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Seeing is believing: changing attitudes to disability.

*A review of disability awareness programs
in Victoria and ways to progress outcome
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Acronyms

CI&D	Community Inclusion and Development
SYA	Scope Young Ambassadors
TRA	Theory of reasoned action
TPB	Theory of planned behaviour

Section one: Introduction

Background

Scope is one of the largest providers of services to people with a disability within the state of Victoria. Scope provides a range of services to both rural and metropolitan communities. Traditionally Scope's client group primarily included people with physical disabilities, particularly cerebral palsy, their families and carers. These services included accommodation, therapy, adult day services, respite and employment services. Over time the focus of Scope services has shifted to encompass people with a wide range of disabilities as well as focusing beyond service delivery to community development activities. Scope's mission is to provide integrated services that enable people with physical and multiple disabilities to achieve their potential in welcoming and inclusive communities (Scope, 2005). This involves not only working with people with disabilities, families and carers, but also working with the wider community to create a more accessible, accepting and inclusive society.

Scope's mission led to the creation of the Community Inclusion and Development unit in 2001. During the period 2001-2007, the Community Inclusion and Development unit (CI&D unit) aimed to work in collaboration with people with disabilities and their families, organisations, government departments and other key stakeholders, to resource and support people with disabilities to enhance their active participation in a more inclusive Victorian community. The CI&D unit aim incorporated and worked towards the five priority goals as stated in Scope's Strategic Plan 2005-2008:

- To provide person centred and family centred support.
- To work with others to create welcoming and inclusive communities.
- To improve organisational effectiveness and efficiency.
- To increase Scope's influence.
- To increase Scope's financial independence (Scope, 2005).

Scope's strategic goals and the CI&D unit aim are also closely related to the *Victorian State Disability Plan 2002-2012* (Department of Human Services, 2002). This plan states that by 2012, Victoria will be a stronger and more inclusive community; a place where diversity is embraced and celebrated; and where everyone, regardless of their abilities, has the same opportunities to participate in the life of the community (Department of Human Services, 2002: 7). The State Disability Plan includes the specific goal of building inclusive communities, similar to that of Scope's second strategic goal. The State Disability Plan recognises the need to

strengthen the Victorian community so that it is more welcoming and accessible, so that people with a disability can fully and equally

participate in the life of the Victorian community. Building inclusive communities means strengthening communities so that people with a disability have the same opportunities as all other citizens of Victoria to participate in the life of the community – socially, economically, culturally, politically and spiritually (Department of Human Services, 2002: 9).

The CI&D unit worked towards each of Scope's five priority goals, as well as the goals of the State Disability Plan in a number of ways. One approach to creating welcoming and inclusive communities is through community disability awareness programs. The CI&D unit offered a range of community education and training programs designed to change the way community members think and act in regards to disability.

Community education

Raising community awareness regarding disability is a key component in creating more welcoming and inclusive communities. Some of the barriers that have been recognised in creating welcoming and inclusive communities are physical and attitudinal barriers. Communities within Victoria are becoming more accessible through physical measures with the introduction of building requirements, such as ramps, and also through the public transport system, which is becoming more wheel-chair friendly. Through such measures, people are becoming increasingly aware of the physical barriers people with disabilities face and how the community can help reduce these barriers.

Reducing attitudinal barriers can be somewhat more challenging. Although people with disabilities have existed in all societies, "the degree to which they are integrated or excluded varies according to predominant cultural perceptions" (Priestly, as cited in Yazbeck, McVilly & Parmenter, 2004: 97). As Yazbeck et al argue:

Developing an understanding of the attitudes that predominate in a community, which in turn influence the actions of its members, is critical if we are to bring about social change and ...[promote] an inclusive society (Yazbeck et al., 2004: 97).

Yazbeck et al (2004: 109) conducted a study of attitudes towards people with a disability within Australia and found that despite the introduction of inclusive legislation, such as the State Disability Plan (Department for Human Services, 2002) and *A Fairer Victoria* policy (Victorian State Government, 2005), disability phobia still exists in Australia. The study concluded that the best predictor of attitude towards people with a disability is a person's prior knowledge of or experience with a person with a disability (Antonak et al. as cited in Yazbeck et al., 2004: 109). This finding relates to the premise that a general education campaign through the mass media, would be a first step towards raising the profile, experiences and needs of people with a disability (Disability Services, 2001: 8). Yet while raising general awareness is important, it is also recognised that attitude change occurs mainly through

personal contact with a person with a disability (Lippa, 1994: 243; Disability Services, 2001: 16). It is as a consequence of findings such as these that the CI&D unit at Scope conducts community disability awareness programs.

Aim

This study was initiated by the Scope CI&D unit in order to increase understanding of the evidence surrounding attitude change, particularly related to attitude change of community members towards people with a disability. In recognition of the explicit role of disability awareness programs to date as a mechanism of attitude change, the study also aimed to broadly determine the extent and type of disability awareness programs in Victoria, and to assess the outcomes of these. Finally, the study aimed to explore possible methods for better determining the outcomes of such programs in terms of their effect on attitude and behaviour change.

For the purpose of this project, the following goals were defined:

- To map what formal disability awareness programs are conducted by Scope and other organisations throughout Victoria;
- To determine the nature and aim of each program and how they operate;
- To find out what, if any, evaluation has occurred for each program;
- To establish any patterns of success regarding the programs that operate throughout Victoria;
- To undertake a search for literature regarding attitude change and evaluation of attitude and behaviour change through awareness programs;
- To establish any links between the programs that operate, how they operate and current theory regarding attitude change;
- To use the gained knowledge to propose a framework that may lead to the development of a tool to better measure attitude change resulting from disability awareness or community education programs.

Method

Research was conducted during September to December 2006. This study used a variety of methods to gain the relevant material needed for the project. These methods included:

- An internet search, identifying Victorian based disability awareness programs;
- Contacting and interviewing (in person or over the phone) the coordinators of each identified program to determine program format and outcomes of each program;
- Discussions with program presenters and observations of programs to determine program ingredients and outcomes;

- Review of literature regarding community attitudes of people with disabilities, community awareness campaigns and attitude change.

The internet search helped to identify twelve organisations, including Scope, that deliver disability awareness programs regularly. The majority of organisations are not for profit agencies that focus on the field of disability. Most of the agencies are Victorian based, with a small number being national in scope. Each website gave brief descriptions of the organisation, the awareness programs they run, how the awareness programs are conducted and who their intended markets are. One of the twelve organisations to have disability awareness programs on their website no longer conducts awareness training. This is due to the cost that awareness training involves and the lack of research into how effective the programs actually are.

Each website gave a contact name and email or phone number as a contact point. Initial contact was made with each organisation either through email or over the phone and interview times were arranged. Each organisation was asked a number of questions regarding the disability awareness programs they conduct, what these programs involve and any evaluation that has been undertaken (refer to Appendix One for complete list of questions asked of each organisation). Discussions were held with both the coordinators of the programs and program educators (i.e. program presenters) where possible. Two of the organisations hold awareness programs in schools, and three of these school sessions were observed to gain a clearer understanding of what the programs involve. In this way, each of the twelve organisations identified as currently operating formal disability awareness programs in Victoria provided data for this study. Due to the interest from participants, it was decided to publish a full listing of disability awareness programs currently provided in Victoria as an appendix to this report.

A literature review was conducted using internet databases as well as library resources. The main databases used were Proquest 5000 and Informat databases. Library resources were related to the field of social psychology, which is the study of how people influence people (Lippa, 1994: 4), as well as health promotion. Given the enormous breadth of work undertaken around attitude and behaviour change, this literature review has attempted to summarise the major theoretical positions, as well as identify useful information related to actualising theories into practices related to disability awareness programs. However, to do this area justice a much longer study would be required. A significant resource for this work has been Kevin Murfitt's recent doctoral thesis (Murfitt, 2006) which has summarised much of the literature relevant to changing attitudes towards people with a disability. Researchers also met with Dr Murfitt of Deakin University to discuss key theories and approaches.

Section Two: Data analysis

This section includes presentation of relevant literature in regard to the process and measurement of attitude and behaviour change, as well as data from interviews with presenters of existing disability awareness programs in Victoria.

This section seeks to:

1. Outline the prevailing ideas about attitude change;
2. Outline some methods for the measurement of attitude and behaviour change;
3. Identify the key components of the existing disability awareness programs in Victoria.

The final section (Section Three) will seek to propose some ways forward for both the further development of disability awareness programs and their evaluation.

Literature Review

Creating Inclusive and Welcoming Communities

One of the key goals of the *Victorian State Disability Plan 2002-2012* is to build inclusive communities (Department of Human Services, 2002: 11). Yet despite the introduction of inclusive policy such as this, many Victorians still face inequalities and barriers to fully participating in their community. The creation and strengthening of inclusive and welcoming communities would involve reducing these inequalities and barriers that people with disabilities may face.

The State Disability Plan defines inclusive communities as involving a number of factors. Inclusive communities are places where:

- People have a sense of belonging;
- People can contribute to the community with a shared sense of the responsibilities of citizenship;
- People can participate in all aspects of community life;
- People are valued for the contributions they make to the community;
- Families are valued and supported;
- People have their rights respected and can take action if they are discriminated against;
- People have strong social, cultural and volunteer networks;
- People are listened to for their views on local issues;
- Supports and services respond to the needs of local community

(Department of Human Services, 2002: 35).

In short, a welcoming and inclusive community will allow all people, regardless of their abilities, to participate fully in their community through a number of avenues.

