

# What makes housing inclusive? Multi-stakeholder perspectives on inclusion and well-being for people with intellectual disabilities

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**Abstract:** Inclusive housing for people with intellectual disabilities has increasingly replaced institutional models in policy discourse. However, less attention has been paid to how housing becomes inclusive in practice and how accessibility principles translate into everyday living environments. This qualitative study explores what makes housing inclusive from a multi-stakeholder perspective, drawing on five focus groups conducted in Spain with people with intellectual disabilities, family members, professionals, policymakers and community representatives (n = 36). An inductive thematic analysis identified five interrelated environments shaping residential inclusion: physical, social, supportive, community and symbolic. Findings show that inclusive housing cannot be reduced to compliance with architectural standards or small-scale provision. Instead, it emerges from the interaction between accessible and adaptable design, cognitive and sensory accessibility, personalised and flexible support, meaningful social relationships and active connection to the surrounding neighbourhood. Participants emphasised the importance of spatial personalisation, privacy, life-course adaptability and continuity of support as central to experiencing housing as home. At the same time, rigid funding schemes, housing market barriers and gendered inequalities limit real choice and the effective implementation of independent living. The study conceptualises inclusive housing as a lived, relational and place-based process aligned with Design for All principles, linking built environment design, support systems and structural conditions in the production of wellbeing.

**Keywords:** inclusive housing, Design for All, accessibility, intellectual disabilities, community inclusion, built environment, independent living.

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## 1. Introduction

In recent decades, there has been a shift away from institutional residential models towards more inclusive forms of housing for people with intellectual disabilities, grounded in principles of autonomy, independent living and community inclusion. This shift has been influenced by the *Convention on the Rights of Persons with Disabilities* (United Nations, 2006), which establishes the right to live independently and be included in the community as a fundamental human right.

Despite this growing international consensus, access to adequate, sustainable and genuinely inclusive housing remains a structural challenge. Shortages of accessible housing, rigid service models and persistent institutional logics continue to restrict real opportunities to develop life projects within the community (Eley et al., 2009; Wright et al., 2017; Versegny et al., 2019). Research has shown that relocation from institutional settings to community-based housing does not, in itself, guarantee inclusion or that housing will be experienced as home, a process often described as transinstitutionalisation (McConkey et al., 2005).

This requires attention to the everyday logics through which housing arrangements may reproduce or challenge institutional forms of control. From this perspective, institutionalisation is not only a matter of building type, but also of routines, rules and normalising practices that regulate daily life (Foucault, 1977). Similarly, stigma and labelling processes shape whether housing is socially recognised as an ordinary home or as a marked and exceptional setting (Goffman, 1963). These perspectives are consistent with relational approaches in health and social geography, which understand wellbeing as produced through interactions between people, material environments, social relations and available resources (Duff, 2011).

Beyond material and support-related conditions, housing also has a symbolic dimension that helps explain how a dwelling becomes a home. This dimension refers to the personal, social and cultural meanings that people assign to the spaces they inhabit, which shape identity formation, sense of belonging and emotional wellbeing (Quesada-Cubo et al., 2025). In this sense, home can function as a space of refuge, self-expression and self-realisation, supporting holistic wellbeing across social, physical, emotional, material and spiritual domains. For people with intellectual disabilities, however, this symbolic dimension may either support dignity, agency and recognition, or reproduce stigma, dependency and exclusion when choice, privacy and self-expression are limited. This understanding resonates with recent work on ontological security in housing, which links home to stability, control, belonging and the relational conditions that make everyday life feel secure (Plage et al., 2023). From a health and social geography perspective, housing should therefore be understood not merely as a physical space, but as a key social determinant of biopsychosocial wellbeing, with direct impacts on physical, psychological and social health (Wright et al., 2017). When physical, social or relational barriers are present, residential environments may become disabling, reproducing experiences of control, dependence or isolation (Yuzwa et al., 2025). This place-based perspective is particularly relevant for people with intellectual disabilities, whose experiences of housing are shaped not only by accessibility or support provision, but also by recognition, choice, relationships and participation in everyday life.

Previous studies have identified factors associated with positive residential experiences, including smaller-scale living arrangements, personalised support and opportunities for social participation, highlighting the role of housing context in everyday living environments (Bowey et al., 2005; Stainton et al., 2011; Friesinger et al., 2019). However, there remains limited clarity about how these factors interact in everyday life to enable housing to be experienced as inclusive and meaningful, particularly from the perspective of people with intellectual disabilities themselves. Their voices have often been mediated through professional or family discourses, shaping how residential needs and preferences are interpreted and acted upon (Rapley and Beyer, 1996; McConkey et al., 2004).

People with intellectual disabilities are a heterogeneous group, characterised by diverse life trajectories, aspirations and support needs. This diversity challenges standardised residential solutions and reinforces the need for flexible and personalised approaches that can adapt across the life course (Randell and Cumella, 2009; Ellis et al., 2020). In line with Design for All principles,

inclusive housing therefore cannot be conceived as a uniform technical solution, but as the outcome of environments that are accessible, adaptable and responsive to diverse users.

