The research presented in this Final Report investigates the nexus between housing assistance and social inclusion from the perspective of people living with disabilities themselves, as well as a range of stakeholders assisting people living with a disability. As noted in Section 2.2, housing assistance in the context of this research is assistance that:

... helps people meet their basic human need for shelter and security and can also improve living standards, health and wellbeing and participation in society. Housing assistance is available to many Australians who need help in finding suitable housing and who may struggle to meet housing costs. This could be caused by a range of factors including affordability, family conflict, domestic violence, discrimination, disability or health status. (AIHW 2008b)

Stakeholders involved in the fieldwork for this research included those providing housing and support services and those interested in social inclusion broadly. Importantly, the insights provided by participants in the research highlight the clear

links between housing assistance, or, rather, *appropriate, stable and affordable housing*, social inclusion and wellbeing for the target population.

## 1.1 Research aims and methodology

In order to build our understanding around these important public policy challenges, the research was specifically structured to:

- Develop a deeper understanding of the ways housing assistance programs contribute to social inclusion for people with disabilities.
- Identify those aspects of housing assistance that have social inclusion impacts in order to produce policies, which produce stronger social inclusion outcomes in the future.
- Document the ways, in which social inclusion among people with disabilities varies by location (metropolitan/non-metropolitan, inner versus outer urban) and type of disability, as well as the role housing assistance plays in these outcomes.
- Examine the housing transitions of persons who have moved from institutional to more independent forms of housing and how this has affected their levels of social inclusion.
- Examine why some people may choose not to move from institutional settings and what impact institutional housing assistance may have in terms of social inclusion outcomes.
- Explore the relationship between type of disability and social inclusion outcomes. Positive social inclusion outcomes may be relatively predictable for some people with disabilities, for example the mobility-impaired. However, for other groups—for example those with psychiatric disabilities or cognitive impairment—the dimensions of housing assistance that contribute to positive social inclusion outcomes will be difficult to predict and they need to be known in order to better tailor both the housing stock and housing assistance.
- Consider ways, in which housing assistance and support services could be integrated to maximise social inclusion outcomes.

A number of data sources and a range of methods were used to meet the research aims.

The first stage of the research involved a literature and policy review to set the context for the research and to highlight what we already know about disability and housing generally. It also considered the changing program and policy environments around disability and housing, as well as the limited information around the nexus between housing and social inclusion/exclusion for the population generally, and people living with a disability in particular. This review and analysis is presented in the Positioning Paper for the project.

For the second stage of the project, reported in this Final Report, primary data were collected from a non-random sample of people living with a disability receiving housing assistance, and representatives of agencies supporting people living with a disability.

The people living with a disability who participated in this stage of the research were recruited with the assistance of a number of agencies in the three jurisdictions covered by the research: NSW, SA and Victoria. These agencies included both specialist disability services agencies, as well as support groups for people living with a disability and disability-specific and mainstream housing agencies. Interview participants self-selected for participating in the research, identifying self-reported

disability and/or receipt of a Disability Support Pension (DSP). The vast majority were in receipt of a DSP or had some form of government acknowledgement of their disability or impairment—through Centrelink, referral to disability specific employment services and/or receipt of government-funded specialist support because of their disability or disabilities.

People interviewed had a range of *types* and *levels* of disability (discussed further in Section 3.1) and received a range of different types of housing assistance: public and community housing, including cooperative housing, CRA and for a very small minority in SA, government homeownership assistance through HomeStart Finance. Some participants in the study lived in government-funded or privately operated residential facilities and others in supported residential facilities or group or cluster homes.

The focus of the data collection for the second stage of the project centred on:

- The current housing situation of people living with a disability, as well as their housing histories and experiences, housing and support needs and the impact of their disability on their housing.
- The general level of social and economic participation of people living with a disability, including their satisfaction with their connectedness to the community, services, employment, family and friends, and their thoughts around their ability to deal with a crisis and have their voice heard.
- The importance of the concept of social inclusion to participants, and their daily life.
- Participants' thoughts around social inclusion/exclusion, satisfaction with their social inclusion outcomes, and perspectives on individual and structural barriers to social inclusion, particularly those who stemming from their disability.
- The role of housing assistance in promoting social inclusion/affecting social exclusion, and the impact of other considerations and issues on social inclusion/exclusion, for example, support needed, social networks, et cetera.

Participants were provided with the opportunity to comment on broader housing assistance measures and housing and disability policy.

As noted in the Positioning Paper, these data were gathered through:

- *Semi-structured face-to-face interviews with people living with a disability* receiving housing assistance who have experienced significant housing transitions over their life course. This component of the research involved interviews in three jurisdictions: NSW, SA and Victoria. People receiving a range of types of housing assistance (defined below) were interviewed.

Twenty interviews were originally planned for each of these states, however, because of practical issues and the preferences of participants in the research, some 98 interviews were conducted and fewer focus groups carried out. Many participants in the research, particularly people with mental health issues, indicated a preference for one-on-one interviews rather than a group discussion. Some participants also indicated they were more comfortable with phone interviews. Most of the phone interviews conducted were with people with severe social phobias and it was clear from these interviews that this group generally has poor social inclusion outcomes, although some in this group were happier when isolated (by general community definition: socially isolated or socially excluded) or could only function in settings with a small social circle whom they trusted and were confident with.

The interview discussions were structured around a self-reporting measure of housing and social inclusion/exclusion outcomes for people living with a disability. Interview questions centred on the four key elements for (measuring) social and economic participation and community connection identified in the Australian Government's Social Inclusion Agenda as important for determining and promoting social inclusion/exclusion: working, learning, engaging and having a voice (discussed further in Chapter 2 of this Final Report).

Table 1, on the following pages of this report, provides a profile of some of the key characteristics of the participants in this research—including gender, age, housing tenure, living arrangements, source of income and broad *type* of disability/ies.

- *A focus group with people living with a disability in each jurisdiction.* Again, the focus of this component of the research was to investigate the disability, housing assistance and social inclusion nexus from the perspective of people living with a disability. Focus groups were held in regional NSW (seven participants) and Victoria (eight participants) as part of this process.

The focus groups with people living with a disability covered the same range of issues as were covered in individual interviews and some participants expressed a preference for a focus group setting to discuss issues and their experiences. The majority of participants, however, asked to be interviewed one-on-one.

- *Interviews and a focus group with service providers and social housing providers* were held in each jurisdiction to discuss the nexus between disability, housing assistance and social inclusion from the perspective and experience of representatives of these agencies.

Central to the research method was giving a voice to people living with a disability. This voice is clearly represented throughout the rest of this document, and shows the importance of housing assistance for the social inclusion, health and wellbeing of people living with a disability.

## **1.2 Structure of the Final Report**

This section of the Final Report has briefly introduced this research on housing assistance, social inclusion and people living with a disability. It has also outlined the research methodologies engaged to furnish the insights discussed. Chapter 2 of the report provides a short summary of the literature review and policy context that discussed in detail in the Positioning Paper. Chapters 3 and 4 discuss the key research findings from the research across New South Wales, South Australia and Victoria. The findings of the research are discussed for the jurisdictions collectively, with reference to jurisdiction-specific issues where pertinent. The discussion in these chapters highlights the importance of housing assistance for social inclusion and the wellbeing of people living with a disability. Chapter 5 draws together the key conclusions from the research and outlines implications for policy.

**Table 1: Profile of participants in study, selected characteristics**

Gender	Age	Tenure	Housing type	Living arrangement	Income source	'Type' of disability	Other notable characteristics
Male 50% n = 49	Range: 23–64  Mean: 46.5  Not stated: n = 9	Public housing: n = 17 (34.7%)  Community housing <sup>1</sup> : n = 18 (36.7%)  Community housing group home: n = 2 (4.1%)  Community housing cooperative <sup>1</sup> : n = 1  Private rental <sup>1</sup> : n = 7 (14.3%)  Boarding house: n = 1  Homeless: n = 1  HomeStart (SA only): n = 1  Nursing home: n = 1  <sup>1</sup> All in receipt of CRA	Flat/unit/townhouse (one bedroom): n = 21 (45.7%)  Flat/unit/townhouse (two-bedroom): n = 10 (21.7%)  Flat/unit/townhouse (three- bedroom): n = 1  Flat/unit/townhouse (unspecified): n = 2 (4.3%)  Bedsit: n = 1  House (three-bedroom): n = 5 (10.9%)  House (four-bedroom): n = 1  Boarding house: n = 1  Group home: n = 2 (4.3%)  Boarding house: n = 1  Homeless (couch surfing): n = 1  Not stated: n = 3	Lone person: n = 37 (75.5%)  Couple only: n = 1  Couple + children: n = 3 (6.1%)  Couple and adult child: n = 1  Sole parent + children: n = 0  Group of two or more unrelated adults: n = 5 (10.2%)  Other: n = 1	DSP only: n = 35 (71.4%)  DSP and wages: n = 8 (16.3%)  Newstart: n = 3 (6.1%)  Other <sup>1</sup> : n = 3 (6.1%)  <sup>1</sup> Includes DSP and studying, DSP and carers payments	Intellectual only: n = 5 (10.2%)  Physical only: n = 9 (3 wheelchair users) (18.4%)  Psychiatric: n = 22 (44.9%)  Sensory only: n = 0  Child with a disability: n = 0  Multiple disabilities Total: n = 13 (26.5%)  Including: Psychiatric and physical: n = 8 (16.3%)  Psychiatric and intellectual: n = 2 (4.1%)  Sensory and physical: n = 2 (4.1%)	Time at current address:  Range one month–25 years (n=38)  Multiple disabilities: includes two men for whom a physical injury has contributed to their mental health issues

Gender	Age	Tenure	Housing type	Living arrangement	Income source	'Type' of disability	Other notable characteristics
Female 50% n = 49	Range: 18–66  Mean: 41  Not stated: n = 8	Public housing: n = 18 (36.7%)  Public housing transitional/emergency: n = 3 (6.2%)  Public housing movable unit (Vic): n = 1  Community housing1: n = 10 (20.4%)  Community housing group home: n = 2 (4.1%)  Private rental1: n = 12 (24.5%)  Owner/occupier2: n = 1  HomeStart (SA only): n = 1  With parents3: n = 1  <sup>1</sup> All in receipt of CRA <sup>2</sup> Recently inherited house from relative. <sup>3</sup> Considering move to group home.	Flat/unit/townhouse (one bedroom): n = 6 (12.5%)  Flat/unit/townhouse (two-bedroom): n = 22 (45.8%)  Flat/unit/townhouse (three- bedroom): n = 2 (4.2%)  Flat/unit/townhouse (unspecified): n = 3 (6.3%)  House (two-bedroom): n = 2 (4.2%)  House (three-bedroom): n = 6 (12.5%)  House (four-bedroom): n = 1  House (unspecified): n = 2 (4.2%)  Bedsit: n = 1  Group home: n = 2 (4.2%)  Other: n = 1 (Granny flat)  Not stated: n = 1	Lone person: n = 33 (68.8%)  Couple only: n = 2 (4.2%)  Couple + children: n = 2 (4.2%)  Couple and adult child: n = 1  Sole parent + children: n = 4 (8.3%)  Group of two or more unrelated adults: n = 6 (12.5%)  Not stated: n = 1	DSP only: n = 30 (61.2%)  DSP and wages: n = 15 (30.6%)  Newstart: n = 0  Other1: n = 4 (8.2%)  <sup>1</sup> Includes DSP and studying, DSP and parenting, DSP and carers payments	Intellectual only: n = 9 (18.8%)  Physical only: n = 8 (4 wheelchair users) (16.7%)  Psychiatric: n = 18 (37.5%)  Sensory only: n = 2 (4.2%)  Child with a disability: n = 2 (4.2%)  Multiple disabilities Total: n = 10 (20.8%)  Including: Psychiatric and physical: n = 9 (18.8%)  Psychiatric and intellectual: n = 1  Sensory and physical: n = 0  Not stated: n = 1	Time at current address:  Range one month–20 years (n = 32)  Multiple disabilities: includes four women for whom a physical injury has contributed to their mental health issues

Gender	Age	Tenure	Housing type	Living arrangement	Income source	'Type' of disability	Other notable characteristics
Total n = 98	Range: 18–66 Mean: 43.7  Not stated: n = 17	Public housing: n = 35 (35.7%)  Public housing transitional/emergency: n = 3 (3.1%)  Public housing movable unit (Vic): n = 1  Community housing <sup>1</sup> : n = 28 (28.6%)  Community housing group home: n = 4 (4.1%)  CH Coop: n = 1  Nursing home: n = 1  Boarding house: n = 1  Homeless: n = 1  Private rental <sup>1</sup> : n = 19 (19.4%)  With parents: n = 1  Owner/occupier <sup>2</sup> : n = 1	Flat/unit/townhouse (one bedroom): n = 27 (28.7%)  Flat/unit/townhouse (two- bedroom): n = 32 (34.0%)  Flat/unit/townhouse (three- bedroom): n = 3 (3.2%)  Flat/unit/townhouse (unspecified): n = 5 (5.3%)  House (two-bedroom): n = 2 (2.1%)  House (three-bedroom): n = 11 (11.7%)  House (four-bedroom): n = 2 (2.1%)  House (unspecified): n = 2 (2.1%)  Bedsit: n = 2 (2.1%)  Group home: n = 5 (5.3%)  Boarding house n = 1  Homeless (couch surfing)	Lone person: n = 70 (72.2%)  Couple only: n = 3 (3.1%)  Couple + children: n = 5 (5.2%)  Couple and adult child: n = 2 (2.1%)  Sole parent + children: n = 4 (4.1%)  Group of 2 or more unrelated adults: n = 12 (12.4%)  Not stated: n = 1	DSP only: n = 65 (66.3%)  DSP and wages: n = 23 (23.5%)  Newstart: n = 3 (3.1%)  Other <sup>1</sup> : n = 7 (7.1%)  <sup>1</sup> Includes DSP and studying, DSP and parenting, DSP and carers payments	Intellectual only: n = 14 (14.4%)  Physical only: n = 17 (17.5%) (7 wheelchair users)  Psychiatric: n = 40 (41.2%)  Sensory only: n = 2 (2.1%)  Child with a disability: n = 2 (2.1%)  Multiple disabilities Total: n = 22 (22.7%)  Including: Psychiatric and physical: n = 17 (17.5%)  Physical and intellectual n = 3 (3.1%)  sensory and physical n = 2 (2.1%)  Not stated: n = 1	Time at current address:  Range one month–20 years (n=70)

	<p>HomeStart (SA only): n = 2 (2.0%)</p> <p>With parents<sup>3</sup>: n = 1</p> <p><sup>1</sup>All in receipt of CRA</p> <p><sup>2</sup>Recently inherited house from relative.</p> <p><sup>3</sup>Considering move to group home.</p>	<p>n = 1</p> <p>Other: n = 1 (Granny flat)</p> <p>Not stated: n = 4</p>				
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## 2 BACKGROUND

### 2.1 The social inclusion imperative in public policy

The current Labor Government has embarked on a broad agenda of public policy reform since their election to office in late 2007. Central among these reforms has been the introduction of a Social Inclusion Agenda, focussed on promoting and improving the wellbeing of *all* Australians. All government policies and programs, and their funding mechanisms and reporting structures, have been restructured to reflect this new imperative, with priorities in this regard formalised in Australia's Social Inclusion Agenda—*A Stronger, Fairer Australia*—launched in early 2010 (Australian Government 2009a). Actions to promote social inclusion span Federal and state/territory spheres, driven by the ongoing work, and commitment of, the Council of Australian Governments (COAG) to improved social inclusion for all Australians.

The rationale for the social inclusion imperative in public policy has been widely discussed and promoted (see, e.g. Tually & Beer 2010), and emphasises the Social Inclusion Agenda as the means for:

... [b]uilding a stronger and fairer Australia through a new approach to reducing disadvantage and increasing national prosperity. (The overriding aspiration of the Social Inclusion Agenda—Australian Government 2009a, p.2)

... building a nation in which all Australians have the opportunity and support they need to participate fully in the nation's economic and community life, develop their own potential and be treated with dignity and respect. (Australian Government 2009a, p.2)

The Australian Government notes that achieving such a broad vision and aspiration:

... means tackling the most entrenched forms of disadvantage in Australia today, expanding the range of opportunities available to everyone and strengthening resilience and responsibility.

This involves *making sure that income, financial support and services meet people's essential needs*. It goes beyond minimum standards of living to the *skills and relationships that underpin people's long-term wellbeing and the economic opportunities through which they can develop themselves*. In the long run, individuals, families and communities are the most important shapers of social inclusion. (Australian Government 2009a, p.2, emphasis added)

Actions to improve social inclusion for Australians and achieve the government's vision for an 'inclusive society' are centred on improving the economic, social, political and cultural participation of the most vulnerable in society (see Australian Social Inclusion Board 2010 for discussion). A useful summary of the key factors for improving social inclusion outcomes (termed 'protective factors') and the key barrier to social inclusion ('risk factors' for social exclusion) is given in Table 2. This perspective is taken from the key document guiding social inclusion focus across the Australian Public Service, the *Australian Public Service Social Inclusion policy design and delivery toolkit* (Australian Government 2009b).

Notably, economic security, including access to affordable housing, access to appropriate services locally and good mental and physical health feature among those factors known to help individuals deal with set-backs and manage negative life events. Poor mental health, poor access to services and poor health outcomes, on the other hand, have the opposite effect, and are known risk factors for social exclusion. The

findings of this research reinforce these views—from the perspective of people living with a disability.

**Table 2: Protective factors to strengthen social inclusion and risk factors for social exclusion**

Protective factors	Risk factors
<p>These help people to deal with set-backs and manage potentially. Negative impacts on their lives and thereby strengthen social inclusion).</p>	<p>These undermine a person's ability to cope when faced with adversity and thereby increase social exclusion.</p>
<ul style="list-style-type: none"> <li>→ stable, safe and resilient communities</li> <li>→ good relationships</li> <li>→ access to appropriate services in local area</li> <li>→ <i>good physical and mental health</i></li> <li>→ good literacy, English language and communication skills</li> <li>→ economic security (e.g. having affordable housing, secure employment and reliable transport).</li> </ul>	<ul style="list-style-type: none"> <li>→ experiencing discrimination or feelings of social isolation, high crime rates, past traumatic events (e.g. torture, natural disaster)</li> <li>→ damaging relationships, including the receipt of poor parenting</li> <li>→ lack of access to appropriate services</li> <li>→ poor physical and poor mental health, substance misuse</li> <li>→ poor literacy, English language and communication skills</li> <li>→ poverty.</li> </ul>

Source: Australian Government 2009b, p.13, emphasis added

At a finer level of detail, the social inclusion imperative underpinning current public policy is focused on ensuring that *all Australians have the capabilities, opportunities, responsibilities and resources to learn, work, connect with others and have a say*. That is, to:

- *Learn*, by participating in education and training.
- *Work*, by participating in employment or voluntary work, including family and carer responsibilities.
- *Engage*, by connecting with people, using local services and participating in local civic, cultural and recreational activities.
- *Have a voice*, in influencing decisions that affect them (Commonwealth of Australia 2009, emphasis added).

