Royal Commission
into Violence, Abuse, Neglect and Exploitation of People with Disability

Research Report

Outcomes associated with ‘inclusive’, ‘segregated’ and ‘integrated’ settings for people with disability

The University of Melbourne

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This research report was commissioned and funded by the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. To inform the work of the Royal Commission, it analyses evidence of outcomes associated with 'inclusive', 'segregated' and 'integrated' settings as they apply to the safeguarding of people with disability in accommodation and community living, employment and education.

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Executive Summary

People with disability, their families and advocates have provided the Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability ((‘the Royal Commission’; DRC) overwhelming evidence of how they have been segregated and excluded from Australian society, and how they have been the victims of neglect, exploitation, violence and abuse. The DRC has revealed that it has been the policies and service systems that we in Australia have established and supported, and which have enabled and hidden the acts of individuals, that are the cause of such abuse. It is these policies and systems that need reform, along with a change in the hearts and minds of the community, if people with disability are to achieve full citizenship and life free from violence, abuse, neglect, and exploitation.

This research was instigated by the Royal Commission to complement the evidence before it and to answer the question, based on the prevailing evidence base and consistent with the United Nations Convention on the Rights of Persons with Disabilities (Article 16); ‘what should be done to promote a more inclusive society that supports the independence of people with disability and their right to live free from violence, abuse, neglect and exploitation?’ (Letters Patent, 2019).

Based on the Royal Commission’s brief, and acknowledging the complexity of that brief, the research was divided into three domains: accommodation and community living; employment; and education. This report reflects these domains, their complexity and nuance. However, it integrates the findings and subsequently proposes evidence-informed ways forward for policy and practice to promote the inclusion of people with disability in Australian society with reference to where they live and spend their time, together with their opportunities for education and employment.

To achieve the objectives of the research, each of the three domains of the study adopted a similar multiphase design. For each of the domains of accommodation and community living, employment, and education, an evidence review of peer-reviewed literature was undertaken (originally retrieving 35,000+ potentially relevant documents). The design of these reviews was supported by a reference group, including people with disability and policy makers. The retrieval of literature included systematic searches, complemented by a scoping review process to ensure the inclusion of all relevant literature. The synthesis and subsequent conclusions based on the literature were augmented with reference to international conventions, commonwealth and state legislation, and policy documents.

Findings arising from these three evidence reviews were then summarised into propositions which were subsequently tested using an online two-round Delphi technique, which included harnessing the views of experts from Australia and from overseas. The expert panel included people with disability (>50%). The Delphi panel considered propositions across all three domains of investigation. Finally, the authors synthesised and integrated the overall findings across the three domains to inform a final set of recommendations for policy and practice. The recommendations are detailed in section 6, structured according to the six key questions posed by the DRC.

Here it should be noted the review of the literature revealed that the key concepts of inclusion, integration and segregation, together with notions of quality and safety were to be understood in diverse ways. Similarly, the indicators of inclusion were discussed differently across various communities of experience, such as those who identified with having a physical disability, a sensory disability, a cognitive or intellectual disability, a neurological disability, impairments attributable to a psychiatric condition, or a psycho-social disability. However, it was evident that despite this diversity, some common actions were required at both a macro and micro level.

At a macro level, we need to leverage legislative instruments, policy, service provision and the ways in which we structure and organise our communities. We need to embrace diversity as a fundamental characteristic of the human condition. We need to adopt universal design in all elements of policy and practice (and not just with respect to physical access). We need to address issues of stigma, discrimination and the tyranny of low expectations that arise from biases and fear that pervade our community. We need to address structural inequalities, including access to housing, education, employment, and the means of economic and political participation. At a micro level, we need to remove barriers and ensure the individual is made welcome, and establish a community where individuals feel welcome, where they know they belong and are safe, where they can source the specialised supports they need, and where their voice is heard and acted upon.

Our findings reveal that notions of inclusion and segregation have been largely defined by those who lay claim to expertise arising from academic and professional accreditation. There has been limited engagement directly with people with disability and limited opportunity for those with lived experience to voice and define the circumstances in which they experience segregation and inclusion. When building an inclusive community, it is essential that all members of that community are authentically engaged in the process. The lived experience of people with disability needs to be extended greater respect in both research processes and the development of policy, together with the delivery and evaluation of service provision. Importantly, the principles and practices of both co-design and co-production need to be well understood and consistently applied.

For social inclusion at a whole-of-community level to occur, the needs of the individual must continue to be recognised. For these reasons, specialist knowledge and skills are required. While such knowledge and skills have historically existed in specialist, and at times segregated, services, there is a need to both continue the availability of specialist services and also increase the capability of services in the wider community to accommodate and address the needs of individuals. This includes ensuring the education and training of professionals across a range of community and health services, together with educational providers and those involved in employment services. This is particularly needed to ensure the community inclusion of people with complex and multiple disabling experiences. Here it should be noted that specialist knowledge and skills to support people with disability need not be, and should not be, relegated to services in segregated settings.

There is a need to move beyond simplistic notions of physical location or dichotomies of inclusion vs segregation. Multi-dimensional typologies provide more useful frameworks. The policy and practice agenda needs to encompass consideration of initiatives to address physical access and presence in the community, social connectedness, and the deeper experience of psychological inclusion – where social connectedness and full, active, and influential membership (citizenship) of a community (a local community, a school community, or a workplace community) are clearly articulated in legislation and policy, and translated into practice that is the subject of scrutiny and review.

The settings in which people live their lives are powerful influences (determinants) of their health, wellbeing, educational outcomes, employment outcomes, safety, and quality-of-life. There are many discrete elements of these environments at work; including prejudice and discrimination, a lack of knowledge and understanding of the needs and potential of people with disability, and a paucity of capability in the wider community to welcome and support people with disability. We need to ensure that these insidious elements, all too often ascribed to, and evident in, segregated settings do not unwittingly permeate integrated and inclusive settings as an unintended consequence of poor policy and planning. Inclusion, be it in the community, in education or in employment, does not simply happen, it needs to be intentionally made to happen. Inclusion requires political will, economic resources, and social capital, with the individual with disability at the heart of the process.

1 Introduction

1.1 The Royal Commission

The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability (‘the Royal Commission’; DRC) was established by the Australian Government on 4th April 2019. The Commissioners were directed to make public inquiries and to conduct research to formulate recommendations for legislative, policy, administrative and structural reforms. Specifically, they were asked: ‘what should be done to promote a more inclusive society that supports the independence of people with disability and their right to live free from violence, abuse, neglect and exploitation?’ (Letters Patent, 2019).

Of concern to the Royal Commission and consistent with Article 16 of the United Nations Convention on the Rights of Persons with Disabilities that highlights freedom from exploitation, violence and abuse, were two key questions. How to promote the safety and quality-of-life (QoL) of people with disability. The Royal Commission is particularly concerned for the needs of people sometimes labelled as having ‘profound’ or ‘severe’ disability.

In written submissions and oral evidence to the Royal Commission, researchers, policy makers, service providers and members of the community posited a range of positions and recommendations as to what might constitute inclusion and its place in policy and practice. This report does not seek to replicate these submissions but to add to information available to the Royal Commission by documenting and analysing evidence in the published peer-reviewed scientific literature.

1.2 Questions for research

This is one of several research projects commissioned by the Royal Commission and questions posed included:

1. How are the terms ‘inclusion’ and ‘segregation’ understood and applied in the literature?
2. What constitutes good inclusive practice; are there models or examples of these working?
3. What are the safety and quality outcomes for people with disability (and peers and others) of settings generally identified as inclusive or segregated?
4. What are the essential requirements for services to succeed in ensuring the safety of people with disability and quality in their everyday life?
5. Are there any beneficial outcomes evident in segregated settings for safety and quality in everyday life? How could these be replicated in inclusive services or settings?
6. Are there limitations or gaps in the current research base relating to inclusive and segregated settings and how might these be addressed?

1.3 The research processes

The current project was sub-divided into three domains for consideration based on the Royal Commission's brief. These were: accommodation and community living; employment; and education for children with disability (Note – post-secondary education options were outside of the brief for this report and will be addresses elsewhere by the DRC). The structure of this report reflects these domains and their complexity. It concludes by integrating the findings from these three domains and suggests promising, evidence-informed ways forward for policy and practice.

A multiphase study was undertaken that commenced with a review of published peer-reviewed literature. The literature was used to inform a two-round online Delphi study in which a series of propositions were put to a panel of Australian and international experts. The Delphi panellists' expertise included lived experience of disability, research, policy development and service provision. The results informed the final interpretation of the literature and the subsequent recommendations for policy and practice.

1.4 Core concepts and definitional considerations shaping this report

Early in the research process, it became apparent that the literature covering each of the three domains of inquiry was organised differently and at different stages of development in complexity and considerations. The key concepts of inclusion, integration and segregation and notions of quality and safety were understood in diverse ways. Also, concepts and indicators of inclusion were discussed differently across various communities of experience, such as those who identified with having a physical disability, a sensory disability, a cognitive or intellectual disability, a neurological disability, impairments attributable to a psychiatric condition, or a psycho-social disability (with reference to the National Disability Insurance Scheme Act 2013, S24).

It should also be noted that the concept of 'disability' is a contested construct. Its definition regarding individual impairment (the medical model) vs a phenomenon arising from deficits in the environment (the social model) vs a failure of society to accept the naturally occurring variation of what it means to be a person (the diversity model) is the subject of contemporary debate in literature and the community more broadly.

Consequently, there was no single definition of inclusion or disability to guide the inquiry or to emerge from the literature. However, there were several concepts and considerations which influenced the formulation of this report and its subsequent recommendations. These included:

> Article 19 of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD) (Living independently and being included in the community) which positions inclusion in the context of people's exercise of choice (eg where they live and with whom they live), their access to a range of supports (particularly those at home and in the community that prevent isolation or segregation), and in the context of people having access to facilities, services and opportunities ordinarily available to the general population;[1]

Article 24 of the UNCRPD (Education) which positions inclusion in the context of the provision of individualised supports and individualised environments that maximise academic and social development;[2] and

Article 27 of the UNCRPD (Work and employment) which positions inclusion in the context of a labour market and work environment that is open and accessible to persons with disabilities.[3]

Inclusion can be considered at macro level in terms of physical access with political, systemic, economic and social structures. However, while community access and presence and concepts of integration, involvement and engagement (concepts primarily concerned with people's physical location) can, and do, lay the foundations for inclusion, they should not be mistaken for inclusion, or used as uncritiqued proxies to establish if inclusion has been realised. Rather, inclusion is a concept grounded in authentic interpersonal relationships and concepts of being part of a community and of belonging to that community.

Importantly, while integration and involvement in the mainstream of society – where people live, learn, work or socialise might set the scene for inclusion, such concepts and experiences do not necessarily bring the same safeguards that authentic inclusion might offer.

Inclusion needs to be enabled and fostered at a macro level; leveraging legislative instruments, policy, service provision and the ways in which we structure and organise our communities. We need to address issues of stigma, discrimination and unfounded, and often low, expectations that arise from biases and fear. We need to address structural inequalities, including access to housing, education, employment and the means of economic and political participation.

Issues of inclusion need to be addressed and are arguably most powerfully experienced at the micro level; at the level of the individual. Inclusion is most evident where an individual is made welcome, where they feel welcome, where they know they belong and are safe, and where their voice is heard and acted upon. Bengt Nirje described, 'a world where people are free to be themselves among others'.[4] Arguably, it is only then that people can live a quality life free from violence, abuse, neglect and exploitation.

2 Methods

2.1 Structuring the research

This project was informed by a brief and series of questions prepared by the Royal Commission and the brief considered the many written and oral submissions made. The current investigation did not attempt to duplicate data already available to the Royal Commission and on the public record. Rather, the research was designed to expand the evidence base available to the Royal Commission to inform its deliberations.

In consultation with the Royal Commission and its internal panel of experts, the research team developed strategies to retrieve and appraise current research evidence to address the Royal Commission’s questions. These strategies generated evidence to inform the work and subsequent recommendations with specific reference to ‘what should be done to promote a more inclusive society that supports the independence of people with disability and their right to live free from violence, abuse, neglect and exploitation?’ (Letters Patent, 2019).

Given the breadth of the Royal Commission’s brief and questions, the project was organised around three sub-project teams: accommodation and community living, education, and employment. These teams each addressed the core question for the Royal Commission across different life domains. All three teams met regularly to share information and cross-reference relevant literature.

The evidence informing the project was primarily derived from a systematic review of peer reviewed literature. Propositions for policy and practice were formulated and their ecological validity tested using a two-round online Delphi study. The results of the Delphi informed the final deliberations and formulation of recommendations for policy and practice which addressed the Royal Commission’s original questions.

2.2 The literature review

The breadth of the brief and the complexity of the multiple questions raised by the Royal Commission meant it was neither feasible nor appropriate to conduct a traditional systematic review of the literature. A process more akin to a scoping review was adopted. A scoping review suits situations where little is known in advance about the extent and consistency of the literature in a field, or where exploration of the literature is not readily focused by a single research question.

As with systematic reviews and rapid reviews, scoping reviews identify key concepts, theories and resources in a field and survey the findings of the major research studies. They may be indicative rather than exhaustive. They are also more likely to be iterative and organic as new insights progressively emerge from the literature.

To ensure integrity of process, a systematic approach was adopted to the search, identification and final selection of the literature forming the basis of the three reviews. In the development of the various search strategies, each sub-team consulted with specialist research liaison librarians who provided advice on databases to be searched according to the topics of inquiry. They also provided advice on the construction of the search algorithms specific to each selected data base.

The sections of this report (accommodation and community living, education and employment) document the search strategy adopted by each sub-team. This includes a listing of bibliographic search engines, specification of search terms and the combinations of terms that were applied, and details of the inclusion and exclusion criteria used to short-list the literature in each section. The use of terms which could be understood to imply a deficit model of disability, such as 'severity of disability', do not reflect the preferred language or perspective of the authors but the terminology of the original brief from the Royal Commission based on submissions from a broad cross-section of the community.

The software application, Covidence, was used to manage the quantity of literature retrieved by each team. The web-based tool supports the processes of rapid reviews, systematic reviews and scoping reviews and allows the importation of citations and full articles retrieved from bibliographic search engines, ready for screening by multiple reviewers. Covidence also provides keyword highlighting and records the voting of multiple reviewers. It enabled each of the three teams to retrieve and review thousands of articles over several months, and to short-list the several hundred most relevant papers for each domain of inquiry.

From an original library of 35,888 sources, 1478 sources formed the final literature review. This was necessary to address the breadth and depth of the questions posed by the Royal Commission and the complexity of the issues. Narrowing the topic of inquiry and refining the research questions might have made the process more efficient but would have risked excluding literature that subsequently contributed to the overall findings. This could have resulted in an inability to draw multiple considerations from wide-ranging research within and across each of the three domains of inquiry.

The quality of studies for inclusion were considered according to criteria established by McVilly et al.[5] This appraisal tool was designed for use in systematic reviews incorporating quantitative and qualitative literature. It is informed by quality criteria recommended by the Social Care Institute for Excellence,[6] the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA),[7] and the Effective Public Health Practice Project as described by Thomas et al.[8] The tool incorporates: reference to the literature; having a research focus; having ethics approval; providing details of the method and procedures; describing the participants; the tools used; details of the data analysis; details of the findings; discussion of results and implications of the findings; and supporting references.

The processes and results of the three reviews are described in detail in each dedicated section of this report. The final synthesis of each review formed the basis of the propositions for legislative, policy and practice reform which were then put to the Delphi Panel for review and evaluation.

2.3 The Delphi study

Following the retrieval, review and short-listing of peer-reviewed articles, each sub-team generated a series of propositions for legislative, policy and practice developments based on the analysis of the literature and consensus decision making. The propositions generated were made available to the other teams for comment. To test these propositions, a two-round online Delphi study was conducted with the protocol reviewed and approved by the University of Melbourne Human Research Ethics Committee (Project Reference Number: 21419).

The Delphi technique is a well-established approach in the social sciences and draws on the collective experience of a panel of people identified as experts in the topic of inquiry. The panel members answer a series of questionnaires in two or more rounds. After each round, a facilitator provides an anonymised summary of the experts' opinions from the earlier round and asks a further series of questions. The Delphi technique can take a variety of forms including generating, rating and prioritising ideas or concepts, and it can be used to generate a consensus view by repeatedly asking panel members to consider shortlisting ideas based on the collective views of panel members from previous rounds.

One substantial advantage of the Delphi technique over a focus group approach, especially when conducted online, is that panel members can be blinded to the identity of their fellow panellists and so the process can be democratised. So, each panellist can express their views independently of their role or expertise in relation to other panellists, while at the same time reflecting on and responding to the views of the other panellists. This was important given the diversity of the panel for the current Delphi that included academics, policy makers, service providers, and people with the lived experience of disability, including people with intellectual disability.

Traditionally, the first round of a Delphi study invites panellists to generate the key concepts for consideration in response to a focus question or defined topic of inquiry. For the current Delphi, these concepts had already been generated and formulated into evidence statements and propositions based on the literature retrieved by the three sub-teams through a consensus decision making process within each team.

Potential Delphi panel members were selected based on their prominence in research, policy leadership, advocacy and engagement in public/community life. Consideration was given to gender, area of expertise and/or role in the community and, importantly, priority was given to engagement with people with lived experience of disability. Consideration was given to conducting multiple expert panels based on accommodation and community living, employment and education. However, it was deemed important to subject the propositions to a single panel of persons with expertise from across the disability sector to test the ecological validity of the findings.

2.3.1 Delphi round 1

While 33 people were initially identified as potential participants in the Delphi panel, the final panel comprised 14 respondents. Eight experts had lived personal experience of disability and 6 had disability sector expertise as academics, practitioners and/or carers. They included people with expertise in accommodation and community living, education and employment from across Australia and overseas, predominantly the UK and Canada. The final pool of 14 participants were methodologically acceptable and sufficient for a Delphi study (Delphi is not a method based on the number of participants, but the stratification and depth in expertise of the panel) and proved adequate for the current purposes as they represented a range of perspectives across relevant areas of expertise.

Prior to the first round of the Delphi, panellists were given a background paper that summarised the literature on which the evidence statements and propositions had been based.

In the first round of the Delphi for the Accommodation and Community Living and the Employment domains, panellists were asked to rate the *importance and feasibility* of each proposition with reference to the Royal Commission's primary focus: 'What should be done to promote a more inclusive society that supports the independence of people with disability and their right to live free from violence, abuse, neglect and exploitation?'

It was acknowledged that the propositions could relate to a variety of issues relevant to advancing the interests of people with disability. However, it was emphasised to panellists to consider each proposition specifically with respect to how it might affect or influence the circumstances in which people with disability might live a life free from violence, abuse, neglect and exploitation.

Each item was rated on scales ranging from 0 to 10 for importance and feasibility. The scales were anchored with extreme end points of 'not at all' and 'absolutely/completely'. They used a visual drag function, without any visible numbers showing between the two extreme anchors, to minimise cognitive load on panellists and negate their need to read numbers.

An optional open field for comments was provided for each section and panellists were encouraged to use this to explain or qualify their ratings. They were also asked for their thoughts concerning current barriers and potential future enablers to address such situations.

The Accommodation and Community Living domain consisted of 20 evidence-informed statements, giving rise to 46 propositions. For some statements there was a single proposition and for other statements there were up to 5 propositions for panellists to consider and rate.

The Employment domain consisted of 26 evidence-informed statements, giving rise to 43 propositions. For most statements there was a single proposition, while for other statements there were up to 3 propositions.

For the Education component, the structure was different given the nature of the literature in this area and the subsequent findings of the literature review. The concepts of inclusivity and segregation have long been the subject of educational research so the Education domain could be more focused in its propositions in the first round.

Subsequently, the Education Delphi asked panellists to consider 6 issues influencing educational practice: how learners and their learning needs are identified; the content of curriculum and what learners learn; the kind and level of participation available to learners; how learners are taught; where children learn; and the governance of, and who decides about, educational provision.

For each of these 6 areas, policy and practice options were proposed and panellists selected an option they considered best for achieving safety and quality in education for children with disability in Australia, particularly children with severe or profound disability as this sub-group was a particular concern for the Royal Commission. For each question, there was also an optional comments field for panellists to explain their responses and offer proposals or suggestions.

The results for Delphi round 1 are documented in each of the three domain-specific results sections of this report. They informed the considerations of the three sub-teams as they progressed their synthesis of the literature and provided the basis for Delphi round 2.

2.3.2 Delphi round 2

Several statistical techniques were used to appraise any emerging consensus among the panellists. However, this proved difficult given the range and distribution of ratings, so the research team decided that, for a proposition to advance to the next round, it had to be rated as important and feasible by at least 75% of the panel. Given the distribution of ratings across the items, a median score of 6/10 was the cut-off to determine if an item had been deemed important or feasible by any single panellist. So, where 75% of panellists rated a proposition at 6 or above, it progressed to consideration in Delphi round 2.

In the second round of the Delphi for the Accommodation and Community Living domain and the Employment domain, panellists considered a short list of the original propositions, some of which had been edited for clarity in response to panellists' comments in round 1. For the Accommodation and Community Living domain, 35/46 propositions progressed to the Delphi round 2. For the Employment domain, 34/41 progressed to the Delphi round 2. For the Education domain, given its structural differences, all 6 areas of consideration from the Delphi round 1 were included for consideration.

For the Accommodation and Community Living domain and the Employment domain, panellists categorised each proposition according to its priority for action, considering the Royal Commission's overarching question of 'what should be done to promote a more inclusive society that supports the independence of people with disability and their right to live free from violence, abuse, neglect and exploitation?' Subsequently, each proposition could be allocated to one of four categories: the highest priority for action; a moderate priority; the lowest priority; and not currently a priority for action. Then, within each of the 3 main priority areas (high, moderate, and low), Delphi panellists were asked to rank these for action with 1 signifying the most important.

For the Education domain, panellists were asked if they agreed or disagreed with priorities and options for each of the 6 key areas of consideration, based on the analysis of the Delphi round 1 results.

For all 3 domains, panellists could provide a comment or explanation of their responses. Finally, Delphi panellists were asked to comment on a 'big question' for each of the 3 domains, formulated by the research teams with reference to the literature and Delphi round 1 results.

The results were used by the research team to reflect on the literature they reviewed and synthesised. Subsequently, they were incorporated into the formulation of the overall conclusions and recommendations for research, policy and practice in response to each of the Royal Commission's original questions.

2.4 Structuring the report

Research was structured around 3 domains based on the Royal Commission's original brief: accommodation and community living; employment; and education.

The processes associated with the literature retrieval and synthesis, the Delphi study and the subsequent findings for the 3 domains follow. Effort has been made to bring consistency to the reporting of these processes and their findings, but the following sections also reflect the bespoke approaches and processes necessary to address the Royal Commission's questions related to the domains.

3 Accommodation and Community Living

In this section of the report, we first outline the methods by which the literature informing our work was identified, retrieved, and refined. We present our observations concerning the key characteristics of the literature, its strengths and limitations. We then document our findings as they relate to accommodation and community living for people with disability.

We present an analysis of how integration, inclusion and segregation are conceptualised in the literature, noting how these constructs vary according to the field of research and the various communities of focus. We report on how concepts of what constitutes quality and what constitutes safety also vary across the literature. We then document how the findings of the literature review were used in the two-phase online Delphi study and integrated with the subsequent findings of this study as they pertain to accommodation and community living.

This section of the report concludes by presenting recommendations for policy and practice as they relate to the safeguarding of people with disability in the context of accommodation and community living.

3.1 Method for accommodation and community living literature retrieval and review

A systematic search of peer-reviewed literature was undertaken using bibliographic databases: Pubmed; EBSCOhost; EMBASE; ProQuest; PsycINFO; Cochran Library; Scopus; and Web of Science.

Each search included the terms and truncations outlined in Table 1 below.

Table 1. Accommodation and community living literature search terms

Term 1: Disability Related	Term 2: Accommodation Related	Term 3: Leisure Related	Term 4: Inclusion related	Term 5: Safeguarding related
Disab* (disabled, disability, disable) Impair* (impaired, impairment) Condition Psychosocial Mental Chronic	Accommodation supported living independent living assisted living congregated living Home Housing out-of-home care foster care Rent* (renter, rented) Tenant* (tenanted, tenants) Landlord Dwelling Hostel	Day program Leisure Exercise Gym Beach Community access Community Activit* (activity, activities)	Inclu* (include, included, inclusion) Exclu* (exclude, excluded, exclusion) Segretat* (segregation, segregated, segregate) Separat* (separate, separated) Integrat* (integration, integrated) Closed	safe* protect* violen* abus* neglect* force* brut*

The keywords were used across 3 sets of searches to establish a comprehensive coverage of the literature. In combination, these terms produced the following initial search string:

> (Disab* OR Impair* OR Illness OR Condition OR Psychosocial OR Mental OR Chronic) AND ((Accommodation OR “supported living” OR “independent living” OR “assisted living” OR “congregated living” OR Home OR Housing OR “out-of-home care” OR “foster care” OR Rent* OR Tenant* OR Landlord OR Dwelling OR Hostel) OR (“Day program” OR Leisure OR Exercise OR Gym OR Beach OR Community OR Activit*)) AND (Inclu* OR Exclu* OR Segretat* OR Separat* OR Integrat* OR Closed) AND (safe* OR protect* OR violen* OR abus* OR neglect* OR force* OR brut* OR rough)

Applying this search string to the databases produced 70,000+ articles for review. Accordingly, proximity limiters were added to the search string to reduce results to a workable amount. The revised search string read:

> (Disab* OR Impair* OR Illness OR Condition OR Psychosocial OR Mental OR Chronic) NEAR/5 ((Accommodation OR “supported living” OR “independent living” OR “assisted living” OR “congregated living” OR Home OR Housing OR “out-of-home care” OR “foster care” OR Rent* OR Tenant* OR Landlord OR Dwelling OR Hostel) OR (“Day program” OR Leisure OR Exercise OR Gym OR Beach OR Community OR Activit*)) NEAR/5 (Inclu* OR Exclu* OR Segretat* OR Separat* OR Integrat* OR Closed) NEAR/15 (safe* OR protect* OR violen* OR abus* OR neglect* OR force* OR brut* OR rough)

This revised search string identified 10,802 articles for review. They were retrieved and uploaded into Covidence to be screened by the research team according to inclusion and exclusion criteria.

The key inclusion criteria were:

- published in English
- published during or after 2006. The United Nations Convention on the Rights of Persons with Disabilities was created in 2006, signalling a paradigm shift in the rights of people with disability
- addresses one of the following:
    - how inclusion and segregation are understood in the literature
    - safety outcomes of inclusive or segregated settings
    - versions/examples/models of inclusive practice
    - examines disability and inclusion/exclusion AND leisure OR accommodation
    - benefits and limitations of segregated and inclusive settings
    - the requirements for successful inclusion in leisure and accommodation.

The key exclusion criteria were:

- drug/clinical trial
- acute conditions (eg injuries lasting less than 3 months)
- dissertations
- hospital settings (except where people reside in psychiatric units for longer than 3 months, or as a venue for social connection groups)
- person being held in a setting because of a justice-related order (as negotiated with the DRC, taking into account separate work to be commissioned).

Using these inclusion and exclusion criteria, the team performed a 3-part screening process of the 10,802 articles. In the initial screen, the team reviewed the title and abstract of each of the articles, assessing their relevance. During this screening process, the research team identified and removed 10,027 articles deemed irrelevant according to the established search criteria.

The remaining 775 articles were subject to a second screening process. Each article was read in full text, ensuring its content met the inclusion criteria. Consideration was given to the quality of the literature, as described in the review methodology (section 1.6). Subsequently, 205 articles were removed, leaving 570 articles clearly identified for inclusion, and a further 203 articles requiring additional screening due to lack of agreement between team members in relation to the inclusion and exclusion criteria. These 203 articles were subject to further screening which included an additional team member undertaking a full text review.

Consequently, 457 papers were retained to inform the analysis and synthesis for the accommodation and community living review.

3.2 Findings from the accommodation and community living literature review

This review focused on contemporary literature from 2006 and covers Australian and international research for the provision of accommodation and support of community living for people with disability. However, countries vary in how they have understood disability, formulated policy and organised their institutions, systems and services. This includes the development of policy and provision of services with respect to accommodation and community living. As a result, some research findings from studies undertaken outside Australia might prove difficult in their direct application here. We have prioritised ideas and initiatives that could most readily be applied in an Australian context.

We address what current research can tell us about ‘quality’ and ‘safety’ outcomes for people with disability associated with ‘inclusive’, ‘segregated’ and ‘integrated’ accommodation and community living settings. We focus on 3 core areas articulated by the Disability Royal Commission:

1. how terms such as ‘integration’, ‘inclusion’ and ‘segregation’ have been understood and applied in the literature associated with accommodation and community living settings
2. what ‘safety’ and ‘quality’ outcomes have been found for people with disability by research into ‘integrated’, ‘inclusive’ or ‘segregated’ accommodation and community living settings and
3. are there and key features of better practice within the research literature that appear to facilitate positive ‘quality’ and ‘safety’ outcomes for people with disability in this context?

Here we report our core findings.

3.2.1 Key characteristics of the research literature

The literature is characterised by 7 notable features. Below, we outline these features and describe potential reasons for their formation.

3.2.1.1 Increase in volume of literature concerning outcomes in accommodation and community living

As indicated in Figure 1 and Table 2, since 2006 the volume of publications relating to the ‘inclusion’, ‘integration’ and ‘segregation’ of people with disability in accommodation and community living settings has trended upwards since 2006.