In this article, Design for All is understood as the integration of physical, cognitive, sensory and social accessibility into housing and neighbourhood environments from the outset, together with adaptability across the life course and compatibility with personalised support. This approach links accessibility and wellbeing by making everyday environments more legible, manageable and emotionally secure, thereby supporting autonomy, orientation and self-determination (Barnes, 2011; Yong et al., 2023).

The aim of this study is to explore the factors that shape inclusive housing —understood not as a specific residential model but as a lived place shaped by material, social and relational conditions— as experienced by people with intellectual disabilities, drawing on the perspectives of multiple stakeholders. To do so, the analysis applies the five-environment framework developed by Quesada-Cubo et al. (2025) —physical, social, supportive, symbolic and natural environment— to examine how these dimensions interact in everyday living environments.

## 2. Methodology

### 2.1. Design and approach

The study adopted a qualitative phenomenological and interpretative approach, from a constructivist perspective, suitable for exploring subjective and contextual experiences related to social and attitudinal barriers (Taylor and Bodgan, 1987; Kitchin, 1998). Discourses were understood as situated expressions linked to specific social positions. Collective identities are shaped by processes of categorisation of social reality, through which groups develop shared meanings, delimiting boundaries between "us" and other social groups (Berger and Luckmann, [1966] 1984; Águila, 2023, 2024).

The study formed part of a R&D&I national research project FRI-HOUSING (Friendly Housing) "Inclusive and sustainable environments for people with intellectual disabilities. Diagnosis and evaluation of items for the identification of 'friendly housing'", involving 11 universities and more than 35 specialist researchers with expertise in intellectual disability, housing, and/or social inclusion.

### 2.2. Participants and sampling

Participants were recruited in Spain through intentional, heterogeneous sampling stratified by stakeholder group. Thirty-six participants took part in five focus groups: 1) people with intellectual disabilities; 2) family members; 3) neighbours and community agents; 4) policy and institutional stakeholders; 5) professionals and researchers with expertise in the field.

Group composition ensured sociodemographic and residential context diversity to guarantee heterogeneity, but these were not used as analytical categories, as the analysis focused on the stakeholders as analysis units, understanding their discourses as expressions of meaning schemes, collective habitus, and differentiated social positions (Martín-Criado, 1997). Detailed characteristics are presented in table 1.

### 2.3. Technique and instrument

Focus groups were selected for their suitability in exploring interactional dynamics and facilitating collective construction of meanings in context with limited prior knowledge. In the field of intellectual disability, it facilitates collective expression and reduces barriers associated with written communication (Kitzinger, 1994; Sim, 1998).

A semi-structured script with open-ended questions was used, organised around seven thematic areas: space and infrastructure, economic and management aspects, political and institutional aspects, social relations, personal development, and gender.

### 2.4. Procedure and data analysis

Sessions were held between January and March 2025 and led by two researchers.

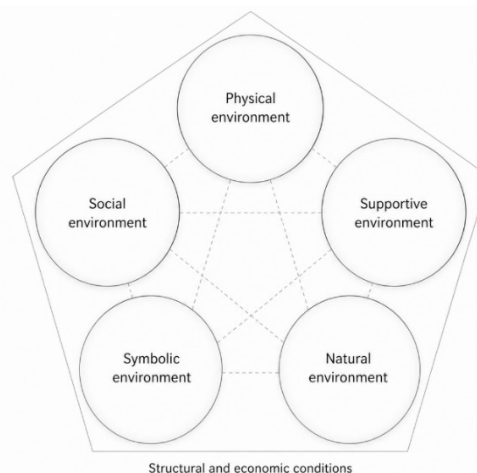
Participants completed a sociodemographic questionnaire and signed an informed consent form. The study was approved by the Ethics Committee for Studies Involving Human Subjects (CEIH) at Pablo de Olavide University (Protocol Code: 24/4-5). Inclusive research adaptations were incorporated to support the participation of people with intellectual disabilities. Information and consent materials were provided in accessible language, and the study aims were explained orally before the session. The discussion guide used short, clear and open-ended questions, avoiding technical terminology. Participants were given sufficient time to respond, and facilitators used clarification and reformulation when needed.

Data were analysed using inductive thematic analysis supported by Atlas.ti (v. 25), combining inductive and abductive logic. Credibility was strengthened through intersubjectivity discussion among researchers, the systematic review of emerging codes and themes, and the inclusion of representative quotations (Ruiz-Ruiz, 2009).

## 3. Results

The findings show that inclusive housing is produced through the interaction of five interconnected environments shaping the residential experience. A complementary section addresses the structural and economic conditions influencing independent living, with gender inequalities considered across the analysis. This conceptual structure is synthesised in Figure 1.

*Figure 1. Conceptual model of inclusive housing: five interconnected environments shaped by structural and economic conditions.*



### 3.1. Natural environment

This dimension was mentioned less frequently than other domains, but was valued for its therapeutic, and emotional role. Access to green spaces or contact with nature and animals was associated with more pleasant and balanced living environments.

One neighbourhood participant summarised this idea by pointing out: "*The connection with nature, animals [...] It connects you more with who you are than with what you think*" (P5, neighbourhood).

Overall, this dimension was understood as a complementary facilitator of wellbeing rather than a central element of residential inclusion.

