



# Disadvantage and the health of people with psychosocial disabilities

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- Definition of disability and models
- Health of people with disability
- Socio-economic disadvantage: trends over time, gender and impairment type
- Social capital/social inclusion: gender and impairment type
- Employment: labour force participation, unemployment, working conditions
- Proposed research: employment, discrimination, locational
- Potential strategies/programs

1. Improving access to social and economic resources including participation key priority of Australian National Disability Strategy
2. Recommended monitoring including by age, gender, impairment type etc:
  - Australian National Disability Strategy
  - World Report on Disability
  - Australian Social Inclusion Agenda

- ‘Medical’ model of disability
- ‘Social’ model of disability – emphasises the social, cultural and economic barriers that people with impairments experience in day-to-day life (Oliver 2004)
  - Barriers are due to disablism which is defined by Carol Thomas (2010) as “*social imposition of avoidable restrictions on the life activities, aspirations and psycho-emotional well-being of people categorised as ‘impaired’ by those deemed ‘normal’. Disablism is socialrelational in character and constitutes a form of social oppression in contemporary society – alongside sexism, racism, ageism, and homophobia. As well as enacted in person-to-person interactions, disablism may manifest itself in institutionalised and other socio-structural forms.*” (Thomas, 2010, p. 37)

- Biopsychosocial model – social and medical model.
  - The *United Nations (UN) Convention on the Rights of Persons with Disabilities*, describes disability as resulting ‘from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others’ (United Nations General Assembly 2007)
  - *International Classification for Functioning Disability and Health (2001)*. Disability and functioning are viewed as outcomes of interactions between *health conditions* (diseases, disorders and injuries) and *contextual factors* (external and personal factors).



## Australian strategies and policies

- National Disability Strategy in 2011 - developed through extensive consultation with people with disabilities and their families; Disability People Organisations (DPOs); service providers; and policy makers
- Productivity Commission's report (2011)
  - Concluded that disability services are inadequate and poorly coordinated
  - Major recommendation was the introduction of a National Disability Insurance Scheme that would provide individually-based packages for people with severe and permanent disabilities
- National Disability Insurance Scheme (introduced in 2014) - a scheme that received bipartisan support as well as a groundswell of community activism through one of the largest campaigns witnessed in Australia (Every Australian Counts) (160,000 members)





- United Nations Convention on the Rights of Persons with Disabilities - to which Australia became signatory in 2007. seeks to ensure “the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity.” The Convention promotes principles such as individual autonomy in decision-making, freedom from discrimination, full and effective participation and equality of opportunity, accessibility and respect.
- World Report on Disability (produced by the World Bank and World Health Organisation) which provides a global account of the health and wellbeing of people with disabilities as well as their access to services, education and employment and makes recommendations directed toward government and civil society to enhance the lives of people with disabilities.
- World Health Assembly resolution WHA66.9 which recognises and adopts many of the recommendations of the World Report on Disability as well as the implementation and monitoring of the UNCRPD

- WHO International Classification of Functioning, Disability and Health (ICF) (2001) ([ABS, 2010a](#)).
- Disability = limitation, impairment or restriction in everyday activities that had lasted, or was likely to last, for a period of 6 months or more.
- Six impairment categories:
  - sensory and speech (sight problems not corrected by glasses, hearing problems or speech problems);
  - intellectual (difficultly learning or understanding things);
  - physical (including things such as blackouts, difficulty gripping things, limited use of legs or feet and restricted activities due to chronic pain);
  - psychological (mental illness or a nervous or emotional condition),
  - acquired brain injury (head injury, stroke or other brain damage), and
  - other impairment (restricted in everyday activities due to a long-term health condition such as migraines).

- Adult Australians with disabilities earn 68% relative income of those without disabilities – lowest of 27 OECD countries (OECD, 2009)
- Very few studies separated outcomes for different types of impairments:
  - Australia – students with mental health problems had the lowest secondary school completion rates and students with sensory impairments the highest (although still 5% lower than students without disabilities (Karmel 2005)
  - Australia and internationally – lowest labour force participation for people with mental health problems (Hogan 2012; Hum 1996; Jones 2011)
  - In Australia, people with mental health problems are more likely to experience housing problems including periods of sustained homelessness while people with sensory impairments have housing profiles similar to general population (Beer et al. 2011; Dalton et al 2007)



# Socio-economic disadvantage and disability

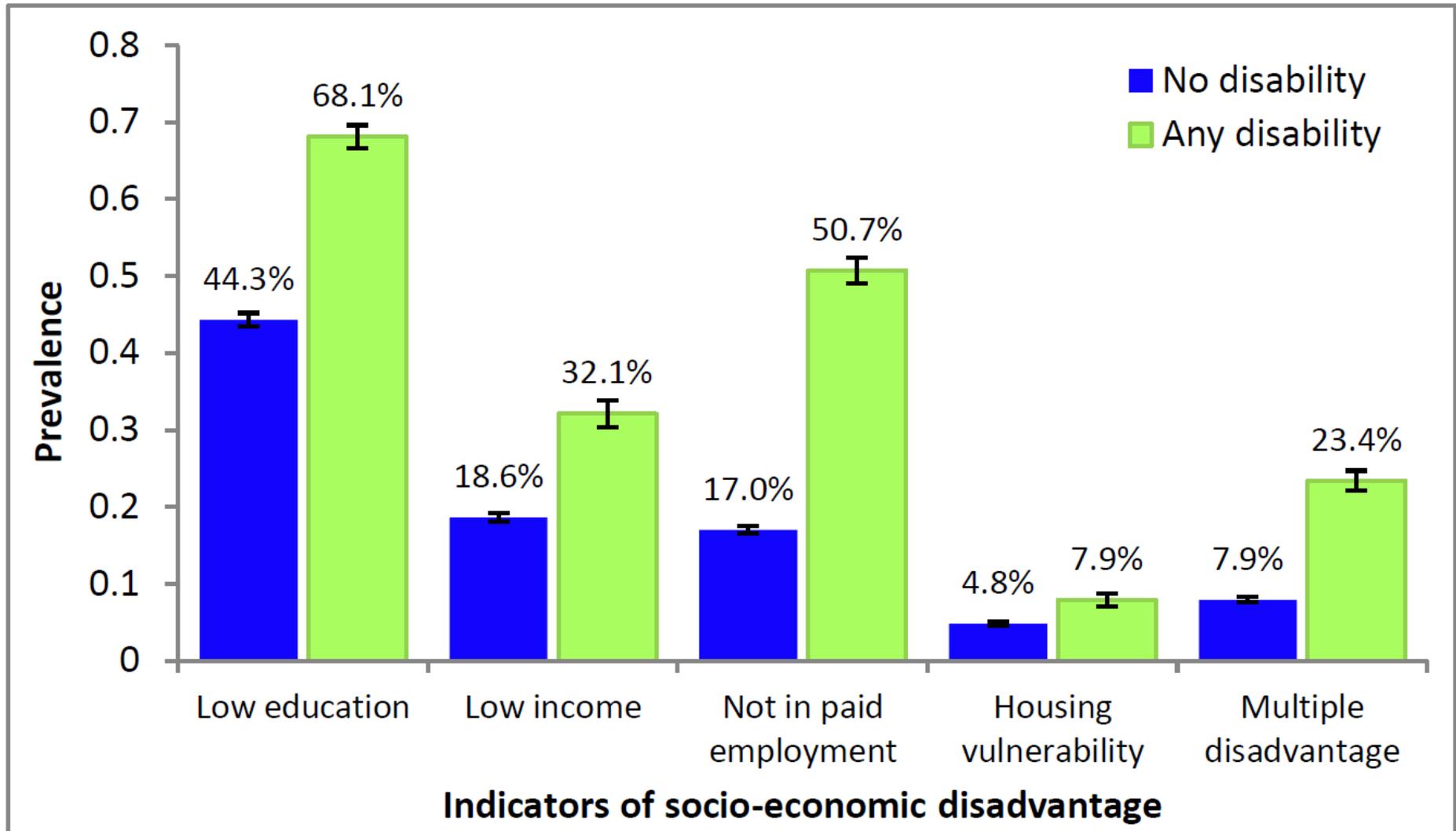


- 1999, 2003, 2009 Survey of Disability Ageing and Carers survey, a cross-sectional national survey conducted by the Australian Bureau of Statistics (ABS)
- Face-to-face interviews
- 72,075 people; analysis restricted to working age adults (25 to 64 year olds (37,641 people excluded), and excluded people living in cared accommodation (hospitals, nursing homes and other homes such as children's homes) as there were limited data collected on this subgroup (845 people excluded, of which 96.2% had a disability).



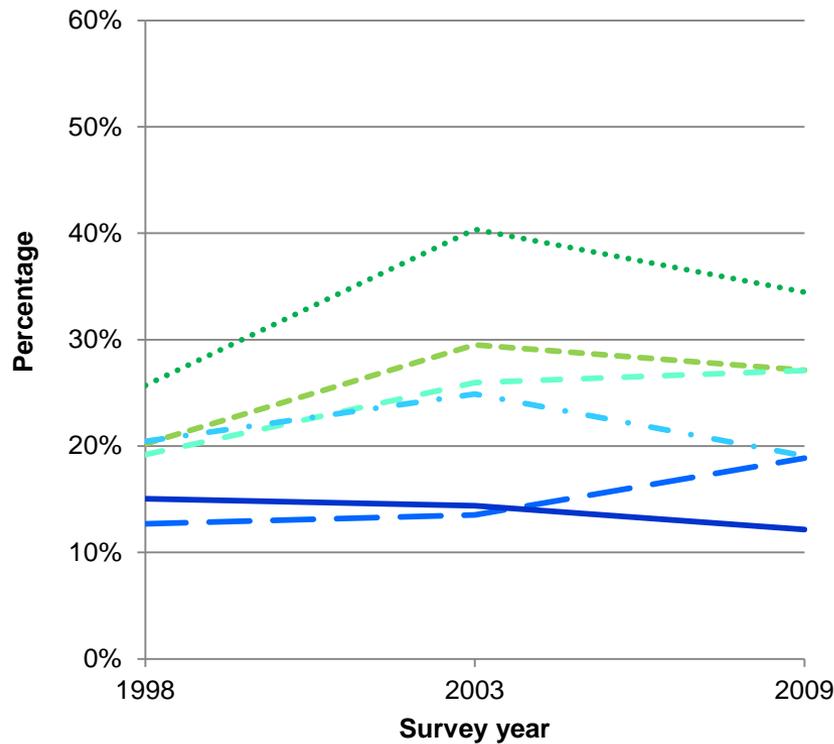
- Low education = did not complete year 12
- Low income = in lowest 30% of income distribution
- Not being in paid employment (includes people classified as unemployed as well as those not in the labour force)
- Housing vulnerability = low income private renter
- Multiple disadvantage = 3 or more of above

Prevalence of each indicator of socio-economic disadvantage for people with and without disabilities.

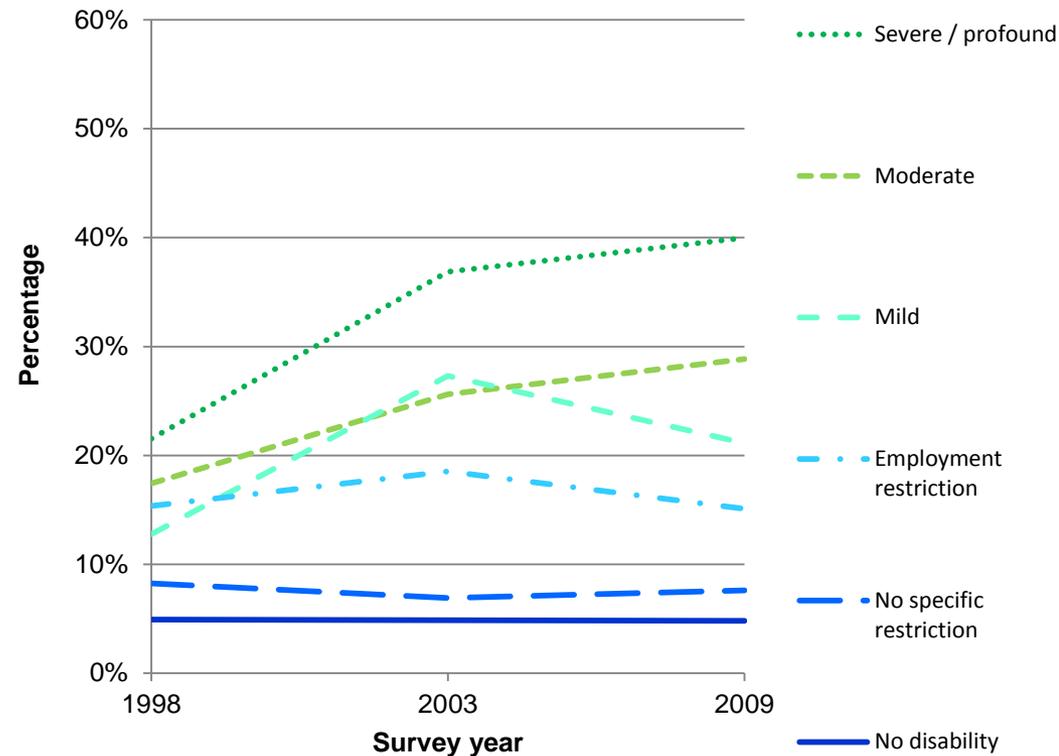


Proportion of people experiencing multiple disadvantage in 1998, 2003 and 2009, by disability severity and sex.