As noted earlier, people living with a disability and people with mental health issues are among the key groups for focusing social inclusion effort. '*Assisting in the employment of people with disability or mental illness by creating employment opportunities and building community support*' is one of the initial priority areas of governments in terms of addressing social exclusion and promoting inclusiveness. This study then, is an important addition to our understanding of social inclusion and disability. It adds to our scant knowledge on the role of stable housing (in this instance through housing assistance) in social inclusion outcomes for people living with a disability and people with mental health issues.

### 2.1.1 *Housing and disability policy and the Social Inclusion Agenda*

As discussed in detail in the Positioning Paper for this project (Tually & Beer 2010), housing and disability policy are two areas of public policy that have undergone significant reform over the past four years. Like all other areas of public policy, the new National Partnership payments and agreements guiding and supporting these

policy arenas nationally<sup>1</sup> now include an upfront commitment to ‘addressing the issue of social inclusion, including responding to Indigenous disadvantage’ (stated in the preliminaries to both agreements), and a strong social inclusion imperative guides the objectives, outcomes, outputs and performance indicators underlying these arrangements.

Importantly, funding available under arrangements such as the National Affordable Housing Agreement (NAHA) and the National Disability Agreement (NDA)—the key frameworks guiding housing and disability policy nationally—is now tied to, and contingent upon, state and territory governments working with the Australian Government to improve and promote the economic, social and political participation (i.e. social inclusion outcomes) of people receiving assistance under these agreements. Box 1 highlights this overriding commitment to social inclusion as the guiding principle of the NAHA.

### **Box 1: Key features of the NAHA and its social inclusion focus**

#### **National Affordable Housing Agreement**

Effective: 1 January 2009 (ongoing; first agreement for five years).

Funding: \$6.2 billion over the five years of the Agreement (COAG 2008, p.6); allocated to states/territories on a per capita basis.

Agreement of the COAG with the ‘aspirational objective: ... *that all Australians have access to affordable, safe and sustainable housing that contributes to social and economic participation*’ (COAG 2009a, p.3).

The NAHA is a whole of government framework detailing outcomes, outputs, reforms and progress measures to improve housing affordability for low to moderate income households; reduce homelessness; improve Indigenous housing circumstances and reduce disadvantage; and better integrate mainstream and specialist housing and human services, including disability services (COAG 2009a, p.3). It funds the following: social housing, assistance for private renters, accommodation and necessary support for people who are homeless or at risk of homelessness, assistance for home purchasers; and some planning reforms to improve housing supply (COAG 2008, p.6).

Under the agreement, the Australian and state and territory governments have committed to a range of outcomes:

- (a) *People who are homeless or at risk of homelessness achieve sustainable housing and social inclusion.*
- (b) People are able to rent housing that meets their needs.
- (c) People can purchase affordable housing.
- (d) People have access to housing through an efficient and responsive housing market.
- (e) Indigenous people have the same housing opportunities (in relation to homelessness services, housing rental, housing purchase and access to housing through an efficient and responsive housing market) as other Australians.
- (f) Indigenous people have improved housing amenity and reduced overcrowding, particularly in remote areas and discrete communities (p.4).

The NAHA includes a range of reforms that signatories have agreed to work toward, such as (c) ‘creating mixed communities *that promote social and economic opportunities by reducing concentrations of disadvantage that exist in some social housing estates*’; and (h) ‘creating incentives for public housing tenants to *take up employment opportunities* within the broader employment framework’ (p.7).

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<sup>1</sup>For example, for Healthcare; Schools; Skills and Workforce Development; Disability Services; Affordable Housing (COAG 2008).

Emphasis on social inclusion as the key focus and end-point for government-funded and delivered actions also underpins the National Partnership Agreements for Homelessness, Social Housing and Remote Indigenous Housing that support the NAHA. A concern for social inclusion is also evident in the Social Housing Initiative under the Nation Building Economic Stimulus Program (see Tually & Beer 2010, Chapter 2). For the Social Housing Initiative in particular, the 'reform directions' guiding the Initiative specify that funding for social housing sector growth is conditional on: 'better social and economic participation for social housing tenants by locating housing closer to transport, services and employment opportunities' and 'reducing concentrations of disadvantage through appropriate redevelopment to create mixed communities that improve social inclusion ...' (COAG 2009b, p.14).

It should also be noted that the newly released *National Disability Strategy*—'a 10-year national plan for improving the life for Australians with disability, their families and carers' (Commonwealth of Australia 2011, p.8)—similarly emphasises social inclusion priorities and outcomes. This strategy centres on improving the independence and wellbeing of people living with a disability through community participation and is based on a social model of disability. An overview of this key policy document for disability services and the disability sector is provided in Box 2.

## Box 2: Overview of the National Disability Strategy

The National Disability Strategy (NDS) is a new policy framework established through a national partnership agreement between Commonwealth, state, territory and local governments. It was officially launched in February 2011 through the endorsement of the Council of Australian Governments (COAG), and extends upon the disability policy reform work of the National Disability Agreement signed by all levels of government in 2008. The NDS is strategically informed by an extensive national public consultation process, and by the 2008 Australian government ratification of the *United Nations Convention on the Rights of Persons with Disabilities*.

The key aims of the NDS are to set out long-term policy and program development goals across all levels of government, that:

Provide a comprehensive policy framework for guiding government activity and coordinating public policy across mainstream and disability-specific areas.

Improve the capacity of mainstream services to address the needs of people with disability across government, industry and community.

Give voice to the challenges that people with disability face, and ensure that the needs and rights of people with disability are included in all public policy that impacts on their lives.

Promote the social inclusion and community participation of all people with a disability.

In implementing these strategic goals, the NDS sets out six priority areas for action:

### *Inclusive and accessible communities*

Policy directions include accessibility of the built and natural environment; improved accessibility and choice of housing and transport; reliable and responsive communication and information systems; and improved participation of in the economic, sporting and cultural life of communities.

### *Rights protection, justice and legislation*

Policy focus on access to justice; removing barriers to social inclusion (such as discrimination); raising awareness of, and monitoring, human rights and social justice issues, and preventing violence and exploitation.

### *Economic security*

Focus on promoting employment opportunities, income support and improved access to affordable housing options with security of tenure.

### *Personal and community support*

Focus on a sustainable, person-centred and self-directed disability support system; greater acknowledgement of the important role of families and carers; and improved availability of community and personal support services that meet the specific needs of people living with a disability, their families and carers.

### *Learning and skills*

Policy focus on bridging educational outcomes and opportunities gaps for people with a disability; ensuring the responsiveness of government early childhood, education and training development reforms/initiatives for people with a disability, and improving pathways for life-long learning and further education.

### *Health and wellbeing*

Focus on capacity-building for health service providers; universal health reforms and initiatives, and effective prevention and early intervention programs that meet the needs of people with a disability. More broadly, this strategic goal emphasises the importance of addressing fundamental determinants of health and wellbeing—such as choice, control, social supports and community engagement.

Source: Commonwealth of Australia 2011

### 2.1.2 *Measuring and monitoring social inclusion*

A range of measures or indicators have been developed to monitor and guide the social inclusion actions of governments (see Tually & Beer 2010, Section 2.2.4). In line with the whole-of-government focus of the national Social Inclusion Agenda and desired outcomes of governments, these actions cut across all areas of public policy and service-delivery. Table 3 provides a summary of the Australian Government's current suite of social inclusion measures and indicators relevant to this research.

Fieldwork for this research was centred around the participation measures outlined in Table 3: *work, learn, engage, have a voice*. However, as is shown the remaining sections of this report, the resource measures outlined in the table were (and remain) of clear importance in terms of the housing, disability and social inclusion nexus for participants in the research. Pertinent among the resource measures is the acknowledged issue of low economic and material resources and the impact of this on outcomes, as well as the specific employment-focus of measures for people with disabilities in particular—reinforcing the general 'work' measure outlined in Table 3. In many instances, a multitude of these resource measures were acting as barriers to social inclusion for people living with a disability or multiple disabilities.

Notably, the measures provided in Table 3 show the acknowledged range and reach of factors identified as important in promoting and improving social inclusion and therefore individual wellbeing. They also show the clear importance of housing, economic, social and community resources in shaping social inclusion outcomes. This research confirms the importance of such resources in the lives of people living with a disability.

**Table 3: The Australian Government's social inclusion measures and indicators**

Domains	Headline indicators	Supplementary indicators
<b>Participation measures</b>		
<b>Work</b>	Employment rate → Employment/population ratio Children in jobless families → Children under 15 years old in jobless families (where parents are jobless) Long-term income support recipient → Long-term (12 months) and very long-term (2+ years) full-rate, non-education related, working-age income support payment recipients (including transfers between payments) as proportions of the population aged 15–64 years	Persistent jobless families with children → Persons in jobless families with children under 15 years old (where jobless for 12 months or more) Jobless households → Persons living in jobless households Long-term unemployment → Long-term unemployment rate
<b>Learn</b>	Young people not fully engaged in education or work → Proportion of 15–24-year olds that are fully engaged in education and/or work Year 12 equivalent attainment → Proportion of 20–24-year olds attaining Year 12 or Certificate II	
<b>Engage (Social and community participation)</b>	Contacted family/friends → Proportion of people aged 18 years and over who contacted family/friends in past week Participation in community groups → Proportion of the people aged 18 years and over that were involved in a community group in the last 12 months	Got together socially with family/friends → Proportion of people who got together socially with friends/relatives not living with them in past month Voluntary work → Proportion of people aged 18 years and over that undertook voluntary work in past 12 months Participation in community events → Proportion people aged 18 years and over who participated in a community event or activity in past 12 months

<b>Have a voice (Political and civic participation)</b>	Participation in citizen engagement activities → Proportion of people aged 18 years and over that participated in selected citizen engagement activities in the last 12 months	
<b>Resources measures</b>		
<b>Material/economic resources</b>	<p>Low economic resources and financial stress/material deprivation</p> <p>→ Composite measure of low economic resources (to be determined, based on low levels of income, wealth and expenditure, and deprivation)</p> <p>Persistent low economic resources</p> <p>→ Low economic resources (as defined above) for over two years (a minimum of 3 time points marking the beginning, middle and end of a two-year period)</p> <p>Note: These two indicators need conceptual and data development. For example, need to develop the actual indicator and more frequent household wealth and/or expenditure data.</p>	<p>Low economic resources</p> <p>→ Proportion of population with low disposable income and low wealth (bottom three deciles equivalised of both disposable income and wealth)</p> <p>Financial stress/material deprivation</p> <p>→ Proportion of population with five or more selected financial stress/deprivation items.</p> <p>Real change in income for low-income households</p> <p>→ Change in average real equivalised disposable household income of 2<sup>nd</sup> and 3<sup>rd</sup> deciles</p> <p>Relative income inequality</p>
<b>Health and disability</b>	<p>People with long-term health conditions affecting their ability to participate in employment</p> <p>→ Number and employment rate of people with a disability (by level of severity).</p> <p>People with mental illness affecting their ability to participate in employment</p> <p>→ Number and employment rate of people with mental illness (by level of severity).</p> <p>Self-assessed health</p> <p>→ Proportion of population with fair or poor self-assessed health.</p>	<p>Life expectancy</p> <p>→ Life expectancy (years)</p> <p>Subjective quality of life</p> <p>→ Proportion of population reporting overall satisfaction with their lives</p>
<b>Education and skills</b>	<p>Literacy and numeracy</p> <p>→ Proportion of Year 9 students achieving literacy (reading and writing) and numeracy benchmarks.</p> <p>Adult literacy/ numeracy</p>	<p>Poor spoken English</p> <p>→ Proportion of people aged 5 years and over who do not speak English well or at all.</p> <p>Non-school qualifications</p>

	<p>→ Proportion of 15–75-year olds with at least minimum standard of prose literacy and numeracy.</p> <p>Early child development</p> <p>→ Proportion of children in first year of school assessed as ‘developmentally vulnerable’ on two or more domains in the Australian Early Development Index (AEDI).</p>	<p>→ Proportion of people aged 25–64 years and over with non-school qualifications.</p>
<b>Social resources</b>	<p>Support from family/friends in time of crisis</p> <p>→ Proportion of people aged 18 years and over who feel that they are able to get support in time of crisis from persons living outside household.</p> <p>Autonomy—having a voice in the community</p> <p>→ Proportion of people aged 18 years and over who do not feel able to have a say in the community on issues that are important to them.</p> <p>Access to Internet</p> <p>→ Proportion of people with access to the Internet on home computer.</p>	<p>Autonomy—having a voice in family</p> <p>→ Proportion of people aged 18 years and over who do not feel able to have a say in their family on issues that are important to them.</p>
<b>Community and institutional resources</b>	<p>Access to public or private transport</p> <p>→ Proportion of people aged 18 years and over who say they have difficulty accessing public or private transport.</p> <p>Access to health service providers</p> <p>→ People deferring recommended treatment due to financial barriers.</p>	<p>Access to justice services</p> <p>→ Proportion of people aged 18 and over reporting difficulty accessing justice services.</p> <p>Access to service providers</p> <p>→ Proportion of people aged 18 years and over reporting difficulty accessing services, by type of service and private/public provider (e.g. aged care, child care and employment services).</p> <p>Tolerance of diversity</p> <p>→ Acceptance of diverse cultures in local community.</p>
<b>Housing</b>	<p>Homelessness</p> <p>→ Proportion of population that are homeless (total and those experiencing primary homelessness (rough sleeping)).</p> <p>Housing affordability</p>	<p>Housing affordability</p> <p>→ Number of affordable houses available to purchase per 10 000 low-income households</p> <p>Repeat homelessness</p>

	→ Proportion of low income private renter households with housing costs exceeding 30 per cent of household income.	→ Proportion of people experiencing repeat periods of homelessness.
<b>Personal safety</b>	<p>Feelings of safety</p> <p>→ Proportion of people aged 18 years and over who feel unsafe at home or in their local community at night (excluding family violence).</p> <p>Children at risk/Child protection</p> <p>→ Children aged 0–17 years in substantiations of notifications received during (year) (number and rate per 1000).</p>	<p>Family violence</p> <p>→ Proportion of persons experiencing family violence in past 12 months.</p> <p>Victim of personal violence</p> <p>→ Victims (aged 18 years and over) of selected personal crime.</p> <p>Victim of household crime</p> <p>→ Victims (aged 18 years and over) of selected household crime.</p>
<b>Multiple and entrenched disadvantage</b>		
<b>Multiple and entrenched disadvantage</b>	<p>Multiple disadvantage</p> <p>→ Three or more of the six selected areas of disadvantage (income, work, health, education, safety and support).</p> <p>Entrenched disadvantage</p> <p>→ Three or more of the six selected areas of disadvantage for two years or more.</p> <p>Note: indicators need further development based on analysis of other social inclusion indicators for selected key disadvantage groups.</p>	Indicators to be developed—for several key life stages (early childhood and school age children), youth, working age population and older people

Source: Australian Government 2009a, pp.78–81

## **2.2 Social inclusion, housing assistance and people living with a disability**

As noted in the introduction to this Final Report, and in the Positioning Paper that set the context for this research, there is a dearth of literature on housing and disability in Australia generally, let alone specific studies on the role of housing assistance in the economic and social circumstances of people living with a disability. This absence exists despite growing recognition of the importance of appropriate, stable and affordable housing in the health and wellbeing outcomes of all individuals. Housing is increasingly recognised as shaping access to/maintaining the services and support we all need for our sense of self- and community-worth and wellbeing.

Social inclusion is a priority of national governments both in Australia and in other nations (Gillard 2007) and is also a policy concern for state, territory and local governments (Arthurson & Jacobs 2003). Debates over social inclusion/social exclusion have a long history both nationally and internationally (Beer & Morphet 2002) but relatively little attention has been paid to how disability intersects with housing assistance and social inclusion. This section focuses on the relationship between disability, housing and social inclusion and considers which aspects of disability result in social exclusion (Goggin & Newell 2005). Before moving on to this discussion, however, it is pertinent to first define the three key concepts used in this research: social inclusion, housing assistance and disability.

### *2.2.1 Defining social inclusion*

Other research for the Australian Housing and Urban Research Institute, by Arthurson and Jacobs (2003), defines social inclusion as describing:

... the ideal situation whereby individuals are able to participate in the relevant institutions of society and to share in the goods and services ... That is, bringing people into mainstream society versus people outside of the mainstream of society. (Glossary)

Social inclusion is often conceptualised in terms of being the opposite of social exclusion: the intense and multiple disadvantages that can arise for individuals, groups and some places because of isolation and segregation from the formal structures and institutions of the economy, society and state. The (then) Blair Labour Government's Social Exclusion Unit, further adds to this, noting that, social exclusion is:

... a shorthand term for what can happen when people or areas suffer from a combination of linked problems such as unemployment, poor skills, low incomes, poor housing, high crime environments, bad health and family breakdown. (cited in Beer 2003, p.71)

The issue of access to necessary structures, services and supports is central to the concepts of social inclusion and social exclusion.

Further insights about the concept of social inclusion and the term disability, including discussion of the importance, relevance and controversy over these terms, are provided in the Positioning Paper for this research (see Tually & Beer 2010, Chapter 3).

The definition of social exclusion has been discussed more extensively elsewhere (see Beer & Maude 2001), but it is important to note that the term is generally used to refer to multiple and linked social, economic and cultural problems within an area or group. It is concerned with 'joined up' problems, to use the language of the social exclusion literature. However, it should be noted that the concept of social exclusion

has not received universal acceptance in academic and policy circles, even within Europe where its origins lie (see, e.g. Blanc 1998). That being said, the concept of social exclusion has been widely adopted within the European Union's social policy programs.

Housing researcher Somerville (1998) reviewed policy documents and academic work on social exclusion and its relationship with housing, and concluded that those suffering from social exclusion experience greater disadvantage than poverty alone. He argued that what these groups have in common, and what lies at the heart of all processes of social exclusion, is a sense of social isolation and segregation from the formal structures and institutions of the economy, society and state (Somerville 1998, p.762).