### 3.2. Physical environment

#### 3.2.1. External infrastructure: scale, model and environment

Criticism of institutional models was widespread, particularly among families and professionals. Traditional residences were described as rigid environments organised around functional logic that subordinate individual needs. As several professionals point out: "*The organisation of a macrostructure always prevails over daily needs, which are evolving and changing*" (P1, professional).

This criticism was not directed not at the size of facilities but at their underlying logic, as institutionalisation was understood to depend less on buildings than on how support is organised: "*It's not the walls that make the institution... you can care for three people in a small space and still be an institution*" (P3, professional). Deinstitutionalisation therefore requires transforming service logics.

Families expressed ambivalence, combining mistrust of large facilities with concern about the lack of alternatives, especially in situations of ageing carers or care-related crises, such as health deterioration or loss of informal support. This resulted in limited real choice and reinforced socioeconomic inequalities: "*If I want a residence closer to my home, I have to wait four or five years*" (P3, family member).

Across groups, there was consensus that no single residential model is appropriate for everyone, highlighting the need for flexible solutions tailored to individual life projects: "*Generalising a model is repeating the institutional model. Each person should live in a different home*" (P4, professional).

Participants across stakeholder groups identified location as crucial for autonomy and inclusion, particularly access to transport, health centre and everyday services. However, tensions arise between centrality and periphery, giving rise to the rural-urban debate, as some value the tranquillity of less dense environments and closer relationships.

Residential continuity and familiarity with the neighbourhood were seen as protective: "*It gives them more security... knowing the place perfectly*" (P5, family member); while forced moves were experienced as disruptive and distressing: "*At the end of your life, you are in an unfamiliar place... that you have not chosen*" (P4, professional).

Neighbourhoods could function either as sources of informal support — "*If you have a question, you go to the shopkeeper*" (P3, family member)— or as sites of stigma — "*Because they classify us. It seems that we are inferior to them*"— (P2, person with an intellectual disability), indicating that inclusion depends on active community mediation rather than physical presence alone.

Environmental accessibility was understood in broad terms across stakeholder groups, encompassing physical, cognitive and procedural dimensions. Cities were widely described as still largely inaccessible, highlighting the need for improvements in transport, signage and everyday access.

Clustered housing elicited ambivalent views. Most families, professionals and neighbours agreed that a high concentration of housing units for people with disabilities in the same location can generate segregating dynamics, often described as “ghettos”. This is not due to proximity itself, but to the risk that such concentration may limit interaction with the wider community and a lack of social diversity. As one participant explained: *"It is important to live with other people with disabilities but isolating them in specific groups goes against their integration into society... you need diversity to grow"* (P6 and P4, neighbours). More nuanced positions emerged mainly among policy and institutional stakeholders, who accepted small-scale or limited forms of clustering—understood as a relatively small number of housing units located in proximity—when clearly linked to community connection and the sustainability of support.

Tensions also emerged around the visible identification of residential resources for people with intellectual disabilities (e.g., through signage or external markers). While professionals and policy actors tended to avoid explicit identification due to its potential stigmatising effects, some neighbourhood participants supported more standardised forms of identification as a way to promote visibility and mutual understanding. The central dilemma lay in how to make housing recognisable without reinforcing labels.

### 3.2.2. Internal infrastructure: spatial design and material and technological resources

With regard to the interior of the home, there was broad agreement that accessibility should be understood in a comprehensive way and not limited to the removal of architectural barriers. Across stakeholder groups, participants emphasised the need to incorporate cognitive supports, clear signage, accessible instructions for domestic appliances and predictable spatial organisation. The adequacy of many existing resources was questioned: *"Are residences for people with disabilities really adapted so that they feel comfortable there? No. Most are not"* (P2, family member).

Physical accessibility was identified as essential. Elements such as lifts, ramps, wide doors, adapted bathrooms and ground-floor dwellings were repeatedly prioritised. From a technical and institutional perspective, participants advocated a combination of universal design and personalised adjustments, recognising that needs vary depending on the individual and their stage of life.

The personalisation of space emerges as a central condition for housing to be experienced as home. Age, level of support needs and life stage were seen to shape different requirements, calling for flexible designs that can adapt over the life course and take into account sensory accessibility and changing levels of dependence. As one professional stated: *"Decisions about space will be defined by the person, not by the resource"* (P3, professional).

Regarding interior layout, there was broad consensus on the need to balance privacy and shared living. The preference for single bedrooms was almost unanimous, associated with privacy, rest, control and personal and even religious practice. *"In my house, my room alone, just as I like it"* (P6, person with intellectual disability). At the same time, participants valued the presence of sufficiently large, shared spaces that enable interaction and shared activities.

Participants from different stakeholder groups identified the internal scale of cohabitation as another relevant factor. Positive assessments of small-scale arrangements (typically three to four residents) predominated, as these were seen to promote closer relationships and reduce overcrowding. However, professionals warned of the risk of reproducing institutional dynamics in small homes if numerical reduction is not accompanied by changes in how support is organised. Finally, material and technological resources were viewed as potential facilitators of autonomy. Home automation and other domestic technologies were valued when intuitive and accompanied by appropriate training for both residents and staff. However, participants also identified cost and complexity as potential sources of inequality or stigmatisation. This reinforces the view that technology should complement, rather than replace, human support.