As mentioned, there are a number of barriers still existing within society, preventing many people from fully participating in their community. Both physical and attitudinal barriers can prevent communities from becoming fully welcoming and inclusive. While physical barriers can be relatively easy to overcome, such as installing ramps for wheelchair access to buildings, reducing attitudinal barriers is more complex. Attitudinal barriers are reinforced and perpetuated by “non-supportive environments without opportunities for social interaction” (Rillotta & Nettelbeck, 2007: 20). Inclusion is therefore dependent on the provision of information and education as well as opportunities for interaction between people with and without disabilities (Rillotta & Nettelbeck, 2007).

Definition of Attitude and the Link to Behaviour

Attitude

Lippa (1994: 21) defines attitude as a learned evaluative response, either positive or negative, directed at an object or person. Attitudes can affect a person's behaviour, bias a person's perception and processing of information, and motivate social cohesion and conflict (Hilton & Von Hippel, as cited in Murfitt, 2006: 21). Attitudes are social phenomena, which emerge from and are embedded in social interaction (Wood, as cited in Murfitt, 2006: 48).

Broadly speaking, attitude theorists postulate that we develop attitudes in three ways:

1. we learn attitudes through conditioning and modelling,
2. we form attitudes to serve needs in our personality, and
3. we think through our attitudes logically, developing them from related beliefs and attitudes or inferring them from our behaviour (Lippa, 1994: 220).

Attitudes can be enduring though some authors argue that, because they are learned behaviours and highly dependent on the quality of information that informs them, they are also susceptible to change (Rillotta & Nettlebeck, 2007; Olson & Zanna, 1993).

Our attitudes help us to evaluate the people, places and things we encounter each day (Lippa, 1994: 211). Murfitt (2006) argues that most researchers agree that attitude is formed/expressed *after* an individual evaluates the pros and cons of an issue. That is, attitude is an evaluative process, albeit influenced by a range of less explicit mechanisms (ie cultural norms, beliefs and discourses).

Behaviour

We all have attitudes, and these attitudes influence our behaviour in many complex ways. Theorists have diverse explanations about the link between attitudes and behaviour, and the various contributing factors that affect behaviour (where attitude is only one of these). Murfitt (2006) argues that a widely accepted explanation of the link between attitude and behaviour is the Theory of Planned Behaviour (a modification of an earlier Theory of Reasoned Action). This theory identifies the contributing factors that influence behaviour to be:

- attitude toward the behaviour (based on evaluations of the outcomes from this behaviour);
- subjective norm (that is, ideas about conforming with the beliefs of others); and
- perceived behavioural control (that is, perceptions about the person's skills, opportunities and resources to undertake the behaviour) (Murfitt, 2006: 30 citing Ajzen & Madden, 1986).

The Theory of Planned Behaviour also states that having a detailed plan of action is important to ensure success of the new behaviour (Schifter & Ajzen, 1985: 844).

Murfitt (2006) highlights that behaviour is also influenced by a range of additional factors including one's emotions (likes and dislikes), perceived moral obligations, and self identity, among others. Different factors may be more or less influential depending on the context in which the behaviour occurs (Murfitt, 2006).

It is because of the great influence attitude has over human behaviour that much study has been conducted regarding the phenomenon of attitude. Whilst a sizeable body of research has been undertaken around changing attitudes towards marginalised groups or overcoming stereotypes, less work has been undertaken specific to disability. To date, there are only a small number of studies which have focused on attitudes towards people with disabilities and their integration into wider society in Australia with most studies focusing on integration in education settings (Yazbeck et al. 2004: 99).

Understanding of attitude change in fields outside of disability

While there has been limited study regarding disability and attitude change, there has been extensive study on general attitude change or attitude change regarding other fields. Theories of attitude change outlined in these studies shed light on the often tacit understandings underpinning disability awareness education.

There are many theories of attitude change discussed in the literature. Perhaps the most significant divide is between those that emphasise the importance of exposure as a key driver of attitude change, and those that argue for a more complex set of factors influencing this.

The theory of exposure or contact

Zajonc (2001) argues that "repeated exposure to something is sufficient to change an individual's attitude towards it" (Rillotta & Nettelbeck, 2007: 19). This draws on Allport's theory which argues that "contact with members of a stereotyped or minority group leads to more positive attitudes" about them (Murfitt, 2006: 54 citing Allport). This emphasises the importance of direct contact with the attitude object (ie representative/s of the group about which the negative attitudes are held) as a mechanism of attitude change.

Recent commentators have argued that exposure is not sufficient of itself, but is dependent on a range of factors for its impact (eg. Yazbeck et al, 2004). Allport (cited in Rillotta & Nettelbeck, 2007) argues that the nature of the exposure or contact is critical, along with its frequency, duration and perceived status of the respective groups or individuals in contact. Attitude change is more likely to be successful where contact occurs within a supportive environment where each party has equal status (Allport cited in Rillotta & Nettelbeck, 2007) and pursue shared goals (Allport cited in Murfitt, 2006).

Further, some researchers contend that for attitude change to occur in relation to marginalised or stereotyped groups, a further set of factors is required. These include: “an opportunity to get to know each other; information which disconfirms the stereotype; active cooperation; and a positive experience” (Desforges et al, 1991 cited in Murfitt, 2006: 149). Additionally, later research argues the importance of the contacted group to be seen as representative of the broader group about which the stereotype is held (Murfitt, 2006).

In his thesis, Murfitt (2006) combined theories of attitude change with an interest in the context in which attitude change occurs. Murfitt draws on Bronfenbrenner (1989) to argue that not only is the contact between attitude holder and attitude recipient important, but so is the context in which it occurs (Murfitt, 2006). He suggests that it is the nature of the interactions between parties, along with the aspects of various levels of the environment in which it occurs including the personal views of the parties, and the policy and wider discourse environment in which the interaction takes place. This view emphasises the importance of the interaction and its context, rather than ‘contact’ alone.

In summary, Yazbeck et al (2004) argue that

It is not enough to have exposure to people with intellectual disabilities; contact must be structured and organized along a meaningful dimension (Rees et al., 1991) and the quality of the contact influences attitudes (Eiginbrood & Retish, 1988; McConkey & McCormack, 1983). (Yazbeck et al, 2004: 98)

Theories of persuasion

A major theory of attitude change is that of persuasion, described by Olson and Zanna as “attitude change resulting from exposure to information from others” (quoted in Murfitt, 2006: 45). In recent times, research has identified two paths to persuasion. The first path is that where people are able and are motivated to process information carefully. This is considered to be the most enduring type of attitude change and is largely dependent on the strength of the message. The second path occurs when people are not able or not motivated to process information carefully. This path, known as the “peripheral route” is therefore one of less consideration, where the message is less influential, and where people are likely to draw on ‘quicker’ mechanisms such as relying on established norms or stereotypes. It is possible for both paths to interact as part of attitude formation and change (Murfitt, 2006: 46).

Much of the work on attitude change has focused on the factors regarded as enhancing the persuasive value of the desired change. Key aspects of persuasion may focus on:

- community located initiatives
- enhancement of the benefits of change
- removal of the barriers to change
- management of communication variables.

Enhancing benefits and removing barriers – community located initiatives

Dr Doug McKenzie-Mohr developed the concept of community-based social marketing, specialising in environmental initiatives and changing behaviours and attitudes towards sustainable behaviour. Community-based social marketing (CBSM) is founded upon research in the social sciences that demonstrates that behaviour change is most effectively achieved through initiatives delivered at the community level (McKenzie-Mohr & Smith, 1999). These initiatives focus on removing barriers to an issue or activity, while simultaneously enhancing the issue or activity's benefits (Ibid). CBSM involves four steps:

- I. Identifying the barriers and benefits to a behaviour;
- II. Constructing a program to overcome these barriers;
- III. Implementing the program across the community;
- IV. Evaluating the effectiveness of the program.

I. Identifying the barriers and benefits to a behaviour.

Barriers to a behaviour can be identified through literature reviews, focus groups and survey research. These barriers may be internal to the individual, resulting from a lack of knowledge regarding the issue, or the barriers may be external, such as structural changes that need to be made in order for the behaviour to be more convenient (Ibid).

II. Constructing a program to overcome these barriers.

Developing an awareness program designed to overcome these barriers must take into account recognised behaviour change techniques. McKenzie-Mohr emphasises the use of personal contact as research indicates that people are most likely to change their behaviour and attitude in response to direct appeals from others (Ibid).

An effective way of communicating desired attitudes and behaviour is through the use of norms. Developing community norms, such as environmental legislation, can encourage people to behave more sustainably (Ibid). Programs promoting awareness and attitude change should communicate what are accepted behaviours. This may in turn influence conformity from the participants, due to individuals observing the behaviour of others in order to determine how they should behave. Behaviour change through conformity can have long lasting effects (Ibid). In order to effectively use norms and demonstrated behaviour for attitude change, the norms or desired behaviour should be visible and highly noticeable.

III. Implementing the program across the community

Implementation of the program across the community is an iterative process where evaluative feedback may lead to changes within the program structure.

IV. Evaluating the effectiveness of the program

The final step of community-based social marketing is the ongoing evaluation of the program implemented. Data collection should include assessments of how the messages are being received (attitudes), which delivery methods are having the greatest impact (recognition), and how behaviour is changing, with

observed behaviour being the preferred data collection method over self reported behaviour changes (Smith, 2005: 41).

There are a number of examples of such behaviour change approaches in Australia within the public health sphere. These include studies regarding the efficacy of attitude and behaviour change programs such as skin protection or anti-smoking campaigns.

Within Australia the anti-smoking “Quit” campaigns are thought to have been quite successful in decreasing the number of young children taking up smoking. The “Quit” campaigns were conducted through the mass media, with advertising on both television and radio, as well as through school education programs. The main aim of the school programs was to encourage young people not to start smoking (Cronshaw, 1986). It was determined that students were less likely to smoke if they were involved in learning experiences designed to develop knowledge, positive attitudes and skills. These programs included information, discussion and activities related to the following:

- Personal health and safety
 - Why people smoke
 - Pressures to smoke through peer pressure, advertising or adult role models
 - Immediate and long term affects of smoking
 - Passive smoking
 - Positive self image
 - Non smokers’ and smokers’ rights
 - Decision making
 - Effective refusal techniques
- (Cronshaw, 1986).