Somerville went on to note that social exclusion has three drivers within advanced economies:

1. Social exclusion can arise out of disadvantage within the labour market.
2. It may be a consequence of political/legal structures that disadvantage some individuals or groups and disenfranchise them from publicly provided benefits.
3. Exclusion may arise out of predominant ideologies.

We know from the literature that in addition to purely structural inequalities (e.g. unemployment) social exclusion involves important ideological processes such as racism and discrimination that limit people's life chances (Somerville 1998; Bessant 2001, 2003, 2005). Authors such as Somerville and Bessant have highlighted, for example, that entrenched processes of discrimination in our social, legal and political systems affect the capacity of different groups to enjoy fundamental civil rights and liberties, and deny disadvantaged individuals many of the basic material and social supports that others in a more privileged position tend to take for granted. These include financial and social independence, access to justice, freedom of movement, and the ability to exercise personal choice and control over important dimensions of life.

In this way, the concepts of social inclusion and exclusion are important in the context of this research if and when people with disabilities are excluded from mainstream society and its institutions; that is they have a reduced capacity to gain access to the goods and services offered by society, they are subject to the negative impacts of predominant ideologies and/or they are disenfranchised by political or legal structures.

One of the critical issues for this research is to understand if and how disability generates 'social exclusion' in the sense of stripping away a sense of control over one's life.

### *2.2.2 Defining housing assistance*

The AIHW provides possibly the best definition of housing assistance as relevant to this research and for the general Australian context:

Housing assistance helps people meet their basic human need for shelter and security and can also improve living standards, health and wellbeing and participation in society. Housing assistance is available to many Australians who need help in finding suitable housing and who may struggle to meet housing costs. This could be caused by a range of factors including affordability, family conflict, domestic violence, discrimination, disability or health status. (AIHW 2008b)

The AIHW notes that 'Housing assistance is an important part of Australian governments' social and economic policy. For various reasons including low income, poor health status and discrimination, some people need assistance with housing' (AIHW 2008a, p.ix).

The key housing assistance programs nationally are:

- Social housing funded under the NAHA, such as public and community housing and specific housing for Indigenous Australians.
- CRA provided to private renters.
- First Home Owners assistance, such as the First Home Owners Grant and other state and territory provided assistance for home buyers, this includes HomeStart loans in South Australia and the Northern Territory and KeyStart housing finance in Western Australia.
- The Supported Accommodation Assistance Program.

In terms of this research, people receiving any of the assistance above were eligible to participate in the project—provided they also met the disability eligibility requirements for the research. Most participants were in receipt of CRA or were housed in public or community housing.

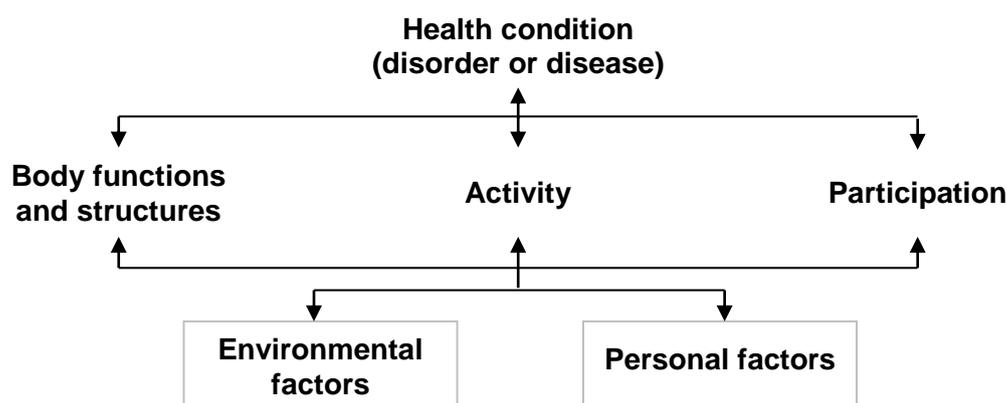
### *2.2.3 Disability*

As noted in the Positioning Paper for this research (Tually & Beer 2010, pp.38–9) defining disability is a difficult task. This is because disability is both a social construct and phenomenon and a lived experience that varies greatly between individuals and groups within society. The World Health Organisation's widely used International Classification for Functioning, Disability and Health, notes that disability (and the related issue of functioning) are multidimensional concepts concerning: 'the body functions and structures of people; the activities people do and the life areas in which they participate; and the factors in their environment that affect these experiences'. Helpfully, they summarise these multidimensional relationships schematically—see Figure 1. Disability then, is best conceptualised in terms of a health related condition, disease or disorder that impairs, restricts or limits an individual's activity/ies and participation, and that is shaped by their environment.

The health conditions causing a disability can be generally classed into five main 'types': intellectual, cognitive, psychological, physical/mobility and sensory. This research specifically targeted people with lifetime or longer-term cognitive, psychological, physical/mobility disability/ies.

Most participants in the research were in receipt of a DSP, and therefore have 'formally' been acknowledged by the Australian Government as living with disability.

Figure 1: Conceptualisation of multi-dimensions of disability



Source: WHO 2001

#### 2.2.4 Defining and measuring disability

The measurement of disability is significant, because disability as a social phenomenon and a lived experience varies greatly between individuals and groups within society. Beer and Faulkner (2009) suggested that there were three key dimensions of disability that were pivotal in shaping the housing careers of people with disabilities:

- the extent of the disability
- the source of the disability<sup>2</sup>
- the type of impairment.

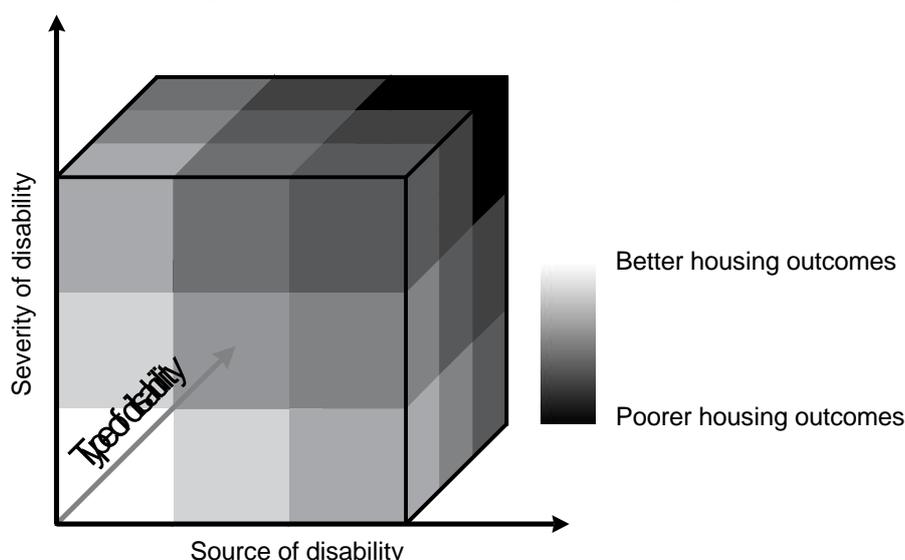
Beer and Faulkner's (2009) conceptualisation of this relationship is presented in Figure 2. This conceptualisation of disability and its impact on the housing career attempts to reflect the multidimensional nature of disability. Critically, while some types of disability may have little, if any, impact on housing, others profoundly reshape the capacity of individuals and their household members to move through the housing market or gain access to housing assistance. The figure reinforces the findings of Beer and Faulkner's research in the disability and housing field (see also Beer & Faulkner 2011, especially Chapter 7), which there are multiple housing careers among this population, but poorer housing outcomes for the population generally are clearly linked to the severity and type of disability generally.

The ABS provides the most robust estimates of disability within the Australian population and defines disability as:

... any limitation, restriction or impairment, which has lasted, or is likely to last, for at least six months and restricts everyday activities. Examples range from hearing loss, which requires the use of a hearing aid, to difficulty dressing due to arthritis, to advanced dementia requiring constant help and supervision. (ABS 2004)

<sup>2</sup>The International Classification of Functioning, Disability and Health (ICF) notes that environmental factors are important contributors to the source of disability (see AIHW 2003b).

**Figure 2: Conceptualising disability and its impact on housing career**



Source: Beer and Faulkner 2009, p.3

In the 2003 ABS *Survey of Disability, Ageing and Carers*, one in five people in Australia (3 958 300 or 20.0%) had a reported disability. This rate was much the same for males (19.8%) and females (20.1%). After removing the effects of different age structures, the ABS found that there was little change in the disability rate between 1998 (20.1%) and 2003 (20.0%). The rate of profound or severe core activity limitation<sup>3</sup> also showed little change between 1998 (6.4%) and 2003 (6.3%) (ABS 2004).

The AIHW (2003a) discussed the various approaches to measuring disability both internationally and within Australia, including the development of estimates based on: all disabling conditions; disabling conditions and activity limitations and participation restrictions; all disabling conditions and a severe or profound core activity restriction; and main disabling condition. Clearly, how disability is defined will influence the count of persons with disabilities and the discussion presented here focuses on both severe and profound core activity limitations, as well as all disabling conditions.

### 2.2.5 *Estimating the number of people with a disability or disabilities*

The AIHW (2007) completed a major piece of work estimating the current and future demand for specialist disability services. Their work focused on enumerating the population using services funded under the Commonwealth State/Territory Disability Agreement (CSTDA). It is important to note that a minority of people living with a disability received services funded by the CSTDA and even persons with severe impairments may not have been assisted. However, most persons with a significant disability benefitted from these services and therefore, it provides a useful quantitative modelling of the population experiencing disability and/or impairment in Australia. The AIHW estimated that in 2004–05 there were 200 493 users of CSTDA services in Australia and that this number had grown from 187 806 in 2003–04 (AIHW 2007, p.1). Importantly, of this number:

- 17 per cent (33 787 persons) used accommodation support services
- 46 per cent (92 610 persons) used community support services
- 22 per cent (44 166 persons) used community access services

<sup>3</sup>Coreactivities are defined by the ABS as 'communication, mobility and self-care' (ABS 2011a).

- 12 per cent (23 951 persons) used respite services
- 32 per cent (64 835 persons) used employment services.

An intellectual/learning disability was the most common form of primary disability supported by the CSTDA (45%), followed by: physical/diverse disability (19%); psychiatric disability (8%) and sensory/speech disability (7%). However, data presented in the AIHW report (2003a) show that physical/diverse disabilities are the most common among the disability population (see also AIHW 2005, p.213).

The AIHW (2007) also estimated the level of unmet demand using data from the ABS *Survey of Disability Ageing and Carers*. They assumed that the CTSDA target group corresponds to the survey definition of people with a 'severe and profound core activity limitation'—that is, people who *sometimes* need help with self-care, mobility or communication. On this basis, the AIHW estimated that there was an unmet demand for CSTDA-funded accommodation and respite services of 23 800, but within a range between 15 900 and 31 700. This includes a percentage of 'under-met demand', that is, persons who had some, but not all, of their needs supplied.

The most recent ABS *Survey of Disability, Ageing and Carers* (SDAC) conducted in 2009 shows that the overall prevalence of disability has fallen by 1.5 percentage points since 2003, when the last SDAC was undertaken (ABS 2011a). According to the ABS, this decrease is mostly due to a decline in the proportion of Australians disabled by physical health conditions like asthma and heart disease. This slight decline in disability prevalence notwithstanding, disability still affects a significant proportion of the Australian population, with almost one in five Australians (18.5%) reporting a disability in 2009 (ABS 2011a). The SDAC showed that in 2009, there were 1.27 million persons in Australia with a 'severe or profound core activity limitation', and 680 300 were aged 64 years and under (ABS 2011b). Of those with a severe or profound core activity limitation, 152 100 were living in cared accommodation and 1.12 million were living in households within the general community (ABS 2011c).

Table 4 outlines the main conditions causing disability among Australians according to the most recent and 2003 SDACs.

AIHW estimates (2007) suggest that between 2006 and 2010, the number of people aged under 64 years with severe or profound core activity limitations would rise to 752 100 persons. Clearly, the number of persons with significant disabilities is substantial and the potential implications for housing assistance profound. Nationally only 4.2 per cent of persons with severe or profound core activity limitations occupy specialist housing and this is to be expected given the policy settings that have been in place for two decades or more in all jurisdictions (Quibell 2004). Disability, therefore, is an issue for mainstream housing provision and housing policy, and the capacity of people with disabilities to gain access to adequate and appropriate housing through the market is a test of social inclusion for this critical group within society.

**Table 4: Main condition causing disability, all persons 2003–09, Australia**

<i>Main condition</i>	2003					2009				
	0-17 years	18-44 years	45-64 years	65 years and over	Total	0-17 years	18-44 years	45-64 years	65 years and over	Total
	%	%	%	%	%	%	%	%	%	%
<b>Physical conditions</b>										
Cancer, lymphomas and leukaemias	*0.1	*0.1	0.6	1.0	0.3	—	*0.1	0.6	1.0	0.3
Endocrine, nutritional and metabolic disorders (total)	*0.1	0.2	0.8	2.2	0.6	*0.2	0.2	0.8	2.3	0.6
Diseases of the nervous system (a)	0.6	1.4	1.6	1.8	1.3	0.5	1.4	1.8	1.8	1.3
Diseases of the eye and adnexa	0.3	0.2	0.4	1.6	0.5	0.1*(b)	0.2	0.4	1.6	0.4
Diseases of the ear and mastoid process	0.5	0.6	1.8	4.9	1.4	0.3(b)	0.4(b)	1.7	5.5	1.4
Diseases of the circulatory system (total, all types)	*0.1	0.3	2.1	8.8	1.8	*0.1	0.2	1.5(b)	7.4(b)	1.4(b)
Diseases of the respiratory system (total, all types)	1.1	0.6	1.2	3.4	1.2	0.6(b)	0.4(b)	1.0	2.9	0.9(b)
Diseases of the digestive system	—	0.2	0.4	0.8	0.3	*0.1	0.2	0.4	0.9	0.3
Diseases of the musculoskeletal system and connective tissue (total, all types)	*0.2	3.5	12.1	20.1	6.8	0.2	2.7(b)	10.5(b)	20.7	6.5
Congenital and perinatal disorders	0.6	0.2	*0.1	—	0.2	0.3(b)	0.1	*0.1	0.1*(b)	0.2
Injury, poisoning and other external causes										
Head injury and acquired brain damage	*0.1	0.2	*0.1	**0.1	0.1	*0.1	0.2	0.2	*0.1	0.2
Other	0.2	0.9	1.7	3.0	1.2	*0.1	0.8	1.5	2.4	1.0
Total	0.3	1.1	1.8	3.0	1.3	0.2(b)	1.0	1.7	2.5	1.2
Other physical conditions (d)	0.7	0.6	1.2	3.1	1.1	0.5	0.5	1.0	2.7	0.9(b)
<b>Total, physical conditions</b>	<b>4.5</b>	<b>8.9</b>	<b>24.2</b>	<b>50.9</b>	<b>16.8</b>	<b>3.0(b)</b>	<b>7.3(b)</b>	<b>21.4(b)</b>	<b>49.2</b>	<b>15.4(b)</b>
<b>Mental and behavioural disorders</b>										
Psychoses and mood affective disorders										
Dementia and Alzheimer's	—	—	—	2.7	0.3	—	—	—	2.3	0.3
Depression and mood affective disorders	*0.1	0.7	0.8	0.7	0.6	—	0.6	1.0	0.6	0.6
Other	—	0.2	*0.2	*0.2	0.2	np	0.3	0.2	0.1	0.2
Total	*0.1	0.9	1.1	3.5	1.1	—	0.9	1.3	3.0	1.1
Neurotic, stress-related and somatoform disorders										
<i>Nervous tension and stress</i>	—	0.2	0.6	0.6	0.3	—	0.2	0.5	0.3(b)	0.2(b)
<i>Other</i>	*0.1	0.2	0.6	*0.2	0.3	0.2(b)	0.3	0.7	0.5(b)	0.4(b)
Total	*0.1	0.5	1.2	0.9	0.6	0.2(b)	0.6	1.1	0.9	0.7
Intellectual and developmental disorders	2.3	0.8	0.2	*0.1	0.9	2.5	0.6	0.2	0.2	0.9
Other mental and behavioural disorders	1.5	0.4	*0.1	*0.2	0.6	1.2	0.3	0.1	0.1	0.4(b)
Total, mental and behavioural disorders	4.0	2.6	2.7	4.8	3.2	3.9	2.4	2.7	4.2	3.1
<b>Total, all conditions</b>	<b>8.4</b>	<b>11.5</b>	<b>26.8</b>	<b>55.7</b>	<b>20.0</b>	<b>6.9(b)</b>	<b>9.6(b)</b>	<b>24.2(b)</b>	<b>53.5(b)</b>	<b>18.5(b)</b>

Source: ABS 2009, p.9

Notes:

\* estimate has a relative standard error of 25 per cent to 50 per cent and should be used with caution

\*\* estimate has a relative standard error greater than 50 per cent and is considered too unreliable for general use

— nil or rounded to zero (including null cells)

np not available for publication but included in totals where applicable, unless otherwise indicated

(a) Excludes Alzheimer's disease, which is included in Psychoses and mood affective disorders.

(b) The difference from the 2003 rate is statistically significant.

(c) Excludes Down syndrome, which is included in Intellectual and developmental disorders.

(d) Includes infectious and parasitic diseases; diseases of the blood and blood-forming organs; skin conditions; genito-urinary system diseases; and symptoms and signs not elsewhere classified.

## 2.3 Housing, housing assistance and disability

There is a limited body of work investigating the interplay between housing, housing assistance and disability in Australia. Notable past work in this regard includes research completed as part of AHURI's National Research Venture (NRV) 2: *21st century housing careers and Australia's housing future* (see Kroehn et al. 2007; Saugeres 2008; Zacharov & Minnery 2007; Tually 2007; Beer & Faulkner 2009). The disability component of NRV 2 focused on the housing needs and experiences of persons with four types of disability: mobility impairment, psychiatric disability, cognitive impairment and a sensory disability. The research also considered the housing of family members with care responsibilities. Other key Australian research in this field has been undertaken by Fisher and colleagues of the Social Policy Research Centre at the University of New South Wales (Fisher & Purcal 2010; Fisher et al. 2009; Parker & Fisher 2010). Fisher's work provides important insights into housing outcomes and challenges for people with mental health issues in particular.