### 3.3. Supportive environment

#### 3.3.1. Support conditions and sustainability

The working conditions of support staff emerges as a cross-cutting concern, particularly among professionals and institutional managers. Participants from different stakeholder groups described a sector characterised by low pay, high staff turnover and difficulties in recruiting and retaining qualified personnel, all of which undermine continuity of support and its overall quality. As one institutional manager noted: "*We face a significant challenge: retaining the professionals who are leaving us*" (P4, political-institutional).

This precariousness was linked to the low social value attributed to care work and to the feminisation of the sector, especially in direct support roles. Insufficient staffing ratios and contractual instability were described as generating overload and discontinuity, negatively affecting trust and the development of meaningful relationships. Across groups, there was a shared call for the dignification of support, including formal recognition of professional roles, employment conditions commensurate with responsibility, and an understanding of support as a guaranteed right rather than a voluntary service.

#### 3.3.2. Intensity, flexibility and organisation of support

One of the central debates concerned the intensity of support required. Families and some community members tended to favour intensive and sustained support over time, reflecting a protective perspective, whereas professionals and policy actors emphasised the need for flexible support that can be adjusted across different life stages. As one institutional representative summarised: "*support never diminishes, but its intensity changes depending on the moment*" (P2, political-institutional).

People with intellectual disabilities expressed specific needs for practical everyday support—such as household tasks, organising daily routines or accompaniment—and particularly valued staff availability and proximity: "*I would need someone to be looking out for us*", "*someone who helps us cook and answer our questions*" (P3 and P5, people with intellectual disabilities). At the same time, tensions were evident between aspirations for autonomy and the practical constraints of the environment, especially in areas such as health care and administrative procedures.

Organisational rigidity within many services was identified as a *significant* barrier. Rules relating to visits, schedules or the use of shared spaces were seen to reproduce institutional logics that limit control over one's own home and generate frustration: "*I'd like to be talking in the living room, but they won't let me*"; "*I think that's unfair*" (P5 and P7, people with intellectual disabilities).

Families highlighted the value of gradual transitions towards new living arrangements to reduce anxiety, adjust expectations and support skill development. Stable support figures—such as personal or professional assistants and community connectors—were seen as particularly important for ensuring continuity.

### 3.3.3. Professional competencies and support approach

Person-centred support was consistently identified as the ethical and operational framework guiding practice. Across all groups, there was agreement that support should adapt to individual needs rather than individuals adapting to services, shifting the focus from the resource itself to the person's life project. "*We have to provide support in an individualised way*" (P2, professional).

The ability to choose support was particularly valued, in line with emerging self-directed support approaches. Across stakeholder groups, participants described this as a profound cultural shift: moving from doing for to supporting to and recognising the home as a space of privacy and decision-making. As one professional explained: "*If you're going to be in my home, which is my private space, I'm the one who decides*" (P1, professional). However, participants acknowledged that implementing such approaches remains constrained by persistent structural limitations.

Professionals also stressed the importance of creating safe contexts for self-determination and informed decision-making, providing accessible information, supporting risk assessment and respecting the right to make mistakes as part of learning. "*We must respect people's right to make mistakes*" (P3, professional). In parallel, they emphasised the need to manage expectations realistically without undermining aspirations for autonomy, addressing frustration through emotional support rather than prohibition. Empowerment was thus described as a relational process grounded in listening, horizontality and respect.

Developing skills for independent living was identified as another core competency. Both professionals and people with intellectual disabilities highlighted the value of practical, gradual and context-based learning—such as cooking, shopping, managing appointments or household tasks—that enables progressive gains in autonomy. "*You can give me the push, but I have to carry on to the end*" (P4, person with intellectual disability).

Financial management emerged as one of the most debated areas of support. While people with intellectual disabilities called for greater control over their own money —"*having my money available*" (P5, person with intellectual disability)— families expressed concerns about everyday financial security, reflecting ongoing tensions between protection and autonomy.

### 3.3.4. Families, care and respite

Families continued to play a central role in support, particularly where residential alternatives were limited. Family narratives were shaped by concerns about future respite and continuity of care, influencing both residential decisions and practices of overprotection. These concerns were especially pronounced for women with intellectual disabilities, who were subject to greater restrictions linked to safety.

Professionals and institutional actors questioned the sustainability of the family as the primary provider of care, pointing to extreme situations associated with ageing carers—"*a 60-year-old man cared for by a 90-year-old woman has been told he's better off with his family, and that's simply not true*" (P5, professional)—and to the implicit transfer of responsibility to siblings. Participants agreed on the need for housing models to include clear respite strategies, supported by stable formal services that complement, and when necessary, replace informal care.

There was also broad consensus that progress depends on effective coordination between public administrations, service providers, academia and families. The lack of practical coordination was identified as a structural barrier: *“the lack of bridges between administrations is a huge obstacle”* (P1, professional). Participants called for shared strategies that combine political commitment, specialised training and networking, in order to reduce the gap between policy frameworks and everyday practice.

### 3.4. Social environment

The findings highlight that residential inclusion depends not only on internal living arrangements but also on the quality of social relationships and effective connection with the wider community.