These programs were thought to give the students the skills and knowledge to make informed decisions regarding smoking.

The anti-smoking programs involved changing attitudes towards smoking through information processing, social learning, stereotypes and persuasion, all key concepts in the field of attitude change (Murfit, 2006: 169).

Managing the message – communication variables

Broadly speaking, persuasion is strongly linked to communication. In this context, there are four broad features involved in persuasion and consequently attitude change. These factors are:

- Communicator variables: who is delivering the message.
- Message variables: what is the message?
- Channel variables: how is the message being delivered?
- Audience variables: who is the message being delivered to?

(Lippa, 1994: 239).

Each of these factors needs to be taken into account when developing an awareness campaign.

Communicator variables

Evidence suggests that speakers who are perceived to be credible, expert, trustworthy and unbiased are most persuasive (Lippa, 1994: 240). This is reinforced in the community based social marketing literature which stresses the importance of:

- Using credible sources to present your message, preferably a person who is thought to be an expert in their field;
- Using personal contact where possible to deliver the message, exploiting the influence other people can have on individual attitudes and behaviour (McKenzie-Mohr & Smith, 1999).

Message variables

McKenzie-Mohr & Smith (1999) highlight the importance of framing the message appropriately. Positive messages are more likely to gain acceptance and support. Negative messages, such as possible economic losses due to the exclusion of people with disabilities from the workforce, can also be effective if used appropriately. They argue that the message must be easy to remember, as all actions regarding attitude change require reliance upon people remembering the message. Messages that are easily understood and give clear knowledge of what to do, and how and when to do it are more likely to be adopted. Given their advocacy of community located initiatives, they argue the importance of messages that include personal or community goals.

Lippa (1994) contends that messages are more likely to be successful when they engage personally with their audience. Chaiken's (1987) heuristic model argues that when people are personally involved with the topic of persuasion they engage in a more careful, thoughtful analysis of the message, its contents and implications (Lippa, 1994: 266). This is described above as the first path to persuasion. Chaiken's heuristic model contends that when people are not personally involved with the topic of a persuasive message they change their attitudes according to heuristics. This is an example of the second or 'peripheral' path to persuasion, discussed above. Heuristics are similar to schemas, which are a cognitive model or mental category, presumably based on previous experience or learned information, that an individual holds regarding objects, people or groups (Lippa, 1994: 22). People can apply their schemas as a first quick attempt to understand a person or object. Schemas relating to social judgements can often be based on samples that are too small and biased to be considered entirely accurate (Ibid: 206). Olson and Zanna similarly conclude that personally involving messages motivate people to process information carefully. If a message is not personally involving the audience will not be highly motivated and their judgements will be based on previously developed schemas or ideas relating to the issue at hand (cited in Murfitt, 2006: 46-47).

Channel variables

Community based social marketing highlights the use of captivating information, stating that without the attention of the audience, behaviour change will not occur. McKenzie-Mohr & Smith (1999) state that one of the

most effective ways to ensure attention is to present information that is vivid, concrete and personalised.

Messages can be delivered through varied means, such as the mass media or in-person presentations. While the mass media can be greatly effective in message delivery, face-to-face mediums can have greater impact on individual perceptions and attitude change. It is quite easy to turn off a mass media message, yet it is difficult not to listen to a person presenting their message personally. Studies show that personal presentations, delivered to either an individual or group, are more likely to capture the attention of the audience, thus stimulating more thought and commitment to the message being delivered (Lippa, 1994: 243).

Audience variables

Finally, the target audience can greatly affect what message is delivered and how it is delivered. McKenzie-Mohr & Smith (1999) stress the importance of knowing the target audience, their current beliefs, needs and expectations.

Attitude Change and Disability

As stated above, while there has been some research conducted about attitudes towards disability in education settings, there has been relatively little research about attitudes in broader social and community settings. This section will deal with literature about attitude change about disability in these broader settings, as well as literature that identifies the demographic factors linked to particular attitudes about people with disabilities.

Factors affecting attitude change about disability

Several studies provide evidence about the ingredients of attitude change in the context of disability awareness. Some of these studies reinforce theories of contact or exposure, whilst others engage with a wider range of factors influencing attitude change. Some studies have dealt with the program ingredients affecting outcomes of attitude change activities.

On the basis of existing research, Murfitt (2006) argues that

there is well established evidence that direct contact with people who have a disability is a key factor in fostering positive attitudes towards them (Murfitt, 2006: 149).

Murfitt (2006: 169) states that attitude change towards people with disabilities is most likely to occur through experience, and therefore attitude change should be based on experience when ever possible. This experience can range from an everyday event to a once off occurrence through a formal awareness program. Although continual contact over a period of time between people with disabilities and people without a disability is preferable.

As part of his study, Murfitt identifies which of the four factors identified as influential by previous research (Allport, 1954; Desforjes et al, 1991) had the

most impact on attitude change within a specific disability awareness program. He finds that the most influential factor in the disability awareness program under review was that of equal status between mentor and mentee (person without a disability and person with a disability), followed by getting to know each other, and working on a mutual goal. Of least importance was the specific disability information provided as part of course materials (Murfitt, 2006). This suggests that the experience of an active and equal relationship was more influential than the provision of targeted information. An interesting feature of Murfitt's research is his finding that people with a disability (ie the recipients of negative attitudes) are agents of the change process via their active interaction with others and the process of development they experience themselves. Rather than passive recipients, they are critical agents of change (Murfitt, 2006).

Other research endorses this emphasis on mutual experience and interaction. Recent research by Rillotta and Nettelbeck (2007) also suggests that the longevity of the experience is a critical factor, arguing that their research and evidence from other studies (eg Fritz, 1990) shows that outcomes from programs significantly increase where programs have a longer duration (ie, in their case comparing a 3-session program with an 8-session program in schools). Murfitt, too, argues that his research evidences that a "relatively long term" activity is a core ingredient of successful attitude change (Murfitt, 2006:169). This is consistent with various theories and research regarding attitude change about stereotypes and prejudice. Such research argues that the provision of sufficient time is a critical factor in enabling people to process and assimilate information that is persuasive against stereotypes, and that the lack of time leads to the adoption of stereotypes (see Murfitt, 2006: 52 who summarises other research).

Murfitt (2006: 169) concludes his study, stating that positive attitudes towards people with disabilities would most likely develop when awareness programs addressed three key factors:

1. Interactions between people with disabilities and people without disabilities must be based on experience as much as possible;
2. There must be equal status in the relationship between the person with a disability and the person without a disability;
3. Each person should be working towards a common goal

Murfitt believes that if these key factors are addressed, positive attitudes towards people with a disability are more likely to emerge. Through Murfitt's study regarding people with disabilities in employment situations, it was found that through structured employment activities, the participants were able to take action towards a common goal. Through working towards a common goal over a sustained period of time, the participants developed positive attitudes towards people with a disability as individuals and as a group (Murfitt, 2006).

Demographic characteristics linked to attitudes about disability

A range of research about attitudes towards disability has found that particular demographic factors, such as gender, age, education etc, can be linked with the presence of particular attitudes about disability.

In 2004, Yazbeck et al undertook research regarding Australian attitudes towards people with intellectual disabilities. They identified a number of core predictors of a person's attitude towards people with disabilities. Yazbeck et al (2004) found that positive attitudes towards people with a disability prevailed among young people (ie. 18-25 years), people with higher educational attainment (in particular tertiary education) and people with previous experience of people with a disability (Yazbeck et al., 2004: 106). Gender or language spoken had little or no influence over attitude towards people with a disability (Yazbeck et al, 2004), though other research found gender to be a significant predictor (eg Yuker and Block, 1986 reported in Yazbeck et al, 2004).

The relative consistency of these findings (at least across some domains) leads Yazbeck et al (2004) to argue that research suggests that attitude change programs about disability could benefit from a greater focus on identified target groups (eg. middle to older age groups, people with lower education levels and those with no experience of people with a disability).

Evaluation of Disability Awareness Programs

As discussed earlier, this study is premised on the understanding that positive attitudes towards disability are necessary for an inclusive community. Currently there is a need to gather better information on the attitudes and behaviour of the community towards people with disabilities and people's experience of discrimination resulting from their disability (Office for Disability Issues, 2005). To date, little study has been done to ensure that the disability awareness programs being conducted in Victoria have a high likelihood of actually changing attitudes and behaviour towards people with disabilities in the long-term. There may be a variety of reasons for this, one being the complexity of current attitude and behaviour evaluation tools and the time it would take to complete a longitudinal behaviour study. Most Disability Awareness programs conduct evaluation immediately after the presentation through feedback forms. Self-report measures such as these are the most widely used research technique to evaluate effectiveness of various change programs (Dowling, 2001: 56).

This section aims to support an informed understanding of research into attitude change, particularly research to determine attitude and behaviour change as a result of disability awareness programs.

In identifying a research process to assess the effectiveness of disability awareness programs, the tasks for researchers are to:

- Identify what constitutes 'positive' attitudes and behaviours (ie define 'positive');
- Determine effective methods for determining the presence of attitudes;
- Determine effective methods for determining behaviours (this may involve determining the level of correlation between attitude presence and actual behaviour and the other factors affecting this in the context);
- Identify what mechanisms have been effective in changing attitudes and behaviours.

The following summarises some of the literature in regard to research issues and approaches in this area.

What constitutes 'positive' attitudes and behaviours about disability?

