Addressing homelessness amongst persons with a disability: Identifying and enacting best practice.

The University of Adelaide
Hanover Welfare Services
Melbourne City Mission
The University of Melbourne

National Homelessness Research Projects

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September 2011

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Department of Families, Housing, Community Services and Indigenous Affairs

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Title Page

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A FaHCSIA National Homelessness Research Project

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Non-Technical Summary

Outline
Persons with a disability are vulnerable both to, and within, homelessness because of their many have low incomes, may have limited engagement with the labour market, and limited housing options. While attention has been given to the relationship between poor mental health and homelessness, persons with other types of disability – physical, sensory, intellectual – are also at risk. The goal of this research is to understand the homelessness risks confronting persons with a disability and how best to meet their needs. This project addresses research priorities around improving service practice; understanding referral pathways through services; preventing homelessness through early intervention; and, identifying resilience and protective factors.

Keywords: Housing, Disability, Homelessness

This project fills an established evidence gap on homelessness and disability by researching the pathways into homelessness and the use of homelessness services by persons with mobility, sensory and intellectual disabilities (including acquired brain injury). It also reviews the international literature on models for best meeting the needs of persons with a disability who are homeless, and the range of prevention and resilience strategies available to government and non-government agencies. The research develops solid evidence that can be used to enhance both services specifically targeted at persons with a disability experiencing – or at risk of – homelessness, as well as mainstream services. The purpose of the research is to generate a body of evidence that will enable service improvement, provide early intervention points that limit the number of persons with a disability entering homelessness, and enable the development of appropriate policies that build resilience amongst individuals and households affected by a disability.

The aims of this research project were:

1. To identify, through a review of the international and national literature, effective strategies for keeping persons with mobility, sensory and intellectual disabilities (including acquired brain injury) out of homelessness;
2. To assess the level of risk of homelessness (primary, secondary and tertiary) amongst the population with a disability through the analysis of the HILDA and GSS data sets;

3. To obtain the views of persons with one of the targeted disability types on the pathways into homelessness, the factors placing them at risk of homelessness, the types of policy and service intervention that would either limit a period of homelessness or rule it out altogether; and
4. To develop policy and service delivery options that effectively address homelessness and the risk of homelessness amongst persons with mobility, sensory and intellectual disabilities, and,
5. To communicate the results to the policy, service and wider communities, including the disability community.

Findings and Implications

This research provides evidence that persons with a disability have a greater exposure to the risk of homelessness than the general population, and that different disabilities predispose individuals to different levels of homelessness risk. While different disability groups within Australia receive different types of housing support, some groups are especially disadvantaged, these groups would benefit from additional, targeted support. While we intentionally did not focus on mental illness in this study, it was nevertheless clear in both analytical phases of the research that this is a major risk factor for homelessness. While participants were intentionally selected following a criteria that their primary disability was not mental illness, a substantial number of participants (around half) were found to have a mental illness in addition to their principle disability.

The finding also reinforces the significance of co-morbidity within the population of interest for this study as well as multiple and complex disadvantage. Many of the participants had more than one disability which is likely to have worked in combination to increase their risk of homelessness. The large scale quantitative phase of the research suggested this, and the more focussed qualitative phase found clear evidence of this co-morbidity among the respondents. We therefore highlight this as an important future area of research focus, namely to unpack the effects of multiple disability and multiple disadvantage on homelessness risk and housing outcomes.

The qualitative phase of the research also highlighted a number of important findings around housing. Accessing appropriate housing was a substantial issue for many of these respondents with disabilities, and many had long residential histories or poor quality, unsafe, unaffordable, and insecure housing. The social housing sector was difficult to access as well, though many hoped for access in the very long term. We suggest that in part, the problems faced by this group are housing related, and an acute shortage of low cost appropriate housing was a major systemic problem. We further highlight the importance of good service provision for this group, and the severe consequences of service system failure. Access to key services made a substantial difference to participants' lives and this appears in part due to the dedication and advocacy of particular services and workers.

Finally, this research has a number of implications both for the further development of policy and the delivery of both homelessness services and mainstream support for persons with an impairment. One of the key issues to emerge from the literature review (Button et al 2010) was that persons with intellectual disabilities were likely to be over-represented amongst the homeless population. The quantitative analysis undertaken as part of this project and presented in this report provided similar conclusions: persons with a disability – and especially learning or intellectual impairments – were more at risk from precarious housing than any other group within the study. Importantly, persons with moderate impairments were more likely to be at risk as their disability was sufficient to affect their interactions within broader society. However, this was no to such an extent that they received a comprehensive package of assistance

1. Background

Just over 22 per cent of the population have a disability or long term health condition. Persons with a disability and their family members with care responsibilities are at risk of homelessness because of low incomes, limited engagement with the labour market and restricted capacity within the private rental sector (Beer and Faulkner 2008). The relationship between mental health – including psychiatric disability – and homelessness is well established (AIHW 2007) and acknowledged within current policy frameworks (FAHCSIA 2008). Persons affected by other forms of disability, however, are also likely to be at greater risk of homelessness than the general population but their needs have not received the same degree of attention in public debate and policy development. The need for this research is made more acute because persons with a disability are not a uniform group and their pathways into homelessness – potential and experienced – will vary by disability type, location and severity of their disability. There is therefore a real need to develop a much stronger understanding of the intersection between disability and homelessness.

In part, the failure to consider the issue of homelessness and disability has reflected the urgency of other needs of this group, including the imperative for the development of additional housing options (consulting report) and the appropriate funding of support services. There has been significant reform of funding for disability services by the Federal Government. However, we contend that there is no specific attention within this reform agenda given to the needs of those with a disability who might 'fall out' of this system of support through homelessness.

The experiences of persons with a disability in the housing market are frequently very different to those of the general population (Beer and Faulkner 2008) and further differentiated by type of disability. While little work has been undertaken in this area, we can assume that the pathways leading to homelessness amongst persons with intellectual, sensory and physical disabilities are also distinctive when compared with the population overall and each other. There is therefore a need to understand these diverse pathways, the policy levers that can avert homelessness and the service provision structures that are most effective in assisting these individuals.

This project fills the evidence base gap on homelessness and disability by researching the pathways into homelessness and the use of homelessness services by persons with mobility, sensory and intellectual disabilities (including acquired brain injury). It also reviews the international literature on models for best meeting the needs of persons with a disability who are homeless, and the range of prevention and resilience strategies available to government and non-government agencies. This research will develop a solid evidence base that can be used to both enhance services specifically targeted at persons with a disability experiencing – or at risk of – homelessness, as well as mainstream services. The purpose of the research is to generate a body of evidence that will enable service improvement, provide early intervention points that limit the number of persons with a disability entering homelessness and enable the development of appropriate policies that build resilience amongst individuals and households affected by a disability.

2. Purpose

This project fills the evidence base gap on homelessness and disability by researching the pathways into homelessness and the use of homelessness services by persons with mobility, sensory and intellectual disabilities (including acquired brain injury). It also reviews the international literature on models for best meeting the needs of persons with a disability who are homeless, and the range of prevention and resilience strategies available to government and non-government agencies. This research will develop a solid evidence-base that can be used to enhance both services specifically targeted at persons with a disability experiencing – or at risk of – homelessness, as well as mainstream services. The purpose of the research is to generate a body of evidence that will enable service improvement, provide early intervention points that limit the number of persons with a disability entering homelessness and enable the development of appropriate policies that build resilience amongst individuals and households affected by a disability.

The project includes a number of discrete components that each contribute to the overall purpose of the research. This includes:

- Completion of a review of the literature on homelessness and disability, with particular attention paid to the pathways into homelessness amongst these groups, good practice in the provision of homelessness support services to persons with a disability and the development of resilience and prevention behaviours amongst the affected population;
- The analysis of the Household, Income and Labour force Dynamics in Australia (HILDA) survey two as well as the ABS's General Social Survey (GSS) to assess the number and nature of households with one or more persons with a disability at risk of homelessness;
- The use of one-on-one interviews and focus groups to collect qualitative data on homelessness and the risk of homelessness amongst people with a disability;
- Collation of the research results and the development of options for policy makers and service providers; and,
- Dissemination of the findings to policy makers, service providing agencies, the disability community and the public.

This project directly addresses a number of the research priorities and key research questions within the National Homelessness Research Agenda and directly considers the needs of persons with a disability; a group whose experiences are of on-going policy relevance and importance to the Australian and State/Territory Governments. The project directly examines critical evidence-base needs within the National Homelessness Research Framework and has a strong capacity to inform policy development and service delivery by:

- Assessing the level and profile of need for homelessness support within a vulnerable segment of the population;
- Identifying national and international best practice in supporting homeless people at risk of homelessness or currently homeless;
- Giving 'voice' to homeless persons with sensory, intellectual and mobility disabilities;
- Identifying, and then developing strategies to overcome barriers for avoiding homelessness amongst persons with these types of disability; and,
- Disseminating the results to policy makers, service delivery agencies, the disability sector and the wider community.

3. Objectives

The overarching aim of this project is to generate a body of evidence that will enable service improvement, locate early intervention points that limit the number of persons with a disability entering homelessness and enable the development of appropriate policies that build resilience amongst individuals and households affected by a disability. The specific aims of this research project are:

- To identify through a review of the international and national literature effective strategies for keeping persons with mobility, sensory and intellectual disabilities (including acquired brain injury) out of homelessness;

- To assess the level of risk of homelessness (primary, secondary and tertiary) amongst the population with a disability through the analysis of the HILDA and GSS data sets;

- To obtain the views of persons with one of the targeted disability types on the pathways into homelessness, the factors placing them at risk of homelessness, the types of policy and service intervention that would either limit a period of homelessness or prevent it altogether; and

- To develop policy and service delivery options that effectively address homelessness and the risk of homelessness amongst persons with mobility, sensory and intellectual disabilities, and,

- To communicate the results to policy makers, service providers and wider communities, including the disability community.

The project is being undertaken in five phases:

Phase 1. THE LITERATURE REVIEW. A review of the national and international literature on homelessness and the risk of homelessness amongst people with non-psychiatric disabilities.

Phase 2. THE QUANTITATIVE ANALYSIS. This will assess the level of risk of homelessness amongst the population with a disability. This phase of the project will be based on two large, high quality data sets, with samples that representatively reflect the Australian population – the General Social Survey (GSS) and HILDA.

Phase 3. THE QUALITATIVE COMPONENT. This is based upon face to face interviews with persons with a disability at risk of homelessness or who have experienced homelessness.

Phase 4. POLICY FOCUSSED EVALUATION. In this phase of the research the project team will assess the outcomes of the research, write up a draft report and begin to develop and test policy options through a series of policy maker workshops.

Phase 5. COMMUNICATION OF RESULTS. This final phase of the project involves the dissemination of results – with the agreement of FaHCSIA – via seminar presentations, website publication, workshops with practitioners and briefings to key policy makers.

4. Research Phase Reports

This section of the report details the research and findings from the three phases undertaken so far in the project.

Phase 1: The Literature Review (a summary)
Phase 2: The Quantitative Analysis
Phase 3: The Qualitative Analysis

4.1 Phase 1: The Literature Review (a summary)

The Literature review constituted the first phase of the research, and was submitted as an earlier separate report. It examined the global and national literature on the provision of services and supports for persons with a disability who are homeless; the types of service and policy intervention that are effective in preventing or reducing the period of homelessness; strategies for building resilience amongst those at risk, and appropriate service delivery frameworks. The major findings are presented below.

4.1.1. The Information Gap

This report presented the findings of a review of the literature on the relationship between disability and homelessness in Australia and internationally[1].

The report does not consider the issues associated with psychiatric disability/mental illness and homelessness because:

a) There is a considerable body of research already completed in this area;
b) this is an area of acknowledged policy priority; and
c) The project seeks to inform policy and develop a stronger evidence base in the other areas of disability where there is much less information.

One of the most important findings of the report is that the issue of homelessness and non psychiatric disability has been largely ignored by the Australian research community. While there is a larger body of research available globally, it too is limited in its extent. This conclusion underlines the importance of the current research project.

There is more published research on cognitive disability and homelessness than for the other types of disability considered in this report, but even in this instance the evidence base is patchy and incomplete.

4.1.2. The Incidence of Disability

Disability is widespread across the Australian population and approximately 3.9 million Australians have a disability of some form. This equates to approximately 20 per cent of the Australian population when using the ABS definition of disability. In addition, in 2003 there were 2.55 million persons providing care for a person with a disability and many members of this group (78 per cent) cared for persons who lived within their household. A significant fraction of these carers (188,900 individuals) had disabilities themselves (ABS, 2003).

The sheer size of the population affected by disability means that inevitably a significant number of persons with a disability, will experience homelessness at some time. Current housing arrangements mean that some individuals are more vulnerable to homelessness than others, and of the 3.9 million persons with a disability:

- 3,678,800 resided in private dwellings (2,966,200 with other people)

[1] We note that since the completion of the literature review a National Disability Strategy (Commonwealth of Australia 2011) has been released by the Commonwealth. The strategy document outlines a 10-year national policy framework to guide government activity across six key outcome areas and to drive future reforms in mainstream and specialist disability service systems to improve outcomes for people with disability, their families and carers. One of the six key outcome areas of the document is Economic Security, and within this to 'Improve access to housing options that are affordable and provide security of tenure' (p. 44). The Strategy notes the current commitment of the Commonwealth, State and Territory governments to work together to develop a National Quality Framework to achieve better outcomes for people who are homeless or at risk of homelessness - including people with disability - by improving the quality and integration of services they receive (p. 45).

- 177,800 lived in non-private dwellings e.g. nursing homes
- 279,500 were accommodated in 'other' non-private dwellings (not defined)

Some 10,600 people lived in non-private dwellings and occupied dwellings where care was not provided, although 10,100 individuals within this group had some form of activity limitation or restriction. Accommodation in this category included hostels for the homeless and other temporary accommodation.

4.1.3. Homelessness and Disability

The 2006 Census report on homelessness did not provide data on persons with physical, sensory, intellectual or brain injury. Similarly, the SAAP (NAHA) data collection has not collected information on the above groups but did record information at the point of entering a service on whether a person was affected by a psychiatric disability. SAAP (NAHA) data also reports the extent of unmet need. This data source indicates that 54 per cent of requests for help with physical disabilities and 55 per cent of requests for help with intellectual disabilities were not met directly by homelessness services. Rather, the individuals requesting help were referred to other agencies. Similarly, 46 per cent of requests for help with psychiatric problems and 35 per cent of requests for assistance with psychological problems were not met directly. There is an absence of data on whether other services were able to meet the needs of these clients, but it is clear that there is a substantial body of disability-related need within the population presenting at homelessness services.

Evidence about physical, sensory, intellectual or brain injury amongst the homeless population is primarily drawn from *ad hoc* research. This shows that in many cases at the point of seeking help less 'obvious' disabilities are unlikely to be identified and sometimes are undeclared. People may also have more than one disability but these may not be identified until after a person has used a service for an extended period of time. Staff in homelessness services, are often not specifically trained to identify disabilities or health conditions, despite early identification being of enormous assistance to clients with a disability. The available evidence suggests that mental health problems are high amongst the homeless population. Incidences of acquired brain injury are similarly thought to be substantial but there is not a reliable evidence base to establish the frequency or impact of this disability. Traumatic brain injury is an issue of concern because it is often acquired before a person becomes homeless i.e. through violence. Alcohol induced brain injury is also a major concern. This is regarded as a cause of homelessness by some researchers because it diminishes a person's ability to retain their home and function independently. Using data from Canada, Hwang et al (2008) found that approximately 70 per cent of cases of acquired brain injury occurred before the onset of homelessness**.**

4.1.4 The Broader Housing System and Persons with a Disability

From their large scale study of housing careers undertaken in Australia in 2007-09, Beer and Faulkner (2008) reported that persons with a disability were less likely to live in a family household that included children and were more likely to live with another person. Both the ABS and Beer and Faulkner (2008) noted that a relatively high percentage of persons with a disability live in households which own their housing outright and a smaller percentage are purchasing their home. In their study almost 43 percent of people with physical activity limitations or restrictions lived in housing that was owned outright, while a further 23 per cent lived in households who were buying their home. The remaining one third of this group was spread over a wide range of housing tenures with the third largest group comprised of those living in rented (other) accommodation (undefined by the ABS). This accounted for 15per

cent of all people with physical activity limitations but did not include people living in boarding arrangements.

Beer and Faulkner (2008) concluded that that housing opportunities and transitions of persons with a disability are determined by the nature, scale and source of the disability e.g. whether a person was born with a disability or whether they acquired that injury in adult life. Critically, some forms of injury leading to disability were compensated and may result in sufficient funding to make significant housing choices later in life. Beer and Faulkner suggested that the housing careers of persons with a disability varied significantly by disability type, with persons with a psychiatric disability (not included in this study) experiencing far greater variability in housing over their life course. They were also more likely to experience homelessness than either the general population or other disability groups. According to this research, people with cognitive impairments often exhibited stable housing careers and many were dependent upon family provision throughout their lives. However, the housing of persons who acquired a brain injury later in life would be very different to that of an individual born with a developmental disability.

Beer and Faulkner (2008) also used data from a national survey to develop a broad scale picture of the housing circumstances of this section of the population. Notably, they found that persons with a disability were over-represented in the social housing sector, with 39 per cent of households containing a person with a disability renting from a social landlord.

4.1.5. Models of Housing Supply

People with disabilities who need to move away from home may be directed to non-private dwellings – that is, residential care homes. Supported residential facilities (SRFs) will also accept referrals for persons with a disability and some homeless people may be diverted into this type of accommodation. SRFs are potentially important in any discussion of homelessness and disability in Australia and it is likely that many persons with a non-psychiatric disability end up in this form of accommodation. This type of accommodation is not included in counts of homelessness, presumably because it offers long-term accommodation. Some commentators have argued that SRF accommodation should be categorised as substandard housing within Australian cultural definitions because people in ‘pension’ level SRFs share rooms, often have no privacy and limited residency rights. Boarding houses may also accept referrals to accommodate people with disabilities who are then counted as homeless if they have been living in that accommodation for 13 weeks at the time of the Census. It has also been noted that for the 2009 – 2015 period, the Commonwealth Government has committed to provide almost $8billion in funding to the state and territory governments for increased and improved specialist disability services such as supported accommodation, targeted support and respite as part of the National Disability Agreement.

Social housing is often regarded as being inappropriate, particularly with regards to the range of adaptations that may be agreed to by the provider, which may not fully respond to the needs of people living with a disability.

Of the range of social housing available in Australia, community housing is regarded as more responsive to the needs of people with disabilities than public housing. Barriers to accessing public housing include:

a) Being deemed too ‘high functioning’ to be considered for priority housing; and
b) Being accommodated temporarily in a boarding house.

The latter is a significant impediment to entry into public housing as it removes the individual from the Category One priority housing list.

It is not known how many people with differing types of disabilities become homeless. A recent Australian study found that 59 per cent of young people with an intellectual disability became homeless when they left out-of-home care.

Homelessness pathways research has failed to identify the trajectory or trajectories into homelessness likely to be followed by persons living with disability. Mackenzie and Chamberlain (2003) have argued that the pathways into homelessness affecting persons with a psychiatric disability is different to that found within the general population, but failed to fully articulate the pathways. The processes and conditions that place people at risk of homelessness embrace structural, institutional and individual factors. Examples of structural factors include poverty, lack of paid work or the absence of affordable housing. Institutional factors include the social frameworks and practices that can drive individuals into homelessness or increase their risk of homelessness. This includes policies and legislation preventing persons under the age of 18 from holding a tenancy; the practice of excluding some persons from priority housing; and the waiting list criteria applied by social landlords. Individual factors are the unique and personal struggles that may pattern a person's life and may include incidences of abuse, violence, or adverse childhood experiences. Non-psychiatric disability may well constitute a previously unrecognised structural factor in the incidence of homelessness across Australia.