**A: Multiple disadvantage (Female)**

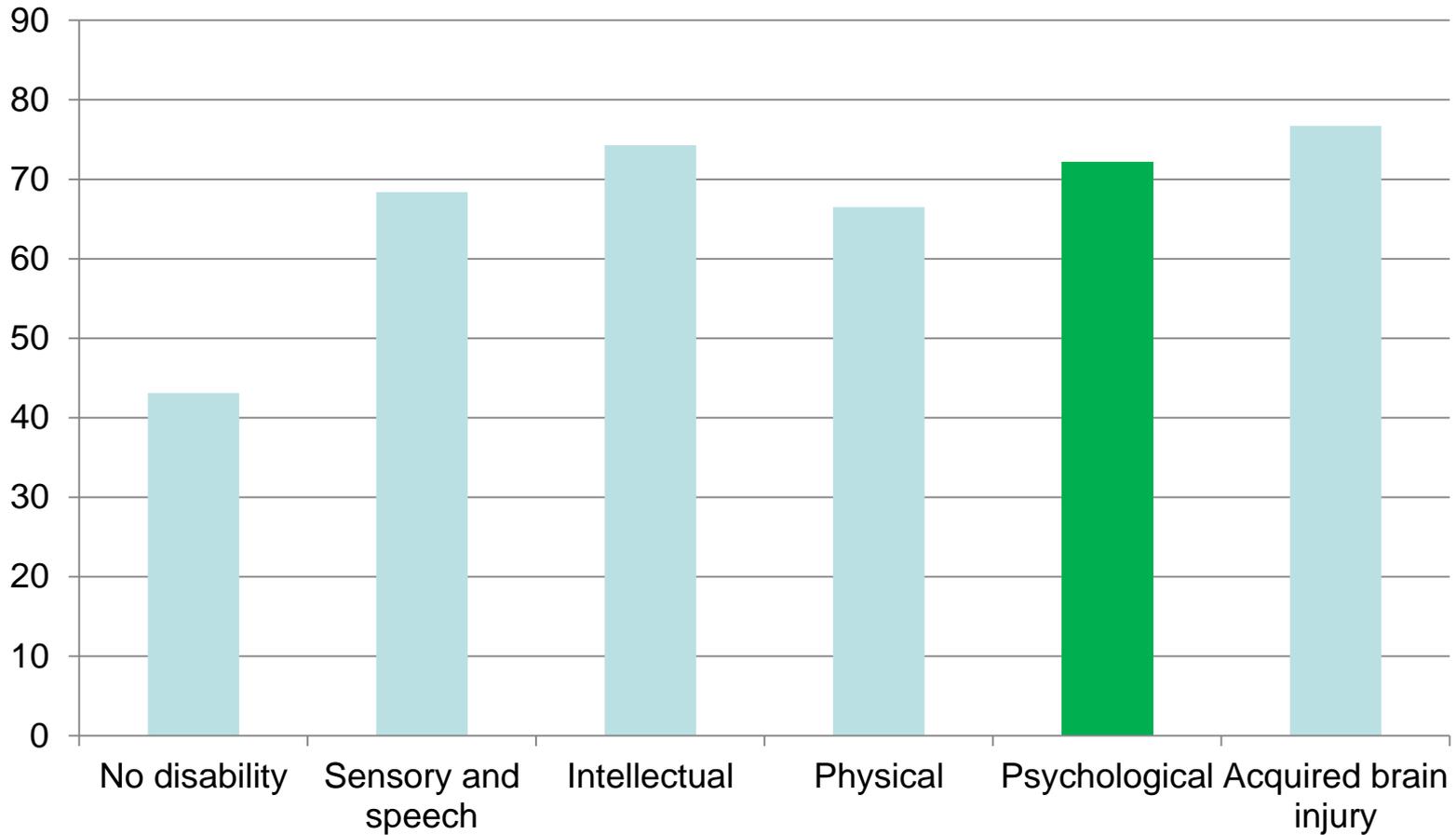


**B: Multiple disadvantage (Male)**

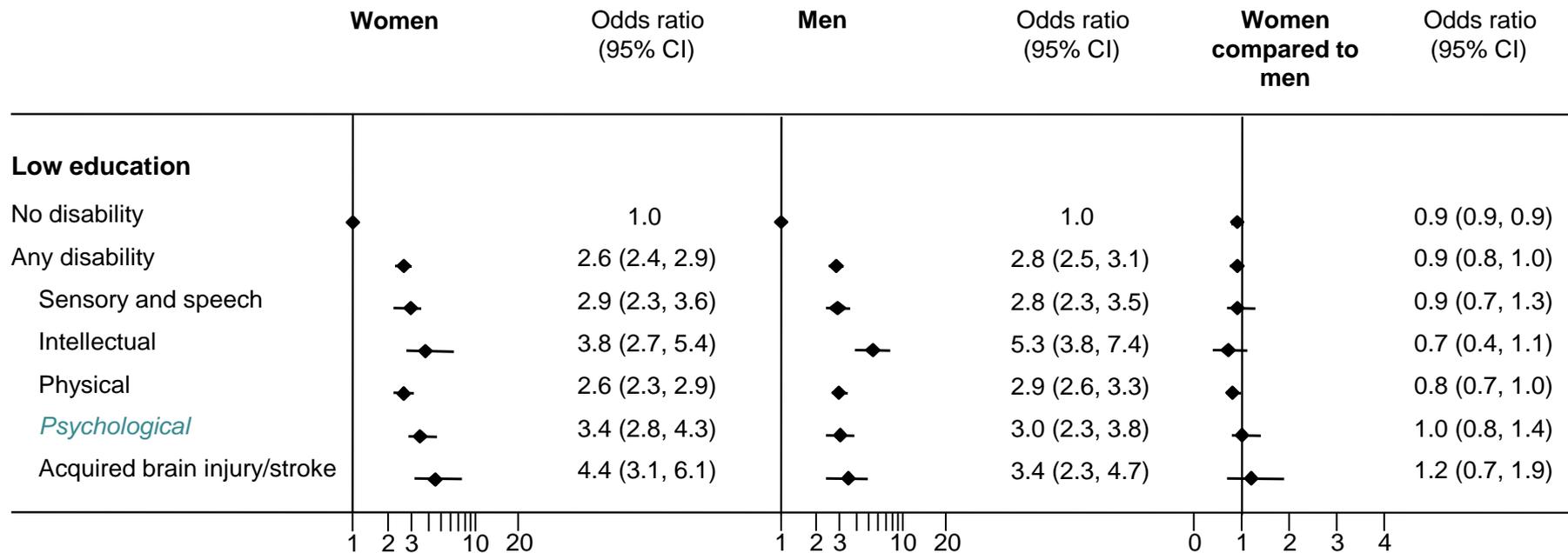




## Low education (%)

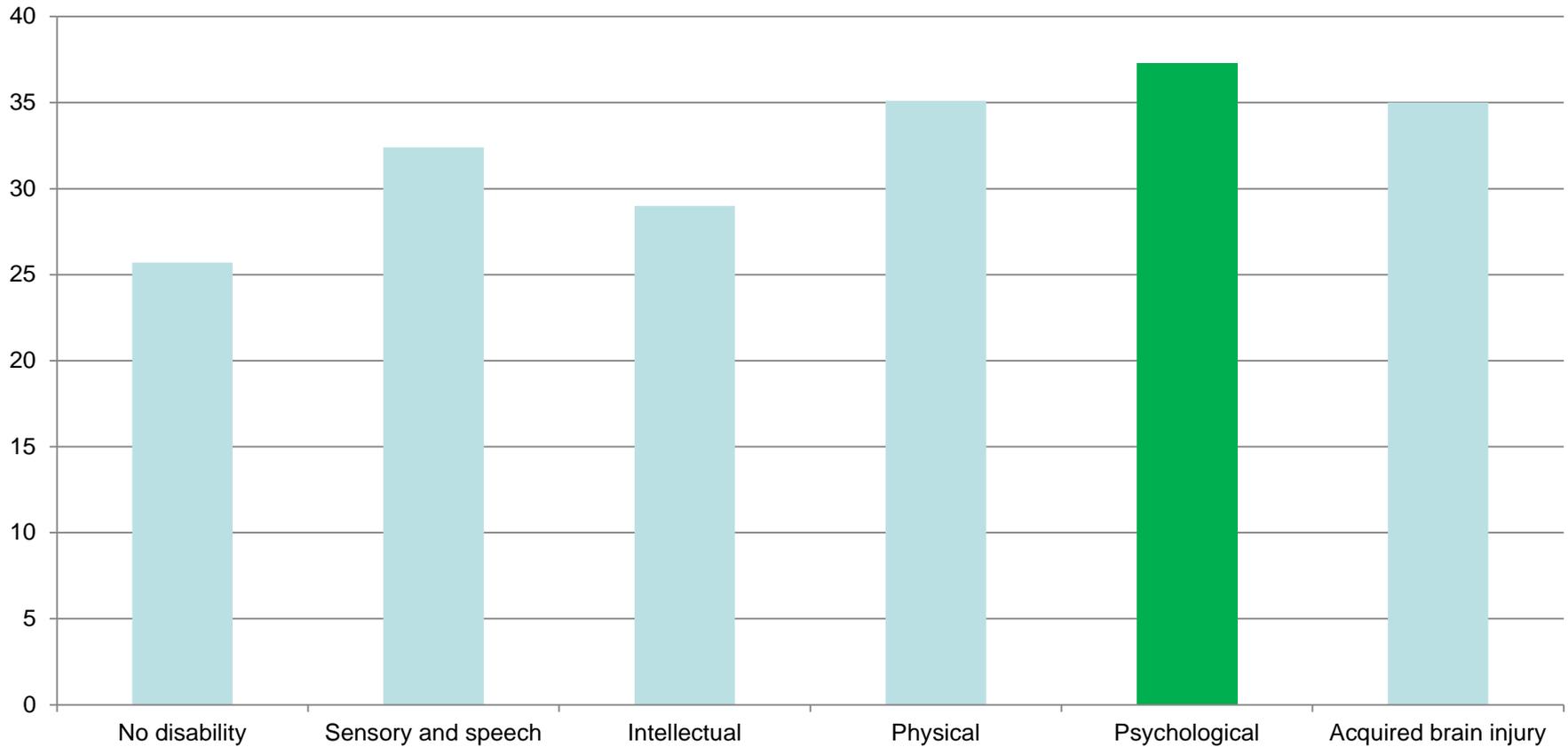


Relative odds of low education by disability and impairment type (compared to those with no disability), and the relative odds of low education by gender, 25-64 years