A key task for researchers is to determine what are the indicators of positive attitude, ie. what constitutes 'positive'. Some research demonstrates that understandings of what comprises 'positive' attitudes towards and about disability varies between people with and without disability. From the perspective of those without disabilities, a positive attitude may be understood as being 'nice' or 'helpful' whereas, for people with a disability, the definition of a positive attitude "means dispensing with the category of disability entirely" (Makas, Finnerty-Fried, Sugafoos and Reiss cited in Yazbeck et al, 2004: 97).

Most researchers have focused on identifying more 'generic' desired attitudes and behaviours and developing data collection instruments to capture these. Only a few of these data collection instruments have been developed by utilising categories identified as important by people with a disability themselves (Henry et al, 1996), hence one critique (given the evidence above) may be whether or not they measure domains of importance to people with a disability. Additionally, a further critique may be that many measure attitudes at a societal level (ie how society should treat people with a disability), which is considered to be influential but potentially different from attitudes at a person level (ie. an individual's reactions to people with disabilities) (Gething, 1994). The following lists some of the dimensions for which there are existing measurement scales or data collection instruments, but does not engage with the critique about their effectiveness or methodological appropriateness.

- beliefs about the application of eugenics to people with a disability¹;
- degree to which people with an intellectual disability should be integrated into society² ;
- degree to which people with and without intellectual disability should associate / interact (including willingness to recognise, live near, or be associated with)³;

¹ The Scale of Attitudes Towards Mental Retardation and Eugenics – Revised, Antonak et al, 1993 cited in Yazbeck et al, 2004

² The Mental Retardation Attitude Inventory, Antonak & Harth, 1994 cited in Yazbeck et al, 2004

- degree to which the rights of people with intellectual disability should be upheld in community⁴;
- beliefs around the moral character and social behaviour of people with intellectual disabilities⁵;
- degree to which people with intellectual disability require support and protection (including beliefs about level of supervision in daily life and protection from dangers of community life)⁶;
- degree to which the life goals and human rights of people with and without intellectual disability are the same⁷;
- beliefs about the perceived differences between people with and without disability;⁸
- degree to which people with intellectual disability should be able to express opinions and make decisions concerning their lives (ie empowerment)⁹;
- extent to which people with intellectual disability should be part of their local community (ie everyday community life)¹⁰;
- level of discomfit in interacting with people with disabilities¹¹.

What are the current methods for determining attitudes and behaviours?

Ensuring attitudes can effectively be used as predictors of behaviour

Much research focuses on identifying attitudes as indicators or predictors of behaviour. That is, researchers rely on identifying attitudes and argue that this is sufficient evidence of future actions. As discussed above, other theorists argue that attitude is only one factor influencing behaviour. Whilst there is some critique of this relationship (noted above), most research engages with the range of factors identified as affecting the efficacy of this method to develop a more effective method of attitude measurement.

For researchers, one of the key concerns in research method revolves around the notion that attitude is a predictor of behaviour. Much research has found a poor correlation between the presence of particular attitudes and actual behaviour (detailed in Murfitt, 2006). A range of researchers suggest the need to explore other factors affecting behaviour including:

³ Ibid.

⁴ Ibid.

⁵ Ibid.

⁶ The Community Living Attitudes Scale-Mental Retardation, Henry et al, 1996 cited in Yazbeck et al, 2004)

⁷ Ibid.

⁸ The Attitudes Towards Disabled Person's Scale (Yuker, Block & Young, 1970, cited in Gething, 1994) and Scale of Attitudes Towards Disabled Persons (Antonak & Livneh, 1980 cited in Gething, 1994).

⁹ The Community Living Attitudes Scale-Mental Retardation, Henry et al, 1996 cited in Yazbeck et al, 2004).

¹⁰ Ibid.

¹¹ The Interaction with Disabled Persons Scale, Gething, 1994.

- the context in which attitude formation and behaviour occurs;
- the ability and the opportunity to act.

Various researchers agree the importance of context-specific investigations, and recommend an approach that identifies desired attitudes and behaviours within each individual program and / or site context (Murfitt, 2006).

The following discussion will summarise the key methodological issues in attitude change research.

The importance of context in predicting behaviour

Murfitt (2006) emphasises the importance of context in processes of attitude change, and in research to determine attitude change. Murfitt uses Bronfenbrenner's ecological model to describe the different levels of context that influence attitude formation and behaviour (Bronfenbrenner, 1989). As described by Murfitt, these include: the microsystem (ie. the immediate environment of an individual including family, workplace and attitudes or beliefs of significant others); the mesosystem (ie. the combined influence of the microsystems such as family, the workplace, school and peers); the exosystem (ie. the settings 'once removed' from the person's immediate experience, such as a parent's workplace); and the macrosystem. (ie. societal influences, such as social class, race or religion) (Murfitt, 2006).

In terms of research design, Murfitt argues that any measurement of attitude change needs to be contextually located, ie related to and judged in the 'real' world context/s given that people change their behaviour based on the contexts each action is situated in. In this way, attitude/behaviour measurement needs to seek measurement opportunities in a range of diverse contexts over time (Murfitt, 2006), as there is evidence to suggest that testing in more distant, clinical contexts bears little relationship to actual behaviour in life settings (Murfitt, 2006).

Given that most research does not have the capacity to track actual behaviours across diverse contexts and time events, then researchers argue for the need for increased attention to the explicitness and compatibility of attitude and behaviour measures. Murfitt (2006: 27) states that any attitude and behaviour measures need to be compatible in terms of the action, target, context and time. This means that research methods need to ensure that the evidence they are collecting relates to specific behaviours about specific groups that have clear and precise contexts of time and place, rather than generalised attitudes about groups or generalised intentions.

The importance of control over behavioural opportunity, and other factors

As discussed above the Theory of Planned Behaviour predicts a relationship between a number of factors and the actual behaviour. Assessing an individual's attitude and perception of societal norms, as well as their belief of

the consequences of their actions, and their perceived control over their behaviour and outcomes resulting from such behaviour, can result in the prediction of their level of intent (Murfitt, 2006). The Theory of Planned Behaviour postulates that the more favourable the attitude and subjective norm, and the greater the perceived control, the stronger the individual's intention to behave in a particular manner will be. The stronger a person's intention, the more the person is expected to try, and hence the greater the likelihood that the behaviour will actually be performed.

Schifter & Ajzen's (1985: 847) study regarding the theory of planned behaviour and weight loss determined that the theory of planned behaviour was successful in predicting intentions of the participants to lose weight and was moderately successful in its prediction of actual weight loss. The evaluation method regarding weight loss was quite complex and was completed over a period of time. The study was conducted over two stages with participants filling out a set of questionnaires at each stage. The questionnaires began with a series of background questions concerning the participants' age, height, weight, previous attempts at weight loss and what they considered to be their ideal weight. The questionnaire also dealt with perceived control, asking the participants to scale the control they felt they had over their weight loss through a variety of questions.

Murfitt (2006) in his study of attitude change in regard to the employment of people with a disability resulting from a mentoring / awareness program, adapts the Theory of Planned Behaviour to guide data collection. In general, he collected data in relation to key areas identified in the Theory of Planned Behaviour, namely:

- participants' most relevant beliefs about the advantages and disadvantages of the desired behaviour (ie. employing people with a disability);
- participants' most important referents (ie people whose opinions they most take notice of);
- participants' perceptions about the level of control they have over the desired behaviour (ie. employing people with a disability, worded as: please list the factors that may hinder you recommending ...[the behaviour, ie, employing people with a disability], and, please list the factors that may help you recommending ...[the behaviour], Murfitt, 2006:98).

In addition, in response to other influences on behaviour generated by other research he added the categories of:

- level of past experience with disability, and
- level of perceived moral or ethical obligation (Murfitt, 2006: 109).

Murfitt adopted a pre and post program testing approach against these elements, and a comparison with a control group that did not participate in the

program. Participants were asked to rank the answers on a seven point scale anchored by terms like 'likely/unlikely' and 'good/bad'.

Significantly (and in contrast to other research), Murfitt generated the specific sub items against most categories by first doing more qualitative, open-ended surveying of a small sample of participants where he asked them to identify the key beliefs, referents and control elements. These items were then collated and ranked, and used as the basis of the pre and post testing. In this way, he uses a more grounded theory approach to generating item concepts than is usual in this field.

Other considerations

One barrier, identified by some researchers, when evaluating the success of disability awareness programs is the fear that people may have with expressing their true feelings regarding people with disabilities. There is a high level of sensitivity involved with people with disabilities and people may not feel comfortable stating their true beliefs and attitudes if these are not in accordance with societal views of inclusiveness. Yazbeck et al. (2004: 99) included the use of the Marlowe-Crowne Social Desirability Scale, which is an established research tool that can be used to predict a participant's tendency to choose socially desirable responses on self-report questionnaires. Interestingly, Murfitt's study found social desirability to bear little influence on participant responses (Murfitt, 2006).

What mechanisms are effective in changing attitudes?

As discussed above, a range of mechanisms and factors have been considered influential in changing attitudes.

Murfitt (2006) designed his research to explicitly test the efficacy of some of the ingredients of attitude change related broadly to the influence of personal contact (as opposed to persuasion). His study asked participants to complete a pre and post qualitative survey designed to elicit changes in attitude and the elements of the program most influencing these. Program elements were constructed from the major theories emerging from research to date about personal contact, namely the influence of:

- pursuing a mutual goal;
- participants having equal status;
- the opportunity to get to know each other;
- information which disconfirms the stereotypes (ie disability information provided as part of the program);
- active cooperation; and
- positive experience (Murfitt, 2006: 149).

Participants were asked to rate, on a scale of 1-10, the relative importance of each factor in the development of their views about the behaviour (ie. the

employment of people with a disability). Additionally, participants were asked to identify benefits to themselves and their organisations (ie what did you gain) as a result of their participation; how the program might be improved; and the level of attitude change experienced.