4.1.6. Risk Factors and the Hidden Homeless

Risk factors are regarded as exerting a cumulative impact, with the greater the number and severity of impacts the more likely the onset of homelessness. In general, disability is not identified as a significant risk factor for homelessness although research has shown it can be important where individuals are unable to sustain independent tenancies. Phinney et al (2007) found there was a statistically significant relationship between physical health problems, housing instability and homelessness especially where financial resources decreased and housing costs could not be paid.

The published and grey literature tells us that people with disabilities often remain hidden and they may not always be easily identified within the group of homeless people who seek help. The literature suggests that people with disabilities often live on low incomes and thus when a crisis occurs they may be at risk of homelessness. People with disabilities are often undiagnosed upon entry into homelessness-specific housing and support services and this means that support is either not provided or only offered after a considerable delay. They may also have dual or multiple problems that commenced either before or after homelessness.

Overall, the issue of homelessness and disability has not been examined in detail in Australia and this is a significant gap within the evidence base. This may be because they are 'channelled' into other housing arrangements and their needs are rarely documented whilst being assisted by accommodation and support services.

4.2 Phase 2: The Quantitative Analysis

In this quantitative phase of the research we examined the prevalence of risk of homelessness amongst populations with a disability. Two large Australian datasets were analysed – the Household, Income and Labour Dynamics in Australia (HILDA) Survey and the Australian Bureau of Statistics' General Social Survey (GSS). As discussed in the literature review, much of the existing Australian research on homelessness and disability has primarily been *'ad hoc'* qualitative research. Few studies have used large datasets. While the pool of qualitative research has begun to map the array of issues confronting persons with a disability, it has not provided insights into the broad characterisation and prevalence of risk of homelessness for people with a disability. The quantitative findings presented here address this knowledge gap.

In this study we classify risk of homelessness for the Australian population along a ten-point continuum. Those with the highest relative risk are classified at level 10, and those with the lowest risk classified at level 1. Importantly, our approach builds on previous research which, to date, has principally focussed on the classification of homelessness (for example Chamberlain and Mackenzie, 2008) and the experiences of populations classified as homeless (for example Lee et al. 2009). Because this study looks more broadly, we examine the populations with a disability who have experienced homelessness, those who may be at risk or on the edges of homelessness, as well as those who may be protected from the risk of homelessness. As such the findings have broad relevance for the development of homelessness and housing policy and services for the disabled population.

This analysis shows that Australian populations with a disability are distinct from populations without disabilities in terms of their risk of homelessness. Beyond simple higher level risk, this analysis has revealed distinct patterns across the entire homelessness continuum, indicating sub-populations who may either be protected from, or made more vulnerable to homelessness, by their disability.

While the broader project is focussed on three main categories of disability – intellectual, sensory, and physical – this quantitative analysis also includes a broader range of disabilities (such as psychological disability) in order to compare risks between disability types, as well as to gain an indication of which groups may be relatively protected or vulnerable. This report examines the relative risk of homelessness among populations with disability in three ways:

1. Level of restriction (e.g. profound, mild, schooling)
2. Category of Disability (e.g. intellectual, physical)
3. Specific Disability Types (e.g. hearing problem, chronic or recurring pain)

The following methodology section details the data and index construction. This is followed by a summary of findings for each of the three disability classifications used.

4.2.1. Method

The quantitative component of this study sought to assess the level of risk of homelessness amongst the population with a disability based upon an analysis of the HILDA and GSS data sets. These two large, robust and valuable datasets collect ongoing health and housing information about the Australian population. As many previous researchers have highlighted (e.g. Smoyer, 1998; Blignault and Haghshenas, 2005), secondary datasets are not usually targeted to the specific research question under investigation. Most commonly they have been collected for different or more generalised purposes; hence they may not fully allow analysis of specific population or research questions. To address these issues we examine multiple datasets, resulting in a greater depth of understanding.

The HILDA survey is an annual, household-based longitudinal survey of around 18,000 individuals in 7,000 households. It has been conducted each year for the last decade. The HILDA dataset collects a wide range of data by surveying adult members of participating households every year via face-to-face interviews and a self-completion questionnaire. Importantly for this study, the HILDA dataset allows us to monitor housing costs, residential stability and mobility, and income while comparing population characteristics, as well as type of disability over time. The analysis in this research uses the most recently released longitudinal data collected across nine annual waves.

The GSS is an ongoing cross-sectional survey conducted by the Australian Bureau of Statistics (ABS) every four years. It collects data on a range of personal and household characteristics of people aged 18 years and over resident in private dwellings, throughout non-remote areas of Australia. This survey is designed to provide reliable estimates at the national level and for each state and territory, and to enable analysis of the relationships between a range of social circumstances and outcomes. Beyond its reliability and robustness, this data is of particular value to this analysis. The dataset allows us to examine the relative prevalence of disabilities and long term health conditions with respect to their severity. In this study, the analysis is based on data from the most recently released collection of the GSS dataset, collected in 2006.

The analysis builds an Index of Relative Homelessness Risk (IRHR) to examine and compare outcomes across the population, with outcomes for individuals with disabilities and long term health conditions. The index builds upon previous, recently published work on housing precariousness developed by a number of the authors (Mallett et al 2011). In this earlier study, a measurement tool was developed and used to estimate the prevalence, concentration, and character of vulnerable housing across Australia. In order to measure risk of homelessness for this current study a composite index was constructed which was designed to reflect affordable and secure housing (as detailed in table 1 below). This index is measured across whole populations and scaled to form a continuous index with a range from 1 to 10.

Disability was measured across the population using the two datasets. The General Social Survey allowed the measurement of the index by populations classified by their level of disability restriction and also by category of disability. The level of disability restriction data is classified by the ABS across five categories, as detailed below:

- *profound – always needs help/supervision with core activities*
- *severe – does not always need help with core activities*
- *moderate – has difficulty with core activities*
- *mild – uses aids to assist with core activities*
- *persons are classified as having a schooling/employment restriction if they have no core activity limitation and are aged 18 to 20 years and have difficulties with*

education, or are less than 65 years and have difficulties with employment (ABS, 2006 cat no 4159.0.55.002).

Disability category was defined in this GSS dataset as being – Sensory (sight, hearing and/or speech), Physical, Intellectual, or Psychological. Within the broader population these groups were unevenly represented, with 14 per cent of the sample population classified as having a sensory disability, 26 per cent having a physical disability, 2 per cent having an intellectual disability, and 5 per cent having a psychological disability. The second dataset, HILDA was used to measure relative homelessness risk for groups with specific disability types.

Table 1: Index components

Cash flow	This variable is a count, at each wave, of the number of cash flow problems that are reported (7 in HILDA, 9 in the GSS). For example, Could not pay electricity, gas or telephone bills on time; Could not pay the rent on time; Pawned or sold something; Went without meals; Was unable to heat home; Asked for financial help from friends or family; Asked for help from welfare/community organisations.
Number of residential moves	In the HILDA analysis this is a cumulative sum of the number of moves undertaken in the previous wave—the count at wave 1 is zero. In the GSS analysis the number of moves in the preceding five years is used.
Evictions	Variable signifying if the individual was evicted from their last accommodation by the landlord.
Low income	Deciles of household income (HILDA - gross annual income; GSS – equivalised gross weekly) which is then reverse coded (the higher the number for LowInc10 the lower the deciles of income).
Housing costs	This variable is constructed using the values for mortgage and rent payments and is structured as deciles of Housing cost. The data are capped prior to generating the deciles—rent greater than $3000 per week (n=168, ~0.01%) and mortgage payments greater than $4345 per week (n=690, ~0.4%) are excluded.

4.2.2. Results

a) Level of disability restriction – insights from the General Social Survey

In the General Social Survey a total respondent pool of 11,436 individuals are represented in the analysis of disability by limitation/restriction. Within this total respondent pool, just under half (42 per cent) are recorded as having at least one disability or long term health condition, and the remaining 58 per cent have none. Among those with a disability or long term health condition, the largest category were those with a non-specific disability, followed by individuals with 'moderate core activity restrictions', 'schooling or employment restrictions', 'severe core activity restrictions', 'profound core activity restriction', and lastly just over 5 per cent had 'mild core activity restrictions'. Using examples provided by the ABS (1998, p. 52):

> *"profound - the person is unable to do, or always needs help with, a core activity task.*
>
> *severe - the person meets one or more of the following criteria:*
> - *sometimes needs help with a core activity task;*
> - *has difficulty understanding or being understood by family or friends;*
> - *can communicate more easily using sign language or other non-spoken forms of communication.*
>
> *moderate - the person needs no help but has difficulty with a core activity task.*
>
> *mild - the person meets one or more of the following criteria:*
> - *needs no help and has no difficulty with any of the core activity tasks, but uses aids and equipment;*
> - *cannot easily walk 200 metres;*
> - *cannot walk up and down stairs without a handrail;*
> - *cannot easily bend to pick up an object from the floor;*
> - *cannot use public transport;*
> - *can use public transport but needs help or supervision;*
> - *needs no help or supervision but has difficulty using public transport."*

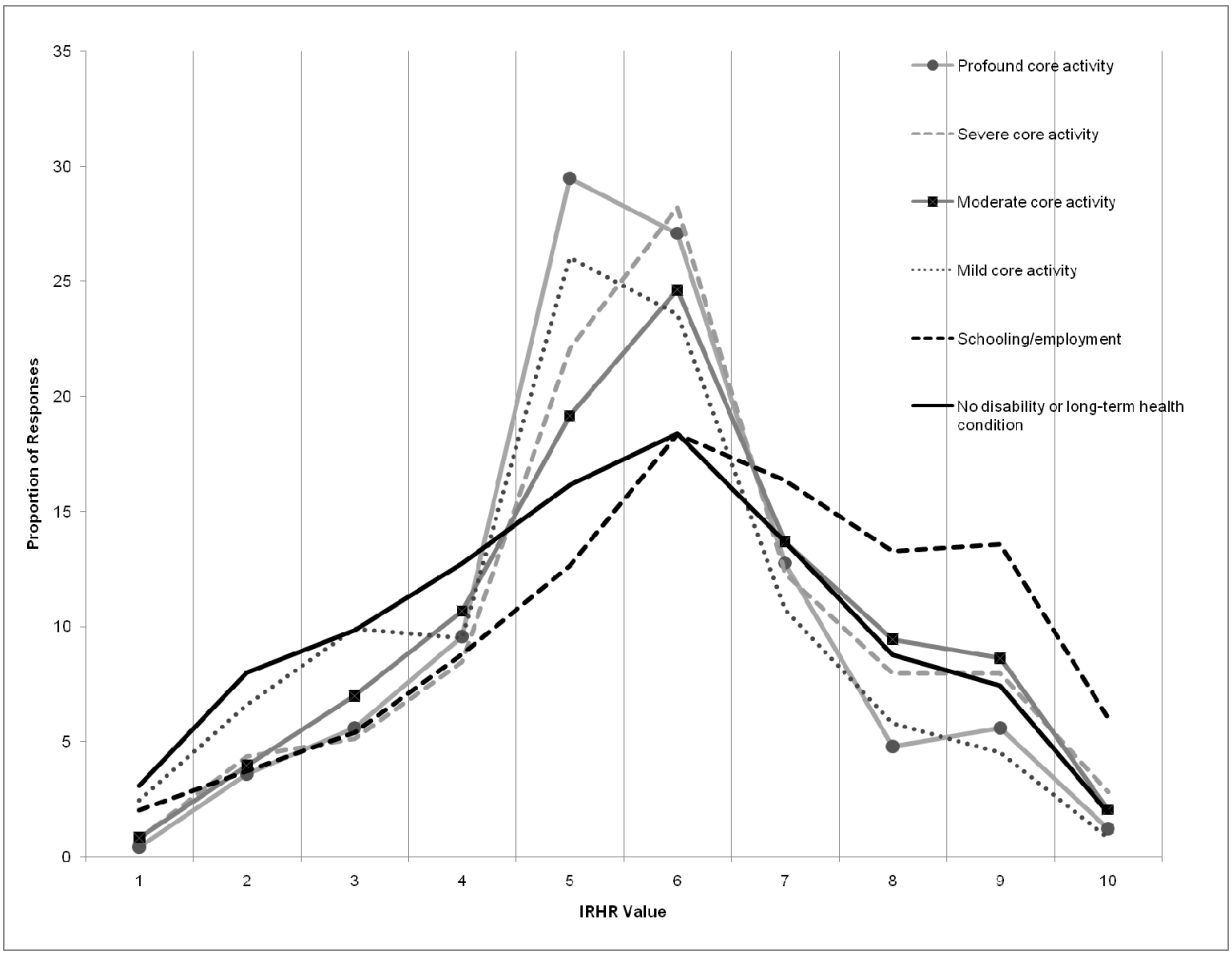
When the characteristics of individuals across this sample was analysed in terms of relative risk of homelessness – as measured by the IRHR - a clear relationship between relative risk of homelessness and the severity of a disability was shown. The strength of this association was statistically confirmed as highly significant (Pr = 0.000). The results are summarised in Figure 1. The figure shows the proportion of persons at each level of disability restriction and by each type of disability by relative homelessness risk score (where 1 is low level risk and 10 is high level risk).

Examining the figure, the IRHR profile of those with no disabilities or long term health conditions (shown as a solid black line) follows a relatively flat 'normal-type' curve. Profiles of those with disabilities differ, in the main being much more concentrated in the mid-value IRHR scores. The exception is the group with schooling/employment restrictions (shown as a dashed black line) who are substantially less concentrated in the lower risk IRHRs (1-4), and much more concentrated than the average in the higher risk categories (8-10). *Importantly, an individual with a schooling/employment limitation is almost twice as likely (33 per cent) to be in these extreme categories as someone without a limitation (18 per cent).*

In interpreting this graph it appears that disability is strongly associated with relative risk of homelessness, and further that within the disabled population, there are differences in risk depending on the severity of restriction. Those with schooling/employment restrictions

appear to be most vulnerable to risk of homelessness, while those with profound core activity restrictions, for example, experience a lower level of risk.

Figure 1: Index of Relative Homelessness Risk Score by Severity of Disability Limitation or Restriction, Proportion of Responses



Data Source: ABS GSS, 2006.

b) Disability category and the risk of homelessness – insights from the General Social Survey

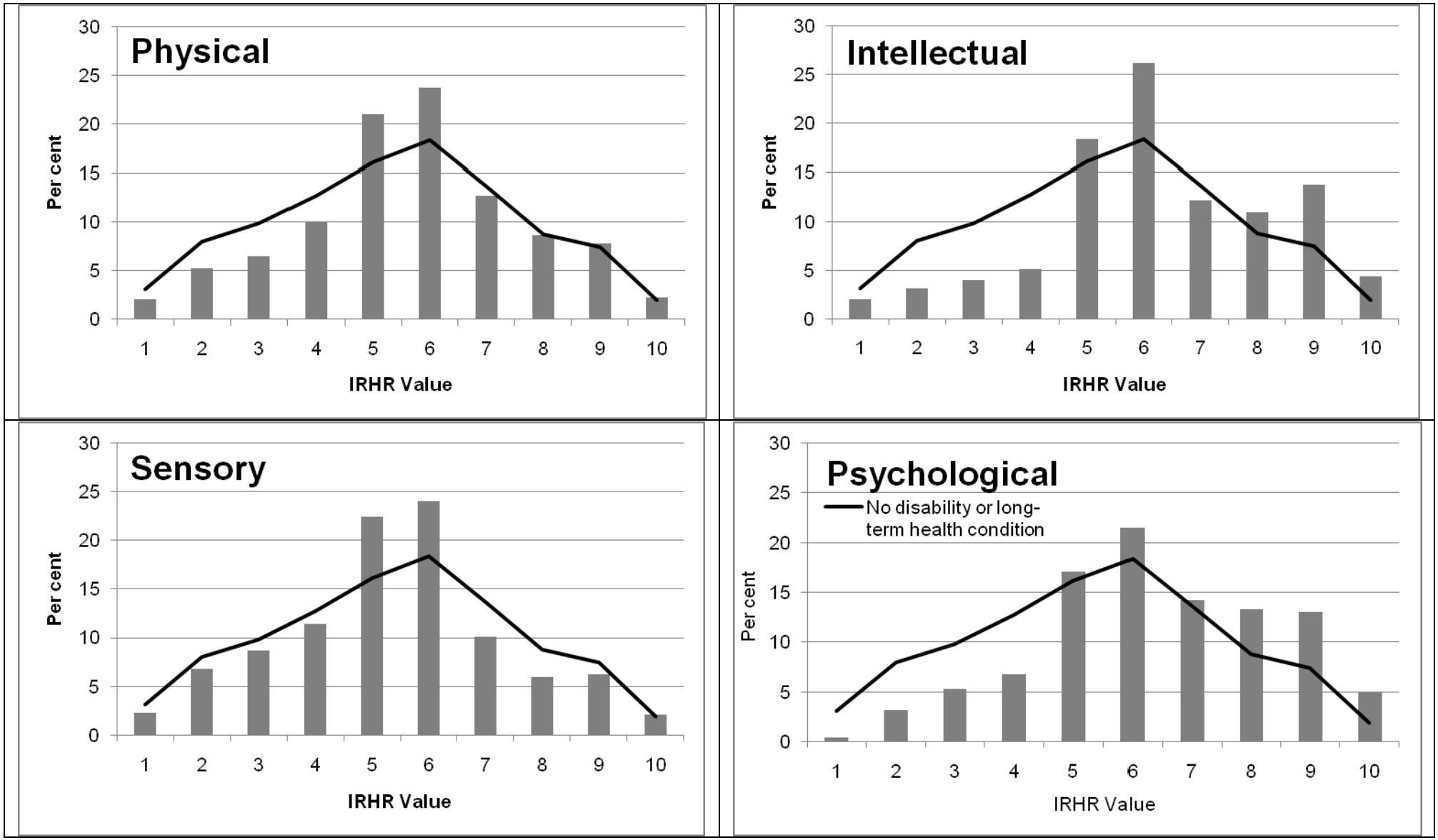
This analysis focuses on four major categories of disability as classified in the General Social Survey – Sensory, Physical, Intellectual, and Psychological. In examining psychological disability, we acknowledge that mental illness is not a focus of this research. However, it is a recognised and much researched cause of homelessness and therefore serves as a useful benchmark when examining the interaction between homelessness and other types of disability

For each category of disability we found a highly significant association between relative homelessness risk and disability type (in each case Pr = 0.000). Figure 2 (below) shows the proportions of each population by IRHR score for the four disability types. For comparison, the IRHR category scores for the population with no disability or long term illness are shown (in black) The analysis highlights the overall difference in relative risk for populations characterised by their intellectual or psychological disabilities, being both underrepresented in the low risk categories, and overrepresented in the high risk categories. Whereas, the pattern for individuals classified as having physical disabilities is more or less similar to the population with no disability or long term illness. In comparison, the population with sensory impairments are less commonly represented in the high risk categories than the no disability population, although overrepresented in the moderate risk categories.

We speculate that these patterns, at least partially, reflect the differential effect of welfare and policy interventions on the relative homelessness risk of individuals with different forms of disability. Because interventions are focussed, and also taken up unevenly across a population, welfare protection is provided, but unevenly. This affects IRHR patterns across and between populations, and we speculate that this contributes to different IRHR profiles between disability types. For example, individuals with Physical and Sensory disabilities have an IRHR profile that is more similar to the population with no disability, and this leads us to question if this is a reflection of the greater effectiveness of housing interventions for this group. Importantly though, the IRHR profile for each of these disability types would doubtless be very different in a policy environment where no welfare interventions were provided, and mapping the IRHR profile changes due to specific large scale interventions is an area ripe for further research.