#### 3.4.1. Coexistence and compatibility among residents

The possibility of choosing with whom to live emerged as a central criterion. For many people with intellectual disabilities, living with friends or a partner was associated with relational continuity and a sense of belonging. For families, this choice also represented a source of security and social fit. However, practical limits were recognised, as certain relational or behavioural difficulties could make some living arrangements unviable.

Across all profiles, participants agreed that age and life stage were key criteria for compatibility. From this shared position, divergent perspectives emerged. Families expressed ambivalent views: some valued heterogeneity—including cohabitation with people without disabilities—as an enriching experience, *“My daughter has suffered from her sister’s condition, but it has enriched her enormously”* (P5, family member), while others called for greater homogeneity in type of disability or level of support. In these cases, homogeneity was framed as a condition for appropriate support rather than segregation, often grounded in negative experiences within generalist services.

People with intellectual disabilities clearly prioritised prior relationships and personal choice over diagnostic categories, expressing resistance to being classified through labels: *“It seems like they are classifying us”* (P5, person with intellectual disability). In some cases, particularly among women, preferences were expressed for non-mixed living arrangements, linked to feelings of emotional safety and everyday wellbeing.

From a professional perspective, a more functional approach was adopted, emphasising the compatibility of support needs rather than diagnosis. Participants warned that unplanned heterogeneity could lead to fragmented activities and the reproduction of institutional dynamics. They stressed that choice should be supported through prior processes of getting to know one another and appropriate preparation: *“There have to be programmes so people can get to know each other”* (P6, professional). With regard to cohabitation with people without disabilities, discourses reflected a tension between its potential integrative value and the risk of turning it into a moral obligation that fails to generate meaningful relationships.

Taken together, positive coexistence was understood to depend on basic elements such as mutual respect, communication, shared responsibilities and agreed norms. However, these dynamics were described as fragile in the absence of stable support or when the composition of the living group was poorly matched.

#### 3.4.2. Social network and meaningful relationships

Peer relationships emerged as a key resource for social life. Participation in associations, community groups or inclusive university programmes was seen as facilitating the development

of meaningful relationships and informal support networks. Nevertheless, participants consistently highlighted the limited nature of relationships with people without disabilities, which were often characterised by subtle forms of social segregation. As one family member explained: *"They help you, they're kind to you, but they don't go out with you"* (P6, family member).

Romantic relationships were valued by people with intellectual disabilities as an important source of autonomy and intimacy. However, family discourses revealed ambivalence, shaped by protective concerns and fear of losing control, exposing a gap between formal recognition of affective life and its practical acceptance. *"Sometimes he says he wants to go out with his girlfriend... it's nice that he has his dreams, his fantasies, but..."* (P5, family member).

Experiences of sexuality were clearly gendered. Male sexuality tended to be more readily normalised, whereas female sexuality was framed through discourses of risk, particularly in relation to pregnancy. These perspectives were seen to limit women's effective exercise of the right to choose and to reinforce protective restrictions.

The family remained the main relational and support network, acting as a source of care and mediation with services. At the same time, this centrality generated internal tensions linked to overprotection, fear of future responsibility transfer and the distribution of care among siblings, particularly in narratives shaped by the ideal of the "good mother".

Neighbourhood and community networks were identified as potential protective factors when based on proximity and trust. However, their existence depended strongly on neighbourhood social capital, housing location and active mediation. Without deliberate support and follow-up strategies, there was a risk that social life would remain confined to the home. As one professional noted: *"The key is the support network you have and the community environment you move in"* (P2, professional).

### 3.4.3. Community, participation and connection

Participation in neighbourhood life and in cultural, sporting or religious activities was described as a condition for citizenship and wellbeing. Such activities not only structured everyday routines but also strengthened self-esteem, social skills and natural support networks. However, participants warned of the risk of creating micro-institutional settings when support was concentrated within the home without meaningful links to the surrounding community: *"If we put a person in a home and don't connect them, we've created a mini-institution"* (P1, professional).

Inclusion was widely framed as a shared community responsibility rather than the sole task of people with disabilities or services. This view underpinned the perceived importance of roles such as the community connector and of strategies aimed at distributing responsibility across local actors. As one family member explained: *"Knowing that you, as a community member, as a librarian or a shopkeeper, also have a responsibility in this"* (P1, family member).

Effective participation was further shaped by structural conditions, including accessibility, transport and the availability of inclusive community services. Lack of knowledge was repeatedly identified as a source of stigma and rejection, whereas everyday contact and mutual understanding were seen as key to normalising coexistence. Examples of temporary cohabitation experiences and contexts involving prior community preparation illustrated how inclusion develops through shared experiences and recognition of people with intellectual disabilities as active community members rather than passive recipients of support. As one participant

summarised: *“The main goal of social change is to change the way we look at things”* (P3, neighbourhood).

### 3.5. Symbolic environment

#### 3.5.1. Identity, self-perception and recognition

Access to one’s own home and to more autonomous living experiences had a strong symbolic impact on the identity and self-perception of people with intellectual disabilities. Families, professionals and people with intellectual disabilities themselves agreed that processes of emancipation—even when partial or supported—reinforced self-esteem, a sense of competence and recognition of adult status. As one family member noted: *“I saw her as more autonomous; she took buses and went out with her friends”* (P6, family member).