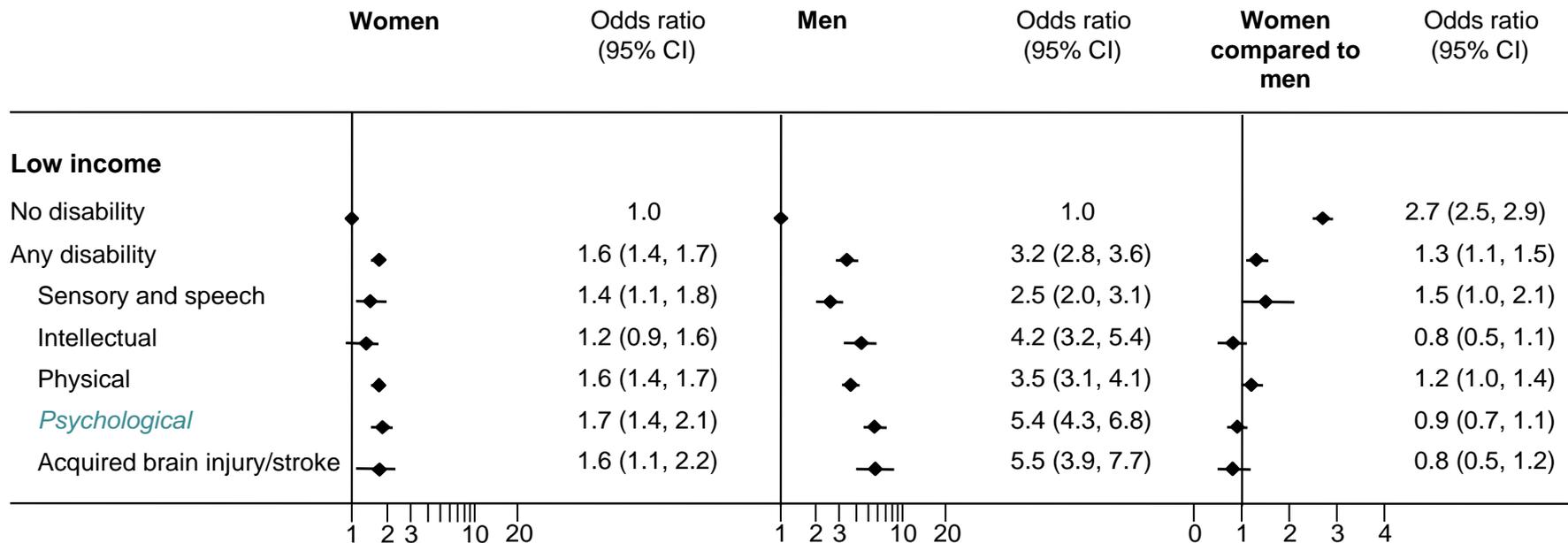


## Low-moderate income (%)



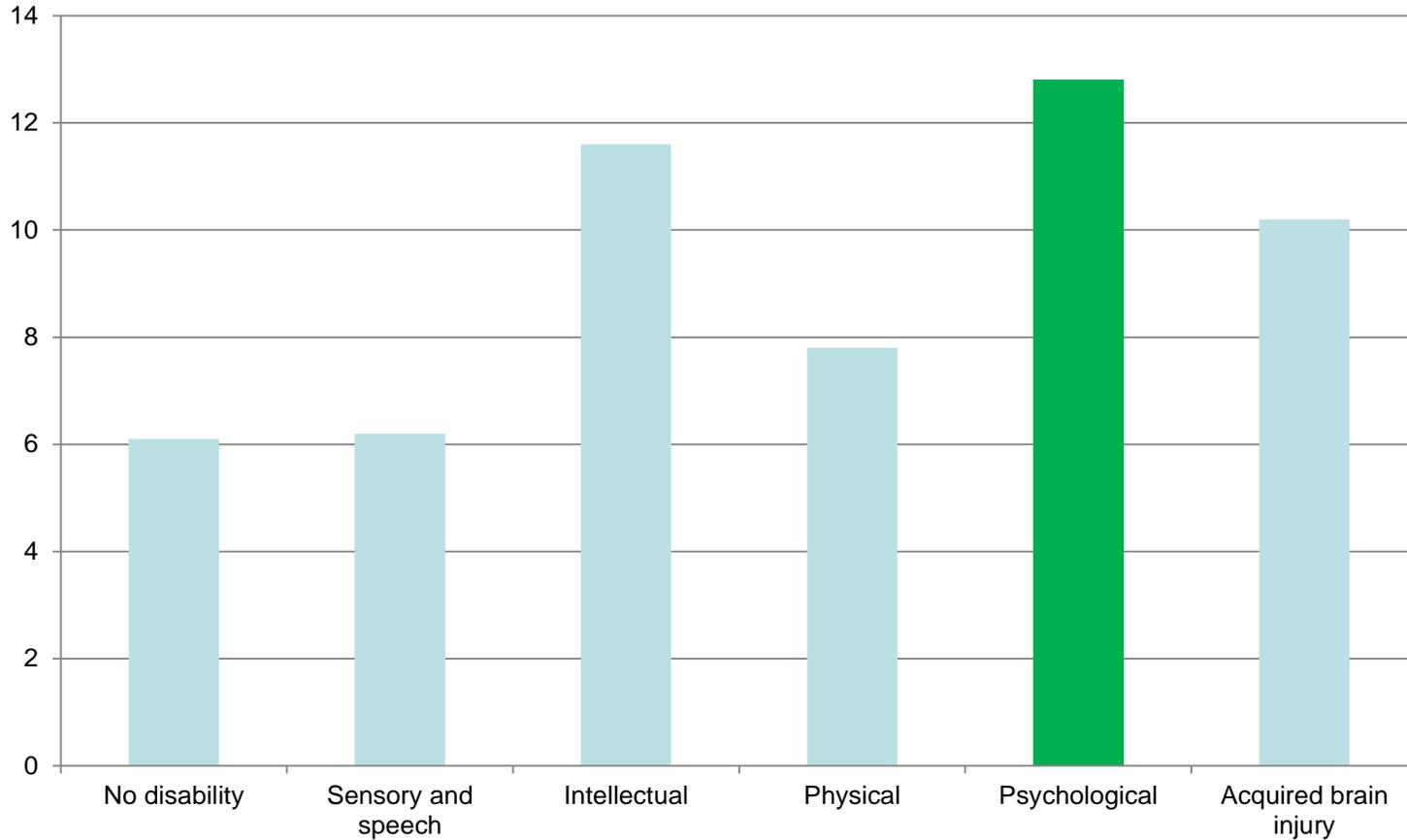
# Income by impairment type and gender (Kavanagh et al. Disability Health 2014)

Relative odds of experiencing low-moderate income by disability and impairment type (compared to those with no disability), and the relative odds of experiencing low-moderate income by gender, 25-64 years

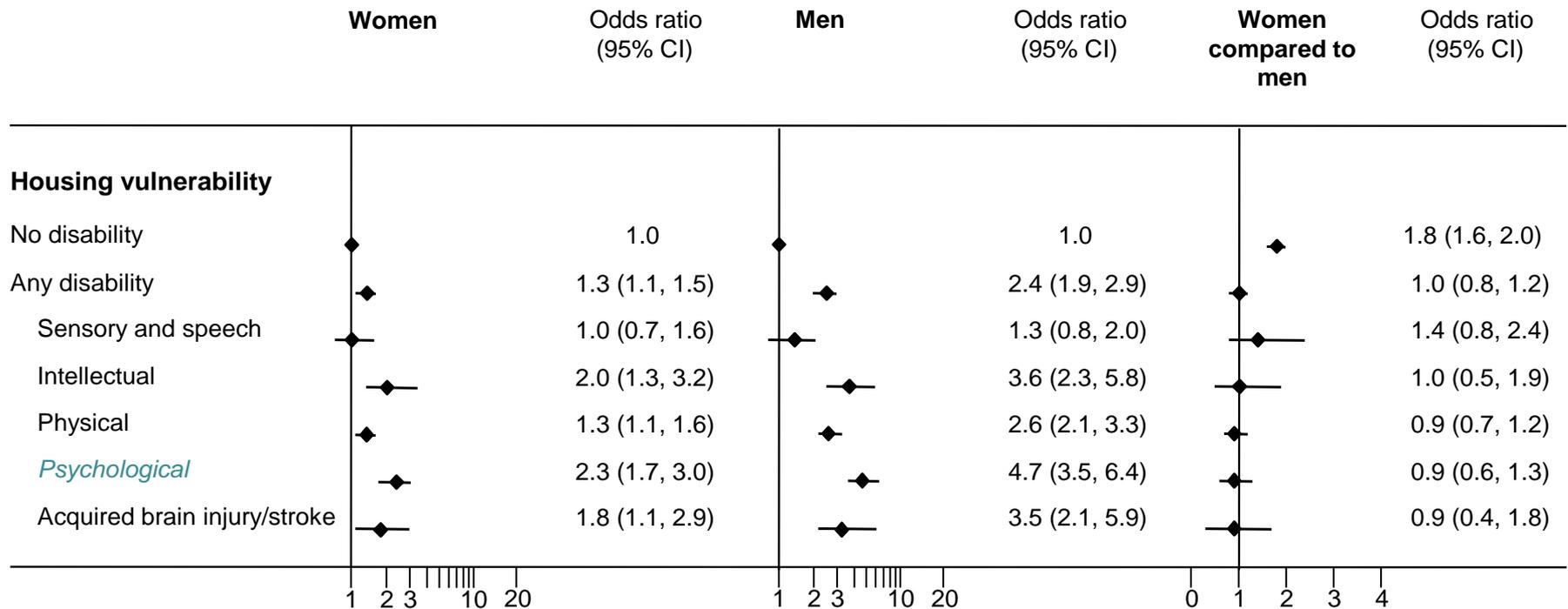




## Housing vulnerability (%)

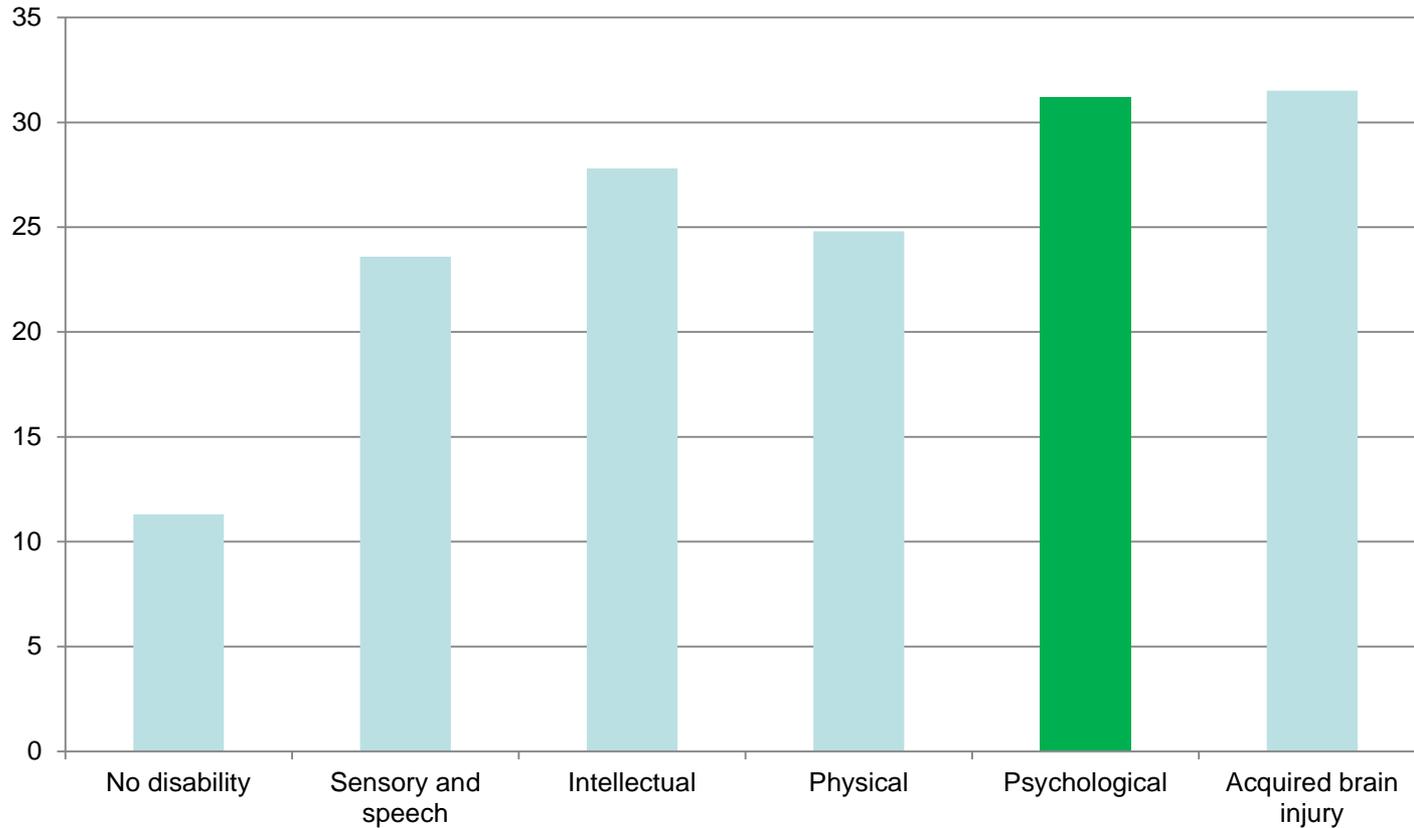


Relative odds of experiencing housing vulnerability by disability and impairment type (compared to those with no disability), and the relative odds of experiencing housing vulnerability by gender, 25-64 years