It is also important to note the small but probable influence of age in this analysis. In the populations classified as having either physical of sensory disabilities, a proportion of these persons would have acquired their disability as a result of natural ageing. In these cases they have experienced a shorter length of exposure to disability, meaning that many would have spent greater periods of their lifecourse in employment, thereby acquiring housing and financial assets. Such shorter exposure length to disability is likely to provide some protection from relative homelessness risk.

Figure 2: Index of Relative Homelessness Risk for Selected Disability Categories



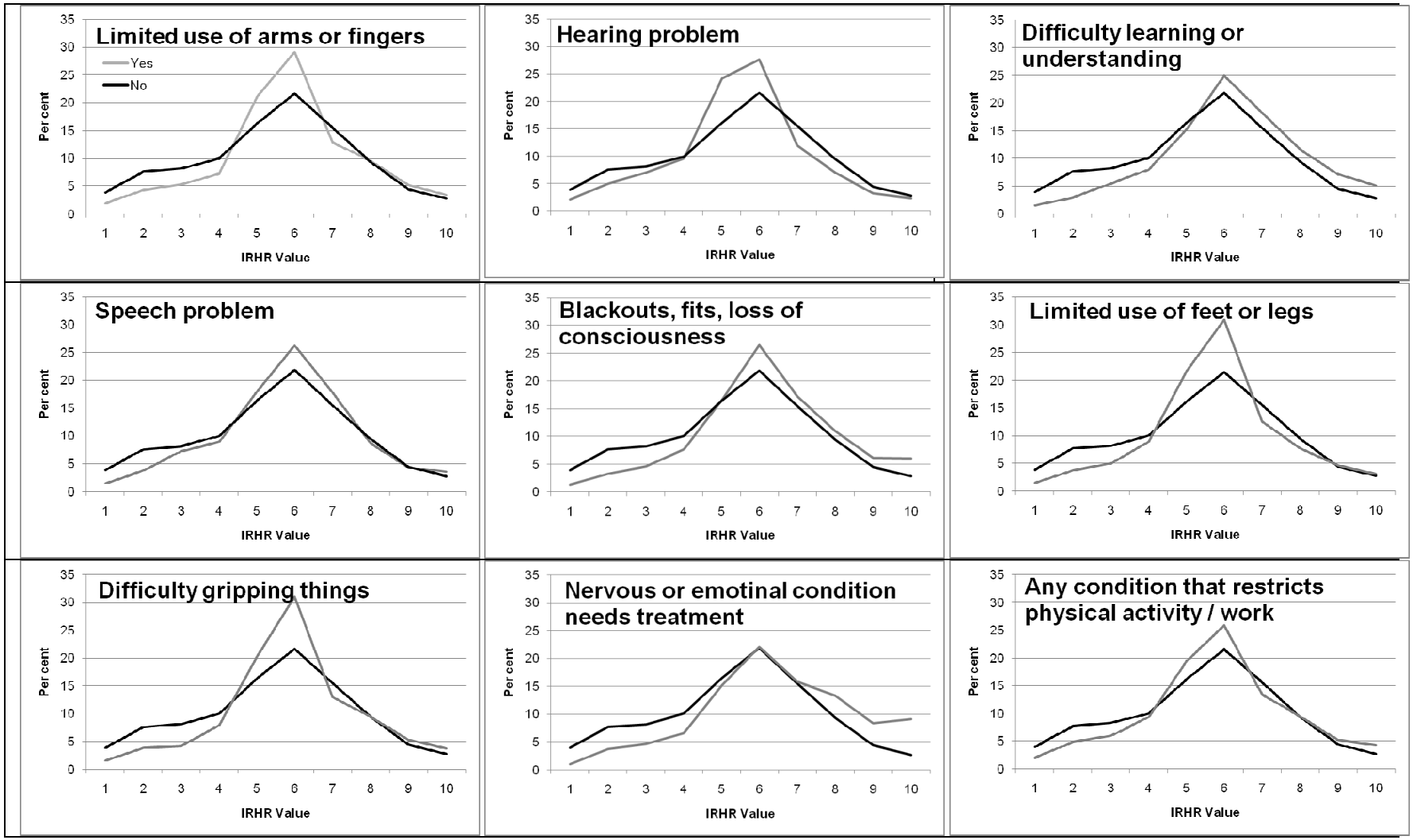
Data Source: HILDA dataset waves 1-9.

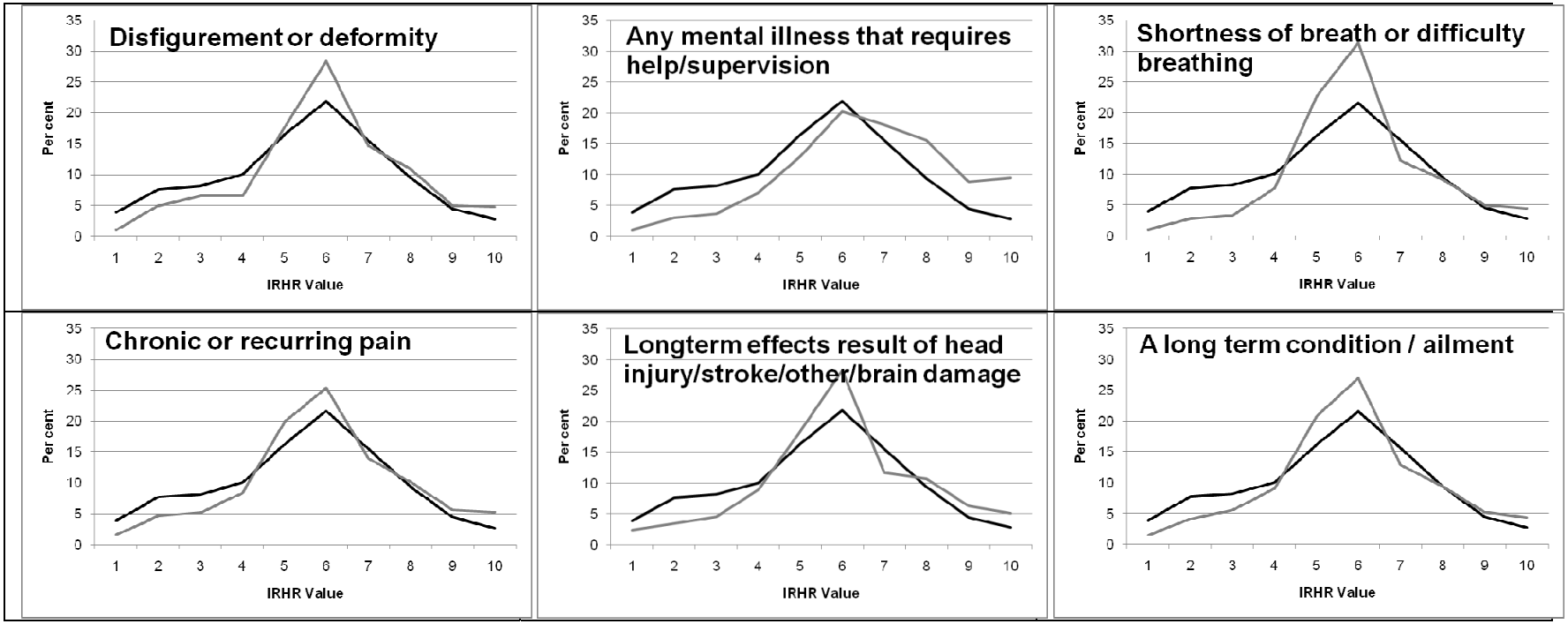
c) Disability type - insights from the HILDA Survey

As noted above, HILDA provides important insights into the wellbeing of the broad Australian population and has the potential to shed considerable light upon the housing/homelessness circumstances of those with a disability. This analysis of disability type is based upon a pooled analysis of over 120,000 responses to the HILDA survey over the 7 years where the data was available. This large dataset allows us to examine robustly the prevalence of specific disability characteristics by the relative homelessness risk of individuals. The nature of the HILDA data collection allows for greater precision in the specification of disabilities and in the analysis of exposure to risk. The results, comparing relative risk for individuals who had specific disabilities (in grey) with relative risk for individuals without those specific disabilities (in black) are summarised in Figure 3 below. A number of findings stand out in these graphs:

- Firstly, in the case of each disability type, individuals with a disability are much less likely to have a low relative homelessness risk (IRHR Value) than those without a disability.
- Secondly, with only one exception, individuals with disabilities are over-represented in the mid ranges of relative homelessness risk compared to those without disabilities.
- Third, those with physical disabilities tend not to be over-represented, compared to individuals without those disabilities, in the higher relative risk of homelessness categories. For these types of disability, similar proportions with a disability are in the higher IRHR categories compared to individuals without.
- For individuals whose disability is related to mental illness or brain injury, there is an increased likelihood of these individuals having higher relative homelessness risk. We highlight here individuals with difficulty learning or understanding, where almost 25 per cent of individuals with this type of disability are in the most extreme levels of homelessness risk (values 8, 9, &10), compared to only 16 per cent of individuals without that disability. Similarly, for individuals with a mental illness that requires help or supervision the results are even more extreme, with 34 per cent of this population in extreme homelessness risk, compared to 17 per cent of individuals without this type of disability.
- Though this research is intentionally focussed on disabilities beyond mental illness, the examination of mental illness in this quantitative analysis has highlighted the very high levels of homelessness risk for individuals with a mental illness, with almost 10 per cent of all individuals in the highest homelessness risk category. While it is not the intention of this research to focus on mental illness, we must highlight it here in our comparison with other disability types, reinforcing the very real risk of homelessness among this population.
- Finally, this examination of individual disability types does not capture co-morbidity within the population. Many individuals in our large sample have more than one disability type, and although the effects of co-morbidity have not been included in this study, we acknowledge that this will also influence vulnerability to poorer relative homelessness risk.

Figure 3: Index of Relative Homelessness Risk by Presence/Absence of Selected Disability Types





Data Source: HILDA dataset waves 1-9

4.2.3. Discussion

These analyses have highlighted and reinforced the underlying assumption of this research – that *persons with a disability have a greater exposure to the risk of homelessness than the general population.* Importantly however, we show that the relative risk of homelessness (and hence any resulting policy response) cannot be generalised for the population with a disability because exposure is not evenly distributed within that population. Across the analyses, individuals with schooling/employment restrictions (33 per cent), those with psychological (31 per cent) and intellectual disabilities (29 per cent), and those with mental illnesses (34 per cent) were especially vulnerable to extreme levels of relative homelessness risk. Individuals with each of these restriction types are much more likely than the population without a disability to be at risk of homelessness – of whom 18 per cent are classified at the same extreme level of homelessness risk.

The results contained in this report reflect the differential homelessness risk across different disability groups in Australia. Critically, differences in the level of government and NGO-provided support available to persons with different types of disability, as well as the familial support which many receive are likely to be the major sources of this differential risk Overall, this report has clearly highlighted a number of sub-groups within the disabled population who are more vulnerable, and hence need additional (and especially targeted) support with their housing.

Beyond the insights into extreme homelessness risk, this analysis also highlights the uneven exposure that some groups have to moderate homelessness risk. These groups, for example those with intellectual disabilities, or specific physical disabilities, such as difficulty breathing, and limited use of arms or legs, have much higher likelihoods of being classified in the moderate homelessness risk categories than the equivalent populations without a disability. This is important because firstly, these groups tend to be equivalently under-represented in the very low risk categories (representing secure and affordable housing), and also because this reflects housing disadvantage and a potential homelessness precondition, which may not be detected in studies which focus only on pure homelessness.

This quantitative analysis clearly confirms the relational prevalence of disability and homelessness risk in Australia. A number of findings are pertinent and should be highlighted in this conclusion for further research, deeper examination in the Phase 3 qualitative analysis, and policy attention.

- Persons with a disability have a greater exposure to the risk of homelessness than the general population.

- Individuals with some disability types (for example learning difficulties or mental illness) are more vulnerable to homelessness, and hence need additional (and especially targeted) support with their housing.

- Though this research is intentionally focussed on disabilities beyond mental illness, the examination of mental illness in this quantitative analysis has highlighted the very high levels of homelessness risk for individuals with a mental illness.

- Though the effects of co-morbidity have not been included in this study, we acknowledge that this may be a substantial influence on vulnerability to homelessness.

- Finally, this study highlights the differential prevalence of risk, but not the triggers or protective buffers that may increase vulnerability or protection from homelessness. These will be examined in the Phase 3 qualitative analysis, and also merit further investigation.

4.3 Phase 3: The Qualitative Component

The qualitative phase of the research sought to expand the current evidence base by exploring the housing and homelessness experience of persons with a disability. In particular, we were interested in people whose disability was physical, intellectual or sensory, rather than primarily psychiatric.

The qualitative component was informed by a number of Research Objectives:

- To explore and document the experience of homelessness or housing crisis amongst persons with a disability;
- To explore the factors placing persons with a disability at risk of homelessness or housing crisis;
- To explore people's experience of services and service systems, and identify the impact of service delivery on their housing outcomes;
- To explore the social, familial and informal support networks of this cohort, and determine the effects of these on their housing pathways;
- To elicit the views of participants on service interventions which could successfully address the problem of homelessness amongst persons with a disability; and
- To identify the types of policy and service intervention that would either limit a period of homelessness or prevent it altogether.

4.3.1 Method

Sample and recruitment

Ethics approval was granted by the University of Adelaide and both Hanover and Melbourne Citymission's Ethics Committees. Following ethics approval, semi-structured interviews were conducted with 30 people with a disability between April and May 2011 in both Melbourne and Adelaide.

Participants were eligible to take part in the study if:

- They were 18 years or over;
- had either a physical, sensory or intellectual disability (including an acquired brain injury); and
- were currently homeless or at risk of homelessness, or had experienced homelessness in the past.

Participants were mostly recruited through homelessness or disability services in both Melbourne and Adelaide. Service providers in relevant service agencies were contacted by the researchers and informed of the study. These service providers then informed potentially eligible clients about the study and assisted those who were interested in participating to make contact with the researchers. In two instances, participants referred an eligible friend to the study.

Once potential participants established contact with the research team further eligibility screening was undertaken before a mutually suitable time and place was negotiated to

conduct the interviews. Most participants were interviewed at the service that had referred them to the study. Some were interviewed at another agency, in a café, or in their own homes.

We contacted a variety of homelessness and disability agencies to assist us with recruiting for the study across both Melbourne and Adelaide. The aim was to ensure that we included people in the study with a diverse range of disabilities.

We recruited through:

- Homelessness and housing support agencies (n = 7);
- a disability service for people with an Acquired Brain Injury (ABI, n = 6);
- one of two day centres for persons who are homeless or disadvantaged (n = 4);
- The Big Issue - a social enterprise to assist people experiencing homelessness into work (n = 6);
- word of mouth (n = 3);
- a Domestic Violence Service (n = 1); and
- an aged care and affordable housing provider for persons with a disability (n = 3).

Voluntary participation and Informed consent

Participation in the study was completely voluntary and subject to the provision of informed consent. There was a specific ethical concern to ensure that participants with Intellectual disabilities (including ABI), were able to give informed consent. Steps were taken to ensure that eligible clients understood the nature of the study and were able to give informed consent. These included:

- Describing the study to participants when the interview was booked in, and then checking again at the start of the interview to ensure participants remembered what the study was about.
- Reminder calls prior to interview to ensure participants remembered the interview and where they needed to be.
- Offering to read all information to participants (regardless of their reading ability)
- Sending participants away with written information and ensuring that they had someone who could read the information to them if they had difficulty reading (all participants had someone they felt comfortable to ask to read this information to them if they had difficulty reading).
- Highlighting both the contact number of the researcher and the ethics committee in the information given out and stating clearly that participants could call either of these numbers to get information about the study.

Interview content

The face to face semi-structured interviews lasted between 30 minutes and one hour. The interview schedule included questions about:

- The person's disability and its impact on their daily life;
- their health;
- their housing and homelessness history;
- how having a disability impacted upon their housing choices;

- their experience with service systems;
- their thoughts on policy or service responses that should be added or improved; and
- familial, social and informal networks of support.

The interviews were digitally recorded and transcribed for coding and analysis. Three researchers selected and read six interview transcripts and together identified categorical and emerging themes. A coding schedule based around the research questions was developed and reviewed by all research interviewers. All interviews were subsequently coded and analysed based on the codes indentified. As part of this process all interviewees were assigned a code to protect their privacy.

4.3.2 Results

a) Participant Profile

Age, Gender and Ethnicity
The majority were men (25). Only five were women. Participants' ages ranged from 28 to 62 years, with an average age of 43 years.

Almost all were Australian born, with one born in Poland and another declining to answer. Two identified as indigenous Australians.

Income
With the exception of one participant on Newstart allowance, the Disability Support Pension (DSP) was their main source of income. Two participants also had additional income. One of these received income from a partner's superannuation. The other had money from the sale of a unit, which was managed by State Trustees.

Parent Status
Half of the participants (n = 15) were parents. One had shared custody; four had regular access/ regular contact with their children. Six had adult children, some with children of their own. Four had no contact with their children.

The types of disability participants experienced included:

- **Intellectual disabilities (6 participants).** This included significant learning delays and difficulties. Some participants gave no further information other than to say they had an intellectual disability. Some were born with these disabilities while others acquired them in childhood as a result of accident or abuse.

- **Acquired Brain Injury (ABI) (15 participants)**. Just over half had an acquired brain injury. One also had a physical disability, and another had additional, unrelated physical and sensory disabilities. While acquired brain injury is classified as a type of intellectual disability, we have separated it out given the number of our participants who experienced an ABI.

- **Physical disabilities (9 participants).** These included nerve damage to hands and feet, obesity, breathing difficulty as a result of pervasive golden staph infection, mobility problems due to stroke, severe arthritis, two knee replacements, cerebral palsy, muscular dystrophy, and severe back injury (though not confined to a wheel chair or walking frame).

History of disability

Six participants had acquired their disability at birth or in early childhood. These participants had learning or intellectual disabilities. For two of these people, the disability occurred in early childhood as result of abuse or an accident.

However, for most participants (n=24), their disability occurred in adulthood. Underlying causes varied. In a couple of cases, disability was related to neurological factors such as a brain tumour and a brain aneurysm.