Concurrently, family discourses revealed significant tensions around the meaning of autonomy. For some families, autonomy was defined in basic functional terms (e.g. personal care or eating), while others set firm limits on what they considered possible or desirable: *“He will never be independent... he won’t live alone or manage his own finances”* (P2, family member). Although framed as protective, these narratives could crystallise dependent identities and anticipate restricted life trajectories.

In contrast, people with intellectual disabilities articulated aspirations aligned with normative life projects—employment, relationships, housing and family—and demanded greater control over time, privacy and everyday decisions, including schedules, visits and personal routines. Excessive rules or constant supervision were experienced as forms of infantilisation that undermined adult identity: *“We are adults now and we also need to go out and enjoy ourselves”* (P2, person with intellectual disability). *Autonomy was thus understood as a gradual process, grounded in personal effort and appropriate support: “What I can’t do in one day, I do in two”* (P4, person with intellectual disability).

From a gender perspective, the findings showed that women with intellectual disabilities were more frequently associated with roles of dependence and care within the family context, which constrained residential emancipation. These trajectories did not always reflect personal choice, but rather gendered expectations that limited access to experiences of autonomy, risk-taking and self-determination.

The possibility of choice and access to understandable information emerged as key components of empowerment: *“If you have a choice... a range of possibilities (...) and you know what you’re choosing”* (P2, political-institutional). Self-perception was also shaped by experiences of stigma and social isolation. Stereotypes and the gaze of others generated discomfort, self-monitoring and withdrawal, while being known and recognised in one’s environment acted as a protective factor against social judgement. Feelings of loneliness were recurrent, linked both to limited meaningful relationships and to a lack of social recognition.

Collectively, the symbolic environment extended beyond housing as a physical space and functioned as a framework for identity validation or denial. Living with support could either foster empowerment or reinforce dependence, depending on the power relations, norms and meanings embedded in everyday life.

#### 3.5.2. Rights, independent living and equality

Beyond individual experiences, the symbolic environment was strongly shaped by a discourse of rights. Professionals and policy actors emphasised that independent living was neither a

concession nor a methodological approach, but a matter of dignity and citizenship: *“It’s an ethical issue... a person shouldn’t be institutionalised”* (P2, professional). Housing was thus framed as a universal right rather than a special or differentiated resource.

From this perspective, housing for people with intellectual disabilities should be *“the same as any other citizen’s”* (P1, professional), avoiding segregating logics and labels that reinforce exceptionality. Equality was articulated in terms of shared rights and responsibilities, including the right to decide, to make mistakes, to participate and to contribute to the community.

However, this rights-based framing coexisted with more conditional discourses, particularly among neighbourhood participants, where the right to housing was sometimes qualified by degree of disability or economic autonomy. This tension highlighted the gap between formal recognition of rights and their practical realisation, shaped by expectations of self-sufficiency and normality.

Professionals also warned of the risk of reproducing paternalistic models under inclusive rhetoric, resulting in *“inclusive”* housing that functioned as mini-institutions, characterised by limited participation in decision-making and predetermined life pathways. In response, self-determination was reaffirmed as a core principle, involving access to accessible information, decision-making support, tolerance of risk and recognition of the right to choose non-normative options. As one participant stated: *“It’s about each person having their own project (...) the possibilities they have and what they can do”* (P3, political-institutional).

From a rights-based perspective, several participants from different stakeholder groups explicitly referred to the double discrimination affecting women with intellectual disabilities. Alongside disability-related inequality, gender-based factors increased vulnerability, particularly in relation to gender-based violence, sexual violence and secure access to housing—issues that remain largely invisible within existing policies and support systems.

### 3.6. Structural and economic conditions

Across all the environments analysed, structural and economic conditions emerged as a determining—and often limiting—factor in the realisation of independent living projects. There was broad agreement that residential autonomy does not depend solely on personal or family will, or on the quality of support, but on an interrelated set of factors including employment, income, access to housing, public funding and a regulatory framework that remains insufficient and fragmented.

#### 3.6.1. Precarious employment and economic fragility

People with disabilities described employment trajectories characterised by precariousness, including part-time contracts, low wages and instability. As one family member explained: *“They are 20-hour contracts... paying 600€”* (P3, family member). This situation generates structural dependence on non-contributory pensions, minimum income schemes or family support, resulting in deeply unequal access to independent living. Families also emphasised how socioeconomic status shapes life opportunities from an early age, reproducing cumulative inequalities over time.

#### 3.6.2. Access to housing and market barriers

Participants from different stakeholder groups identified access to decent housing as one of the main obstacles. Professionals, families and neighbours agreed that the rental market is restrictive and exclusionary, discriminating on the basis of income, profile and disability: *“To rent a flat, they*

*put you through a casting process*” (P2, neighbour). This is compounded by limited housing adaptation and the reluctance of many landlords to make reasonable adjustments. In response, some families resorted to private solutions, such as purchasing housing with their own savings—strategies that are not widely replicable and that reinforce the privatisation of risk.