By contrast, there is a much more robust literature on this topic internationally, including work by Beresford and Oldman (2002), Harrison and Davis (2001), for the UK, and National Council on Disability (2010), Guilderbloom and Rosentraub (2006), Clarke and George (2005), Allen (2003) and Little (2003) on aspects of the US situation. Critically, much of this research reports housing market outcomes for people with disabilities that are very similar to those evident in Australia and this suggests that the outcomes of research could have applicability internationally.

The overwhelming majority of people with disabilities live in the community and rely upon mainstream housing markets and housing market processes to meet their accommodation needs. Published research on housing and disability in Australia clearly shows that people with disabilities are disadvantaged in their housing for a number of reasons and these are discussed below.

- *Low rates of participation in the formal labour force* among people living with a disability or disabilities and their family-member carers has a profound impact on the ability of this group to secure adequate, appropriate and affordable housing. People with disabilities and their family members have reported significant problems in finding and maintaining appropriate employment because of: difficulties in getting to employment; the limited range of employment opportunities available to some sections of the population with a disability; the episodic nature of some disabilities; inappropriately designed workplaces; and the often high costs to individuals and households who work (Kroehn et al. 2007). Family members who provide care and/or support to people with disabilities report that the demands of caring significantly reduces their capacity to find and maintain paid work, forcing them onto income support. The overall impact of low rates of employment is a heightened dependence on pensions and low average incomes; this in turn reduces the capacity of households where one or more people is affected by a disability to meet their housing needs through the market (Beer & Faulkner 2009).
- *The need for housing that is accessible to public transport* is critical for many people with disabilities, but such well-located housing is often relatively expensive and/or the housing form not suitable for a person with a disability. Many forms of higher-density housing, for example, are simply not appropriate for those with a mobility impairment. Households where one or more persons is affected by a disability are often forced to choose between inappropriate accommodation in accessible locations and more appropriate housing in less accessible places. Kroehn et al. (2007) found that even home owners were affected by this

constraint, with some forced to remain in relatively inaccessible homes because of the inability to 'trade up' to housing in more central neighbourhoods.

- *Rental housing is often seen to be inaccessible to people with disabilities*, both because of the high cost of renting privately and the physical characteristics of the dwelling stock. Beer and Faulkner (2009) noted that many households where one or more persons had a disability were confronted by unaffordable housing, with more than 15 per cent of such households paying in excess of 50 per cent of income for housing. From their qualitative research Kroehn et al. (2007) observed that while the high cost of rental housing was a growing concern—and one which had escalated with house price rises since the year 2000—there were other concerns also. Kroehn et al. (2007) reported that many rental properties could not be occupied by households where one or more persons had a disability because of the physical layout of the dwelling, or the reluctance of landlords to make necessary minor renovations. Some landlords were also unwilling to allow tenants to make and pay for renovations themselves.
- *Home purchase is seen to be too expensive and beyond the reach of many households affected by disability*. Saugeres (2008) and Kroehn et al. (2007) both noted that many households where one or more persons were affected by a disability aspired to home ownership but considered it to be beyond their financial reach. They lacked both the capital to establish a deposit and the income to service a mortgage. This problem was seen to have become more acute over the last decade and while the situation may have eased in 2009 as the housing market felt the effects of the economic downturn associated with the Global Financial Crisis, the resurgence in the Australian economy is likely to result in renewed pressure on housing affordability for those affected by a disability.
- *Many people with disabilities are reliant on public rental housing* and this dependence reduces their options within the Australian housing system. Beer and Faulkner (2009) found that people with disabilities were significantly over-represented in the public housing system and this outcome reflects contemporary public housing entry processes. The AIHW (2008c) has noted that people with disabilities now constitute a significant percentage of new entrants into public rental housing because they most clearly meet the 'need' criteria used to access waiting lists.<sup>4</sup> The Disability Housing Trust (Allen Consulting Group 2007) has also noted the lack of alternatives for accommodating people with disabilities, especially those with high support needs. Others such as Williams (2008) argue that there is a need for individualised support packages for those with a disability, with that package including appropriate financial support for housing. Recent developments in national housing policy—including both the National Rental Affordability Scheme and National Affordable Housing Agreement generally—may result in enhanced options for people with disabilities, but as yet, there is limited evidence on the magnitude and direction of any change.
- *There are non-economic barriers to participation in the housing market among some groups within the housing market*. Reynolds et al. (2002) noted that those with a psychiatric disability often struggled to maintain tenancies because of the episodic nature of their illnesses. They observed that persons admitted to hospital would often return to find that during the four to six weeks they were admitted they had been evicted for the non-payment of rent, the failure to pay bills or for other reasons. Beer and Faulkner (2009) reported similar experiences among those with a psychiatric disability in Brimbank, Victoria, while Hulse and Saugeres (2008) noted that psychiatric disability was a key component of precarious housing. They

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<sup>4</sup>It is important to acknowledge that some caution is necessary in the interpretation of the AIHW data in this instance as the Institute applies a proxy, rather than a direct, indicator of disability.

stated that ‘the most striking finding was the incidence of mental health problems ... with many suffering from anxiety disorders and depression, sometimes over many years’ (Hulse & Saugeres 2008, p.2). Similarly, those with a hearing disability may struggle to gain access to information on home purchase because of the absence of information in a form that they can use.

- *People with a disability living in rural and remote regions are seen to be especially disadvantaged* as they are often distant from services (resources and opportunities) and specialist assistance. The AIHW (2009) noted that people with disabilities tend to be concentrated in fringe and outer suburban local governments where housing costs are lower. For example, in Sydney, the greatest rates of disability in the population are in the local government areas of the Blue Mountains, Hawkesbury, Wyong North-East, Blacktown and Liverpool East. In Melbourne the highest rates of disability in the non-aged population are in Melton, Dandenong, the Yarra Ranges and the Mornington Peninsula. While the problems of transport have been noted above, this challenge is especially acute in rural and regional Australia where there may be little, if any, public transport. At the same time government support programs and medical assistance tend to be concentrated in the capital cities, which results in a transport challenge locally and on a regional basis.

The evidence presented above clearly shows that those affected by a disability—and their households—are profoundly affected by social exclusion. They have limited opportunities to participate in the mainstream housing market because of their low rates of employment and consequent limited purchasing power within the market. At the same time, they are further excluded by a range of other processes, including the physical inappropriateness of much of the housing stock, the attitudes of landlords, the challenge of gaining access to centrally located housing, concentration in one of the most marginalised sections of the housing system, and social, communication and legal barriers that effectively exclude people with disabilities from large sections of the housing stock. For example, those evicted from their housing because of psychiatric disability may find gaining access to private rental housing in the future will be difficult if not impossible because of the use of tenant data bases (Short et al. 2007).

## **2.4 Conclusion**

The discussion in this section has shown five key points that highlight the importance of understanding the relationship between housing, social inclusion and disability.

1. Disability is important with regard to housing in Australia as one in five households report that at least one member of the household has a disability.
2. A significant proportion of the population has a profound or severe disability (6.3% of the population) and this severity of disability will likely determine the nature of housing needs.
3. Most people with disabilities live within the community, with specialist accommodation only used by a small minority.
4. The nature, source and extent of the disability can affect an individual’s housing experiences.
5. The published literature shows that people with disabilities experience social exclusion and are confronted by multiple processes that remove or limit their capacity to participate fully in society.

### **3 'I'M LIKE A JIGSAW PUZZLE THAT DOESN'T QUITE FIT': SOCIAL INCLUSION, HOUSING ASSISTANCE AND DISABILITY THROUGH THE LIFE COURSE**

This section considers the individual level factors that have shaped the relationship between housing assistance and disability for the participants in our study and what this has meant for their social inclusion. The following discussion draws upon the outputs of the face-to-face interviews, as well as the focus groups with housing and service providers. In contrast to the following chapters, this chapter focuses upon the personal factors that have mediated the relationship between the individual, their experience of disability or impairment and their housing assistance. These factors include:

- Type and level of disability, including mental health issues as opposed to other 'classifications' of disability.
- Economic resources and disadvantage, especially poverty.
- Life circumstances.
- Neighbourhood issues and safety.
- Issues around interaction with agencies and agency staff.

This chapter shows that the majority of individuals interviewed as part of this study, and accommodated by the organisations that participated in our focus groups, had experienced the compound, overlapping and profound disadvantage that is universally recognised as social exclusion. This has had implications for every facet of their life, including their housing experience.

Critically, it is important to acknowledge that the experiences and views presented in this report are not necessarily typical of the broader population of persons affected by a disability. Those included in the study are individuals who are vulnerable and therefore more likely to be denied social inclusion.

To protect the identity of participants in this research and to preserve the authenticity of their experiences, aliases have been assigned to participants in the discussion. Some details of the circumstances of individuals have also been minimally altered where it was considered these details might also identify a participant or participants.

#### **3.1 'Type' and severity of disability**

As discussed earlier, the nature, type and severity of disability can exert a profound impact on an individual's housing experiences and the degree to which they may, or may not, be socially excluded. Persons with a wide range of disabilities participated in this study. This included those with a psychiatric disability or mental illness, mobility impairments, intellectual disabilities, sensory disabilities and other circumstances. Table 1 provides a summary of the types of disability experienced among the participants in the research. As these data show, psychiatric disabilities—largely mental health related—dominated. In part this is a reflection of the recruitment methodology used, as many agencies assisting people with mental health issues referred clients to us. Importantly, these data also show the broad spectrum of disabilities among participants, and the presence of multiple disability for many participants.

As noted in Table 5, a number of respondents (n = 7), for example, were dependent on wheelchairs for their mobility and this had clear implications in terms of the physical design of their housing and their ability to move around the built environment. Among the group were people living with spina bifida, cerebral palsy and multiple sclerosis. For others, their disability was a mental illness, such as mild or severe depression or bi-polar, obsessive compulsive disorder, borderline personality disorder or a social phobia. While these types of disability generally did not present physical access problems, it did restrict their interaction with the broader community, including accessing necessary services and finding and maintaining employment.

**Table 5: Main disclosed ‘types’ of disability/ies among participants in the fieldwork**

<b>Main broad disability/impairment category</b>	<b>Specific disabilities/impairments among participants</b>
<i>Intellectual disability only</i> (14.4% of sample)	Down syndrome (n = 5) Asperger’s (n = 1)
<i>Physical disability/impairment only</i> (17.5% of sample)  <i>Includes five wheelchair users and two participants who often use wheelchairs (or callipers)</i>	Cerebral palsy (n = 2) Spina bifida (n = 3) Hip and back injuries (including work-related injuries) (n = at least 3) Multiple sclerosis (n = 1) Terminal illnesses (including HIV and Cancer) (n = at least 2) Spinal damage (suicide attempt, vehicle accident) (n = 1) Severe arthritis (n = 1) Carer for child with a physical disability (n = at least 2—and these two cases the child is confined to a wheelchair)
<i>Psychiatric only</i> (41.2% of sample)	Severe and mild anxiety(n = 8) Manic depression (n = 2) Depression—related to life events, including illness and injury, drug related et cetera (n = at least 10) Bi-polar disorder (n = 2) Psychosis (drug-induced) (n = at least 3) Social phobias and paranoia (n = at least 4) Obsessive compulsive disorder (n = at least 5) Epilepsy (n = 1) Acquired brain injury (n = at least 2)
<i>Sensory</i> (2.1% of sample)	Vision and hearing impairments (n = 2)
<i>Multiple disabilities/impairments (including presence of debilitating illnesses)</i> (22.7% of sample)	For example Heart attack causing physical impairment and psychological disability (n = 3) Back injury causing severe depression and/or anxiety (n = 4) Back injury and related incontinence causing severe anxiety (n = 1) Terminal illness causing psychiatric illness (n = at least 3) Childhood polio causing depression and anxiety (n = 1) Severe depression post-illness or because of ongoing illness (including due to thyroid disorder, back injury, violent attack) (n = 3) Depression with/after acquired brain injury (vehicle accidents and drugs abuse related) (n =3)

Note: not all participants in the research clearly stated their ‘type’ of disability. Often, however, their condition was mentioned in regard to their housing needs or Disability Support Pension assessment. For this reason many categories in the table above state n = at least a particular number.

Some of the individuals interviewed had been born with their disabilities, while others had acquired them through the progressive onset of disease, as a result of substance abuse, a vehicle or other accident, including a workplace accident. Some of the participants in the research with mental health issues reported that their mental health issue stemmed from, or was compounded by, an accident or injury that had significantly affected their daily life, family life or attachment to the labour market.

Frequently, individuals reported more than one disability—for example both a psychiatric disability and a mobility impairment, or an intellectual disability and a hearing impairment. For participants with such ‘dual diagnosis’ of disability/impairment, this added to the complexity of their housing experiences and the nature and type of demands they placed on the service provision system.

Many participants lived alone—especially those with a psychiatric disability—or lived with others who also had a disability of some type.

A clear concern for many participants raised in discussions about the nature of their disability and disability generally was concern over how others ‘see’ and ‘define’ disability. For people with mental health issues, this was a concern because they felt that others think and comment that they don’t look ‘disabled’, therefore, they ‘must be fine’ and ‘why can’t they just go and work’. In addition, for people with more visible disabilities, the challenge was often: people thinking they had a cognitive or intellectual disability as well as their physical disability and treating them differently because of this assumption (including family in some cases); or people assuming they couldn’t perform certain tasks or hold down a job, study or live alone because of their disability; or friends, family and strangers being too afraid to offer assistance when they really needed it—such as with shopping, accessing public transport et cetera.

As will be highlighted throughout this and the next section of this report, stereotyping around disability remained a significant concern for respondents, with noticeable impacts on the lives of people living with a disability. It was clear from this research that it is often those with psychiatric disability suffering the most from discrimination, stereotyping and a general lack of empathy and understanding of the wide-ranging implications of such disability on their lives, including their housing needs and social inclusion. Of course, this is not to downplay the impact of other types of disability, but instead to point out that there is a clear and growing need for recognising the debilitating impact of psychiatric disability and to develop and promote strategies to assist people living with such disability into the community, including their neighbourhoods and the labour market where possible and appropriate.

Disability is a social construct, it reflects both the impairment affecting individuals and the social, economic and legal structures that may limit their full inclusion within society. Some of the individuals we interviewed defined themselves according to their disability: it shaped their lives by determining the level and type of support they were able to gain access to, it dictated their income stream, it largely shaped their social interactions—with service providers, medical professionals et cetera—and in some instances, assisted in gaining entry into social housing. Respondents also noted that their disability or impairment affected many of their interactions with the broader population, both in the attitudes of individuals and in their exclusion from many of the day-to-day experiences of mainstream society, such as the world of work. Under these circumstances, housing could, and often did, become a prominent feature of the lives of some individuals with a disability. Many spent a considerable time in their homes and their housing was an important determinant of the broader social resources they could gain access to, both at a neighbourhood level and with respect to their household budgets. Disability, therefore, was in many ways a determinant influence on their lives.

### 3.1.1 *Mental health issues*

Mental health was an important theme in many of the discussions with people with a disability. Psychiatric disability is widely acknowledged as a determinant of homelessness within the Australian population (Mental Health Council of Australia 2009) and many persons with a psychiatric disability are accommodated in social housing of one form or another. Poor mental health affects the ability of individuals to secure appropriate accommodation and contributes to social exclusion in multiple ways:

- Participation in paid employment becomes more difficult, thereby limiting their capacity to secure affordable housing in the market.
- The episodic nature of some psychiatric disabilities makes it difficult to maintain a tenancy, especially when the individual may spend relatively long periods in care (Reynolds et al. 2002).
- Persons with a psychiatric disability may struggle to live with others, including family members, thereby reducing their social connectedness and increasing their personal housing costs.
- Areas where multiple persons with a psychiatric disability are accommodated can suffer social stigma (Jacobs et al. 2011) and reduced amenity. The concentration of persons with a mental illness can exacerbate the conditions of individuals, through noise, nuisance and stress (Kroehn et al. 2007).

The final factor noted above was prominent in at least one of our NSW case studies and there was a perception in this instance that one housing estate was socially excluded relative to the wider society as a consequence of a concentration of people on low incomes and persons with a psychiatric disability.

One of the ways mental health issues found expression was in the number of persons interviewed who engaged in hoarding. Hoarding is an acknowledged problem within both the literature on psychiatric disability and in housing management. Hoarders may keep any type of item and at times hoarding can present a threat to physical health and the proper maintenance of a dwelling. Critically, hoarders are at greater risk of eviction within the private rental market and potentially subject to a council order within home ownership. Hoarding behaviours also represent a major challenge for social housing providers, as a source of complaint by others and potentially a risk to the health and safety of the tenant and their housing and social support worker(s).

Among the hoarders interviewed for this study, it is important to note that for some hoarding was accompanied by squalor—affecting the quality of their living environment, and for others it was not. A small number of the hoarders interviewed had battled with their landlord about their hoarding (all of them social housing landlords) and many had been or were receiving some level of assistance with managing their hoarding; fundamentally, for their own safety and poor property condition. Interestingly, for some of this group being a hoarder was a central part of their identity. In discussing their hoarding many openly explained that their hoarding was a response to a traumatic childhood event or having ‘nothing’ as a child. Therefore, their ‘stuff’ was a security blanket for them. Many of the hoarders interviewed also openly noted that they severely limit the number of visitors to their homes because of their hoarding; fundamentally because they know people won’t understand why they have so much ‘stuff’ and its value to them. Many of the hoarders interviewed reported that their hoarding was contributing to their social isolation.

## 3.2 Economic resources and disadvantage

The persons with a disability interviewed as part of this research reported very low incomes. The overwhelming majority of respondents were dependent upon a disability support pension or equivalent payment for income support. Participants in our study noted that their incomes were extremely limited, only covering the bare minimum for adequate living:

[I] prefer dealing with Housing SA rather than private rental, I'm able to negotiate debt with them, I feel more secure, as I can live there forever. Its affordable ... I could never afford private rental now, particularly if I wanted to eat. I can't put food second again, have put food second before [because of limited finances] and ended up in hospital ... back on path to depression, anxiety. I'm very grateful for Housing SA, [I'm] not struggling anymore.

We need more support for medications financially, anti-depressants are not cheap and not everything is on the PBS [Pharmaceutical Benefits Scheme].

While another added:

I'd be stuffed without public housing. If I had to go back to private rental, there is no way I would be able to keep up my private health. This would put me back into the public mental health system, limit my chiropractic et cetera ... it's very expensive on some medications ... I don't know how I would survive in the private rental market, probably wouldn't, definitely couldn't.