A motorbike accident affected the lives of two people. Ryan's accident occurred four years ago:

> *I had a motorbike accident four years ago, spent three and a half years straight in hospital. My left arm has just been reconstructed of metal so it's all tin there now. Because I was in hospital so long I got golden staph which spread through to my blood and into my lungs so I've been nearly dead six times from it. I lost my house; I lost everything when I was in hospital. My mum and dad both passed away in the first couple of months, I lost my fiancé so I lost everything, hit rock bottom. I was only 95 kilos before my accident and I'd done security for 12 years. Because I was in a coma for a while and bedbound for two and a half years I got up to 302 kilos. (Ryan, 32)*

Zach, meanwhile, had still not fully recovered from a motorbike accident that happened ten years ago:

> *I've had to learn to walk and talk and you know, slowly, slowly it all got better and I'm almost up to what I was normally. No one can really tell me anything, but it's all on me, yes. So, yes, it's* been a *long battle to get there, mate.* (Zach, 39)

For a couple of people, the impact of a fall had similar life-changing consequences:

> *I had a fall nearly three years ago where, I can't remember the fall, but now I know I split my head and my skull and there was brain damage and all I know now is I've lost the hearing in my right ear and when I came out of the coma, I couldn't read, write, talk, walk. I couldn't do anything and in three years, I've come a long way. (Jill, 57)*
>
> *About five or six years ago*, *I* fell *down a couple of steps and I was quite intoxicated…then I went outside and I lost my balance and*

the fresh air hit me and I just went bang. And they rang an ambulance and I went to hospital and I fractured my skull from the top down to the bottom…Then I went to rehab after I got let out of hospital, because the neurosurgeon said I wouldn't be able to walk again. I spent six months doing the physio and…I'm walking again. (Kieran, 47)

Workplace accidents impacted on three people. One person sustained ongoing back problems while another suffered extensive injuries:

I was probably two thirds of the way through one of these testing every 10 metres the cabling networks…and a smelter that was shut down and wasn't meant to be working started up. Don't know, still don't know to the day why it happened but anyway it pumped the sulphur dioxide magnesium phosphorus back through the vent and I was found two and a half hours later…I like started seizing from the chemicals and just on like this part of my head smashed it all to bits. My brain was actually showing and skin and everything were actually open. Eye sockets like so I got chunks out of it everywhere because they couldn't find all the pieces to put back together. I was a bit like Humpty Dumpty in that respect. But, yes, broke my nose, cheekbone, skull, forehead, nice plate in my head. (Joshua, 39)

Disabilities resulting from acts of violence were relatively common among this group of people (n=7). What was particularly striking was the level of violence endured and the life-threatening injuries and long periods of hospitalization that resulted. For example:

Back in 2006 I went to Coles…and basically it was a random assault and robbery. I suppose it was a group…people drunk and bored…just hit and I was in a coma for eleven days and actually the police were waiting for me to die so they could upgrade their charge to murder. So I woke up actually talking to the homicide squad as they said not a lot of people get to talk to us. I suppose it was just a lot of boys who were young and drunk and bored…Basically I woke up eleven days later out of a coma and I couldn't move this side of my[left side of the] body…I had a lot of speech trouble and memory trouble and balance trouble. Yes, basically I woke up in a different world with all of this. (Tom, 37)

I've had the brain injury for a while but it's gotten worse after a couple of months ago when three [people] got stuck into me with pipes. And I was in and out of consciousness and yeah, been in hospital for two weeks and almost lost my eye…Yeah pretty bad. I'm lucky to survive it actually. (Phillip, 44)

My accident that's when I had my disability was about four and a half years ago in September 2006. I fell, I was pushed from a second level balcony, broke 17 bones, in a coma for 8 weeks, and lost use of my left side. (Greg, 34)

> *I was attacked while I was sitting eating my breakfast. I was just about to eat my cornflakes, when a fella came in. He stepped inside the door way and went whack with a meat clever. I had about a dozen staples in the back of my head and a head ache for about a week. That's caused me post traumatic stress disorder, anxiety, panic disorder. (Jamie, 34)*

Five people had more than one disability to cope with; for example, Joel had a range of psychological and physical difficulties that have affected him on a daily basis:

> *Well I've got about ten different things wrong with me. I've got asthma, epilepsy, bi-polar, schizophrenia…I've got a left leg that never healed properly from a broken leg. I broke my left arm when I was younger and had to learn to write with my opposite hand. I was in a car accident and I had a mild brain injury and my right knee is all shattered so it hurts when I walk but I still have to walk …I have a slipped disc in my back from a cupboard falling on me when I was a child when I went to reach something I shouldn't have. I get headaches from the car accident. (Joel, 37)*

The impact of disabilities on daily life - Living with an Intellectual disability

Persons with an intellectual disability mostly reported problems reading and dealing with written information. These issues are heightened for them when dealing with government departments and agencies such as Centrelink, Child Protection and state housing authorities.

> *With waiting, filling out forms and stuff like that. I had to take it into Centrelink and try to get them to fill it out. It's a tizzy. But travelling and that is fine as long as I get a name straight or whatever or a number of a street, I can always ask somebody. But it's this over years of learning how to spell, stuff like that…That's how I've learnt to read. It's reading the Big Issue backs. So that's how I'm learning to read as well so I can recognise words but 20 minutes later I'll - wouldn't - can't remember how to write them in a sentence. (Debra, 41)*

The impact of disabilities on daily life - Living with an ABI

Participants with ABIs reported problems with their short term memory and difficulty organizing their thoughts. As Phillip explained:

> *Forgetting people's names, forgetting things to do. I write a lot of things down. It stuffs me up big time when I can't think of anything, like a friend's name and stuff like that. It's not just names that I'm worried about; it's everything else that goes with it. Like you talk to me and 10 minutes later I'll be thinking what in the hell did she just say then, you know what I mean? (Phillip, 44)*

The memory problems experienced by participants had an impact on their capacity to get to appointments, remember to complete paperwork or follow instructions around medication or medical tests.

My doctor got me to do some tests and stuff but I lost the things or forgot to go and do it or I got told not to eat so many hours beforehand and then we'd forget and I'd go to do it and they'd tell me "Did you eat?" and I'd say "Yes". (Ben, 28)

Others with ABIs also had trouble with their balance:

And my balance – yes. When I have to have a shower I have to hold on to the bath. When I have a shave I've got to hold on to the ... so yes. (Kieran, 47)

Steps and I do not get along. I get dizzy just out of the blue. Have to be careful and have help walking. (Jill, 57)

Some participants talked about not being able to do the sort of work they used to and trying to return to their old lives.

I've got my license back now but there is a restriction because of my memory, I'm only allowed to drive for a 50 k radius from home. (Simon, 49)

Another participant, Joshua had an ABI, epilepsy and vision impairment from a workplace accident involving chemicals.

I have two seizures roughly a week ….in the winter about two a week. In the summer anywhere between maybe hypothetically six and 20. …….I get……flashing out of the one eye. I can't focus properly but you sort of try to as much as you can. That's why I sort of look away from people because their head is starting to sort of warp. (Joshua, 39)

While participants' impairment had a direct impact on their lives their impairment also affected them in other ways. For example, some participants reported feeling extremely frustrated by their injuries and impairments.

See I forget a lot of things and I'll probably leave and I'll think shit, now I remember what I should have told her and all that stuff and think Jesus Christ. (Phillip, 44)

Participants with ABIs also spoke about how they cope with or manage their disability in their daily lives. Some stressed the importance of routine:

Yeah I've got to get in the routine, to sort of to remember to like waking up at a certain time, you know what I mean? ….And I wish there was a way to stop it, that's all I've wanted in life, just this brain injury to…. I know it's never going to fix itself or it's not going to get fixed but I want to try. (Phillip, 44)

It's like I've got to write down at breakfast, lunch and dinner times eat something …….when I'm by myself I can't look after myself like that which is really whack [appalling/strange]. (Ben, 28)

The impact of disabilities on daily life - Living with a Physical disability

Participants living with physical disabilities found that their disabilities impacted on their lives in ways specific to their particular disability.

One participant had ongoing back problems from a workplace accident. He was sleeping rough at the time of the interview and carrying a large bag with his possessions in it all day. While he tried to keep the weight he carried to a minimum, he reported feeling very cautious about how far he travels and his mode of transport as he is constantly worried about his back injury flaring up.

On adjusting to have a disability, Ryan commented:

> *It's a lot harder but I cope pretty well with it. At the start no I didn't but you learn to adapt as you do with life. I've still got my motorbike I can ride around but I started walking a bit more, catching public transport and that so I can do all that okay not the best but still getting out there having a go. Just started boxing at the gym again so yeah it's getting there. Where I am you're up three floors so it's a bit hard to get in and out. (Ryan, 32)*

Commenting on his nerve damage, another explained:

> *Me hands feel like they're dead. I can move me fingers back and forth like that, but I've got no strength in me hands, because it's the ulna nerves and stuff. I've had all nerve conductivity tests done with a neurologist. I said, "I can't work because I can't hold things." And the neurologist said, "I'm not surprised you can't work with hands like that". (Max, 62)*

Others talked about the ongoing pain associated with their physical disability:

> *Before I had the pain medication I was in bed and my niece came up to me and said "what's the matter Uncle?" because I was crying and I'm looking at the toilet, and I wanted to go to the toilet and I couldn't get up. (Damien, 51)*

Another participant commented on the difficulties of having a disability and finding an intimate partner.

> *I found it hard to have a girlfriend because if you tell them the truth that you've got all these disabilities, not many people want to go out with you. If you don't tell them the truth then they accuse you of being a liar, some of them do. So it's sort of a double-edge sword. (Joel, 37)*

Others simply had trouble getting in and out of their housing. One participant with significant mobility issues commented:

> *The only trouble is the stairs and if the lifts don't work I've got to try and walk down the 40 flights of stairs. (Robert, 57)*

Mental health

While this study was focused on intellectual, sensory and physical disabilities, 14 of the participants had also been diagnosed with a mental illness. These included:

- Depression (6 participants)

- Anxiety (1 participant)
- Posttraumatic Stress Disorder (3 participants - one related to acquiring their disability)
- Schizophrenia (1 participant)
- Both bi-polar and schizo-affective disorder (1 participant)
- Bi-polar disorder, anxiety and Posttraumatic Stress Disorder (1 participant)
- Agoraphobia and Posttraumatic Stress Disorder (1 participant)

Health

We asked participants to rate their current health status. Overall, respondents rated their health positively, with 9 participants rating their physical health as good or excellent. Some rated their health as moderate (9 participants). Nine participants said their health was particularly poor. Participants' rating of health was not related to the type of disability they reported. Three participants did not answer this question.

Participants were also asked to describe any ongoing health problems that they had. Just under half of all participants (14) reported ongoing health issues, in addition to their disabilities. These included:

- Asthma
- Diabetes
- Celiac Disease
- Hepatitis C
- Insomnia
- Cancer (skin, prostate)
- Psoriasis
- Repeated episodes of pneumonia
- Varicose veins
- Ongoing vision problems
- Lost full use of one leg, dependent on walking stick
- Ongoing pain management due to back injury.

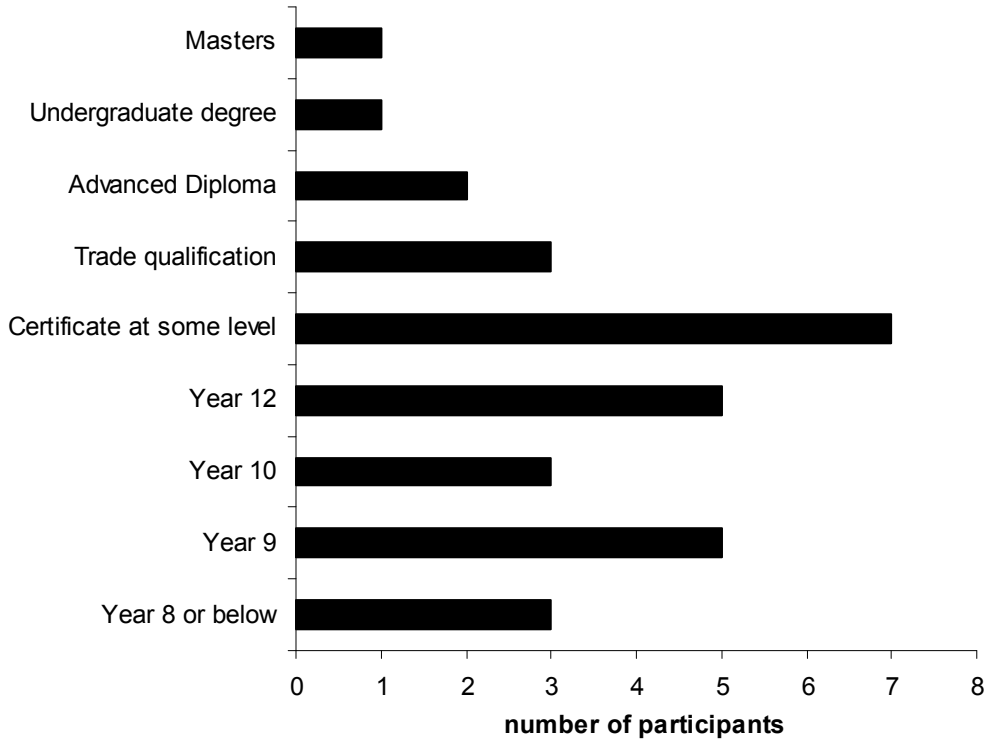
Employment, Education and Training

The majority (28) had an employment history, though these histories varied considerably. Some had extensive work histories. One had worked as an electrician for most of his working life; another had worked as a real estate agent for many years, while others had owned their own businesses. People who had worked for long periods had acquired their injuries later in life after gaining substantial work experience. Some had numerous low paid roles and others had had only one or two employment experiences that were supported, such as selling the Big Issue. These participants typically had Intellectual (not ABI) disabilities.

A number of participants wanted to return to work and some were actively pursuing this.

As figure 1 shows, participants' educational background were diverse. A number had left school early (had completed year 9 or below). One person had not commenced high school) and five had completed year 12. Around half (14) had some sort of post secondary training or qualification.

Figure 4: Participant's highest level of educational attainment (n = 30)



Participant Profile - Key Points

- Participants most commonly experienced some kind of intellectual disability with many having ABIs. Some had physical disabilities.
- Some had been living with disability since birth or early childhood.
- Most had acquired their disability in adulthood; a few were coping with multiple disabilities. In most cases, this was brought on through significant trauma.
- People's disabilities had significant impacts on their day to day lives.
- Almost half of all participants had significant ongoing health issues.
- Almost half also had a psychiatric disability.
- Almost all participants (n = 28) had some kind of employment history – with those acquiring disabilities later in life having the most extensive work histories.
- Almost half (n = 14) had some kind of post secondary training or qualification.

4.3.3 Discussion

a) Housing and experiences of homelessness

This section explores participants' experiences of homelessness and housing. It identifies three distinct groups of participants:

1. Those who had extensive histories of homelessness across their lives
2. Those whose first experience of homelessness was after the onset of their disability
3. Those who had not experienced homelessness, but had instead experienced unstable housing after acquiring their disability.

A further subgroup of those who had extensive histories of homelessness was identified – those with multiple and complex needs.

In examining these three groups of participants, this section looks at whether people's experience of homelessness was related to their disability.

This section also examines where people were currently living at the time of interview and whether their housing was secure, affordable and suitable or adequate for their needs. It also describes the specific housing needs of this group as a whole, and the difficulties they have experienced in obtaining housing.

People with extensive histories of homelessness

Many participants (23 out of 30) had extensive histories of homelessness. Of this group, 18 people had disabilities they acquired later in life. All of these participants experienced homelessness prior to the onset of their disability. Of the remaining five, one had had a physical disability since birth and had lived for a long time in a caravan park – albeit reasonably happily. The remaining four people had lived with intellectual disabilities since birth or early childhood, and had experienced repeated periods of homelessness throughout their lives.

George had lived with an intellectual disability since childhood, and had his first experience of homelessness after his mother and subsequently, his-father, both died. He stayed with his brother for a while but left as a result of them not getting along. After leaving his brother's place, George moved around for a while, and also stayed at a homelessness service. Eventually, he received public housing due to an application his late father had lodged before his death.

For another participant, Joel, it was unclear whether he had been homeless before or after acquiring a brain injury following a car accident. Joel identified having multiple types of disability and ongoing health issues, including schizophrenia. He has experienced long term unstable housing. In his account, he had moved through different boarding houses and hostels over the last eight to nine years. Joel has also stayed in a homelessness crisis service and had a temporary living arrangement with a stranger who put him up for a period of about six months.

I stayed at the [service] for a while and then I found a person who took me in at one stage. I wasn't sure about it but it was OK for six months but I'm not sure I'd ever do it again… Because it was very unstable. There was a lot of violence at the time.

For a time, Joel also lived in share housing but this living situation didn't work out:

I lived with a flatmate for 12 months at one stage but one day he got angry at me for swearing too much and he just kicked me out of the house without getting any of my possessions. I wasn't very happy about it. (Joel, 37)

Kieran (47) was homeless for three to four years after being unable to make the rent on a private rental property:

I had my sister and my brother living with me, but then my brother passed away and my sister moved out, and I was in a three bedroom house by myself and I couldn't afford it….So I left. And that's when I become homeless.

After losing his housing, Kieran stayed with friends and family, occasionally sleeping rough. A few years ago he fell down some stairs while drunk and suffered serious head injuries – including an ABI.

Tom (37) was living in boarding houses prior to his accident, but he got by:

I was actually living in a boarding house at the time when I was between jobs, but I've always been at work and getting $150 dollars a day and you always knew that even if you were broke and were homeless you could fix it, just go to work for a day or two.

Tom suffered an ABI after being assaulted randomly on the way home from the supermarket. After some time in hospital he discharged himself – without being fully able to care for himself. He found himself a caravan in a caravan park, where he stayed for a few months and subsequently moved to an unregistered boarding house. After multiple stays in substandard and unsafe accommodation, a homelessness service assisted him to move into community housing – where he was living with his partner at the time of the interview.

Multiple and complex needs sub group

Further analysis revealed that many of those participants with extensive histories of homelessness had experienced multiple and intersecting forms of disadvantage. In service contexts this group would typically be classified as 'having multiple and complex needs'.

Ten participants could be categorised in this way. Five of these had intellectual disabilities, three had ABIs and two had a physical disability.

These participants often had significant experiences of trauma and abuse, and/or had lived in institutional settings. While they were not specifically asked about experiences of violence and abuse, four disclosed childhood abuse and neglect. All four were raised in

state care as a result of abuse. A further two participants were also raised in state care but we do not know the circumstances that surrounded this.

Of those who spoke about their state care experience, some had moved through multiple foster families or stayed in institutions as children. For example, Joshua was taken into state care when he was nine and, after stays in boys' homes, moved through many different foster homes. When these foster situations fell through he sometimes slept rough:

> *Over the next probably I think three years roughly on and off I went through 16 different foster homes. Didn't last more than two weeks. (Joshua, 39)*

Eventually (after seven years) Joshua was placed with a family he connected strongly with whom he regards as his parents.

Debra, another participant, first experienced homelessness after leaving her family home at 15 years of age. She was abused by her father. Following police involvement and she was taken into state care.

For many of these participants their first experience of homelessness occurred early in life – in their mid-teens; but one person was just four and half years of age.

> *I've been on the streets for 30 odd years. Hobart, Melbourne, Adelaide, Perth, Queensland and Sydney. I lived on the streets when I was 4-1/2 years of age in [city]. There's no food vans going around then. (Adam, 36)*

Not all participants disclosed histories of abuse, but all had had multiple traumatic experiences. While not raised in state care, three participants had been in and out of prison multiple times over many years.

Robert's most recent episode of homelessness occurred when he separated from his wife. This period of homelessness lasted many years:

> *Probably eight to 10 years I was on the streets. I lived in the old [suburb] ball ground in the grandstand, had a tent up in the park up there, had a tent over there, slept at the back of [name of church] done it all done it rough. (Robert, 57)*

Robert was also homeless when he was younger:

> *It actually happened before that; when I was younger I went to Queensland and I was on the streets up there…Yeah. If I wasn't on the streets I was in jail, go to jail just for the three meals and a warm bed. (Robert, 57)*

Phillip was homeless on and off over many years and in and out of prison while using drugs. Of his ABI he says:

> *Probably just been batted around the head too much I suppose many years ago and not so long ago, yeah so. (Phillip, 44)*

Another of the participants, Ben, left home after getting his girlfriend pregnant in his first year of secondary school. He explains:

> *I moved out when [girlfriend] got pregnant when we were in Year 8 and I left school to get a job at a bakery, got into speed. When that ended, so when that job, the house I was living at was outside of home and it was like a friend's house from school and I was living there. When I left that house I was on the streets because my girlfriend at the time would kick me out of home from using drugs because she never used and I couldn't kick this habit. And then I'd be on the streets doing the wrong thing, the police would pick me up, I'd end up in jail, loved it. Somewhere to stay, got some food. And then I'd get out, go back to my girlfriends until I'd get kicked out again and that same process happened for years until one day when she kicked me out for the last time I said I've had enough of this. (Ben, 28)*

These participants were extremely socially isolated, except for one person who was a regular at a local day centre and had re-established contact with his children and siblings.