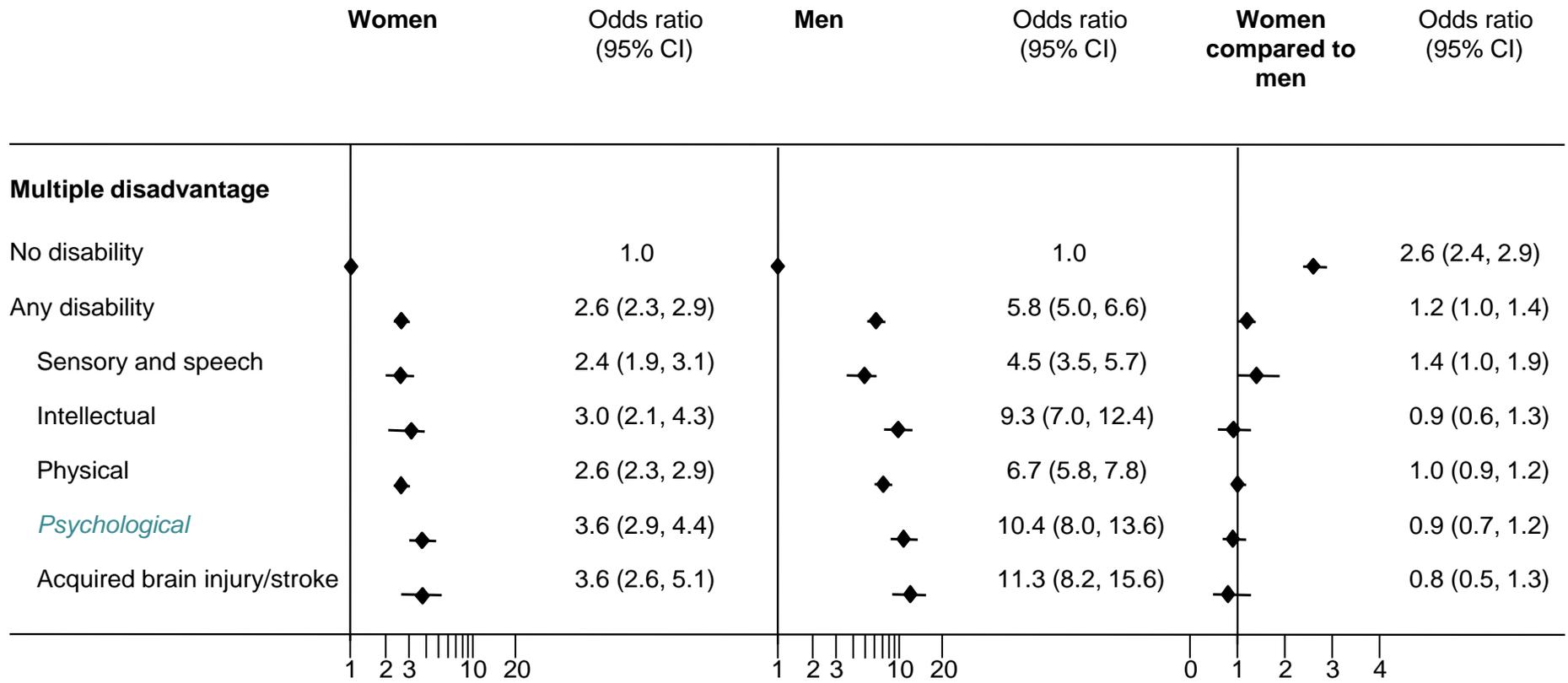




## Multiple disadvantage (%)



Relative odds of experiencing multiple disadvantage by disability and impairment type (compared to those with no disability), and the relative odds multiple disadvantage by gender, 25-64 years



- With few exceptions, women and men with disabilities fare worse on all indicators compared to their same sex counterparts across all impairment types
- Greatest inequalities are for paid employment
- People with psychological, intellectual and acquired brain injury tended to have the worst outcomes
- Multiple disadvantage was high across all groups
- With few exceptions inequalities between women and men with the same types of impairments was not found (some differences when women with any disability were compared with men with any disability)



# Social capital and disability



1. Do people with and without disabilities have different levels of social capital (informal and formal networks and social support), and are there differences for people with different impairment types (sensory and speech; physical; intellectual; psychological)?
2. Does self-rated health vary between people with and without disabilities and for people with different impairment types?

Bourdieu's approach emphasises:

1. The actual or potential resources that flow from networks
2. Power: how people access, or are denied access to, network based resources
3. Focus on individual rather than collective

- **Social networks: structural aspects of Bourdieu's approach**
  - Informal networks
    - Bonding ties – close networks of family and friends – help 'get by'
  - Formal networks
    - Bridging – weaker and heterogeneous ties between people of dissimilar backgrounds (e.g. age, ethnicity) and may generate resources not accessible through bonding ties
    - Linking ties – relationships across formal and institutional power in society
  - Social support – flow from networks
    - Financial
    - Practical
    - Emotional

- Mostly shown to be beneficial for physical and mental health but not always consistent
- Most consistency with trust rather than community participation

## General Social Survey (2010)

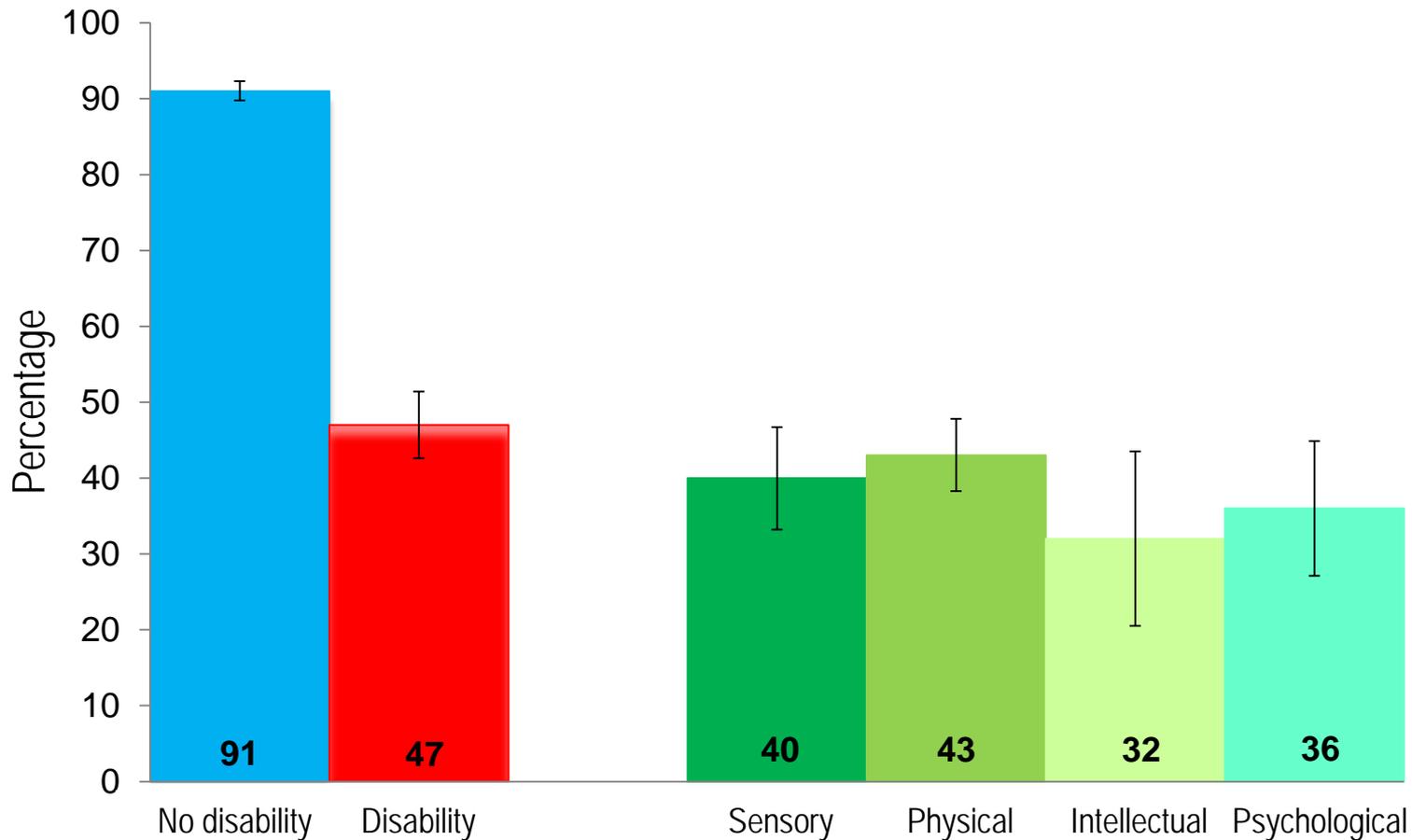
- Nationally-representative population-based cross-sectional survey
- Conducted every 4 years by the ABS
- Interviews with a randomly selected participant from 15,028 dwellings
- Focus on social dimensions (health, income, family relationships, and social and community involvement)

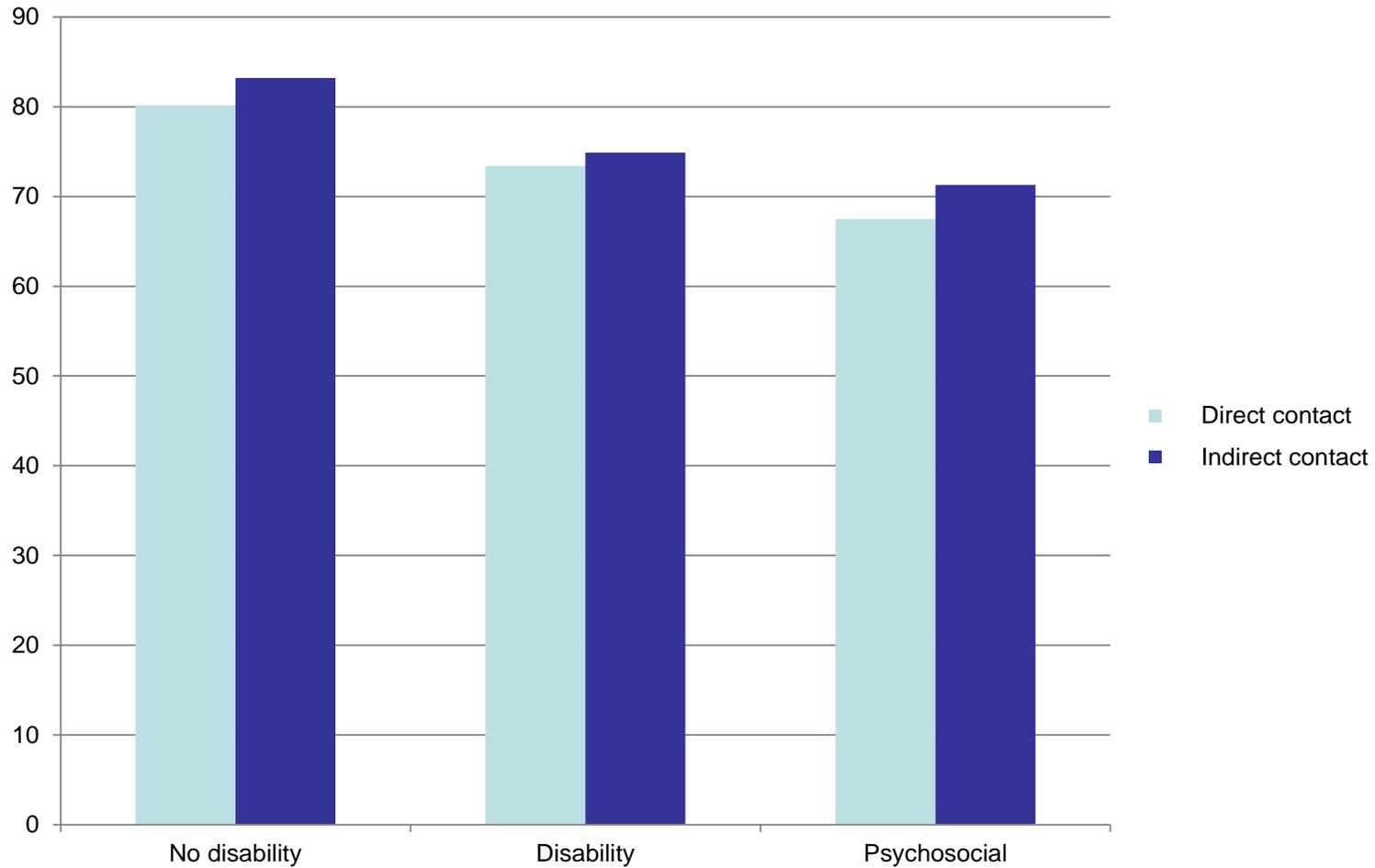
## Social capital measures

- Informal networks
  - Face to face contact with family or friends at least once a week or more
  - Telephone, email & mail contact with family or friends a few times a week or more
- Formal networks
  - Belonging to a group (active involvement in a group in last 12 months)
  - Personally knows someone in an organisation they would feel comfortable contacting for information or advice
- Social support
  - Financial support (could raise \$2000 within a week if needed suddenly)
  - Practical support (could ask for small favours)
  - Emotional support (at least a moderate number of family &/or friends to confide in)