Low incomes affected many dimensions of their life: it restricted social interactions with the broader population; it limited their options within the housing market—by effectively guiding them into, and keeping them within, social housing; it increased reliance on publicly-provided services—such as health services; and it increased reliance on public transport. The latter, in turn, reinforced the importance of housing and especially the location of the dwelling for determining access to services and other resources.

Importantly, limited economic resources resulted in constrained social interactions and in many instances, a degree of social isolation (see Box 3).

### **Box 3: Isolation, economic resources and social exclusion: the case of John**

John is a 59-year old man who lives in Adelaide. He lives in a bedsit within a four-storey apartment complex and relies upon the disability pension for his income. When he can, he takes on *part-time work* fixing household appliances to supplement his income, but recently that source of work appears to have dried up. He either walks or catches public transport to the places he wants to visit, but rarely travels far from home.

John comes *from a disadvantaged background*. He was orphaned in his early teenage years, and while he had a sister and a brother, both have subsequently died and he has lost *contact with his broader family*. He has three children with a former partner, but he has relatively little contact with them also.

John's major social activity is limited to going to the pub on pension day and supporting one of the National Rugby League teams. His income is insufficient to cover too many days at the hotel drinking with acquaintances. *John noted that his very low income severely limits what he can do to remain socially included.*

More broadly, respondents with a disability reported considerable difficulty in finding work. The limitations that may be imposed by their disability were an impediment to employment, with some reporting that maintaining employment was as challenging as finding a job in the first instance. People with a disability who lived in the outer

suburbs reported compound challenges, including inadequate public transport links to possible places of work and few employment opportunities within the region. Regardless of location, many respondents noted that the wages from the type of work they could secure was limited, and provided only a small incentive to enter employment. This said, for others, finding appropriate work was a personal and financial goal, however, many in this group raised concern about finding a workplace (or study environment) that fits with their disability-related needs, whether these be physical/access related or about flexibility to take time off work at short notice because of 'flare-ups' in their condition.

### **3.3 Life circumstances**

The life circumstances of individuals with a disability exerts a critical influence on their housing and the degree to which they enjoy full inclusion within Australian society. Critically, while disability per se may predispose some individuals to social exclusion, in many instances it is simply an additional compounding factor within an already disadvantaged life.

#### *3.3.1 Family background*

Family background had a significant impact on the vulnerable people living with a disability included in this study. Many had experienced non-standard care arrangements in their younger years and youth, including:

- Periods in state care.
- Living with grandparents or other relatives.
- Episodes of juvenile detention.
- Being orphaned.
- Neglect by parents or other family members.
- Abuse (including sexual abuse).

Relationship breakdown was the most common reason for participants reporting the aforementioned care arrangements.

Other participants in the research noted that they had been subject to challenging life circumstances during their adult life, including instances of domestic violence, abuse and neglect by family members, spouses and children. Others had experienced periods of institutionalisation, including, for some, as a child.

I was in ... Boys Home as a child, there for two or three years, or maybe 12–18 months, can't remember. It was a melting pot ... the naughty, lost, lonely, rejected, broken. My parents weren't parents. Was in another home before that. It was pretty rough, boys were in lock down, very sterile, very military, a cage within a cage, boys on one side and girls on the other, had solitary cells as well. [People] were there for all reasons, bad, good, disabled.

Many of the people who had been in institutions reported that during their time in such places, they forged relationships with others who led them 'astray', took up criminal acts or self-medicated with illegal substances. For many these actions were a survival strategy or coping mechanism. These experiences remind us of the lasting impact of some events on the mental health of some people within the community.

In a number of instances, family arrangements earlier in life were sufficiently traumatic to result in a complete severing of family connections. For these individuals, their distancing of themselves from family members added to their sense of broader social isolation and increased their degree of vulnerability.

### 3.3.2 Substance abuse

Substance abuse was an important theme in the life histories of some people living with a disability. In some instances, misuse of alcohol or other substances had directly contributed to their disability, in the form of an acquired brain injury (ABI) or the onset of psychiatric disability (see Box 4).

#### **Box 4: Alcoholism and marginalisation: Eric's journey**

Eric is a long-term private renter. He has lived in his current unit in the suburbs for years. His landlord is an old lady, who he gets along well with, and while he has issues with some of his neighbours, he is *generally happy with his housing situation*. He does not feel at risk of eviction and homelessness despite the age of his landlady. Eric reported that he would argue through the courts for the continuation of his tenancy should she die. *Eric receives rent assistance which he stated 'helps me a lot' with housing costs. His unit is in a good location, close to all the services he needs and his church, as well as public transport and support services and groups.* He reported that church is very important to him, as a source of fellowship and support.

Eric has a psychiatric disability and has been on a disability pension since 1986. Eric attributed his disability to severe alcohol abuse, which he struggled with for many years. He last worked in the late 1970s and was sacked from this job for alcohol-related issues. His alcohol-dependency saw him lose many friends and he moved interstate because of this. He was homeless one weekend many years ago and slept on the beach. Eric credits an exorcism with curing his alcoholism. He noted that it is tough living in the private rental market at times. 'We get by on less than old people get ... in the past much of my money went on alcohol and smoking ... now I spend it on books ... it goes just as quick'. Eric reported that he strongly controls his money, choosing to spend only a small amount of what is left after the rent on social activities. *He would like to participate in more social activities, but commented that the cost of activities, as well as getting to them, was prohibitive.*

Some people living with a disability suffered the second order impacts of substance abuse, including the consequences of living with a partner or other household member with a significant addiction. Substance abuse contributed to a wide spectrum of adverse conditions for persons with a disability, including a greater exposure to the risk of domestic violence, reduced disposable income, contact with the law enforcement system, risk of additional disabilities and the threat of eviction.

The compounding impact of substance abuse on the lives of persons with a disability, and their sense of social inclusion is illustrated in Box 5.

### 3.3.3 Homelessness and precarious housing

The experience of homelessness was relatively common among persons interviewed as part of this study, especially those with a psychiatric disability. Experiences of homelessness among interviewees included sleeping rough, such as living in bushes, up trees and on beaches, living in motels and caravan parks, couch surfing, staying in and moving between refuges and being trapped for longer than necessary in institutions such as rehabilitation centres and respite facilities.

A number of factors contributed to the incidence and severity of homelessness among persons with a disability. Key factors included: periods of incarceration, having been homeless as a young person, a history of substance abuse, experience of either neglect or abuse either from a partner, parent(s) or caregiver, and the presence of social phobias.

**Box 5: Substance abuse and marginalisation at a young age: Peita's experiences thus far**

Peita is a 20-something-year old woman who lives alone in a small public housing property in the city of Adelaide. She has severe anxiety and depression. Peita experienced periods of homelessness as a youth, after leaving home because of family breakdown and drug issues. She attributed her mental health issues to drug abuse and has experienced periods of psychosis and drug-induced depression as a result of smoking marijuana. She noted that her experience with psychosis was the catalyst to getting off drugs.

Peita has lived in a number of precarious housing situations; the majority of them in the private rental sector. The last of these before she secured Housing SA accommodation was a small poor quality granny flat in an associate's backyard. This was expensive for the quality of the housing and she struggled with her living costs. Peita was on the waiting list for public housing for seven years. Her recent and first experience as a public housing head-tenant was traumatic. She was assaulted near her property, a small bedsit, and found living in close proximity to people from a range of backgrounds and with a range of challenging behaviours difficult, impacting on her anxiety levels.

Peita's current Housing SA property meets all her needs for safety and security, and she is happy with its location and neighbourhood. She noted that it is well located for transport options, services and also not too far from her educational institution, so she aims to re-engage with her study more fully soon.

Boarding houses and equivalent accommodation played an important role in the lifetime housing experiences of persons with a disability who have experienced homelessness. Boarding houses are often seen to provide a minimum, affordable, level of accommodation but can present significant challenges for persons with a disability because:

- Few are modified for access for persons with a physical disability.
- The behaviour of other residents is often challenging for persons with a disability, especially those with intellectual or psychiatric disabilities.
- The short-term nature of much boarding house accommodation does not match the needs of persons with a disability, who often have specific needs that need to be planned for and met well in advance of immediate needs.

Lack of privacy, concerns over personal security and the widespread use of soft and hard drugs by other residents were raised as other reasons why respondents actively avoid or have left boarding house style accommodation—as noted in Lee's experience (Box 6). Lee commented that living in '[The rooming house was] worse than my time in the resettlement [refugee] camp in Philippines'.

The experience of homelessness, however, is commonly a pathway into social housing for persons living with a disability and this in turn provides greater stability in their housing. Homelessness, of course, carries with it multiple dimensions of social exclusion because of:

- The limitations it necessarily imposes on the security offered to the individual and their possessions.
- Its impact on their health.
- As a result of the environments to which they are exposed.

Often homelessness is one of a number of adverse processes affecting the lives of individuals with a disability (see Boxes 7 and 8).

### **Box 6: The drawbacks of rooming houses: Lee's experience**

Lee lives in a community housing property in inner Melbourne. He arrived in Australia in the early 1980s from Vietnam. En route to Australia he spent some months in a refugee camp in the Philippines.

Lee was diagnosed with Multiple Sclerosis in 1984 and receives the DSP. The severity of his Multiple Sclerosis has fluctuated dramatically over the last 25 years and he has been confined to a wheelchair twice. After one of his 'bad' episodes, he had to learn to walk again, following four months in hospital. As Lee was the first member of his family to resettle in Australia, he had limited support networks and was reliant on his friends in the Vietnamese community and from his church. His MS has affected his speech; a challenge for communication for someone for whom English is a second language.

Lee separated from his wife a few years ago and until securing his current housing has lived in a number of places in outer Melbourne, including staying with friends. The worst accommodation he lived in during this time was a rooming house. He reported having no privacy and concerns with his personal security and security of his possessions, including his food in the shared kitchen facilities. Drugs were a major concern for him in the rooming house and added to his safety concerns.

While living at the rooming house, Lee was *unable to have his young son visit or stay with him*. He reported that during this time, and while he was living in other unstable housing, his ex-wife and social services withdrew access rights to his child. On the positive side, Lee stated that it 'forced me to better living conditions ... It wasn't good, it was unsafe, I felt unsafe'.

Lee eventually moved into the private rental market with one of the other rooming house residents; an arrangement that lasted for a couple of years. His health fluctuated during this time and he struggled with his housing costs. A hospital social worker put Lee in contact with his current community housing landlord. *While originally he refused the unit because it was so far away from his family and friends, he eventually decided to accept the property; a decision he has not regretted. He loves the 'community' in his building*. Most importantly, he has been able to re-establish visitations with his son and this and his housing has helped stabilise his illness and life. At the time of interview, his MS was well controlled and he is 'out of the tunnel and the crisis' after years of struggling.

### **Box 7: Homelessness, disability and social exclusion: Brett's story**

Brett is a man in his 40s with a long history of incarceration and homelessness. He has lived a reasonably nomadic lifestyle between periods in prison. His current period of six months out of jail is the longest he has been 'outside' in the last 15 years. Currently he has a small public housing unit on a notorious housing estate in that community. He reported being grateful to have this unit despite the challenging conditions on the estate. While Brett has had assistance with his housing post-release, he reported that he has always had difficulty maintaining tenancies because of his drug dependency and consequent mental health issues and the *cost of housing, particularly in the private rental market and with boarding houses*.

Finding a job has been difficult for Brett. He has worked on and off in the past, and before developing his drug habit, he held a well-paid job in the trades. Brett recently lost his driver's license, further limiting his employability. For now Brett describes himself as 'in a holding pattern', while he is evaluated for a DSP. He is being supported by a job services provider and Offenders Aid and Rehabilitation Service (OARS) and highly values the practical assistance he receives through a local community centre where he can get phone cards and bus tickets when needed to help make ends meet.

### Box 8: Family homelessness with a physical disability: Anthony and Joanne's journey

Anthony (36-years old) and Joanne (34-years old) have been married for about four years. They currently live in the outer suburbs of Melbourne. The couple have a young primary school aged child. Joanne has an older son who recently moved out of home.

Anthony was stabbed in a violent drug-related incident in 2007 and has been a paraplegic since. Anthony spent many weeks in hospital following the attack. He is now reliant on a wheelchair for his mobility and has experienced many difficulties with finding suitable housing. He reported a long history of housing problems and periods of homelessness, due to drug abuse and theft to support his expensive daily drug habit. Anthony's hard drug habit continued until recently. He noted that this was 'to self-medicate' to help him cope with his situation.

Around the time Anthony became a paraplegic, Anthony and Joanne found themselves homeless. The couple and their young child spent a night sleeping in their car after a major argument with Joanne's Mother who kicked them out of her home, where they had been living. The family approached a number of agencies for assistance. Anthony commented that because they were a family with a person with a disability, they were told it was going to be very difficult to find them suitable accommodation and on more than one occasion the agency assisting them with finding accommodation asked if Anthony and Joanne's older son would consider going into a single men's facility and Joanne and her young child into a refuge. They considered this option to be an insult.

The couple were eventually found temporary accommodation in a motel suitable for someone in a wheelchair. Because at the time they had two children living with them, Anthony and Joanne were required by the motel owners to rent two motel rooms at a cost of \$360. They did not receive rent assistance to help with these costs. The motel rooms did not have basic facilities for washing and cooking, and this was a major concern for the couple—as not being able to prepare their own food was expensive. The family considered moving to a caravan park, but found that to be just as expensive as the motel and after being at the motel for a while the owners allowed them to use other motel facilities for cooking et cetera. While living at the motel, Anthony fought for compensation from the perpetrator of his attack through the court; a time he described as very stressful and that nearly forced him back into drugs. Anthony noted that the lack of help for a family in his predicament was astounding. The family were told it would be an 18–24-month wait for appropriate transitional housing and were promised assistance that didn't happen. They 'were sick of getting their hopes up'.

After eight months in the motel, Anthony and Joanne were put in contact with a specialist disability and housing support organisation in Melbourne by a social worker at Anthony's rehabilitation centre. Soon after the family were offered a brand new wheelchair-accessible community housing property. While they commented that the location was probably not near the medical services Anthony needs, and therefore where they would normally have chosen to live, once they inspected the place they thought it was an opportunity for a 'new start'. 'We love the place'.

Since moving into their community housing property, *Anthony has been able to continue with his rehabilitation, and, most importantly their young child has become much more settled.* Their child is now *happily engaged with a local school*—having been enrolled in five schools by the age of six. The couple reported that this has been one of the most important outcomes from their housing.

Reflecting on their homelessness experience, Anthony and Joanne commented that *being homeless had eaten up their minimal cash reserves*, which they were now recharging because of their stable and affordable housing. They were also emphatic that much more needs to be done to accommodate homeless families where one or more members of the family have a disability/ies and said that 'I don't think anybody wanted to listen' to their struggles. 'No one would rent to us because we didn't have jobs ... not enough savings in the bank ...'. And Joanne commented that 'I really think the government needs to sit down and reassess housing for people with disabilities and support for them and their carers ... [there] needs to be more accommodation for disabled people with families'.

Some of the participants in the research who had experienced homelessness in the past commented that it was difficult for them to move away from some of the bad influences in their lives that they had established when they were homeless. On the other hand, others noted that the relationships they had built with other homeless people, whether they were a positive or negative influence on their life, were important as they represented some of the only social connections they had at the time and these people could identify with their struggles and general situation.

On the whole participants in the research who reported homelessness at some time in the past, noted that having affordable and secure (social) housing was central in stabilising their lives and their mental health. Most of these participants also emphasised the role of stable housing in allowing them to seek out the social opportunities they are comfortable with, although clearly the level of social interaction was limited by their economic and social resources, as well as their disability. Many participants with significant mental health issues, for example, reported self-imposed isolation, related to social phobia. Among this group, many also reported that while they have socially isolated themselves, stable housing and access to necessary services had improved their wellbeing; although problem neighbours were clearly a concern to this group and participants as a whole (discussed further in Section 3.4).

### *3.3.4 The role of health services and professionals*

A number of participants in this study believed that medical intervention/health services had failed to adequately deal with their disability and, in some instances, added to their degree of social exclusion. There was a common perception that there was a shortage of medical and allied health professionals with sufficient skills to understand and deal with dual diagnoses and that a 'medical model' of disability was unable to deal with the complexities of their condition or their need for on-going care. A number of participants commented they felt the medical profession had put them in the 'too hard basket', and as one woman living with a dual diagnosis of thyroid dysfunction and severe depression reflected: 'I'm like a jigsaw puzzle that doesn't quite fit'.

The issue of health services and professionals is important in the context of this research, because the overwhelming majority of persons with a disability interviewed as part of this study remained in contact with the health system on a regular basis. The health system, therefore, is an important avenue for the dissemination of information and new ideas, for generating a sense of connectedness to the rest of society and for the delivery of services.

A small minority of older participants with mental health issues reported that they continue to struggle with the broader implications of past medical treatment and diagnoses no longer considered appropriate.

## **3.4 Neighbourhood issues and safety**

A feeling of safety and security in the home is important to all residents, regardless of their income, disability status, age, gender or household arrangements. Many of the persons interviewed as part of this study reported that they were not able to enjoy a sense of security or privacy in either their home or the neighbourhood in which they lived. These participants reported that such feelings of insecurity affected their sense of inclusion within society, adding to their perceived feelings of alienation and level of stress. For some, they reported these feelings were a barrier to participating in social activities or seeking employment or training.

Most participants emphasised the importance of a quiet neighbourhood for their sense of wellbeing and this was especially true for persons affected by a psychiatric

disability. One set of interviews was undertaken in two large scale public housing estates in New South Wales and respondents there were particularly vocal in expressing concerns about a range of issues that related to privacy and security. Concerns they raised about their neighbourhoods included:

- The risk of victimisation associated with being a disabled person in a highly disadvantaged neighbourhood, where the person with a disability could be seen to be an 'easy target' by predatory individuals or groups.
- Poor accessibility for persons with a mobility impairment. Concerns about this included references to the home, poor access to public transport and neighbourhoods that could not be traversed easily because of the distances involved, the lack of footpaths, or adverse road traffic flows.
- A perception of high levels of violence within the neighbourhoods that reduced their willingness to engage with others within their locality.
- The impact of anti-social behaviour, including graffiti, youth gangs and drug dealing.
- The presence of adverse social networks in the neighbourhood that are perceived to be a threat to both the individual and their families.

Importantly, the reality of these threats to their wellbeing is, in some ways, less significant than their awareness, as it is the perception of risk that shapes behaviour, especially among vulnerable groups within society. People with a disability may, effectively, become 'trapped' in their homes because of their perception of risk if they were to leave it.