Interestingly, this qualitative study appeared to yield more conclusive results about levels of attitude change than the use of data collection instruments adapted from the Theory of Planned Behaviour arena.

Conclusions about research method for researching attitude change toward disability

Murfitt (2006) and others make a compelling case for a focus on attitude about specific behaviours in specific contexts. This suggests that though there are range of measurement and data collection methods in existence about attitudes toward people with a disability, these may not be immediately valid or useful in evaluating disability awareness programs, without significant adaptation.

Additionally, given the differences in defining positive attitudes held by people with and without disabilities, work to define positive attitudes and behaviours in specific context, should include consultation of people with disabilities to enable them to identify areas of importance to them.

Murfitt's (2006) use of the Theory of Planned Behaviour and his additional data collection to determine the key program ingredients of change, are both potentially useful as a broad structure to designing evaluation methods for disability awareness programs. Utilising this framework, an evaluation method would include pre and post program data collection around:

- participants' most relevant beliefs about the advantages and disadvantages of the desired behaviour);
- participants' most important referents (ie people whose opinions they most take notice of);
- participants' perceptions about the level of control they have over the desired behaviour (ie. the factors that may hinder and enable the behaviour).

Additionally, post program data collection could include questions around the relative impact of the following potential program ingredients (if relevant):

- pursuing a mutual goal;
- participants with and without disabilities having equal status;
- the opportunity to get to know each other;
- information which disconfirms the stereotypes (ie disability information provided as part of the program);
- active cooperation; and positive experience.

Data Analysis: Current Victorian Disability Awareness Programs

An essential part of creating welcoming and inclusive communities for people with disabilities is through raising awareness of disability and people with disabilities within our communities. There are many ways in which disability awareness can be promoted. Disability awareness can be conducted through the different forms of mass media as well as through general day-to-day or once-off interactions between people. For the purpose of this project, only formal disability awareness programs within Victoria were studied.

Formal disability awareness programs were defined as those that deliver structured, in-person presentations designed for a range of audiences.

Target Audience

Within Victoria, thirteen programs were found to be currently conducting formal disability awareness programs. This included the programs of eleven agencies as well as Scope's two community awareness programs that are each designed for different target audiences. Each agency is a not for profit organisation with a focus on disability.

The majority of programs are designed for general community groups and school groups. School groups consist of students from preparatory to year twelve, covering all levels of schooling. Two (15%) of the programs conducted in Victoria are aimed at specific year levels in schools. The Whitehorse Disability Awareness Project has designed its school awareness program to accommodate primary school children, while the Scope Young Ambassador (SYA) program has been designed for older secondary school students. Yet while the participants' age groups may vary, the two programs are similar in their structure, presentation and content.

As well as school and community groups, some of the programs are directed towards other external organisations, specifically human relations and management departments, as well as employment agencies and health professionals. Two (15%) of the programs were directed at university students undertaking courses such as nursing and medicine.

Duration of Programs and Number of Participants

The length of each program can vary from half an hour to whole day programs. A few of the organisations structure their programs to the needs and requirements of the group accessing the program, and the length of the program then depends on how the program is structured from these requirements. The majority of disability awareness programs are once off sessions, between half to three hours in duration. Only the Whitehorse Disability Awareness Project and SYA program (ie 15% of programs) conduct a number of sessions over a period of time with the same participant group.

The number of participants in each program can vary greatly. Some agencies have no minimum or maximum number of participants required, while other agencies take no more than twenty (20) people. Half of the agencies are able to cater for between fifty and one hundred (50-100) participants per session.

Cost of Programs to the Consumer

The cost of each program also varies depending on the organisation. Eight (61%) of the thirteen programs are free of charge. Two of these organisations offer free programs to community groups, while charging a fee for university sessions or professional organisations. A small number of organisations charge a nominal fee, while one organisation offers their course free of charge, with an option to make a donation. Most program costs are covered by the organisations themselves. Four (31%) programs charge a fee, yet the majority of costs are substantially subsidised by the organisation conducting the program. The Victorian Deaf Society offers a free program but requires the consumer to cover the cost of an interpreter. The Whitehorse Disability Awareness Project currently offers their programs for free but they are investigating how they can charge for services in the future to make their programs more sustainable.

Program content

All programs are based on a social model of disability, discussing disability issues, personal experiences of living with a disability and what people with disabilities can achieve. Seven (54%) of the programs include a small amount of medical information as well as general information and discussion regarding social issues. Only Vision Australia specifically includes a significant amount of medical information within their programs.

Intended Outcomes of the Programs

It was found that beyond raising general awareness about people with disabilities within the community, most organisations had not been able to spend much time reflecting on the specific intended outcomes of their programs.

In the absence of this data, researchers of this project postulated a series of outcomes that aimed to reflect the intentions discussed or observed within programs. Program intentions and focus were then assessed against this framework, via the mechanism of discussion or observation. It should be noted that this framework is an initial formulation only and analysis reflects the subjective conclusions of the researchers/observers rather than via more rigorous testing.

As discussed above, researchers postulated four main outcome goals that an awareness program may work towards. These intended outcomes are as follows:

Table 1: Disability Awareness Program Outcome Framework

Outcome level	Outcome theme	Outcome description
1.	General awareness	Raising general awareness that there are people in the community who have disabilities. Raising disability from an invisible individual issue to a visible community issue.
2.	Understanding issues	Learning what the needs, issues and experiences people with a disability may have.
3.	Attaining specific knowledge and skills	Fostering the skills to address the needs of people with a disability. Gaining the knowledge and skills to identify strategies and actions. For example developing communication skills or understanding of communication aids.
4.	Taking action	Individual or group <i>action</i> concerning disability issues, shown through observed behaviour change, policy change or structural change

All (100%) of the disability awareness programs analysed in this study involve intended outcomes 1 and 2: that is, raising general awareness of disability; and learning what the needs, issues and experiences people with a disability may have.

Only half (50%) of the programs address outcome 3: developing the skills to address the needs and issues people with a disability may face. These programs not only discuss the needs and issues surrounding people with disabilities, but also how to address these needs and issues. For example, some of the programs go on to discuss language, what words can be offensive and what words are more appropriate to use when communicating with a person with a disability or when discussing disability issues. A small number of programs discuss ways in which different people communicate as a result of their disability. Through these programs, participants gain knowledge and skills that would enable them to better communicate with people with a range of disabilities. For example the Victorian Deaf Society teaches a few basic Auslan (Australian Sign Language) signs throughout their awareness course.

Most programs have a general long-term goal of creating a more inclusive community through positive behaviour change of community members towards all people, including people with a disability. For this project behaviour change has been included in the definition of intended outcome 4. Only four programs (31%) were identified as having specific behaviour change goals. These programs specifically name behaviour change within their

program descriptions and plan their programs accordingly. The Down Syndrome Association of Victoria and Latrobe City Rural-Access awareness programs both direct their programs to health care professionals and students. These programs have the aim of encouraging a shift away from a pure medical focus that health professionals may have when interacting with people with disabilities. These courses encourage health staff and students to use more appropriate language with patients who may have disabilities as well as their families. They openly encourage behaviour change of health professionals and students towards people with disabilities, aspiring for more accessible and inclusive health services.

The Down Syndrome Association of Victoria awareness program explains how important it is for health professionals and students to properly support people with Down syndrome and their families. Their program includes such statements as:

Treat parents and children with acceptance and respect. Allow them freedom of expression. Be honest with them, but not patronising. Give empathy and understanding but not sympathy and pity, which is maudlin and implies that there is no hope. Be positive – looking to the things which can be done rather than those which can't – however, be realistic. (Down Syndrome Association of Victoria, n.d.)

This is suggestive of broad behaviour change but lacks concrete examples and specific skills.

The Scope Young Ambassador (SYA) program aims for positive behaviour change towards people with disabilities among the participating students. SYA aims to achieve this through raising awareness and understanding of the lives of people with disabilities. SYA also aims to:

- Create tolerance and acceptance of others;
- Enhance leadership skills and encourage young people into a life-time commitment to volunteering;
- Promote a sense of civic responsibility in young people (Scope, n.d.).

The program has also resulted in some structural change through the community service component of the program. For example, a group of students participating in the SYA program created a 'beach wheelchair hire' service at a number of local councils, enabling better access for people with disabilities to Melbourne's beaches

Who Delivers the Presentation

The majority of disability awareness programs were found to be presented by a person with a disability. Out of the thirteen programs identified throughout Victoria, nine of these programs (69%) are presented by a person with a disability. This corresponds with current research that suggests that personal contact and creating a personally involving message is the best method

resulting in attitude change (Murfitt, 2006). For these programs the participants are exposed to a person with a disability throughout the program.

The Whitehorse Disability Awareness Project is the only organisation that has a number of different people with varying disabilities do a number of presentations over time. This project is directed at school children, requiring the children to attend five hour-long workshop presentations throughout a school term. Each of the workshops is conducted by a person with a disability, with different people conducting three of the workshops and the final workshop being conducted by all three presenters. Having a number of people with different disabilities conducting presentations expands the participants' experience of people with disabilities. Research suggests that while meeting one person with a disability may lead to acceptance of that person, that person may be seen as an exception and it may not lead to general attitude change regarding all people with a disability (Lippa, 1994: 311). Therefore a program that includes the involvement of a number of people with varying disabilities will be more likely to change the way a person views all people with disabilities, rather than their views of just one person (Lippa, 1994: 313)

A few of the programs are presented by representatives of the organisation conducting the program. Other programs are presented by carers or parents of a person with a disability and some are delivered by therapy or welfare professionals. These programs do not involve participants meeting or interacting with a person with a disability. A small number of these programs occasionally have a person with a disability attend as a guest speaker, although this is not the norm and happens only occasionally. Three of the organisations that currently do not have a person with a disability presenting the program are interested in involving people with a disability in their programs and are looking into how this could be achieved. These organisations recognise the value of having a person with a disability presenting disability awareness programs.