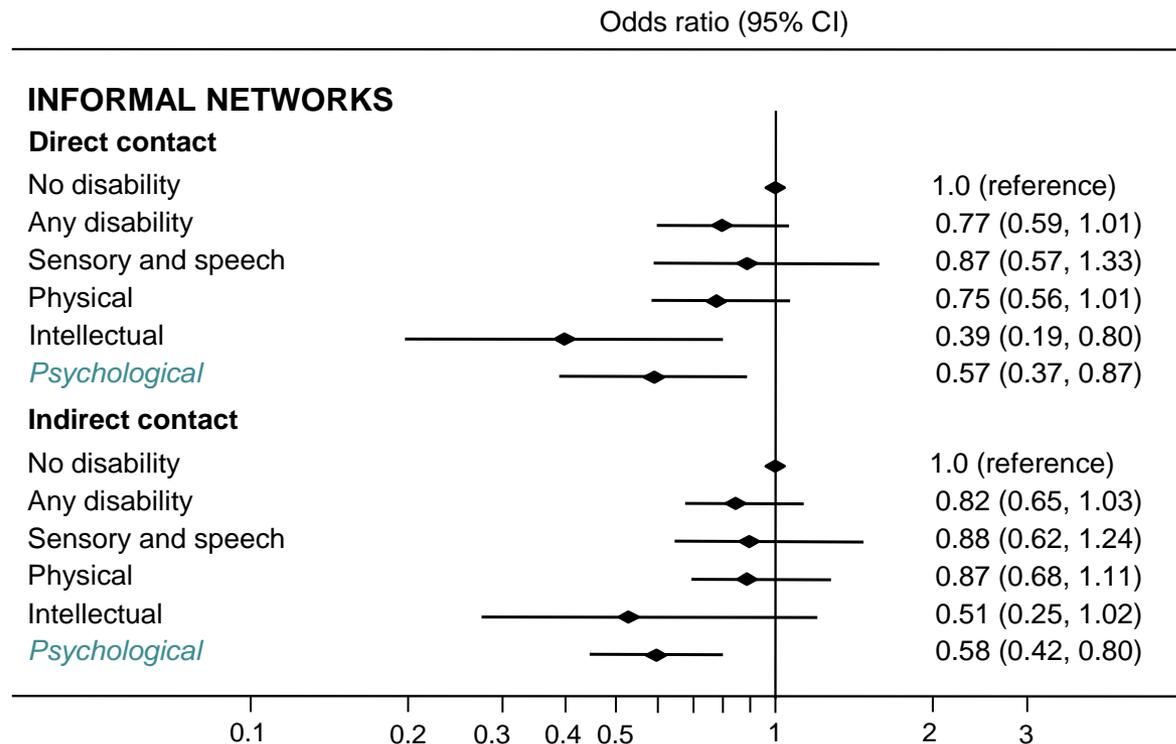


Proportion of people reporting 'good or better' self assessed health by impairment type

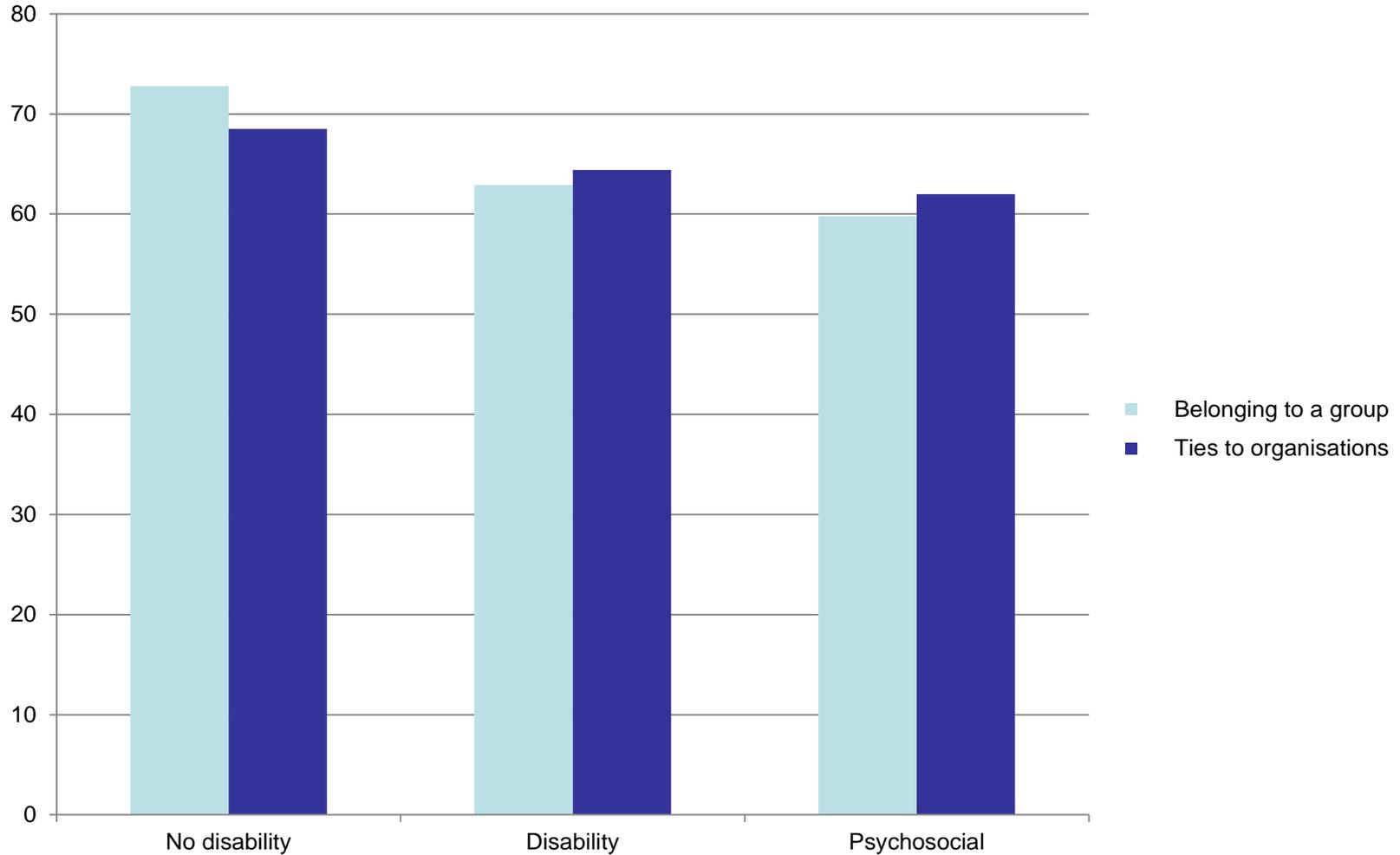




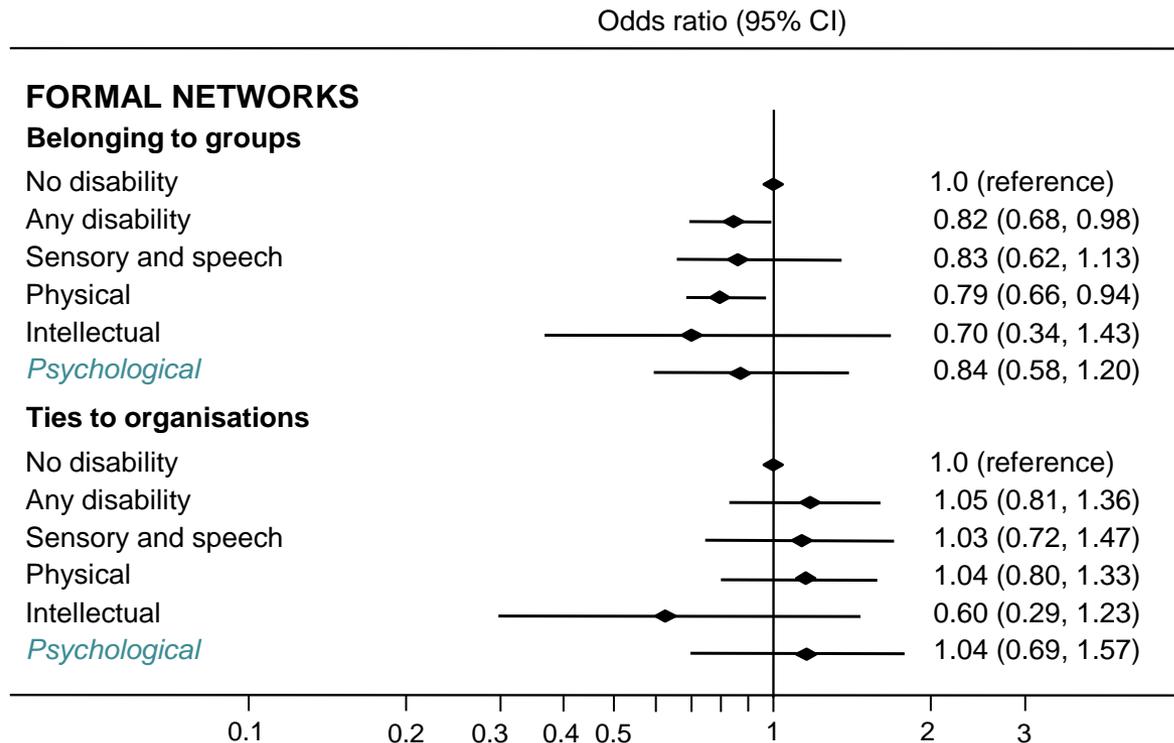
Relative odds of three indicators of **informal networks** by disability and impairment type (compared to those with no disability).