Three participants had also experienced seemingly random acts of violence. For example:

> *I've had the brain injury for a while but its gotten worse after a couple of months ago when three Aboriginals got stuck into me with pipes. (Phillip 44)*

Another participant was assaulted on the way home:

> *I went to [suburb], did my shop, and walked home. I walked into the pub; I had one beer, and walked home with my groceries. I got attacked in the side of the head; I was still buzzed, whacked around my left ear. (Adam, 36)*

In addition to abuse in childhood, two women in this group had both stayed in a women's refuge after escaping domestic violence as adults. Both women had children who were themselves in state care.

In addition to experiences of abuse and violence, many in this group also experienced a number of other forms of disadvantage:

- Five of these ten participants disclosed having substance use issues, either currently or in the past.
- Six of these ten participants had a diagnosed mental illness. One suffered from Posttraumatic Stress Disorder as a result of the abuse he experienced as a child.
- Only two of these participants had completed high school or had any post-secondary qualifications or training.

Of those five participants with acquired disabilities, four experienced ongoing homelessness after acquiring their disabilities. Only one did not, but he was in public housing at the time.

First experience of homelessness after the onset of disability

For three participants, their first experience of homelessness was after acquiring their disabilities. However, for Max (62), his homelessness was not related specifically to disability, but rather being forced to leave his home after his wife took out an intervention order against him for violence. He was told to leave by the police but not given any assistance to find alternative accommodation.

Ryan, 32, acquired his physical disabilities after a motor bike accident. As mentioned previously, he spent three and half years in hospital after complications with a gold staph infection which he caught in hospital. He was discharged from hospital into homelessness:

> *Once the hospital says 'yep you're okay all your vitals are fine you're out of here', the social workers tried but they've got bosses and that saying nup we need the beds see you later…. they go oh you're getting out of here go to [homeless service] and they'll help you. It's like you've just gotten out of hospital and the thing you want to do is just go home and get some rest but you've got to get out carrying all your stuff over here and … So you've got to go out and you've got to live in squats, yeah you've got to do all that or go to a friend's place and stay with them, whatever you can do…*I've *even sneaked back into the hospital into one of the hospital beds and spent the night, it took them the night to realise. (Ryan, 32)*

Damien, 51, was also discharged into homelessness after leaving hospital. Damien had worked as a real estate agent and was a home owner. He had separated from his wife and was living in a caravan owned by a friend before his accident. He described it as beautiful with a lovely view of the sea. He then suffered a drug induced stroke. His friends who owned the caravan he had been staying in did not want him to return to the caravan in case something happened to him. The hospital offered no support. He then cycled through unsafe and substandard boarding houses and private rental share housing. He also stayed with friends and family temporarily. Eventually he walked into a disability service that helped him to get housing by linking him with a homelessness service.

Those who did not experience homelessness, but experienced precarious housing

Four participants never experienced homelessness before their accidents but were precariously housed after their accidents. All of these participants had good support from family after their accidents and three also had well planned transitions out of hospital and into rehabilitation.

Jill suffered an ABI after a fall while living in her flat on her own. She had a particularly seamless transition from hospital back into her flat:

> *There was a lady, I don't remember where she came from or who she was, she helped me get the disability pension and the disability parking. I remember how she looked. I remember where she took me to get the form and she went to Centrelink with me and she filled the form out with my answers or whatever and that's how I got the disability pension. Where she came from, I have no idea. And the [hospital], they spent five weeks with me trying to walk up the stairs and*

walking, transport, different physiotherapy. How they got on to me, I don't know. (Jill, 57)

Her husband returned from overseas and she moved back in with him. He is her main carer. However, Jill has concerns about how stable her relationship is and does not know what she will do if it ends, making her situation precarious.

Greg (34) lived with his dad for two years after he acquired an ABI from falling down some stairs. He then moved into a Transitional Living Centre (TLC) for 5 months and now lives in private rental.

After his aneurism, Simon (49) went from hospital to a rehabilitation centre. From there he stayed with his mother for two weeks and then moved to a TLC for some months. Simon had glowing things to say about both the TLC and the support from his mother and sister.

Being in private rental, both Simon and Greg are precariously housed.

Another participant, Steven did not have a good transition from hospital, though he had support from his parents. He was discharged with no support after suffering from a rare brain tumour at 21 years of age. However he had been living at home with his parents prior to being in hospital and was able to return there. He experienced precarious housing when his parents subsequently separated and he lived in a caravan for a time, before moving back in with his mother at her new public housing property. Some years later he took over the lease on her property when she passed away, and has since had a transfer to another public housing property.

b) Current housing

Table 2 below shows that at the time of interview, only one of the 23 participants were living in their own home, seven were in public housing, three in community housing (including one community run boarding house) and three were living in private rental. Some people were accommodated in private rooming houses, one was in a Supported Residential Service and two were in transitional housing. One person was sleeping rough; another was able to stay on a couch at friend's place. One participant had left her accommodation that morning due to safety concerns and was looking for somewhere to stay that night.

Table 2: Participant's Current Housing Summary

	Number by Disability type
Owner-occupier	1 ABI
Public housing – Flats, units or bedsits	3 ABI 3 Physical 2 Intellectual
Public housing – Boarding houses	1 ABI 1 Physical
Community housing – flats	3 ABI

Community housing – rooming house	1 Physical
Transitional housing[2]	2 ABI 2 Physical
Private rental	3 ABI (1 also with physical)
Private rooming house	1 ABI 1 ABI + physical
Supported Residential Service (SRS)	1 ABI
Affordable housing for people with a disability	1 Intellectual 1 Physical
Primary homeless*	2 Intellectual 1 Physical

As indicated in Table 2, around half the participants had relatively secure tenure where it is accompanied by a lease that offers some level of permanency. This is usually the case with public or community housing and, to a lesser extent, private rental.

For those remaining participants, housing was more precarious given that tenure was likely to have been extremely limited or non-existent. This is typical of temporary accommodation such as transitional housing and boarding or rooming houses. Certainly, those who slept rough or 'couch-surfed' had no tenure at all.

Affordability

Several participants (n = 7, with either ABIs or Intellectual disabilities) had their finances managed by State Trustees and were unable to answer some of the questions regarding housing affordability.

It was only possible to ascertain housing affordability for around half the participants. They generally said their housing was affordable; this included some people who were in private rental as well as privately run boarding houses.

Others reported difficulty with the cost of their housing especially where they had incurred additional expenses. For example, one person in public housing was repaying a Centrelink debt:

> *I'm only living on like $230 a week. That's all I'm living on…most of the money I get from [my casual work] goes to my children. So I'm only living on like $230 a week, and then I have to pay for my food, pay for my electricity and pay for everything else…I mean I'm paying back Centrelink…for [my children] so I'm lucky to have $200 left a fortnight. (Debra, 41)*

Another had rent arrears to repay, which left very little to live on:

> *Yeah because I've been in and out of hospital still I've fallen in rent arrears and I owe them $1200. Now my normal rent is say $260 fortnight which you can cope with that and got about 150 left but I've got to pay money to catch up so by the time I do that I've*

[2] Transitional housing is managed by housing agencies, and usually involves a medium term or three month lease until other accommodation is found.

> *only got $40 left a fortnight to survive on and you can't do it. (Ryan, 32)*

Participants tended to prioritise paying their accommodation costs even though this often meant they could not easily afford other necessities. As one person explained:

> *I think your dole - it's not really generous and you don't get a lot but there's two things I've been bought up is you've got to pay your rent and your food first and then what you got left is your fun money, you know, if you want, yes. So they're always the priorities. (Zach, 39)*

Some people experienced difficulty because of the cost of medications and special dietary foods. For Max, who was living in public housing, this was a weekly struggle:

> *Yeah, I pay $130 a week…and once I buy all the celiac food and medications for diabetes and that, you know…you run out of money every single week, you know. Sometimes I go to the food vans, but I can only have the soup, because you can't eat bread, you can't eat sandwiches, you can't eat rolls, you can't eat pies, you can't eat pasties. (Max, 62)*

After separating from her husband and becoming financially stressed, Samantha (45) spoke about going without food in order to pay the rent and feed her dog:

> *That's when I had to go to Families SA and I was a wreck. I had to get them to pay a couple of my bills because I just couldn't do it. She did my financial thing and she said, "How are you surviving?" I said, "Well, Buster [her dog] is but I'm not." I'd go without food for him. Absolutely. He eats everything.*

Suitability

Participants were asked about the overall satisfaction and suitability of their current housing. Only a few expressed a high level of satisfaction about their current housing. Others reported a number of concerns. Some, for example, talked about concerns with security in the area or in the accommodation and lack of privacy. Some mentioned difficulty with location, either because it was far from family and friends or far from transport facilities, making things difficult to access.

In relation to particular disabilities, two participants with physical injuries experienced a lot of difficulty with stairs:

> *Yes but the only fault with it is the stairs. I'm finding it really difficult getting up and down the stairs. Because plus I've got L5 disk collapsed. So that's even making it a lot harder because it's in the lower spine. (Debra, 41)*

> *I keep going in for the knees, at the moment it's pretty bad, it comes good but because of the weather it changes. And living on the 20th floor doesn't help because if there's a fire or anything I can't get downstairs or not that many anyway…I've had a transfer [within the state public housing authority] for nearly three years now for a one-bedroom ground floor [unit] but still haven't got it which is pretty bad. (Robert, 57)*

For some, it was the poor standard of repair that was exasperating. One person, living in private rental, faced increases in rent while trying to get essential repair work done to the property without any success:

> *I've rung the landlord, I've rung her, and I've said what the hell is going on, why is there another rent increase, yet you haven't bothered coming around and fixing anything. The stove, two broken hot plates at the back, the oven light isn't working. I've got a shower, sorry a hot water system that's continually running, running, running. No-one is doing anything about it. I am not paying your extra rent. I am not going to do any of that unless you fix these things and here is your VCAT notice, 14 days to fix it. Still nothing and I've served them with that. I just got served a 60 days' notice that overrides everything. (Joshua, 39)*

Many people highlighted that they had particular housing needs as a result of their disability. Some struggled to achieve housing that met these needs.

Timely access to housing following the onset of the disability was considered especially important by those people with an ABI because as Tom explained, housing played an important part in recovery and being able to manage the disability:

> *I'd say the housing affected my recovery. I probably didn't get the right recovery because you'd moved…And what else is frustrating is with doctors and occupational therapists they were…trying to impress in me how important it is to have routine…lots of routine to stop me from getting frustrated, disheartened...I'd try…to manage injuries but because I was constantly changing environments and sudden change I found throws me off a bit… because my senses were a bit scattered I was sort anxious and that was causing anxiety and depression…it becomes fatiguing to constantly have to process it basically. (Tom, 37)*

Unstable housing compounded his health and mental health issues because he was unable to develop a routine which he believed was vital to his recovery.

Housing that is suitable or appropriate is also a key factor, whether it is related to the physical structures of the accommodation, for example no stairs, or access for wheelchairs:

> *Yeah, having a wheelchair was hard…[It took] about 12 months to find a house that… had the right sort of things for a wheelchair,*

> *but yeah since I've been out of my wheelchair my chance of finding accommodation has…been easier. (Greg, 34)*

For Simon location of services and public transport were top of the list:

> *Yeah well there's certain criteria…I would make sure that it had to be close to public transport, close to the shopping centre, and mainly public transport because I use public transport every day, and it's something that I didn't use for 25 years and all of a sudden…the public transport around [here] is fantastic. (Simon, 49)*

Joshua needed to live close to a particular hospital where he received ongoing care and hospitalisation in relation to his ABI, epilepsy and other ongoing physical health needs. Related to the chemical burns he experienced, Joshua frequently over-heated. This caused seizures and meant that Joshua needed to have housing which was air conditioned.

Jamie (34) found it difficult to find accommodation where he could keep his two dogs. His dogs were extremely important to him for his sense of wellbeing, and for a sense of protection after suffering posttraumatic stress relating to an assault. Unfortunately, he had lost accommodation in the past for having his dog there:

> *Um, got kicked out of there because a fella dobbed me in for having my dogs. I'm used to having my dogs… The [support service for ex offenders] bloke said, "You've got two options. You can stay and get rid of your dogs or take the dogs and go". I said, "Well you're not leaving me much of a choice". I took the dogs and left. Slept on the street for two or three months… If I didn't have my dogs, I don't know where I'd be. I'd probably be in jail for a long time or even worse. I don't know.*

When asked, Jamie said he would rather sleep on the street and be with his dogs than give them up.

Difficulty accessing housing

The dissatisfaction and disillusionment of failed attempts to access housing are clearly illustrated in the experiences described below:

> *Eventually everybody who has a disability will eventually be homeless in some period of their life because (a) there is not enough housing; (b) there is not enough public housing or social housing for anyone like that. If you have any kind of, and a lot of disabilities…You have marriage breakups, job ending, whatever so people can't afford to rent. People can't afford to actually pay for food, pay for bills, pay for all of that, so they end up being homeless and when you're disabled and you're homeless, well you may as well say, you're shit, you're in the crapper, because no-one is going to help you get out. You're on the bottom of the pile. (Joshua, 39)*

Debra's attempts to access public housing were frustrated by all the paperwork and bureaucracy, made all the harder because of her learning difficulty:

> *It's just how I come across with things; I misunderstand them with the reading. Sometimes I say "No, I don't understand that" and then they don't know what I mean by I don't understand something. I said "Well can you break it down so you can explain what it means?" and some of them just couldn't be bothered. So now I say "Right, what's the criteria of, what is the meaning of this?" and there's only one worker actually from [agency], one that's explained a lot more to me, and then that's how I got my place…Because it's taken me eight years to get…into the Ministry of Housing. (Debra, 41)*

In contrast to these negative experiences, only one person talked positively about their situation, saying that his disability had helped him with his housing:

> *With my condition, and I suppose I'm lucky in a way because…I got the transfer in eight months instead of five years, apparently it pulls a hell of a lot of [strings]. (Steven, 48)*

Problem with private rental – cost and discrimination

Many highlighted their inability to secure accommodation in the private rental market. This was in part due to the costs relative to their incomes:

Phillip (44) commented that he had never had private rental as he could not afford it:

> *Yeah if you're not earning a decent wage it's pretty expensive*

One person currently living in public housing spoke about his past difficulties covering the cost of private rental accommodation:

> *I've had private rentals, I had one in [suburb] but the rent is too much and you don't get much rent assistance or anything like that. Everyone thinks $100 rent assistance but that's nothing if you're paying $200 a week or $225 what I was paying that's $450 and you're only getting $100, it's a lot of money. And then you've got to buy your food and now the food [price] is going up. (Robert, 57)*

Discrimination by landlords in the private rental market was keenly felt by some participants. One person said:

> *If I came out with the fact that I'm on a pension they're not going to want to give you a house are they? (Ben, 28)*

Another reflected on a recent experience of submitting applications for rental units with his housemate (both with ABIs):

> *We were both on DSP, and we didn't get them, and I think it may have been [because] here were two men with disabilities looking for houses, we found that hard. (Greg, 34)*

Another added:

> *It's made other people sceptical I guess, 'Oh, he's on a disability. He doesn't work. How is he going to pay for the rent?' (Simon, 49)*

Experiences of discrimination in relation to housing were seen as part of a broader lack of understanding about the capacities of people with a disability. For example, one person with an ABI talked about how people assumed he was drunk because of his poor balance. Another person with an ABI described how he had gone to look at a private rental unit which was in shocking repair:

> *This bloke thinks well I've got a disability so he thinks I'm going to take the place. I said 'no'. I said '[you] need to paint, plaster the walls, paint them, do some of the woods and that'. He goes 'you know it's going to cost [you']. So I didn't take it. (Kieran, 47)*

Housing and Experiences of Homelessness - Key Points

- Many participants had extensive histories of homelessness.
- Some participants with extensive histories of homelessness also had repeated experiences of trauma, abuse and institutionalisation. Many of these participants also had histories of substance abuse and had diagnosed mental illnesses. These participants could be classified as 'having multiple and complex needs' in a service context
- Three participants had their first experience of homelessness after the onset of their disability.
- Four participants did not experience homelessness after acquiring their disability, due in the main to good exit planning from hospital and very supportive families. They were however precariously housed and at risk.
- Participants' disabilities and ongoing health issues meant that they had specific needs in relation to their housing. Some stressed the importance of timely and appropriate access to housing in recovery from acquired injuries and wellbeing
- Many participants reported difficulty obtaining any kind of housing
- A number of participants had difficult accessing private rental housing either because of the cost of this housing in relation to their incomes, or because of discrimination.

c) Informal support networks

We sought to understand the informal support networks that participants have and the kind of support they have received. To do this we asked participants about their relationships with family and friends, and where they go for help if they need it, be it someone to talk to, help with their housing, or other forms of practical support. We also looked at the role that friends and family played in participants housing/ homelessness histories.

The Importance of family relationships

Many participants had ongoing and strong connections to their families. These family relationships were a key source of emotional, practical and material support. Several had one or two key family members who were actively involved in their lives that was their main source of support – either an immediate family member, such as a parent or sibling, or an intimate partner.

Some participants commented on the role of family and intimate partners played in supporting them during housing crisis. Simon commented on the difference that having a strong and supportive family has made to him:

> *The only other people that were helping me look for a place where my family, my sister who has been amazing. You don't realise how much you rely on your family when something like this happens and they could have easily turned their back on me and they didn't. They've been fantastic and I owe them. I owe them everything. …I'm lucky that I've got good friends and good family and I'm blessed so I'm still alive. (Simon, 49)*

Ben said of his girlfriend:

> *But I mean if I was to get evicted from where I am now, I'd be, I don't know what I would do. I would be on, well my girlfriend wouldn't allow it but I'd be on the streets without her. I keep coming back to that thinking I'd be fucked without her. (Ben, 28)*

Others commented specifically on the forms of practical support that family and partners provided, including transportation to, and support with, medical and other appointments.

Jill had her husband, and to a lesser extent her brother, as her main support:

> *My husband is my chauffeur. He takes me to my doctors' appointments to here and picks me up…Without him, I would be up the creek…My brother lives in ... which is about five minutes by car away and he has come and helped me when I've needed it and that so and I've lost my parents. So that's my main connection. (Jill, 57)*

While many participants could rely on family for some support others were either reluctant or unable to ask family for support. Some did not want to disclose their living situations to family members because they were embarrassed or fearful it would cause distress to their family. For example, Ryan who was living in a particularly rough boarding house explained:

I won't tell my sister, she's come to the place I'm living in once at the moment and she just started crying as soon as she walked in there. (Ryan, 32)

Others commented on the importance of housing stability in allowing them to reconnect with family members. Robert had been estranged from his family since he became homeless many years earlier. For the past few years he has been stably housed and this stability has meant he could focus on reconnecting with his children:

But now I'm starting to see my kids again after 12 years and its making me think what I missed out on, I missed out on bringing the kids up and things like that. The oldest one was nine when I left and she's 34 now, it's a long time ago…Yeah I'm back in their lives, a phone call every now [and then] *it's good. (Robert, 57)*

Having only recently being housed in transitional housing near his mother for only a couple of months Phillip had taken on a caring role for his mother who had complex health issues and lived nearby. This participant had siblings but did not see them very much and they did not provide much assistance with the caring work or give much support to Phillip. Despite having an ABI, and only recently acquired housing, he was the main carer for his mother. Phillip reported that he didn't have any friends and had trouble asking for help.