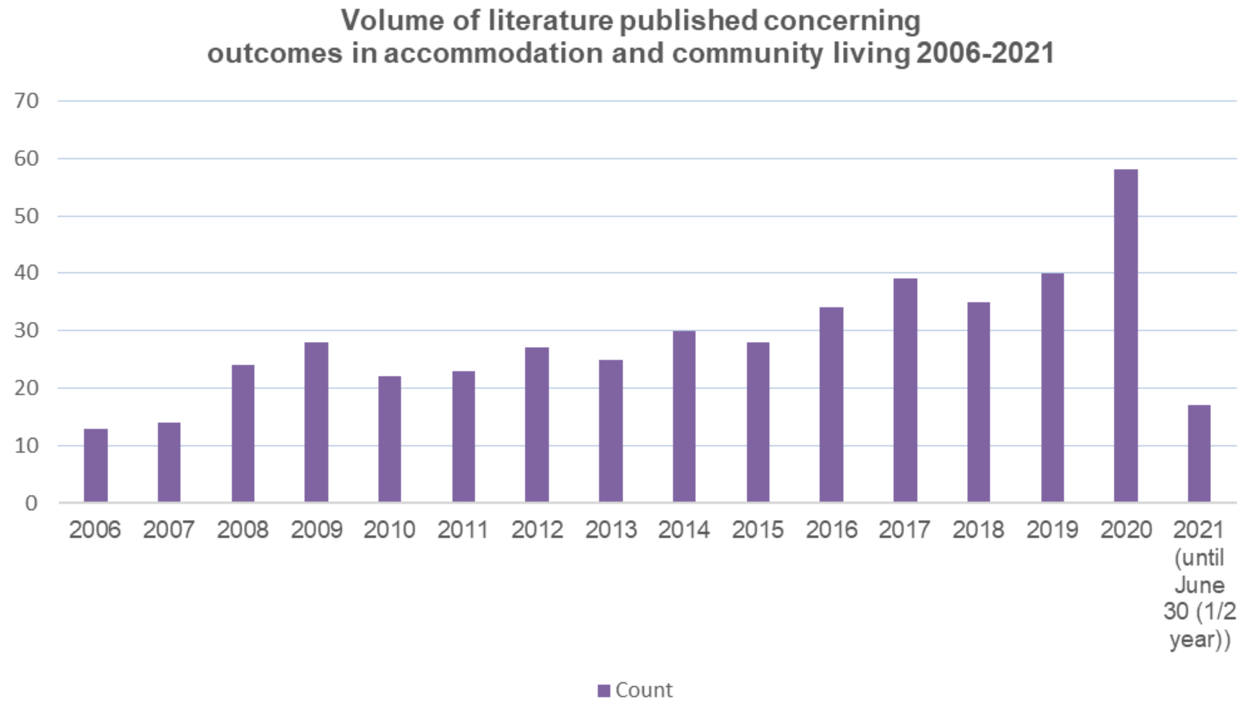

Figure 1: Volume of literature published from 2006 to 2021 concerning outcomes in accommodation and community living

Table 2: Percentage of publications relating to the 'inclusion', 'integration' and 'segregation' of people with disability in accommodation and community living settings

Publication period	Percentage
2006-2008	11.15%
2009-2011	15.97%
2012-2014	17.94%
2015-2017	22.10%
2018-2020	29.10%

One potential factor contributing to this increase is the adoption of the UNCRPD in 2006. Article 19 of the UNCRPD states that States Parties must recognise the:

> equal right of all persons with disabilities to live in the community, with choices equal to others, and shall take effective and appropriate measures to facilitate full enjoyment by persons with disabilities of this right and their full inclusion and participation in the community, including by ensuring that: a) Persons with disabilities have the opportunity to choose their place of residence and where and with whom they live on an equal basis with others and are not obliged to live in a particular living arrangement; b) Persons with disabilities have access to a range of in-home, residential and other community support services, including personal assistance necessary to support living and inclusion in the community, and to prevent isolation or segregation from the community; c) Community services and facilities for the general population are available on an equal basis to persons with disabilities and are responsive to their need.[9]

It is plausible that following the UNCRPD's adoption in 2006, there has been an increase in research investigating the 'inclusion', 'integration' and 'segregation' of people with disability in the community, including in relation to places of residence. This does not mean that all research fully embodies the tone or emphasis of the UNCRPD.

3.2.1.2 An emphasis on health science research

The second notable feature of the literature is that most research has been undertaken in the health sciences. As Table 3 below indicates, approximately 75% of literature we collected has been published in health science journals, with around 30% of this published in public health and nursing journals; around 25% published in applied psychiatry, psychology and community mental health journals; and approximately 21% published in applied disability practice research journals. The remaining 25% of literature we retrieved falls largely within social science journals (around 12%), social work journals (3%), and law and justice journals (approximately 3%). A further 7% of literature has been published in 'other' journals, such as tourism or public administration.

Table 3: Areas in which disability has been the focus of scientific investigation

Journal Focus	Count (%)
Health Sciences	345 (75.49%)
Health Sciences (including nursing, public health, rehabilitation, occupational therapy, exercise and sports science)	137 (29.97%)
Psychiatry, psychology and community mental health	113 (24.72%)
Applied disability practice research	95 (20.78%)
Social Sciences (including social and housing policy)	53 (11.59%)
Social Work	14 (3.06%)
Law and justice (including violence)	12 (2.62%)
Other	33 (7.22%)

The emphasis on health science research in Table 3 reflects a broader pattern in funded and supported disability research. The choices academics make about where to publish their research are typically informed by the conventions of the disciplines within which they are housed. An academic housed within a public health department, would be expected to publish most of their work in leading public health journals. An academic housed within a social work department would be expected to publish most of their work in leading social work journals. Indeed, making regular and recognisable research contributions to one’s specific disciplinary field is core to academics being hired and promoted. The distribution of disability-focused research publications in Table 3 reflects that most disability-focused academics currently employed within universities are commonly housed under the umbrella of ‘health sciences.’

3.2.1.3 Limited inclusion of people with disability in research

The third key feature of the literature about the ‘inclusion’, ‘integration’ and ‘segregation’, ‘quality’ and ‘safety’ of people with disability in accommodation and community living concerns inclusion of people with disability in research. As Figure 2 indicates, only 30% of literature we collected directly engaged with people with disability. So, almost two-thirds of literature did not ask people with disability about their experiences or perspectives.

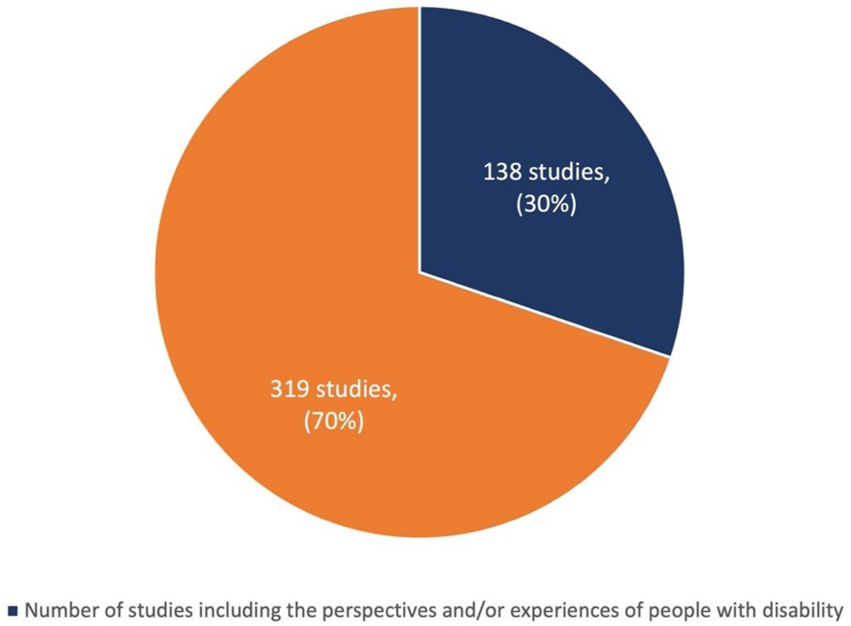

Figure 2: Proportion of studies directly engaging with people with disability

The lack of inclusion and direct engagement with people with disability in research that concerns their experiences and outcomes is a concern for how the disability research agenda is set and investigated, and it is a social and human rights issue.

As Figure 3 further illustrates, when people with disability have been included in studies concerning the ‘inclusion’, ‘integration’ and ‘segregation’, ‘quality’ and ‘safety’ in accommodation and community living, there is a tendency to focus on people with psychosocial and intellectual disabilities. Approximately 87% of the studies we collected focused on this specifically, with almost half (48.55%) focusing only on people with psychosocial disability and 21% focusing on people with intellectual disability alone. Even in studies that considered people with physical, sensory, acquired, psychosocial and/or intellectual disability, there was greater emphasis on people with psychosocial disability and with intellectual disability.

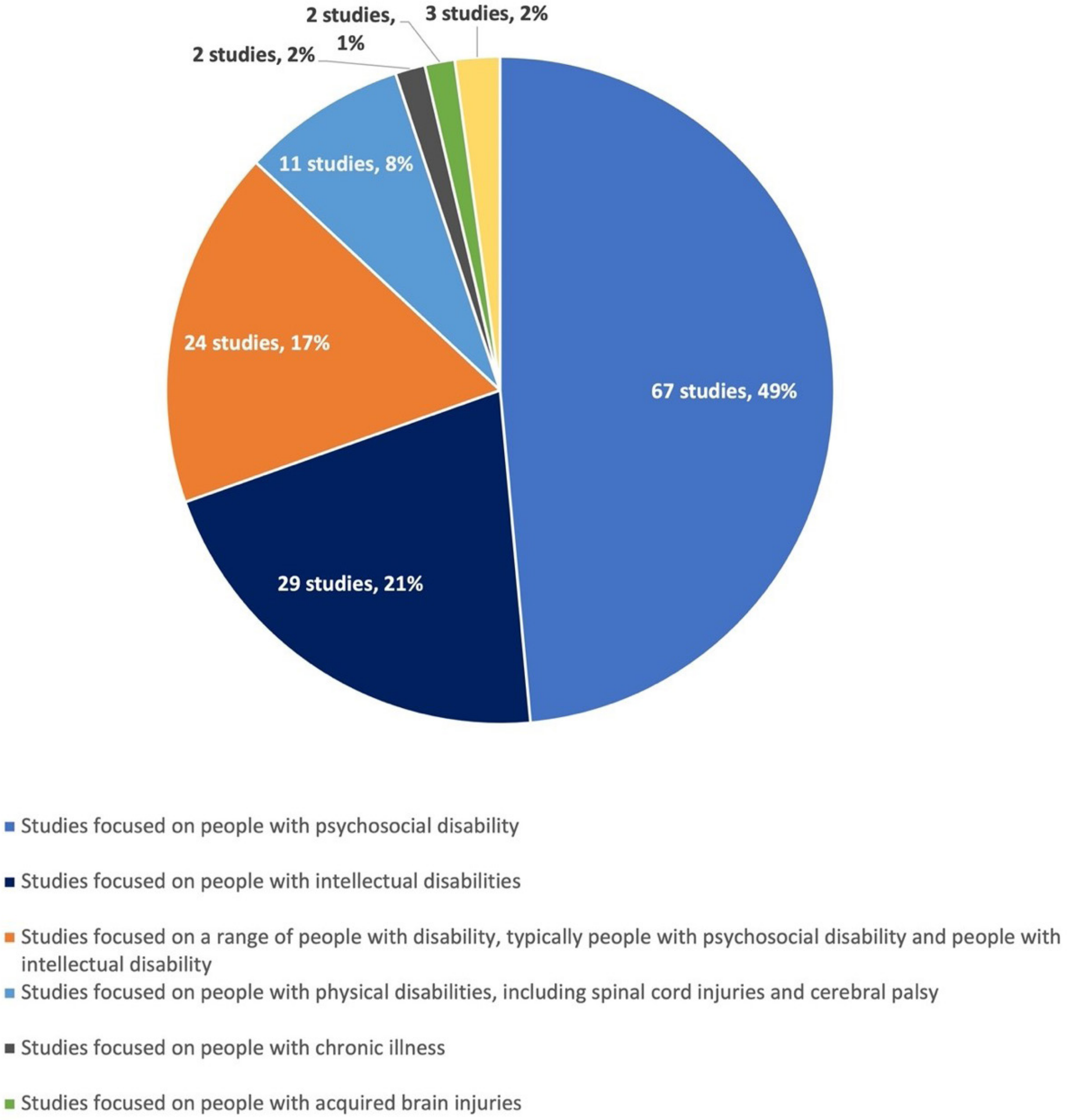

Figure 3: Focus of studies involving people with disability by category of disability

This tendency to focus on people with psychosocial and intellectual disabilities when considering the ‘inclusion’, ‘integration’ and ‘segregation’, ‘quality’ and ‘safety’ in accommodation and community living may occur for numerous reasons. One possible reason is that people with psychosocial and intellectual disabilities may experience significant points of tension and we draw out some of these later.

3.2.1.4 Different levels of engagement with the concepts of ‘integration’, ‘inclusion’ and ‘segregation’

The fourth characteristic of the literature we collected relates to ‘integration’, ‘inclusion’ and/or ‘segregation’ as primary areas of focus. As Table 4 shows, of the 457 publications we reviewed, 223 identified these issues as their *primary* area of focus.

Table 4: Integration, inclusion and segregation as primary foci of research

Primary issue in focus	Count and percentage of total literature engaging with issues of 'integration', 'inclusion' and/or 'segregation' in accommodation and community living as the primary area of focus
Integration	138 (61.88%)
Inclusion	80 (35.87)
Segregation	5 (2.24%)
Total collection of literature with a primary focus on 'integration', 'inclusion' and/or 'segregation'	223 (48.90%)

However, these 223 publications did not engage with 'integration', 'inclusion' and segregation' evenly. Almost two-thirds of this sub-set of publications (61.88%) attended to 'integration' as their primary area of focus, with a further 35.87% having 'inclusion' as the primary consideration. Only 2% of literature focused on 'segregation'. In section 3.2.4 we consider why 'segregation' features so minimally in contemporary research.

3.2.1.5 'Integration', 'inclusion' and 'segregation' are population-specific concepts

The fifth characteristic of the literature is that the terms 'integration', 'inclusion' and 'segregation' are largely used in the context of specific populations. As Table 5 indicates, 'integration' is commonly used in the context of people living with psychosocial disability. Of the 138 texts collected primarily focused on 'integration', 81% engaged with this concept in terms of people living with psychosocial disability. Of the 80 texts focused on 'inclusion', 82.5% engaged with this concept in the context of people with physical, sensory, acquired and intellectual disabilities.

Table 5: Integration, inclusion and segregation considered across categories of disability

Outcome in focus	Population in focus	Count of literature focused on this topic and population
Integration	Psychosocial disability	112
Integration	Physical, sensory, acquired and intellectual disabilities	26

Outcome in focus	Population in focus	Count of literature focused on this topic and population
Inclusion	Psychosocial disability	14
Inclusion	Physical, sensory, acquired and intellectual disabilities	66
Segregation	Psychosocial disability	4
Segregation	Physical, sensory, acquired and intellectual disabilities	1

It also became apparent in our review of the literature that there are significant differences between the assumptions, meanings and expectations ascribed to these population-specific terms.

3.2.1.6 Minimal consideration of diverse identities and intersecting experiences

The sixth notable characteristic of the literature was that over a quarter (27.35%) of the literature considered the diversity among and between people with disability. However, there is great variation in the attention paid to the experiences of different communities of people with disability. For example, while 57% of the 'diverse identities' literature considered the experiences of younger or older people with disability, only 14% considered the experiences of women and girls with disability, approximately 6% considered the experiences of LGBTQI+ people with disability, and 3% considered the experiences of First Nations people with disability.

Table 6: Consideration of issues of diversity in the disability related literature

Elements of identity considered	Count	% Of the literature considering diverse identities	% Of the total body of literature collected on accommodation and community living
Age	71	56.80%	15.53%
Older people	49	39.2%	10.72%
Young people	22	17.6%	4.81%
Gender and Sexuality	25	20%	5.47%
Women and girls	18	14.4%	3.93%
LGBTQI+ Communities	7	5.6%	1.53%

Elements of identity considered	Count	% Of the literature considering diverse identities	% Of the total body of literature collected on accommodation and community living
Race	20	16%	4.38%
Racialised populations outside Australia	16	12.8%	3.50%
Aboriginal and Torres Strait Islander peoples	4	3.2%	0.8%
More than one element of identity	**9**	**7.03%**	**1.96%**
Total	**125**	**100%**	**27.35%**

3.2.1.7 The paucity of research that considers the diverse identities and intersecting experiences and outcomes of people with disability has been recognised by the Disability Royal Commission as a problem that needs to be addressed.

The final characteristic of relevance is the notable absence of current scholarly literature on the experiences and outcomes of people with disability living at home with parents and/or siblings. The US is increasingly tracking the number of people with disability living with their parents[10], but these data are less well captured in Australia. We can discern that in 2009, there were about 446,300 Australians with a disability living with their parents.[11] A 2020 Australian Institute of Health and Welfare report indicated people with severe or profound disability are more likely to live with a parent or other relative[12]. Recent reports and inquiries suggest a key barrier preventing people with disability from leaving their parents' home is 'limited access to support for independent living'[13], with the ongoing provision of care affecting the carer's paid employment and contributing to low-income households[14]. There is a need for further research in relation to the integration, inclusion and outcomes of people with disability living with family members.

3.2.1.8 Summary of key findings about the characteristics of the literature

This section of the report presented 7 key findings:

1. The volume of publications relating to the 'quality' and 'safety' outcomes of people with disability in 'inclusive', 'integrated' and 'segregated' accommodation and community living has trended upwards since 2006.
2. Most of the research in this field has been undertaken by scholars in the health sciences; this reflects where most disability-focused scholars are employed within Australian universities.

3. Only 30% of literature concerning 'quality' and 'safety' outcomes of people with disability in 'inclusive', 'integrated' and 'segregated' accommodation and community living includes the direct experiences and perspectives of people with disability.
4. 'Integration' is a far more developed and explored concept than 'inclusion', with the concept of 'segregation' infrequently considered.
5. 'Integration' and 'inclusion' are typically used in relation to specific populations of people with disability. 'Integration' is primarily used in the context of people with psychosocial disability, whereas 'inclusion' is primarily used in the context of people with physical, sensory, acquired and intellectual disabilities.
6. There has been minimal consideration in research on 'quality' and 'safety' outcomes of the diversity among and between communities of people with disability.
7. There is an absence of Australian research considering the amount, experiences and outcomes of people with disability living with family.

These core characteristics of the literature concerning 'quality' and 'safety' outcomes of people with disability in 'inclusive', 'integrated' and 'segregated' accommodation and community living inform and limit the focus of the following sections of this report.

As indicated above, the majority of literature collected on 'integration' (81%), focused on people with psychosocial disability and the following section focuses on people with psychosocial disability.

3.2.2 How 'integration' is understood in the current research

There is no standard definition for integration but many of the 138 research publications we collected primarily focused on issues of 'integration', drew upon Wong and Solomon's 2002 definition of *community* integration.[15] This definition was developed in the context of people with psychosocial disability and includes 3 key dimensions:

1. Physical integration: 'the extent to which an individual spends time, participates in activities, and uses goods and services in the community outside his/her home or facility in a self-initiated manner'[16]
2. Social integration: includes an 'interactional dimension' where the person 'engages in social interactions with community members that are culturally normative',[17] and a 'social network dimension', where the individual's social network reflects 'adequate size and multiplicity of social roles' as well as 'positive support and reciprocity, as opposed to stress and dependency'[18]
3. Psychological integration: 'the extent to which an individual perceives membership in his/her community, expresses an emotional connection with neighbours, and believes in his/her ability to fulfil needs through neighbours, while exercising influence in the community'.[19]

We now consider how most of the research on integration presents the *importance* of pursuing and facilitating community integration for people with psychosocial disability in the context of accommodation and community living.

3.2.2.1 Recovery: The commonly presented reason for pursuing integration in accommodation and community living for people with psychosocial disability

Article 19 of the UNCRPD supports that the pursuit and facilitation of the full community integration and participation of people with disability is a right of all people with disability, and it is an obligation for state parties to fulfil.[20] However, this rights-based understanding of community integration is not commonly presented within the literature we collected. Instead, most of the research we reviewed appears to be based on an assumption that the importance of community integration lies in its association with the 'recovery' of people with psychosocial disability.[21] For example, scholars outline how community integration is 'well recognised as an important component of recovery for individuals with serious mental illnesses',[22] or that social integration 'remains a major goal of recovery-oriented mental health services'.[23]

The association with the 'recovery' of people with psychosocial disability appears to influence current engagements with community integration in at least 3 interconnected ways. First, associating community integration with 'recovery' seems to influence how community integration is understood as a goal and obligation. Most of the literature does not critically engage with community integration as an objective to be pursued and facilitated as a goal in, and of, itself. Rather, it is primarily presented as a *means* by which to achieve the apparently more significant end-goal of 'recovery'.

Second, this shift from community integration as the goal to recovery as the goal appears to influence expectations about what needs to occur to facilitate community integration for people with psychosocial disability. Several publications on accommodation and community living present 'community integration' as largely achieved if a person with psychosocial disability remains in the community and is not re-hospitalised (ie they remain 'recovered').[24] Indeed, as Bromley and colleagues note in their qualitative study of the perspectives of people with psychosocial disability on community integration, many definitions of community and community integration 'reply upon a dichotomous distinction between inside and outside mental health institutions'.[25]

Third, when the emphasis shifts from what is needed to facilitate the full, meaningful inclusion and participation of all people with disability in the community, to what is needed to stop specific people with disability from being re-hospitalised, other shifts occur. For instance, considerations of the role of state parties and the broader community in facilitating the meaningful inclusion and participation of people with disability in the community appear to move into the background. In their place, considerations of what interventions and treatments might be needed to facilitate the full 'recovery' of individuals with psychosocial disability come to the fore.

It is important to note these various shifts in emphases are familiar. The seeming shift to prioritise the 'recovery' of people with psychosocial disability, and the subsequent emphasis on interventions and treatment, align with the 'medical model of disability'. Under this model, all 'problems' associated with the disablement of people with disability in the community and broader society are viewed as residing within, or stemming from, the person themselves.[26]

Specifically, people who engage with disability from a medicalised conception understand the ‘problem’ of being disabled as stemming from the impairments and functional limitations of individual people with disability. Consequently, the ‘solution’ to disablement is typically pursued through investigations and investments in interventions for people with disability that ‘fix’, ‘recover’ or ‘treat’ these individualised limitations and differences.[27]

3.2.2.2 Community integration is everyone’s responsibility: A less common reason presented for pursuing integration in accommodation and community living

While most literature we collected presented integration as a means to achieve the end-goal of ‘recovery’, there is a growing, but much smaller body of studies focused on community integration itself as being the end goal. This work is primarily generated from the social sciences and is informed by qualitative research methods, such as semi-structured or narrative interviews with people with disability, and/or the use of photovoice. There are two important features of this alternate work on community integration worth noting.

First, it identifies a broader set of factors associated with community integration than those outlined above. Indeed, this alternate body of work presents community integration in terms of the opportunities people with disability, specifically people with psychosocial disability, have to: take risks, have reciprocal relationships and express self-determination;[28] live in preferred communities, have social connectedness to these communities and feel affinity with these surroundings;[29] and feel ‘accepted as yourself’, which includes not being understood in limiting ways such as only being a ‘mental patient’.[30] As expressed by a woman with psychosocial disability in a study by Vervleit and colleagues[31], community integration is realised when *all people* are accepted for who they are and are allowed to be themselves, and when differences are not seen as things to be ‘fixed’:

> It’s weird sometimes. I am weird. I know it. But I don’t want to change that because I think that everyone is different, so why can’t I be different too? It makes me special. […] I am even so special that it cannot be repaired [laughs].[32]

Second, this alternate body of work makes it clear that community integration is *everyone’s* responsibility. It is not possible for all people to be accepted for who they are, to have reciprocal relationships, social connectedness and develop feelings of affinity unless *everyone* contributes to this process. However, often, this shared responsibility for community integration is not being met.[33]

3.2.2.3 Barriers to full community integration of people with psychosocial disability

Two factors are commonly identified as frustrating the full community integration of people with psychosocial disability. The literature indicates that community integration is often limited by the attitudes of communities towards psychosocial disability.[34] This barrier was powerfully captured below by a woman with psychosocial disability:

> I’m part of a different community because I have a mental illness. Some people, I would just choose not to be around, because sometimes I talk and I stutter because of the medication, or sometimes I might be having a conversation in my mind and go somewhere else for a minute, so I’d rather be with people that can deal with that, and probably already expect that from me, than somebody that doesn’t really know me and doesn’t really know that I have a mental illness, and then I have to go through the trouble of explaining why I stutter, or explaining why my mind wanders off sometimes, and then people think you have a mental illness - some people think you’re dangerous, or maybe you’ll snap and kill somebody - you know, I don’t want people to think like that about me.[35]

But there are other barriers to community integration. Interviews with people with psychosocial disability often capture associations between limited employment opportunities and/or social welfare and limited community integration.[36] As a person with psychosocial disability explained in the context of their repeated movement between the community and being hospitalised:

> I was so ill I could not look after myself ... but at the same time I used the hospitalisations when I had no money for food and that kind of thing. I used the system on my fingertips, at the same time I could not get out of it. I did not get better from that. Sometimes [during hospitalisations] I was very ill, other times I used that side when I had no other choice. I was on the streets in [city] begging for money.[37]

Crucially, this body of literature clarifies that stigma and other barriers to support and access in the community do not simply limit or deter the full, meaningful integration of people with psychosocial disability. Rather, these elements also contribute to painful feelings of rejection and experiences of loneliness, separation and isolation for people with psychosocial disability.[38] This was expressed by a woman with psychosocial disability:

> I am alone wherever I am. It is dreadful to be lonely and forgotten and isolated. I have nobody.[39]

3.2.2.4 Summary of key findings concerning ‘integration’

This section of the report presented 4 key findings in relation to how current accommodation and community living research defines and uses the term ‘integration’ in the context of people with psychosocial disability:

1. There is no standard definition for the term ‘integration’, but research referred to Wong and Solomon’s 2002 definition of community integration which includes the physical, social and psychological integration of people with psychosocial disability in the community.
2. Most research appears to assume the goal of community integration is linked to, and sometimes subordinate to, ‘recovery’. This association may limit expectations on state parties and the broader community about what is required to enable community integration.

3. When the perspectives and experiences of people with psychosocial disability are centred and valued in research, a more expansive definition and set of expectations is put forward. This research understands that community integration is everyone's responsibility and involves creating and fostering opportunities for people with psychosocial disability to: take risks, have reciprocal relationships and express self-determination; live in preferred communities, have social connectedness to these communities and feel affinity with these surroundings; and feel 'accepted as yourself', which includes not being understood in limiting ways, such as only being a 'mental patient'.
4. Currently, poor community attitudes, mental health stigma and other support and access barriers work against community integration of people with psychosocial disability. As a result, many people report rejection, loneliness, separation and isolation from the broader community.

In section 3.2.5 we consider some 'quality' and 'safety' approaches already taken to better facilitate community integration of people with psychosocial disability in accommodation and community living. We turn now to 'inclusion'.

3.2.3 'Inclusion' in accommodation and community living; current research findings and limitations

> I just feel I want to be wanted. Want people to like me and want to be needed in the world. I just don't want to be with people and friends that don't like me, that's all. I don't ask for much *(woman with intellectual disability)*.[40]

Approximately 80% of literature focusing on 'integration' is focused on people with psychosocial disability. Similarly, 82% of the literature on 'inclusion' focuses on people living with physical, sensory, acquired and/or intellectual disabilities.[41]

Much of the literature on inclusion focuses on the physical presence of people with disability in communities including the use of goods and services; the social interactions and social networks of people with disability; and the perceptions of people with disability about feeling included or excluded in the community. However, there are several points of distinction between the literature on integration and inclusion and we outline 4 key findings from the literature.

3.2.3.1 An emphasis on the access of people with physical, sensory and acquired disabilities

The terminology of 'inclusion' is predominately used in the context of people living with physical, sensory, acquired and/or intellectual disabilities. When this is broken down further, it becomes apparent that almost all the literature on 'inclusion' (92.42%) in the context of accommodation and community living specifically focuses on people with intellectual disabilities. It is also apparent that the literature on the inclusion of people with intellectual disabilities differs in emphasis to that for people with physical, sensory, and/or acquired disabilities.

The literature relating to the inclusion of people with physical, sensory, and/or acquired disabilities almost exclusively focuses on access. This literature is often also focused on low- and middle-income countries. There is a study of the preferences, needs and satisfaction levels of urban space user's with and without disability in Cyprus.[42] There is a series of studies into the accessibility and preparedness of civil society to advance inclusion for people with disability in rural areas of South Africa, Botswana and Malawi.[43] There is also a study of the accessibility of buildings and transport as a facilitator for the socioeconomic inclusion of women with physical disabilities in Bangladesh.[44] Crucially, this literature concludes that the concept of 'access' has been too narrowly conceived and that access should involve thinking about 'adaptability, safety, comfort, dignity, density, legibility and autonomy' in design principles.[45]

In these ways, much of the small body of literature on the inclusion of people with physical, sensory, and/or acquired disabilities, appears to engage with the concept of inclusion identified by Wong and Solomon.[46] It attends to those elements needed to facilitate the *physical presence* of people with disability in communities, including the use of goods and services. This emphasis was not apparent in the literature on inclusion that focuses on people with intellectual disabilities.

3.2.3.2 Inclusion as feeling safe, welcome and like you belong, and having friends: the perspective of people with intellectual disabilities

Almost all literature relating to the inclusion of people with intellectual disabilities focuses on the second and third dimensions of Wong and Solomon's definition[47] and there is an emphasis on social interactions and social networks. There is also an emphasis on the extent to which people with intellectual disabilities feel they are part of, and belong to, different communities.

These studies suggest that being 'included' in the community means a range of different experiences but for most, being 'included' was closely associated with feeling safe and welcome, like you belong.[48] As a young person with intellectual disability put it in Robinson and colleagues' study:

> For me, what it means to feel like I belong is I can go anywhere and just feel comfortable.[49]

However, the literature suggests that inclusion – of belonging to a safe, welcoming community – is not commonplace for people with intellectual disabilities.[50]

Furthermore, and of major concern for policy and practice, is the high incidence of loneliness reported among people with intellectual disability.[51] Research supports the importance of friendship to people's health and wellbeing, and the potential for support and advocacy or safeguarding that comes with friendships.[52] However, supporting and promoting opportunities for people to re-establish, maintain and develop new friendships is rarely evident in policy and practice.

3.2.3.3 The commonplace experience of the exclusion of people with intellectual disabilities

As for people with psychosocial disability, the literature on the community inclusion of people with intellectual disabilities suggests it is common for people to experience stigma, negative community attitudes and discrimination in the community.[53] Sometimes these experiences were recognised by support workers in the context of accommodation and community living. However, sometimes, support workers are part of the problem as the following two quotes illustrate for people with severe and profound intellectual disability:

> My experience is that the residents are overlooked. People never speak to the residents. People can be quite ignorant. A person brushed by [a resident] and nearly knocked him down. It can be frustrating at times (Support worker).[54]
>
> We really cannot expect much from these men [with disability] because of the time they have spent in institutions. It will be easier to have inclusion with the next generation (Support worker).[55]

These negative experiences do not just affect how people with intellectual disabilities feel in the immediate moment. As Feldman and colleagues explain, these experiences can reinforce feelings of 'Otherness' and exclusion which can affect whether some people with intellectual disabilities feel welcome to move through various spaces and communities going forward.[56]

3.2.3.4 Summary of key findings concerning 'inclusion'

The vast majority of research concerning 'inclusion' of people with disability in the context of accommodation and community living focuses on people with intellectual disabilities (92.42%). This report presented 3 key findings in relation to how accommodation and community living research defines and uses the term 'inclusion' for people with physical, sensory, acquired and/or intellectual disabilities:

1. The small collection of literature almost exclusively focuses on 'inclusion' as an issue of access, where access is understood to include 'adaptability, safety, comfort, dignity, density, legibility and autonomy' in design principles.[57]
2. The more significant body of literature on the 'inclusion' of people with intellectual disabilities suggests that, for many people, 'inclusion' was closely associated with feeling safe and welcome in the community, and like you belong.
3. People with intellectual disabilities are clear about what it would mean to be included in the community, but it is far more commonplace for them to report their exclusion from the community. This is a similar to one of the core findings made in the context of 'integration' and people with psychosocial disability in section 3.2.2.2.

Below we consider 'quality' and 'safety' approaches already taken to better facilitate community inclusion of people with intellectual disabilities.

We turn now to the final term of interest: ‘segregation’.