\*Models were adjusted for age, sex, education, equivalised household income and labour force status



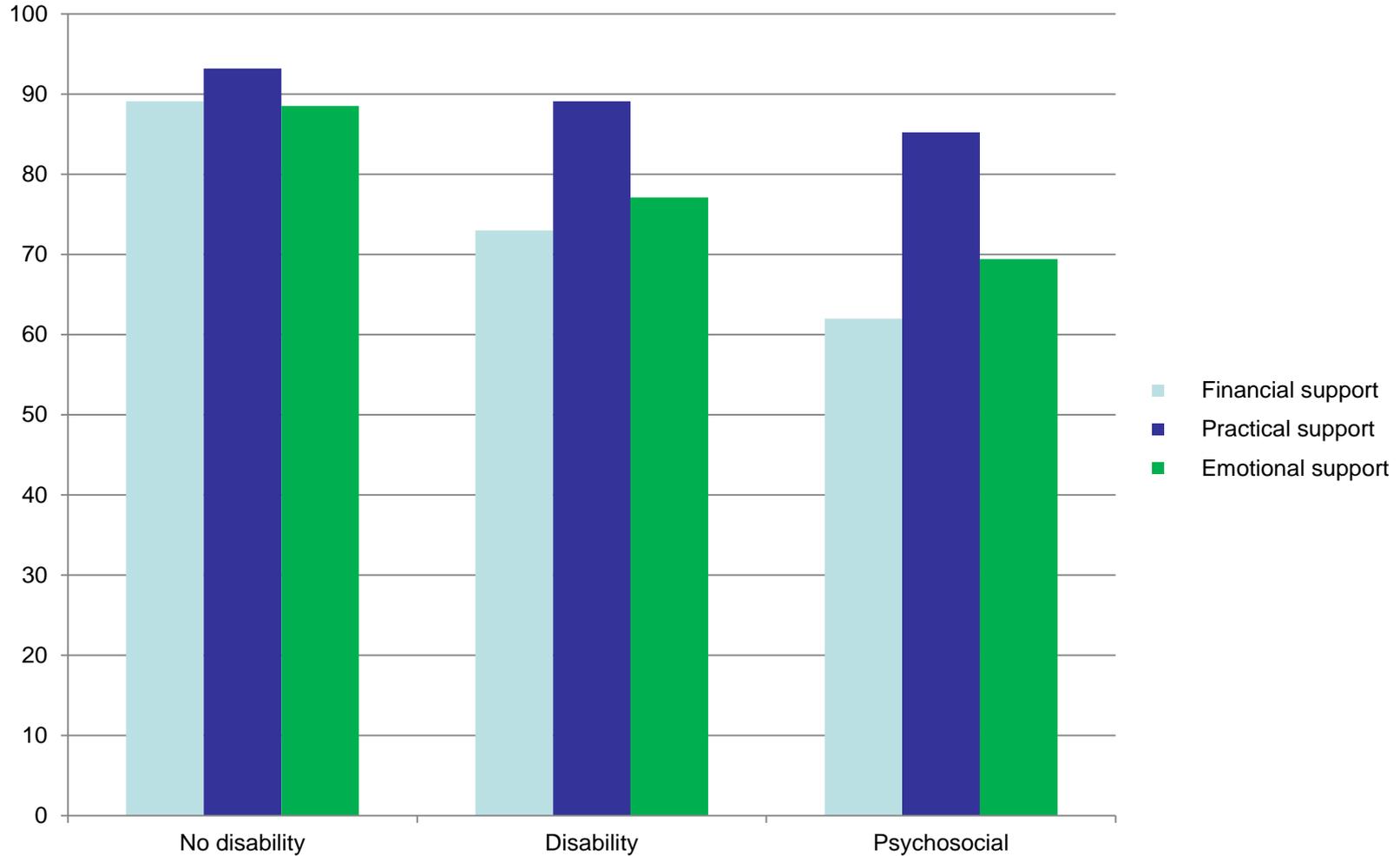
Relative odds of three indicators of **formal networks** by disability and impairment type (compared to those with no disability).



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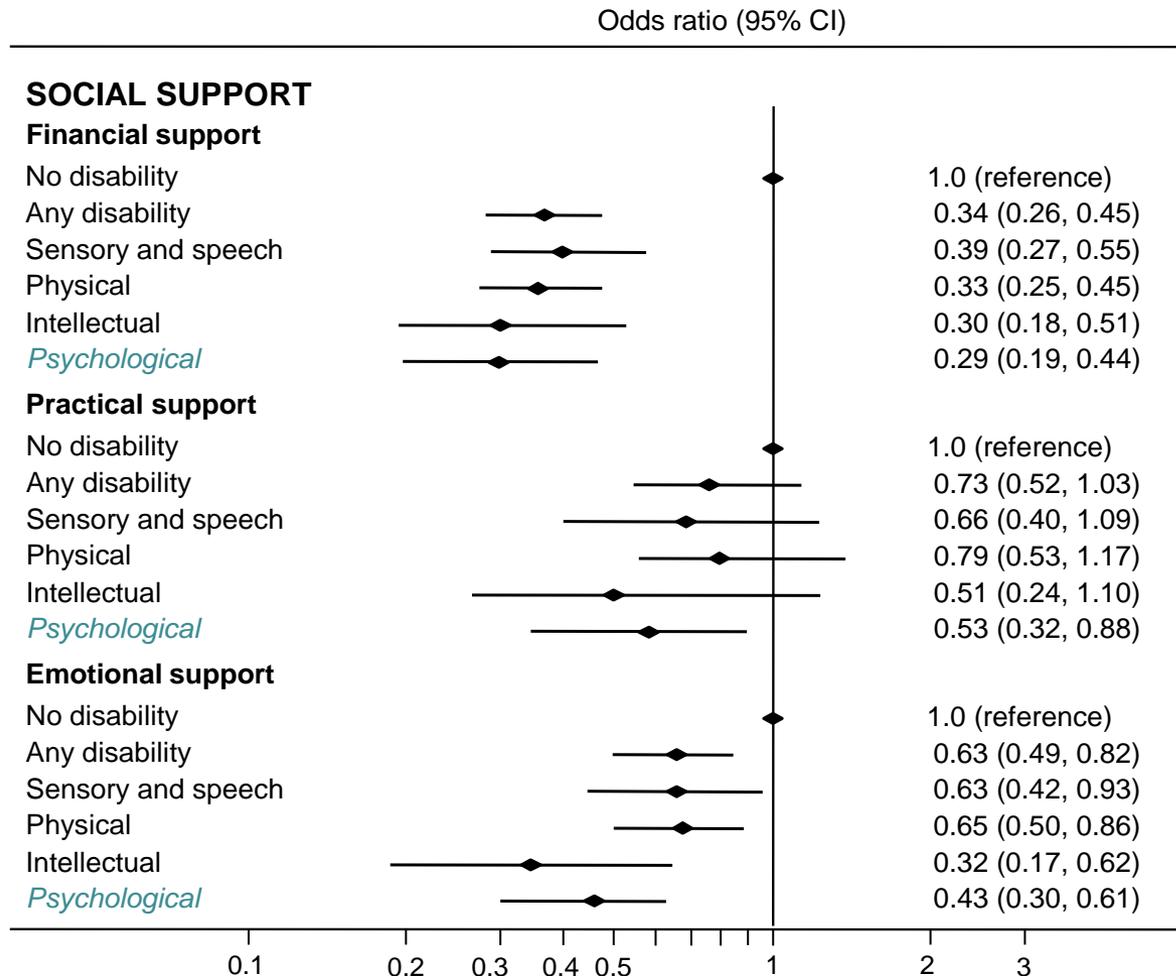
# Social support (%) (Kavanagh et al. Disability and health, 2014)





# Logistic Regression Results: Social Capital and Disability (Kavanagh et al. Disability and Health, 2014)

Relative odds of three indicators of **social support** by disability and impairment type (compared to those with no disability).



\*Models were adjusted for age, sex, education, equivalised household income and labour force status

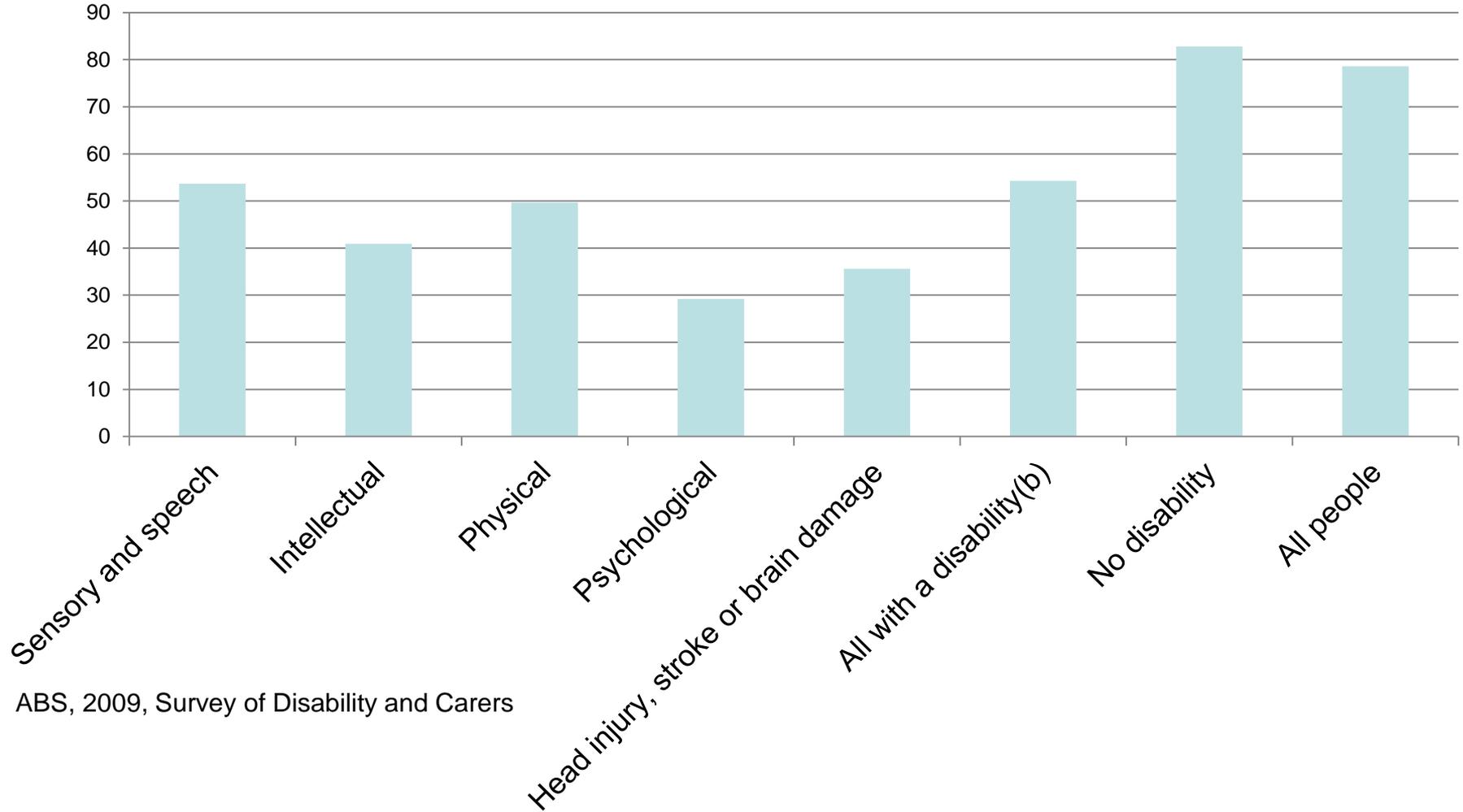
- People with disabilities had poorer self-assessed health than people without disabilities.
- People with disabilities had poorer informal networks, financial support, emotional support compared to people without disabilities.
- People with intellectual and psychological impairments fared worst for all outcomes.