State care and estrangement from family

As discussed earlier, six participants disclosed during their interviews that they had been raised in state care. For these people, relationships with family were more difficult. While four participants had contact with either foster or biological family members only one of these could actually call on a family member for support in a time of need.
Adam, who was currently trying to determine the identity of his biological parents, felt that he didn't belong anywhere. He commented:

When you are in a situation like this, you are just like a walking question mark; you're like a lost soul. (Adam, 36)

Joshua, who had moved through many foster homes, had connected with one family and regarded them as his family. Despite being in contact, they live in different states and he hardly ever saw them and did not receive much support from them:

Talk to my foster family on relevant dates as in like birthdays, Christmases, but otherwise, yes, since my accident I don't sort of go down there that much as I said and, to be honest with you, dad is now retired. He doesn't travel that much so I don't get to see him that much over here (Joshua, 39)

Friendships

Ryan commented on the friends that he lost after his accident and the depth of the friendships he had formed since becoming homeless. For Ryan it was the recognition that these friends gave him and the opportunities to provide each other with mutual support that was so important.

I did have a lot of friends when I had everything but when everything is gone I have one friend that hung around out of about 40, one of them. But I tell you what in the places I've been going people on the streets and the friendships I've made are much stronger than anything I've had in the past. For example my birthday back in January like from friends, family and that nothing but I had people from the street turning up with bloody gifts and that; they can't afford to do that. You're recognised. Like I look after a lot of people, a lot of people can't look after themselves with an altercation or anything like that and I'll step in and I've taken a couple of guys where I'm living looking after them. But yeah you build a lot of good friendships (Ryan, 32)

One participant had few friends as most of his friendship circle was focused on using drugs and drinking, and he had distanced himself from them in the process of getting clean:

I sort of, I've let everyone go and I've just not wanted to meet anyone else because just the sort of people I attract are the bad people that are going to want to bring me and want to do things that are going to get me in trouble and I've been trying to stay away from that shit. And it is not as easy as it sounds. I've only been doing it for so long. (Ben, 28)

Debra commented that while she had friends, she generally kept to herself and liked to try and keep busy as a way of coping:

Yes, I talk to a couple of friends of mine but I just try to keep to myself. Try to keep my privacy up so I can get to work and this – that's why I work seven days a week. (Debra, 41)

Social isolation: having no one

In some cases (n = 5) people had no one to turn to for support. Joshua explained:

I've just got to a stage where I physically want to work. I physically want to get out and socialise with people because I have no social life. The TV is my best friend…yes, my TV is always there for me…I am simply on my own with no one, no help, no nothing so they're the cards I am dealt. (Joshua, 39)

Another participant commented:

Three weeks I spent in hospital after the stroke, I had not one visitor. Not one. I made my own visitors up by getting in touch with a priest who had a church on the ground there and he'd come to visit me (Damien, 51)

Informal supports and homelessness

Around 10 participants had stayed with friends or family during a period of homelessness. For five of these participants, staying with friends and family was a short term stop gap which was interspersed with sleeping rough, squatting and staying in cheap hotels/ hostels. A further two participants stayed briefly with family after exiting prison.

While some had been born with intellectual disabilities, all those who had acquired their disability in adulthood had been homeless prior to acquiring their disability. For these participants staying with friends and family was a short term stop gap that provided basic shelter but did not prevent ongoing homelessness.

Three participants lived with family longer term (years) after their accidents. These participants had not been homeless before acquiring their ABIs. In these cases, family provided protection against ongoing homelessness.

Informal Support Networks - Key Points

- Family members were critically important in providing informal support to this group
- Family support (either biological or foster) was limited for those participants who had grown up in state care
- While some participants had friends, there was a limit to the support that friends provided
- Some participants were particularly socially isolated and had no one to talk to or turn to for help
- In some cases family offered protection against homelessness by offering long term accommodation. However most commonly for these participants friends and family provided short term shelter during periods of homelessness.

d) Service Systems

This section explores participants' experience of various service systems. It describes positive experiences where participants had their needs met, as well as cases where participants were not cared for appropriately. It also looks at the difficultly participants' experienced finding long term housing solutions in the homelessness services system.

Services accessed

As a result of disability and experiences with homelessness, participants came into contact with a range of services, including:

Housing and homelessness services

- Homelessness services
- Community Housing Agencies
- State Housing Authorities
- Domestic Violence Services

The justice system

- Prisons
- The Court System
- State Trustees

Health services

- Centrelink
- G.P.s,
- Nurses,
- Hospitals,
- Allied health (such as physiotherapists)
- Psychologists, Neuropsychologists
- Disability Services
- Drug and Alcohol Services
- Mental Health services

Other services

- Day centres
- Material Aid providers
- Child protection (for their own children, or themselves when they were children)
- Domiciliary services (home help)

Positive experiences of services

Participants reported some very positive service experiences, including: the range of assistance available at some services; the committed advocacy of specific organisations and workers, the timeliness of service responses, and the skill and expertise of some workers.

For example, Ben was very happy with the range of services provided on site by a housing/homelessness support agency:

> *And I thought they were grouse. You could go there with an issue and there would be people in all different areas to be able to sort those issues. I mean I thought who invented this, this is the coolest. (Ben, 28*)

The dedicated advocacy of specific organisations and individual workers was observed and affirmed by some participants. This advocacy had practical, material outcomes for participants. Importantly, it also demonstrated that their workers had recognised and responded to their very real needs.

For example, Debra's public housing application was rejected after a supporting agency did not/was unable to contact her when an offer was made. Fortunately her housing worker at another agency vigorously followed up with the Victorian Office of Housing:

> *And with [service name], one of their workers is fighting to get me back on the list. It took the lady two months and I had my place, yes, she fought very hard. Now she's left there and it's a shame because she was a good worker. (Debra, 41)*

Damien described how the head of an organisation came with him to court when his support worker could not attend and helped work out a plan for him to repay outstanding fines and avoid prison and the Sherriff:

> *I had this thing come in the mail that they were gonna arrest me from past fines that I hadn't addressed, And it was either address these fines, it was $5,200 or, I had a Sheriff come around saying "you need to do something about it". So, [the Head of the agency] picked me up, went into town, he knew the situation and he's not the type to look his nose down at people. [He]'s standing there, he's the head of the [agency] next to me, [while] I'm telling the story to this teller. I now have got no warrants any more, and I'm paying $30 a fortnight for this $5000-something I owe. And when it's all finished I'll just bank… First time too in the last two months, I'm able to bank every fortnight. Not a lot, but, $20, is something. (Damien, 51)*

The skill and timeliness of response of some workers made a big impact on participants. For example, it was Ben's drug and alcohol counsellor that recognised his ABI and immediately referred him on to be assessed by a skilled practitioner:

> *The original drug and alcohol counsellor saw, was noticing that when I was coming back to see a doctor the third and fourth time, I wasn't even remembering meeting her the week before and she goes "You've seen me three times" and I'm like "No I've never met you before". And she's like "Well", and that's when she put me onto this lady who specialises in this stuff. And then this lady took me somewhere else and then, yeah I mean*

apparently it's being getting drilled into my head that I've got this ABI thing. I wouldn't have known, I just thought I was stupid. (Ben, 28)

For Robert, the timely response of a nurse from a local service was critical to his care, in terms of recognising how ill he was:

The nurse rang me that morning actually and I had a bit of pain in my back and she rang the ambulance straight away. Well the ambulance came and I ended up in hospital for 14 days with pancreatitis. …Yeah, if she didn't call I wouldn't have done anything; I would have just lain on the couch. (Robert, 57)

For Simon, the State Trustees have been particularly responsive to his immediate needs:

Oh yeah, and if ever I need anything extra, all I have to do is ring the State Trustees and they if I say listen I need, I'm going out on Saturday night and I need an extra $50 and I need it because we're going out for a meal and I want to buy a present for a birthday, they will put the money straight into my account., (Simon, 49)

The appropriateness and quality of the service system response to their situation was noted by some participants. For example some had well supported transitions from hospital after acquiring their ABI; two participants also gave rave reviews of a Transitional Living Centre (TLC) where they stayed. One described it as pivotal, while another stated that his transition out of the TLC into private housing was smooth and supported.

Practical assistance was highly valued during these transitions. Debra described the assistance she got from one service with reading and writing as "great".

Some participants had strong connections to particular services and said they would go there if they needed anything or needed to find out about other services.

The role of services in creating a sense of community and belonging

When asked about where they would turn for support – be it emotional support, advice, financial support, help with their housing, or assistance to find services – around a third of participants said they would contact a service. Many talked about services that had gone above and beyond, or particular workers they had connected with strongly who made them feel valued and that they were part of a community.

Damien turned to his GP for help when he needed it:

I could do it through my doctors, 'cause they had the social worker who visits them…They virtually were like neighbours for me with my tablets. They saw my dilemma I was in, got my tablets. I now go in there once a fortnight to get a dose set, day and night…And they're lovely people there. (Damien, 51)

Zach would turn to his disability worker:

If I was sick I would probably ring up my disability pension people and they're real good, they give me lifts and help pay or whatever, or work things out if I needed them. (Zach, 39)

Jill was in contact with one key service that had played an important role in linking her into other services. She stated:

I wouldn't even know where else to go and I just assume that [worker] would know where to look. (Jill, 57)

Some people had a strong sense of belonging at a service and the community of people who regularly attended at that service: For example, Sam felt a strong sense of community at a day centre:

Like, for example, you have no cigarette. Sometimes they give a cigarette and I give them cigarette. And besides that, these people here sometimes have the room, have a flat, and one time it's raining and because he is my friend he says [Sam] you can sleep my place, but just only for two days, or two nights, because I am in trouble with [agency]. So I sleep there for two nights and then I go away…Yes, I have friends. I have plenty friends. I love this place. (Sam, over 50)

For Robert, one service not only offered him material aid but crucially provided him with a strong sense of community and, the capacity to participate as a volunteer.

Yeah that's pretty good; that keeps me active and not thinking about other things like being lonely, it gives me something to get out. That's why I come here every day when it's open. I come here and volunteer and play pools and things like that…Yeah, I normally come here so I get my food here and if I ever need a loan or something I can always get it from here; I get clothes from here if I need them if they've got my size. This place keeps me going, it's not like the old days when I used to drink I used to feel sorry for myself but I'd just keep drinking. Now it's a couple of drinks and stop, which they're all proud of me now and I'm proud of myself too. (Robert, 57)

One participant talked about being in a band at a service he went to regularly. Another talked about the strong connection he had with other service users at a disability service for people with an ABI:

All the members, we all have the ABIs and we're all in the same boat, and we're all friendly. We all understand one another…Yeah, since the injury it's probably the best thing that's ever happened to me. (Steven, 48)

<u>*Navigating the service system*</u>

Participants commonly reported they had had great difficulties navigating the service system, even when they were in regular contact with some services. Many described difficulties finding out about needed services, and their entitlements. Many of those who did manage to source the range of needed services had only found out about them incidentally or through word of mouth.

Some commented they initially had no idea where to get help:

I didn't even know that you could get rental assistance from Centrelink. I didn't know. (Max, 62)

It was not uncommon for people to spend some time when first experiencing homelessness not knowing where to go to help or who to turn to. For some this took years.

Others found themselves having to learn how to live with a disability as well as having to navigate complex service systems on their own:

> *I was like, any help I got was off my back, of me making phone calls and saying, hey, help me out, what's happening, I'm lost here, no one - I'm on my own here. What's going on, you know? It's the only reason why I got help, yes. (Zach, 39)*

Navigating a complex service system was made more difficult by services sometimes giving conflicting information. As Debra explained:

> *I went up to the [service] not long ago and I said "Oh, look I need some help to get some bombs for cockroaches. I've got cockroaches, big ones". "Oh, we don't help in that". I said "Beg your pardon. I got told by Ministry of Housing you can help". And I said "Well I'm sitting here until you do help". (Debra, 41)*

When services and institutions failed to provide appropriate support

Some participants had particularly negative experiences with services and institutions. The costs of large institutions failing to provide appropriate care or support have been significant for participants. Services and institutions failed when appropriate support or follow up was not provided, or there was no link between different services they received.

Two of the participants who acquired their disabilities through workplace accidents had not received compensation through WorkCover.

Sam, who acquired a serious back injury, had made a WorkCover claim and went to court with his previous employer. However, he did not complete the process as he found it too stressful, and became depressed:

> *My mum is still alive on that time, my mum said to me stop that work [name], stop that one because you are the same and you have – because I was depressed, I was worried, I couldn't find a job… That's why my mum said stop that one, any way you can get the money from the government and if you win you have the money, but you cannot get anything in the government. So I listen to that advice of my mum. So I told to that just ignore everything as long as I can get the money, a little bit money in that way. (Sam, over 50)*

Another participant, Joshua, had workplace injuries that were extremely severe, including serious head injury and ABI. He died but was resuscitated in the ambulance on the way to hospital. Despite being hospitalised for months after the accident, he was never given information on how to apply for WorkCover – from his employer, or staff at the hospital. His brother attempted to get information from his employer but was 'given the run around'. Joshua has never received any compensation for his injuries.

Despite prison staff knowing that Phillip had been homeless prior to his incarceration; he received no support to find housing after his release. He left prison and became homeless:

> *But I was going in and out of jail, just to be somewhere to stay or trying to get them inside to help you with the housing, coming out, and they'd do nothing for you in there. And yeah they normally just throw you out and that's it. (Phillip, 44)*

Another participant who was in hospital for years following a motor bike accident was discharged into a situation of homelessness:

> *But I was going in and out of jail, just to be somewhere to stay or trying to get them inside to help you with the housing, coming out, and they'd do nothing for you in there. And yeah they normally just throw you out and that's it. (Phillip, 44)*

Another participant who was in hospital for years following a motor bike accident was discharged into homelessness:

> *No, they go oh you're getting out of here go to [homeless service] and they'll help you. (Ryan, 32)*

When TAC coverage ended for Ryan, and he was still in hospital he was told to apply to Centrelink for his income. He received no assistance from the hospital:

> *I applied for DSP and as I said and I've been knocked back and I thought going from TAC which is a form of a disability payment which it is. I would have been taken straight off that and put straight on DSP but no they just cut you off it after three years and I'm still in hospital and no you've got to apply for New Start or Disability…I was actually in hospital at the time I had to hop on the tram and go down to the Centrelink office, put in my application and get back to hospital. (Ryan, 32)*

Some services did not ask whether people had disabilities and two participants gave examples of staff in services refusing to read written information to them, even after they asked for help explaining that they had limited or no reading.

Another participant stated that he was moved on from a hostel specifically because he had an ABI and received no substantive help with his accommodation.

Difficulty gaining desirable housing outcomes

Participants acknowledged that there was a limit to what homelessness services could do given that they were overburdened and struggled to supply housing for people in need. As Simon stated:

> *Yes, because they can't produce wonders when they're not there, when there's no housing and stuff like that, there just isn't none, you get what I mean, and it's not their fault. They're still trying as hard as they can. (Simon, 49)*

The state of the homelessness service system meant that a number of participants who accessed it had to wait a long time (years) to be placed in permanent housing, and in the meantime stayed in housing that was less than ideal.

Some participants (most with physical disabilities) had particularly poor housing outcomes through the homelessness services system and were placed in substandard, unsafe housing.

One participant left his community housing unit of many years because of significant safety and security issues with neighbouring tenants and a lack of response from his housing provider to his concerns. He went to a number of homelessness services to ask for help but was told his best option was to stay. He said:

> *But now I am homeless, compared to that place it's better to be homeless than I stay there. (Sam, over 50)*

Another participant was sent to a notoriously dangerous privately run rooming house. He said:

> *Mate you're better off just going up there and just put a gun to your head instead of putting up with all that shit, why don't they close that place shit hole down.. As soon as you walk in the door, "Oh do you want school? Oh, have you chosen? Do you want this? Do you want that? You got a cigarette? You got cab?" No wonder person just likes to hit him sometimes. You got all your junkies there. You got your pill poppers there. You got your hookers there. (Adam, 36)*

Ryan, who was still recovering from significant injuries after discharge from hospital, was staying in a community managed rooming house and also had safety concerns. He reported there had been three murders in the building in the last few months.

Another participant with an ABI had stayed in an unregistered boarding house and commented that his worker was unable to visit him there due to safety concerns – yet he was expected to live there. This negatively impacted on his recovery:

> *Yes well one place, as I said it was an unregistered boarding house and the actual support worker I had in [suburb], they actually stated, their boss stated that we can't send our support worker to there because the place isn't registered and it's not safe. If it's not safe for them is it safe for me to live in there a person who's got ABI. (Tom, 37)*

Two participants (Both with ABIs) talked about their experience being placed in medium term share accommodation by homelessness agencies. Both found their housemates particularly difficult to share with. Ben explained:

> *Well he would and or he would like come home at 2:00 in the morning and turn the stereo up and just be completely, and I'd come flying out of my room and just be like hey dickhead, pull your head in, I'm asleep. And because I'm trying to change, because I've got my son now, I don't want someone around anyway that's going to be like that around kids…..(Ben, 28)*

Ben was also concerned about having his medication and possessions taken by his housemate.

Joel also found his housemate difficult to live with and as a result his housing broke down again:

I lived in a house that they got me with a guy but I found him very hard to live with. He was the guy that kicked me out after I swore too much. I swore four times in a day and he thought that was too much. I found it hard to live with him anyway because he only said five words a day and it was just bizarre, very bizarre. (Joel, 37)

Another participant expressed his frustration about time limited stays in crisis accommodation which ultimately means people cycle in and out of crisis accommodation as homeless agencies struggle to find housing for clients:

Six or four weeks they are not going to give you a place in four weeks. They are not going to give you a place in six weeks. They're just going to chuck you out, put you in a motel for two nights back, five days on the streets and you got to ring in and if you don't ring up, they ring up, and then you got to ring up, that's when you say shove it because I'm not going to ring up anymore. (Adam, 36)

While some participants (n = 11) were in public housing at the time of interview, many were waiting for housing to be allocated and had been waiting for years, some more than a decade.

Some participants reported problems with lost applications and paperwork and simply not knowing when, if ever, they would receive public housing. Two participants had had their applications lost by state housing authorities and after long waits had to start the process over. Kieran requires help to do this:

I got in contact with them a couple of times and they said your file was moving up. Your file was moving up. Fifteen years later, where is it? They lost it. It's in the bottom. Lost it. (Kieran, 47)

Two participants were currently in public housing but required transfers due to medical conditions. Robert (who has a physical disability) commented on the wait time and the risk to his health and safety created by the delay.

I keep going in for the knees, at the moment it's pretty bad, it comes good but because of the weather it changes. And living on the 20th floor doesn't help because if there's a fire or anything I can't get downstairs or not that many anyway…Yeah they turn the lifts off so it's pretty hard that way. I've had a transfer in for nearly three years now for a one-bedroom ground floor but still haven't got it which is pretty bad….now they want more docs' reports which is ridiculous because I've already handed them in twice. They give me the one first and then they swap and they lose them and then you've got to get new ones and now they want new ones again. It's not my fault they're losing them; they should put it on a computer. (Robert, 57)

Debra required a transfer but had not yet put in the paperwork that was required, and with her limited reading and writing ability this was most likely not going to happen without support from a worker – which she did not have.

When another participant was told that he would be waiting five to ten years for a transfer within public housing, he simply left:

Because I suffered sciatica, I couldn't get up and down the stairs so I had to hand the keys in…They said we'll give you transfer in five to ten years. I said,

"See you later there's your key, bye" and walked out. What's the good of having a place if you can get up and down stairs? (Adam, 36)

Two participants had not received public housing because they had not been able to keep in contact with the state housing authority. In one case this was due to homelessness, and in the other because the participant was moving between prison and homelessness. However, in both cases housing workers from homelessness services have ensured these participants are back on the wait list.

A couple of participants had accessed public housing in the past and were repaying debts from failed tenancies so they could re-access public housing.