3.2.4 Segregation: A largely unrecognised and unexamined concept in current research

Only 2% (n=5) of collected literature on accommodation and community living directly focused on ‘segregation’ or related terms such as ‘separate’. There was a broader collection of literature primarily focused on ‘integration’ and ‘inclusion’ that offered insight into segregation. We outline 3 key findings in relation to the concept of segregation.

3.2.4.1 A lack of recognition of what constitutes segregation in the community

The lack of literature on segregation does not mean that segregated accommodation settings and community living experiences are absent. There are numerous examples in the literature of group home settings, day service centres or disability-specific arts and leisure programs. However, there is little to no recognition that these settings and experiences constitute segregation of people with disability in the community. Instead, it is common for the literature to focus on how these settings and experiences fulfil or facilitate ‘integration’ and ‘inclusion’ of people with disability in the community.

3.2.4.2 Limited recognition of segregated settings as working against the full inclusion of people with disability

Minimal literature directly engaged with the concept of segregation, but a handful of studies engaged with the concept of inclusion and spoke to some of the effects of segregation in the community. There was some recognition that segregated accommodation settings and community living experiences do not uphold human rights principles of deinstitutionalisation and community living for people with disability.[58] There was also recognition that law and litigation, particularly in the US, can play a role in the pursuit of deinstitutionalisation and community living.[59] Finally, there were suggestions that the focus on closing large institutions that warehoused people with intellectual disability has detracted from addressing the broader aims of deinstitutionalisation and community living.[60] This can lead to service delivery based on a narrow conception of ‘community presence’, as opposed to meaningful participation and feelings of connection and belonging.[61]

3.2.4.3 A focus on the transitions between ‘integrated’ and ‘segregated’ settings

A final focal point relates to factors and dynamics that may contribute to someone transitioning between living independently and ‘segregated’ settings. Almost all literature on transitions between settings focused on young people with disability and older people with disability transitioning into aged care facilities. There was a common recognition that more people with disability could be kept out of segregated accommodation settings if greater structural and social supports were provided for them, their families, friends and communities. For example, it has been found that older adults with psychosocial disability disproportionately reside in aged care facilities, and younger adults with psychosocial disability are increasingly being admitted into aged care facilities, despite both groups being capable of remaining in the community with greater support.[62]

Similar findings were made for people with intellectual disability moving to aged care facilities.[63] It has also been found that younger and older people with disability who are at risk of being moved into segregated residential settings, such as group homes and aged care facilities, can be assisted to remain in the community if family and support networks receive additional supports.[64] Key factors influencing family members' decisions to transition a person with disability into a segregated form of accommodation included income, the age of the person with disability and a perceived need for a more protected or secure environment for that person.[65]

3.2.4.4 Summary of key findings concerning 'segregation'

Minimal literature directly focuses on issues of 'segregation' in the context of accommodation and community living. Some insights can be gained through closer examination of the literature on 'integration' and 'inclusion'. There are 3 core findings in relation to how current accommodation and community living research defines and uses the term 'segregation' for people with disability:

1. There is little to no recognition that group home settings, day service centres or disability-specific arts and leisure programs constitute segregated settings.
2. There is some recognition in the literature that simply enabling people with disability to be present in the community through smaller-scale, communal living settings, does not uphold the human rights principles of deinstitutionalisation and community living, and works against the meanings of 'inclusion' and 'integration' articulated by people with disability.
3. Younger and older people with disability are being moved into residential aged care facilities earlier than their peers. Research suggests that more people with disability could be kept out of these segregated accommodation settings if greater structural and social supports were provided for them, their families, friends and communities.

3.2.5 'Quality' and 'safety' in accommodation and community living: current research, potential approaches and their limitations

According to the Disability Royal Commission, 'quality' occurs when a person with disability:

> is free from neglect; has choice of who to live with and where to live, and choice about daily routine; participates in chosen and meaningful activities; experiences emotional and social support; is allowed to express personality, talents and creativity; has opportunity to achieve goals; experiences significant and reciprocal relationships with a range of people; has opportunities to contribute to and participate in the community; is enabled to develop an enhanced sense of belonging and pride in identity; and functions independently at home and while travelling.[66]

‘Safety’ includes:

> being free from violence and abuse, including restrictive practices; developing a sense of dignity and autonomy; experiencing the promotion of informal safeguards – being known and valued in the neighbourhood and network of social communities; and experiencing the promotion of positive attitudes towards people with disability.[67]

These visions are not fully reflected in current research. Most studies engaged with ‘quality’ in the context of accommodation and community living and focus on ‘quality-of-life’. This concept has its roots in the World Health Organization’s 1947 definition of health as a ‘state of complete physical, mental and social well-being, and not merely the absence of disease and infirmity’.[68] Arguably because of this history of the construct of quality-of-life, most studies ultimately speak to physical, mental and social wellbeing.[69] Only sometimes do these factors overlap with the vision of ‘quality’ articulated by the Disability Royal Commission.

A similar issue occurs for ‘safety’. Current literature predominately focuses on identifying potential risks of harm within specific settings, most often in the home of older people with disability or in aged care settings,[70] and/or in documenting and comparing reportable incidents of harm in these contexts.[71] Again, this conception of ‘safety’ as the risk of falls and the use of restrictive practice (restraints) or reportable incidents does not fully capture the factors and outcomes envisioned by the Disability Royal Commission in relation to ‘safety’ or how safeguarding might be achieved in quality services and inclusive communities.

More closely aligned with the focus of the Disability Royal Commission, a Delphi study involving 249 service personnel generated 291 unique safeguarding statements in its first round and a short-list of 31 items in its second round.[72] The short-listed items received a rating of at least 9.5/10 from respondents in terms of importance in safeguarding people with disabilities against neglect and abuse. The items were grouped according to organisational issues, staff education and client education and were:

Organisational issues

1. Encourage complaints, and act on them.
2. Reinforce a culture that supports human rights by means of ‘walking the talk’, where good practice is modelled by managers.
3. Encourage, foster and develop an environment for people to discuss concerns.
4. The voice of people with a disability and their families, and the outcomes they wish for, need to be on the table and part of the process.
5. Open communication that resonates with everyone about rights and responsibilities.
6. High standards when recruiting staff.

7. The organisational culture encourages staff to speak up if they suspect something is not ‘right’.
8. Take any allegation seriously.
9. Provide an environment where people with disabilities are able to speak up regarding neglect and support them to do so.
10. Staff feel safe and are encouraged and supported to report issues.
11. Checks on hiring staff in terms of criminal history.
12. Working with children checks when hiring staff.
13. Stable staffing group with a strong positive culture.
14. Regularly talk with the people who are supported.
15. Recognise early signs through regular conversation.
16. Understand change in a client by listening to what they are saying and asking questions.
17. Capacity for clients to report confidentially to a person they trust who can take action.
18. Open communication that gives the client a voice and respect.

Staff education

19. Develop staff awareness of, and commitment to, human rights.
20. Deliver professional development on empowerment for people with disability.
21. Train direct support staff to understanding and recognise signs from non-verbal clients.
22. Staff being aware of what abuse and neglect is and how to make a formal complaint.
23. Train staff to understand their role in identifying neglect and abuse and when to advocate for an individual.

Client education

24. Educate the person with disability on how to report instances of abuse and neglect.
25. Empower the person with the knowledge that they can speak up.
26. Teach and support people with disability to speak up if they have been mistreated.
27. Ensure people have communication supports to enable them to voice their concerns.
28. Train people with disabilities in self-awareness of when they feel things are not right and in protective behaviours.
29. Regularly talk about the proper actions for people to take if they feel unsafe.

30. Empower people with a disability to know their human and rights and how to exercise them.
31. People should be informed of what is right and wrong and how they can expect people to behave towards them.

In conducting our research, we ensured the search terms we used in data collection were broad enough to look beyond the literature on quality-of-life and safety risks to capture key factors of interest to the Disability Royal Commission. We outline 3 key insights that emerged.

3.2.5.1 Segregated and/or communal living settings work against the quality and safety outcomes set by the Disability Royal Commission

The Senate Community Affairs Reference Committee 2015 report into violence, abuse and neglect against people with disability in institutional and residential settings supported the view that 'institutional and congregate care models of service delivery are themselves major factors in the prevalence of violence, abuse and neglect of people with disability'[73]. Several studies show that segregated and/or communal living settings do not fulfil the Disability Royal Commission vision of quality and safety. Indeed, studies suggest these settings often have the opposite effects.

Drake's study of people with psychosocial disability and intellectual disability living in licensed boarding houses in Inner Sydney found that although these settings are located in the community, they are better conceived as institutions.[74] Drake explains that boarding houses 'fail to uphold the human rights principles of deinstitutionalisation';[75] they are characterised by the 'outdated skills and knowledge of proprietors; and their congregate and for-profit model result in institutionalised practices'.[76] Crucially, Drake's study indicates poor outcomes for people with psychosocial disability and intellectual disability. These occur due to lack of relationships, choice, safety and privacy. Drake explained that people in boarding houses have: 'a lack of choice about the duration of showers, when to eat meals, how tea or coffee was taken, and with whom they shared a bedroom';[77] have little to no access to health care services; are subject to restrictive practices; and rarely develop relationships with anyone beyond boarding house staff, external service workers and those with whom they lived.

There are similar findings in some group homes for people with intellectual disabilities. Some studies indicate that people with intellectual disabilities are not provided with opportunities or accessible means to become involved in their own healthcare decisions;[78] feel unsafe in their environment;[79] and are subject to restrictive practices, at times for reasons of convenience.[80] A recent report by the Office of the Public Advocate in Victoria, *I'm too scared to come out of my room*, provides some of the first qualitative evidence of peer-to-peer violence and abuse in group home settings[81], and a recent ANROWS report suggests significant recognition and response barriers for people with disability when seeking justice for this form of domestic violence[82]. However, these issues are rarely reflected in the scholarly literature and further research is required. Some studies also suggest that people with intellectual disabilities in group homes rarely develop relationships beyond other residents or staff, with those relationships ending when other residents or staff leave the home.[83] These outcomes don't reflect the quality and safety expectations of the Disability Royal Commission.

Gill argues a need for system change in the group home context so people with intellectual disabilities are understood and engaged with 'as competent and active agents in their own lives'.[84] Gill says this focus is needed because 'giving individuals with intellectual disabilities more control over their residential lives is one concrete example that can mitigate a reduction in abuse'.[85] Gill posits a connection between settings that actively deny people with intellectual disability the right to be recognised as sexual and to explore full sexual lives – such as institutions and group homes – and problematic responses when sexual abuse and assault are discovered.

The lack of support for people with intellectual disabilities to explore full sexual lives was highlighted in several studies. This lack of facilitation and support denies the right of people with intellectual disabilities to full sexual expression[86] and places people at risk of undiagnosed and untreated sexually shared infections.[87] Key factors identified in the literature as affecting this fundamental right of people with intellectual disabilities include the absence of sexual health promotion and practices surrounding safe sex,[88] and the limiting, ableist, homophobic and typically heteronormative-promoting assumptions and attitudes of professionals.[89]

However, group home practices vary, and some scholars have considered factors that may contribute to 'better' cultures and outcomes for people with intellectual disabilities. These studies suggest the organisational culture of different group homes can account for some differences in residents' quality-of-life outcomes.[90] Group homes with 'better' cultures typically comprise staff with a positive regard for people with intellectual disabilities and take a person-centred approach to their practice.[91] Although, as other studies make clear, 'better' cultures within group homes settings cannot fully remove the limits on choice and control built into the design of group homes. These are where common areas act as places where staff exercise authority and counteract an individual's expressions of choice and control in these communal spaces;[92] and budget restraints and other concerns about efficiencies can limit the amount, type and timing of community involvement supported by staff.[93]

Two main approaches have been taken in recent years to address choice, control and independence in accommodation and community living.

3.2.5.2 Personalised housing support produces better outcomes for people with disability

> I got my freedom. I could come and go in my apartment. And I could tell people who could come into my house and who can't…[94]

Fisher and Purcal compared 6 case studies of personalised housing support for people in Australia with disabilities who sometimes require access to 24-hour formal or informal support.[95] The case studies included examples of personalised housing for people with psychosocial disability and significant intellectual, physical and sensory disabilities. Two of the examples provided housing services for First Nations men and young people. The term 'personalised housing support' refers to how the case studies 'used a person-centred approach in service planning, design and provision'.[96] In each case study, support hours assisted people with disability to live in their home and, depending on the specific support needs of the person with disability, support hours were used to undertake activities such as ‘shopping, cooking, personal care and case management’.[97] Through interviews with people with disability, Fisher and Purcal’s analysis showed four positive outcomes that align with the expectations of the Disability Royal Commission for quality and service, including:

- Improved social networks that are actively encouraged and assisted by the housing support approach (eg through support workers assisting people with disabilities to reflect on their interpersonal skills).[98]
- Empowerment to make choices and decisions about their housing environment and day-to-day activities. Such choices and decisions were enhanced through information and skills training, such as self-management and assertive communication.[99]
- Receiving support to use general (mainstream) services in the community, such as libraries, gyms, pools and cafes.[100]
- Becoming more independent at home through the provision of skill development and support to undertake domestic tasks to look after a home.[101]

Crucially, Fisher and Purcal’s analysis showed ‘the average cost in the case studies is broadly similar to the cost in group homes’,[102] and so independent, personalised living options should feasibly be considered as an avenue for governments to move away from group homes.

Similar positive outcomes for people with disability have been documented in other studies of supported community living. Watson, Fossey and Harvey conducted a qualitative meta-synthesis of the experiences of people with psychosocial disability living in supported housing.[103] ‘Supported housing’ referred to ongoing, ‘ordinary’ housing in the community that is de-coupled from treatment and support but includes ‘flexible and individualised support’.[104] The meta-synthesis of 19 studies showed supported housing gave people with psychosocial disability a sense of privacy, control, stability and security, and a foundation for engaging in activities and developing or renewing the confidence and motivation needed to pursue and achieve goals beyond the home environment.

At the same time, this meta-synthesis showed that, despite the efforts of people with psychosocial disability, and at times their support workers, to foster social networks and meaningful relationships in the community, these efforts are not often reciprocated. Indeed, Watson, Fossey and Harvey found that many people with psychosocial disability in supported housing feel lonely, ‘cut-off’ or excluded from others and experience stigma.[105]

A similar set of ‘conundrums’ were found by Bigby, Bould and Beadle-Brown in their study of the experiences of 34 people with intellectual disability living in supported housing in Victoria.[106] Their study shows that while people with intellectual disability could identify ways in which supported housing was ‘better’[107] than living with parents or in group homes, and speak to the new freedoms of choice they enjoyed ‘more than anything’,[108] there were missing pieces and tensions. For example, people with intellectual disability spoke about the uncertainties and inconsistencies they faced around paid support – having different workers arriving to provide support, support arrangements changing without consultation and/or not being sure how much support they would receive due to changes in funding. These all worked to undermine the freedoms of choice and control gained through supported housing arrangements. Crucially, like the people with psychosocial disability in Watson, Fossey and Harvey's analysis,[109] the people with intellectual disability in Bigby, Bould and Beadle-Brown's study also spoke of being lonely, rejected by family and others in the community and of experiencing poor relationships with some neighbours.[110]

We note these findings are consistent with a key observation made in the quality-of-life literature. Although good quality-of-life outcomes are diminished or impossible in unsafe environments that lack choice and control (ie environments outlined in section 5.1), simply addressing those environments through providing supported accommodation provisions that offer choice and control does not produce good quality-of-life. Rather, *additional investments* in environments, structures and communities that work to *enhance* a broad range of outcomes for people with disability are needed.[111] Below we outline a primary, though limited, way in which this additional range of outcomes has been approached to date.

3.2.5.3 Facilitated leisure and art activities: a common avenue pursued for fostering the quality and safety outcomes envisioned by the Disability Royal Commission

Participation in facilitated community 'sport/physical activity' and 'art/theatre' activities appears to foster many core factors identified by the Disability Royal Commission associated with 'quality', and positively influence the quality-of-life of people with disability.[112] Research suggests that participation in these facilitated activities offer opportunities for a range of people with disability to: experience emotional and social support;[113] express personality, talents and creativity;[114] experience reciprocal relationships with a range of people;[115] contribute to, and participate in, the community;[116] and develop a sense of belonging.[117] One person with psychosocial disability put it in the context of a physical exercise program:

> You feel part of something…it is part of your life, it's actually living, not existing, its enjoyment.[118]

There is, however, a point of complexity and tension to be outlined.

As previously flagged, most facilitated 'sport/physical activity' and 'art/theatre' activities occur in a segregated manner. These activities are run within group homes for people with intellectual disability and exclusively delivered to residents, or they are part of in-patient services for people with psychosocial disability and are exclusively delivered to these service users, or through outpatient and day centres for people with disability specifically. While these activities enable a range of important positive outcomes for people with disability, many of which are aligned to the Disability Royal Commission's vision for 'quality', these activities do not necessarily contribute to the inclusion and integration of people with disability in the broader community.

One factor that appears to inform the limited, targeted design and delivery of facilitated 'sport/physical activity' and 'art/theatre' activities is safety or, to be precise, the factors envisioned associated by the Disability Royal Commission with 'safety'. Targeted 'sport/physical activity' and 'art/theatre' activities do not just facilitate the positive 'quality' outcomes outlined, they are regarded by people with disability as 'safe' and 'welcoming' environments and as places and interactions free from violence and abuse, where you are valued and positively regarded.[119]

However, if we look more closely at how people with disability characterise these environments, it becomes apparent that part of the reason these targeted, disability-specific environments feel safe and welcoming is because of the stigma and negative attitudes people with disability continue to encounter in the broader community. There are also structural barriers, such as lack of income and inaccessible transportation, that continue to make it difficult for people with disability to engage in these communities more broadly.[120] A person with psychosocial disability put this in the context of a physical exercise program:

> I would feel very worried about going out – I just have to force myself out…coming to the centre helps, as I know it is a familiar place and staff.[121]

A study by Pahwa and colleagues suggests these feelings of safety and being welcome are not necessarily specific to the *activities*, but just the *environment.*[122] As Pahwa and colleagues explained, people with psychosocial disability using mental health services often talk about these services as a 'safe haven' against the lack of physical safety and stigma in the general community'.[123] Similar findings have been made in the context of 'care farms' in the Netherlands.[124]

There has been a suggestion within the literature that some of these 'safety' issues can be addressed through 'sport/physical' and 'art/theatre' activities that are not segregated. Nitzan recently found in arts-based groups that 'integrate' people with and without psychosocial disability, place no emphasis on diagnosis and instead emphasise 'equality', this was an important 'corrective experience' which enhanced senses of belonging to the community, social relationships and combated stigma.[125] While we support further exploration of, and investment in, 'integrated' activities that emphasise equality for participants, the 'corrective' impact may be small scale. Facilitated integrated activities may prove beneficial individually, but may do little to address broader, structural issues identified in this chapter.

3.2.5.4 Needing to keep the bigger picture in sight: Structural inequality and poorer outcomes for people with intersecting experiences

As observed earlier, just over a quarter (27.35%) of the literature we collected included people with disability whose experiences of disability and inclusion, may intersect or be influenced by age, gender, sexual orientation, ethnic origin or race, the particular situation of First Nations people and cultural and linguistic diversity. As outlined previously, this literature on 'intersecting experiences' is uneven in its attention. While 71 studies considered the experiences of older or young people with disability in the context of accommodation and community living, only 18 studies considered the experiences of women and girls with disability, 7 considered LGBTQI+ people with disability, and 4 considered First Nations people. All literature on intersecting experiences associated with ethnic origin or race pertained to racialised populations outside Australia, mostly the US.

It is important to clarify that the 'intersecting experiences' literature is limited in at least one other crucial way. Although it can be categorised as *including* people whose experiences may be shaped by disability and other elements, including women, young people or First Nations people with disability, very few studies expressly draw out intersecting experiences as their primary area of focus. On the few occasions this has occurred, it is crucial to recognise it occurs in the context of exclusion, discrimination and violence – not inclusion, integration, quality and safety. Indeed, much of this small body of literature recognises how experiences of colonialism,[126] racism,[127] gender-based violence[128] and discrimination against LGBTQI+ communities[129] shape the experiences of violence of many people with disability.

What is common across these diverse intersecting experiences is a consistent thread of poverty, best captured in the following quote from a person with disability responding to a question about how they would imagine a safe future:

> I would have really strong stability, meaning that I wouldn't have to worry about being homeless again and I wouldn't have to worry about my living situation or money or just basic necessities and maybe actually have a few friends.[130]

This quote acts as a key reminder of the importance of the bigger picture when considering how best to facilitate 'inclusion', 'integration', 'quality' and 'safety' in the context of accommodation and community living. Specifically, it reminds us that while we may have identified some approaches that better facilitate 'quality' and 'safety' outcomes at an individual level, unless we attend to structural inequalities that shape so much of the experience of people with disability, we limit possibilities.

3.2.5.5 Summary of key findings concerning 'quality' and 'safety' outcomes for people with disability in the context of accommodation and community living

We have presented 4 key findings in relation to 'quality' and 'safety' outcomes for people with disability in relation to 'integrated', 'inclusive' or 'segregated' accommodation and community living settings:

1. Studies show that some segregated and/or communal living settings such as group homes and boarding houses do not fulfil the vision of quality and safety outlined by the Disability Royal Commission. While some group homes are considered to have 'better' cultures and outcomes for people with intellectual disabilities, this cannot fully remove the limits on choice and control built into the design of group homes.

2. Supported accommodation settings which personalise their delivery of support produce better quality and safety outcomes.
3. Fostering participation in facilitated ‘sport/physical activity’ and ‘art/theatre’ activities in the community have been the two main ways that ‘quality’ and ‘safety’ outcomes for people with disability in ‘integrated’, ‘inclusive’ or ‘segregated’ accommodation and community living settings have been approached. While research suggests participating in these facilitated activities can lead to some positive outcomes, many of these activities currently only take place in segregated contexts.
4. There is a paucity of research concerning the ‘quality’ and ‘safety’ outcomes of people with disability who have ‘intersectional experiences.’ However, available literature makes clear that there is a need to address individual and structural barriers to ‘inclusion’, ‘integration’, ‘quality’ and ‘safety’.

3.3 Key findings from the Delphi for accommodation and community living related policy and practice initiatives

In preparation for round 1 of the Delphi panel, we derived 46 evidence-based recommendations from the literature review to put forward for assessment and feedback. In round one, the Delphi panellists agreed that 35 of the 46 recommendations were important. These recommendations consistently received endorsement by 75% or more of the panellists at or above the median rating of 6. They are shown in table 7.

The recommendations can be grouped into 6 broad categories:

1. The need to move beyond a relatively narrow medical and health sciences paradigm when considering issues of disability and what matters to people with disability.
2. The need to move beyond relatively simplistic understandings of inclusion in the context of physical space and location.
3. The need to understand a quality life is a multifaceted experience, inclusive of objective and subjective factors.
4. The need to acknowledge and address structural disadvantage, such as issues relating to access to education, employment, and civic/political participation.
5. Life course perspectives are important, taking into account people’s changing circumstances.
6. The need to ensure the voice of people with disability is heard with respect to research and policy development.

For some recommendations – ones with clear agreement and those where only people with lived experience agreed on their importance – the panellists provided feedback that allowed us to make clearer and more relevant recommendations before moving to Round 2 of the Delphi Study.

In Round 2, recommendations most commonly ranked by panellists as being of highest priority were:

- The voice of people with disability needs to be elevated in developing policy and supportive practice around inclusion.
- The voice of people with disability needs to be elevated with respect to policies and practices supporting opportunities for self-expression and self-determination.
- Greater priority needs to be given to the expertise of lived experience to inform policy and practice.
- Policies and practices need to go beyond supporting people to be merely present in their community, to supporting active participation in their community.
- Policies and practices need to go beyond supporting people to be merely present in their community, to enfranchising them to exercise governance in organisations and their community.
- There needs to be a shift in focus for research and policy development to address structural disadvantage, with a focus on redressing poverty and economic disadvantage.

When asked to address the 'big question' that might make a difference in the safety and quality of people's experience of accommodation and community living, thematic analysis of the panellists' answers suggested a number of major themes (Note - the order of presentation is not intended to imply any particular priority, and all should be considered equally important for consideration in policy and practice).

Table 7: Accommodation and community living Delphi items with the highest level of endorsement with respect to importance

Topic	Policy / Practice Recommendation
Research focus	Research to inform policy and practice needs to be framed and commissioned with greater alignment to the social model of disability.
Community integration and inclusion framed in the context of health-related research	The voice of people with disability needs to be elevated in developing policy and supportive practice around inclusion. The voice of people with disability needs to be elevated with respect to policies and practices supporting opportunities for self-expression and self-determination. The voice of people with disability needs to be elevated with respect to policies and practices supporting the pursuit of reciprocal relationships

Topic	Policy / Practice Recommendation
The priority and privilege of researchers, policy makers and service providers	Greater priority needs to be given to the expertise of lived experience to inform policy and practice. The principles and practices of co-design and co-production need to be better understood and more widely applied in the development and evaluation of disability policy and practice.
Families often speak on behalf of people with disability, especially those with intellectual disability and other cognitive impairments	Wherever possible, the views of proxies should be tested and triangulated, especially when speaking on behalf of adults with disability.
Inclusion considered predominantly in the context of a physical experience	Policies and practices need to go beyond supporting people to be present in their community, to supporting a sense of belonging to their community. Policies and practices need to go beyond supporting people to be merely present in their community, to supporting active participation in their community. Policies and practices need to go beyond supporting people to be merely present in their community, to supporting them to influence and take up roles of leadership in organisations and their community. Policies and practices need to go beyond supporting people to be merely present in their community, to enfranchising them to exercise governance in organisations and their community.

Topic	Policy / Practice Recommendation
Predominance of a (health sciences/medical) deficit-focused research agenda	There needs to be a shift in focus for research and policy development to address socio-cultural issues that place people with disability at risk of neglect, abuse, exploitation or violence. There needs to be a shift in focus for research and policy development to address structural disadvantage, with a focus on countering stigma and raising community expectations of people with disability ie raising expectations about what people might achieve in education, personalised living arrangements, employment, social and political participation and contribution to their community. There needs to be a shift in focus for research and policy development to address structural disadvantage, with a focus on discrimination and circumstances giving rise to discrimination. There needs to be a shift in focus for research and policy development to address structural disadvantage, with a focus on discrimination including calling out and penalising situations of discrimination.
Congregate living arrangements as a potential source of risk of neglect, abuse and violence	The dangers inherent in small-scale community living options need to be recognised and addressed by building relationships of care and protection and by the provision of safeguards involving service monitoring and advocacy.
Individualised options as a potentially safer alternative for many people with disability	Policies and practices support people with disability to pursue personalised accommodation options of their choice, regardless of their assessed level of disability.

Topic	Policy / Practice Recommendation
Current ‘inclusive practices’ continue to congregate people and limit opportunities	There is a need for policy and practice to develop strategies for facilitating engagement of people with disability with the wider community. There is a need for policy and practice to develop strategies for facilitating engagement of people with disability with those they identify as peers and companions, regardless of disability. Policies and practices designed to promote and support community integration need to be formulated, embedded and enacted on a macro level and intentionally included in community life and infrastructure, including in legislation and policy framing for all sectors of the community and economy.
People with disability find themselves at risk of violence, abuse, neglect and exploitation linked to situations characterised by experiences of structural inequality, in addition to disability related issues such as colonisation, racism and sexism.	When addressing issues of structural inequality in the community broadly, the voice and interests of people with disability need to be considered and incorporated into systemic solutions. Mechanisms by which systemic solutions can consider the voice and interests of people with disability include anti-discrimination legislation.
Limited conceptualisation of what might constitute institutional service provision	There needs to be broader recognition of what constitutes institutional service provision, beyond the scale/design of a facility. When appraising the extent to which a service is institutional, greater attention needs to be given to daily routines, the patterns or rhythms of those routines and the opportunities people have to influence and control these routines.
Both younger and older people are at risk of neglect, abuse and violence	Policies and practices focusing on individualised supported living need to be prioritised to enable people to pursue their choice of lifestyles, safeguarded against neglect, violence, abuse and exploitation. Inclusive practice could be fostered in the context of policies and programs supporting ageing in place for those currently residing in a home of their own.

Topic	Policy / Practice Recommendation
Families have an important and influential role in the lives of many people with disability	Policies and practices need to be formulated to address the support needs of families, recognising they provide a supportive context that can, when appropriately supported, off-set the need for institutional care. There needs to be a shift in focus for research and policy development to address structural disadvantage, with a focus on redressing poverty and economic disadvantage.
Quality-of-life is a multifaced construct and includes objective and subjective experiences	The assessment of quality-of-life should include objective indicators that reflect the values and priorities identified by those with disability. The assessment of quality-of-life should include subjective indicators, like personal wellbeing, that reflect the values and priorities identified by individuals with disability. Services and service systems need to be assessed by the extent to which they are likely to deliver quality-of-life, including safeguarding against neglect, abuse and violence.
While safety and security are important, they are not sufficient to guarantee a quality life experience	Policies to simply address safeguarding are insufficient. Additional investments in environments, structures and communities to intentionally enhance quality-of-life and wellbeing are needed.
There is a range of circumstances and activities of value to people with disability, especially where they experience unconditional regard and reciprocity	Policy and practices need to recognise that facilitated activities involving reverse integration are only a first step and that participation in mainstream activities are important for the realisation of inclusion. Policies and practices need to recognise and promote opportunities for people to re-establish, maintain and develop new friendships.
Sexuality is fundamental to a person's experience of humanity	The policy agenda needs to explicitly call out the imperative to recognise people with disability as sexual beings with sexual identity. The right to, and the supports needed to, express and experience a sexual life need to be recognised and articulated across legislative and policy instruments and reflected in the development of the standards by which services are to be evaluated.

3.4 Conclusions and recommendations concerning accommodation and community living for people with disability

When people with disability are asked what ‘integration’ or ‘inclusion’ means in accommodation and community living, they consistently report a number of key features. It means feeling welcome; feeling like you belong; being free from stigma, violence, and abuse; having options to choose from *and* being allowed to choose. These features align with the Royal Commission’s vision for ‘quality’ and safety’.

However, current research illustrates it is far more common for people with disability to voice experiences of exclusion, rejection, discrimination, disadvantage, inequality, stigma, neglect, maltreatment, violence and abuse.

Perhaps we do not see the vision of integration and inclusion actualised because of how facilitating inclusion and integration have been approached across different groups, different policy agendas and different service systems. For example:

- Inclusion can be subservient to the goal of ‘recovery’ of people with psychosocial disability, where ‘recovery’ often translates to non-hospitalisation (ie, non-institutionalisation), and this is taken to be by implication inclusion in the wider community.
- Experiences deemed inclusive are facilitated while people with disability remain in segregated or otherwise limited contexts, such that the ‘inclusion’ of people with intellectual disability is perceived to be achieved by people being accommodated in suburban communal residences (group homes), not large-scale institutions; or by participating in community-based activities though still in practical contexts that perpetuate segregation.
- Policy and service objectives focus on interventions in the lives of people with disability to ‘fix people with disability’. For example, inclusion is seen as working to change the presence of people with disability in the community, but not as something communities need to take shared responsibility for addressing structural inequalities and interlocking experiences of oppression and discrimination.