The most striking example of the impact of neighbourhood and anti-social behaviour was seen in a regional area of NSW (see Box 9). In this place we undertook a number of interviews with unrelated tenants of a public housing estate and all of these respondents commented extensively on how negative the estate was as a living environment, battles with crime and violence, as well as poor quality housing. Most wanted to leave the estate, but also noted that living there was better than the alternative of being on the streets. Sadly one respondent commented that he felt safer when he was sleeping on a local beach. An interesting trend evident among the residents of this estate living with a disability was that many reported maintaining certain relationships, including with neighbours, even if they were known to be a bad influence, in order to avoid victimisation by other individuals and groups living on the estate.

Many of the respondents in the NSW regional community discussed above commented that concentrating large groups of people with social and economic problems together in one estate was not productive and something needs to be done to address such concentrations of disadvantage. This sentiment was echoed by tenants in other areas where social housing was concentrated. In one inner Sydney social housing apartment block, for example, one of the tenants noted that 'bad tenants bring their social networks' and in this instance this included 'junkies'. For this tenant, the presence of tenants and associates with anti-social behaviour problems was adding to his stress. He further noted that:

I class this place as my home, others just see it as a place to stay ...  
[Landlords] need to give more care to other tenants ..., screening tenants et cetera ...

### Box 9: Neighbourhood issues and their impact on disability and housing, regional NSW

Peter has lived in a regional community in NSW since arriving from overseas in 1983. He has three children and is now separated from his wife. He was previously a home buyer, but post-separation fell out of homeownership. Recently, Peter suffered a massive heart attack while at home in his public housing unit and was revived by one of his teenage children. He now has diet controlled diabetes. He attributes some of the stress that caused his heart attack to living on the public housing estate in the regional city. 'Living at [particular housing estate] was a bad experience, with drugs, needles lying around ... My stress levels were higher there'.

Peter was recently transferred to a more appropriate detached public housing dwelling in a 'better' area of the regional city, and credits his stable mental and physical health to living in this more pleasant environment. 'I feel less stressed and better able to cope, *I now [have] more time to focus on my health et cetera*'. His new home has *good access to the services he needs, as well as public transport* and he highly values the opportunity to exercise offered by the location of his home: 'I live right near a lake with a walking track for exercise around it. It's very calming, part of [my] therapy'. Peter described his time at the estate as like 'being between a rock and a hard place [and was] *so grateful for a stable home*'.

Janet, a middle-aged Aboriginal woman, has lived in the same regional community as Peter for many years. Like Peter, she also used to live on the same notorious public housing estate until recently when she was moved to a brand new small block of flats in another area of the town. Like Peter, Janet was transferred from her property on the estate when the state housing authority decided to upgrade some of the properties on the estate. She placed herself on a transfer list less than one year into the four-year period she lived on the estate, primarily because of arson attacks on her property and building. Janet felt that her time on the estate was damaging to her mental and physical health and was constantly worried for her children and grandchildren on the estate. As with a number of other tenants spoken with about the estate, cockroaches and rodents were mentioned as a serious problem and attempts to eradicate them were fruitless.

Janet noted that it has been quite a struggle to find appropriate accommodation and that 'there is lots of housing available in bad areas that is disgraceful and like living in a ghetto ... [Its] not an environment to bring kids up in at all'. In her new home she 'feels safe and [it] feels like home'.

Two other residents of the same estate, Adrian and Nick, also raised a number of concerns about their housing. For Adrian, a 55-year old man with a mental illness who has lived on the estate for around four years, the prevalence and visibility of drug taking and dealing were of specific concern. He noted that the police are regularly at the estate, dealing with severe violence. Nick, a 38-year old ex-prisoner with an acquired brain injury and mental illness, was less concerned about these issues as he had developed a range of strategies for dealing with such issues and people have generally left him alone. Nick's concerns about the estate centred mainly on the quality of the housing and the ongoing rodent problem.

Adrian and Nick live in the same block on the estate and look out for each other. Both agreed that this has been an important way of protecting themselves from violence and abuse from other estate residents. Nick's views of the estate were also clearly shaped by his recent and recurrent homelessness experiences and for the most part he was grateful just to finally have a roof over his head. This had allowed him to establish links with the medical services he needs, as well as a local job network provider.

On the other side of the coin, a small number of the residents of the estate in the NSW regional community noted that their common housing histories (or, rather, for most, long-term experiences of homelessness) and the challenges of living on the estate had meant they had 'ended up with a network of people [from the estate] they can and do trust' and '... if they were to transfer [from the estate] they would lose their network'. This network of friends was important for a number of reasons: for mutual protection from 'bad influences' and 'bad neighbours'; from being violently attacked, particularly on the estate at night; and for company. The strength of these

relationships between some of the tenants was demonstrated by the fact that a number of them (all men) would only be interviewed together for this research.

Importantly, it should also be noted here that concerns about safety among interviewees also centred on practical concerns about ground floor apartments and break-ins. A number of the women living alone interviewed for this research commented that they have asked their landlords for improved security measures such as window grilles and security alarms linked to emergency services. For some this was to ease their fears about home invasion, for others, it was considered a necessity following a break-in, repeated break-ins or a violent incident.

One participant noted:

[It's] important to have some security system for houses for people [with a disability] living alone, a button for security should be part of the housing, part of the package of support. For a period of time I felt very scared, it affected my wellbeing. Because I need the ground floor I have frontage to the street.

Another, a young visually impaired girl living in an area notorious for 'junkies', expressed similar views:

I'm not planning to live here a long time. Sometimes feel the landlord doesn't care ... too many junkies, drug use in the area ... house has been broken into twice, feels unsafe, I can't see properly, I need window locks, I'm on ground floor near back alley, need locks on windows ... I grew up in a high rise flat.

Interestingly, these concerns were raised as frequently among women living with physical disabilities as those with mental health issues.

A second important dimension of the neighbourhood in which persons with a disability lived was their sense of privacy. Many reported that they needed both time for themselves and the sense that they could achieve that privacy readily in order to secure their sense of wellbeing. As one respondent noted:

If I couldn't get my time to myself and couldn't get bad people away from me, I don't know how I would be.

### **3.5 Interaction with agencies**

The ways in which people with a disability interact with agencies has a profound impact on their quality of life. Many persons with a significant impairment are in receipt of support services, often from multiple agencies or providers. While some of these are offered as part of their disability 'package', in other instances, those with a disability need to seek out new services in order to find accommodation, employment or other help. In many instances, persons with a disability reported difficulty in gaining assistance because they had trouble identifying a point of entry to a service, or struggled to find the 'right' individual who understood their problem and was able to offer assistance. The case of Anthony and Joanne discussed earlier exemplified this (see Box 8). The couple were full of praise for the specialist disability and housing service that had helped them find an appropriate home. And, this was not only because of finding the physical home, but because they were able to keep their family together, they were listened to and their worker within the agency kept them updated on progress with finding accommodation regularly. Anthony commented that they still are in regular contact with the worker at the agency and he has assisted them post-moving into their home with other supports such as taxi vouchers. The couple credited a whole range of wellbeing outcomes for themselves and their daughter to finding the right supports and the 'right' person, and repeatedly told us that they couldn't believe how things had changed for them. 'We thought we'd get a place in community housing

that would stand out, but you can't tell ... it's amazing. I don't believe it'. Anthony commented that because of this, he has been able to focus on getting physically stronger, is working on managing his pain and related anger and now has a goal to drive again and in the longer term to get a job:

I want to work, I want to be able to buy nice things et cetera ...

Box 10 provides another example of the challenging (and positive) experiences reported by respondents in their interactions with agencies and (often multiple) support systems.

**Box 10: Dana's experiences negotiating the hospital, rehabilitation, compensation, citizenship and housing systems**

Dana was an international student studying a post-graduate degree when she was badly injured in a car accident. The injuries she sustained in the accident left her paralysed and she has been confined to a wheelchair since. Dana couldn't return to the family where she was being billeted at the time of the accident because the property was three-storey, making it impossible for her to access.

Dana spent 18 months in hospital and rehabilitation following her accident. She reported that much of the time spent in these institutions was not necessary and very costly to the government, and was due to authorities not being able to find her suitable accessible accommodation. Dana negotiated the legal system following her accident and received a compensation payment for her accident. The compensation from her accident was recompense for lost earnings, but did not specifically cover her housing costs. Post her accident, Dana also applied for and received residency in Australia.

Eventually, Dana was offered and moved into a fully-accessible community housing property. She was able to secure this property with the assistance of a specialist-disability focused housing organisation. She has been in this property for some seven years, despite it being technically a 'transitional' property. With the assistance of a disability-specific housing support service, she has tried to negotiate having her property transferred from the transitional housing pool but this has been unsuccessful to date. Dana is 'unsure about where I will go from my current property ... know that a move would be detrimental to my health, and impact on my mental stability'. Dana reported that private rental was not an option because 'it's too expensive' and because most properties 'are not wheelchair friendly'. She noted she would like to purchase her current house, but acknowledged that this is unlikely without some sort of homeownership assistance.

Dana noted that she has been able to *re-engage with her post-graduate studies*, as well casual employment, because of her housing and its location. However, she noted a particular concern with the accessibility of the built environment and *she is highly dependent on her car for her social connectedness as public transport is impossible for her to negotiate*. She has actively lobbied local and state government about accessibility concerns, including for a residential disability parking place near her home and regarding the accessibility of trams and buses.

In some instances, the impediment to gaining access to assistance was a feature of the disability service or referral processes, in other cases it reflected the particular circumstances of the person living with a disability. Critically then, it is desirable for services to have both well trained staff and multiple entry points, such that persons living with an impairment can seek out assistance from individuals they are comfortable with and seek assistance on multiple occasions. Those who feel they are unable to gain assistance are effectively excluded from society as they may be denied access to critical resources.

On numerous occasions, participants noted the need for better, clearer and more accessible information outlining available support and identifying the range of organisations and agencies that can potentially offer assistance and pathways

through the assistance available—including for housing assistance. Stakeholders concurred with these views from their experiences assisting individuals with a disability or disabilities. Interestingly, social housing providers and support agencies/workers also commented widely on the issue of interaction with and between agencies themselves, noting that negotiating with the multiple players involved in assisting a client can also be difficult at the agency/worker level. As one representative of a disability-specific support agency noted:

... dealing with so many different agencies, it's like Chinese whispers. The further along the story gets, and the more people involved, the further away from the outcomes you want [for the client].

### **3.6 Conclusion**

This chapter has discussed the individual level factors identified by participants as shaping their disability and housing (or homelessness) experiences, and how these have impacted on or reinforced their personal wellbeing and social inclusion/exclusion. Sadly, for most, these factors endure. The discussion clearly notes that housing is an important part of the life experiences of people living with a disability, and one that can, and has, exerted sometimes contradictory impacts on the life circumstances. For some individuals at some times in their lives, it has served as an important resource and stabiliser. For others, it has served to constrain their opportunities and limit their capacity for social inclusion. This is particularly evident for those with concerns about their personal safety and neighbourhood issues, as well as those living in housing that is poorly located in relationship to necessary supports and social networks.

On the whole, it is evident from the information presented in this section that many participants are trapped within a complex web of competing pressures, with their wellbeing outcomes and levels of functioning and inclusion in mainstream society and its institutions shaped by factors not always within their control.

## **4 COMMUNITY CONNECTION, SOCIAL INCLUSION AND THE ROLE OF HOUSING ASSISTANCE**

The previous chapter considered some of the major factors affecting the lives of people with a disability. It discussed the impact of low incomes, dependency on a statutory income and the quality of neighbourhoods on the lived experiences of affected individuals. The discussion extends this analysis to focus more specifically on the key determinants of social inclusion and the interaction between those dimension of wellbeing and people with a disability. In so doing, it sets out to provide an evidence base that will enable us to answer the key questions that have driven this research.

### **4.1 Social interaction**

Social interaction is one of the key determinants of social inclusion within contemporary societies. The interactions we enjoy and maintain provide the networks that help us as gain access to resources and secure assistance when needed. It is through our networks that we generate and share social capital, which in turn helps us to improve our lives. Persons who lack social connections may become isolated, and as recent research has shown, social isolation can have profound health effects for individuals. A review of more than 300 000 people across 148 previous studies has highlighted the magnitude of the risk presented by social isolation to health. In comparison to other well known risk factors, the absence of supportive social relationships is equivalent to the health effects of smoking 15 cigarettes a day or drinking more than six alcoholic drinks per day. Social isolation is more harmful than not exercising and twice as harmful as obesity (Holt-Lundstad et al. 2010). Social isolation may be more evident in the population of persons living with a disability than in general society.

The interviews with persons living with a disability and focus groups with service providers conducted for this research highlighted the fact that many individuals with an impairment rely heavily upon their families for their social interactions. Disability often means that friendship networks are small, and while they are often supportive and of considerable depth, they are limited in their range. In part this reflects other dimensions of the lives of persons living with a disability: the reliance of many on public housing for their accommodation often limits the range of social opportunities to them and they often reside in relatively inaccessible places. Moreover, the inability to find and secure paid employment cuts off one important avenue for social interaction, limiting what is a common experience for the broader working population. Additionally, not being engaged in paid work was noted widely as impacting on the economic resources available to some respondents; economic resources seen as necessary for some types of activities and socialisation.

A number of individuals reported that at times they 'just needed a friend they could turn to' but 'making friendships was one of the hardest things that them to do due to their disability'.

Social interactions can present challenges as well as opportunities. Some people with a disability reported that family and friends can operate as a barrier to independent living. In a number of instances, people with a disability reported that their parents stopped them from living independently because they were concerned for their wellbeing. The affected individuals, while appreciating the motives of their parents, were concerned that they were being held back from leading a more 'conventional' independent life and developing new or extended social networks. As one person said:

My family was really worried when I said I was going to move out [in her late 30s] ... They had a view of me as the 'old' disabled person [I was before living in a community residential unit for a few years], they were worried about the dollar side, safety ... I wasn't looking for permission, but for their support.

The case described in this quote is an interesting example of some of the challenges faced by some people living with a disability and the importance of housing assistance in self-determination. Further details about this case are provided in Box 11.

#### **Box 11: Louise's journey to independent living**

Louise is a 49-year old woman. She has spina bifida and spent nearly 40 years living at home with her parents. In the last 10 years, she moved out of her family home into a Community Residential Unit (CRU) and then her current unit, where she lives alone. Louise noted that these moves were prompted by her desire for independence and concern about where she would live when her parents pass away. She moved out to the CRU just after her father died.

Louise's commented that her time in the CRU was challenging. She chose to move to this facility to learn living skills such as cooking and cleaning, to help with her transition to independence. It was also a stepping stone to other accommodation, which she had some difficulty finding, even with support from the Department of Human Services. At the CRU she lived with four other residents, most of them with intellectual disabilities. Living with different personalities in the facility was difficult, and one resident had violent outbursts. She also cited concerns with the professionalism, compassion and dedication of facility staff and carers. The residents all had different support needs. 'It was claustrophobic, others needed carers all the time and I didn't ... I went out a lot or shut myself in my room ... *going out was costly*'. After seven years in the facility—'four years too many—I was craving privacy'.

Initially, Louise's family were not supportive of her decision to move to independent living. She expressed that they had 'a lack of understanding about how far I had come in independence'. She acknowledges that while her time in the CRU was overall not the best experience 'it assisted me to mature as a capable person'. She explored private rental options while living in the CRU but 'couldn't even afford the base rate and the quality of the properties was really bad'. She looked into private rental options for a period of three years. Finally, a DHS worker put her in contact with the community housing provider who is her current landlord. While she has some issues with the accessibility and practicality of her current home, *she feels well supported now by her family and friends, has been able to secure paid employment and has negotiated access to good support services and workers.*

Another single woman with a significant lifetime mobility impairment commented that:

I moved out for space and independence, made up my own mind. My mother was disgusted. I had a relatively normal childhood, but poor experiences in the education system ... my brother still doesn't get it [why she moved out].

Importantly, the reluctance of family members—such as parents—to sanction a move to independent living (in part a housing decision) served to limit the social interaction and connectedness of many adults with a disability.

It is important to acknowledge also that not all familial relationships were viewed positively. As one respondent noted:

My own kids don't understand my mental health [issues], they don't want to understand, 'she's embarrassing et cetera.' ... it's not a good relationship with that daughter.

Others noted similar concerns with their friends:

I have only a few friends, and no family here [in Australia] ... sometimes I'm lonely ... My friends don't understand my depression, I don't try anymore, they don't understand.

This respondent also noted the importance of her dog in addressing her loneliness. Moreover, walking her dog got her out into the community and she found that often people talked to her while she was out with the dog. Many quite socially isolated people interviewed noted the importance of pets to their wellbeing, in their therapy, as company, and for giving them a sense of purpose and reason to get out of bed each day. They were also important for security and it was important for them to have housing where they could have pets.

In a number of instances, people with a disability felt trapped in households they would rather leave and dwellings they would willingly depart from. They remained for a number of reasons, one of which was the difficulty in gaining access to, and affording, alternative housing.

There has generally been an impact on [my] mental health from my housing over my life. I've always been a renter, not meeting the 'Australian dream' of buying a house, what you work and live for. I have this sense of insecurity [where I live now]. I feel somewhat, no, quite, trapped. I'm not happy where I am, but financially I couldn't cope in private rental and this would have a mental health impact.

Another reason was because of personal—economic or social—investment in their 'home' over a long period:

Originally, when I moved into Housing Trust, I was told I could buy the house, but they changed their mind and so I spent money modifying the house, doing improvements et cetera, now I can't get those dollars back.

And, as noted earlier, concerns with neighbours and neighbourhood limited social interaction for some:

I panic as soon as I open [my] door ... walk into the backyard and I worry about what I'm going to cop. I dread going out the front and back gate. I spend more time in my house than I would if I felt safe ... I don't trust anyone here.

Some individuals we interviewed were socially isolated, effectively bereft of friendship networks and without supportive family. Beer and Faulkner (2009) noted that persons with a psychiatric disability were often socially isolated, partly because family members found it too challenging for them to remain within the household. Similar outcomes were evident in this study, but what was made clear in this study was the very high cost of such isolation. Interviewees noted:

- Few contacts apart from service providers and government officials.
- A profound sense of isolation and of 'time on their hands'.
- Limited information sources.
- Reduced physical mobility because of reduced social mobility.

Not all people with a disability, however, were socially isolated. The case of Craig (Box 12) demonstrates this.

The research also showed the importance of carers, both paid and unpaid, for the social connectedness of people with a disability. In some instances, carers may be the only source of social interaction for individuals with an impairment. This may serve as a barrier to a wider circle of friends or it may be an important enabler and lens into broader society.