Service Systems - Key Points

- Participants accessed a wide range of services
- The service system provided a lot of positive support for participants, in terms of range of support, and the dedication and commitment of particular services and workers.
- Some services also provided a sense of community and belonging for people
- Finding out about services was challenging for many and occurred often through word of mouth. Initially many participants had been unsure where to go for help.
- The consequences for participants when services and institutions failed were severe. This included homelessness, stalled recovery from injury, and getting lost in the system.
- Obtaining desirable long term housing outcomes for participants through the homelessness and housing systems was extremely difficult, with participants often spending significant time in accommodation that was unsafe, substandard and inappropriate to their needs, in addition to long waiting times for public housing.
- From these participants' stories, it seems that the homelessness system itself is fraught and not conducive to good housing outcomes, with good outcomes only being achieved through the dedication of particular workers and in some cases luck.

e) Participant views on what should be done

We asked participants what they thought should be done to address homelessness amongst persons with a disability. Participants' suggestions fell broadly into three categories – improving access to housing, addressing costs of living, and improvements to services.

> *Maybe be a bit more sympathetic towards us, and just try and look at it from our point of view, it's a very scary world out there with those of us with the ABIs. (Steven, 48)*

More housing

A number of participants indicated that simply having more housing would help in alleviating homelessness amongst persons with a disability. One suggestion for addressing the lack of supply was to reclaim abandoned or disused buildings.

More affordable housing

A number of participants commented on the difficulty in finding appropriate low cost housing. For them, the solution was to increase the supply of quality housing, making it affordable for people living on a pension.

> *Well first of all the cost of living (on a) disability (pension) doesn't cover it. The government says you have to have 55 percent of your income allegedly towards rent where now if you actually go to get a property there is no 55 percent of your income. For single people there is nowhere where you can get 55 percent of your income if you want to live by yourself that is. (Joshua, 39)*

Decent quality housing

Ensuring that people were placed in housing that was of a reasonable quality was raised by some participants. They commented that quality housing made people feel included and gave them pride:

> *Low income people shouldn't just be put in draughty old houses they should be put in something that's... because it comes down to the motivation of them feeling like they're being included too…that's something that I've definitely noticed, the quality of housing dictates, it doesn't necessarily but it does affect how people behave and they've got no pride. (Tom, 37)*

Housing specifically for persons with a disability

George (42) suggested housing specifically for people with disabilities. Ryan explained the importance of this given that homelessness services don't have the resources to provide additional assistance to people with disabilities:

> *Places like [service] and that with the amount of people going in and out of there they can't concentrate solely on people with disabilities so as long as they've got them in off the street…… I don't know maybe if you had some funding where you could just have a small team that could concentrate on people with disabilities or something like that that might help. (Ryan, 32)*

Another participant felt that homelessness services often simply found the first available bed for people without much concern for how appropriate that housing was for that persons needs.

More assistance to find housing – additional support

A number of participants commented on the difficulties they had had trying to access private rental. Some had made numerous applications to no avail because of the high demand/ competition for a limited number of available low cost rental properties. This competition made people on a pension less desirable tenants compared to those on a wage. Participants suggested there needed to be more assistance to access private rental to overcome these barriers.

Joshua commented on the difficulty of obtaining private rental without a rental history after a period of homelessness:

> *As I said we can't afford to live on disability and we can't afford to live, if your homeless, you will not and that's the other thing too, if you're actually homeless you will not be accepted by a real estate agent into a house because there is no prior rental market. So unless you have someone that is willing to lie for you you're in a catch 22 too. (Joshua, 39))*

Cost of living

Participants reported difficulty meeting the cost of living on a pension, with some accessing material aid occasionally to get by despite being in public housing. This was partly about housing, but also about the cost of other items such as medications, food and bills. They wanted to see an increase in the rate of DSP and increased subsidies for medications.

Joel commented:

> *I've written to Julia Gillard about this but I haven't heard back….. I told her I think there should be a raise in the disabled wage. I think they should throw out the idea that we only get paid $1.50 - $3.50 an hour and that we at least earn as much as a McDonalds worker who earns about $5 an hour or something thereof even as a teenager because the cost of living is just getting ridiculous nowadays and if disasters keep happening, I don't know even if I'll be able to keep my job at [my causal job] because some people look at your nowadays and say I can't afford it. And that's the reality of it. (Joel, 37)*

Employment and training

Joshua expressed his frustration at wanting to work but being told by Centrelink that he was assessed as having 'volunteer only' capacity. This had meant being given no assistance to find work. As he explained:

> *Okay, it is volunteer work, they don't want me to get paid for it, how the hell I am meant to get ahead in my life?...I've gone to Centrelink for help. They've said they can't help me. I've been to probably six or seven other different joints and said to them, 'look I've got a disability, if you're willing to take me on for a couple of weeks. You know I'm serious about showing my attitude to this job, would you be willing to employ me if things work out?' (Joshua, 39)*

Another wanted to see funding set aside for persons with a disability to help fund further education and training and to give them additional help to find work:

> *Because I think in a lot of cases people with disabilities could do better jobs than just doing menial tasks in places like disabled factories. (Greg, 34).*

Health outreach to people's homes (and to homelessness services)
One participant commented on the importance of having health services come to them, and having someone check on them:

> *We used to get our blood pressure checked and things like that and they used to come to our houses and see if we were alright, if we were missing for a week they'd come see where you are. That's what the disability need more people to check on them. (Robert, 57)*

More workers, time with workers, consistent workers
On the one hand, some Participants wanted to see more workers at services to make it easier to get support, and be able to keep the same worker. On the other, Christine had had so many workers she found it difficult to remember who was who. She estimated she has had 18 workers in the last eight years.

Ben explained the difficulty of changing workers all the time:

> T*he same worker, not bouncing around, …and having to explain your story to each different person, because I've had a whole bunch of housing workers, it's like their turnover for staff is really high, it's like every six months they go offload you and they get a whole bunch of people, it's really frustrating. That's really frustrating because if you get someone that knows your story and actually does do that job, it's really helpful. (Ben, 28)*

More inclusiveness and effort in working with people with a disability
Two participants in particular had extremely limited ability to read. Both of them commented on the variable experiences they had with services – homeless services in particular. Some services had sat with them and read information to them and explained the content to ensure they understood their rights or how a process worked. However, both had had experiences of services that had refused to read material to them, even after they disclosed they could not read.

More information on where to get help
A simple and practical suggestion was for more information on services for people who are experiencing homelessness and disability in forms that can be taken away. This was particularly helpful for persons with an ABI who had short term memory problems who may have difficulty remembering new information about services they have been given verbally. Participants also wanted more information about where to get help generally.

Less restrictive eligibility criteria for disability services
Two participants gave examples of being told that they were not eligible for support from disability services despite clearly having disabilities and requiring assistance. Joshua explained:

> *…My acquired brain injury I have seizures with it so I don't fall under the ABI categories. Epilepsy, I don't fall under the epilepsy guidelines because I have an acquired brain injury. So they're technicalities where they just sort of, how do you put it, rephrase or refresh the words just to make them sound better for themselves…But Centrelink they've got a social worker who refers you out to somebody else. The social worker couldn't refer me*

to anybody…I was very lucky that I was referred to here [homelessness service] and got to speak to [worker] otherwise, yes; I don't know where I'd be to be honest with you. (Joshua, 39)

Participants also wanted to see ongoing support for persons with a disability who required or wanted it, including in some cases 24/7 support where people had severe disabilities and health issues.

Improved processes within State housing Authorities regarding applications and transfers within public housing

Most participants had had some experience dealing with state housing authorities around public housing. Participants frequently reported feeling frustrated with the process involved in applying for public housing or requesting transfers. They felt that processes were not transparent and that paperwork was often lost and had to be redone. Adam stated:

Well, we put an application these days and just leave you hanging off of a piece of string if you're going to do anything you are better off doing it yourself these days because you've don't know where the paperwork is going to go you don't know whether the person's filed it that day, whether it's going to be sitting in the back of the file and they should be on to it. (Adam, 36)

What should be done - Key Points

Key changes and improvements participants wanted to see included:

- More housing that was appropriate to their needs, affordable on their incomes and of a decent quality
- Housing and housing support specifically for persons with a disability
- Improvements to cost of living through an increase to the rate of DSP and increased subsidies for medications and bills
- Additional support around employment and training
- Increased health outreach services
- More workers and being able to keep the same workers (across service types)
- More information on where to get help – and information in brochure form that they could take away
- Easing of eligibility for disability support
- Improvements to processes surrounding Public Housing

4.3.4 Discussion of Key Themes

The second phase of this research looked at the prevalence of risk of homelessness amongst persons with a disability and found that disability heightened the risk of homelessness, and that specifically persons with intellectual or psychiatric disabilities were more at risk of homelessness[3]. This phase of the research focused on a small sample of persons with a disability who had experienced homelessness in part to understand why this group is at higher risk.

Using semi-structured qualitative interviews with 30 participants we explored people's housing and homelessness histories and the relationships between their experiences of homelessness and their disability. People's experiences of services, their informal support networks, and what they thought should be done to address homelessness amongst persons with a disability were also examined.

Persons with a disability who experience homelessness

Given that so little is known about this particular group, the profile of participants is an important finding in and of itself.

While five participants had intellectual disabilities since birth or early childhood, and one had a physical disability since childhood, most had acquired their disabilities later in life. Most commonly this was an acquired brain injury though some had also acquired physical disabilities in adulthood. Some participants had multiple types of disability and around half the participants also had psychiatric disabilities. The increased risk of homelessness amongst persons with intellectual or psychiatric disabilities identified in the quantitative analysis was certainly reflected in our sample (tellingly, this was also despite a focus in recruitment on primary disabilities that were not related to mental health).

Disabilities impacted on daily life in the most basic and profound ways

Persons with intellectual disabilities found reading and writing, including completing forms, and dealing with large services systems quite difficult. Those with ABIs had trouble with their short term memory and organising their thoughts. This made it difficult to handle basic aspects of self care, such as eating, taking medication and getting to appointments. Some also had trouble with dizziness and balance.

Routine and stability were particularly important for these participants in managing their disability. Those with physical disabilities had issues specific to their particular impairment – for some their main difficulty was mobility and ongoing pain, for another it was using his hands. In addition to their disabilities, around half of the participants also had significant ongoing health issues.

Most had an employment history

The vast majority of participants had work histories, with some currently in casual employment. As is to be expected, participants who acquired disabilities later in life tended to have more substantial work histories. Conversely, those with life-long Intellectual disabilities had less work experiences and lower educational attainment.

[3] Note: we acknowledge that persons with a psychiatric disability were outside of the direct focus of this research, they were included in a limited sense in the quantitative phase of the project for the purposes of comparison and context. The very high prevalence of homelessness risk for this group does therefore necessitate their mention in this phase 3 report.

Around half the participants had completed some kind of post-school training or qualification.

Extensive histories of homelessness and multiple and complex needs
Examination of participants' housing histories revealed that their experiences fitted into one of three distinct groups. Of those participants who acquired disabilities later in life, some had their first experience of homelessness or precarious housing after they acquired their disability. However, most had histories of homelessness (many of them experiencing homelessness for many years) prior to acquiring their disability. Further analysis revealed a clear sub-group that experienced multiple and intersecting forms of disadvantage prior to acquiring a disability. All but one of the participants with an intellectual disability since birth or childhood fitted into this group as well. This group appears to be the client group commonly referred to as having multiple and complex needs.

Four key themes emerged from this phase of the research:

a) The importance of housing,
b) the role of informal networks,
c) the importance of good service provision, and
d) the severe consequences of services system failure for this group.

a) The importance of access to housing

Those with a history of homelessness continued to experience homelessness after the onset of disability. Many participants had experienced intermittent homelessness prior to acquiring their disabilities. This experience largely continued after their disabilities were acquired. There were few people who had never experienced homelessness.

Of those who never experienced homelessness all were precariously housed after acquiring a disability. Family support was key to preventing homelessness among this group. Crucial, too, were planned exits from hospital. While family, and sometimes friends, offered protection against homelessness, generally they could only provide short term shelter at times of crisis when homelessness was imminent.

Many participants had lived in housing that was unsafe, substandard and unsuitable. A number of participants had been referred to boarding or rooming houses, transitional and share accommodation through the homelessness service system. Participants typically faced significant wait times for longer term (both community and public) housing.

It was extremely difficult for participants to obtain any kind of housing. And it was difficult for them to gain desirable long term housing through the homelessness and housing system.

Participants' current housing was not always suitable.

Their housing at the time of interview was not always affordable or suitable to their needs. This had a detrimental effect on their ongoing recovery and, for some, contributed to their ongoing health problems.

b. The role of informal networks

Informal networks of friends and family provided emotional support, community connection and practical assistance. Some participants relied heavily on family for practical support.

Key friendships for participants seemed to be with people who had been through similar experiences – such as those at a day centre or specialist service for those with an ABI.

Some participants had no social support network, and these tended to be people with the most complex histories who required the most support.

c. The importance of services

As a group, participants accessed a wide range of services. This is consistent with the multiple needs of this group.

Committed advocacy and being able to offer a suite of services made a key difference to participants' lives. Participants gave a number of examples of the positive impact of services on their lives. This was largely due to the range of support offered by services and the dedication and committed advocacy of particular services and workers.

Some services also provided a sense of community and belonging for people. Day centres where people could socialise as well as access formal support and material aid were key to people's sense of well being and connection

d. Complexity of the services system and service failure.

Many had difficulty initially finding out about where to get the help they needed.
Some services failed to provide basic information about and referral to other services. Many found the support they needed through word of mouth or incidentally. Some had significant periods of time, particularly at the point of crisis (e.g. following acquisition of their injury or housing crisis), where they had no idea where to go for help, especially in relation to being homeless. As indicated previously, for some, this period lasted for years. It seemed there was a lack of information on where to get assistance with homelessness and housing. Other services did not always make appropriate referrals for housing and homelessness support.

Participants that needed more information on where to get help needed it in a form that could easily be taken away and re-read (such as in a brochure). Again, this was particularly relevant for those with short term memory problems (e.g. from an ABI) or difficulty reading.

Poor housing outcomes were due in part to a shortage of housing. Participants felt that there was an acute shortage in low cost appropriate housing available for services to place them in. There was simply nowhere to go. From participants' stories, it seems that the homelessness system itself is fraught and not conducive to good housing outcomes. Where good outcomes were achieved, it was primarily due

to the dedicated advocacy of particular workers. When asked what should be done to address homelessness amongst this group, participants wanted to see an increase in the supply of housing that was appropriate to their needs, affordable on their incomes and of a decent quality. They also wanted to see improved process around accessing and moving within public housing.

The consequences for participants when services and institutions failed were severe. There were cases of people being discharged from hospitals and prisons into homelessness, further compounding their trauma. Some participants were excluded from services through discrimination. Others were left in limbo after failing to be referred on for appropriate assistance despite being in obvious need. In these cases it seemed that no particular service or institution took responsibility for these people.

4.3.5. What we don't know

This qualitative component of the research has given us a more in-depth understanding of the experience of homelessness and services amongst persons with a disability. However, significant gaps in knowledge still need to be addressed.

Auditing of current policy context and services available
It is difficult to make substantive recommendations in relation to policy and service responses without first gaining a clear understanding of the existing policies and services operating for this group. Specifically we need to know more about: existing disability services, the operation of current homelessness and housing services, and other service systems such as State Trustees, TAC and Worksafe. We also need to know more about the intersections between these services systems.

Service gaps for specific sub-populations
There appeared to be gaps in existing services for sub populations of participants – for example ongoing support for adults with intellectual disabilities, ongoing support for non-drug related ABIs, and ongoing support for those who have grown up in state care.

Barriers for services in providing assistance
We also need to know more about what barriers services may face in providing support to this group. This includes understanding if services require further training for staff in how to better respond to the needs of this group, and whether additional resources such as specialist workers are required. This was particularly pertinent for prisons, hospitals, homelessness services, and the Workcover and TAC systems.

Given that persons with a disability, in particular those with intellectual disabilities or psychiatric disabilities, were found to be more at risk of homelessness, it is pertinent to find out if this group is over represented in the homelessness service system.

5. Policy/Program implications

Potentially, the research presented in this report has profound implications both for the delivery of existing programs and the development of new policies. In order to better understand those policy and program outcomes two workshops were held in the latter stages of the project. The first workshop was held in Melbourne in August 2011 and the second was conducted in Canberra in early September. The participants for the first workshop were drawn from state government, non government service providers and peak organisations. Those involved in the second workshop were drawn from a range of Australian Government Departments and from the ACT Government. Participants in the two workshops were presented with a summary of the project outcomes and were asked to consider two key questions:

- What actions are needed to achieve the targets established in the White Paper on Homelessness, *The Road Home?*
- What steps can be taken by the Australian Government, State governments and service providers to better meet the needs of homeless persons with non-psychiatric disabilities?

In addition, the participants were asked whether the findings presented by the researchers were consistent with their experience and understanding of this topic.

The outcomes of the two workshops will be discussed together as there was considerable overlap in the views and perspectives of the two groups and each is discussed as a key policy theme.

Theme 1: There is a need to acknowledge that the homelessness experiences of persons with a non-psychiatric disability are unrecognised or under recognised within the population of homeless persons

Participants in the workshops noted that there is little recognition that a significant percentage of persons who are homeless have a non-psychiatric disability. This was also one of the key issues to emerge from the literature review (Button et al 2010). Moreover, persons with intellectual disabilities were most likely to be over-represented amongst the homeless population. The quantitative analysis undertaken as part of this project and presented in this report also came to this conclusion: persons with a disability – and especially learning or intellectual impairments – were more at risk from precarious housing than any other group within the study.

While a small minority of persons with a non-psychiatric disability become homeless, we estimate that this group could constitute more than 20 per cent of the homeless population. Determining the prevalence of non-psychiatric disability amongst the homeless population is a priority, and the experiences of this group warrant elevation in policy discussion in order to achieve greater programmatic attention. As a first step, more attention should be paid to the nature, source and extent of disabilities amongst persons using homelessness services within the data collection methods of the Australian Institute of Health and Welfare.

One of the workshops considered the desirability of including a disability flag – alongside the homelessness flag – within the Centrelink data collection. It was believed that such an indicator would both raise awareness and make it possible to pursue assertive intervention where both flags are present.

The critical policy implication is that there is a pressing need for wider recognition that the disabilities affecting persons who are homeless or at risk of homelessness are not limited to psychiatric disability. While psychiatric disability may have a substantial impact on the lives of many vulnerable persons, it may not be the only disability affecting that individual. It is highly likely that homelessness can contribute to the onset of mental illness, so that persons with an intellectual disability who become homeless may then develop a psychiatric disorder. In addition, there is a need to investigate the incidence of intellectual disability amongst the clients of homelessness services and provide adequate and appropriate services for those living in shelters or other precarious housing. As a first step, more attention should be paid to the nature, source and extent of disabilities amongst persons using homelessness services within the Australian Institute of Health and Welfare's data collection.

Theme 2: Individuals with moderate disabilities often miss out on services. Those whose disabilities are substantial but not acute may not gain access to services or other support because there is greater need elsewhere within the disability services sector. Importantly, persons with moderate impairments appear more likely to be at risk of homelessness as their disability may be sufficient to affect their interactions within broader society, but not to an extent such that they receive a comprehensive package of assistance. The qualitative findings supported this conclusion also. There was considerable discussion in both workshops about the risks confronting persons with mild to moderate intellectual disabilities and how their impairment may preclude them from participation in the labour market but not be severe enough to result in a package of disability services. Some service providers also noted that this group is at increased risk of homelessness because they struggled with cognitive tasks which could make it difficult to pay rent, complete paperwork, and remember to turn up to appointments.