Perhaps the vision for inclusion and integration has not come to fruition because of how we have focused our attention in research and evidence, too. As Section 3.2.1 makes clear, we’ve built strong foundations to fund and support health-focused research that allow us to determine critical issues about wellbeing from a health perspective. But there is minimal scaffolding to support research in the social sciences and humanities – areas of research better suited to revealing and posing solutions to the broader social and structural factors impeding inclusion.

As the recently updated *Australian and New Zealand Standard Research Classification 'Fields of Research'* codes make clear, disability-focused research in Australia and Aotearoa New Zealand is only recognised as currently falling under the disciplinary divisions of: health services and systems; nursing; Aboriginal and Torres Strait Islander health and wellbeing; Māori health and wellbeing; Pacific people's health and wellbeing; and public law and education.[131] A much wider and more comprehensive range of research needs to be supported to address things at an individual, community and structural level.

With respect to policy and practice, there is a need to address: organisational issues and management practices that, at best, fail in their duty of care to resource the necessary oversight of service provision, and, at their worst, focus on safeguarding organisations rather than people; workforce issues where staff don't receive necessary training, mentorship, or supervision; client issues, where people with disabilities are isolated and disempowered and lack the necessary knowledge, means and support to voice their concerns; and external factors, including family and community attitudes, lack of disability awareness by law enforcement agencies, and a lack of any properly constituted national agency to register and oversee the direct care workforce.

From our review of the literature, and considering the views of the Delphi panel, we recommend:

Rethinking accommodation

- Congregated accommodation settings (eg, institutions, hostels, and boarding house-like facilities) need to be closed. They are unsafe and unable to deliver on the expectations of (and obligations imposed by) the UNCRPD and the objectives of the National Disability Insurance Scheme (NDIS) Act.
- Group home accommodation (understood under NDIS policy as accommodating no more than 4 or 5 people) to be subject to close scrutiny, recognising that while such services can effectively address the support needs of some people, the risk of institutionalised practices being adopted remain high, and the safety of residents and their quality of service (including the exercise of individual choice and control, and inclusion in the wider community) require intense, sustained and well-resourced evidence-based strategies and accompanying oversight.
- Individualised (personalised) supported living options co-developed with people with disability, their families and representative organisations be supported as a priority in policy and practice, consistent with the expectations of (and obligations imposed by) the UNCRPD and the objectives of the NDIS Act.
- Invest in personalised supported accommodation, co-developed with people with disability and their representative organisations, with clear expectations about what personalised means.

Addressing the barriers to inclusion in community life

- Invest in anti-stigma campaigns and other work to address community attitudes and discrimination.

- Work with multiple and diverse communities of people with disability to better understand and address structural disadvantage and how the experiences of people are shaped by poverty and discrimination associated with age, sex, gender, gender identity, sexual orientation, intersex status and ethnic origin or race, including the situation of First Nations people and culturally and linguistically diverse people with disability.

Fostering inclusion in community Life

- Work with people with disability and their representative organisations to develop clear expectations about shared responsibilities for fostering welcoming communities where people feel they belong. Embed these expectations in policies and regulatory frameworks.
- In policy and practice, support people with disabilities to pursue, establish and sustain relationships and friendships.
- Address the lack of support available for people with disability, including those with intellectual disabilities, to be recognised as sexual beings and to fully explore and express their sexuality.

Broadening the research agenda to better inform policy and practice

- Invest in research that support the visions for quality and safety articulated by the Disability Royal Commission and which is co-designed and co-produced by people with disability.
- Recognise that disability is a social issue (not simply a bio-medical issue), and that many of the issues needing to be addressed are best addressed through the lens of the humanities and social sciences.

4 Employment

In this section of the report, we first outline the methods by which the literature informing our work was identified, retrieved and refined. We present our observations concerning the key characteristics of the literature, its strengths and limitations. We then document our findings as they relate to employment for people with disability.

We present an analysis of the meaning of inclusion and segregation as they pertain to employment. We examine the barriers and enablers to participation of people with disability in workforce, including a review of participation in disability-specific employment services. We then consider issues related to workplace safety and the quality of the workplace experience for people with disability. Our analyses then turn to the impact of integrated and segregated settings on people with disability, what happens when 'sheltered workshops' close, and the opportunities offered by 'social enterprises'. Our analyses include a brief consideration of issues relating to transition to retirement, acknowledging this is a large area that warrants further consideration. We then document how the findings of the literature review were used in the two-phase online Delphi study and integrated with the subsequent findings of this study as they pertain to employment for people with disability.

This section of the report concludes by presenting recommendations for policy and practice as they relate to the safeguarding of people with disability in the context of employment.

4.1 Method for employment literature retrieval and review

A systematic search of peer-reviewed literature was undertaken using bibliographic databases: EBSCO host; Proquest Central; Ovid by Elsevier (PsychInfo); the Cochrane Library; the Campbell Collaboration; and Google Scholar.

Each search included the terms and truncations as outlined in the table below.

Table 8: Employment literature search terms

Term 1: Disability Related	Term 2: Employment Related	Term 3: Inclusion Related	Term 4: Disability workplace related	Term 5: Outcome related
Disab* (disabled, disability, disable) **Impair* (impaired, impairment)** **Chronic Condition** **Chronic illness** **Chronic disease** **Handicap* (handicapped)**	Employ* (employment, employed, employ) work* (work, worker, works, working) job* (job, jobs) unemploy* (unemployment, unemployed) underemploy* (underemployment, underemployed) lab*r (labor, labour) hire* (hire, hires, hired) hiring; salary	Inclu* (include, included, inclusion) Exclu* (exclude, excluded, exclusion) Segretat* (segregation, segregated, segregate) Integrat* (integration, integrated)	Support* (support, supportive, supported, supports) protect* (protect, protects, protected) Competitive Open Sheltered workshop Protected workshop	Violence Abuse Neglect Exploitation Unemployment rates Underemployment access income pay poverty earnings discrimination harassment skills training leave burnout inequality bullying abuse mentoring promotion career “reasonable adjustment” “inadequate adjustment” Restricted practices forced labo*r job security work hours working time excessive hours financial independence fair treatment

The keywords were used across 3 sets of searches to establish comprehensive coverage of the literature. These terms produced the following initial search strings:

> **Set 1:** (inclus* OR intergrat* OR segregat* OR exclus*) AND (disab* OR impair* OR (chronic AND condition) OR (chronic AND illness) OR (chronic AND disease) OR handicap*) AND (employ* OR work* OR job* OR unemploy* OR underemploy* OR labo*r OR hire* OR hiring OR salary)
>
> **Set 2:** (support* OR Protect* OR competitive OR open) AND (disab* OR impair* OR “chronic condition” OR “chronic illness” OR “chronic disease” OR handicap*) AND (employ* OR work* OR job* OR unemploy* OR underemploy* OR labo*r OR hire* OR hiring OR salary)

Set 3: (“sheltered workshop” OR “sheltered workshops” OR “protected workshop” OR “protected workshops”)

These search strings produced 80,000+ results. The number of databases was reduced to gain greater specificity.

Where available, limiters in databases were applied to restrict results to publications in English from 2006 onwards and the adoption of the United Nations Convention on the Rights of Persons with Disabilities. A revised list of keywords was also developed, focusing on outcomes identified by the Royal Commission and related work, and these keyword strings were added to 3 sets of search terms.

The revised search strategy produced 14,835 articles for review and 930 duplicates were removed, leaving 13,905 articles. The articles were uploaded into Covidence to be screened according to the agreed inclusion criteria.

The final key inclusion criteria were:

- Published in English.
- Published during or after 2010 to ensure we covered contemporary research and reflected the Commonwealth Government’s National Disability Strategy 2010–2020.
- Covering employment experiences of people with disability.
- Focused on individuals at least 16 years of age, or the relevant age in the jurisdiction where the study was conducted.
- At least one dimension or practice of inclusion/integration/exclusion/segregation being evaluated.
- At least one relevant personal or organisational employment outcome in relation to participation, safety or quality.

A review of titles and abstracts resulted in 898 articles provisionally meeting the inclusion criteria. Priority was given to a full text review of 74 papers that specifically addressed the Australian context. Where findings from these papers did not fully address the questions posed by the Royal Commission, manual searching of additional references in full text was undertaken. Consideration was given to the quality of the literature, as described in the review methodology (section 1.6). This resulted in the inclusion of research articles, book chapters and industry and government reports from Australia and internationally.

Consequently, 339 publications were retained to inform the Employment review.

4.2 Findings from the employment literature review

This review focused on literature from 2010 onwards and covers Australian and international research related to employment and labour force participation of people with disability. However, countries vary in how they have understood disability, formulated policy and organised their institutions, systems and services. This includes the development of policy and provision of services. Some research findings from studies outside Australia might prove difficult in their direct application to the Australian context. We have therefore prioritised ideas and initiatives that could most readily be applied in this context.

Here we address what current research can tell us about the 'quality' and 'safety' outcomes for people with disability associated with 'inclusive', 'segregated' and 'integrated' employment settings. We focus on 3 core areas of interest articulated by Disability Royal Commission:

1. how terms such as 'integration', 'inclusion' and 'segregation' have been understood and applied in the literature associated with employment.
2. what 'safety' and 'quality' outcomes have been found for people with disability by research into 'integrated', 'inclusive' or 'segregated' employment.
3. key features of better practice within the research literature that appear to facilitate positive 'quality' and 'safety' outcomes for people with disability in the context of employment.

We reviewed 339 relevant papers. Most of the studies investigated employment for people with intellectual disability, followed by physical disabilities. Studies about sensory and psychiatric disabilities/severe mental health issues were also found.

4.2.1 The meaning of inclusion and segregation with respect to employment

Inclusion was given a variety of meanings, many of which were implicit. This saw 'inclusion' as a synonym for 'access' to employment and participation in the competitive labour market,[132] also known as open employment where people with and without disabilities use similar means to attain employment, work alongside each other and have similar employment conditions, typically with the exception of job accommodations. It also saw more specific meanings of the felt experience of 'being included'.[133] Some argued segregation/integration was not a dichotomy but a continuum[134] and that inclusion and structural segregation could co-exist with inclusion equating to feelings of being included.

According to this typology, it would be possible for people with disability to be structurally 'integrated' in competitive or open employment but experience feelings of exclusion. Similarly, people with disability may be structurally 'segregated' in protected work settings but experience feelings of inclusion.

Ferdman's multilevel perspective on inclusion could provide more nuanced understandings as it specifies different levels of (felt) inclusion – society-wide, organisational, workplace, workgroup and interpersonal.[135] Applying this framework, a person with a disability might experience feelings of inclusion in their workgroup but exclusion by their organisation and/or by society.

The term 'segregation' was more straightforward. It consistently denoted different types of work settings for individuals with disability separate from setting where individuals without disabilities were employed.

4.2.2 Participation in the workforce and the issues associated with safety and quality

In Australia, longstanding patterns indicate people with disability are less likely to participate in the workforce and to be employed and are more likely to work part-time or be underemployed than people without disability.[136] This contributes to higher rates of poverty and a range of poorer health outcomes, including mental health.[137] Most OECD countries show similar trends.[138] This group has had one of the lowest employment participation rates for people with disabilities.[139]

Most frequently studied outcomes in Australian and international academic literature were participating in open employment, labour force participation and job seeking and being employed. Less frequently studied were not being discriminated against in recruitment and selection, exclusion because of lack of adjustments, organisational costs of support and adjustments, and the relative costs/benefits to people with disabilities participating in employment.

Factors assisting and supporting people with disability to participate in the workforce include improved accessibility across life domains like transport, informal support from their community such as family and networks, strengths-based approaches to job seeking,[140] and early intervention programs to get people into education and work.[141] For example, the availability, reliability and affordability of transport influences the capacity of people with disability to participate in paid work and tertiary education.[142] In turn, apprenticeships, traineeships and further education leads to increased participation of people with disability in the labour force.[143]

A study by Lewis and colleagues in Western Australia involving matched pairs enrolled in a vocational training program found that people with disability who completed an apprenticeship or traineeship had better outcomes for hours worked, job tenure and income. Those who commenced an apprenticeship but did not complete it also had positive outcomes. The authors speculate this may be due to the greater length of an apprenticeship and the signals it provides about job readiness and employability. Lewis et al. argued that even participating in an apprenticeship enables the individual to learn vocational skills, become socialised into the workforce and form relationships that increase their social networks.[144]

Much of the literature, however, focuses on individual people with disability rather than organisations, employers or the workplace context. Scott and colleagues argue this holds true for research undertaken from the medical and social models of disability.[145] While there are some studies of employers, managers and co-workers of people with disability, this area would benefit from further investigation to increase understanding of how organisations can create more inclusive work environments. Meacham and colleagues used a case study approach to explore the ethical management of workers with intellectual disabilities in the hotel sector.[146] Based on interviews and focus groups that included managers, supervisors and people with disability, they identified key areas that made a positive difference.

First, investing time and resources in the induction of people with disability helped them feel they 'fitted in' and overcame anticipatory anxiety about being segregated in the workplace. Second, enabling and encouraging people with disability to participate in decision-making at work led to an increased sense of autonomy and being supported. Experiencing the workplace as inclusive had further flow-on effects for people with disability with some reporting a greater sense of family and social inclusion as a result of their employment.

This study is noteworthy in identifying specific human resource and management practices that positively impact on felt inclusion by people with disability. These findings could help managers acquire a better understanding of how to create an inclusive and supportive environment.[147] Other factors that assist workforce participation include workplace flexibility, supportive policies, individualised support and adjustments and co-worker support. However, these are less available to employees aged 45 years and older with chronic illness, demonstrating how disability can intersect with age to compound disadvantage.[148]

Overall, researchers have commented on the almost exclusive focus on the supply side of the labour market – people with disability themselves and the services that support them to gain employment – and a lack of attention to the demand side,[149] particularly the potential of small to medium-size enterprises to employ people with disability. Based on interview research with employers in South Australia, Hemphill and Kulik argue that disability employment services providers should focus on addressing concerns of employers who have not hired people with disability or who are 'light hirers', rather than continue to target existing employers of people with disability or those who are overtly opposed.[150] Such a strategy is more likely to result in decisions to employ people with disability in open employment.

4.2.2.1 Barriers to participation in the workforce

The dynamics of open employment pose the most barriers for people with disability to enter and maintain a job in a non-segregated setting. Most commonly mentioned was stigma and discrimination, especially on the part of employers. This can be attributed to inadequate awareness of disability and inclusion, lack of awareness of the government support available to employers, and misconceptions with respect to the (low) cost of most workplace adjustments.[151] A lack of stability (casualisation) and flexibility in open employment increased the likelihood that people with disability would seek work in segregated settings.

Stigma varies with the type and severity of disability with mental illness/psychiatric disorders being among the most negatively perceived.[152] Studies undertaken in the UK including systematic literature reviews have found employers indicated they would be unlikely to hire someone with a psychosocial condition.[153] Job candidates without a disability and candidates with a non-psychiatric disability rated more favourably in comparison. When they are hired, individuals with severe mental illness are more likely to be employed in lower-paid, lower-quality precarious jobs.[154]

This pattern of low-quality jobs and/or underemployment has been observed for individuals with a disability more broadly.[155] People with disability face particular barriers securing jobs that utilise their skills and abilities.[156] Baldwin et al. found a high rate of overeducation for their current jobs among employed people with high-functioning autism spectrum disorder.[157] In turn, negative experiences of work, including poor work conditions, increased the likelihood of job loss. Based on an analysis of Australian Bureau of Statistics (ABS) data from 1993 to 2012, Hong found that, for men, having a disability was positively associated with working as a labourer or in sales and it was negatively associated with being in management or technical occupations.[158] Hong also found a residual disability pay gap, even after any productivity-related factors were considered.[159]

Importantly, some studies show the experience of people with disability in open employment settings affects their propensity to participate in the future, potentially creating a ‘discouraged jobseeker’ effect. In a two-year qualitative study in Queensland, Gladman and Waghorn explored the experiences of people with mental illness in the workforce.[160] They found positive experiences generated a range of benefits including feeling more confident, optimistic and capable of managing their condition. Negative experiences, such as stigma and discrimination, increased stress, low remuneration and a lack of support at work, lead to labour force withdrawal. The authors concluded that while work is generally considered beneficial for the mental health of people with disability, this is not always the case and can have longer-term impact on employment participation and aspirations.

This point was also observed by El-Knoury Antonios.[161] Adopting a phenomenological approach, she investigated how social work students with physical disabilities experienced and made sense of the work-based placements that form a compulsory part of their degree. She found many respondents had encountered multiple barriers including stigmatisation, lack of workplace adjustments and low expectations of their abilities and capacity. This negatively impacted their sense of self and disrupted the formation of their professional identity. If they also had a supportive work environment, some reported positive effects including greater skills in self-advocacy and interest in different areas of social work. However, accounts of negative treatment and attitudes from those around them were far more prevalent and contributed to the risk of placement non-completion.

4.2.2.2 Participation and disability employment services

In research and commentary relating to disability employment services (DES), a number of criticisms and ‘missed opportunities’ were apparent. Overall, DES in Australia focus mostly on placement, rather than ongoing support. This contributes to a short-term emphasis in service provision and financial disadvantage for people as the disability support pension is withdrawn.[162] A lack of consistency was noted in the quality of support from DES for open employment. Some DES staff seem to lack the skills required to meet the needs of people with specific types of disability.[163] In addition, the number of people with disability, specifically intellectual disability, participating in open employment programs has stalled after initial growth.[164]

There are several opportunities for DES to improve outcomes for people with disability, including strategic job matching and post-placement support;[165] early interventions and an individualised approach to placement;[166] and focusing on educating and developing relationships with employers.[167] Services designed around specific types of disability and tailoring support to the individual were seen as showing the most potential to improve employment outcomes.[168] This latter model was referred to as a 'person-centred' approach and followed many of the principles that underpin the Individual Placement and Support (IPS) model used in other countries under the label 'supported employment'. It was originally developed in the US for individuals with severe mental illness but has since been implemented with other types of disability.[169] Its widespread take-up among developed countries has been underpinned by evidence which demonstrates its relative effectiveness in facilitating open employment among people with disability.[170]

Focused on securing jobs in open, competitive employment, it is distinctive in its rapid and customised approach to job search, zero-exclusion principle, tailoring support to the individual and considering their aspirations and preferences, and providing them with ongoing support in employment.[171] It also involves providers building relationships with potential employers to understand their business needs. In Australia, Donelly et al. found that identifying individual support needs and tailoring services accordingly assisted people with disability in securing employment.[172]

More broadly, scholars reviewing the sector have recommended that disability employment services adopt a more person-centred approach for the individual with a disability, as well as investing more time in becoming familiar with potential employers before presenting them with a proposed candidate.[173] This represents a paradigmatic shift in the way disability employment support services have been conceptualised and delivered and the need to manage this change and develop a different skillset in service providers should not be underestimated.[174]

4.2.3 Safety in the workplace

There is a lack of academic Australian research on outcomes of abuse, neglect and exploitation of people with disability in employment. This gap also exists in the international literature, not just in relation to employment but to people with disability and their experience of social life more broadly.[175] Among the literature included for review, the impact of stigma and discrimination on psychological wellbeing was an identifiable theme, specifically its negative impact on anxiety and self-esteem. While simply having a job is considered a protective factor for psychological health, as discussed previously, barriers exist to people with disability participating in open employment.

These include stigma and discrimination by supervisors and colleagues and a lack of understanding of individual needs of people with disability, especially intellectual and psychiatric disability. In a study of disability discrimination complaints made to the Australian Human Rights Commission, Darcy, Taylor and Green found employment was by far the most common area of complaint, indicating workplace injustice and hostility towards people with disability is a significant and ongoing problem.[176]

Of particular interest were studies showing how specific groups of people with disability experienced, or were more at risk of exclusion, disadvantage and violence, such as workplace harassment and avoidance. Using an analysis of ABS data, Temple et al. found that while the majority of people with disability experience discrimination and avoidance in workplaces, this is higher for those with psychosocial and physical disabilities, and for younger and middle-aged people with disability.[177] International literature suggests a need for greater attention to intersectional disadvantage, specifically how disability interacts or intersects with gender, race/ethnicity, socio-economic background, education level, age and location.

Shaw, Chan and McMahon used data from the US Equal Employment Opportunity Commission to analyse whether other social categories had an impact on the prevalence of disability harassment.[178] They found certain types of people with disability were more at risk of experiencing harassment and a hostile work environment. Gender was the most significant factor with women reporting significantly greater rates of harassment. Type of disability was the second biggest explanatory factor – those with behavioural, sensory and neurological disabilities had higher rates of harassment. The next most significant predictors were age (35 years or older) and race/ethnicity, specifically American Indian and Hispanic.

Chih Sin and colleagues’ review of knowledge about violence, harassment and abuse towards people with learning disabilities in the UK yielded several insights with broader relevance.[179] They noted a ‘strong link between impairment and social class’.[180] Given the greater rates of poverty and higher unemployment and underemployment among people with disability, we could expect inability or reduced ability to earn income from employment contributes to social and economic vulnerability. This also affects housing and accommodation: people with disability are more likely to live in areas with a high rate of crime. Economic dependence and general financial insecurity are also risk factors for violence and abuse – if not in the workplace, at least partly as a result of being excluded from opportunities to earn sufficient income to sustain themselves and their families.

Further, women with disabilities were more likely to experience sexual harassment and assault, though our literature search suggests a paucity of research with what is known largely based on public reporting of legal proceedings. This illustrates the need to apply an intersectional lens to understanding the complexity of disadvantage experienced by people with disability in and out of work. In the Australian context, Soldatic argues more attention needs to be paid to the interaction between disability income changes and the extreme disadvantage experienced by Indigenous Australians with disabilities who have been in the workforce but are not unemployed.[181] These changes have generated housing and food insecurity and had a detrimental impact on physical and mental health and constitute additional barriers to employment. Gilroy and colleagues advocate for the development of an Indigenous disability workforce strategy to develop community-centred and culturally appropriate employment support programs and to attract, develop and retain Indigenous workers in the disability support sector.[182]

Protective factors that could assist in creating safe work conditions for people with disability include a cooperative and participative work culture, supportive relationships with colleagues and supervisors, meaningful work that allows for skill development[183] and a physically, socially and culturally inclusive work environment.[184] We did not identify studies directly evaluating the relationship between workplace disability accommodations/supports and experiences of workplace abuse among people with disabilities. However, research did indicate that working in an environment where accommodations and support is not available can hinder performance and social integration. In turn, lower performance and social integration are related to stigma and workplace abuse towards people with disability and other minority groups.[185]

More action by employers, particularly human resources, to monitor and improve attitudes towards people with disabilities is needed, as is specific guidance on inclusive policies and procedures related to the key points in an employee's lifecycle, like recruitment, training and promotion.[186] Murfitt and colleagues suggest that initiatives such as marketing campaigns featuring positive disability employment cases and incentives for small to medium-size organisations to employ people with disability could increase employer engagement and address negative attitudes that contribute to unsafe work environments.[187] We did not identify direct evidence of the effectiveness of marketing campaigns to change the attitudes of colleagues and employers towards workers with disability. However, decades of research in persuasion and consumer behaviour indicate that following consumer psychology principles can be a promising avenue to change attitudes towards workers in the broader community and at work.

One concrete action that would address risk factors for participation, safety and quality of employment is to increase flexibility of number of days/hours worked, where to do the job and tasks. In their study of workers 45 years and older with chronic illness or health conditions, Saunders and colleagues found little or no workplace support.[188] A lack of workplace flexibility, such as time off to attend to health management or the ability to work from home, made it more difficult to sustain workforce participation. More flexibility would have increased the sense of safety and inclusion at work. In a similar vein, Villotti et al. found lack of work flexibility can negatively affect psychological and emotional health, whereas longer job tenure, schedule flexibility and support from supervisors, co-workers and family and friends can contribute to felt experiences of safety.[189]

4.2.4 Quality of the workplace experience

As previously mentioned, there is significant overlap between participation, safety and quality of employment. The types of jobs available and the conditions and hours of work, including job security, will be associated with particular risk and protective factors. 'Quality' employment – work that is freely chosen, secure, providing an adequate income, experienced as meaningful and fostering individual development – will be a protective factor for safety.

Many points discussed under participation and safety are also relevant to evaluating the quality of employment available and experienced by people with disability.

This is illustrated by the substantive elements of the structure of 'decent work' released by the International Labour Organization (ILO).[190] These include employment opportunities, adequate earnings and productive work, decent working time, stability and security of work, equal opportunity and treatment, safe work environment, and social dialogue and workers' representation. The concentration of people with disability in low-skill, low-paid insecure work, inadequate income, unemployment and underemployment, lack of access to training, discriminatory treatment, a hostile and exclusionary work environment and lack of autonomy and voice at work, would fail to meet the ILO's standard of 'decent work'.

The ILO's framework is useful because it provides greater nuance to the evaluation of 'decent work'. The different structural elements have the potential for a more in-depth analysis of the quality of work for people with disability in open employment, segregated settings and social enterprise. For instance, jobs in segregated employment may be relatively secure and stable but provide inadequate income and opportunities for voice at work. Conversely, people with disability may experience a hostile and exclusionary work environment in open employment settings and discriminatory treatment.

However, there are shortcomings to the ILO's principles. It is unclear whether each of the elements should be equally weighted, and the measurement of decent work focuses on objective indicators rather than how work is experienced by people with disability.[191] Clearly objective material indicators are important, particularly given that the greater proportion of people with disability live in poverty and are concentrated in the lowest quintile of household income, particularly those with more severe or profound disabilities.[192] However, such a measure should be supplemented by qualitative evidence about whether, and how, people with disability experience social and economic inclusion in the labour market. This includes attention to the potential benefits of employment beyond income, such as skill development, growth, meaning from work, social relationships and expansion of personal networks.

Compared to the academic literature on participation of people with disability in the labour force, there is scant research specifically on the quality of work. The Meacham et al. study of workers with intellectual disabilities in the hotel sector is one example of Australian research that addresses issues of work quality in its coverage of task variety and skill development and participation in decision-making.[193] In other research comparing open employment, segregated settings and social enterprise, Meltzer et al. found people with disability experienced work in social enterprise as more meaningful, interesting and it allowed for greater interaction with other staff and clients without disabilities.[194] However, they wanted more paid work hours so could have potentially been considered underemployed.

Even in relatively high-status occupations, people with disability can experience exclusion and a lesser quality of work life, compared to workers without disabilities. While there is relatively little literature on people with disability as managers and leaders, the studies that exist have shown how ableist assumptions about senior roles constrain people with disability's freedom to act and impose additional emotional and psychological work to accommodate others.[195]

Boucher talks about women leaders with disabilities feeling obligated to engage in ‘surface acting’ to mask how they feel and presenting an always-optimistic front when interacting with others.[196] Such work creates added fatigue and stress. In Roulstone and Williams earlier study, managers they interviewed reported limiting their career development and not seeking other opportunities for fear of losing the accommodations they currently had.[197] So they were ‘boxed-in’, facing a ‘glass partition’ which is analogous to the ‘glass ceiling’ that describes the invisible but persistent barriers women experience in progressing to senior levels of organisations. Workplace change due to change in senior staff or organisational restructuring provoked feelings of great precarity for the same reasons.[198]

In educational and health settings that strive for the inclusion of students and patients/clients with disabilities respectively, people with disability working in these contexts have reported difficulties in navigating the expectations of their workplace and ableist occupational stereotypes. Studies of doctors, nurses, social workers and other allied health professionals with disabilities have commented on the persistent barriers, narrowed career choices and attributions of incompetence others make because being professional *and* being disabled seems contradictory.[199]

Similarly, in educational settings, teachers with disabilities have been reported as facing exclusion and discrimination despite working in schools that attempt to foster the inclusion of students with disabilities.[200] Even in higher status, higher skilled occupations then, people with disability experience exclusion which may be heightened because of contradictions between ableist work cultures and occupational ideals. This constrains the employment choices of people with disability and limits their career progress.

4.2.5 The impact of integrated versus segregated employment

There is little Australian literature directly comparing outcomes for people with disability in segregated – sheltered employment, Australian Disability Enterprises (ADEs), other segregated enterprises, versus integrated – open employment work environments in the Australian context. Many of our final conclusions might be based on what is occurring in one context or the other, not one relative to the other.[201]

In literature comparing segregated and integrated work settings in other countries, some outcomes are clearer than others. In the UK, Cimera et al. studied the outcomes of matched samples of people with disability working in segregated and non-segregated settings.[202] The authors found those in non-segregated settings earned significantly more than those in segregated contexts, like sheltered workshops. In a related study, he also found the greater financial benefit of integrated compared to segregated employment had increased over time since the 1980s. He concluded that supported employment returned a greater cumulative economic benefit over their career. However, research from Spain indicated there was greater employment stability for people with disability in sheltered employment settings,[203] a finding also supported in research by Inclusion Australia.[204]

The US has long pursued an explicit objective of obtaining competitive, integrated employment for people with disability before resorting to other options.[205] Noting the failure of sheltered employment to transition or prepare people with disability for work in open labour markets, they discuss research that indicates competitive employment leads to a range of psychological, social and economic benefits, such as improved social skills, financial literacy and self-confidence.[206] This more recent evidence base presents a more unequivocally positive evaluation of open employment than some earlier research.

In the case of self-esteem, one study found no differential impact of integrated versus segregated employment among workers with mild intellectual disability,[207] whereas another study found higher self-esteem among workers in integrated settings.[208] Similarly, two studies found loneliness to be more prevalent among workers with disabilities in integrated employment than among those in segregated employment.[209] However, at least 3 studies have identified better quality-of-life among workers in integrated settings relative to segregated employment.[210]

These differences in impact on subjective experiences could be partly due to the specific nature of the workplaces in how inclusive or exclusionary they are in practice and attitudes towards workers with disabilities. Verdugo et al. found no overall difference in quality-of-life between workers across both contexts, but higher task typicality ie doing the same work as others, and number of hours of direct external support were related to higher quality-of-life among workers in integrated settings.[211]

Of note are 2 relatively recent Australian studies addressing comparisons between different employment settings. Tait and colleagues used a survey to assess quality-of-life among middle-aged people, aged 30–50, with intellectual disabilities.[212] They found that simply having a job was associated with all four QoL dimensions: satisfaction; community belonging; competence; and independence, with no differences between individuals who worked in segregated and integrated employment settings. However, more needed to be done to extend the working lives of people with disability and to provide employment opportunities as they aged.

Meltzer, Kayess and Bates compared how people with intellectual disabilities experienced working in sheltered employment, open settings and social enterprise.[213] Participants found securing work in open employment the most difficult and it was often unstable, limited in tasks and exposed them to discrimination and stereotyping. There were fewer barriers to sheltered employment and it offered greater stability and the potential for flexibility and job variety. Social enterprise and sheltered employment were experienced as more supportive than open settings. These findings highlight that increasing the proportion of people with disability in open competitive employment also depends on creating work environments that are experienced as inclusive.