# Psychosocial impairments and employment



# Labour force participation by impairment type

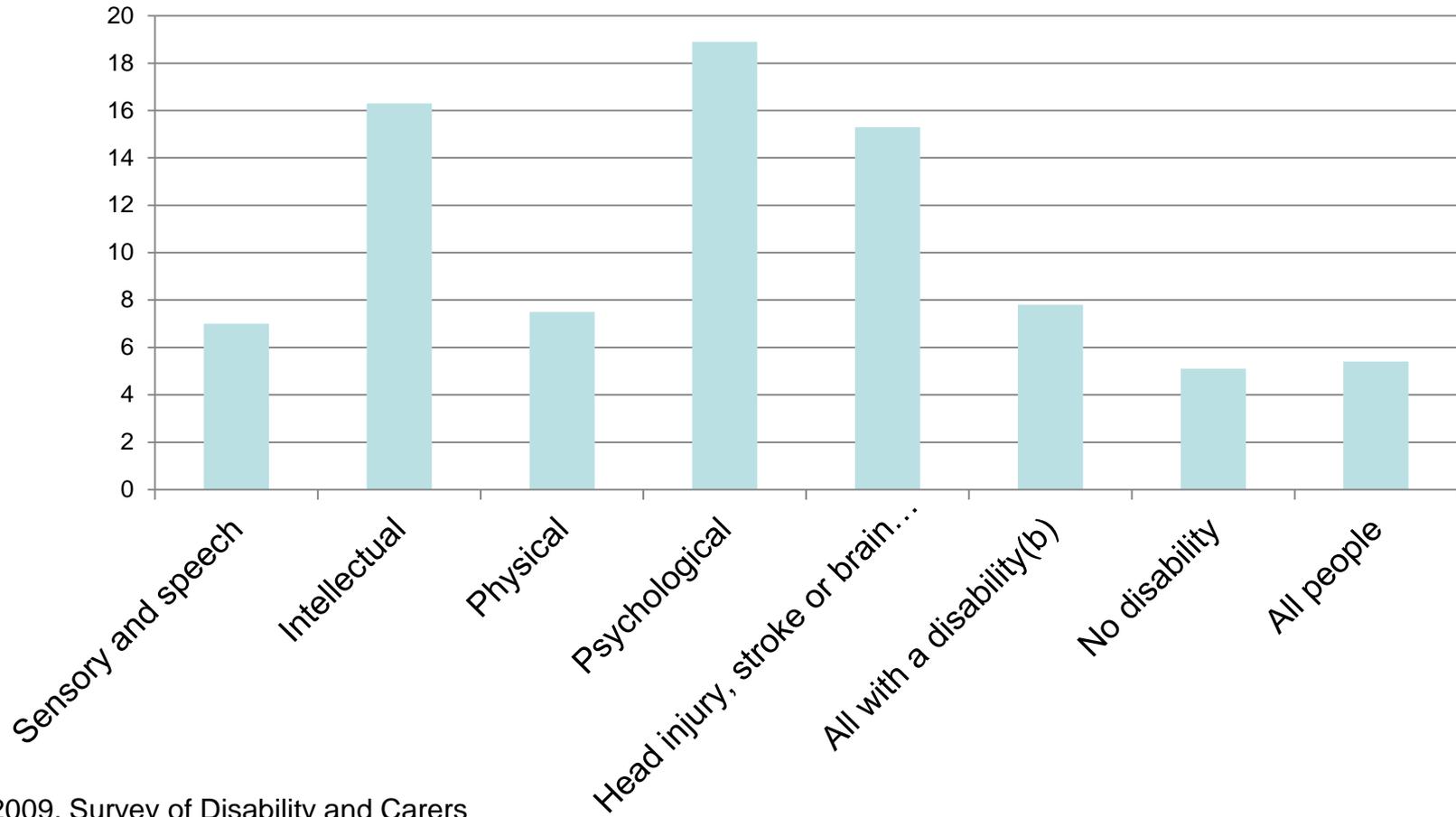


ABS, 2009, Survey of Disability and Carers

$(\text{Unemployed} + \text{employed}) / (\text{unemployed} + \text{employed} + \text{not in labour force})$



## Unemployment rate

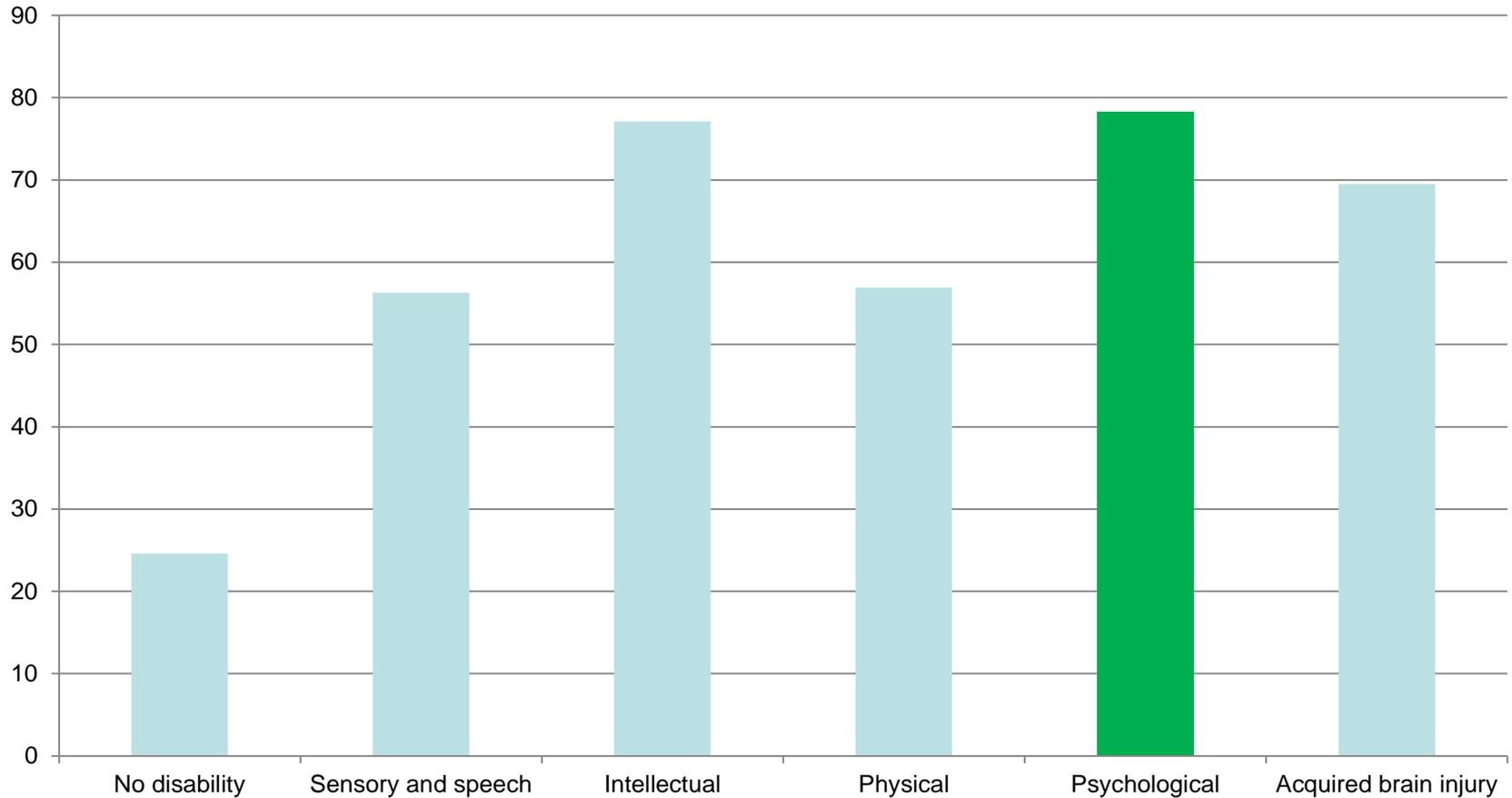


ABS, 2009, Survey of Disability and Carers

$(\text{Unemployed}) / (\text{unemployed} + \text{employed} + \text{not in labour force})$

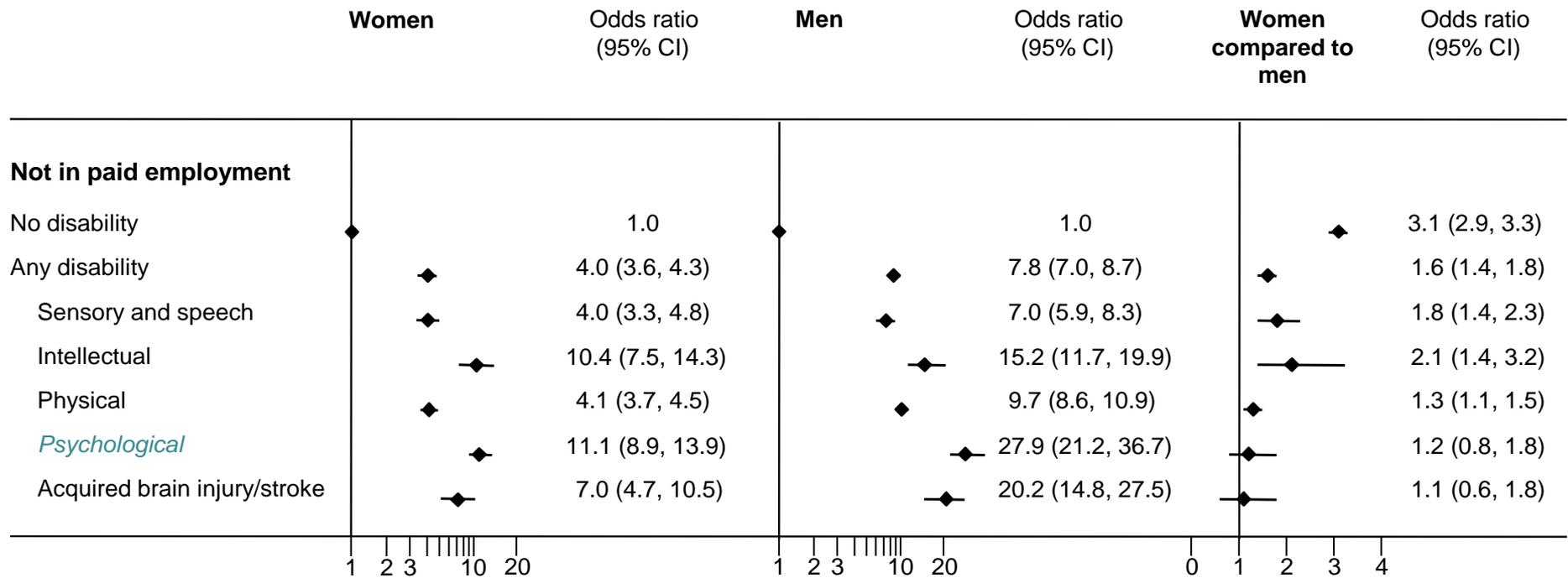


## Not in paid employment (%)



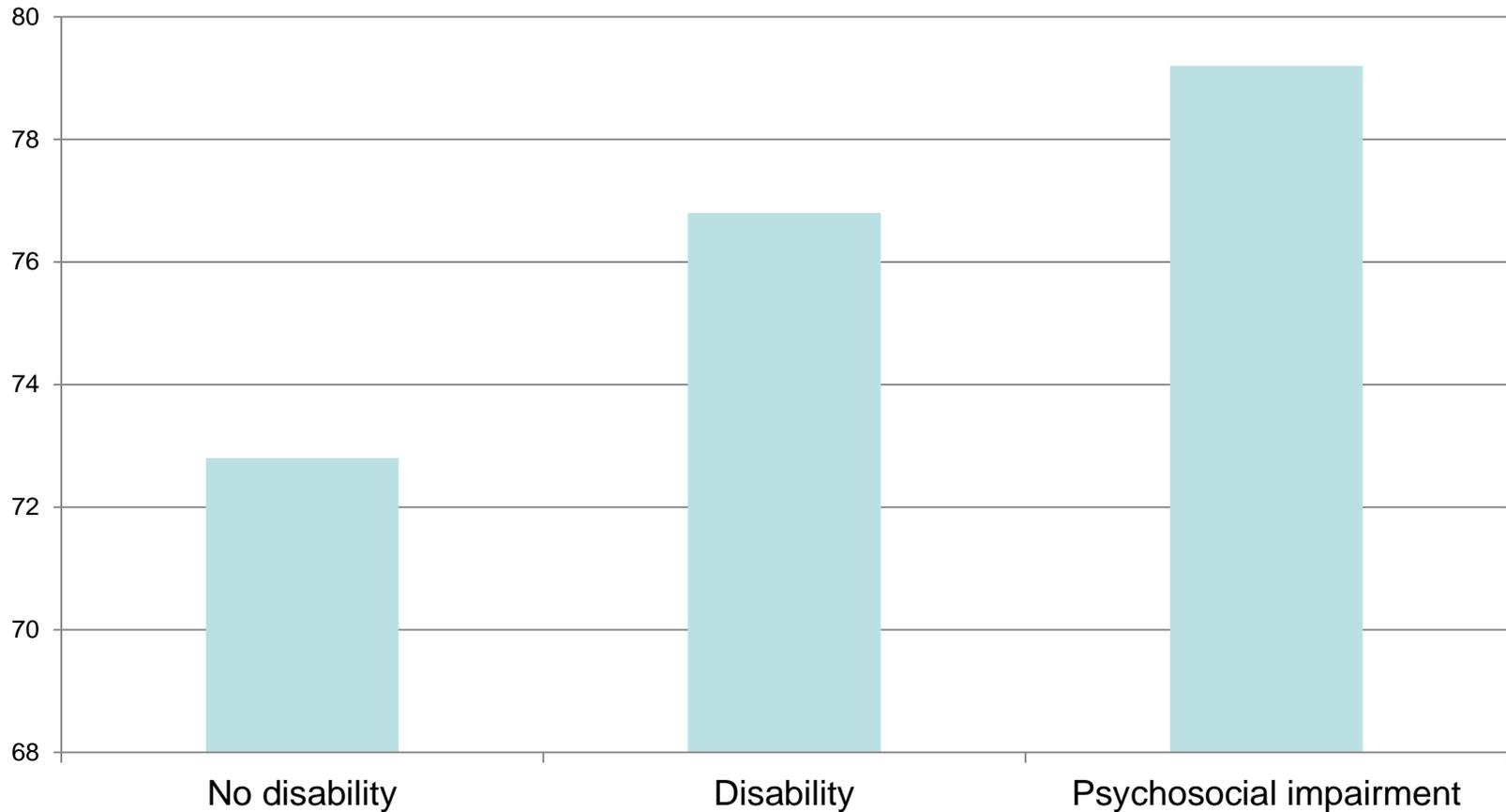
(Employed)/(unemployed + employed + not in labour force)