### 3.6.3. Financing: rigidity of the system

There was widespread agreement that supported housing models are not necessarily more expensive than traditional residential provision when support levels are equivalent: *“It has been empirically proven that it is not more expensive”* (P3, political-institutional). Nevertheless, funding remains tied to rigid places and service models, limiting the personalisation and portability of support. Participants criticised the fact that refusing a residential placement often entails losing access to public funding and called for models in which individuals receive a financial allocation linked to their personal support plan: *“The citizen should be the one with the money and the decision-making power”* (P1, professional). At the same time, it was acknowledged that a substantial proportion of actual support continues to fall on families, without explicit recognition by the system

### 3.6.4. Public policies: fragmentation and territorial inequality

Public policies were identified as a key yet problematic area. Families expressed a persistent sense of institutional abandonment —“fend for yourself”—while professionals and policy makers highlighted the dispersion of competences and lack of inter-administrative coordination as *significant* structural barriers. Regulations were perceived as outdated in relation to current practices and innovation within the third sector —“*people are ahead of what administrations are capable of offering*” (P1, professional)—and significant territorial inequalities between autonomous communities were emphasised. In parallel, some regulatory advances were noted, such as the inclusion of the Home Care and Support Service in the reform of the Dependency Law, which formally recognises the right to develop independent living projects with support.

## 4. Discussion

The findings indicate that inclusive housing should be understood as a relational and situated experience rather than as a residential resource in itself. Living in the community does not guarantee inclusion or experiences of home unless everyday organisational practices are transformed (McConkey et al., 2005; Bigby et al., 2017; Quesada-Cubo et al., 2026). This finding is consistent with Article 19 of the Convention on the Rights of Persons with Disabilities, which frames independent living and community inclusion as rights that require not only residential placement in the community, but also real choice and access to the supports and services necessary to participate on an equal basis (United Nations, 2006). From a Health & Place perspective, inclusive housing emerges as a lived, place-based determinant of wellbeing, produced through everyday practices, relationships and access to social and material resources (Duff, 2011).

The main theoretical contribution of this study is to conceptualise inclusive housing as a lived, relational and place-based process produced through the interaction of five environments: physical, social, supportive, symbolic and natural. In doing so, the model extends supported housing and deinstitutionalisation literature by shifting the focus from the type of residential provision or the transition away from institutional settings to the everyday conditions through which housing becomes, or fails to become, inclusive. This framework moves beyond approaches that focus primarily on housing type, size or physical accessibility, and instead shows how

inclusion depends on the articulation of design, support, social relationships, community connection and rights-based recognition. In practical terms, the findings suggest that architects, urban planners and housing providers should design housing environments that support neighbourhood integration, proximity to everyday services and transport, cognitive and sensory accessibility, adaptable layouts, privacy, voluntary interaction and flexible person-centred support. These implications are particularly relevant to the social and supportive environments, as spatial design alone cannot generate inclusion if housing remains socially isolated or if support is rigid, discontinuous or organised according to institutional logics.

A further finding concerns the differentiated ways in which housing and inclusion are understood across stakeholder groups. While people with intellectual disabilities prioritised choice, privacy and control over everyday life as key markers of adult identity, families and professionals tended to manage these aspirations within frameworks shaped by protection and risk perception. This tension between autonomy and protection is widely documented in previous research (Rogers et al., 1994; McConkey et al., 2004). In this study, it is reflected in residential decisions and support practices that may either enable or constrain self-determination. In this context, the findings reaffirm the existence of limited real choice, restricting opportunities to decide where, how and with whom to live (Eley et al., 2009), and highlight how such constraints are frequently produced through institutional, organisational and spatial arrangements rather than individual capacity.

The results also challenge standardised residential models and reinforce the heterogeneity of people with intellectual disabilities, characterised by diverse life trajectories, preferences and aspirations. This underscores the need for flexible and personalised housing solutions (Versegny et al., 2019; Ellis et al., 2020). In this regard, research on technologically enhanced housing environments, such as smart homes, suggests that design innovations may support autonomy, safety and social connection when integrated with community-oriented and person-centred approaches (Ellis et al., 2020; Turnley et al., 2023). However, our findings indicate that technological solutions alone are insufficient to guarantee inclusion if not accompanied by supportive, relational and community-based conditions.

Although preferences for small-scale and adaptable housing align with earlier studies (Bowey et al., 2005; Stainton et al., 2011), this pattern further reinforces the idea that neither technological innovation nor changes in physical scale alone are sufficient to ensure inclusive living. The analysis shows that reducing scale alone does not prevent the reproduction of institutional dynamics if the underlying logic of support remains unchanged. Supporting informed, non-delegated decision-making and enabling residential choice across the life course therefore emerge as key conditions for inclusive housing (McConkey et al., 2004).

The social environment emerged as a particularly fragile dimension. Coexistence, social networks and community participation were shaped by the compatibility between residents, the stability of support arrangements and the social capital of the surrounding environment. The persistence of limited social relationships and endogamous networks is consistent with earlier findings on the weakness of relational inclusion (Rapley & Beyer, 1996; Bailey et al., 2024). From a spatial perspective, the findings suggest that physical proximity to the community does not necessarily translate into meaningful social connection, as neighbourhood context and built environment play a critical role in shaping everyday wellbeing and participation (Bigby et al., 2017; Friesinger et al., 2019; Versegny et al., 2019; Stoeckel et al., 2022).