4.2.5.1 Can beneficial outcomes to segregation be replicated in open employment settings?

Several points are worth considering in relation to the translation of any beneficial outcomes from segregated into open employment. As discussed earlier, Australian and international studies have reported some beneficial outcomes to segregated employment including greater stability of employment,[214] perceived task variety,[215] and higher felt levels of interpersonal and workgroup inclusion, compared to open settings.[216]

Multiple factors that can be enhanced in open employment may support the translation of environment free from stigma appears to be one key protective factor across multiple studies for the social inclusion of people with disability in any form of employment.[217] These findings point towards the need for tailored, experiential, de-stigmatising disability awareness training for employers/co-workers in open employment settings. Similarly, managers require training on effective management of workers with disability.

Task design is another important factor that would impact a sense of skill utilisation and belonging in open employment for people with disability. Task typicality[218] and task variety[219] have been associated with better workplace experiences for people with disabilities in segregated employment. For similar outcomes in open employment, jobs need to be designed with embedded flexibility of time, place and tasks as required, based on capability assessments and current personal conditions. Providing workers with a plan that details task variety and ongoing skills development may help. Given the importance of task typicality, managers would need to engage in efforts to prevent task-based segregation in open employment.

Research has also indicated that segregated workplaces provide more stable employment opportunities for people with disability.[220] Guaranteeing job stability in open employment would require a whole-of-system approach. At the individual level, earlier education and vocational training that support skill development and person-job fit, and housing arrangements that provide outside-work stability, are crucial to job retention in any population.[221]

At the organisational level, 3 factors already mentioned would be important: job design, colleagues' attitudes towards people with disability, and managers' skills to manage people with disability. Additionally, long-term on-the-job support is necessary to provide scaffolding across different work transitions that employees might go through, such as onboarding, meeting new colleagues and changes in job tasks.[222] Finally, government might consider strategies like retention payments to incentivise organisations' longer-term employment of people with disability, without restricting voluntary job change or career development of people with disabilities.

4.2.6 What happens to people with disability when sheltered workshops are closed?

We did not identify research directly addressing the issue of what happens to people with disability when segregated forms of employment are shut down. However, we found people with disability who start their careers in a segregated setting do not typically move to open employment. Similarly, those working in segregated settings are unlikely to have previously been in open employment.[223]

In Europe, there has been some evaluation of pilot studies of transitional, blended models of employment where integration and segregation are seen as two ends of a spectrum. In the Netherlands, people with disability have been placed in integrated employment settings but work as a group within the larger whole.[224] This is an 'enclaved' approach to open employment that may be worth further exploration in an Australian context as a (temporary) mechanism for assisting with the shift from segregated to integrated employment.[225]

However, from the workers' perspective, research indicates that the perception of workplace-person fit and job-person fit experienced by people with disability in segregated employment reduces their intention to leave these settings and their efforts to identify alternative forms of employment.[226] From a system-level perspective, transition away from sheltered workshops into open employment is hampered by support staff with limited expertise on employment interest and training, the limited developmental potential of the tasks performed eg low-skill variety task, and the limited variety in workplace experiences that people with disability have in sheltered workshops.[227]

This situation is further complicated by the fact that sheltered workshops and Australian Disability Enterprises largely operate as not-for-profit entities, relying on donations and government support to subsist.[228] While ADEs pay productivity-based wages based on the relevant rate for similar work in open employment, the lack of self-sufficient capability in this sector reduces its potential to pay decent salaries or invest in the required training for staff so they can help develop skills that people with disability will need to transition to open employment.

If competitive, open employment is the desired policy goal, it is important to focus efforts on the education-to-work transitions of younger people with disability and support them in their early work experiences to directly enter open employment settings. In the design of transition to work programs, it is important to pay attention to the type of organisation running the programs and the connections they have with other entities. More specifically, the current network of employers associated with a specific organisation managing transition to work programs can be a key factor in defining what kind of employment is made available to people with disability post-program, and the kind of expertise people with disability will develop during the program.

Research has shown that transition to work programs that have partnerships with ADEs, such as relying on ADEs to provide work experience, were more likely to transition people with disability into jobs at ADEs.[229] This homophily can severely hinder the capacity of some transition to work programs to effectively place people with disability in open employment. The same study also found that when transition to work programs had better relationships with agencies that facilitate open employment, people completing the program were more likely to attain jobs in open employment.[230] Again, the design of transition to work programs and the quality of the network of the organisations managing these programs can have a significant impact on employment outcomes.

4.2.7 Social enterprises as an alternative

Social enterprises have a longer history in Europe and the United Kingdom,[231] but are relatively new in Australia.[232] They have been broadly defined as 'any organisation that focuses on social change'.[233] While social enterprises vary widely in their size and nature of their operations, they share some key characteristics including not-for-profit status, being purpose-driven, engaging in commercial activity, building social capacity among disadvantaged groups (both relationships and skills), and reinvesting in the organisation and the communities they serve.[234] In the face of slow or stalled progress in raising the labour force participation rate of people with disability in open employment, social enterprises represent an alternative source of work.[235] This is borne out in research by Barraket and colleagues who found social enterprises grew in significance as employers of people with disability in Australia between 2010–2016.[236]

The employment options of people with disability could be increased with an expansion of the social enterprise sector. Studies have shown the positive outcomes that could be delivered to people with disability, particularly intellectual[237] and psychiatric disabilities,[238] through involvement with these organisations.[239] International evidence suggests social enterprises can balance employer and employee needs and provide work that is structured, flexible and experienced as meaningful.[240] Other benefits of working in social enterprise include an increase in wellbeing, opportunities to develop skills and social relationships in the broader community, more supportive supervision, collegiality with co-workers[241] and flexible HR practices[242] that demonstrate 'encouragement, understanding and accommodation' of the needs of people with disability.[243]

Research including the experiences and perspectives of people with disability themselves[244] indicates they appreciate the community interaction and inclusion, skill development and variety of tasks that employment in a social enterprise brings.[245] Factors that enhance participation in social enterprises include flexibility, support on the job, job security and support beyond the workplace, such as assistance with housing.[246]

For social enterprise organisations, employing people with disability can offer advantages. One recent study in the hospitality sector in the US showed how social enterprise hotels and restaurants that employed people with and without disabilities felt they were offering a different kind of experience to clients, creating greater integration and opportunities for contact between people with and without disabilities, and serving a market that had hitherto been unaddressed by mainstream hospitality.[247]

However, given the diversity of social enterprise organisations, there will inevitably be differences that affect the extent to which they deliver positive outcomes for people with disability. The leadership of an organisation may accord greater priority to business concerns than to retention and development of people with disability when these two are in conflict.[248] In addition, there is variation between social enterprises run by groups and those run by people with disability themselves. Parker Harris, Renko and Caldwell have argued that 'some of the most successful social entrepreneurs solve problems they personally experience, using familiarity of a social problem to inspire relevant and effective solutions.'[249]

Following this logic, encouraging people with disability to start social enterprises could develop innovative solutions focused on creating greater accessibility and inclusion. However, it would require considerable investment in training and resources to increase the likelihood of survival and success. Some models of social enterprise in Canada involve people with intellectual and/or development disabilities as non-share capital partners supported by ongoing coaching by a cooperative. This approach seeks to increase the self-determination of people with disability.[250]

In Australia, some ADEs have become social enterprises. This generates additional complexity as it would require substantial change in the cultures, structures, practices and orientation of ADEs and their senior management.[251] Therefore, when evaluating social enterprises who employ people with disability, it is important to understand the specific context, history, governance and employment practices of the social enterprises concerned.

More generally, while social enterprises have been recognised as having potential to increase the employment choices available to people with disability and are worthy of further exploration, academic literature has indicated several challenges to providing positive outcomes to people on a larger scale. People from other disadvantaged groups may also be prioritised, leading to less capacity to offer enough paid working hours to people with disability.[252] While some social enterprises focus on providing (unpaid) training and skill development, from the point of view of economic independence for people with disability this situation is not ideal, certainly in the longer term. Further, working in social enterprise does not necessarily, or even typically, lead to open employment for people with disability.[253] In addition, many social enterprises struggle to be financially viable and are limited in their capacity to offer longer-term security of employment. They are also concentrated in certain sectors, such as hospitality or cleaning, which may be more vulnerable to economic downturn.

Cooperatives have been identified as another approach for people with disability to have more control over their employment conditions,[254] providing an alternative to sheltered and open employment. In this context, cooperatives are autonomous associations of people with disabilities and their allies who voluntarily cooperate in the creation of jointly owned and democratically controlled enterprises to meet common economic and socio-cultural needs.[255] Research indicates that, with adequate design such as appropriate job design, job autonomy, ongoing support to keep their jobs and voice, and a respectful environment, cooperatives can provide people with meaningful work, good salaries, opportunities for skill development and community connections. Those work conditions, in turn, seem to allow people with disability to have higher productivity, self-esteem and self-efficacy, a sense of social inclusion and a broader set of lifegoals.[256] Many of the same caveats to social enterprises will apply in the case of cooperatives. The design of workplace relations, social and instrumental support available and level of self-determination embedded in day-to-day management practices will create a different environment.

4.2.8 Transition to retirement

A life-span approach to the employment of people with disability needs to consider retirement arrangements. Lack of proper transitional arrangements towards retirement can have a serious impact on the prevalence of risk behaviours and negative health outcomes in the general population.[257] Lack of planned activities and social connections at retirement means that people with disability might end up experiencing inactivity, social isolation, feelings of loneliness and all the negative health outcomes associated with those risk factors.[258]

Transition-to-retirement programs can help workers with disability better integrate into society when they retire.[259] These programs can include a well-trained mentor to work with the person to carve out time from their current job to start making the transition to retirement, and to craft a set of activities and responsibilities that are safe and of interest to the person outside work and in the community. Workers with disability should be able to exercise choice about whether, and how, they retire, with specific attention to those working within segregated employment settings.

4.3 Key findings from the Delphi for employment related policy and practice initiatives

In preparation for round 1 of the Delphi panel, we derived 43 evidence-based recommendations from the literature for assessment and feedback. In round one, the Delphi panellists agreed that 27 of the 43 recommendations were important. These were the recommendations consistently receiving endorsement by 75% or more of the panellists at or above the median rating of 6. They are shown in table 9. While there were 10 recommendations that varied considerably in the panellist's assessment of importance, there was evidence to suggest they were consistently favoured by panellists with lived experience of disability. The recommendations favoured by panellists with lived experience of disability can be grouped into 3 broad categories:

1. suggestions to provide co-workers and supervisors with training and broader community campaigns to change negative attitudes/reduce stigma against people with disability in relation to employment readiness, interest and capability.
2. proposals to improve and support social enterprises as a way to enhance the participation, safety and quality of work life for people with disabilities.
3. recommendations to conduct more research to directly compare and better understand the employment outcomes of people with disabilities across integrated, segregated and other models of employment.

For some recommendations the panellists made comments and provided feedback that allowed us to make them more relevant and clearer before moving to Round 2 of the Delphi Study.

With their ratings and comments, Delphi panellists expressed serious doubts about maintaining or supporting segregated employment to foster participation, safety and quality of work among people with disabilities. This is in contrast with some of the academic literature we reviewed, where with better oversight and other changes, segregated employment was described as a potentially viable employment alternative.

In Round 2, two recommendations were consistently ranked as being of high priority. These also reflected key issues identified in the academic literature. These recommendations for policy and practice were:

- Policies should specify that ‘inclusion’ does not equate to mere participation in the mainstream workforce. ‘Inclusion’ must reflect the necessary conditions such as barriers to be eradicated and supports to be provided, for people with disability to remain productive and healthy in open employment.
- Enhancing the labour force participation of people with disability needs an integrated approach that encompasses education, housing and family support. For example: facilitating engagement with the education system; targeting transition from education to work; providing instrumental support and training to families of people with disability on how to support their employment; and providing a financial safety net and oversight to help guarantee housing security.

The full list of evidence-based recommendations endorsed in Round One and used in Round Two of the Delphi panel are below.

Table 9: Employment Delphi items with the highest level of endorsement with respect to importance

Topic	Policy / Practice Recommendation
Understanding inclusion and exclusion at work	Policies should specify that ‘inclusion’ does not equate to mere participation in the mainstream workforce. ‘Inclusion’ must reflect the necessary conditions ie barriers to be eradicated and supports to be provided, for people with disability to remain productive and healthy in open employment.

Topic	Policy / Practice Recommendation
Factors related to Participation (in the labour force and in employment)	Enhancing the labour force participation of people with disability needs an integrated approach that encompasses education, housing and family support. For example: facilitating engagement with the education system; targeting transition from education to work; providing instrumental support and training to families of people with disability on how to support their employment; and providing a financial safety net and oversight to help guarantee housing security. Current labour market conditions for people with disability should be investigated to systematically evaluate the impact of COVID-19, ensuing lockdowns and workplace restrictions. If open employment of people with disability is the ultimate goal, more attention needs to be given to the structural changes that would enable that to be achieved. Structurally, job designs that emphasise time, place and task flexibility should be prioritised. Disability support services should have a stronger emphasis on ongoing workplace-based support for people with disability eg coaching, review of efficacy of adjustments, and their managers/ co-workers. The effectiveness of JobAccess and the degree to which it meets the needs of different local labour markets should be evaluated. Employers need to provide support for the creation of workplace-based and inter-organisational support networks for people with disability. Better training and oversight of specialist disability employment services, including awareness of alternative models of employment, are needed. Training and incentives for disability employment services targeted towards providing ongoing support is needed eg coaching and review of workplace accommodation arrangements beyond basic placement. Australia should assess how to implement a coherent individual placement and support model among disability services providers. The social enterprise sector requires oversight and evaluation with respect to the impact on continuing, safe, high-quality employment. Specific attention should be paid to the wages, skill development and working conditions within what were formerly Australian Disability Enterprises.

Topic	Policy / Practice Recommendation
Factors related to safety	A systematic evaluation should be undertaken of the experiences of people with disability in all forms of employment including income, skill variety, career development, perceived options for alternative employment, workplace abuse and neglect, and other problems and benefits currently being encountered. Fit-for-purpose complaint mechanisms should be established and the position of state and national Human Rights Commissions or other statutory bodies to address workplace issues for people with disability should be strengthened. Positive media campaigns and community education could help reduce stigma and discrimination for people with disability in open employment. Resourcing local campaigns that target particular sectors or regions should be considered. There should be provision of tailored, experiential, de-stigmatising disability awareness training for employers/co-workers in open employment settings and leaders/managers require training on effective management of workers with disability. Workplaces having inclusive policies in place, and procedures to protect and support people with disability tailored to their individual needs could help reduce stigma and discrimination. Government should consider whether external enforcement mechanisms could assist in the diffusion and effectiveness of such policies and procedures.

Topic	Policy / Practice Recommendation
Factors related to quality: open employment settings	In all forms of employment, there should be flexibility of time, place and tasks based on capability assessments, appropriate job matching and current conditions. All employees would benefit from such flexibility and assessment. Where organisations are receiving financial incentives from government to employ people with disability, they should be required to prepare task variety and development plans relevant to the person with disability being employed as a condition for receiving the incentives. This requires proper external monitoring. Consideration should be given into how to incentivise the longer-term employment of people with disability, eg retention payments, without restricting voluntary job change or career development of people with disabilities. If an organisation receives financial incentives to employ people with disability, retention and promotion of people with disability should be measured and reported to regulatory agencies. Independent exit interviews need to be performed when people with disability leave. Given the future risk of automation and disappearance of low-skill entry-level jobs, specific policy attention should be devoted to the implications that trends in the future of work have for people with disability, including a focus on those with intellectual disabilities. Education and training should also prepare people with disabilities for high-skill jobs. National campaigns and organisational training programs on the conditions of people with disability in Australia might be necessary to sensitise co-workers and should be informed by previous local and international campaigns that have been successful in promoting attitudinal and behavioural change. Organisational social responsibility and community engagement initiatives could focus on up-skilling and the social inclusion of people with disability. Such initiatives should be done in close partnership with established institutions in the disability sector.
Factors related to quality: segregated employment settings eg sheltered employment	Individual, comprehensive and ongoing assessment should be conducted before stopping income support for people with disability. Short term employment should not lead to stoppage of income support. Regular and ongoing support of employees with disability should be provided to enhance individuals' occupational wellbeing, confidence, productivity and career progression.

Topic	Policy / Practice Recommendation
Factors related to quality: social enterprise settings	There should be government income support eg full or partial payments during internships, NDIS package funding, and proper oversight of social enterprise operations to prevent exploitation, contingent upon developmental opportunities for people with disability to prepare them for open employment.
Potential models of inclusive employment for Australia: social enterprise	A social enterprise-specific whole-of-organisation approach, including training programs and resources to help those leading these organisations, should be developed to provide optimal employment and development to people with disability.
Potential models of inclusive employment for Australia: Individual Placement and Support (IPS)	The Individual Placement and Support model should be investigated to see if it could be introduced more systematically in Australia, including assessing what change this would require among existing disability services providers.
Potential models of inclusive employment for Australia: transition-to-retirement programs	More attention should be given to Transition-to-retirement (TTR) programs which have been demonstrated to help workers with disability better integrate into society when they retire. Workers with disabilities should be able to exercise choice about whether, and how, they retire, with specific attention to those working within segregated employment settings.

Topic	Policy / Practice Recommendation
Gaps and limitations of existing literature	More research should be undertaken that directly compares the outcomes of participation, safety and quality for people with disability and the experiences of people with disability in segregated, integrated and social enterprise settings. This should include attention to opportunities and experience of meaningful work, social interaction with people without disabilities, skill variety and development and flexibility. It should also explore why people with disabilities or their families may be opting for segregated rather than integrated employment settings. To inform policy initiatives, greater research is needed on current experiences of people with disability in Australian Disability Enterprises and segregated settings to investigate why they remain in this type of employment rather than open settings. Alternative models in use internationally should be evaluated for their efficacy in producing outcomes of participation, safety and quality for people with disability, Analysis should be undertaken of how they could be adapted for an Australian context and what system, institutional and policy changes would be needed.

We asked the Delphi panellists to address the ‘big question’ of what might make a difference for the employment of people with disability. Thematic analysis of the panellists’ answers suggested 3major themes: enacting anti-discrimination strategies (ie actions that would level the playing field for people with disabilities); enacting supply-side strategies (ie actions that would help people with disability be job-ready); and enacting demand-side strategies (ie actions that would create or facilitate open employment opportunities for people with disabilities).

1. Anti-discrimination strategies

   Fair wages: eliminate the ‘subminimum’ wage and make it illegal for people with disability to be paid a lower wage than people without disability.

   End segregated employment: sheltered workshops and sheltered workshops calling themselves ADEs should be eradicated.

   Colleagues and supervisors’ attitudes: supervisors require training on how to manage people with disability and supervisors and colleagues need to take part in de-stigmatisation interventions.

2. Supply-side strategies

   A life-span approach: A whole-of-sector personalised and consistent approach that focuses on the lifespan and puts the voice of the person with disability at the centre, paying attention to what they need across their lives all the way to retirement.

   Education: an education system that is tailored to, and supports the needs and aspirations of, people with disability is an essential component in the pathway to open and inclusive employment.

3. Demand-side strategies

   Ongoing on-the-job support: make available support through an induction/buddy/mentor, who is available when needed and particularly when the roles and responsibilities of the person with disability change.

   Work flexibility: reconceptualising inclusive employment as more than working 5 days a week from 9am to 5pm. Focus on supporting skills utilisation and task performance, instead of hours of work.

   Quotas: implementing and regulating quotas of employment for people with disability in public sector and then in private sector organisations.

4.4 Conclusions and recommendations concerning employment for people with disability

Reviewing the Australian and international literature on the experiences of people with disability enabled us to identify key patterns in participation, safety and quality of work life. We were also able to make comparisons between segregated and integrated employment settings and the potential of social enterprise as an alternative employment option. Importantly, this review provided insights into the different institutional arrangements and policy legacies that influence and constrain what is considered appropriate, plausible and realistic, and how these expectations can be culture bound. For example, what is deemed acceptable in Spain in relation to sheltered employment would not be culturally acceptable in the US where any form of segregation is considered as violating the civil rights of people with disability.

No policy or institution is value-neutral, though it might appear that way due to its familiarity. That does not mean it cannot be questioned or changed. The responses of the Delphi panellists indicated that what have been discussed as reasonable and desirable employment arrangements and support for people with disability in the academic literature may no longer be the case. There was academic evidence indicating that segregated employment could have some benefits, compared to the experiences of people with disability in open employment. However, there remains a question of whether segregated employment can continue without the support of key stakeholders, specifically those in the disability movement and others, advocating for people with disability.

Overall, we conclude there is a lack of research in the sphere of employment relating to many of the outcomes of interest to the DRC. Relatively few studies directly compare integrated and segregated work settings. A large proportion of the available literature emanates from the US and reflects this specific jurisdiction, its history and systems; eg focusing on ex-veterans and macro-level cost-benefit analysis of shifting people with disability from social security to paid employment.

Many studies are focused on outcomes that are basic/minimum, such as gaining a job, participating in the labour force and income levels rather than exploring where and how quality jobs can be created and maintained for people with disability. There are some examples of researchers practicing an inclusive research methodology, involving people with disability in co-designing the research and/or asking people with disability themselves about their experiences rather than their parents or service provides, but there is scope to do much more.

Because of the nature of work, which typically involves significant exchanges, dealings and negotiations with others as well as a physical and social environment, an interactional model of disability is worthy of further exploration with respect to policy and service developments in the field of employment. Boucher explained and applied this model in her study of female leaders with disability.[260] It enables a conceptual distinction to be drawn between impairment ('traits inherent to a person') and disability as 'the experience of being socially oppressed as a consequence of having a disability' while still taking both into account.

There have already been calls for Australian disability employment services to adopt a more person and strengths-based approach, like the individual placement and support model and customised model in use in some other countries such as the US.[261] Smith and colleagues also provided guidance on how this transition could be managed and practically implemented.[262] In addition, greater attention to the interconnections between employment and other domains of social life, such as earlier education, transport and housing would make a positive contribution. These areas are often split apart in academic research and policy but are clearly experienced by people with disability as inseparable: lack of adequate vocational training, inaccessible transport, insecure housing and living far from work would all constitute barriers to attaining and retaining a job. While these matters have commonly be addressed independently in the research literature, they need to be brought together in policy and considered together in any service initiatives.

Phasing out segregated employment would appear a sensible medium-term policy direction, with a short-term policy agenda designed to prevent new people entering such situations of segregated employment in the first instance. However, careful attention needs to be given to any unintended consequences that would be detrimental to people with disability currently working in these settings. While it might not be appropriate for people to continue in segregated employment that is typically low paid and often in poor quality conditions, the loss of income, sense of purpose and social connectedness that can come with these workplaces much also be taken into account in any transitional arrangements.

Without a concerted effort to achieve 'decent work', people with disability may be left with fewer employment options and options of relatively low quality in terms of pay and conditions (including social conditions). Improving employment opportunities will require changes in the type and length of employment support available, such as ongoing coaching beyond placement and the management of people in employing organisations. Some organisational changes seem relatively simple to address, such as a lack of flexibility about where, when and how work is done (referred to in legislation as policy as reasonable adjustment or reasonable accommodation); others may require more fundamental rethinking of what constitutes a 'job'. Regardless of the specific initiative, it has more chance of implementation if it is accompanied by concrete guidance and examples of how it can be operationalised in the workplace. Providing these resources would help current managers and disability employment providers start to reconceptualise what could be achieved.

From our review of the literature, and considering the views of the Delphi panel, we recommend:

Adopting a life-span approach to employment

- Economic exclusion (and dependence) in adulthood and middle and later age increases the vulnerability of people with disability and is not produced by a single event, but by the interaction of factors across a person's life and over time.
- Educational opportunities can greatly influence a person's employment opportunities and subsequent career path. This can be in the form of both opportunities to develop vocationally relevant skills and, importantly, a personal vision of having a place in the workforce (and what that place might look like). Beginning to work on employment after a person has left school is too late. Policy and practice need to embed the beginning of the journey to employment into the school years.

Acknowledging and resourcing key points of transition in people's lives

- Support should be provided at key times, such as when a person is transitioning from school to adult life.
- Pathways from secondary school to Vocational Education (VET) or Higher Education (University) need to be mapped out in policy and resourced in practice
- Pathways from post-secondary education to employment need to be mapped out in policy and resourced in practice. Here, similar to the secondary school experience, employment support needs to commence while people are still engaged in the education sector, and not left to after graduation.
- Employment needs to be considered more than simply the attainment of a job, but rather the opportunity to develop and explore a career. For these purposes, policy needs to ensure support is either provided on an ongoing basis or at least reviewed at regular intervals based on individual circumstances. This is particularly so as an individual's interest and skills change over time and / or the circumstances in an individual workplace change over time.

Actively challenging prevailing assumptions and associated low expectations

- The opportunities presented to people with disability appear to be largely a product of social and economic circumstances and the assumptions (low expectations) of some parents, teachers and employment service providers. Challenging and changing these starting assumptions requires a shift in what is considered possible and beneficial for people with disability, particularly for those with severe and profound disabilities.
- Poorly paid work conducted in the context of precarious employment, and in environments unacceptable to the wider community should not be allowed to continue. Such work should not be excused under the misapprehension that such work can act as a ‘training ground’ or ‘stepping-stone’ to higher quality employment.

5 Education

In this section of the report, we first outline the methods by which the literature informing our work was identified, retrieved and refined. We present our observations concerning the key characteristics of the literature, its strengths and limitations. We then document our findings as they relate to education, primarily for children with disability. We note that post-secondary education was outside of the brief for this report and it to be addressed elsewhere by the DRC.

To assist with the interpretation of a relatively complex literature, we begin by analysing how disability and its ‘severity’ have been defined in the literature, together with key constructs such as segregation, integration, and inclusion. We document lived perspectives on education and provide an overview and analyses of the possibilities and challenges in educational innovation. Following which we turn to an analysis of the twin-track approach with respect to the social and medical models of disability as they apply to education. We then seek to move the debate beyond a polarised agenda, present elements of good educational practice and identify a number of options for safe and quality education for children with disability. Our review includes detailed analyses of the two educational systems from overseas: Italy and Finland. We document how the findings of the literature review were used in the two-phase online Delphi study and integrated with the subsequent findings of this study as they pertain to education for children with disability.

This section of the report concludes by presenting recommendations for policy and practice as they relate to safe and effective education for children with disability

5.1 Method for the education literature retrieval and review

A systematic search of peer-reviewed literature was undertaken using bibliographic databases: OVID (PsychInfo); EBSCOhost (Academic Search Complete, CINAHL Complete, Education Research Complete, Educational Administration Abstracts, ERIC, Family and Society Studies Worldwide, SocINDEX with Full Text, Sport Discus with Full Text); ProQuest (Education Database, ASSIA, LLBA, Sociological Abstracts; the Campbell Collaboration; Scopus; and Google Scholar. A hand search of key journals was also undertaken, and the grey literature searched relevant international and Australian legislation and policy sites.

Each search included the terms and truncations below.

Table 10: Education literature search terms

Term 1: Population - school-aged children with disability	Term 2: Intervention and Context terms - educational provision - general and special	Term 3: Outcome terms - educational quality and safety, best practice, school choice
disab*, impair*, disorder, condition, handicap, "special education*", SEN, profound, severe, pervasive, multiple, complex intellectual, physical, social, emotional, communication, behavioural, autis* OR ASD, developmental, deaf OR "hearing impair*", blind OR "vision impair*"	"inclusive education", "inclusive practice", integration, desegregat*, mainstream*, deinstitutional*, "disability rights", "education for all", "equal opportunit*", equity, "right to education", "social integration", learning, curriculum, school*, inclusi*, regular, integrat*, mainstream, "general education", "regular education", desegregat*, practice*, pedagog*, differentiat*, individualis*, modifi*, remedia*, "universal access", "universal design", "special school", "special* education*", specialist, segregat*, separate, "special needs", "additional provision"	equal, access, safe*, quality, model, exemplar, excellen*, best-practice, prefer*, choice OR "school choice", select*, effective, non-discriminat*, safe*, achieve*, potential, soci*, success*, wellbeing, participat*, inclusi*, transition, lifelong, belong*, bullying, restraint, exclu*, seclu*

The key inclusion criteria were:

- 2006 onwards, which is the date of UNCRPD.
- Like-minded educational systems – NZ, UK, USA, Canada, western Europe.
- Population – school-aged children with disability.
- Concept – disability-inclusive education.
- Context – primary and secondary education (K-12).
- General and special education.
- Outcome studies about educational quality and safety.
- Focus on profound/severe disability.

The key exclusion criteria were:

- Post-secondary school education as negotiated with the DRC.
- Broad inclusion beyond disability focus.

The search strings produced 11,181 articles. Due to the multiple search strategy, many of these were retrieved more than once and so the number was reduced to 4411. Key journals and grey literature were then hand searched and snowball searching was also undertaken to retrieve government policy statements and related data. Consequently, a further 173 articles were added and a total of 4584 articles were upload into Covidence to be screened by the research team according to the agreed inclusion criteria. Consideration was given to the quality of the literature, as described in the review methodology.

The research team, including one member with self-declared lived experience of disability, then completed two rounds of title and abstract screening and 3902 articles did not meet the inclusion criteria.

Consequently, 682 publications informed the Education review.

5.1.1 Defining disability and its severity for the purposes of education

The Australian Disability Discrimination Act 1992 (DDA)[263] defines disability in the context of the medical model, so an attribute (conceptualised as a deficit) in the individual. The DDA defines disability not only as current bodily or mental loss, disfigurement, disorder or disease and inability to learn as others do, but the past or prospective existence of such conditions and existence where it is imputed to exist.

The Disability Standards for Education (DSE)[264] uses the DDA definition, as does the Nationally Consistent Collection of Data (NCCD),[265] which has provided specification for the imputation category to enable teachers to report difficulties learning and managing at school as disabilities. These policies and their definitions entrench and perpetuate a medical/deficit focused understanding of disability in the education system.

Via the NCCD, students with disability are identified according to the disability category for which they predominantly require adjustment – physical, cognitive, sensory or social/emotional – and the level of adjustment they need to access education on the same basis as others. This relies on Quality Differentiated Teaching Practice – a first level of unfunded good teaching, followed by three levels of progressively more funded support – Supplementary, Substantial and Extensive.