How is the Program Delivered?

Although the disability awareness programs conducted throughout Victoria are undertaken by different organisations and may have slightly different intended outcomes, the delivery of the programs is quite similar. The majority of programs involve the presenter discussing a range of issues related to disability. The programs may also include information regarding the different aids and equipment used by people with disabilities and general disability services information.

The programs that are presented by a person with a disability involve the presenter giving a personal account of their experience of life with their disability, how they manage their disability and what they have achieved. These presentations sometimes involve power-point slides with photos, pictures or worded information. It was noted that the presenters focused strongly on their abilities and achievements. The majority of disability services currently work within a strengths based framework, focusing on the abilities of

clients and the community and what they can achieve and future possibilities, rather than what can not be achieved. Presentation content was consistent with this approach. Some programs involve activities by the presenter or participants, demonstrating how a person may perform various tasks if they have a disability.

All programs include information regarding the similarities between people with disabilities and people without disabilities. Most programs discuss how to better communicate and appropriate language to use when communicating with a person with a disability. For programs that are conducted by parents, carers or representatives of auspicing organisation, information included in the presentation may incorporate the grief process families may go through, but also positive experiences a person with a disability may bring to the family. They may also include discussion on how to better involve people with disabilities in the community or positions of employment.

Each program includes question time throughout or at the end of the presentation. Most organisations believe that question time is an important and integral part of the presentation. This time allows participants to ask any questions they may have. It was acknowledged that it is important to make the program environment safe, without judgement. Many participants have questions regarding different aspects of disability, but feel that some questions may be inappropriate. Creating a safe environment throughout the presentation allows participants to feel comfortable in asking any question they have. The apparent aim is to reduce any anxieties people may have regarding disability and people with disabilities.

Evaluation of Existing Disability Awareness Programs

The majority of organisations in this study were found to conduct some form of evaluation through evaluation forms or feedback sheets, completed by the participants of the program. Most program evaluations ask participants to comment on the level of usefulness they found the information to have and the program format, rather than how the program has changed their view of disability or their behaviour in relation to it. The findings of this project show that most evaluation of awareness programs measures program presentation, information and retention (ie persuasion or message elements).

It was found that the majority of organisations conducted participant evaluations immediately after the conclusion of the program through feedback / evaluation forms. Only three organisations (23%) currently have no evaluation tools in place, but recognise the importance of program evaluation and will be investigating evaluation tools for the future.

All evaluations conducted through feedback forms included general questions regarding the presentation of the program and how the presentation or format could be changed and how useful the information was to the participants, rather than how the program has helped change their views regarding people with disabilities. Most organisations acknowledged the difficulty in evaluating immediate or long-term behaviour change.

Three organisations conduct regular or annual reviews of their disability awareness programs. While these reviews do not evaluate participant behaviour change as a result of the programs, they do examine how relevant the programs are to their intended audience and how the programs may be altered to remain relevant and consistent with current trends.

Section Three: Implications

This study explores and attempts to summarise the very complex terrain of attitude and behaviour change theory and research. It also documents the processes and outcomes (where available) of current Disability Awareness Programs in Victoria. Given the history of both arenas, it is timely to merge the two sets of knowledge and know-how in order to identify ways forward for Disability Awareness Programs.

Implications for the nature and delivery of Disability Awareness Programs

This study identifies a number of important considerations for Disability Awareness Programs, in terms of what can be considered to bring about effective attitude change. These can be summarised as follows:

1. Direct contact between program participants and people with a disability is likely to be the most influential form of attitude change. Features of direct contact should include:
 - longevity of contact (ie. a sustained period of time);
 - the ability/ time to get to know each other;
 - equal status of people with and without a disability; and
 - a focus on the person with a disability as connected with and representative of other people with a disability;
 - mutual work on shared goal;
 - positive shared experiences.
2. Programs that are longer in duration rather than short, one-off activities allow time for attitude change to build incrementally;
3. Programs need to be focused on behaviours in contexts that the participant has control over, ie. the ability, resources, skills, authority to enact. That is, a focus on actions the participant can do in their everyday context.
4. Programs need to be personally involving and experiential, or at least, complement the traditional persuasive message approach with elements of this.

Additionally, there is some evidence to suggest that some groups in community may require a heightened level of focus than others. For example, people over 25 years, people with lower levels of education, and people without previous experience of disability, are all likely to hold more negative views of people with a disability.

At present, Disability Awareness Programs in Victoria appear to focus on what is described in this research as the first and second levels of awareness: making people with a disability visible, rather than invisible; and understanding the issues facing people with a disability (See Table 1).

Whilst some programs include some general skills, few appear to focus on building specific skills in specific contexts, and identifying clear action or behavioural plans. The model of awareness raising developed by researchers here, could be a useful framework for programs to review their aims by, as well as to design delivery, content and evaluation.

In order for programs to refine and implement key elements identified in this study, they will require sufficient resourcing which is unlikely to be immediately available to them. The elements identified above require a level of customisation of programs to specific audiences and contexts, as well as extended delivery, and the high level involvement of people with a disability. Such ingredients require the active support of government and non government funding programs.

The research summarised in this report also suggests that there is need to expand beyond the traditional focus of Disability Awareness Programs. Attitude and behaviour change is influenced by aspects of the context and of the broader attitudes endorsed within this context. This requires targeted work within the specific contexts in which Disability Awareness Programs are delivered, ie. schools, universities, workplaces, local government and community groups. This work would involve:

- Work to develop the policy and regulatory environment of these contexts to ensure these support the desired attitudes focused on by awareness programs. Ensuring that policies and structural practices 'line up' or are consistent with desired attitudes and behaviours is likely to increase these positive behaviours;
- Work to address the barriers to action within specific contexts, identified by participants, to enable participants to enact behaviours (that is, have the skills, opportunities and resources) and be rewarded (rather than disadvantaged) with positive benefits when they do act in this way.

This kind of work is often undertaken by community development or inclusion workers, though is not well identified by organisations as a task of attitude and social change. This work needs to be understood as complementary even necessary to that of Disability Awareness Programs and could be undertaken as an expansion of these programs or by other staff or organisations, so long as the work is linked and co-ordinated.

Implications for Future Evaluation of Disability Awareness Programs

Whilst there is an enormous literature in regard to researching attitude and behaviour change, there remains no easily identifiable tool that would be immediately applicable to evaluating the outcomes of Disability Awareness Programs.

However, Murfitt's study offers some useful directions for the design of research to evaluate and identify outcomes from awareness programs, including a focus on:

- participants' most relevant beliefs about the advantages and disadvantages of the desired behaviour;
- participants' perceptions about the level of control they have over the desired behaviour;
- the relative impact of various aspects of program design and delivery including: pursuing a mutual goal; participants having equal status; the opportunity to get to know each other; information which disconfirms the stereotypes (ie disability information provided as part of the program); active cooperation; positive experience.

Additionally, the model of awareness raising adopted here may also provide a useful base for research design, especially if undertaken with reference to existing research and theories, such as those discussed here. It is clear that organisations delivering Disability Awareness Programs in Victoria would positively receive advice and support to research their activities, but require resourcing as well as access to expertise to do so. This is an area in which government could play a role in funding a research project to design a useful evaluation and outcomes tool, in consultation with program providers.

It is likely that any research process developed would focus on some level of pre and / or post program data collection, and would be unlikely to be able to assess the maintenance of attitude change beyond program conclusion.

Conclusion

The State Disability Plan and Scope's Strategic Plan both include the goal of making Victoria a more welcoming and inclusive community for all people regardless of their abilities. Community and individual attitudes can greatly affect how people with disabilities experience their lives within the community. Reducing negative or fearful attitudes towards people with disabilities in society is a key factor in creating inclusive communities and these can be addressed through community disability awareness programs.

This study identifies thirteen Disability Awareness Programs operating in Victoria. Most already encompass the identified strategy of contact between people with and without a disability. Most focus on general awareness raising and most lack the longevity identified here as critical to significant attitude change. That is not to suggest that these programs are not achieving outcomes. The problem is that we are unable to determine the level of these nor which elements of the program are critical to their success.

In order to further develop and increase their influence as agents of change towards inclusive community, Disability Awareness Programs are likely to require additional resourcing to further incorporate the elements suggested here as critical to attitude and behaviour change. Whilst most undertake some form of program evaluation, all would benefit from support to develop an appropriate research and evaluation approach to measure outcomes and key ingredients of success.

References

- Allport, G.W. (1954). *The nature of prejudice*. Reading, M.A: Addison-Wesley.
- Antonek, R. & Livneh, H. (1988). *The measurement of attitudes toward people with disabilities: Methods, psychometrics and scales*. Springfield: Charles Thomas.
- Bronfenbrenner, U. (1989). Ecological Systems Theory. *Annals of Child Development*, 6: 187-249.
- Cronshaw, Susan. (1986) *Usage of Resource Materials in Schools*. Quit Evaluation Studies: Volume 1.
<http://www.quit.org.au/downloads/QE/QE1/QE1Ch6.html> – accessed 27/9/06
- Department of Human Services. (2002) *Victorian State Disability Plan 2002-2012*. Victorian Department of Human Services. Melbourne.
- Desforges,D.; Lord,C.; Ramsay,S.; Mason, J.; Van Leeuwin, M.; West, S. & Lepper, M. (1991). Effects of structured cooperative contact on changing negative attitudes toward stigmatized social groups. *Journal of Personality and Social Psychology*, 60, (4), 531-544.
- Disability Services (2001) *Understanding Community Attitudes about Disability: Laying Foundations for Participation through Community Inclusion*. DisAbility Services.
- Dowling, Grahame R. (2001) The Alpha, Beta, Gamma Approach to Measuring Change and its use for Interpreting the Effectiveness of Service Quality Programs. In *Australian Journal of Management*. Vol. 26, No. 1. June 2001.
- Down Syndrome Association of Victoria. Web site
http://www.dsav.asn.au/dsp_aboutDS.cfm Accessed on 8/12/06.
- Fritz, M. F. (1990). A comparison of social interactions using a friendship awareness activity. *Education and Training in Mental Retardation*, 25, 352-359.
- Gething, Lindsay (1994). The Interaction with Disabled Persons Scale. *Journal of Social Behaviour and Personality*, 9: 23-42.
- Henry, D.; Keys,C.; Jopp, D. & Balcazar, F. (1996). The Community Living Attitude Scale, Mental Retardation Form: Development and Psychometric Properties. *Mental Retardation*, 34, (3): 149-158.
- Lippa, Richard A. (1994) *Introduction to Social Psychology*. Brooks/Cole Publishing Company. USA.