From a symbolic perspective, housing functioned as a space of identity validation. Living with support could strengthen self-esteem and social recognition, but it could also reinforce dependent identities when decision-making was substituted or overly supervised. These findings

are consistent with research linking residential self-determination to adult identity and subjective wellbeing (Bigby et al., 2017; Douglas et al., 2023). A gender perspective is particularly salient, as women with intellectual disabilities appeared more exposed to residential trajectories marked by overprotection and restricted autonomy, reinforcing patterns of double discrimination (Traustadóttir & Johnson, 2000).

Finally, the findings indicate that the viability of inclusive living is deeply shaped by structural and economic conditions, including employment insecurity, housing market barriers and rigid funding systems, which contribute to spatially uneven opportunities for inclusion (Fisher et al., 2010; Douglas et al., 2023; Blood et al., 2024).

The qualitative and contextual nature of the study limits the generalisability of the findings. In addition, the perspectives of people with intellectual disabilities with higher or more complex support needs were underrepresented. Although inclusive adaptations were used during data collection, the study did not include validation or co-interpretation of the findings with people with intellectual disabilities. Future research should incorporate participatory analysis or member-checking strategies, alongside complementary and longitudinal methods, to capture a wider range of support needs and examine how experiences of inclusive housing and wellbeing evolve over time and across different territorial contexts.

## 5. Conclusions

This study highlights that inclusive housing for people with intellectual disabilities is not merely a physical resource, but a lived, relational and place-based social process that shapes autonomy, identity, wellbeing and community participation. Drawing on the perspectives of multiple stakeholders, the findings show that independent living does not fail due to a lack of individual aspirations, but because physical, social, support and economic environments often fail to sustain it (Wright et al., 2017; Quesada-Cubo et al., 2026).

By conceptualising inclusive housing as a lived place produced through interactions across domestic, neighbourhood and structural levels, the study underscores the need to move beyond rigid residential models towards flexible, personalised and sustainable solutions that can respond to diverse life trajectories. Strengthening direct participation in residential decision-making and the advancement of rights-based approaches, consistent with the principle of “nothing about us without us”, are central to this process.

The findings also reveal how formal equality continues to coexist with practical inequalities, particularly affecting women with intellectual disabilities, highlighting the importance of integrating a gender perspective into housing, support and policy frameworks. These inequalities are not only social but also spatial, reflected in differential access to housing options, support networks and opportunities for independent living.

Taken together, promoting inclusive and independent living requires moving beyond dwelling-level solutions towards the development of health-promoting places, supported by coordinated housing, care, accessibility and community policies. From a Design for All perspective, this involves embedding physical, cognitive and social accessibility within planning and design processes from the outset, ensuring that housing environments anticipate diversity and remain adaptable across the life course. Recognising people with intellectual disabilities as full citizens with diverse and legitimate life projects requires sustained attention to spatial, social and structural conditions. It also requires attention to how design decisions shape equal opportunities in everyday life.

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During the preparation of this article, the authors used ChatGPT (OpenAI) to assist with the translation of portions of the manuscript into English and to improve language clarity and grammar. After using this tool, the authors carefully reviewed and edited the content as needed and assume full responsibility for the final version of the manuscript.

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## 8. Appendix

*Table 2. Sociodemographic characteristics of the focus groups.*

Profiles	N	Gender	Age (range/mean)	Level of education	Specific selection characteristics
Persons with intellectual disabilities	7	4 male 3 female	23–61 years ( $\bar{x}$ = 36.42)	Primary education (1); secondary education (2); vocational training (2); degree from the University of Training for Employment and Independent Living (2).	Degree of disability: mild (3), moderate (3) and severe (1). Residents in: supervised housing (3), family homes (3) and institutionalised residence (1). Occupation: employed (1), unemployed and seeking employment (4), pensioner (2).
Family members	7	3 male 4 female	56–62 years ( $\bar{x}$ = 59.57)	Secondary education (3); university studies (4)	Parents or guardians with varying levels of support needs: extensive (1), limited (3), intermittent (3). Employment status: active (3), inactive (4). Monthly income: between €583 and €1,500 ( $\bar{x}$ = €1,038)
Neighbourhood and community environment	7	2 male 4 female	28–66 years ( $\bar{x}$ = 46.3)	Primary education (1); secondary education (2); university studies (4)	Neighbours living in different types of housing (2), members of community associations (3) and volunteers from community organisations (2). Employment status: active (3), inactive (4). Monthly income: between €1,800 and €3,250 ( $\bar{x}$ = €2,533)

Profiles	N	Gender	Age (range/mean)	Level of education	Specific selection characteristics
Political agents and representatives of organisations	7	3 male 4 female	45–65 years ( $\bar{x}$ =56.28)	Secondary education (1); university studies (6)	Political representatives with responsibilities in housing and/or disability (3), representatives of the boards of directors of public and private organisations (4).  Territorial scope: regional (3), local (4)
Professionals and research staff	8	2 male 6 female	36-65 years ( $\bar{x}$ = 49.37)	University studies (5); PhD (3)	Regional directorate of national disability association network (2) professionals from private entities (3), university lecturers and researchers specialising in the fields of psychology, sociology and sports science (3).

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