The Australian Bureau of Statistics (ABS) definition focuses on functional impact. Disability is any limitation or impairment restricting everyday activities like self-care, mobility and communication for at least six months. Profound or severe disability is when help with self-care, mobility or communication is always or almost always needed.[266] In school, approximately 60% of substantial or extensive adjustment is provided for cognitive limitation and approximately 30% for social-emotional limitation.[267]

The ABS draws on the International Classification of Functioning, Disability and Health (ICF),[268] which defines disability as a dynamic interaction between health conditions and environmental and personal factors which is the bio-psycho-social model of disability. This identifies disability as an aspect of normal human functioning and does not presume disability exists in the same way, or even at all, simply by virtue of a condition.[269]

An insidious problem with identifying disability for funding provision is the location of disability in the person.[270] While the NCCD uses the DDA's deficit-oriented definition to calculate the fullest extent of disability, it avoids an individual focus by collecting data on the type and level of adjustment needed by four broad categories of disability.[271] The NCCD produces a support-based, rather than a prevalence, estimate of disability.[272]

Internationally, markedly different proportions of the school-aged population are identified as having disabilities and educational difficulties.[273] The figure is 6.6% in Germany,[274] 13% in Canada,[275] 1.4% in Sweden (with a further 6% receiving special support of some kind),[276] 8.5% in Finland (with a further 25% of primary and 16% of secondary-aged children in part-time (temporary) special education at any one time),[277] 2.5% in Italy,[278] 16% in the UK,[279] 14% in the US,[280] and 9% in New Zealand.[281] In Australia, just under 19% of school-aged children are registered as having an education-related disability, including 'inferred disability' in the Nationally Consistent Collection of Data.[282] In the Australian Bureau of Statistics, this figure is just under 8%.[283]

This is due less to differences in the presence of normative and low-incidence disabilities for which there are measuring instruments and agreed criteria (Category A/Disabilities, according to the Organisation for Economic Cooperation and Development (OECD)[284] than to different ways categories of non-normative and high-incidence educational needs are identified for support provision reasons (Category B/Difficulties). The OECD's comprehensive model of special educational needs showed the proportion of children with Category A/Disabilities in England, US, France and Japan varying by just 3.5%, but those with Category B/Difficulties varying by over 14%.[285] Different ways of funding contribute to this and financial provisions to schools on the basis of disability prevalence lead to increased disability identification.[286]

In Australia, the NCCD funding model has supported increased identification and the NCCD statistic of disability-requiring-support-at-school is more than double that of the ABS.[287] The figure for severe and profound disability is the same (4.5%) and similar to Italy's total figure (3.4%). In Italy, those with learning difficulties are regular students needing quality regular teaching.[288] In the US, they constitute an additional 33% whose 'specific learning disabilities' necessitate additional funded support.[289] This 'supply side' and educationally-based approach accords with the OECD's definition of students with special educational needs, as 'those (for whom) … additional public and/or private resources are provided to support their education'.[290]

For disability in Indigenous Australian children, information about prevalence and type is limited.[291] According to the ABS,[292] the rates of severe disability are similar for Indigenous and non-Indigenous children aged 0–14. However, this is likely an under-representation due to formal assessment of disabilities and learning difficulties occurring less frequently[293] and greater reluctance to define oneself by a Western medical category.[294]

5.1.2 Defining profound and severe disability

The DRC has a particular concern for students ‘sometimes labelled as having “profound” or “severe” disability’. In the context of violence, abuse, neglect and exploitation in Australian schools, who are these children and in which contexts are they being educated?

According to the ABS, profound or severe disability is where help is mostly or always needed with self-care, mobility or communication.[295] According to the NCCD, substantial or extensive support need is where help is mostly or always needed to access education on the same basis as others. Using NCCD data, when the numbers of students receiving Substantial and Extensive support are combined, they represent a similar proportion of the school population to the ABS severe or profound disability category of 4.5%. It is impossible to know whether this is the same population as the NCCD classifies students according to the main reason learning support is required. This may not coincide with a disability category or any formal category at all.

Profound/severe disability in education is a broader category than low-incidence disability which, in the US, is defined as occurring in less than 1% of the population[296]. It consists of vision or hearing impairment or simultaneous vision and hearing impairment; significant cognitive impairment; or any impairment for which a small number of personnel with highly specialised skills and knowledge are needed for children with that impairment to receive an appropriate education[297]. A much larger group experiences significant difficulty at school. These are children with various cognitive and/or behavioural disabilities such as specific learning disability (SLD) which is a high-incidence and sometimes contested category, according to Lui, Bessudnov & Black[298]; intellectual disability (ID); social, emotional and behavioural difficulties (SEBD); attention deficit hyperactivity disorder (ADHD), and autism spectrum disorder (ASD).[299] ASD occurs in almost 6% of the Australian population and is frequently diagnosed as profoundly/severely disabling.[300] So more than half (54%) of disability in school-aged children in Australia is profound/severe.[301] Three-quarters of this group are boys – an unusual fact given that outside the 0–14 age group, girls and women are more likely to be profoundly/severely disabled. The largest difference between males and females in Australia for disability occurs in children 5–14 years.

Cognitive limitation/intellectual disability is the most common reason for all levels of support at school at just under 60% of substantial and extensive support. This is followed by social-emotional difficulty which receives 33% of substantial/extensive support.[302] So, profound/ severe disability is principally significant intellectual and social-emotional impairment. This explains why the 3 major difficulties at school are learning, fitting in socially and communication and why disability in general, and autism in particular, go together in the school years in such a striking way.

Intellectual impairment is the most common disability group affecting school-aged children, followed by sensory and communication impairment, which includes difficulties with social communication, and psychosocial impairment. Autism is the most reported condition affecting 28% of those reporting disability. Of that number, 65% are profoundly or severely affected and need help to manage the cognitive, emotional, social and communication requirements of school.[303] Other common conditions are attention deficit disorder/hyperactivity which impacts 1 in 6 children with disability and phobic or anxiety disorders impacting approximately 1 in 7.

Boys are disproportionately disabled in school. They are more likely to have disability and more likely to be profoundly disabled. They predominate in the 3 major difficulties at school, across all types of disability, in special classes in mainstream schools and in special schools. Figure 4 depicts the situation of boys, disability and school.

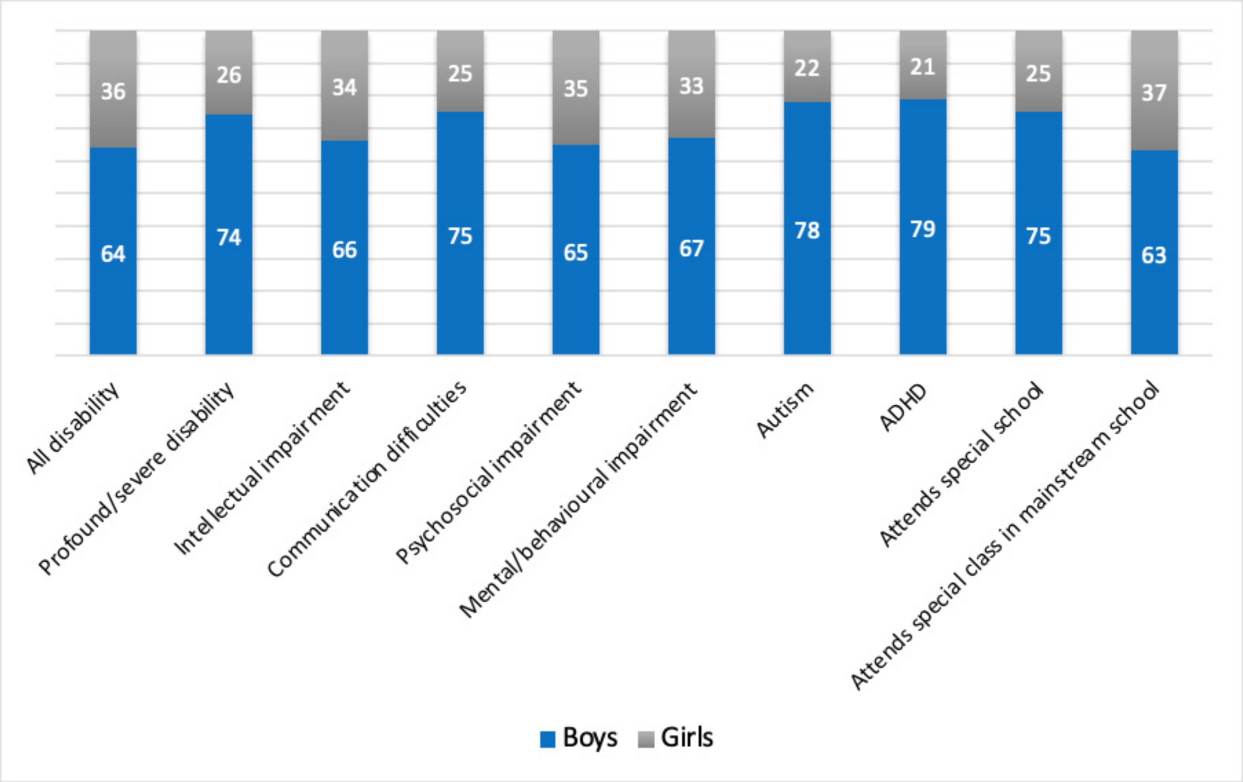

Figure 4: Breakdown by sex of disability and school placement, 2018 (Source: Australian Bureau of Statistics, Disability, Ageing and Carers, Australia: Summary of Findings 2018)

In Australia, children with disability predominantly attend mainstream schools – 99% with disability and 80% with profound/severe disability. Approximately 20% of children with disability in mainstream schools spend a proportion of their learning in special classes or resource rooms – three-quarters with profound/severe disability.[304] So, 20% of students with the most profound/severe disabilities attend special schools and 50% of them have autism.[305]

Australian special schools cater for students with disabilities and/or social and emotional problems.

“A special school requires one or more of the following characteristics to be exhibited by a student before enrolment is allowed: mental or physical disability or impairment, slow learning ability, and/or social or emotional problems”.[306] Special schools include special assistance schools as defined under the Australian Education Act 2013. They are non-government schools primarily established to cater for students with SEBD.[307]

Between 2015–2018, the number of special schools in the government and Catholic education systems remained stable but there was an increase of 31 independent special schools. One explanation for this rise in special schools is that school systems are becoming more inflexible due to the accountability practices of neoliberal reform.[308] Neoliberalism is seen as in fundamental contradiction with inclusive education.[309] However, this does not explain the stable numbers in the government and Catholic school systems, nor the similar growth in independent general schools. Between 2015–2018, 50 of the 73 new schools in the country were independent. It also doesn't align to the most recent 2018 figures that show that, since 2015, for children with profound and severe disability there has been a shift away from special schools and special classes in mainstream schools towards general class attendance in mainstream schools. This reverses a trend of the previous 6 years. Important to note is that while attendance at special school can result in segregation, it can also be the result of segregation,[310] and it may not be in a child's best interests to return them to a setting that is unchanged. Independent special schools act as 'withdrawal' educational settings, enrolling students with histories of non-engagement.[311]

According to independent school data from Victoria, a common scenario for students with intellectual disability and/or other severe or profound limitations in the first half of their schooling is to attend a mainstream school and then move to a special class or school for secondary school.[312]

5.2 Findings from the education literature review

When applying the 6 questions posed by the Royal Commission to current research, it became apparent that some variation was necessary to address the issues in the context of policy and practice. To review the education literature, some questions were amalgamated and recast:

1. How are the terms inclusion and segregation understood and applied in the literature?
2. What constitutes good inclusive practice and are there models or examples of where these are working?
3. What are the safety and quality outcomes for people with disability (and, if relevant, peers and others) of settings generally identified as inclusive or segregated?
4. What are the essential requirements of a safe and quality mainstream educational system for all children?

In evidence given to the Royal Commission there were numerous accounts of violence, abuse, neglect and exploitation of children with disability at school, such as the following:[313]

- inappropriate and disproportionate application of disciplinary sanctions are being given to students with disability, rather than attempting to ascertain the causes of the behaviour and providing the support the student needs
- a disconnect between the existing legal requirements for the provision of reasonable adjustments or supports and the provision of adjustments at school level, particularly, rigidities in addressing the challenges of implementing a policy of inclusive education (adopting a 'one size fits all' approach), leading to failures to provide individual adjustments and support for students with disability

- complicated and poorly understood systems of funding to provide support for children with disability in schools and lack of auditing leading to unevenness in practice and significant disparities between schools
- limited data available to inform policy making on the nature and extent of suspensions and exclusions, part-time attendance of students with disability and the use of restrictive practices in schools
- insufficient training and equipping of teachers to apply a philosophy of inclusive education in mainstream schools.

Notably, the Royal Commission has been given different recommendations as to the optimal school setting for inclusion. These are illustrated in the final 2 recommendations from respondents to the Royal Commission's *Education and Learning Issues Paper*[314]:

- Separate education settings should be reduced or eliminated, including no new separate schools created.
- Separate schools, classes and units should be maintained, with safeguards to prevent and monitor violence, abuse, neglect and exploitation.

When interpreting the literature and addressing the Royal Commission's questions, this review took into account these varying opinions and compiled an evidence base on which policy and practice recommendations could be formulated.

5.2.1 How are the terms segregation, integration and inclusion understood in education?

Reference was made to the UNCRPD (Article 24)[315] and 241 position papers. In addition to the core issues of segregation, integration and inclusion, consideration was given to the lived perspective of people with disability, the possibilities and problems encountered when attempting to progress such possibilities, issues related to the dichotomy of the social model vs the medical model and the need to move beyond this polarised debate, and inclusion as a multidimensional construct.

5.2.1.1 Segregation in education

Segregation is the provision of education to students with disability in separate environments designed or used to respond to a particular impairment or various impairments in isolation from students without disabilities.

The question of location is the most vexed and discordant aspect of the inclusive/special education debate.[316] The literature frequently equates segregation with special education[317] when traditionally, the understanding has been that special education is a service that may or may not involve a separate place.[318] It may be more accurate to refer to the whole twin/multi-track system as segregated and special and mainstream schools as its two aspects.

5.2.1.2 Integration in education

According to the UNCRPD, integration is the process of placing students with disabilities in existing mainstream educational institutions with the understanding that they can adjust to the standardised requirements of such institutions. This has also been described as a failed attempt to include because it does not address the system-level factors standing in the way.[319] When a system with fundamental characteristics unsupportive of inclusion attempts to include, the resulting experience for those being included is typically negative.[320]

The research also notes that while the term integration is now defined negatively, it was originally a positive term that included addressing excluding and discriminatory factors.[321] This tendency for terms connected to disability to evolve in a negative direction is occurring now with 'inclusion.' The peers of children with disability are calling them 'inclusion children' who belong in 'inclusion classrooms', meaning segregated.[322]

5.2.1.3 Inclusion in education

The UNCRPD says inclusion is 'a process of systemic reform embodying changes and modifications in content, teaching methods, approaches, structures and strategies in education to overcome barriers, with a vision to providing all students of the relevant age range with an equitable and participatory learning experience and the environment that best corresponds to their requirements and preferences'.[323]

When applied only to children with disability, the UNCRPD notion of 'environments corresponding to requirements and preferences' does not appear to rule out separate settings when deemed appropriate. However, General Comment 4 (GC4)[324] presents dual educational systems as incompatible with inclusion. The UNCRPD also calls for overcoming barriers to mainstream placement and transferring resources from segregated to inclusive environments, so it is generally considered that the UNCRPD mandates a single education system.[325] From this full or universal inclusion perspective, special schools are an expression of societal exclusion.[326]

The goal is for schools and curriculum to extensively reform so children can be educated in the one place.[327] Hence, a location-based focus continues to predominate.[328] There are different views about what full inclusion, or a single education system, should entail. For some, inclusion means no separation at any time.[329] For others, such as the US, mainstream participation of 80% is regarded as full inclusion.[330] This contrasts with Italy's single-track system where inclusion means any proportion of general education attendance—a statistic that is not gathered or examined.[331]

Despite the provision of definitions from the UNCRPD, and the enormous amount of literature and opinion generated, the consensus is agreement about the meaning of inclusion in education has not been achieved.[332]

5.2.1.4 The lived perspective on education

A full range of views about the placement aspect of inclusion comes from qualitative studies exploring the lived experience of mainstream schooling for individuals with a disability. The dominant sentiment of these 51 articles is that inclusion is experienced now, or it is not achieved.

> It is more of a feeling I think ... to feel included in something. It is like the teachers, the teaching and the other kids. It is more of a feeling of being happy, welcome and belonging in the environment.[333]

> If the support isn't there in mainstream, then it will never be inclusion ... it can't be inclusion ... you can't belong or be included if the help isn't there. It takes an awful lot of support and thought from the teacher to make sure children are included. Sometimes the wrong thing is done, such as saying 'get a partner ...' often autistic children don't have anyone to go to so are left alone.[334]

5.2.1.5 Possibilities and problems with innovation

The concept of inclusion emerged in North American and European research.[335] Inclusion in education is based in the social model of disability, which opposes both the medical (individual) model and all forms of non-mainstream treatment and provision.[336] However, consensus on this global norm remains elusive. This is partly because the international legislation is conceptualised practically in positive and negative directions. Positively, as key inclusion features and negatively, as what needs to be removed.[337] This continues to hamper discussion.[338]

A 2014 European conversation about inclusive education identified four qualitatively different categories of definition[339]:

1. Placement meanings – inclusion as placement of students with disabilities in general education settings (UNCRPD integration definition).
2. Meeting the academic and social learning needs of students with disabilities in any setting.
3. Meeting the academic and social learning needs of all students.
4. Creating inclusive communities.

These move from mere presence of children with disabilities in mainstream schools to the broadest possible remit. This suggests inclusion in education might look different at different stages. However, the first option is not recommended in any of the literature – essentially it is a straw man, and the final option moves beyond the topic of disability and inclusive education.[340] The other options progress from a focus on children with a disability to a focus on all learners but do not consider system-level factors.

Göransson and Nilholm's research concluded there is insufficient research and knowledge of the factors supporting inclusive processes in schools and of what schooling should accomplish or what inclusion meant to support decision-making about programs of useful empirical research.[341] Follow-up investigations by the authors noted different depths of discussion about the meaning of inclusion across 'position' and 'empirical' articles. The former contained many developed discussions and analyses of meaning from different critical theoretical perspectives, the latter assumed mainstream placement is the core meaning.[342]

Conceptual confusion continues despite the 'massive amount' of knowledge creation and multitude of reviews,[343] and the appropriateness of a mainstream only allocation for all continues to be questioned. New theories of inclusion are not lending themselves to application in school systems, schools and classrooms and there is a tendency to generalise – studies from different countries with different educational systems are being treated as the same. There is an overall issue of research being too decontextualised, of the construction of inclusive practices becoming a theoretical pursuit, and of 'solving problems in theory while leaving practice untouched'.[344] Hence, the recommendation for developing more practical theories and examining current theories closely for their practical value. Research about inclusion has to be contextualised to further develop more inclusive practices.

Both narrow (focused on the individual child) and broad (focused on all children and the broader society) definitions of inclusion have problems. The narrow definition neglects system-level contributions to exclusion and the broad definition overlooks unique disability-related needs.[345]

The narrow definition provides an appropriate focus on the child as a learner alongside others – all at different points on the one learning journey.[346] For all learners, curriculum content and pedagogy need to be tailored to point of readiness to learn. However, if differentiation contributes to disability being singled out and 'othered', personalising instruction to learning need will fail to support inclusion, which it must do.[347] Essentially, this is inclusion as exclusion. The research notes situations where the term 'inclusion' becomes derogatory eg an 'inclusion classroom'. This is the opposite meaning to the concept's intention.[348] To offset this, there must be a consistently inclusive pedagogy,[349] and all system-level factors contributing to ongoing stigma and discrimination must be addressed.[350] In addition, psycho-social variables that impact inclusion success need to be better understood.[351]

The inclusive education discussion is replete with contested terms and ideas–not only inclusion, segregation and integration, but disability, disability prevalence, education and polarised views about place. The UNCRPD has not resolved this. This is not because its own perspective is not evident but perhaps because it contains an oversimplified dichotomy in casting 'segregation' and 'inclusion' as a step away from each other.[352] Only Italy, Spain, Iceland and Norway are inclusive according to this understanding, as by policy they are single-track.[353] However, while they provide some lessons and pointers, they are not seen as unequivocally successful or necessarily better than multi-track systems elsewhere.[354]

Inclusion is a contemporary term with a long association with accepted and established values, like equal opportunity, social respect and solidarity, that support and express what it means to be human in community. At this broadest level it is not controversial. In education, it has been generally applied more narrowly to children with disability, but now to all forms of educational disadvantage. Practically, it calls for access and presence, educational and social participation, and achievement and progress within a common curriculum.[355] The aspect of local school presence continues to be heavily debated between those arguing for special school closure[356] and those believing separate provisions have an ongoing place for some children.[357]

In broader writing on disability, people with a disability have been called the 'canary in the mine', alerting everybody to wide-spread system problems that they experience first and most severely.[358] Some parents have described the pathologising of their child's poor experiences at school as an example. In their reflections, the labels around autism spectrum disorder and mental (social emotional and behavioural) disorders do not describe disability in their child so much as in the system.[359] A similar 'danger alert' function has been seen in circumstances where children with disability continue to express preferences for special education or segregation.[360] By identifying the mainstream as 'not for the likes of us', they indicate it is not properly for anyone.

5.2.1.6 From social and medical models to a twin-track approach

In the social model, skill development, behaviour change and capacity building 'interventions' are deficit-oriented, inappropriate and express society's attachment to a 'functionalist paradigm' that locates the source of problems in the individual.[361] Looked at through an educational lens and applying social constructivist learning theory, instructional 'intervention' at school that develops skills and capacities where they don't exist is a duty of society and expresses the belief that all children can learn.[362] Classrooms contain curricular expectations – they are unmistakably interventionist settings.[363] Children are learners and it is their responsibility to learn. One suggestion for moving beyond this unhelpful social-vs-medical model debate is to draw on the World Health Organization's more complex twin-track model of disability, the *International Classification of Functioning, Disability and Health (ICF)*.[364]

The ICF sees disability as a 'dynamic interaction between a person's health condition, environmental factors and personal factors.'[365] (see Figure 5).

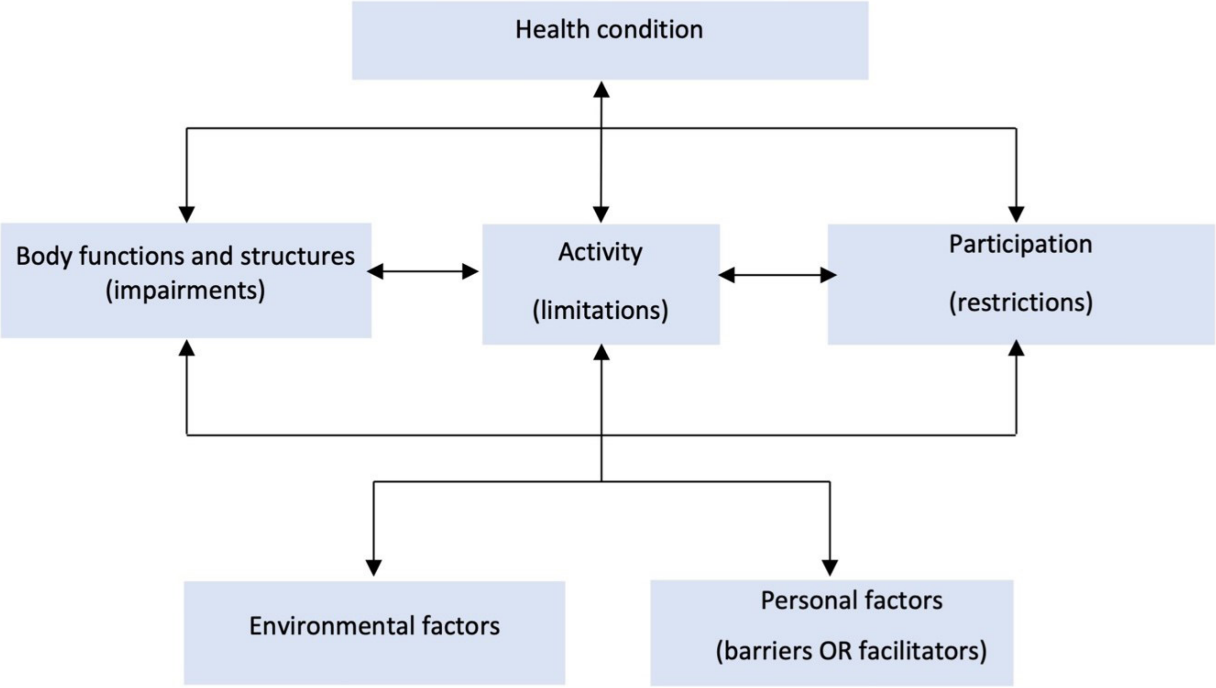

Figure 5: ICF components.[366]

Using the ICF, life domains and their activities are analysed for their capacity demands. The high demand of the life domain of education on children can be seen in the steep rise in disability identification at school entry. Within the interconnected school community, this translates to a requirement for greater teacher support. Inclusion defined in relation to this multifactorial model involves considering the school system and the child.

This focus on lived experience and the child's own 'sense of belonging'[367] in defining inclusion is echoed in a recent systematic review looking at approaches to mainstream inclusion and social participation for adolescents with ASD.[368] In the studies analysed for that review, 2 distinct definitions of inclusion were identified:

- being socially accepted in the educational context and socially participating in the group and school (the experience of inclusion now).
- being physically placed in the mainstream, thus leading to social participation ('holding out' for inclusion in the future).

Four types of studies were identified: 2 types focused on students with disability and 2 focused more on teachers and parents. Analysing the inclusion definitions of these studies highlighted that the definition used in the teacher/parent studies did not comprehend or support student preferences for separate settings. From a perspective that only general education settings qualify to be called inclusive, a preference for a special setting can only be seen as an example of enculturation into society's ableist perspective.[369] On the other hand, the definition used in the student studies, permitted a more flexible application and responsiveness to student choice.

> My parents came up with this decision ... Actually, they didn't even take a second to think this out; to their mind being educated means being educated in the mainstream.[370]
>
> In some classes, ... they say specifically to me, 'Er, Ben, have you finished?' And I'll just say, erm ... 'No' or, 'Yes, I am'. And then, then, then, that allows them to move on, because they know that I'm finished and ... they just hold on then and they say it again, but it's not like a harassment thing, it's just to make sure I've done it ... and then I say, 'Yes, I'm done', and then they just move on.[371]
>
> It is no fun playing with the rest if the teacher has forced them to let you join the game. You know that it would not be fun anymore.[372]

5.2.1.7 Moving beyond polarisation in the debate

Considering the intractability of the debate between the polarised 'medical/deficit' and 'social/radical' models, there is a proposal for a 'fox' rather than a 'hedgehog' stance, [373] so-called after the philosopher Berlin[374]. This means a less all-encompassing and unchanging unitary vision. It supports more flexibility in relation to tensions and less than ideal situations and refraining from investing one perspective with all the value and the other with none. It seeks connections, being open to change over time, accepting that plural values sometimes conflict and hard choices may need to be made, and that less than perfect solutions need to be selected.

For inclusion, its complexity suggests multi-dimensionality and the need for progressive realisation. The dilemmas of choice within each of its aspects reflect the tensions in plural democracies between treating all as the same (commonality) and all as different (differentiation).

When predominantly equated with place, inclusion can reduce to integration.[375] To offset this, a proposal that it consists of interconnecting but distinct aspects[376] was taken to a group of 132 education policymakers from the US, Netherlands and England. They endorsed its description as a multi-dimensional construct, with each dimension expressing something of the tension in fundamental values supporting individuals to live in community[377]:

1. Identification or how disability is identified. Inclusion requires learners and learning needs to be identified and non-identified. Areas of deficit must be identified but an inclusion frame alerts to dangers of othering or stigmatising in identifying people by their deficits[378] and suggests ways to offset this in data collection and reporting.[379] It also calls schools and teachers to a child-centred perspective, rather than looking at the teaching role simply through the lens of educational objectives and targets that students must reach.[380]

   > [When the assistant comes to give me help] ... Well it makes me feel that it's only just me that needs the help and it's no one else in the room that needs help it's just me—'cos like she comes up to us, and that lot, it's like why is it me?[381]
   >
   > I don't mind outside the class as long as it's not for the whole lessons because I like being in with my mates. I don't like getting taken out because it makes me feel like I'm different towards the others.[382]

2. Curriculum or what is taught and why. Inclusion requires broader consideration of what learners learn and the purposes for knowledge. There are several potentially conflicting options: traditional knowledge-based curricula focused on subject-based content; person-centred curricula focused on self-discovery and self-development; socially purposed curricula that recognises socialisation or societal reconstruction purposes and reflects the diversity of the society; and competency-based curricula focused on knowledge, skills and concepts sequenced progressively to achieve performance standards.[383] Inclusion also requires the curriculum to be modifiable for tailored learning experiences.[384] Tensions exist around the degree of commonality and differentiation to support. Within distinctive curriculum provision for students with profound/severe learning disability, there are tensions between functional skills-based curricula and opportunities for breadth and balance, between entitlement and individual needs, and between individual choice and organisational constraints. Insufficient research has been conducted into distinctive curricula and acceptability to learner needs.[385]

   I think that if we do not like writing they should teach us trades and crafts. If we do not like academic work, we can learn something else ... I used to enjoy (art), but this was given least priority as it was considered a waste of time.[386]

   I'm getting my first qualification in year 9 ... Functional Skills level 1 ... [if I didn't] ... I wouldn't get no GCSE's, wouldn't get no qualifications, wouldn't get a job ... I thought of my education, that's what I've really got to think about ... forgetting about all the childish stuff I used to do. Getting on with my life.[387]

3. Participation or what involvement is possible. Inclusion requires consideration of kind and balance of participation and protection in shared settings. Environmental/system-level factors must be addressed and enabled to function in support of inclusion, so provisos must ensure that exclusion and exclusion attitudes don't result.[388] This includes peers.[389] There is high incidence of bullying of children with disability in mainstream schools, particularly secondary schools.[390] The need for balancing protection and participation and hearing the views of children and parents is emphasised in the literature.[391] Large-scale studies in England and Europe highlight the individual views of children and young people about the degree of participation they desire.[392]

   ... they could help me more, stop the people from bullying me but they didn't, and pupils kept bullying me ... it was a chain reaction [...] kids were bullying me and basically I took things in my own hands because teachers weren't doing anything. So I just used to beat them up because they beat me up and teachers didn't like that, and I got suspended [...] they could just sit me down and talked to me. But they never did. Then they didn't like what they got after ...[393]

   I was very stressed trying to cope with the noise, the large class sizes, the constant changing of classrooms ... It was awful moving to the next class. Everyone was coming out and it was just swarmed with people pushing, running, shoving, throwing bottles.[394]

4. Pedagogy or how learning is supported. Inclusion requires individualised teaching support to be provided in a non-marginalising way.[395] This expresses the tension between providing for the needs of the student and ensuring they are not singled out for negative attention

because of that provision. Teachers must begin with an assumption that all children can learn, an acknowledgement of their responsibility to teach all children in their class and a commitment to extending their generally available teaching to all.[396]

I had teachers ... that supported me a lot – gave me self-confidence. They urged me to take part in everything. I always felt they were on my side ... Whenever I was reluctant to participate in some activities, they would say ‘Come on, you don’t have to do everything, you can do this and that!’ and they kept encouraging me. This is because they accepted me; and that made me stronger ... I started being active in the classroom, in the schoolyard, during the excursions; there was a place for me.[397]

5. Placement or where learning takes place. Inclusion requires considering different places of learning for their different aspects of inclusion. Tensions exist regarding the priority and centrality of these aspects. Mainstream schooling speaks to the right of all children to learn together and to access and benefit from the same facilities and opportunities.[398] Specialist schooling speaks to the right of children with disability to placement where their learning needs are best met and to access the environment best suited to them so they can benefit optimally from their educational experience.[399]

   It wouldn’t be fair on students if everybody was in one school because people learn at different speeds, some faster, some slower – this wouldn’t be right. I believe this isn’t right, as the child might not be able to cope. It is just like an ingredient ... like a big pot ... you can’t just throw every ingredient in ... only certain ingredients work with other ingredients.[400]

   It is also a bad idea for some to go to an autism school as some people are very impressionable and make them be more autistic ... or special. It could be better in mainstream if they tried to support autistic children more and be flexible to help.[401]

   I don’t like that, it’s when, you’re not a baby and you’re 14, you know, 14, if you’re in a mainstream school then you’ll be treated like an adult, you would more or less have the same privileges as, umm, be treated the same as, you know ... The teachers always treating me like babies in the school when you’re not. People out of school calling you names, if, ‘cause, if they find out about your school and being nasty to you.[402]

6. Governance or who makes the decisions about educational provision. Inclusion requires educational provision governance to reflect inclusive principles. Tensions exist between autonomous school governance independent of local authority and supporting local/community-controlled school governance. An inclusive vision may include the participation of children in different schools in the local setting, including separate special schools, but where all are part of the one cluster and all are under mainstream school-level control.[403]

Between the poles of tension, the education policymakers recognised more than one possible position.[404] There are options more focused on the individual and differentiation and others more focused on identification within the group. Options at the one end presume the appropriateness of segregation on the basis of individual differences and at the other tend to inclusion on the basis of the normality of diversity. Considering this more complex description may support progress towards greater inclusion. Table 11 sets out the possible positions for consideration of the Delphi panel.