### Box 12: High level social inclusion: Craig's story

Craig is a 39-year old man who lives alone in a three-bedroom Department of Housing home in a regional city in Victoria. He moved to that city from Melbourne almost 20 years ago to attend university. While a student he lived on campus and reported that getting around the campus was not too much of a challenge for him as someone confined to a motorised wheelchair. Craig took five years to complete his degree, and after this moved into a private rental property with a flat mate where he lived until recently, when his flat mate moved back in with his family. Craig was assisted to secure his current public housing property by a local disability-specific support agency in the regional. This agency has supported him for many years now and because of his relatively high needs, Craig has support workers to assist him with meals, showering and some other everyday tasks such as shopping.

Craig's current home has been modified to meet his needs, and he received assistance with this from his support agency. *He described his home as comfortable and safe and he has good neighbours.* His house is also *located near public transport and his place of employment;* these are very important requirements for him as he does not drive. Craig works three and half days a week in an occupation that utilises the skills he learnt in his degree. Prior to working in his current job, Craig worked weekends as a radio DJ; a lifetime passion of his and continues to do this as a volunteer.

Craig has a good support network locally, including family and many friends from university, work and radio. This network of people has helped him to secure both his current job and DJ work, as well as supporting his active social life. At times Craig reported that he feels like he is 'doing too much': work, radio, bowling, football, bands, pubs et cetera.

Dependence upon a limited range of contacts is questionable and it suggests that more needs to be done to extend the social connections of people with a disability. While strategies and approaches for addressing social connectedness were generally not raised during interviews, an interview with a 29-year old man with Asperger's syndrome and obsessive compulsive disorder, and his mother, showed the value of support programs for people with particular disabilities. She reported that:

[Matthew] was at a group through [a state-wide agency for a particular disability] doing Art. The group was great for Matthew; people there had similar [issues] to Asperger's. The group folded because of the difficulty of getting there et cetera. Getting support is getting harder. The frustrating thing is meeting requirements for support. He misses out on support, missing out because of a label.

Matthew's mother further noted that:

With [name's] disability we have found that people often fall through cracks, he's not disabled enough [and then] ... we have tried to get Matthew into social groups, but have found many groups people have lower level functioning and this makes him have behavioural issues. He is on a waiting list for people with disability, to match with volunteers [for social interaction/socialisation].

Other participants in the research emphasised the importance of more formal support groups and churches for social interaction. They also noted that such groups were an important part of their therapy, with many expressing similar views to the following about their involvement with such groups:

I have more tools now, I feel like with my depression again, it won't take me down like it used to, [because of the friends I have there].

Overall we can conclude that the social interactions of people with a disability differ from the broader population and in many instances serve to limit the level of social inclusion of this group. On numerous occasions, we heard from people living with a

disability and service providers supporting people living with a disability that they had been taken advantage of by neighbours and 'friends'. One young man in a small regional town in NSW had to move from his previous home because of this. He had been dragged into criminal activity because of friends taking advantage of his innocent nature and naivety and also had his motorbike stolen by the same group of friends. Fortunately for this young man he was already being supported by a local disability agency and had built up a relationship and trust with one of his workers, who once he informed them about what was going on, were able to assist him to move and disassociate himself from these 'bad influences'.

Housing and housing assistance clearly plays an important and specific role with regard to social interaction for people living with a disability. This is because:

- Some forms of housing assistance assign people with a disability to locations where developing and maintaining social connectedness is difficult.
- The high cost of housing keeps some persons in households characterised by adverse social relationships.
- Housing support can exacerbate the tendency of some individuals to shun social interaction and live isolated lives.
- Concentrating persons with a disability in large housing estates with other social tenants, including others with a disability—and especially a psychiatric disability—has adverse consequences.

In considering the dimensions of social connectedness experienced by people living with a disability, it is important to point out that a small number of respondents commented at times that they were simply too well connected! That is, their on-going commitments to disability organisations and their networks of colleagues and friends created substantial demands on their time that they would, at times, prefer to see reduced.

At times it feels like I am doing too much, the social stuff is getting harder. I might like to scale back.

## **4.2 Employment and education**

Employment and education remained a significant challenge for people living with a disability. Many persons with significant impairments had little, if any, capacity to find and maintain work. For others, their impairment status at a particular point in time may have had an adverse impact on their longer-term employment and education prospects. Some reported that periods away from school, TAFE or university because of their disability had meant that they had not completed their qualifications, and therefore had restricted opportunities. At least three of the younger people living with a disability reported they had to abandon schooling or study because of their disability and for two of these people, because of homelessness. One participant reported paralysis after a vaccination, requiring years of rehabilitation, including therapy to learn to walk. Another participant was seriously injured in a car accident and similarly required extensive therapy and rehabilitation.

The difficulties encountered in relation to study were captured by one young woman:

[I] studied last year as a florist. I found a bus that is direct route. Had difficulty with course, as I needed to do a placement [to get my certificate]. I got some help from TAFE but couldn't find somewhere happy to take me on a placement with my sight problem.

The latter quote reminds us that often there are 'unconventional' barriers to participation in activities people without disability take for granted. More 'conventional'

barriers to employment were also raised by interviewees. Prominent among these was the issue of affordable childcare for those people living with a disability caring for children, and their need for work that allows flexibility to care for their children when they are sick or outside school hours.

In addition, respondents with a psychiatric disability found it exceptionally difficult to meet the challenges of work. Problems that were discussed in the interviews included paranoia toward co-workers and the consequences of social phobias. Other participants with mental health issues noted the need for flexibility in work arrangements, to assist them to cope with the episodic nature of their illness. Most people reporting this need found it impossible to find such work and had struggled with maintaining work because of this. The comments of one young woman with severe anxiety and depression summarised the challenges faced by many in this regard:

I didn't work the majority of the last 10 years because of depression ... [my] depression has always been a fluctuating thing, it might come and bite me in the butt at any point, but while its under control I'll make the most of it [by volunteering].

A small number of other participants in the research (including some fathers) noted that they simply can't contemplate returning to work because they are totally focussed on restoring their family. For some among this group this entailed negotiating the child support and legal systems for visitation, for others it meant working with the department to get their children out of state care. These diverse situations highlight the complexity of challenges facing many people living with a disability.

Another respondent captured the conundrum many faced about work, volunteering, study and socialisation:

I'm at my happiest when I don't have any commitments and saddest when I'm not contributing, cause I'm socially isolated.

Such thoughts were commonly expressed by people with social-phobias and other mental health issues.

Housing assistance was not seen to play an important role in the employment and training prospects of many persons with an impairment. This was because the social housing they occupied was relatively remote from public transport and this made it difficult to get to employment places. Location, therefore, has one potential impact. Secondly, some social phobias found expression in the home, including the tendency towards hoarding. Housing assistance made possible the development or continuation of hoarding, which in turn served as a barrier to wider social interaction and employment. That said, issues around hoarding are most properly seen as a matter of socialisation and mental health, rather than an area for housing policy intervention.

A number of respondents noted that volunteering was a very important part of their social lives and was seen to be a step towards paid employment for some. Housing assistance played an important role in volunteering, as secure and affordable housing facilitated volunteer engagement and helped establish community roots.

I do volunteer work because I want to be connected and giving to the community.

Many participants in the research noted that volunteering was the most appropriate 'work' activity for them, because it was more flexible and less stressful and they were able to vary their time commitment and involvement as needed. Moreover, for many it allowed them to interact with a cross section of the community and provided an important opportunity for social interaction—with colleagues and customers. These

factors were also considered as important influences on social inclusion for people living with a disability involved in mentoring and supporting people with similar needs through disability-focussed support groups.

### **4.3 Access to services**

Access to services was important for people with a disability and their households. The face-to-face interviews suggested that the housing location was and remains of critical importance to people living with a disability, and, specifically, housing affected the ability of households to visit general practitioners, psychiatrists, psychologists and other allied health professionals.

Those who lived in non-metropolitan regions and those with poorer levels of family support were more likely to suffer from limited access to services. Often persons with an impairment relied upon family members to take them to key appointments and the absence of such support sometimes had debilitating impacts. Critically, persons with a disability who lived alone were more likely to report the absence of a family member to assist them with appointments, and this reinforces the importance of household structure and access to family housing for this group. Persons in regional areas noted that it was sometimes necessary to travel to the capital city for health or other services, which made it more difficult to remain within a non-metropolitan region. Many participants in this group noted there was a difficult trade-off between remaining in affordable housing in regional areas and moving to a less affordable housing market in order to gain access to the supports they needed.

The availability of general practitioners with a speciality in the area of disability was a particular concern for many persons with an impairment. The tendency of some social housing providers—and housing market processes—to concentrate disadvantaged households affected by disability in particular locations had the potential to overwhelm local service provision—especially in this critical area of health. Other respondents noted that mental health services were frequently overwhelmed and that gaining access to the support that persons needed was difficult and challenging. In many instances, interviewees, especially service providers, commented that mental health services seemed only to be taking on emergency cases.

Physical barriers to services remain for many people with a disability. Gaining access to shops and other retail services can be challenging in the absence of hand rails, ramps and other aids. While this may not be an issue of housing *per se*, it does reflect the broader limitations imposed on persons living with a disability by the built environment.

Also, it is important to acknowledge here that access to public transport was a critical force in shaping the capacity of people with a disability to get to and from the services they needed. Many respondents were unable to drive because of their disability, or because of the cost of maintaining a car, and for these people in particular, access to public transport was crucial. Persons living in regional and outer metropolitan locations were concerned with the frequency, quality and appropriateness of the public transport available to them. The inaccessibility of public buses and trams was of concern for many, and in Adelaide, a number of people living with a disability noted that often they do not know when a disability accessible bus is coming until they can see the accessible sign on the front of the vehicle. In saying this, it is important to note that timetables are available on the internet and over the phone indicating where and when accessible buses are scheduled on particular routes, however, many of the respondents reporting this as a barrier to accessing services et cetera. did not have easy access to the internet. For these respondents, this added to their need to plan

every detail of their travel and daily life to ensure access to services and environments others take for granted.

In discussing the findings of this study from the perspective of people living with a disability, it is pertinent to point out that for a small but significant proportion of interviewees physical access to services was not their concern. Instead, many participants in the study, almost exclusively people with mental health issues, reported social barriers to accessing services; mostly self-imposed social barriers related to social phobia.

The stakeholders interviewed also offered a number of pertinent perspectives on the issue of access to services and the role of this in social inclusion. Whilst most concurred with the views expressed above, it is important to note that many stakeholders reported still seeing too many people with a disability or impairment falling through the cracks in terms of access to services, and especially disability- and medical-related services. As one stakeholder noted:

Support services are not fluid enough to help people move out. Some people are stuck living with their family because they can't get the supports in place.

For this respondent, and many others, information around the range of supports available and eligibility for such supports was considered to be overly complicated. They also reported that often information is inaccessible for people living with a disability and their families.

Adding to these concerns, stakeholders also noted that ideas around being able to transition people through different levels of intensive support to less intensive support are not always relevant for people living with a disability, adding to their concerns over access to appropriate services for the duration of their need.

#### **4.4 Dealing with crises**

One of the key findings to emerge from this research was that housing plays a pivotal role in stabilising mental health challenges and in assisting persons to deal with their impairment, regardless of type of disability. As one respondent noted:

Good housing helps. There's less to worry about, so you can put more of your resources into solving other problems ... If you have a good base you can handle other problems as they arise.

Others added:

With stable housing ... I'm able to put more resources into other problems.

[Regarding ability to deal with a crisis] ... I feel insecure because I don't work anymore, I have less to draw on ... but stable housing makes a lot of difference ... if you put me in another area I'm going to be terrified.

Another participant with severe anxiety issues commented that her 'anxiety settled when I moved'. This tenant (see Box 5) reported that her mental health conditions flared up in her previous public housing property because of the location and neighbours in her previous public housing property: '... the bedsit was really bad ... other tenants were "troubled", I was grateful for it, [it was] affordable but dangerous'. She found it hard to deal with crises while living in this unsuitable property.

A middle aged female respondent with a severe lifelong physical disability now confined to a motorised wheelchair commented:

I always wanted a good size house and quality ... this new house has a good vibe and feeling, appearance is important. I'm not scared or lonely, my

emotional issues are about other things. In my old house I wouldn't have coped mentally. I get a calmness from my [home] environment being more suited to my needs.

The small public housing unit where this respondent lived for 20 years was being sold by the state housing authority, prompting her move. With the assistance of a disability specific housing agency, this respondent was able to find a brand new community housing property (an economic stimulus property) in another area of the city, closer to her work and well located with regard to services. Importantly, her new home was fully disability accessible, overcoming the problem she had with the width of doorways in her 40-year old public housing property.

Critically, the ability to attain and remain within affordable, appropriate and secure housing was central to the social inclusion of people with a disability. Housing not only provided a shelter over their heads and access to services, it also served to bring stability to their lives overall and provide a platform for their further personal development and engagement with the community. The stability offered by social housing in particular was frequently cited as a key reason for entering, and remaining within, this tenure.

Our research showed that persons without strong family connections or other supports were less likely to receive the benefits of stable housing. In part, this reflected the time and effort needed to enter social housing, as often persons with an impairment have limited knowledge of the opportunities and of how to enter social housing. Therefore, more attention needs to be placed on promoting social housing among people with a disability and providing them with information.

#### **4.5 Having a voice**

Having a voice within the community is one of the key dimensions of the Australian Government's Social Inclusion Agenda (see Tually & Beer 2010). The findings of this research show that housing and housing assistance affects the capacity of individuals with an impairment to be heard and contribute to broader society—by determining the nature of the communities in which they live. Once again, social and economic processes that result in the concentration of people with a disability in disadvantaged areas that may be remote have the potential to limit their social engagement and deprive them of a voice. More broadly, there was concern that the mass media reinforces negative perceptions of persons with a mental illness, which in turn limits their capacity and willingness to express themselves within the community.

Advocacy, for oneself and by and for others, is another dimension of having a voice within the community. Many people with a disability are both reliant upon government income support and major users of a range of services. For them, the ability to negotiate and argue for access to services is important. This is not easy in all cases because, as one respondent noted:

There are the most extreme cases (of disability and crisis) who will get their case heard first, but there are other people who are plodding along like me, and it's always harder (to get your voice heard). We don't quite fit.

In this context, housing assistance is just one of a spectrum of areas where people with a disability need to either have an advocate or act as an advocate for themselves in order to secure the best possible outcome. Potentially, therefore, housing assistance becomes another pathway for disadvantage, as those unable to represent themselves effectively may be excluded from some forms of assistance. Approaches that sought to build the advocacy skills of persons with a disability within the housing assistance sector would empower them in all dimensions of life. For some

respondents, being able to live independently for the first time in their lives, and having a level of autonomy around life choices and decisions had clearly assisted them to have a voice; their own voice. For example,

Housing stability [in community housing] has given me the ability to join different boards et cetera ... voicing [my] opinion.

A number of participants in the research noted that having a voice was difficult for them, however, because of poor community awareness and acceptance of a particular disability and its impact on the daily life and functioning of people affected. This issue was most commonly raised by people suffering mental health issues. Some respondents felt that being open about their mental health issues might affect how their landlord or a potential landlord would feel about them:

There has been more press about mental health issues, but it's negative, in the sense that it isn't balanced ... There is a huge stigma to mental health. I live that stigma and even within my own family ... people with mental health [issues] are avoided, and I avoid [talking about] it because of the stigma. I'm afraid to admit to my [housing] cooperative that I have mental health [issues]. I'm afraid that I wouldn't get a position. There is a fear [in the community] that mental health people will hurt you, that's what it's about. They will hurt, rob kill.

Others noted that their marginalised position within the community generally made overcoming stereotypes and stigmatisation difficult and this was particularly hard for social housing tenants, especially those in identifiable social housing properties.

#### **4.6 Physical barriers, daily life and social inclusion**

Participants in this study reported a range of physical barriers that affected their capacity to participate fully in social life. As may be expected from earlier research (Kroehn et al. 2007; Beer & Faulkner 2009) this included:

- House designs that were either inaccessible to a person with a disability or inappropriate. Persons in wheelchairs had, perhaps, the most visible challenges, but even those with a mental illness reported a range of housing design needs that were not met. For example, for privacy, screening from others, noise minimisation, a sense of defined space, lowered benches in kitchens, flat showers, power points and light switches at reasonable height.
- The need for housing modifications that were not always undertaken. This problem was most evident in the private rental sector where landlords were often unwilling to undertake adaptations. However, problems were also reported in the social housing sector and among those households in home ownership.

A number of participants in the research, and the majority of service providers interviewed noted that more needs to be done in terms of the design and accessibility of housing. As one woman living with a mobility disability commented:

[Housing modifications] should be seen as an ongoing investment, as they will be used by the next tenant as well.

And,

Housing should be about meeting the needs of the client and not just about maintaining a pool of housing.

A number of stakeholders noted that in general it remains difficult to arrange necessary disability-related modifications to homes, and particularly modifications beyond the 'standard' range—grab rails, accessible showers et cetera. On the whole, many participants in the research with experiences around modifications commented

that the process of assessment and delivery of modifications simply takes too long. This has an impact on the wellbeing of clients.

The need to have a dwelling that met their needs was important for a range of reasons. Many respondents had either multiple impairments or severe disabilities that presented multiple challenges for their housing. For these groups, therefore, *appropriate housing needs to be well located, have friendly and accepting neighbours, be accessible to public transport and services, and be amenable to support services—including those delivered in the home, as well as those that the individual travels to access.* In too many instances this combination of qualities was not available.

On the issue of physical barriers and housing design, the participants with physical disabilities strongly emphasised the need for housing that has adequate space for the equipment they need because of their disability, as well as space for their carer(s) and family members to stay when needed. It was clear from discussions around this issue that these needs were sometimes recognised by social housing providers, but that this was a severe challenge for those in the private rental market, as it meant they were paying higher rental rates for space that they cannot recover with a disability-related subsidy or by moving in a flat mate. Many respondents, and some of the stakeholders in the disability sector interviewed, reported the need for additional disability-related space requirements to be better dealt with in the social housing allocations processes, as well as through housing assistance measures such as Commonwealth Rent Assistance. This issue of poor recognition of the physical space needs of people living with a disability in the assessment processes for housing assistance as well as income support was an issue raised repeatedly by the stakeholders working to assist people living with a disability or multiple disabilities or impairments with their housing and support generally.