- McKenzie-Mohr, Doug & Smith, William. (1999) *Fostering Sustainable Behaviour: An introduction to community-based social marketing*. Gabriola Island, B.C. New Society.
- Murfitt, Kevin F. (2006) *Attitude Change in Employment of People Who Have a Disability*. Deakin University, School of Psychology. Melbourne. Australia.
- Office for Disability Issues. (2005) *Work in Progress The NZ Disability Strategy 2004-2005*. Office for Disability Issues. New Zealand.
<http://www.odi.govt.nz/nzds/progress-reports/july04-june05/chapter-one.html>
Accessed October 5th 2006.
- Olson, J.M. & Zanna, M.P. (1993). Attitudes and attitude change. *Annual Review of Psychology*, 44, 117-154.
- Rillotta, Fiona & Nettelbeck, Ted. (2007). Effects of an awareness program on attitudes of students without an intellectual disability towards persons with an intellectual disability. *Journal of Intellectual and Developmental Disability*, 31, (1), 19-27.
- Schifter, Deborah E. & Ajzen, Icek. (1985) Intention, Perceived Control, and Weight Loss: An Application of the Theory of Planned Behaviour. In *Journal of Personality and Social Psychology*. Vol. 49, No. 3, 843-851.
- Smith, John. (2005) Community-Based Social Marketing. In *Solid Waste & Recycling*; April/May 2005; 10, 2; CBCA Business.
- Scope (2006). *Scope Strategic Plan 2005-2008*
http://www.scopevic.org.au/about_annualreport.html – accessed 28/11/06, 10:30am
- Scope (n.d) Young Ambassadors Secondary School Information Pack. Scope. Melbourne.
- Yazbeck, Marie., McVilly, Keith. & Parmenter, Trevor R. (2004) Attitudes Towards People With Intellectual Disabilities: An Australian Perspective. In *Journal of Disability Policy Studies*. Vol. 15, No. 2. 97-111.
- Yuker, H.; Block, J. & Young, J. (1970) *The measurement of attitudes towards disabled persons*. New York: Ina Mend Institute

Appendix One

Interview questions for organisations that conduct disability awareness training program.

- What is the nature of programs on offer?
 - Who is the organisation running the program?
 - Who is the program targeted to?
 - How is the consumer referred to the program?
 - What is the length of the program?
 - How many participants per session?
 - What is the cost of the program to the consumer? How is the program funded?
- What are the programs intended outcomes?
 - I. Invisible to visible. Raising general awareness that there are people in the community with disability.
 - II. We know what their needs are, issues are, experiences they have.
 - III. We can address their needs (strategies and skills) Have the knowledge and skills to identify strategies and actions. Eg. developed communication skills/aids
 - IV. Action – played out in behaviour change, policy change, structure change
- What is the content?
 - Is the program based on a social or medical model?
- Who delivers the program?
 - A person with a disability or a non-disabled person?
 - What is the level of exposure to people with a disability throughout the program?
- Evaluation
 - What, if any, evaluation has been done?
 - When was the evaluation done?
 - How was the evaluation carried out?
 - What outcomes occurred?
 - What key things happened during this time that possibly led to this outcome?
 - Ingredients of success, what is believed to make the program successful?
 - What could be changed?

Appendix Two

Organisation Name: **Action on Disability in Ethnic Communities (ADEC)**
 Program Name: **Disability Awareness Training / Cultural Awareness Training**

Who is the target audience?	Smaller community groups, organisations, disability organisations.
How is the consumer referred to the program?	Through general local promotion of ADEC.
How many participants per session?	Maximum of 16
What is the length of the program?	A 3 hour, single session
What is the cost to the consumer?	If it is HAC training it is free. If it is ADEC calender training it costs \$30 per person. The support groups they also run are free.
Who funds the program?	ADEC
Social / medical model?	Social model
What is the program process / model?	One presenter talks about disability, raising general awareness about disability and the different types of disability. Also discusses the impact a disability has on the individual, their family and carers and how different cultures deal with these issues. They also hold support groups for family members and carers from different ethnicity groups to raise awareness about disability, how it affects families and what services are available.
Who delivers the program?	A representative of ADEC
What is the level of exposure to a person with a disability?	Occasionally a person with a disability may contribute to the presentation, but this is not a regular part of the program.
What is the intended aim of the program?	I and II. Refer to next page for details.
Has evaluation been done?	Yes.
When was the evaluation done?	Immediately after the program session.
How was the evaluation carried out?	A general questionnaire is filled out by the participants regarding how effective they thought the program was, if it can relate to their workplace etc.
What outcomes occurred?	There were small changes in the program content, including more discussion on cultural issues.
What could be changed?	They would like to have people with a disability help with the presentation, but feel this is not possible cost wise and do not have access to volunteers.

Organisation Name: **Cystic Fibrosis Victoria**

Program Name: **Awareness programs**

Who is the target audience?	People with CF and their families.
How is the consumer referred to the program?	Through knowledge of CFV.
How many participants per session?	Depends on group accessing the program.
What is the length of the program?	Depends on the needs of the consumer.
What is the cost to the consumer?	Most of the cost is covered by CFV, but there is a part charge to the consumer.
Who funds the program?	15% is government funded.
Social / medical model?	Mainly social, but some medical information is included.
What is the program process / model?	The presenter discusses what CF is and general issues around CF.
Who delivers the program?	Generally a person without CF.
What is the level of exposure to a person with a disability?	None.
What is the intended aim of the program?	II
Has evaluation been done?	Yes – to a degree
When was the evaluation done?	After the information sessions.
How was the evaluation carried out?	Through a written survey.
What outcomes occurred?	They received a very poor response from the written surveys, so no outcomes have occurred as a result of this evaluation.
What could be changed?	-

Organisation Name: **Diversity@Work**
 Program Name: **Disability Awareness**

Who is the target audience?	Mainly organisations - HR and management departments, employment services and some community groups.
How is the consumer referred to the program?	Consumer initiates contact.
How many participants per session?	For business organisations a maximum of 30 participants. For community groups a max. of 20 people.
What is the length of the program?	One-day programs are the standard, but can be delivered as a half-day program depending on the needs of the consumer.
What is the cost to the consumer?	\$302 for a full day public session. The fee depends on the organisation and if the organisation wants the program customised at all. Sometimes do programs for free for different community groups.
Who funds the program?	Has a range of funding sources, some which are continual and some that are not.
Social / medical model?	Social model.
What is the program process / model?	The presenter talks about a range of different disabilities and what issues people with disabilities may face. They used to conduct a leader/mentor program matching a person with a disability with an employer.
Who delivers the program?	A speaker from Diversity@Work .
What is the level of exposure to a person with a disability?	Some presenters have a disability, although it is not specific job requirement of Diversity@Work . It is up to the presenters whether or not they disclose what disability they have, if they do have one.
What is the intended aim of the program?	I and II
Has evaluation been done?	Yes
When was the evaluation done?	Immediately after the session.
How was the evaluation carried out?	Feedback / evaluation forms filled out by participants at the end of the session. The program also includes mini quizzes and role-plays throughout the session to judge the level of understanding of the content by the participants.

What outcomes occurred?	Always consider and act on relevant negative feedback. Ensure that there are constant reviews of the program, making sure that the content is relevant and that expectations are being met. For example they may start to look into the possibility of online training to ensure their programs are consistent with current trends.
What could be changed?	

Organisation Name: **Down Syndrome Association**

Program Name: **In-service programs**

Who is the target audience?	Schools, community groups, hospital staff, university students studying nursing or midwifery.
How is the consumer referred to the program?	Referral by families or their website. Have recently made contact with all maternity hospitals in Victoria. Word of mouth.
How many participants per session?	15 – 20 people. Can do smaller or larger groups too.
What is the length of the program?	Length depends on the number of people attending. Can be from ½ hour up to 2 hours.
What is the cost to the consumer?	A small charge for university presentations. Free to other groups.
Who funds the program?	The program is run by volunteers- they receive no funding.
Social / medical model?	Social with a small amount of medical information.
What is the program process / model?	The presenter talks about their experiences of having a child with down syndrome, the grieving process and positive aspects of having a child with down syndrome. They also discuss barriers their children face. They talk about appropriate language and how to be sensitive to families.
Who delivers the program?	A parent with a child with down syndrome.
What is the level of exposure to a person with a disability?	None.
What is the intended aim of the program?	I, II, III and IV. They teach nursing staff and students how to be more sensitive in addressing the needs of families and the appropriate language to use with the families.
Has evaluation been done?	Yes.
When was the evaluation done?	During or immediately after the session.
How was the evaluation carried out?	Feedback forms for each participant.
What outcomes occurred?	Small changes in presentation format.
What could be changed?	The association is currently looking at how to support people with DS to assist with the presentations. They are currently training people with DS in public speaking.