Theme 3: There is a need for better integration between services targeting the homeless and those directed to the population with a non-psychiatric disability. Participants noted that both 'on the ground' and in the policy environment there are gaps between the two sets of services. There is a need for greater co-ordination between agencies but there is also scope for funding reform that provides resources to meet the needs of persons confronted by both challenges. There was a perception that health and disability rehabilitation services are largely blind to the risk of homelessness amongst the population with a disability and this partly reflects the funding structures that support them.

Theme 4: A more holistic approach to service provision is needed. Participants in the two workshops considered both the current service system and the features of an enhanced system designed to meet the needs of persons at risk of homelessness who have a non-psychiatric disability. There was a clear view that in the further development of the service system there is a need for a housing first approach that also considered the employment, socialisation and other needs of the individual. *One policy option that was considered and evaluated favourably was the appointment of community advocates to work with homeless people with a disability. This pathway would appear to be an attractive pathway for development and has the capacity to help the Australian Government achieve its homelessness targets.*

Theme 5: There is a need to identify points of intervention. Policy makers in particular noted that it is important to identify the logical points of intervention for persons with a disability who are homeless or at risk of homelessness. Suggested points of intervention included: hospitals and particularly, release from hospital, adolescence amongst persons with an intellectual disability, Centrelink, leaving state

care and leaving the prison system. Each of the nominated intervention points requires different strategies and actions, but each offers the prospect of having a real impact and 'turning off the tap' of homelessness.

Turning off the Tap' is one of the key principles of *The Road Home*, the White Paper on Homelessness. The findings of this research and the outcomes of the policy workshop suggest that more needs to be done to ensure that persons with a disability do not exit hospitals or disability services, only to become homeless. Key actions that could be taken here include:

- Enhanced tracking of the housing transitions of persons with a disability once they have left a hospital, rehabilitation centre or other institution;

- Development, and implementation of, housing plans for persons leaving hospitals, rehabilitation centres or other institutions;

- The supply of additional transitional housing specifically targeted to persons with a disability at risk of homelessness should be increased significantly. This housing should be made available for periods of up to one year. It is noted that the National Affordable Housing Agreement (NAHA) has provided additional funds for social housing, with much of the new stock targeted to homeless persons and those with a disability. This research has shown that there is considerable latent demand amongst persons with a disability for adequate and appropriate housing and that further resources, and targeting of social housing allocations, is needed.

Theme 6: Gaining access to affordable and appropriate housing remains a challenge. Participants in both workshops noted the extensive waiting lists for social housing in most state and territory jurisdictions. They also noted that it created an impediment to the provision of housing for persons with a disability at risk of homelessness. Discussion focussed on a range of ways in which this barrier could be overcome, including the potential to develop and apply a 'Friendly Landlord' model targeted at this group. The Friendly Landlord model has been developed in New Zealand and involves a number of non government organisations supporting persons affected by poor mental health. This assistance is provided both as on-going contact and assistance and as a rental subsidy designed to sustain the individual in the private rental market (National Centre of Mental Health Research, Information and Workforce Development 2011). Others noted the potential impact of both tighter targeting of access to social housing, and investment in new stock via the National Affordable Housing Agreement, the National Rental Assistance Scheme and the Nation Building-Economic Stimulus Package

One of the policy implications arising out of this discussion is that consideration should be given to requiring homelessness services to develop and implement plans that outline how they can assist persons with a disability. Where appropriate, additional funding should be provided to services and social landlords to help them modify their properties or employ specialist expertise in order to make their assistance available to those with an impairment or disability. At a more fundamental level, on-going investment is needed to support persons with a disability who are homeless or at risk of homeless in either private rental housing or home ownership. As earlier research has shown (Beer and Faulkner 2009), persons with a disability are over-represented in public housing. While public housing can provide a secure and affordable housing option for this group within the population, it is also reasonable to expect that in the longer term some would aspire to rent in the private

market or buy their own home. Persons with a disability who are homeless, or at risk of homelessness, need to have a range of housing options available to them over time that they can step through as their circumstances change. Some of the ways that government policies and programs can assist persons with a disability gain access to this wider range of housing choices include:

1. Information provision on housing options;

2. Targeted financing to non-government organisations and other service providers for the development of both a market rental sector and home ownership opportunities;

3. Support programs – financial advice, budgeting skills, maintenance assistance, grants for home modifications – for persons with a disability entering private rental housing or home ownership.

Theme 7: There is a need to develop better skills sets within the homelessness workforce. Workshop discussions canvassed the problems of adequate training for persons working in homelessness services. There was widespread acknowledgement that staff in this sector required further training and skill development to both recognise non-psychiatric disabilities and the vulnerabilities it generates within homelessness, and provide appropriate responses. It was also noted that this workforce in particular faces problems with staff retention and remuneration.

6. Further Development

There is scope for both further research in this area and concrete policy/programmatic outcomes associated. Several of the participants in the policy workshops felt that there was a need for further research into:

- Persons with disabilities who become at risk of homelessness as their parents age and are no longer able to provide care;
- Households where carers are on the edge of homelessness;
- Women with disabilities and their risk of homelessness;
- Adolescents with non-psychiatric disabilities; and
- Homelessness amongst carers.

In a broader programmatic sense, there is an on-going challenge to develop early responses to the risk of homelessness confronting persons with a non-psychiatric disability rather than for the onset of a crisis to trigger a specialist response. Assertive outreach and advocacy may well offer a promising pathway forward and has the potential to assist in achieving homelessness targets. A second key programmatic challenge is to build the capacity to respond to homelessness amongst persons with a non-psychiatric disability within several service systems, rather than rely upon conventional homelessness services. Critically this research has shown that persons with a disability end up homelessness via pathways that do not conform to our established understanding of homelessness and its causes. There is therefore a need to build recognition of the risk of homelessness into the rehabilitation system, hospitals, the criminal justice system and mainstream disability services.

7. Conclusion

The findings of the two phases of the research reported in detail in this report (Phase 2 and 3) build upon those of the earlier literature review phase.

We have presented evidence that persons with a disability have a greater exposure to the risk of homelessness than the general population, and that different disabilities predispose individuals to different levels of homelessness risk. While different disability groups within Australia receive different types of housing support, some groups are especially disadvantaged. These groups would benefit from additional, targeted support.

While we intentionally did not focus on mental illness in this study, it was nevertheless clear in both analytical phases of the research that this is a major risk factor for homelessness. While participants were intentionally selected following a selection criteria that their primary disability was not mental illness, a substantial number of participants (around half) were found to have a mental illness in addition to their principle disability.

The findings also reinforce the importance of co-morbidity within the population of interest for this study as well as multiple and complex disadvantage. Many of the participants had a cascade of troubles (Saegert and Evans 2003) which worked in combination to increase their risk of homelessness. The large scale quantitative phase of the research suggested this, and the more focussed qualitative phase found clear evidence of this co-morbidity among the respondents. We therefore highlight this as an important future area of research in order to unpack the effects of multiple disabilities and multiple disadvantages on homelessness risk and housing outcomes.

The academic literature on housing and homelessness discusses both the transitions households take through the housing market (Beer and Faulkner 2011) and the pathways into and out of homelessness (Clapham 2005). Both perspectives emphasise the time dimension to housing and the ways in which homelessness is not simply a point in time experience. Instead, homelessness is the outcome of often a very long process and is not, in itself, necessarily an end state. Homeless people will often move out of homeless for substantial periods, and recurring episodes of homelessness are common. This perspective is important when considering the incidence of homelessness amongst persons with non-psychiatric disability. Through our fieldwork and the literature review a number of frequently reported pathways into homelessness emerged. Each is discussed and presented below:

Figure 5: Pathways into Homelessness for Persons Born with an Intellectual Disability

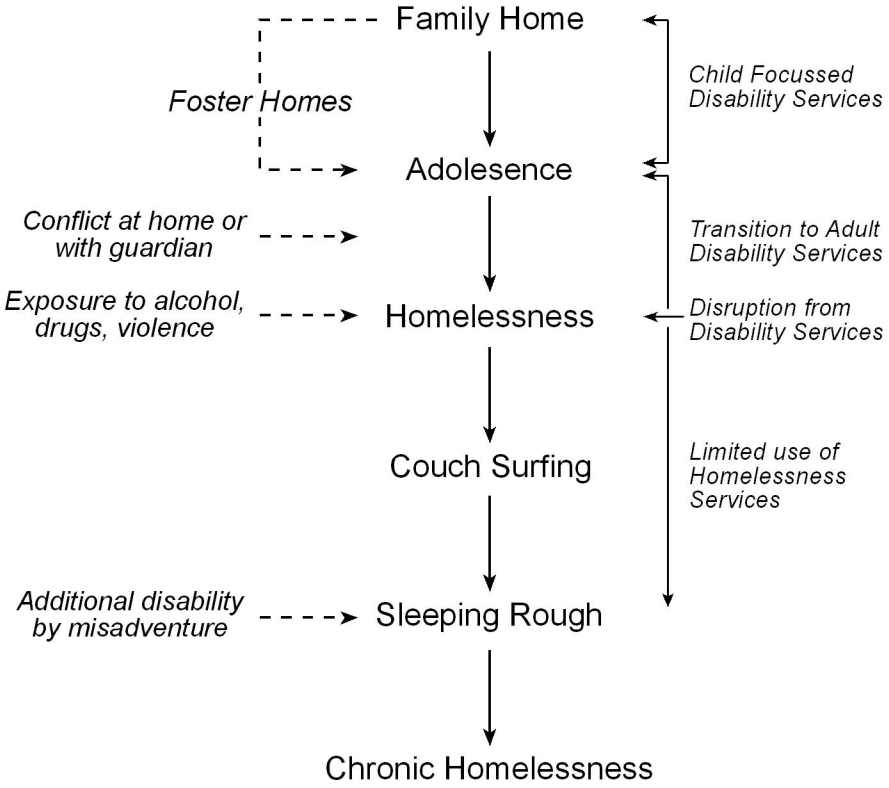


Figure 5 illustrates the ways in which persons born with an intellectual disability may become homeless and experience homelessness in various forms over an extended period. For this group, risk factors include the experience of foster homes or living under the Guardianship of the Minister, with a period of acute risk with the onset of adolescence. For some persons born with an intellectual disability, adolescence carries with it a greater risk of conflict in the home or with a guardian and this challenge is made more acute as individuals move from child focussed services to adult supports. In too many instances individuals 'fall through the gaps' in service provision. Persons born with an intellectual disability may also be disadvantaged in their use of homelessness services. As discussed in the qualitative component of this report, homelessness services frequently do not recognise that clients have these disabilities, they may be exposed to violence, conflict and alcohol, and their skills in connecting to services may be limited. Importantly, persons within this group may acquire additional disabilities while homeless, and while this may include psychiatric disabilities, it also includes non-psychiatric conditions that arise from misadventure or from being subject to assault.

Figure 6: Persons who acquire a disability while homeless

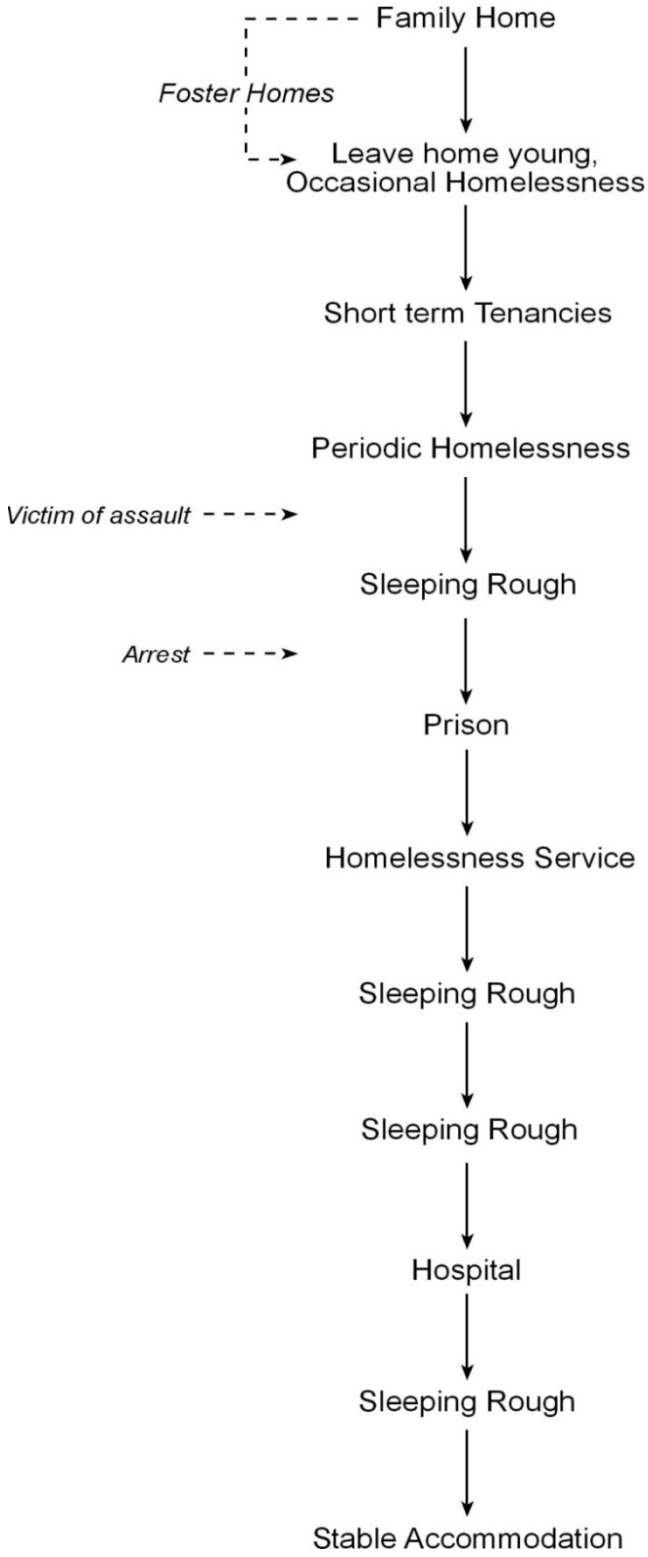


Figure 6 presents a second frequently observed pathway into homelessness for persons with a disability. For this group, homelessness has led to disability, as sleeping rough or living in insecure accommodation has resulted in assault or traumatic injury that has resulted in a loss of cognitive function, sensory loss,

reduced mobility and/or physical capacity. Critically, persons living rough in particular are at risk of violence or accident. Their subsequent disability represents both an enormous impost on them as individuals but also a significant burden on society as a whole. There is the loss of a productive individual, the cost of health and rehabilitation services and on-going income and other support services that result from such incidents. Importantly also, the onset of a disability may exacerbate the homelessness pathway the individual experiences: making it more difficult to exit homelessness and much more challenging to move to a more stable housing pathway. Homeless persons living with a disability, for example, may lack the capacity to undertake work, and may also have a diminished capacity to make good choices, navigate bureaucratic systems and attend to everyday aspects of self care.

Figure 7: Work or Vehicle Accident Resulting in an Acquired Brain Injury

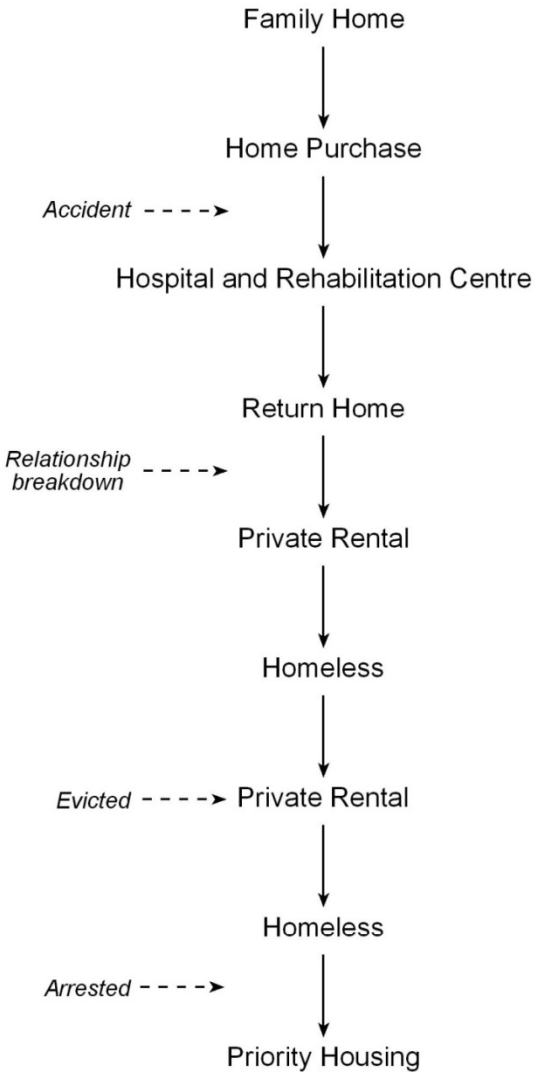


Figure 7 presents a third, commonly experienced, pathway into homelessness for persons with a non-psychiatric disability. In broad terms, this particular pathway was evident in many of the qualitative interviews undertaken as part of this project, especially amongst young males who had had a motorcycle accident. Others experienced comparable outcomes due to a workplace injury. In this pathway,

individuals had been on track to follow a conventional 'housing career' until their accident. This then changed radically with a period of hospitalisation and then rehabilitation, followed by a return to their previous home. In many instances the disability – with associated mood swings, difficulty concentrating etc – contributed to the break-up of their relationship and the movement out of the family home. This was then commonly followed by a series of moves through progressively less secure and appropriate accommodation. Even when housing was rented through the formal private market, it was often of a low standard. Many individuals in this pathway, and the other two pathways discussed in this section, spent substantial periods of time in sub-standard boarding house accommodation that was frequently of poor quality and expensive. Periods of incarceration were evident in the housing pathways of this group and in some respects simply reinforced the long term homelessness of these individuals. For this group, priority housing – including stock made available under the National Affordable Housing Agreement and the National Rental Affordability Scheme – was frequently the only way to leave homelessness behind.

Overall our research has highlighted four key issues:

1. The importance of housing

- Many participants in this study had lived in housing that was unsafe, substandard and unsuitable. A number had been referred to boarding or rooming houses, transitional and share accommodation through the homelessness service system. Participants typically faced significant wait times for longer term (both community and public) housing. We did, however, note that a number of persons interviewed under the qualitative part of the study had been accommodated in new housing targeted at the homeless. This included stock provided under the NAHA and via NRAS. Both schemes appear to have had very positive outcomes for individuals and this suggests that current policy initiatives are beginning to have an impact.

- It was extremely difficult for participants to obtain housing. Similarly, it was difficult for them to gain desirable long term housing through the homelessness and housing system.

- For many their housing had a detrimental effect on their ongoing recovery and, for some, contributed to their ongoing health problems.

2. The important role of informal networks

- Some participants had no social support network, and these tended to be people with the most complex histories who required the most support.

- Informal networks of friends and family provided emotional support, community connection and practical assistance.

3. The importance of services

- Our findings highlight the importance of good service provision, and the severe consequences of services system failure for this group.

- Access to key services made a substantial difference to participants' lives.

- Service impact was related to the range of support offered by services and the dedication and advocacy of particular services and workers.

- Vulnerable individuals with a disability have difficulty finding out about where to get the help they need and some spend significant periods of time without basic information or referral to appropriate services.

- Some services failed to provide basic information or appropriate referral.

4. Poor housing outcomes are due in part to a shortage of housing.

- There appears to be an acute shortage of low cost appropriate housing available.

- When asked what should be done to address homelessness amongst this group, participants wanted to see an increase in the supply of housing that was appropriate to their needs, affordable on their incomes and of a decent quality.

- Participants wanted an improved process around accessing and moving within public housing.

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