Table 11: Pathways to inclusion

Element of inclusion	Priority items within each element
Identification: how is disability identified?	• By medical conditions/diagnosis • By disability sub-group and functional difficulties in relation to the school setting and educational program • Within a broader group of vulnerable/at risk children • By teacher identification of learning adjustments needed • No specific identification, assessment of relative incapacity, or between-student comparisons
Placement: where do children learn?	• Separate special schools exist for the education of children with severe/profound disability • Separate and linked. Children with disability are educated in a range of settings, including separate special schools and separate classes/units linked to regular schools • Same school with formal withdrawal. Children with disability receive a regular school education that includes part-time withdrawal to separate classes/units linked to regular schools • Same school and class with informal occasional withdrawal. Children with disability receive a regular school education that includes opportunities for withdrawal and varying learning groups as needed • All children with disability participate alongside their age peers in all aspects of a regular school education with no separate special provision.
Curriculum: what are children taught?	• The curriculum is alternative with different aims, pathways/programs, levels of progress and assessment mechanisms • The curriculum has the same aims as the standard curriculum, but different pathways/programs, levels of progress and assessment mechanisms • The curriculum has the same aims and pathways/programs as the standard, but different levels of progress and assessment mechanisms • The curriculum has the same aims, pathways/programs and levels of progress, but different assessment mechanisms • A single new and inclusive social curriculum is provided to all learners

Element of inclusion	Priority items within each element
Pedagogy: how is learning supported?	• Teaching is provided by an educational-health team who collaborate to provide therapeutic learning experiences • Disability-specific pedagogies are followed according to condition, and are further individualised for each child's unique educational needs • Pedagogy follows general principles for educating children with disability, with a focus on methods supporting educational objectives to be met • Pedagogy focuses on the teacher-learner relationship and individualising the learning experience appropriately for the learner, using student self-assessment to elicit student voice and with formative assessments • Particular pedagogical support is not provided to avoid discrimination and stigma caused by labelling and singling out. General support to progress in the curriculum is an inherent task of education
Participation: what options and degree of involvement are available?	• Children participate with others of similar disability. Provisos to protection are not needed as disability-specific settings guarantee this • Children participate with same age peers in regular education where access and resource requirements for participation are met, school-wide policies and procedures about respectful relating and anti-bullying are in place, teachers model inclusiveness and respectful relating, and peer interactions occur under adult management and oversight • Children participate with same age peers in regular education where access and resource requirements for participation are met, school-wide policies and procedures about respectful relating and anti-bullying are in place, and teachers model inclusiveness and respectful relating • Children participate with same age peers in regular education where access and resource requirements for participation are met and school-wide policies and procedures about respectful relating and anti-bullying are in place • All children participate freely in a new regular education setting and with a new curriculum focused on bringing inclusion and cooperation across all lines of diversity
Governance: how are schools managed and led?	• State management of the education system • Regional (state-based) responsibility for special and regular school provision in partnership with national government • Exclusive regional (state-based) responsibility for special and regular school provision • Clusters of schools closely link special and regular school provision under state-based oversight • Individual school governance under state-based oversight

5.2.1.8 Prioritising the elements to address

The Delphi panellists were asked to consider 6 dimensions of inclusion and to prioritise them for addressing inclusive education in Australia. All 14 responded in Round 1 and 11 responses were provided in Round 2. The Round 1 proposal was sent back for confirmation in Round 2. The moderate degree of agreement from Round 1 increased to 73% in Round 2 with this order of priority:

1. Pedagogy
2. Identification
3. Curriculum
4. Participation
5. Placement
6. Governance

This level of agreement came in just under consensus. The recommendation is for a further round to determine whether a convergence of opinion was being established. A comment from one of the agreeing panellists is below:

> I think this argument could go on forever but, in my view, if you get the pedagogy and the identification of individual learning/adjustment needs right, other aspects will follow. Of course, there are many variables at play in order to address these priorities but defining them is a great start. [Delphi survey participant]

A comment from one of the three disagreeing panellists is:

> I agree with the order of priorities 3 to 6. However, identification should be the first priority over pedagogy. Without understanding the disability and the strengths and weaknesses that come with it, there can be no improvement to the teaching or participation of students with disability. For example, with Autistic students, they need to be understood in terms of their strengths and weaknesses. In addition, their needs and interests also need to be known. By achieving this level of knowledge, we can then make improvements that are tailored to the Autistic student so that they can have a good school experience. [Delphi survey participant]

5.2.1.9 Identifying the best option for safe and quality education and Australia's current position

Delphi panellists reached consensus on the options most conducive to inclusive educational settings. These results are compared to the current position of Australia in Table 12.

Table 12: Dimensions of educational policy and practice to optimise inclusion and Delphi panellists' perception of Australia's current position in education

Dimension/ element	Optimal option (% agreed)	Australia current position (% agreed)
Pedagogy	Option 4: Pedagogy focuses on the teacher-learner relationship and individualising the learning experience appropriately for the learner, using student self-assessment to elicit student voice in combination with formative assessments (91%)	Option 3: Pedagogy follows general principles for educating children with disability, with a focus on methods supporting educational objectives to be met (63%)
Identification	Option 4: By teacher identification of learning adjustments needed (100%)	Option 1: By medical condition/ diagnosis (57%)
Curriculum	Option 3: The curriculum has the same aims and pathways/ programs as the standard curriculum, but different levels of progress and assessment mechanisms (100%)	Option 2: The curriculum has the same aims as the standard curriculum, but different pathways/ programs, levels of progress and assessment mechanisms (38% – not consensus but achieved the highest number of votes)
Participation	Option 3: Children participate with same age peers in regular education where access and resource requirements for participation are met, school-wide policies and procedures about respectful relating and anti-bullying are in place and teachers model inclusiveness and respectful relating (100%)	Option 2: Children participate with same age peers in regular education where access and resource requirements for participation are met, school-wide policies and procedures about respectful relating and anti-bullying are in place, teachers model inclusiveness and respectful relating and peer interactions occur under adult management and oversight (88%)
Placement	Option 4: Same school and class with informal occasional withdrawal. Children with disability receive a regular school education that includes opportunities for withdrawal and varying learning groups as needed (91%)	Option 2: Separate and linked. Children with disability are educated in a range of settings, including separate special schools and separate classes/units linked to regular schools (88%)

Dimension/ element	Optimal option (% agreed)	Australia current position (% agreed)
Governance	Option 5: Nationally mandated inclusive school system – no special schools (73%)	Option 3: Exclusive regional (state-based) responsibility for special and regular school provision (38% – not consensus but achieved the highest number of votes)

All optimal options reached consensus, except for the Governance option of a nationally mandated inclusive school system which came in just under consensus. The recommendation is for a further round to determine whether a convergence of opinion was being established. A comment from one agreeing panellist:

> Japan has an inclusive approach to classroom learning. Disability is part of the social fabric, and all people need to understand how to communicate across the diversity of students. [Delphi survey participant]

A comment from one of the three dissenting panellists:

> It is possible to mandate an inclusive school system in legislation, but it is very hard to implement and would require massive resources to make it happen, making this option unrealistic. The (Option 4) cluster model of special/regular schools is more realistic and would not only utilise existing resources and structures but would enable collaboration among schools based on their specialist knowledge in supporting students with disability. [Delphi survey participant]

Panellists agreed with the current position of Australia in the Participation and Placement dimensions but for the remaining four elements, consensus was not reached. However, there was agreement that in each case the goal option has not yet been achieved. Panellist recommendations for moving Australia closer towards inclusion will be provided in answer to Question 4.

5.2.1.10 Summarising how segregation, integration and inclusion are understood in education

In the literature, at least 6 types of definitions of inclusion can be discerned:

1. A place-based definition matching Article 24 of the UNCRPD:

   > … being fully educated in the general education classroom and having full access to the general education curriculum, instruction, and peers …[405]

2. A definition still connected to place but broader, encompassing special schools:

   > … all students … valued, accepted and actively participating as members in supportive school communities.[406]

3. A definition locating inclusion not in a place but in participation in learning:

   … engaging all children in the common educational enterprise of learning, wherever they learn best.[407]

4. A definition that views inclusion as a realistic process of navigating values in tension and finding feasible ways forward:

   … a plural value position.[408]

   … a principle of practice, not an end game.[409]

5. A lived perspective definition, locating inclusion in the actual experience of it:

   … being socially accepted in the [educational] context and socially participating in the group and school.[410]

6. A definition linking inclusion to broader schooling reform and to an idealistic and ideologically pure stance:

   … ethical provocation.[411]

For the first and last definitions, mainstream location is requisite to a definition of inclusion – any definitions lacking this aspect are therefore wrong. For definitions other than the first and last, it is the *placement* aspect of Article 24 that locates the area of contention, but to different degrees. For Warnock, the outcome of ‘inclusion as place’ in practice is too frequently considered in the context of physical inclusion, but without reference to addressing emotional inclusion, particularly for children with ASD who continue to be disproportionately bullied in mainstream schools.[412]

For children with disability, preferences vary but there is desire for accessible and welcoming mainstream settings and the lived experience of inclusion now.[413] For some inclusionists there is a concern for a range of options to meet a range of needs,[414] while for authors such as Norwich,[415] of value is the scope for different positions in the balance of priorities given to more than one valid option. This balance reflects political differences across countries in current policy positions about school education. These are an important matter for political discussion in light of the requirements of the UNCRPD.

For Norwich, the commitment should be that all stakeholders together seek a state of affairs that is progressively more oriented to commonality than differentiation.[416] This may include considerations such as different forms of governance, smaller secondary schools that can be more responsive to differences, or more hybrid provisions such as co-located special schools and units that go beyond location to address wider aspects of participation. This concurs with Kozleski and colleagues’ understanding of inclusive education as ‘a principle of practice, not an end game’.[417]

5.2.2 What constitutes good inclusive practice; are there models or examples of where these are working?

Retrieved articles enable this question to be answered at a country level, comparing the inclusion effectiveness of single-track and multi-track systems. The single-track system of Italy and the multi-track system of Finland have been studied and are regarded by many as examples of disability-inclusive good practice.

5.2.2.1 Italy's single-track educational system

In Italy, the percentage of students in mainstream schools is considerably lower than in other multi-track European and North American countries and in Australia (19%).[418] This large statistical difference is due to disability being designated medically.[419]

Italy has been operating as a single-track system for over 40 years, following a 1977 law of total inclusion that closed all special schools.[420] Italy has been described as the nation where inclusion is closest to full.[421] Currently, funding is provided to 3.4% of children with severe and profound disability. General education teachers are supported by co-teaching arrangements to provide multitiered systems of support, universal design for learning and differentiated instruction in regular classrooms.[422] Support staff such as special educators and paraprofessionals, constitute 12% of the teaching workforce.[423] Special education teachers are teachers with extra training who, by law, are equally responsible for the learning of the whole class.[424] However, they are generally employed 4–12 hours per week and shared responsibility with classroom teachers occurs about 50% of the time.[425]

Italian inclusion does not mean full-time general classroom placement.[426] This reality of a single-track system with a variety of placement options highlights the lack of agreement about inclusion. It has been calculated that over 80% of students with disabilities in Italy spend 20–50% of their time outside the regular classroom, or in support rooms with support teachers.[427] This includes over 16% who visit therapy and rehabilitation centres during school hours,[428] and 6% who spend their entire time outside regular classes. Pull-out instruction and a focus on socialisation also tend to increase for students with severe and profound disability as they progress through secondary school. Micro-exclusions also exist with various kinds of separation within the general setting, such as being taught separately or in homogenous special needs groups.[429] While a welcoming attitude towards disability and a sense of responsibility to teach all students has been noted in Italian teachers,[430] there is also high support staff turnover and scarcity of materials and resources that negatively impact outcomes.[431]

Studies are mixed about the efficacy of Italy's inclusive education. In comparisons between Italy and the US,[432] England,[433] Spain[434] and Norway,[435] while teacher commitment to every child is noted and the minimal classification of disability is commended for its avoidance of stigmatising difference, in other ways the single-track system is not significantly functionally different. In some studies, active, cooperative and metacognitive pedagogical approaches have been found to support better academic and social outcomes.[436] In others, learning was better when students were educated fully or partly outside the general classroom,[437] and wellbeing and happiness were consistently lower in mainstream settings.[438] An important factor is the persistence of prejudice about disability which is not reduced by simple contact.[439]

In a Sicilian study, stereotypical perspectives continued to be expressed by teachers, assistants and classmates, impacting the effectiveness of inclusion efforts, despite the number of personnel dedicated to providing support.[440] A recent systematic review concluded that a rationale for the full inclusion of students with severe and profound disability cannot yet be supported by current research,[441] and that more research, including more effective prevention of bullying and hearing from students with disability themselves, is needed.[442]

Finally, the promise of an inclusive society arising from an inclusive schooling system has yet to be achieved in Italy.[443] Beyond school, social and vocational provision for disability is via special and separate settings, including institutions for people with profound and severe disability and for the elderly.[444] Very few workplaces are accessible and only 18% of people with disability of working age are employed, compared to 53.4% in Australia[445]. This has been called 'the strongest betrayal to the inclusion principle: to let people with disabilities and their families benefit from inclusion for a few years and then force them, just when work inclusion should follow school inclusion, to accept special and separate treatments'.[446]

Norwich notes that legislation and policy enactment do not represent the social reality of an inclusive system, and that Italy should not be regarded as a model of inclusion.[447] This has similarly been noted for Iceland – policy-level alignment has not led to actual inclusion.[448]

5.2.2.2 The multi-track educational system of Finland

In Finland, inclusion is defined as 'a range of complementary and cohesive strategies aimed at the prevention of exclusion at a systemic level as driven by the equity agenda'.[449] Diversity is celebrated by seeing varied needs as the norm and providing individualised education and proactive support on the assumption of the educability of every child.[450]

With Iceland and the Netherlands, Finland considers inclusive education as a pedagogical rather than ideological issue connected to the needs of children with disability. Due to this narrow understanding, systemic aspects of class and race and more revolutionary commitments are largely missing.[451] At the same time, Finland's social-democratic approach to education is considered more supportive of inclusion than the neoliberal paradigm prevalent in other Nordic countries and elsewhere.[452]

Finland's focus is on equal rights to education via multiple forms of educational provision for the increasing number of children identified with disabilities.[453] Inclusion entails guaranteeing individual and flexible support, respect and a sense of belonging at school for successful completion of basic education.[454] In 2010, to facilitate greater inclusion, a pragmatic multi-track approach and continuum of placement options was adopted.[455] This three-tier framework contains a second tier of intensified special support, primarily for mild behavioural and learning difficulties in the early years of school. [456] This is delivered via informal part-time special education in general education settings following pedagogical assessment. In 2018, this saw 91% of students with disabilities educated in mainstream schools with 21% fully in mainstream classes, 43% partly in special classes and 27% fully in special classes – a decrease in separate special education of 6% since 2011.[457]

In relation to type of support, 30% of all Finnish students receive Tier 1 part-time general support, 11% receive more intensive Tier 2 preventive support without need for formal diagnosis and 9% receive Tier 3 special support, more typically involving an individualised education plan (IEP).[458]

In relation to curriculum, as a result of special education support, an increasing number of Finnish students with disability are being educated via the general syllabus for all subjects – from 44% in 2011 to 55% in 2018. An additional 40% have one or more individualised syllabuses and 5% have an alternative functional curriculum.[459]

In relation to teaching methodologies, co-teaching in mainstream schools is a key feature of Finnish special education. This takes place via flexible, part-time and informal 'inclusive special education' —small group instruction in resource rooms,[460] and individual teaching.[461] Co-teaching, which is general and special education teachers working together to instruct students with and without disabilities, has been associated with moderately greater academic gains than instruction in separate settings. However, more information about instructional practices and equivalency of students is needed before widespread conclusions about placement can be made.[462]

In relation to funding, in 2010, Finland moved from a pupil weighting system of schools receiving funding based on the number of students with special education needs, to a census-based system where municipalities receive funding based on their number of school-aged children.[463] This has incentivised less costly provisions and enabled more students to be supported each year.[464]

In relation to beyond school learning and employment, an increasing proportion of students in vocational education received special education at school with 84% of those learning in open vocational settings alongside non-disabled peers.[465]

Challenges to inclusive education in Finland include choice of funding model, teacher and pedagogical challenges, and challenges supporting social and emotional outcomes and wellbeing. In relation to funding, the Finnish model has been criticised for contributing to regional inequalities through failing to account for differences in disability prevalence.[466] Teacher and pedagogical challenges include an increase in administration duties and reduced time for co-teacher consultation and co-operation, lack of specificity in special educator and co-teacher roles, and inadequacy of co-teaching training for general education teachers.[467] In relation to profound and severe disability, the extent to which individual learning needs are being met in full inclusion settings requires further research.[468]

A reflection arising from this exploration of two different education systems with their more and less successful features, is that best or good inclusive practice may be better described as optimal practice within each of MacIver and colleagues' system-level elements – structures and organisation, school staff, peers, spaces and objects.[469]

5.2.3 What are the educational quality and safety outcomes of being educated in mainstream and special schools?

The 193 outcomes-related articles and the 80 articles investigating the school community of staff and students were referenced to answer this question. Included were 25 rigorous reviews – systematic, scoping, or meta-analyses – addressing aspects of educational quality and safety.

5.2.3.1 Results of individual reviews and empirical studies

In contrast to the position papers' more critical analysis of the concept of inclusion,[470] the reviews and empirical studies tended to uncritically adopt a placement understanding. Consequently, most have studied the mainstream school environment, as a specialist setting is only inclusive if the definition is other than place.[471] It is therefore difficult to draw conclusions about relative placement merit of mainstream and special provisions and fewer articles were found about special schools overall.[472] In addition, many of the articles are not reviews of the current situation but interventions to improve it, with many of these small-scale and addressing various problematic aspects of educational quality and safety. These studies implicitly recognise that mainstream schooling needs to improve before it can be called inclusive. Collectively, the question these studies address is more along the lines of: how can educational quality and safety in mainstream and special schools be improved? Articles retrieved considered, whether by review or empirical study, the following aspects of the educational system perceived as critical to achieving inclusion/participation[473]:

- school structures, policies, organisation and the roles and responsibilities of school leadership: 7 articles
- teachers – attitudes, pedagogy, behaviour management, and training/professional development needs: 18 articles
- peers – support for inclusion:22 articles and their part in the issue of exclusion/bullying: 16 articles.

5.2.3.2 Current performance and possibilities for improvement in relation to school structures and organisation

Considering different types of schools between mainstream and segregated extremes, Avissar noted four existing models of partnerships: co-location, close proximity, special schools clustered with mainstream schools and acting as resource hubs, and mainstream governance of both schools via a 'school with school' model.[474] This study underlined the need for further exploration of these models, particularly how to overcome barriers to closer partnership, how to ensure sufficient funding for extra staff, and the need for better understanding of student and family perspectives and requirements. In relation to the cluster model, Arthur-Kelly et al. noted a NSW cluster-type model where special schools are resourcing 'Centres of Excellence' for mainstream schools.[475]

As to how funding can be conceptualised to ensure the upholding of commitments to inclusion and educational excellence, Banks et al. note throughput and input models of funding. The former resources schools based on block criteria and the latter directly allocates funds to the student.[476] They identify the challenge of focusing on outputs to prevent school inertia while downplaying requirements for outcomes so not to disincentivise schools. Recommended is an improved 'throughput' model that resources schools based on block criteria and considers distinguishing contextual features.

Regarding the requisite qualities of school leaders, Pazey notes the importance of inclusive attitudes, as all behaviour flows from these and influences school culture.[477] Leaders must rigorously examine their values and attitudes to ensure they are inclusive.

Oskarsdottir and colleagues' ecosystem model of inclusive education leadership identifies three main leadership functions: direction setting, human development and organisational development.[478] Concurring with this, DeMatthews and colleagues[479] and Chapman and colleagues[480] underline the requirement of leadership to establish and convey an inclusive vision, build professional capacity and collaboration, and provide adequate and strategic resourcing aligned to pedagogical purposes. Reviewing practice in Ireland, NíBhroin and King note the impact on collaboration and individualised educational planning of lack of time and resources and the importance of leadership to establishing values and ethics at a systemic level.[481]

Garrick and colleagues[482] noted the impact on teacher wellbeing of inclusive education changes and requirements and recommend reduction of class sizes, particularly in secondary school,[483] and development of improved student behaviour management measures. Oen and Krumsvik stress the need for frameworks, support and skills to bolster the teaching of students with challenging behaviour.[484] Several other authors note the appropriateness of specialist placements for some students, particularly for those with profound/severe ASD and social, emotional and behavioural disorders (SEBD).[485]

5.2.3.3 Current performance and possibilities for improvement in relation to teachers

Teachers have a fundamental role to play in school inclusion and their attitudes, responsibilities, performance and support needs have been extensively researched.[486]

MacIver and colleagues' realist review notes 3 broad determinants of the teaching role that underpin greater inclusion/participation of children with disability in mainstream settings: teaching competence (knowledge, skills and attitudes), commitment to opportunity creation, and collaborative ways of working.[487]

Teaching competence.

Darling-Hammond and colleagues have highlighted core aspects of education that teachers are responsible for and that are critical to child learning.[488] These include strategies that support motivation, competence and self-directed learning. One important strategy is the ability to identify each student's point of learning readiness in order to personalise teaching and progress them from that point. In Australia, the University of Melbourne, has conducted a large-scale Australian study that has demonstrated that a single well-designed general assessment of emergent literacy can track and monitor literacy development equally well for children with and without ASD – a possibility previously questioned.[489] This work extends previous research by the University to progressively track competency for each of the domains of the curriculum.[490] The resulting developmental progressions have been released to all Australian schools and teachers have been able to use them to support student learning from any starting point along the learning trajectory. A Delphi panellist concurred with the usefulness of these diagnostic assessment tools, as they support all learners and assist teachers to personalise their instructions to meet learning needs:

> (My son will) learn a whole lot more if effective communications and supports are in place to share adjustment needed year to year teacher to teacher. Using ABLE assessments would help. [Delphi survey participant]

Spratt and Florian[491] and Black-Hawkins and Florian[492] are two of several articles by Florian demonstrating that pedagogy improves when teachers are taught to reflect on and critique the effectiveness of their own teaching strategies for the individual student, rather than develop disability-specific techniques. Florian's inclusive pedagogy approach has been successfully employed in teacher education in Scotland.[493]

Norwich and colleagues[494] have also analysed differences between Florian's inclusive pedagogy – a mainstream education approach – and practices of inclusive teaching that identify teaching practices for students with more profound and multiple learning difficulties in special education settings. While in Europe over 98% of students with disability are in mainstream classrooms for 80%[495] or more of the school day, there is a need to improve effective teaching in special settings. These efforts focus on the educational participation and achievement aspects of inclusion, rather than the mainstream placement aspect. The articles of the 2018 special edition of the journal Learning Disabilities Research & Practice illustrate advances in intensive intervention taking place in special settings.[496] Cooper and Jacob's analysis of teaching practices effective for students with SEBD are also examples of intensive instruction for that cohort.[497] Additionally, there is extensive material about providing optimal learning support to students with ASD.[498]

Lancaster and Bain focus on the theoretical design principle of 'embedded design' (ED) which scaffolds essential teacher knowledge and skill in a self-repeating and self-reinforcing pattern, from initial knowledge building to design and practice within the instructional design of a course.[499] This has been shown to more effectively develop pedagogical content knowledge and the ability to differentiate teaching to cater for different learning needs.

Opportunity creation

Teachers are responsible for classroom relationships. As well as modelling respect and holding high expectations for all students, they can create opportunities for all students in the classroom to be known and valued and for friendships to develop. Many studies have drawn upon this aspect of the teacher's role to facilitate social inclusion in the classroom and playground, including an extensive body of US interventionist studies by Carter and colleagues.[500] While many of these studies report positive outcomes in improved relationships between students with and without disability, they noted limitations in achieving transfer beyond the classroom, in their small-scale nature, and in the level of support and resourcing they needed to achieve success. This poses the question of achievement at scale. For example, the Hochman et al. study engaged teachers and adult facilitators in a semester-long lunchtime study using peer network intervention to support greater social interaction for four students with ASD.[501] Peer interactions were promoted by this structured method and students' social skills improved in the real-life situation. However, no ongoing relationships were established, and success was recognised as dependent on the extensive social capital of the adult facilitator and that all students included in the study were verbal. The study recommended more extensive research be conducted. This recommendation for more extensive and more quality research is repeated regularly in the literature. Other reviewers note that many studies lack important information, such as socio-cultural data of culturally and linguistically diverse community participants, as is the case with the study just noted. Most interventions are also not undergirded by theory or conceptual frameworks but target and attempt to influence isolated factors. How to draw useful recommendations for the DRC from these studies has been a concern.

> Actually start caring about the students rather than the results they give you. It is about teaching the children and not only caring for the results. Really knowing and paying attention to the children.[502]
>
> I think some teachers think inclusion is 'just ask the pupils a question occasionally' . . . it's not that. It is more everyone gets a chance to be involved and have fun.[503]

Practices of collaboration

Buli-Holmberg and Jeyaprathaban reviewed 24 schools in South Norway that employed differing inclusive structures: no special support, one-to-one support outside the classroom, support for small groups outside the classroom, and general and special teachers co-teaching students with and without disabilities.[504] Co-teaching was found to be most conducive to learning, providing a holistic approach and fostering peer acceptance and inclusion. Requisite to success were a teacher's high expectations of students and a strong sense of personal responsibility and commitment to every student's learning. Regarding adoption of co-teaching approaches, the study noted the need for further study to establish its effectiveness at scale – a recommendation echoed elsewhere.[505]

Norwich and colleagues' have used the collaborative Lesson Study approach for teacher professional development in inclusive practices.[506] While identifying the promise of Lesson Study to improve teacher practice and build collaborative teams, they note that research into the approach in special education has predominantly used low-level experimental evaluation designs comparing Lesson Study with other kinds of practices, rather than using combined methodological approaches incorporating in-depth case studies and flexible intervention designs, such as action research and design-based research, that may yield deeper insights into Lesson Study usefulness. They also note the institutional conditions that must be in place for Lesson Study to be successful, including significant leadership and logistical support that enables teachers to engage in this intensive form of pedagogical learning.

In summary, co-teaching has been found to be effective in mainstream schools, though further high-quality research is needed to ensure its effectiveness at scale.

5.2.3.4 Current performance and possibilities for improvement in relation to peers

The engagement and possible roles of peers in supporting academic and social inclusion and increased participation was covered in 21 studies and reviews, including a number by Carter and colleagues already referenced. However, only 9 of the 21 were original studies and the remaining 12 were reviews or reports. This bears out the frequent comment in the literature that insufficient empirical research has been undertaken to support drawing definitive conclusions about a single best system.

Seven studies were situated in primary schools, 9 in secondary schools and 4 traversed primary and secondary schools. Six studies considered the circumstances of students with severe to profound disability and 11 included students diagnosed with ASD. Four studies included students with ADHD and related social, emotional and behavioural difficulties.

However, there were numerous limitations that were reported, including problems with planning and preparing to implement the project, implementation, results interpretation and with the formulation of recommendations. Study quality continues to be impacted by limitations in study design extending from the planning and preparation phase through to interpreting results and making recommendations.

The critical issue of school bullying was discussed in 16 articles. These issues warrant particular consideration as they relate to inclusive practice and the safety of students with disability in schools.

The situation

In a study interviewing 36 adults with intellectual disability about their school experiences, positive and negative experiences in mainstream schools were reported although overall, the general experience was exclusion.[507] This resulted from discrimination and bullying by classmates, discrimination and lack of differentiated pedagogy by teachers and non-adapted and inaccessible curricular materials and content. Resource rooms were seen as providing better support, permitting breaks from discrimination, a slower learning pace and opportunities to learn from more understanding and competent teachers.[508]

> Not as much people in the classroom ... I’m just more calmer in the school. In mainstream school there’s much more people in there which makes it a more tense atmosphere.[509]

> We have someone ... and ... he helps, he helps us calm down when we’re angry and he talks to us. He’s actually doing a boys group for us where we do stuff, we learn about like cultures and all that just to help us calm down.[510]

At the same time, participants were twice as likely to judge resource rooms as discriminatory and mainstream classrooms as places that should be capable of providing the same benefits in a non-segregating way. This duality of preferring segregated settings but arguing against them highlights the tension of the educational experience for people with disability. The study's conclusions also carried this duality and highlighted the positive experiences of segregated education while also condemning it as 'false' inclusion.

Most of the literature sourced notes there is a greater likelihood of bullying in mainstream settings.[511] Children with disability are over-represented within the dynamic of bullying perpetration. In a study of almost 22,000 middle and high school youth, students with disability were twice as likely to be victimised and engage in reactive fighting as students without disability but had similar rates of perpetration.[512] In addition, when victimised, students with disability are more likely to engage in reactive fighting. Within this group, students with behaviour-oriented disabilities (Emotional/Behavioural Disorder and Attention Deficit Hyperactivity Disorder) engaged in the highest rates of proactive and reactive perpetration of aggression.[513] Students with social and communication-oriented disabilities and emotional dysregulation ASD were more bullied, less accepted, had fewer reciprocal friendships and were less engaged in peer interactions.[514] These results bore out an earlier 152-study meta-analysis that found that 80% of children with disability were not chosen as friends by children without disabilities. Reasons given included social difficulties, externalising behaviours, emotional dysregulation, lack of shared interests and impact of the impairment on the nature of the relationship.[515]

Gender differences in peer acceptance and friendship have also been noted. For those identifying as male, social difficulties are less of a reason for rejection, but there is greater likelihood of rejection when the general class attitude towards disability is unaccepting and when teacher assistants are present.[516] For those identifying as female, social difficulties impact likelihood of acceptance and class attitude is less important.