Organisation Name: **Student Well Being** (Department of Education and Training)

Program Name: **Ability and Disability Awareness**

Who is the target audience?	Mainly school groups – all ages. Community groups eg. football clubs.
How is the consumer referred to the program?	Schools are contacted by the program manager and also word of mouth.
How many participants per session?	Up to 100.
What is the length of the program?	Usually 1 hour, can be up to an all day session.
What is the cost to the consumer?	Free.
Who funds the program?	Department of Education and Training.
Social / medical model?	Social model, with a little medical information.
What is the program process / model?	Through a PowerPoint presentation and discussion by Jim, the presenter. Jim focuses on what he has achieved and how he manages his disability. Also discusses appropriate language to use with people with disabilities, issues people may face and demonstrates his sporting abilities.
Who delivers the program?	A person with a disability, Jim.
What is the level of exposure to a person with a disability?	Throughout the program. Jim conducts the majority of the presentation.
What is the intended aim of the program?	I, II and III.
Has evaluation been done?	Yes.
When was the evaluation done?	Throughout the program with question time and immediately after the presentation.
How was the evaluation carried out?	Through questions asked by the presenter and feedback forms.
What outcomes occurred?	Minor changes to presentation content.
What could be changed?	-

Organisation Name: **Rural Access – Latrobe City**

Program Name: **Disability Awareness Training**

Who is the target audience?	First and second year medical students.
How is the consumer referred to the program?	Through direct contact between Latrobe Rural Access and Monash medical school.
How many participants per session?	10 – 50 people.
What is the length of the program?	½ day for first year students. 2 hours for second year students.
What is the cost to the consumer?	Free of charge. Monash university covers expenses, eg. taxis.
Who funds the program?	Rural Access and Monash.
Social / medical model?	Mainly a social model, with minimal medical information.
What is the program process / model?	The program includes experiential workshops including general talks by the presenter and activities for the students. Discussions on what societal and environmental aspects can be improved within the health services.
Who delivers the program?	A person with a disability.
What is the level of exposure to a person with a disability?	Throughout the program.
What is the intended aim of the program?	I, II, III and IV.
Has evaluation been done?	Not through Latrobe rural access. Each year Monash sends out the results of an in-school evaluation survey.
When was the evaluation done?	-
How was the evaluation carried out?	-
What outcomes occurred?	The program was originally developed as a series of lectures, but through discussions with the students this format was changed to the current model of experiential workshops.
What could be changed?	-

Organisation Name: **Maribyrnong Metro Access / Western Region Disability Network.**
 Program Name: **Speakers Bank**

Who is the target audience?	Schools, community groups, anyone interested!
How is the consumer referred to the program?	Currently promoting the program through the speakers themselves, contacting schools and community groups eg. RSL, emailing through the email network and the Western Region Disability Network website.
How many participants per session?	Depends in the group accessing the speakers.
What is the length of the program?	About a 15 minute talk from the speakers, plus question time.
What is the cost to the consumer?	Free. There are different suggested donation amounts if the consumer wants.
Who funds the program?	Western Region Disability Network
Social / medical model?	Social model
What is the program process / model?	A person with a disability or a carer talks with the group about a certain topic of their choice or just generally about their life story and experiences.
Who delivers the program?	Person with a disability or carer.
What is the level of exposure to a person with a disability?	Continual throughout the program.
What is the intended aim of the program?	I and II
Has evaluation been done?	Evaluation has been done of the public speaking course the speakers all undertook, but no evaluation has been done of the program or its effectiveness or its impact on the audience. As yet unsure how to evaluate this.
When was the evaluation done?	-
How was the evaluation carried out?	-
What outcomes occurred?	-
What could be changed?	The program is quite new and has only just started so as yet no changes have been made.

Organisation Name: **Victorian Deaf Society**
 Program Name: **Deafness awareness training**

Who is the target audience?	Community groups, businesses, government agencies, employers and schools.
How is the consumer referred to the program?	Brochures, referrals from other deaf services, expos and website.
How many participants per session?	2-100 people
What is the length of the program?	1- 1½ hours
What is the cost to the consumer?	The consumer has to cover the cost of the interpreter. The Victorian Deaf Society covers the remaining costs.
Who funds the program?	Victorian Deaf Society, through government funding.
Social / medical model?	Mainly a social model, with a little medical information.
What is the program process / model?	The presenter talks about their experiences resulting from their disability. The presenter discusses how to communicate with deaf people, teaching some basic Auslan signs, they also discuss deaf culture and the deaf community, how to interact and work with deaf people and any issues or barriers deaf people may face.
Who delivers the program?	Run by a man who is deaf with an interpreter.
What is the level of exposure to a person with a disability?	Throughout the program.
What is the intended aim of the program?	I, II and III.
Has evaluation been done?	Yes.
When was the evaluation done?	Immediately after presentation. Also an annual review is conducted.
How was the evaluation carried out?	Through feedback forms.
What outcomes occurred?	No major changes have occurred as a result of the feedback forms.
What could be changed?	

Organisation Name: **Vision Australia**

Program Name: **Speakers Network**

Who is the target audience?	Clubs, schools, community groups, health professionals.
How is the consumer referred to the program?	Referral through other vision impairment services.
How many participants per session?	No minimum or maximum number of participant requirements.
What is the length of the program?	Depends on the number of participants. ½ hour – 2 hours.
What is the cost to the consumer?	Free
Who funds the program?	Vision Australia
Social / medical model?	Medical and social model.
What is the program process / model?	The presenter talks about available services and programs for people with vision impairments, costs of having a visual impairment, experience of people with a vision impairment. Also includes simulation activities.
Who delivers the program?	Can be a person with a vision impairment or welfare or therapy staff.
What is the level of exposure to a person with a disability?	Depends on who is conducting the presentation.
What is the intended aim of the program?	I and II
Has evaluation been done?	No.
When was the evaluation done?	-
How was the evaluation carried out?	-
What outcomes occurred?	-
What could be changed?	Vision Australia acknowledges that evaluation of the programs needs to be conducted.

Organisation Name: **Whitehorse Metro-Access**

Program Name: **Whitehorse Disability Awareness Project**

Who is the target audience?	Mainly school groups Grades 3-6 have been targeted. Also some community groups eg. scouts
How is the consumer referred to the program?	Broad promotion of the project in the local area. Promotion to all the schools in the area
How many participants per session?	50 – 100 students which can be divided into two separate groups.
What is the length of the program?	Five hour long workshops every two weeks, or throughout a school term. A condensed two day program was held with one year 9 class but this proved to be less effective than shorter workshops over a period of time.
What is the cost to the consumer?	Currently is free but are looking into fee for service to make the program more sustainable.
Who funds the program?	DHS, Whitehorse City Council, Brainlink and School Focus Youth Service.
Social / medical model?	Social, no actual medical info, although are looking at including some through partnerships with other organisations.
What is the program process / model?	A presenter with a disability talks to the group about their life, disability, experiences, achievements, use props (aids and equipment) student activities, question time. Consulted with Vic ed dep. so is VELS accredited. Developing a teachers workshop
Who delivers the program?	People with disability. Different presenters for each session with a range of disabilities.
What is the level of exposure to a person with a disability?	Throughout the program.
What is the intended aim of the program?	I, II, III and IV for behaviour change.
Has evaluation been done?	Yes
When was the evaluation done?	At the end of each session and throughout the development of the program
How was the evaluation carried out?	Evaluation / feedback forms. Conversations with teachers / schools and presenters. Booking of program in schools again a good indication of success.

What outcomes occurred?	Slight changes in program model or what is included in program. Eg. more activities or PowerPoint's added, making of a DVD for the introduction session. The current development of a teachers workshop for teachers before the project comes into the schools – tied into normal teachers meetings. Question time identified as most valuable part of project. People with a disability seen as being a more effective speaker than people without a disability. Program has also prompted schools to undertake other activities relating to disability eg. talks by other organisations or individuals regarding different disabilities. Incorporation of the awareness kit into the school curriculum is an action outcome.
What could be changed?	

Organisation Name: **Yooralla**

Program Name: **Community Education Program**

Who is the target audience?	School and community groups.
How is the consumer referred to the program?	Through general promotion of Yooralla and their services throughout the community. The consumer discusses with Yooralla what they are wanting to achieve from the program.
How many participants per session?	Depends on the consumer group.
What is the length of the program?	The length of the program is dependent on what the consumer states they need within the program.
What is the cost to the consumer?	Free
Who funds the program?	Yooralla
Social / medical model?	Social model
What is the program process / model?	The presenter raises general awareness of disabilities within the community. Education regarding the issues people with a disability face. Includes role playing and question time. The presenter talks about their life, both good and bad experiences, what challenges they have faced and how Yooralla has helped.
Who delivers the program?	A person with a disability.
What is the level of exposure to a person with a disability?	Throughout the program.
What is the intended aim of the program?	I and II
Has evaluation been done?	Yes
When was the evaluation done?	Immediately after the program session
How was the evaluation carried out?	Evaluation / feedback questionnaires
What outcomes occurred?	-
What could be changed?	-

Organisation Name: **Paraquad**

Program Name:

Who is the target audience?	Organisations such as Jetstar etc.
How is the consumer referred to the program?	
How many participants per session?	
What is the length of the program?	
What is the cost to the consumer?	
Who funds the program?	
Social / medical model?	
What is the program process / model?	Paraquad does training for companies regarding how to change services so that they are more accommodating for people with a disability. They no longer do specific awareness training because of the expense involved and the lack of knowledge regarding if formal awareness training actually changes behaviour.
Who delivers the program?	
What is the level of exposure to a person with a disability?	
What is the intended aim of the program?	
Has evaluation been done?	
When was the evaluation done?	
How was the evaluation carried out?	
What outcomes occurred?	
What could be changed?	



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