#### **4.7 Stakeholder perspectives**

An important complement to the perspectives provided in the discussion above (and in Chapter 3) was the information garnered from the stakeholder interviews conducted as part of this scoping research on the disability, housing assistance and social inclusion nexus. By and large, the views of stakeholders confirmed the broad findings from people living with a disability: that housing assistance, and access to physically-appropriate, safe, affordable and well-located housing generally, is a crucial factor shaping social inclusion outcomes for the broad group of people termed 'people living with a disability'. As one stakeholder noted:

If you have a stable home, everything starts from there, it's a snowball effect. It creates normality to their life.

In saying this, however, stakeholders emphasised that outcomes are highly variable based on individual circumstances (including the type and severity of disability/impairment), personal resilience, economic resources and the thickness of the social network around an individual, as well as the way the system works to assist people living with a disability or disabilities. Accordingly, *person-centred supports and approaches were discussed as the best way forward for supporting people living with a disability, including in terms of addressing social exclusion resulting from structural and individual level factors.* It is clear from the discussions with stakeholders that a range of structural and system-wide barriers still exist in terms of housing and support services for people living with a disability and these must be understood in terms of their whole-of-life personal, social and economic impact on wellbeing and social inclusion outcomes for individuals (and their carers).

For example, stakeholders noted that in providing assistance and supports for people living with a disability, including housing assistance, *the system is overly reactive*

*rather than proactive, and crisis driven.* As one disability-specific service manager noted:

Policy is for crisis, 'chasing your tail' ... we need to be able to provide continuous support, through early intervention and preventative work ... you need to have the supports in place to walk alongside people ... to respond in a preventative manner.

Another worker similarly noted:

The [support] system itself is crisis driven, often nothing looks positive. For us, it's a matter of going from one problem to another.

Further, the manager of an agency actively involved in putting people with a disability in contact with social housing providers was somewhat *scathing of the length of time people are housed within crisis accommodation*:

In crisis accommodation their anxiety is high; it's not a beneficial placement from a health perspective. It's distressing to see it happening ... the system is still very much blocked.

The crisis driven nature of supports for people living with a disability was a point strongly reinforced by the disability employment service workers in regional NSW spoken to for this research:

Often we can't help [a client] because they haven't got a referral source, and when you need something quick, the system can fall down.

*People with significant and undiagnosed mental health issues were identified by stakeholders as the group at greatest risk of poor social inclusion and wellbeing outcomes because of the crisis approach to managing demand for, and supply of, assistance:*

We can't help people with mental health [issues] if they haven't got a GP [General Practitioner] referral for Housing NSW et cetera.

Notably, the representatives of the disability employment service organisation also emphasised that they spend a significant (and increasing) amount of their time referring back to Centrelink clients who originally referred to them by that agency for job-seeker assistance. This is because they are not fit to find or secure work due to undiagnosed and/or unmanaged medical conditions, homelessness or other instability in their living/housing arrangements impacting on their wellbeing and functioning.

Related to the crisis-focus within the system, the representatives of disability-specific, domestic violence and disability employment services at one focus group in regional NSW concurred that many of their clients' social inclusion outcomes are also being impacted by the emphasis on transitional assistance. Of particular concern here was the use of respite to accommodate clients in need of a new accommodation arrangement or awaiting a transfer to another property or upgrade of their own property. And, this includes for those: (a) with disruptive and/or demanding behaviours (generally those with significant mental health issues) impacting on neighbours, as well as (b) those seeking a transfer because their housing or care arrangements have changed (due to worsening or change in their disability/impairment, death of a carer, issues with neighbours or negative social influences et cetera). *Many stakeholders emphasised that transitional housing is not a beneficial housing outcome for clients—short or long-term, and,*

Some clients can end up de-skilled while in transition, with the loss of social networks and no access to community.

*Reviewing processes around transitional support, and the duration of such support, was considered a priority need in terms of a genuine commitment to social inclusion outcomes for clients.* Stakeholders noted that the situation here is complicated and driven by the ongoing housing affordability crisis nationally, and the lack of affordable housing generally, including in the social housing sector and private rental market.

*Another specific concern for stakeholders are the ongoing cost pressures faced in trying to provide housing in areas with good access to services and transport.* As the discussion in this and the previous chapter notes, this is a critical factor in determining social inclusion outcomes for people living with a disability. Accordingly, as one stakeholder from a large disability-specific and affordable housing agency in Victoria noted:

We put lots of thought into the location of our housing. [We] argue strongly for keeping housing in certain locations.

For this agency, 'certain locations' translated to new builds or acquiring dwellings within one kilometre of particular services and facilities, such as public transport, shops and medical facilities.

Additionally, the housing providers interviewed also strongly emphasised the importance of *having the flexibility to place certain people in certain properties and certain areas*. This was seen as particularly important in higher density and mixed-tenure developments, and effectively allowed allocations officers to engineer the community in a development to minimise social and neighbourhood issues. Having this flexibility was something many agency representatives felt was increasingly difficult in the face of the centralisation of prioritised waiting-lists under the reforms driving the NAHA.

*Expiration of support packages for clients was also recognised widely as a problem* for stakeholders working at the coal face of housing and support for people living with a disability.

Often when people are housed, we find their support drops off. They get caught in a trap where the intensive support is withdrawn because they are now housed, then all supports [fall away].

Many stakeholders noted that the expiration of support 'undoes the good work' with clients, destabilising them. Ongoing commitment to support then, respecting the privacy, dignity and independence of people living with a disability, was clearly something stakeholders were mindful of (and reflected in the philosophical and practical ethos of agencies and workers). *Stakeholders emphasised that commitment to support was fundamental in stabilising clients' lives—personally and within their housing and social and economic circles*, and all noted these factors are central to improving and maintaining social inclusion for people living with a disability.

One of the ways people living with a disability are excluded can be because an agency program stops and puts them in limbo.

Additionally, as the manager of one regional disability-specific support service noted without an ongoing commitment to support, social inclusion outcomes can not only be easily undone, but social exclusion merely transferred:

We [agencies and government] have got to commit to the support. Otherwise, where people were isolated before, the isolation is just transferred.

On this issue, stakeholders also noted the *need for better checks and balances in terms of support provided to clients*; ensuring that people living with a disability have a say in the shape of their support and its evolution over time. This was not something

that stakeholders felt the system recognised or supported well over time. Additionally, a number of the housing providers interviewed for this research noted that they are filling a role as a *defacto* social worker and support worker for many of their clients, advocating to ensure clients get the assistance that they are eligible to receive. Stakeholders noted that these concerns reflect ongoing problems within the social services sectors around pay rates, career development and training for staff.

*Private rental support* was shown up through the fieldwork with stakeholders as an area where agencies and workers are increasingly directing their efforts; largely by necessity. Long waiting periods for social housing, and tightening eligibility criteria, has determined this path for many workers and agencies.

Among the stakeholders interviewed, two agencies were coordinating formal (and successful) private rental support programs for clients, one with government funding and the other funded mostly within the agency's own operating budget. Both of these agencies were in regional areas of their respective states, and reported that they had moved into such support because so many of their clients were struggling with securing accommodation and, importantly, sustaining such accommodation in the longer-term. While costs was clearly still a concern here, workers with these agencies noted that by developing positive relationships with local real estate agents, they have been able to secure better and more accommodation for their clients. This has, however, come at some cost to these agencies. The agencies then work with clients to improve their living skills and wrap around them the supports they need for their daily lives, including in terms of social and economic participation.

Private rental support programs for people living with a disability were seen by stakeholders to also offer the benefit of overcoming known and ongoing issues around discrimination in the private rental sector on the basis of disability and poor labour force attachment. On this point, one manager of an agency offering such support to clients, noted that:

There are no discrimination laws in place with real estate agents, there are with jobs.

Interestingly, workers in agencies who are not involved in private rental support programs for their clients, noted that they are increasingly involved in negotiating with housing providers and real estate agents on behalf of their clients. For some workers, this is because of the impacts on housing and tenancy due to a client's disability. The following issues were commonly raised:

- *Lack of system-wide recognition of the poor living skills of many people living with a disability*; the assumption that clients know instinctively how to manage a house and a tenancy, including paying bills, cooking, cleaning et cetera. Stakeholders noted that there is still a long way to go in this regard and many clients could easily sustain a tenancy long-term with adequate support to improve their living skills and meet their disability-related needs, as well as adequate financial support (including housing assistance). Stakeholders reported that at the current time, the system is not adequately providing such assistance for many people, with obvious impacts on tenancy sustainability and therefore wellbeing and social inclusion outcomes.
- *Mental health and neighbourhood issues.*
- The increasing occurrence (and complexity) of dealing with *hoarding and squalor*, particularly among those with diagnosed and undiagnosed mental health issues.

On the whole, *stakeholders felt that private rental market support programs are one of the key types of assistance currently missing* in the disability, housing and, therefore,

social inclusion nexus. They were emphatic that more resources need to be directed to such activities, particularly in the face of pressure on the social housing sector. Such support, however, must be accompanied by additional resources to fund:

- Agencies to provide and manage such assistance.
- The higher costs of private rental housing.
- Modifications to accommodation to meet the needs of tenants.
- The development of tenants' independent living skills. This was seen as a key concern among all stakeholders and something that must be more widely recognised in policy and programs to improve the wellbeing and social inclusion of people living with a disability.

This latter point was widely raised by stakeholders. Most concurred with the view of one agency worker:

Funding packages don't allow the training and teaching they want. One hour of support a week is not enough to teach someone necessary living skills, cooking, cleaning, bills, shopping.

Notably, the issues of housing cost and poverty (discussed further below) were mediating factors here, and stakeholders felt that *a review of CRA is needed immediately, recognising and accounting for the high and increasing costs of private rental compared with in the past and the inadequacy of this housing assistance measure.*

As mentioned above, *poverty* (including entrenched poverty and potential and real 'poverty traps') was singled out by stakeholders as a serious brake on improvements in the wellbeing of people living with a disability. As one noted:

The known gap in economic situations [for people living with a disability] isn't improving.

Stakeholders spoke of *many clients who they felt were socially excluded because of their low economic resources and the limited money left each week for them to socialise and/or access work*; after housing and disability or impairment-related costs are accounted for. For these reasons, placing people in locations with good access to services, such as public transport, was of paramount consideration in building and consolidating the property portfolios of social housing providers.

Additionally, a small number of stakeholders raised the ongoing issue of the poverty trap that some people living with a disability can find themselves in when they work part-time:

There are disincentives to work for families in particular—because of the loss of benefits. This can be a poverty trap—lose health benefits et cetera.

Finally, it is important to note that some state government policies and structures attracted specific criticism from stakeholders in their assessment of the housing assistance, disability and social inclusion/exclusion nexus. For example:

- Assessment of lone person households as eligible for one bedroom properties only, regardless of their need for space for equipment, carers et cetera.
- Moving flat mates in with public housing tenants when their mental and physical health might suffer as a result. One stakeholder noted this to be a particular issue for many of her clients, and one client in particular who was now settled into a three-bedroom accessible dwelling on his own, due to a bad experience with a previous flat mate was fearful of finding himself in the same situation. The small number of stakeholders who expressed this concern noted that tenants have a

say in the process of choosing a new flat mate, however, the agency has to carry some of the cost of under-tenanted stock if they do not tenant it to department policy standards, and we do not expect these standards of people in the private market.

- Strict standards for tidiness and cleanliness of public housing properties. This was a particular issue for stakeholders working with hoarders and others with psychiatric disabilities affecting their ability to organise their possessions and their ability to clean et cetera.
- The apparent disconnect between housing and disability services within government. Some stakeholders reported that this was impeding success in terms of outcomes for clients, as sustaining a tenancy is dependent on appropriate supports for most people living with a disability and vice versa.

Stakeholders were also somewhat critical of the *information flows between government and the sector* in terms of changes to assessment processes, funding and service delivery mechanisms and policy priorities. This was an area that almost without exception stakeholders felt needed further attention.

## 4.8 Conclusion

Overall, we conclude from this scoping study around the disability, housing assistance and social inclusion nexus that housing assistance plays a very positive role in the social inclusion of people with a disability. This is particularly important for people living with a disability, for as many noted, and one participant succinctly put it,

It is very easy to fall into a crisis when you have a disability.

Our face-to-face interviewees in social housing were appreciative of the support they have received:

I'm happy I've got housing, otherwise my whole life would be different.

[Being in public housing] I have a sense of finding the oasis, and I don't have to move again, unless I f\*\*\* up, and,

In private rental I felt totally disenfranchised ... If I stayed in private rental I wouldn't have the kids ... Private rental is not good, very stressful, it's never home.

Another commented:

I like being able to get to work. I wouldn't know where I'd be today if it weren't for that job. Having no transport and getting my skills up to scratch would be hard, and grandma's getting on so I don't know how I'd keep occupied. Back at home [without independent housing], I wouldn't have these opportunities, not in a small town.

The second quote highlights both the valuable role of housing assistance as an enabler of social inclusion *per se*, and the part it plays in facilitating access to employment and broader participation in society.

Housing assistance, therefore, is an important component of the suite of measures intended to create a more inclusive society across Australia, especially for people with a disability. Appropriate housing can exert a positive impact on the wellbeing of individuals, but must be tailored to suit their needs and circumstances. For example, while some individuals did not like group housing for persons with an impairment, others did. Some with Down Syndrome, for example, believed that group housing made it possible for them to live independently while still gaining support from live-in workers and other service providers. Appropriateness of housing, therefore, is often

determined by more than just the presence of a disability, it includes issues such as the type and severity of the impairment, available economic resources, gender, age, family history and reliance on support workers.

## 5 CONCLUSION

If the housing is not appropriate then it's no surprise that social inclusion is not as good as should be expected [for clients]. (Manager, disability-specific support agency, Victoria)

This research project and Final Report set out to answer two fundamental questions around disability, housing assistance and social inclusion:

- What impact does housing assistance have on social inclusion for people with disabilities?
- How can governments ensure that they maximise the social inclusion benefits from the housing assistance they provide now and into the future?

The research that forms the basis of this Final Report finds that housing assistance has a clear social inclusion dividend from a significant majority of people living with a disability in receipt of such assistance. Based on the 98 in-depth interviews conducted for this research, it is evident that housing assistance has a range of non-shelter benefits and positive social inclusion impacts:

- Housing assistance provides stability in the lives of people living with a disability who would otherwise be vulnerable to a range of negative circumstances and who may otherwise have no sense of control over their lives.
- Housing assistance helps people with a disability deal with other crises in their lives—health, family relationships, monetary concerns et cetera—and adds to their resilience and independence.
- Housing assistance reduces the exposure of people with a disability to very high housing costs and the risk of eviction. It reduces both vulnerability to homelessness and the experience of (recurrent) homelessness. In the absence of housing assistance, it is almost certain that significantly larger numbers of people living with a disability would experience homelessness, and its most acute manifestation—rough sleeping.
- Housing assistance makes it more likely that people with a disability will enter and remain in paid employment. This has social inclusion benefits both for the individual and broader society.
- Housing assistance, in some instances, can help people with a disability find a voice within their community by equipping them with advocacy skills and providing stability in life, which in turn enables engagement with wider social institutions.

In saying this, however, it is pertinent to note that such social inclusion outcomes are tied to a range of factors operating at the structural and individual level. It is clear that the low-income people living with a disability generally are, and can be, a brake on the full social inclusion of this group generally. Poverty remains a major problem for people living with a disability, and a significant concern for those assisting them with their housing and support needs. As the findings of this research demonstrate, those in the private rental market are clearly suffering the most in this regard. And, given the pressure on the social housing sector to house vulnerable people with a range of needs, it is evident that more needs to be done to ensure that housing assistance received by those in private rental market genuinely helps address sustained high housing costs. A review of CRA is needed.

Importantly, in undertaking a review of this assistance measure, governments must also pay attention to the additional living costs carried by people living with a disability generally and those with specific disability-related needs. For example, the extra cost

burden on people living with a disability in the private rental market who need additional space for equipment or carers.

It is also clear from the research findings that much more needs to be done to address the support and housing assistance needs of people with psychiatric disabilities, particularly those with mental health issues. The system of supports for people in this group is clearly highly pressurised, and to the detriment of their social inclusion outcomes. More explicit attention needs to be directed at arbitrary assessment criteria for supports for people living with a disability to ensure that this does not undermine social inclusion outcomes for this group.

There are a number of steps governments can and should take to ensure that the social inclusion benefits arising from housing assistance to people with a disability are maximised:

- First and foremost, the provision of additional social housing will advance the wellbeing and social inclusion of persons with an impairment across Australia. Additional supply, targeted to this vulnerable group within society, will have significant positive impacts.
- Social housing provision for people with a disability should avoid creating areas of concentration of these people. While acknowledging that the demand for social housing exceeds supply and the need of many people living with a disability for urgent assistance, grouping large numbers of people with a disability in one location has negative effects. The supply of social housing needs to be spread across a range of locations and neighbourhoods as much as possible.
- The housing occupied by people with a disability needs to meet the circumstances of the individual and their household as closely as possible. This includes modifications to the dwelling and on-going maintenance, where the disability—such as the presence of a wheelchair in the housing—may require on-going attention.
- Housing assistance for people with a disability should focus on providing accommodation in places with good access to public transport in order to facilitate access to both services and employment.
- Housing assistance programs can and should be used as a vehicle for delivering training and community development programs that help people with a disability find their voice.

Additionally, it is clear that *much more needs to be done to improve outcomes for people living with a disability accommodated in the private rental market*. Lessons can be clearly learned here from existing private rental support programs assisting people living with a disability specifically, such as that offered by Karingal in Geelong, as well as those assisting other vulnerable groups. Another notable example here is the services offered by Housing SA's Private Rental Liaison Officers in South Australia. Directing more resources to agencies to deliver such assistance for people living with a disability, however, should not be at the expense of further investment in social housing. It is clear that this is the best option for many people with severe disabilities and impairments, and particularly those needing specific disability-related modifications to a dwelling. The reality remains, which we still have a long way to go in developing a private rental market responsive to the disability-related needs of tenants.

Regardless of the tenure focus of assistance, the findings of this small scoping study also highlights the immediate need for supports for people living with a disability, including housing assistance, *to concentrate on sustaining tenancies*. Social inclusion

outcomes for tenants will remain sub-optimal if actions to sustain tenancies are not promoted. This is clearly a concern for those with mental health issues in particular.

In conclusion, people with a disability and their households remain one of the most disadvantaged groups within society. Housing assistance, and especially access to social housing, is one measure that governments can take to substantially improve their wellbeing and degree of social inclusion within broader society. People with a disability should remain a priority group in the housing allocation processes of social housing providers and more attention needs to be paid to the interface between health services and housing.

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