Relative odds of not being in paid work by disability and impairment type (compared to those with no disability), and the relative odds of not being in paid work by gender, 25-64 years



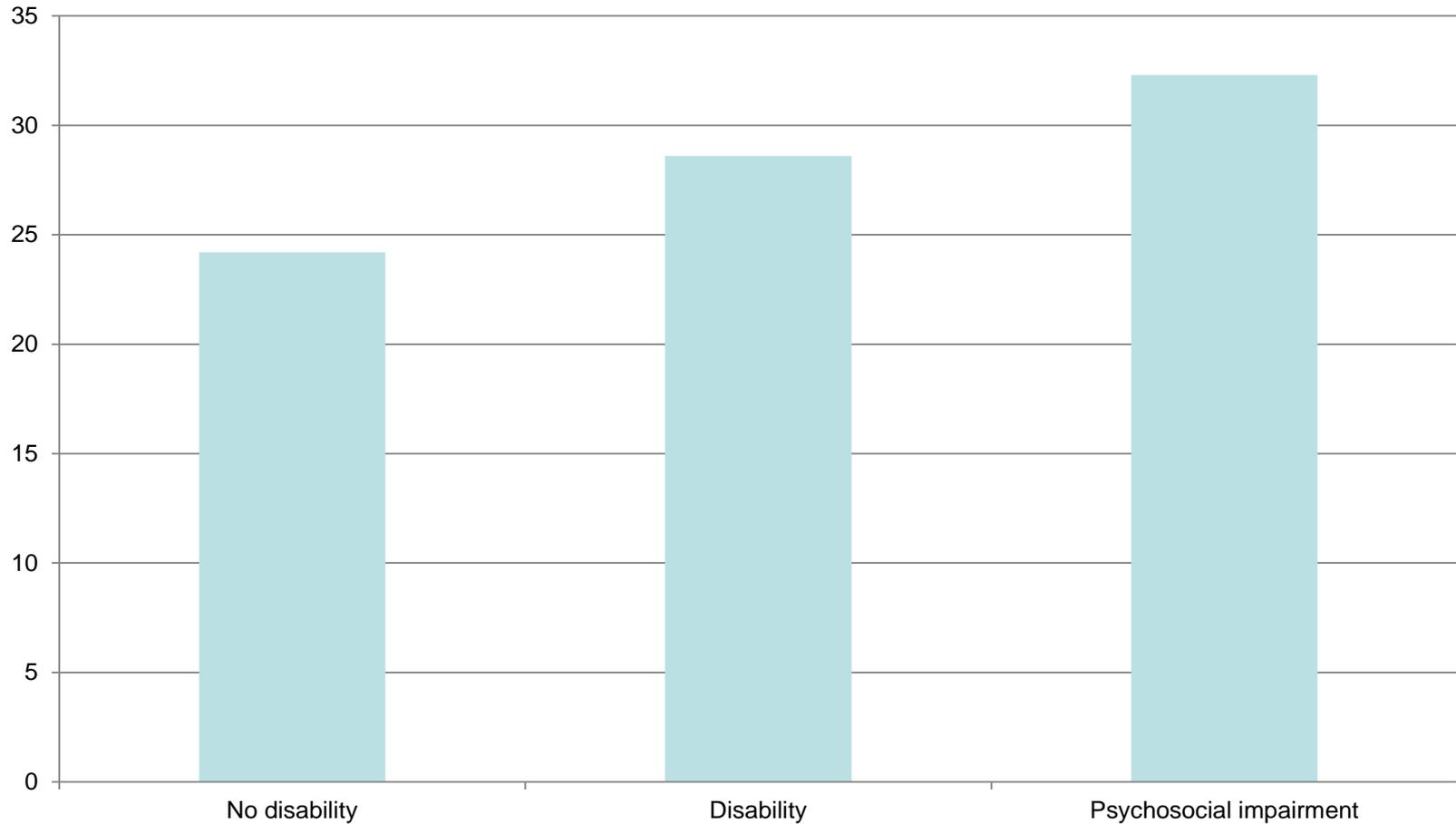


**overall job quality (% reporting either high demands, low control, low security, unfair pay)**



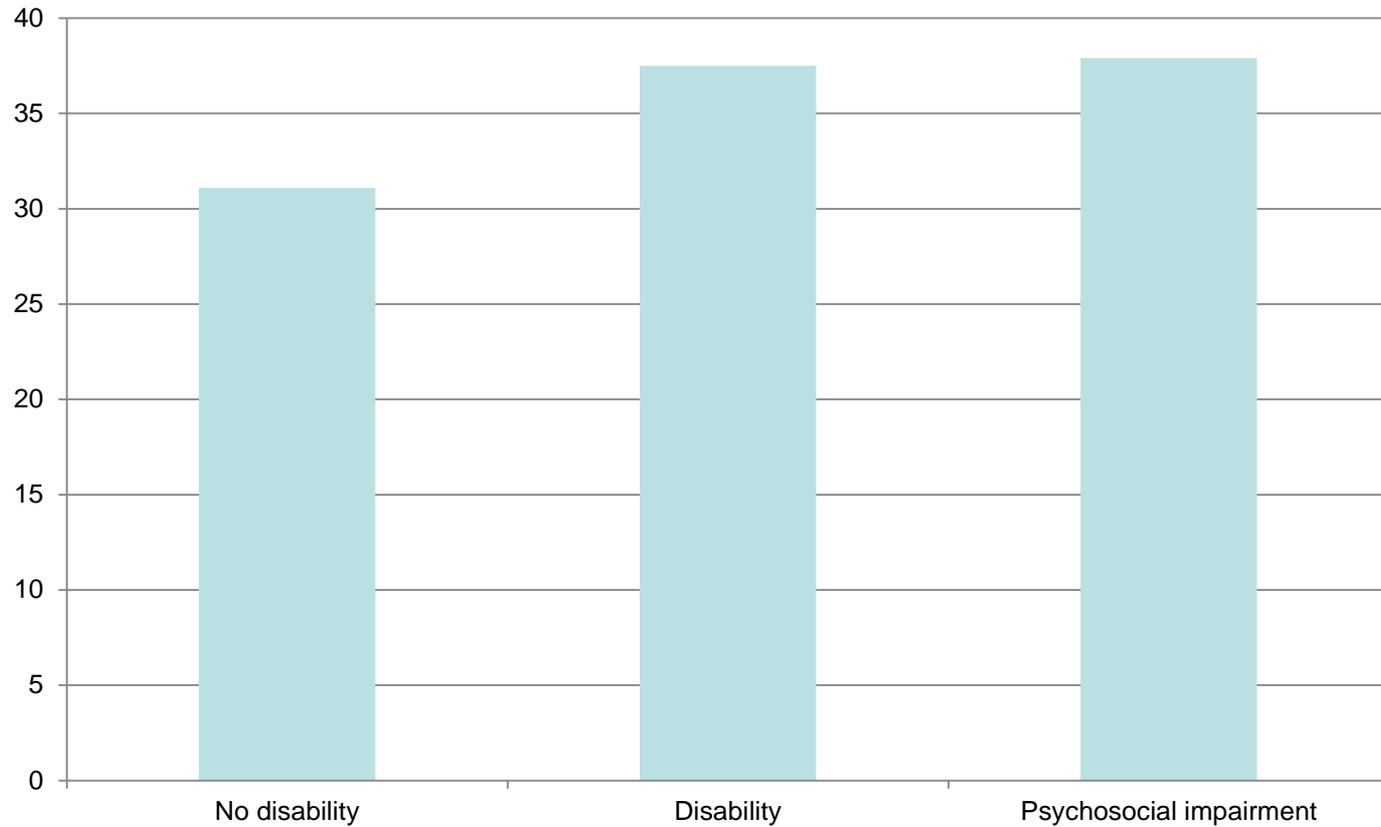


## Unhappy with pay (%)





### Low security





- Very poor employment outcomes for people with psychosocial impairments in terms of participation and job quality
- Low paid employment particularly for people with psychological and intellectual impairments and acquired brain injury:
  - Discrimination
  - Difficulties in adaption of workplaces
  - Limitations of the impairments (more severe)
- People with sensory and speech tended to do better than other groups:
  - age-related
  - people with vision impairments receive non-means tested income support

- Understandings of barriers to social and economic participation
- Better evidence-base regarding health needs of people with disability particular those with psychosocial impairments
- How can current/future services reduce inequalities (e.g. Disability Employment Services)
- What are the locational/community resources that can enable people with disability live a more fulfilling life?

- Importance of numbers for advocacy
  - How will the NDIS address some of these needs
  - How are the mainstream and disability service sector responding to the aspirations and needs of people with psychosocial impairment?
  - How could they better address their needs and aspirations?
  - Importance of monitoring and evaluation



## Disability and health inequalities in Australia

### Research summary

Addressing the social and economic determinants of mental and physical health



#### Introduction

Approximately one in five Australians has a disability. Disability may occur at any time in a person's lifetime or may be present from birth. Some disabilities may be obvious, while others are hidden.

Disability cuts across age, sex, race and socioeconomic background. Yet people with disabilities are rarely identified as a priority population group in public health policy and practice.

Despite the high prevalence of disability, Australian evidence regarding the health of people with disabilities is sparse. The Australian and international evidence that does exist shows that the health of people with disabilities is worse than that of their non-disabled peers across a range of health outcomes such as obesity, diabetes, oral health and mental health (WHO & World Bank Group 2011). Much is known about medical conditions that can cause disability and this is well documented in the medical literature. Many of the health differences are, however, socially determined, rather than due to particular characteristics of the disability itself (Emerson et al. 2011).

People with disabilities are more likely to live in poverty, have poor-quality or insecure housing, low levels of workforce participation and education, and be socially excluded or marginalised; they may also face violence and discrimination related to their disability and have difficulty accessing appropriate health care (WHO & World Bank Group 2011).

This report defines disability and provides an overview of information regarding the health of people with disabilities and the underlying social determinants, using the population-based data that is available.

We live in one of the wealthiest countries in the world and yet all too often people with disabilities struggle to access the very necessities of life – somewhere to live, somewhere to work. All too often they are unable to access education, health care, recreation and sport – the very things most people in the community take for granted.

*National People with Disabilities and Carer Council 2009.*

#### Defining disability

Disability is a complex, contested, evolving concept. Definitions of disability are important because they can directly affect the lives of people with disabilities through, for example, eligibility criteria for programs and benefits, policies and legislation.

The United Nations (UN) *Convention on the Rights of Persons with Disabilities*, which Australia ratified in 2008, describes disability as resulting "from the interaction between persons with impairments and attitudinal and environmental barriers that hinders their full and effective participation in society on an equal basis with others" (United Nations General Assembly 2007).

This definition distinguishes the impairment or health condition (e.g. paraplegia) from the restrictions on participation in society (e.g. unemployment due to discriminatory recruitment practices). The restrictions on participation are not an inevitable consequence of the impairment; they are a result of unfair and avoidable barriers.



- **Kavanagh AM**, Bentley R, LaMontagne, Baker E, Beer A, Mallett S, Howe K, Kelly M. The importance of gender and socio-economic disadvantage for the mental health of people living with disabilities, (2011-2013) VicHealth \$75,000
- **Kavanagh AM**, Bentley R, LaMontagne, Baker E, Beer A, Mallett S, Howe K, Kelly M. The importance of gender and socio-economic disadvantage for the mental health of people living with disabilities, ARC Linkage Project Grant (2011-2014) \$281,992