There is a tendency for teachers to focus on the individual child who is not managing in the environment and to fail to attend to the contribution of the school context.[517] This occurs through holding expectations of compliance that don't support development of assertiveness, deploying teaching assistants and resource rooms in ways that increase isolation, barriers due to the accessibility of the built environment and failing to implement principles of universal design that ensure accessibility from the outset. As a result, students with disability may need more help from their peers, which can be a contributor to peer rejection and victimisation.[518]

Some literature has found bullying in mainstream and special settings to be comparable. These studies note the increased likelihood of students with more severe emotional and behavioural disorders being placed in special settings.[519] There is less diversity and greater severity of disability in contemporary special settings as a result of increased mainstream inclusion.

In mainstream settings, children with disability commonly experience loneliness, reduced connection and less overall social and emotional wellbeing than other students in the same settings.[520] This has been called exclusion within inclusion. Increasing proximity to peers without disability does not consistently or reliably lead to increased social interactions.[521]

System change

Aspects of service design and provision and the strategies adopted by professionals can render young people more liable to be bullied and relates to the dilemma of difference. The reality of varied experiences of inclusion for children with similar difficulties also highlights the contribution of school structure to the degree of inclusion. McLaughlin et al. note the protective factor of large-scale acceptance modelled by teachers.[522]

Teachers are responsible for classroom relationships and have a significant influence upon how students are viewed by their peers. Teachers must run their classrooms and teach the curriculum in a way that all class members can participate without being singled out.[523] This requires consideration of different learners' needs from the outset, which is a principle of Universal Design for Learning.

The physical presence of teacher assistants can be positive and negative. They can act as interpreters or mediators, discouraging harassment or belittling, but can limit opportunities for peers to speak to each other freely.[524]

The role of peers without disability cannot be overestimated. The most effective factor protecting young people against bullying is acknowledged to be social support provided through friendship, or acquaintance, with peers.

5.2.3.5 Results of systematic and scoping reviews and meta-analyses

In summarising the findings of the 25 systematic reviews it is important to note that while some promising results for improving inclusion in mainstream settings are being identified, there is consistent mention of poor study quality impacting reliability of the recommendations. In summary:

- targeted research into curriculum, assessment and reporting (CAR) and into educational outcomes for students with special educational needs and disability is missing. There is insufficient ground-level data to inform conclusions about students' progression and transition.[525]
- with some studies reporting academic engagement higher in inclusive settings and others the reverse, as well as insufficient research overall into academic achievement and adaptive skills, the current state of research is inadequate to fully support the principles of inclusive education for students with multiple, severe and complex disabilities.[526]
- the social aspects of inclusive schooling are under-researched and more and better-quality research is needed.[527]
- many study details are missing, such as socio-cultural data pertaining to Culturally and Linguistically Diverse community participants, so it is not possible to replicate findings.[528]
- there is insufficient evidence-informed practice, understandings of social inclusion and lack of sourcing of the lived perspective from students with disability.[529]

- more and better research is needed into the roles of educators and families in facilitating inclusion in education.[530]
- there are indications that peer-mediated interventions help increase peer interaction, improve social skills and potentially increase social inclusion, and that multi-component social skills interventions develop social skills. However, further work is needed to establish educational utility of interventions for children with ASD.[531]
- more rigorous mixed-method research and better implementation fidelity is needed in investigating the pedagogical practice of differentiation.[532]
- research studies are too focused on the 'what' and 'how' and insufficiently on the 'why' that could inform more meaningful and responsive practice.[533]
- there is a lack of theorising and conceptual framework development in favour of targeting and attempting to influence isolated factors.[534]
- more rigorous and diversified study of the check-in, check-out positive behaviour support intervention for children with emotional and behavioural disorders is required, including analysis of its usefulness for secondary school students.[535]
- while errorless learning for students with intellectual disability led to improvements in discrimination skills, because of unclear or poorly established relationships between the intervention and target behaviour in most cases, it is not possible to establish that it was the intervention producing the change.[536]
- in relation to the effectiveness of function-based interventions for students with learning disabilities including problem behaviours, lack of implementation fidelity means definitive conclusions cannot be drawn.[537]
- there is evidence that function-based intervention (FBI) in inclusive settings has a positive effect on challenging and appropriate behaviour of students with disabilities. However, more research is needed to understand the specific and necessary elements of a multicomponent intervention, and more studies involving secondary-aged students are required to establish effectiveness of FBI for this cohort.[538]
- regarding the use of manualised programs to reduce stigmatising attitudes in mainstream peers, only tentative support can be given. There is a need for more high-quality research.[539]
- it is possible to effect positive changes in peer interactions for children with complex communication needs, however, research is needed to create a strong evidence-base for clinicians and teachers to draw on.[540]
- insufficient research has been conducted on measures to prevent bullying of students with disability. The sample size of studies tends to be too small to lead to convincing conclusions and measurement instruments are inadequate to engender confidence in findings. More robust research is needed, and more effective prevention and intervention strategies must be developed before it can be confidently said that children with disability will receive a safe education in the mainstream.[541]

Recommendations

From the articles retrieved, the research to date suggests that social and emotional outcomes are poorer for students with disability in mainstream schools, particularly secondary school and particularly for some types of disability. Children with emotional and behavioural disorders and ASD fare particularly badly in mainstream secondary schools—the former more as bully-victims rather than pure victims, like the latter.[542] There is a tendency to employ a 'deficit model', labelling children as 'anti-social' or 'aggressive', or as having characteristics making them likely to be bullies or bullied in future. This is simplistic and does not consider the social and interpersonal environment in which bullying occurs. If bullying and school violence are conceptualised as an individual problem located in the individual, responses and interventions will be individual and not contextualised.[543]

Overall, there is a need for improved empirical studies that support replicability. Student perspectives regarding their experiences of schooling must also be referenced more consistently to guide study design.[544]

Finally, the concern of the systematic review conducted by Falla, Sanchez and Casas into the effectiveness of current bullying interventions is noted – as yet there are no clear results about the benefits of bully-prevention programs to conclude that there are established ways to prevent bullying of children with disability in mainstream settings.[545]

5.2.3.6 Summarising academic and social outcomes

In relation to academic outcomes, results are highly varied as to the value of mainstream placement. There are findings that students with disabilities in mainstream settings perform as well as, or moderately better than, those in special schools and findings stating the opposite. Others note the impact of teacher expectations as a significant factor.[546] This suggests the need to attend to other variables with a chief one being the nature of the disability. While some studies address disabilities in particular, recommendations are often made about disability in general. One consequence of this variability in study results is the conclusion that no greater academic benefit attaches to either setting.[547]

Study quality, including quality of interpretation, also contributes to issues related to the reliability of conclusions. For example, in a significant early study, researchers interpreted results of student assessment to be statistically insignificant, warranting mainstream placement for the students under study. Other researchers have re-examined these data and proposed the results were significant and that the mainstream placement with its lack of intensive, systematic and explicit instruction was responsible for the poor academic outcomes of students.[548]

In relation to achieving social and emotional outcomes and wellbeing in mainstream settings, entrenched system-level factors and exclusionary barriers must be addressed. The research calls consistently for more and better research. This review suggests we have not achieved reliable enough results from interventions for general recommendations to be made.

5.2.4 What are the essential requirements of a safe and quality mainstream educational system for all children?

This section will draw together the review results and the responses of the Delphi panel to provide some directions for safe and quality education for students with disability in Australia.

In relation to the articles sourced for this review, the following recommendations are suggested and categorised under the headings:

- More quality research
- Considered decisions within the multidimensional construct of inclusion
- A strengthened educational system

5.2.4.1 More quality research

There is an extensive body of literature on inclusion in education, yet there are calls for the rigour and quality of this research to improve so that reliable recommendations can be drawn. This is most clear in the repeated statements by the authors of the systematic and scoping reviews and meta-analyses sourced for this review. This variation makes it difficult to make overall decisions. We conclude there is a need for further research to inform policy and practice in education, which takes into account the specifics of the Australian context and includes the voices of students with disability and their families.

5.2.4.2 Considered decisions within the multidimensional construct of inclusion

Regarding the 6 options for inclusion, the Delphi process indicated respondents ascribed usefulness to this process. The following thoughts were provided by panellists for how best to progress inclusive education in Australia:

> **Shut special schools.** Just shut them. The issue with why we are building new schools is because our other schools are filled with ableism and discrimination. Go to any home-schooling group, you'll find the misfits, the outcasts, the disabled. Why? Because of ableism. And so, parents yell at people to make special schools for special people and then they are built. They are not always bad. The blind, Deaf schools teach discrete skills, like tech colleges. But - for God's sake, Auslan has been a LOTE subject for years. What would we have done for inclusion if we got every Australian student to learn an Aboriginal English language, to learn AUSLAN? What would we do if we built all schools from the ground up for the person who is least like you? What would happen if we did not build them at all? [Delphi survey participant]

> For students with disability to succeed academically and to make connections with other students, regardless of if they have a disability or not, in terms of the former, **a lot of reform will need to be done** to ensure that students with disability receive the same education opportunities as other students and are sufficiently supported to succeed in school. The latter might be more achievable with **implementation of school structures and campaigns to remove the stigma associated with students with disability**, where they can be recognised as equals to other students. [Delphi survey participant]
>
> I think it is possible and essential for broader inclusion in other part of society. **Change needed in valuing students with disability in the classroom, school needs support and ensure resources appropriately to ensure done well. Need to build capacity.** I am concerned the Victoria state government senior school reform to be implement in 2023 will have the opposite effect forcing students into special school. [Delphi survey participant]
>
> **Personalised aide helps the student integrate with mainstream learning.** [Delphi survey participant]
>
> **All schools need the resources to cater for the needs of students with impairments**. And that the basic knowledge is different for every student. But every student can excel in an area of their choosing. [Delphi survey participant]
>
> **Well planned and researched curriculum, highly developed skills in educators, early education/intervention provision, post school opportunities for preparation for further study and employment options, skill development in the areas of social communication, financial literacy, health and wellbeing education.** Inclusive education is not a destination, a place, an additional curriculum. It relies and depends on a skill set developed in teachers who choose to teach students with disabilities. [Delphi survey participant]
>
> This could take a book to answer! I believe we can do it if we **a strategic and cohesive approach.** It is not simple. The NCCD tells me though that with goodwill and whole of government/sector buy-in the emphases can be changed and people can come on board to achieve what would be a world-leading inclusive approach that focused on all students belonging in their school. I believe the Commission and this study are progressing us toward this goal. We need to keep moving on this important vision. [Delphi survey participant]
>
> A clear mandate for inclusive education with the resources in terms of **skilled educators and financial resources as well as commitment to implement it.** [Delphi survey participant]

These preliminary thoughts suggest emerging degrees of agreement and possible usefulness in continuing this structured process of deliberation and consensus-building, particularly targeting education experts and people with present and past lived experience of disability. The goal would be: broad agreement about the most accurate and helpful options for Australia, the option to be considered optimal, where Australia currently sits in relation to that option, and what is most likely to support us to move forward progressively in consideration of quality research findings as recommended above. Front-of-mind should be the needs of students with different experiences of disability and severity of disability and a one-size-fits-all approaches should be avoided. There is a pressing need for greater stakeholder collaboration to develop a clear and shared understanding of what might constitute good practice in inclusion, with emphasis on ensuring students with disability have safe, educationally and socially effective access to the opportunities of mainstream education.

5.2.4.3 A strengthened educational system

Common guiding premises for research must be established. A recent realist review drawing upon the International Classification of Functioning, Disability and Health (ICF)[549] has considered the system-level factors that a program of inclusion must engage.[550] Realist reviews produce generalisable explanations of how, why, for whom, in what circumstances, and to what extent successful interventions will work successfully again. They are important where interventions are complex, as in education and inclusion.

Complex interventions involve human agency and are influenced by human decision-making and the context in which they are undertaken.[551] Reviewers seeking to understand such interventions must account for the influence of context, hence the realist review. MacIver et al's realist review identified system-level factors supporting optimal school participation/inclusion for children with disability.[552] The 'participation' concept of the ICF's biopsychosocial model was operationalised for the school context.

Participation was defined as active and meaningful engagement in all activities of the role of the learner at school—not only classroom activities and schoolwork but all school-related events and relationships. To ensure participation did not reduce to mere attendance, the ICF's Personal Factors category was accessed, enabling focus on the felt sense of participation/inclusion. Lastly, the MacIver et al. review drew on the ICF's Environmental Factors category to locate broader context and systems mechanisms influencing participation/inclusion at school.[553] The following factors were identified as core building blocks of a safe and effective inclusive education system:

- School structures and organisation. Routines, processes and policies, their supportiveness and the extent to which they are flexibly tailored to the child.
- School staff. Teachers and other school-based professionals and their capability as opportunity creators, their attitudes, knowledge and skills, and the structures of practice they successfully employ.
- Peers. Their attitudes and possibilities for child-to-child support and friendship.
- Spaces. The physical environment and its availability, accessibility and suitability.
- Objects. The available resources, equipment and technology and their availability, accessibility and suitability.

5.3 Conclusions and recommendations concerning education for children with disability

From our review of the literature, and considering the views of the Delphi panel, we recommend:

There are 3 essential requirements for a safer and more effective inclusive education system

- Improve the performance and inclusivity of the five elements above as the essential building blocks of an inclusive education system.
- Foster and strengthen stakeholder collaboration around an agreed progressive description of inclusion that can enable a clear process for moving forwards to be described.
- Resource and grow a sufficient body of quality empirical research that can bring all stakeholders together, producing more definitive findings about best ways forward and identifying and developing best approaches and programs/interventions to adopt.

6 Summary and conclusions

6.1 Summary

This project was commissioned by The Royal Commission into Violence, Abuse, Neglect and Exploitation of People with Disability. It investigated what was known, and what might be done, to promote a more inclusive society that supports the independence of people with disability and their right to live free from violence, abuse, neglect and exploitation.

The research team systematically retrieved and analysed relevant peer-reviewed literature and related policy documents. From an original library of 35,888 sources, 1478 sources distributed over three domains of inquiry as defined by the Royal Commission (Accommodation & Community Living, Employment and Education) formed the core of the final literature review. While acknowledging the decades of research available, the review focused on research and related documents published from 2006 – the year the United Nations adopted the Convention on the Rights of Persons with Disabilities.

It should be noted that the concept of ‘disability’ is a contested construct. Its definition with reference to individual impairment (the medical model) vs a phenomenon arising from deficits in the environment (the social model) vs a failure of society to accept the naturally occurring variation of what it means to be a person (the diversity model), is the subject of contemporary debate in literature and the community. We were guided by the definition of disability adopted by the National Disability Insurance Scheme Act 2013 (S24). However, we note that state and commonwealth legislation and policy in Australia continue to reflect the medical model and to perpetuate a deficit-based understanding of disability. These legislative and policy instruments, though designed with the intention of addressing discrimination and enabling access to services, might represent impediments to inclusion.

While consideration was given to the many written submissions and the oral evidence given to the Royal Commission by researchers, policy makers, service providers and members of the community, this project did not seek to duplicate existing evidence. Rather, it sought to complement and add to the existing evidence.

In addition, a panel of 14 experts from across Australia and overseas, including 8 people with lived experience of disability, were consulted using a multi-round online Delphi study. This incorporated the evaluation of propositions based on the peer-reviewed literature.

As a practical means of addressing the enormity and diversity of the literature and associated issues, the research team worked as three separate, but coordinated, sub-teams. Each team drew on specific areas of expertise organised according to the Royal Commission’s research brief. The 3 domains of interest were: accommodation and community living; employment; and education. Each of the 3 dedicated sections of this report contains specific conclusions and recommendations and the evidence on which they have been formulated.

We conclude that inclusion is a potentially useful construct in policy and practice for supporting the independence of people with disability and their right to live free from violence, abuse, neglect and exploitation. However, what constitutes inclusion and how it might be best achieved remains contested in the literature and among the experts we consulted. Inclusion, though a potentially powerful agent for improving the situation of people with disability, is but one of many areas of concern that needs to be addressed in policy and practice.

It is evident that inclusion needs to be enabled and fostered at a macro level; leveraging legislative instruments, policy, service provision and the ways in which we structure and organise our communities. We need to address issues of stigma, discrimination and unfounded and often low expectations that arise from biases and fear. We need to address structural inequalities, including access to housing, education, employment, the means of economic participation and political participation.

Issues of inclusion also need to be addressed at – and are arguably most powerfully experienced at – the micro level which means at the level of the individual. Inclusion is most evident where an individual is made welcome, where they feel welcome, where they know they belong, where they know they are safe, and where their voice is heard and acted upon. Bengt Nirje described a world where people are free to be themselves among others.[554] Arguably, it is where people live free from poverty, in close personal relationships with others, where they have friends and advocates and where they are free to express their philosophical/religious beliefs, sexual and cultural identities, that people can live a quality life free from violence, abuse, neglect and exploitation.

Below are our concluding observations and considerations for future research, policy, and practice developments, organised according to the 6 questions posed by the Royal Commission.

6.2 Conclusions organised according to the questions posed by the Royal Commission

6.2.1 How are the terms inclusion and segregation understood and applied in the literature?

The understanding of inclusion pertaining to the experience of people with disability has, over the past 15 years, been influenced by the United Nations Convention on the Rights of persons with Disabilities. The UNCRPD notions of inclusion are positioned as the opposite of segregation. Inclusion is posed as an important means of preventing physical and social isolation with respect to health, wellbeing and quality of life.

Inclusion in the context of the UNCRPD is associated with persons having an opportunity to live independently in circumstances of their choosing, with appropriate and effective provision of the supports they need to live in their home and to have access to facilities, services and opportunities ordinarily available to the general population. These markers of inclusion extend into the area of education with people having access to environments and supports tailored to meet their individual needs and which maximise their academic potential and social development. With respect to work and economic participation, inclusion has been understood in the context of people with disability participating in a labour market and specific work environments that are accessible to persons with disabilities and which are described in the UNCRPD as ‘open’.

Overall, our review of the literature suggests the notion of ‘integration’ is a far more developed and explored concept than ‘inclusion’. This should be a matter of concern to researchers and policy makers, given the important distinction between these concepts. Integration is a concept primarily referenced in the literature to being simply a person’s physical presence. Inclusion is a more nuanced concept, grounded in our community’s understanding of diversity and in a person’s relationships and their belonging to community.

While instruments such as the UNCRPD are intended to encompass the interests and expectations of all persons with disabilities, the research literature commonly considers inclusion and segregation with respect to specific populations that are commonly defined in diagnostic categories. This phenomenon could be the influence of literature dominated by the health sciences and related professional disciplines across education and social services. For example, in the literature concerning people with intellectual disability, inclusion is commonly positioned as a goal of policy and practice, so as an end point to be achieved. In the literature concerning people with psycho-social disability, it is positioned as a mechanism by which higher order goals such as ‘sustained recovery’ might be achieved.

Importantly, notions of inclusion and segregation applied to accommodation and community living or education or employment have been largely defined by those who lay claim to expertise arising from prolonged study, academic and professional accreditation and professional experience, typically from an ableist perspective. There has been limited engagement directly with people with disability and limited opportunity for those with lived experience to voice and define the circumstances in which they experience inclusion.

In exploring the policy and practice directions needed for people with disability to live in an inclusive society that supports their independence and rights to live free from violence, abuse, neglect and exploitation, there is a need to move beyond simplistic notions of physical location or dichotomies of inclusion vs segregation. Multi-dimensional typologies provide more useful frameworks that could be applied across policy and practice developments and address issues of physical access and presence in the community, social connectedness and the deep experience of psychological inclusion.

Psychological inclusion focuses on the extent to which an individual perceives membership in their community, expresses an emotional connection with their neighbours and believes in their ability to fulfil needs through community connections. This is potentially one of the least well addressed areas in the literature and is arguably among the most poorly acknowledged in policy and most under-addressed in service and practice.

Our interrogation of the literature reveals a heavy reliance on relatively simplistic dichotomies and ideologically driven notions to define and appraise inclusion and segregation. This is problematic in that people might not live in a large-scale congregate care facility, traditionally referred to an as institution, but their ‘group home’ in the community might still represent a relatively segregated option. Similarly, a person might be situated in a mainstream school or in open employment but remain segregated by virtue of the way the school or workplace is organised, or by their dominant values base.

Despite lengthy debate in the literature and statements such as those exemplified in the UNCRPD, inclusion and segregation remain contested concepts. Inclusion and segregation might more usefully be conceived, at minimum, as a continuum of experience. Ideally, concepts of inclusion and segregation might more usefully be conceived as multi-dimensional constructs which encompasses physical location and the organisation of activities, social connectivity and accompanying psychological experiences. Policy and practice need to be more nuanced and sophisticated and to authentically incorporate the lived expertise of people with disability, as does the research base informing such policy and practice.

6.2.2 What constitutes good inclusive practice; are there examples of these working?

Building on our literature analysis, good inclusive practice needs to consider the multi-dimensional construction of inclusion and segregation. Good practice considers issues beyond simplistic notions of place, physical presence and the form or scale of an environment. Note that we intentionally use the terminology of ‘good practice’ and not ‘best practice’. A paucity of well-constructed research and a diversity of views concerning inclusion and segregation make the assertion that any one practice might constitute a ‘best practice’ inappropriate. That said, from our review and the accompanying Delphi study, it has been possible to identify practices that, when combined and considering systemic and individual needs, are likely to promote a more inclusive society that supports the independence of people with disability and their right to live free from violence, abuse, neglect and exploitation.

On the basis that inclusion encompasses physical, social and psychological dimensions, we need policies that support good practices that enable people with disability to live independent lives, consistent with their chronological and developmental age and support needs, in the context of the inter-dependence typically experienced by the wider community. This includes consideration of where people live, with whom they live, the services they access and the experiences and opportunities available to them.

Key to good inclusive practice is the individual’s opportunity to exercise choice and self-determination, and to have available the supports and empowerment to exercise such rights. These choices might be in everyday situations around the home, choices about personal relationships, career decisions, healthcare decisions, spending money, or exercising the right to vote at an election. Such practice necessarily encompasses the rights to self-expression and to take risks. In embracing inclusion as a community, we need to embrace risk with respect to where we live and where we go to school, the activities we engage in for daily living, recreation, or work, and in our relationships.

Good practice includes supporting people to consider risks and alternatives and to take risks. Good practice also includes policies and practices that mitigate the consequences of taking risks and provide redress when taking risks give rise to violence, abuse, neglect and exploitation. This might include regulating the knowledge, skills and practices of those providing support services and providing redress where supports fail to appropriately meet people's needs and according to the highest standards of community expectations. It may also include ensuring the education and professional development for teachers to work with students with complex and multiple disability is in place and that the same protections afforded to students generally in a school are available to students with disability, and necessary accommodations are made to ensure students can access these protections, like anti-bullying measures. Furthermore, in the context of work, people are able to engage in what the ILO describes as 'decent work' ie participation in productive work, having stability in employment, adequate remuneration, undertaking work in a safe environment, being treated fairly and having access to industrial representation and advocacy.

Good practice in inclusion promotes social connectedness where someone lives, at school, in the workplace and in the wider community. Good practice sets the scene for people being connected with others of their choosing in friendship, experiencing an affinity with their surroundings and feeling accepted and welcome for who they are and who they want to become. Good practice in inclusion values diversity, taking into account gender and cultural identity, including race, ethnicity and religious/philosophical belief.

Good practice in inclusion incorporates the provision of competent support to develop the confidence and skills necessary to pursue meaningful goals and undertake the tasks required in everyday life at home, school, work and in the wider community. Such supports need to be bespoke with individualised approaches in education, person-centred approaches in community living and customised approaches in employment support. They also need to have a developmental trajectory consistent with the person's aspirations. At times, such supports need to challenge the individual and offer opportunities to expand their understanding of what might be possible and their vision of who they might become.

Good practice in inclusion also addresses systemic issues. It challenges misconceptions in the community that foster stigma and the tyranny of low expectations. It addresses fear and apprehension by promoting knowledge and understanding of people with disability and promotes diversity as fundamental to what it means to be a community. It provides for legal redress for discrimination challenges that diminish inclusion.

6.2.3 What are the safety and quality outcomes for people with disability (and, if relevant, peers and others) of settings generally identified as inclusive or segregated?

Safety according to the Disability Royal Commission includes key factors: being free from violence and abuse including restrictive practices; developing a sense of dignity and autonomy; experiencing the promotion of informal safeguards – being known and valued in the neighbourhood and network of social communities; and experiencing the promotion of positive attitudes towards people with disability.

There has been minimal consideration in the research literature with respect to 'safety' as a mechanism to promote or indicate quality outcomes for people with disability. The few exceptions have been for policies and strategies to minimise or eliminate aversive and restrictive practices like physical restraint, mechanical restraint, chemical restraint and seclusion in accommodation and educational settings. Such policies sit at the intersection of human rights and good practice in service provision. Further work needs to be undertaken in this area, especially with respect to increasing the knowledge, skills and competencies to the disability support workforce.

Through the literature, it is difficult to establish that inclusive settings necessarily lead to increased safety of people with disability. Historically, segregated settings have been characterised by relatively high instances of violence, abuse, neglect and exploitation. Such instances have been evident in congregate or institutional and group home living arrangements, special schools and especially residential schools for children with disability, and in sheltered employment.

It must be acknowledged that mainstream education, individualised living arrangements in the community and open employment all expose people with disability to risks of violence, abuse, neglect and exploitation. Such instances span issues as diverse as discrimination, bullying, wage theft and sexual abuse. But these more inclusive settings have the potential to situate people with disability in authentic and meaningful reciprocal relationships with others. These significant others may extend to people with disability relationships that provide safeguards to counter the risk of violence, abuse, neglect or exploitation and, where instances occur, to provide advocacy to seek redress.

6.2.4 What are the essential requirements for services to succeed in ensuring the safety of people with disability and quality in their everyday life?

Accommodation, educational, employment or community services more generally benefit from a clear understanding of what constitutes community expectations and accepted standards. To these ends, legal and policy frameworks to guide and direct services are essential. These could include human rights legislation, employment and industrial legislation and legislation governing the provision of education.

In addition to the regulation of services, we also need to regulate the practices of personnel with those services. This could include expected standards of knowledge, skills and educational attainment or qualifications specific to areas of practice including training and education in areas like reflective practice and ethical decision-making. The lack of such requirements in the disability sector is a long-standing shortcoming and most likely has contributed to violence, abuse, neglect and exploitation although a definitive evidence base is lacking, and research is warranted.

The same issues of fear, misconception, low expectations and stigma that the research evidence documents in the wider community are also apparent in specialist disability services.

Such issues need to be the subject of education and training within disability services and need to be available to the wider community.

Services and service personnel need education and ongoing professional development and to be subject to effective oversight and scrutiny and held accountable for their actions. Historically, state-based authorities have been largely reactionary. The effectiveness of the recently established National Disability Insurance Agency's Quality and Safeguards Commission is yet to be the subject of independent evaluation. However, the NDIS only covers persons accepted as 'eligible participants'. There is a wider population of people with disability not covered by the NDIS. Therefore, it will be critical for disability identifiers to be included in administrative and survey data more generally concerning safety in schools, workplaces and the community. These data should be available to researchers and advocates to strengthen accountability mechanisms and inform legislative, policy and service reforms.

Importantly, people with disability must be central to the design, development and delivery of the services that affect their lives. This includes age and developmentally appropriate engagement with children and their families in the design and delivery of education. The expertise of the lived experience needs to be recognised and respected and services for people with disability need to be led by people with disability. Leadership by those with lived experience parallels what has recently come to be a gold standard for the leadership of organisations and services for Indigenous Australians.

6.2.5 Are there any beneficial outcomes evident in segregated settings with respect to safety and quality in their everyday life and, if so, how could these be replicated in inclusive services or settings?

There are suggestions that segregated settings can bring benefits to some people with disability. There is also evidence that these same benefits could be extended and made available in inclusive mainstream settings. Promoting a wider understanding and subsequent adoption of the principles and practices of universal design could be a promising way forward.

Historically, segregated settings in accommodation, education and employment have provided physical adjustments to support physical access to premises and activities and routines have been adjusted and flexible to accommodate individuals. Such adjustments could be made available in inclusive mainstream settings. Attention to regulations such as provisions in building codes and stronger mandates to implement those codes might help. Similarly, industrial law could be strengthened around reasonable adjustments and accommodations, including flexible working hours and job rotation in the workplace, especially where evidence suggests most physical adjustments come at minimal cost.

Segregated settings have commonly provided opportunities for service personnel to develop specialist expertise, particularly in services designed with specific cohorts or diagnostic groups in mind. There will always remain a need for those with specialist knowledge and skills, especially for working with people with complex and multiple disabling experiences. However, ensuring that disability awareness education is widely available for in-service training – possibly mandated as with in-service training in occupational health and safety, and that pre-service professional development in the vocational education and higher education sectors is inclusive of disability related issues, could upskill our entire community and build capacity for inclusion.

6.2.6 Are there any limitations or gaps in the current research base relating to inclusive and segregated settings and if so, how might these be addressed?

Our review of the literature revealed a number of gaps in research. These could be addressed if disability-related research was prioritised among national research priorities like the National Health and Medical Research Council and Australian Research Council. Research funding would also need to be targeted and there is a National Disability Research Agenda in formation. The extent to which this is supported by government remains to be seen. Supporting such research initiatives could also give validity to this work and attract researchers, including early career researchers, to pursue research related to the aspirations and needs of people with disability.

As highlighted earlier, the predominant paradigm shaping the disability research agenda is that of health and allied health sciences. Disability is also the focus of a relatively small number of legal and educational researchers. There needs to be greater breadth of engagement with the academy, to bring new and innovative perspectives and methodologies. Broadening the research agenda needs to move academic consideration beyond simplistic dichotomies of medical vs social models of disability and to embrace the bio-psycho-social mode of disability promoted by the World Health Organization and exemplified in the International Classification of Functioning Disability and Health. Such moves also need to progress the research agenda, especially in the social sciences, to develop our understanding of the diversity model of disability and how it might further the inclusion agenda.

There is a paucity of research addressing issues of intersectionality as it relates to people with disability. This includes research related to gender and gender identity, culture and cultural identity, and particularly the intersection of disability and Indigenous culture. There is also a paucity of Australian literature to inform good practice in supporting students with disability to transition to post-secondary education ie TAFE and higher education/university and open employment, and how those in segregated employment might realise mainstream employment. There were passing references in the literature to the importance of education to future employment. There were also passing references to how the location of accommodation might interact with employment prospects and how meaningful day activities/employment were considerations when developing accommodation options. However, these areas require future consideration in research and policy development.

It will be important to establish evidence-informed policy that takes into account the dynamics of the Australian labour market, industrial law and the wider economy. The literature references the intersectionality of disability and poverty, but this is largely restricted to the experience of people with disability in low and middle-income countries. Greater acknowledgement of, and attention to, the experience and effects of poverty on people with disability in high income countries, including Australia, needs to feature in research and policy development.

Notably, and arguably most importantly, the major gap in the research agenda lies in who is setting and mobilising that agenda. Those whose lives are most affected by research output are generally absent from the governance and implementation of that research. There needs to be a greater respect for the expertise of lived experience and greater emphasis on the principles and practice of co-design and co-production in research. Furthermore, there needs to be greater opportunity for people with lived experience of disability to enter and progress through the academy to positions of research influence and leadership. This could be achieved with disability-specific equity entry programs, targeted scholarship programs and greater access to reasonable adjustment in our post-school institutes of education.

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